NEW YORK STATE BAR ASSOCIATION

ELDER LAW AND SPECIAL NEEDS SECTION

12.0 MCLE Credits

7.0 in Areas of Professional Practice
2.5 in Ethics
4.5 in Skills
1 in Diversity, Inclusion and Elimination of Bias.

Breakdown of credit hours per individual is dependent on choice of sessions that are attended.

Summer Meeting

Queen's Landing Hotel
Niagara-on-the-Lake
Ontario, CANADA

July 12 – 14, 2018

Section Chair

Judith D. Grimaldi, Esq.
Grimaldi & Yeung, LLP, Brooklyn

Program Co-Chairs

Beth Polner Abrahams,Esq.
Polner Abrahams Law Firm, Garden City

JulieAnn Calareso, Esq.
The Shevy Law Firm, LLC, Albany

New York State Bar Association

FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form—you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

Please turn in this form at the end of the program.

Elder Law and Special Needs Section Summer Meeting
Thursday, July 12, 2018, Niagara-on-the-Lake, Ontario, CANADA

Name:_____
(Please print)

I certify that I was present for the entire presentation of this program

Signature:_____Date:_____

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

New York State Bar Association

FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form—you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

Please turn in this form at the end of the program.

Elder Law and Special Needs Section Summer Meeting
Friday, July 13, 2018, Niagara-on-the-Lake, Ontario, CANADA

Name:_____
(Please print)

I certify that I was present for the entire presentation of this program

Signature:_____Date:_____

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

New York State Bar Association

FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form—you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

Please turn in this form at the end of the program.

Elder Law and Special Needs Section Summer Meeting
Saturday, July 14, 2018, Niagara-on-the-Lake, Ontario, CANADA

Name:_____
(Please print)

I certify that I was present for the entire presentation of this program

Signature:_____Date:_____

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

NEW YORK STATE BAR ASSOCIATION

Live Program Evaluation (Attending In Person)
Please complete the following program evaluation. We rely on your assessment to strengthen teaching methods and improve the programs we provide. The New York State Bar Association is committed to providing high quality continuing legal education courses and your feedback is important to us.

Program Name: Elder Law and Special Needs Law Section Summer Meeting

Program Code: ELDSU18

Program Location: Queen's Landing Hotel, Niagara-on-the-Lake, Ontario, CANADA

Program Date: July 12-14, 2018

1. What is your overall evaluation of this program? Please include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional Comments_____

_____

2. Please rate each Speaker's Presentation based on **CONTENT** and **ABILITY** and include any additional comments.

	CONTENT				ABILITY			
	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
PLEAT	☐	☐	☐	☐	☐	☐	☐	☐
RUSSO(Tax Planning Elder Practitioner)	☐	☐	☐	☐	☐	☐	☐	☐
GREENMAN	☐	☐	☐	☐	☐	☐	☐	☐
WEBER	☐	☐	☐	☐	☐	☐	☐	☐
BARNES	☐	☐	☐	☐	☐	☐	☐	☐
RUSSO (Understanding New Tax Laws)	☐	☐	☐	☐	☐	☐	☐	☐
ROBERT(New Take on Current Issues)	☐	☐	☐	☐	☐	☐	☐	☐
McGRATH	☐	☐	☐	☐	☐	☐	☐	☐
WEINBLATT	☐	☐	☐	☐	☐	☐	☐	☐
BURGER	☐	☐	☐	☐	☐	☐	☐	☐
ABRAHAMS	☐	☐	☐	☐	☐	☐	☐	☐
MEYERS	☐	☐	☐	☐	☐	☐	☐	☐
KRAUZA	☐	☐	☐	☐	☐	☐	☐	☐
SHIFFLETT	☐	☐	☐	☐	☐	☐	☐	☐
GREAR	☐	☐	☐	☐	☐	☐	☐	☐
KEWALRAMANI	☐	☐	☐	☐	☐	☐	☐	☐
BURNER	☐	☐	☐	☐	☐	☐	☐	☐
MARCHESE	☐	☐	☐	☐	☐	☐	☐	☐
MASCALI	☐	☐	☐	☐	☐	☐	☐	☐
ROBERT(Advanced Spec Needs Planning)	☐	☐	☐	☐	☐	☐	☐	☐
BOGART	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

(please turn over)

Additional comments (CONTENT)

_____

_____

Additional comments (ABILITY)

_____

_____

3. Please rate the program materials and include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional comments

_____

_____

4. Do you think any portions of the program should be **EXPANDED** or **SHORTENED**? Please include any additional comments.
☐ Yes – Expanded ☐ Yes – Shortened ☐ No – Fine as is

Additional comments

_____

_____

5. Please rate the following aspects of the program: **REGISTRATION**; **ORGANIZATION**; **ADMINISTRATION**; **MEETING SITE** (if applicable), and include any additional comments.

	Please rate the following:				
	Excellent	Good	Fair	Poor	N/A
Registration	☐	☐	☐	☐	☐
Organization	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐
Meeting Site (if applicable)	☐	☐	☐	☐	☐

Additional comments

_____

_____

6. How did you learn about this program?
☐ Ad in legal publication ☐ NYSBA web site ☐ Brochure or Postcard
☐ Social Media (Facebook / Google) ☐ Email ☐ Word of mouth

7. Please give us your suggestions for new programs or topics you would like to see offered

_____

_____

NEW YORK STATE BAR ASSOCIATION
One Elk Street, Albany, NY 12207
Phone: 518-463-3200 | Secure Fax: 518.463.5993
Return form to Lori Nicoll at lnicoll@nysba.org

Summer Meeting

Elder Law and Special Needs Section

July 12-14, 2018

Queen's Landing Resort
Niagara-on-the-Lake, Ontario, CANADA

Thank You! This program is made possible by the generous donation of time and expertise by members and volunteers. Thank you to our volunteers—and to you, for choosing NYSBA Programs.

This program is offered for educational purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials, including all materials that may have been updated since the books were printed or distributed electronically. Further, the statements made by the faculty during this program do not constitute legal advice.

ACCESSING THE ONLINE ELECTRONIC COURSE MATERIALS

All program materials will be distributed exclusively online in PDF format. It is strongly recommended that you save the course materials in advance in the event that you will be bringing a computer or tablet with you to the program.

Printing the complete materials is not required for attending the program.

To access the complete set of course materials, please insert the following link into your browser's address bar and click 'enter' **www.nysba.org/ELDERSUMMER18MATERIALS**

A NotePad (paper) will be provided to all attendees at the live program site. The NotePad includes lined pages for taking notes on each topic, as well as any PowerPoint presentations submitted prior to printing.

Please note:

- You must have Adobe Acrobat on your computer in order to view, save, and/or print the files. If you do not already have this software, you can download a free copy of Adobe Acrobat Reader at this link: http://get.adobe.com/reader/
- In the event that you are bringing a laptop, tablet or other mobile device with you to the program, please be sure that your batteries are fully charged in advance as additional electrical outlets may not be available at your program location.
- NYSBA cannot guarantee that free or paid WI-FI access will be available for your use at your program location.

ATTENDANCE VERIFICATION FOR NEW YORK MCLE CREDIT AND PROGRAM EVALUATION PROCESS

Attendance Verifications: In order to receive your New York MCLE credit, you are required to complete and return the Verification of Attendance form. If you are attending a multi-day program, you will receive a separate form on each day of the program.

- The form should be filled out and returned to the Registration Staff after the session has ended each day. Please be sure to turn in your form at the appropriate times – we cannot issue your New York MCLE credit without it. Your MCLE Certificate will be emailed to you a few weeks after the program.
- Please note: Partial credit for program segments not allowed. Under the New York State Continuing Legal Education Board Regulations and Guidelines, attendees at CLE programs cannot receive MCLE credit for a program segment unless they are present for the entire segment. Persons who arrive late, depart early, or are absent for any portion of the segment will not receive credit for that segment.

Evaluations: Program evaluations are processed online. After the program is over, you will receive an email from NYSBA with a link to the online evaluation form.

- To complete your registration process, click on the link in the email within the next 72 hours and fill out your confidential online program evaluation.

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Please be sure to fill out the online evaluation form after the program!

Thank you for choosing NYSBA programs.

MCLE INFORMATION

Program Title: Elder Law and Special Needs Section
Dates: July 12-14, 2018 Location:Queen's Landing Hotel, Niagara-on-the-Lake, Ontario, Canada

Total Credits: **12.0 New York CLE credit hours**

Credit Category:
7.0 Areas of Professional Practice
2.5 Ethics and Professionalism
4.5 Skills
1.0 Diversity, Inclusion and Elimination of Bias

This course is approved for credit for **both** experienced attorneys and newly admitted attorneys (admitted to the New York Bar for less than two years). Attorneys admitted 2 years or less are not eligible to receive credit in Diversity, Inclusion and Elimination of Bias category.

Attendance Verification for New York MCLE Credit

In order to receive MCLE credit, attendees must:

1) **Sign in** with registration staff
2) Complete and return a **Form for Verification of Presence** (included with course materials) at the end of the program or session. For multi-day programs, you will receive a separate form for each day of the program, to be returned each day.

Partial credit for program segments is not allowed. Under New York State Continuing Legal Education Regulations and Guidelines, credit shall be awarded only for attendance at an entire course or program, or for attendance at an entire session of a course or program. Persons who arrive late, depart early, or are absent for any portion of a segment will not receive credit for that segment. The Form for Verification of Presence certifies presence for the entire presentation. Any exceptions where full educational benefit of the presentation is not received should be indicated on the form and noted with registration personnel.

Program Evaluation

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Following the program, an email will be sent to registrants with a link to complete an online evaluation survey. The link is also provided above.

Additional Information and Policies

Recording of NYSBA seminars, meetings and events is not permitted.

Accredited Provider

The New York State Bar Association's **Section and Meeting Services Department** has been certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education courses and programs.

Credit Application Outside of New York State

Attorneys who wish to apply for credit outside of New York State should contact the governing body for MCLE in the respective jurisdiction.

MCLE Certificates

MCLE Certificates will be emailed to attendees a few weeks after the program, or mailed to those without an email address on file. **To update your contact information with NYSBA**, visit www.nysba.org/MyProfile, or contact the Member Resource Center at (800) 582-2452 or MRC@nysba.org.

Newly Admitted Attorneys—Permitted Formats

In accordance with New York CLE Board Regulations and Guidelines (section 2, part C), newly admitted attorneys (admitted to the New York Bar for less than two years) must complete **Skills** credit in the traditional live classroom setting or by fully interactive videoconference. **Ethics and Professionalism** credit may be completed in the traditional live classroom setting; by fully interactive videoconference; or by simultaneous transmission with synchronous interactivity, such as a live-streamed webcast that allows questions during the program. **Law Practice Management** and **Areas of Professional Practice** credit may be completed in any approved format.

Tuition Assistance

New York State Bar Association members and non-members may apply for a discount or scholarship to attend MCLE programs, based on financial hardship. This discount applies to the educational portion of the program only. Application details can be found at www.nysba.org/SectionCLEAssistance.

Questions

For questions, contact the NYSBA Section and Meeting Services Department at SectionCLE@nysba.org, or (800) 582-2452 (or (518) 463-3724 in the Albany area).

Table of Contents

Table of Contents Continued

Plenary Session:

General Elder Law and Special Needs Update

Presented By:
Tara Anne Pleat, Esq.

2018 Summer Meeting Update

July 12, 2018

Tara Anne Pleat

Wilcenski & Pleat PLLC

Contents

Federal Law Updates

ABLE To Work Act – HR 1896

ABLE Financial Planning Act – HR 1897

42 CFR 438.402 – Managed Care Appeals and Aid Continuing

Bipartisan Budget Act of 2018, Pub. L. No: 115-123 §53102(b)(1) – Ahlborn Allocations Reinstated

State Law Updates

Pub. Health Law §4403-f(7)(b)(vii) *added by* 2018 N.Y. Laws Ch. 57. – MLTC Lock In

Soc. Ser. Law. Section 366(5)(f)(1) – Pooled Trust Notice

Pub Health Law §4403-f(7)(b)(v)(13) *added by* 2018 N.Y. Laws Ch. 57. – Nursing Home Carve Out

12 NYCRR § 142-2.1(b) amended on 10/25/17, 1/24/18, 4/25/18

New York State Register, October 25, 2017, at 5, I.D. No. LAB-43-17-00002-E.

SSI POMS Updates

SI 01120.200 51 Information on Trusts, Including those established before January 1, 2000, Third party trusts, and trusts not subject to Section 1613(e) of the Social Security Act.

SI 01120.201 52 Trusts est. w/ assets of individual after 1/1/2000

SI 01120.203 53 Exceptions to Counting Trusts Established on or After 1/1/2000

SI 01120.202 54 Development and Documentation of trusts Established on or After 1/1/2000

New York Case Law Updates

Bonin v. Wells, Jaworski & Liebman, LLP, 2017 N.Y. Misc. LEXIS 3830, 2017 NY Slip Op 32097(U) (Sup. Ct. New York County 2017).

Jimenez v. Concepts of Independence, 2018 N.Y. Misc. LEXIS 544, *16-17, 2018 NY Slip Op 30257(U) (Sup. Ct. New York County 2018).

Matter of Wellner v Jablonka, 2018 N.Y. App. Div. LEXIS 2656, 2018 NY Slip Op 02701, (3d Dep't 2018).

Matter of Buttiglieri (Ferrel J.B.) 2018 NY App Div LEXIS 648, 2018 NY Slip Op 00738, (4th Dep't 2018)

Matter of Key Bank 58 Misc. 3d 235 *; 67 N.Y.S.3d 407; 2017 N.Y. Misc. LEXIS 3800; 2017 NY Slip Op 27321

Matter of ***Cronin***, NYLJ, Jan. 19, 2018 at 42

GIS/ADMs

GIS 18 MA/001 (1/11/2018)

GIs 18 MA/002 (2/23/2018)

GIS 18 MA/004 (3/19/18)

GIS 17 MA/016 (10/27/2017)

I

115TH CONGRESS
1ST SESSION

H. R. 1896

To amend the Internal Revenue Code of 1986 to allow individuals with disabilities to save additional amounts in their ABLE accounts above the current annual maximum contribution if they work and earn income.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2017

Mrs. MCMORRIS RODGERS (for herself, Mr. SESSIONS, Mr. CÁRDENAS, Mr. SMITH of New Jersey, and Mr. LANGEVIN) introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to allow individuals with disabilities to save additional amounts in their ABLE accounts above the current annual maximum contribution if they work and earn income.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "ABLE to Work Act of 2017".

SEC. 2. INCREASED CONTRIBUTIONS TO ABLE ACCOUNTS FROM COMPENSATION OF INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 529A(b)(2)(B) of the Internal Revenue Code of 1986 is amended to read as follows:

"(B) except in the case of contributions under subsection (c)(1)(C), if such contribution to an ABLE account would result in aggregate contributions from all contributors to the ABLE account for the taxable year exceeding the sum of—

"(i) the amount in effect under section 2503(b) for the calendar year in which the taxable year begins, plus

"(ii) in the case of a designated beneficiary described in paragraph (7), the lesser of—

"(I) compensation (as defined by section 219(f)(1)) includible in the designated beneficiary's gross income for the taxable year, or

"(II) an amount equal to the poverty line for a one-person household, as determined for the calendar

year preceding the calendar year in which the taxable year begins.".

(b) ELIGIBLE DESIGNATED BENEFICIARY.—Section 529A(b) of such Code is amended by adding at the end the following:

"(7) SPECIAL RULES RELATED TO CONTRIBUTION LIMIT.—For purposes of paragraph (2)(B)—

"(A) DESIGNATED BENEFICIARY.—A designated beneficiary described in this paragraph is an employee (including an employee within the meaning of section 401(c)) with respect to whom—

"(i) no contribution is made for the taxable year to a defined contribution plan (within the meaning of section 414(i)) with respect to which the requirements of section 401(a) or 403(a) are met,

"(ii) no contribution is made for the taxable year to an annuity contract described in section 403(b), and

"(iii) no contribution is made for the taxable year to an eligible deferred compensation plan described in section 457(b).

"(B) POVERTY LINE.—The term 'poverty line' has the meaning given such term by sec-

tion 673 of the Community Services Block Grant Act (42 U.S.C. 9902).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 3. ALLOWANCE OF SAVER'S CREDIT FOR ABLE CONTRIBUTIONS BY ACCOUNT HOLDER.

(a) IN GENERAL.—Section 25B(d)(1) of the Internal Revenue Code of 1986 is amended by striking "and" at the end of subparagraph (B)(ii), by striking the period at the end of subparagraph (C) and inserting ", and", and by inserting at the end the following:

"(D) the amount of contributions by such individual to the ABLE account (within the meaning of section 529A) of which such individual is the designated beneficiary.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

○

I

115TH CONGRESS
1ST SESSION

H. R. 1897

To amend the Internal Revenue Code of 1986 to allow rollovers from 529 programs to ABLE accounts.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2017

Mrs. MCMORRIS RODGERS (for herself, Mr. SESSIONS, Mr. CÁRDENAS, Mr. SMITH of New Jersey, and Mr. LANGEVIN) introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to allow rollovers from 529 programs to ABLE accounts.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "ABLE Financial Planning Act".

SEC. 2. ROLLOVERS TO ABLE PROGRAMS FROM 529 PROGRAMS.

(a) IN GENERAL.—Clause (i) of section 529(c)(3)(C) of the Internal Revenue Code of 1986 is amended by striking "or" at the end of subclause (I), by striking the period

at the end of subclause (II) and inserting ", or", and by adding at the end the following:

"(III) to an ABLE account (as defined in section 529A(e)(6)) of the designated beneficiary or a member of the family of the designated beneficiary.

Subclause (III) shall not apply to so much of a distribution which, when added to all other contributions made to the ABLE account for the taxable year, exceeds the limitation under section 529A(b)(2)(B).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after the date of the enactment of this Act.

○

Social Security

POMS Recent Change

Identification Number:	**SI 01120 TN 51**
Intended Audience:	See Transmittal Sheet
Originating Office:	ORDP OISP
Title:	**Identifying Resources**
Type:	POMS Transmittals
Program:	**Title XVI (SSI)**
Link To Reference:	

PROGRAM OPERATIONS MANUAL SYSTEM
Part 05 - Supplemental Security Income
Chapter 011 - Resources
Subchapter 20 - Identifying Resources
Transmittal No. 51, 04/2017

Audience

FO/TSC: CS, CS TXVI, DRT, FR, OA, OS, RR, CSR, TA, CTE, TSC-CSR

Originating Component

OISP

Effective Date

April 30, 2018

Background

This transmittal provides instructions on how to determine and document the resource status of third-party trusts or trusts established prior to January 01, 2000 for Supplemental Security Income (SSI) eligibility purposes. It also incorporates the "Regional Centralization of SSI Trust Reviews" review process described in SI 01120.202, Development and Documentation of Trusts Established on or after January 01, 2000. As part of the trust review process, the Regional Trust Review Team (RTRT) reviews all trust resource determinations for trusts not previously evaluated or amended trusts before adjudication of any initial claim or posteligibility event.

Summary of Changes

SI 01120.200 Information on Trusts, Including Trusts Established Prior to January 01, 2000, Trusts Established with the Assets of Third Parties, and Trusts Not Subject to Section

1613(e) of the Social Security Act

We updated section headings, revised passive voice statements, and revised cross reference format throughout the instructions to meet POMS transmittal guidelines.
Additionally, we made the following changes:

- **Subsection A,** added Indian Gaming Regulatory Act (IGRA) trusts under trusts that contain assets of third parties;
- **Subsection B,** added definitions for IGRA, pooled and special needs trusts;
- **Subsection G,** clarified the following:
  1. SSI payments are non-assignable by law and SSI payments do not count as income for SSI purposes.
  2. We consider assignment of payments by court orders to be irrevocable.
- **Subsection L,** added instructions for Claims Specialists, trust reviewers, and regional trust leads related to the trust review process; and
- **Subsection N,** reorganized relevant references.

SI 01120.200 Information on Trusts, Including Trusts Established Prior to January 01, 2000, Trusts Established with the Assets of Third Parties, and Trusts Not Subject to Section 1613(e) of the Social Security Act

A. Introduction To Trusts

A trust is a legal arrangement involving property and ownership interests. Property held in trust may or may not be considered a resource for SSI purposes. The general rules concerning resources apply when evaluating the resource status of property held in trust.

1. Applicability of policy instructions

Generally, these instructions apply to trusts not subject to the trust provisions in Section 1613(e) of the Social Security Act, which we evaluate using instructions in SI 01120.201 through SI 01120.204. However, trusts that meet the requirements of SI 01120.203 must also meet the requirements of this section. Use these instructions to evaluate the following types of trusts:

a. Trusts established prior to January 01, 2000 that contain assets of the individual

This includes trusts established before January 01, 2000 that contain assets of the individual, any of which were transferred before January 01, 2000.

If the trust was established prior to January 01, 2000, but no assets of the individual were transferred to the trust prior to January 01, 2000, see SI 01120.201.

b. Trusts that contain assets of third parties

This includes trusts that are:

- established before January 01, 2000 that contain assets of third parties;
- established on or after January 01, 2000 that contain only assets of third parties, or the portion of a commingled trust attributable to assets of third parties; and
- Indian Gaming Regulatory Act (IGRA) trusts established by the Indian tribes that meet the criteria in SI 01120.195F.

NOTE: Trusts established on or after January 01, 2000 that contain assets of a Supplemental Security Income (SSI) applicant, recipient, or spouse (or the portion of a commingled trust attributable to assets of an SSI applicant, recipient, or spouse) must be evaluated under SI 01120.201 through SI 01120.204.

c. Other trusts not subject to Section 1613(e) of the Social Security Act

Trusts established on or after January 01, 2000 to which the instructions in SI 01120.201 through SI 01120.204 do not apply. When it is determined that a special needs trust or a pooled trust exception is met, the trust must still be evaluated under the rules of SI 01120.200.

NOTE: The instructions in those sections generally will refer you back to this section, where applicable.

2. Case processing alert

Trusts are often complex legal arrangements involving State law, Tribal law, and legal principles whose evaluation may require input from agency counsel. Therefore, these instructions may only be sufficient for you to recognize that an issue is present that needs referral to your regional office (RO) for possible referral to the Regional Chief Counsel (RCC). When in doubt, submit your question or issue via vHelp.

B. Glossary Of Terms

This glossary is intended for general reference and does not override or replace applicable State law with respect to matters such as establishment, operation, and termination.

1. Discretionary trust

A **discretionary trust** is a trust in which the trustee has full discretion as to the time, purpose, and amount of all distributions. The trustee may pay all or none of the trust as he or she considers appropriate to, or for the benefit of, the trust beneficiary. The trust beneficiary has no control over the trust.

2. Fiduciary duty

A **fiduciary duty** is the obligation of the trustee in dealing with the trust property and income. The trustee holds the property, with due care, solely for the benefit of the trust beneficiary. The trustee owes duties of good faith and loyalty to exercise reasonable care and skill, to preserve the trust property and make it productive, and to account for it. A trustee is a fiduciary but generally is not an agent of the trust beneficiary.

3. Grantor (settlor or trustor)

A **grantor (sometimes** also called a **settlor** or **trustor**) is the person who provides property to the trust principal (or corpus). The grantor must be the owner of, or have legal right to the property, or be otherwise qualified to transfer the property into the trust. A person may be a grantor even if an agent or another person, legally empowered to act on the first person's behalf (a legal guardian, representative payee for Title II or XVI benefits, person acting under a power of attorney, or conservator), establishes the trust with funds or property that belong to the first person. The person funding the trust is the grantor, even in situations where the trust agreement refers to a person legally empowered to act on the first person's behalf as the grantor. Where more than one person provides property to the trust, there may be multiple grantors. The terms grantor, trustor, and settlor are sometimes interchangeable.

4. Grantor trust (first-party or self-funded trust)

A **grantor trust** (also called a **first-party trust** or **self-funded trust**)is a trust in which the grantor of the trust is also the sole beneficiary of the trust. For information on who may be a grantor, see SI 01120.200B.3. in this section. State law on grantor trusts varies. Consult with your regional office, if necessary.

5. Indian Gaming Regulatory Act (IGRA) trust

An **IGRA trust** is a trust that an Indian tribe establishes under IGRA, regulations promulgated by the BIA, and the tribe's BIA-approved revenue allocation plan. The tribe establishes the trust to receive and invest per capita payments for its members, some of whom are minors or legally incompetent adults, pending distribution of the trust assets to those members after they attain the age of majority or cease to be legally incompetent.

6. Inter vivos trust (living trust)

An **inter vivos trust** (also called a **living trust**) is a trust established during the lifetime of the grantor.

7. Mandatory trust

A **mandatory trust** is a trust that requires the trustee to pay trust earnings or principal to or for the benefit of the trust beneficiary at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings, or it may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or party receiving distribution.

8. Medicaid trust or Medicaid qualifying trust

For definitions of a **Medicaid trust** or **Medicaid qualifying trust**, see SI 01730.048. For additional guidance on these trusts, see SI 01120.200H. For SSI treatment of Medicaid trust exceptions, see SI 01120.203.

9. Pooled trust

A **pooled trust** is a trust that is established and managed by an organization and that contains and pools the assets of multiple individuals in separate accounts for investment and management purposes. This section contains information on reviewing third party pooled trusts. For information on pooled trusts in which the individual account is funded with the beneficiary's own assets, see SI 01120.203.

10. Residual beneficiary (contingent beneficiary or remainderman)

A **residual beneficiary** (also called a **contingent beneficiary** or **remainderman**) is not a current beneficiary of a trust, but he or she will receive the residual benefit of the trust contingent upon the occurrence of a specific event, such as the death of the primary beneficiary.

11. Revoke

The grantor of a trust may have the power or authority to **revoke** (reclaim or take back) the assets deposited in the trust. If the individual at issue (an applicant, recipient, or deemor) is the grantor of the trust, the trust is usually a resource to that individual if he or she can revoke the trust and reclaim the trust assets. For the definition of a deemor, see SI 01310.127.

However, if a third party is the grantor of the trust, and the individual at issue (an applicant, recipient, or deemor) is the beneficiary of the trust, the trust is not a resource to the beneficiary merely because the trust is revocable by the grantor. In a third party trust situation, the focus should

be on whether the individual at issue (applicant, recipient, or deemor) can terminate the trust and obtain the assets for himself or herself.

12. Special or supplemental needs trust

A **special needs trust**, also known as a **supplemental needs trust**, may be set up to provide for a disabled individual's extra and supplemental needs other than food, shelter, and health care expenses that may be covered by public assistance benefits that the trust beneficiary may be eligible to receive under various programs. For more information on special needs trusts containing the assets of the individual, see SI 01120.203.

13. Spendthrift clause or spendthrift trust

A **spendthrift clause** or **spendthrift trust** generally prohibits both involuntary and voluntary transfers of the trust beneficiary's interest in the trust income or principal. This means that the trust beneficiary's creditors must wait until the trust pays out money to the trust beneficiary before they can attempt to claim it to satisfy debts.

It also means that, for example, if the trust beneficiary is entitled to $100 a month from the trust, the beneficiary cannot sell his or her right to receive the monthly payments to a third party for a lump sum. In other words, a valid spendthrift clause would make the value of the trust beneficiary's right to receive payments not countable as a resource.

However, not all States recognize spendthrift trusts, and States that do recognize spendthrift trusts often do not allow a grantor to establish a spendthrift trust for the grantor's own benefit. In those States that do not recognize spendthrift trusts (whether at all or because the trust is a grantor trust), we would count the value of the trust beneficiary's right to receive monthly payments as a resource because it may be sold for a lump sum.

We do not require trusts to include a spendthrift clause. If the trust provides for mandatory periodic payments to the beneficiary, then the trust may need a spendthrift clause for the trust not to count as a resource.

14. Terminate

In some instances, a trustee or beneficiary of a third party trust can **terminate** (or end) a trust and obtain the assets for himself or herself. For more information on Termination as it relates to self-settled trusts, see SI 01120.201B.6.

15. Testamentary trust

A **testamentary trust** is a trust that is established under the terms of a will and that is effective only upon the death of the individual who created the will (the testator). Sometimes third party inter vivos trusts (trusts created during the lifetime of the grantor) serve as wills. A trust into which

property is transferred under the terms of a will, and during the life (inter vivos) of the testator, is not a testamentary trust for the purposes of this section because it is not effective only upon the testator's death, even if the will transfers additional property into the trust upon the testator's death. When evaluating testamentary trusts, field offices should obtain and review a copy of the last will and testament.

16. Third-party trust

A **third-party trust** is a trust established with the assets of someone other than the trust beneficiary (or his or her spouse). For example, a grandparent can establish a third party trust using his or her assets, with a grandchild as the trust beneficiary. Be alert for situations where a trust is allegedly established with the assets of a third party but in reality is created with the trust beneficiary's property. In such cases, the trust is a grantor trust, not a third party trust.

17. Totten trust (bank account trust)

A **Totten trust** (also called a **bank account trust**) is a tentative trust in which a grantor makes himself or herself trustee of his or her own funds for the benefit of another. Typically, the grantor deposits funds in a savings account and indicates, either by the account titling or by filing a writing with the bank, that the grantor is trustee of the account for another person. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the principal passes to the trust beneficiary. Totten trusts are valid in most jurisdictions, but other jurisdictions have held them invalid because they are too tentative. In particular, they generally lack formal requirements and do not state a trust intent or purpose.

18. Trust

A **trust** is a property interest held by an individual or entity (such as a bank), called the trustee, who or which is subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).

19. Trust beneficiary

A **trust beneficiary** is a person for whose benefit a trust exists. A trust beneficiary does not hold legal title to trust property but has an equitable ownership interest in it. As an equitable owner, the trust beneficiary has certain rights that a court can enforce, because the trust exists for his or her benefit. The beneficiary receives the benefits of the trust, while the trustee holds the title and duties. A beneficiary has certain rights relative to the trust, such as to enforce mandatory provisions of the trust, to demand an accounting, and to sue to remove the trustee. The trustee owes certain duties, such as loyalty and attention, to the beneficiary.

20. Trust earnings (income)

Trust earnings (also called **trust income**) are amounts earned by the trust principal. They may take such forms as interest, dividends, royalties, and rents. These amounts are unearned income to any person legally able to use them for personal support and maintenance. If the trust beneficiary has no right to receive or demand the earnings, trust income is not countable to him or her.

21. Trust principal (corpus)

The **trust principal** (also called the **corpus** of the trust) is the property placed in the trust, which the trustee holds subject to the rights of the beneficiary. It includes any earnings on the trust.

22. Trustee

A **trustee** is a person or entity that holds legal title to property in trust for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for the trustee's own benefit. The trustee owes a fiduciary duty to the beneficiary.

C. Policy For Accounts That May Or May Not Be Trusts

1. Accounts that are not trusts

Although titled as trusts, some types of accounts and "trust-like" instruments are not trusts, and generally we should not evaluate them under these instructions for SSI purposes.

a. Conservatorship accounts

A conservatorship account generally is established by a court and administered by a court-appointed conservator for the benefit of an individual. A conservatorship account differs from a trust in that the "beneficiary" of the conservatorship account retains legal ownership of all of the account assets, although in some cases the assets may not be available for support and maintenance. For instructions pertaining to conservatorship accounts, see SI 01140.215.

b. Patient trust accounts

Many nursing homes, institutions, and government social services agencies maintain so-called "patient trust accounts" for individuals to provide them with toiletries, candy, and sundries. Although titled as trust accounts, they are not. For example, the individual might legally own the money in the account, while a social services agency holds the money for the individual and disburses it as necessary for the individual's benefit. For more information on transactions involving agents, see:

- GN 00603.020 Collective Savings and Checking Accounts
- SI 00810.120 Income Determinations Involving Agents
- SI 01120.020 Transactions Involving Agents

c. Achieving a Better Life Experience (ABLE) accounts

An ABLE account is a type of tax-advantaged account that an eligible individual can use to save funds for his or her disability-related expenses. The eligible individual, who is also the designated beneficiary of the ABLE account, must be blind or disabled by a condition that began before the individual's 26th birthday. A State (or a State agency or an instrumentality of a State) can establish an ABLE program. An eligible individual can open an ABLE account through the ABLE program in any State, if the State permits it. ABLE accounts are not trusts, and you should not evaluate them under trust instructions. For more information on ABLE accounts, see SI 01130.740.

2. "In trust for" financial accounts

These accounts may or may not be trusts depending on the circumstances in the individual case. Representative payee accounts and Totten accounts are the most common examples.

a. Representative payee accounts

One of the most common types of "in trust for" accounts is the representative payee account. A representative payee account is not a trust. However, its title may misleadingly suggest that the representative payee is the legal owner of the account principal. If a representative payee deposits current or conserved benefits in an account, the titling of the account should reflect the beneficiary's ownership interest in the account. For instructions pertaining to transactions or determinations involving agents, see SI 01120.020 and SI 00810.120. For instructions pertaining to the titling of accounts established by representative payees, see GN 00603.010.

b. Totten trusts

A **Totten trust** is a revocable trust created by the depositing of money, usually in a savings account at a bank, in the depositor's name as trustee for another. (It may have the phrase "in trust for" in the title.) The typical Totten trust is a kind of "pay on death" account. That is, the depositor names a beneficiary who inherits the funds in the account upon the depositor's death.

D. Policy For Trusts As Resources

1. Trusts that are resources

a. When trusts are resources

Trust principal is a resource for SSI purposes if a trust beneficiary (applicant, recipient, or deemor) has legal authority to revoke or terminate the trust and then use the funds to meet his or her food or shelter needs. The trust principal is also a resource for SSI purposes if the trust beneficiary can direct the use of the trust principal for his or her support and maintenance under the terms of the trust. For the definition of revoke, see SI 01120.200.B.11. in this section.

Additionally, if the trust beneficiary can sell his or her beneficial interest in the trust, that interest is a resource. For example, if the trust provides for payment of $100 per month to the trust beneficiary for spending money, and the trust does not have a valid spendthrift clause, then the trust beneficiary may be able to sell the right to future payments for a lump-sum settlement. The present value of the future payments counts as a resource. For more information on spendthrift clauses, see SI 01120.200B.13. in this section.

b. Authority to revoke or terminate trust or use assets

1. **Grantor**

   In some cases, the grantor has the authority to revoke a trust. Even if the grantor does not specifically retain the power to revoke a trust, a trust may be revocable in certain situations. For information on grantor trusts, see SI 01120.200B.4. and SI 01120.200D.3. in this section.

   Additionally, State law may contain presumptions as to the revocability of trusts. If the trust principal reverts to the grantor upon revocation and he or she can use it for support and maintenance, then the principal **is** a resource to the grantor.

   Additionally, State law may contain presumptions as to the revocability of trusts. If the trust principal reverts to the grantor upon revocation and he or she can use it for support and maintenance, then the principal is a resource to the grantor.

2. **Trust beneficiary**

   A trust beneficiary generally does not have the power to terminate a trust. However, in some instances, the trust beneficiary may have the authority to terminate the trust and gain access to the trust assets or direct the use of the trust principal. Specific trust provisions may allow the trust beneficiary to act on his or her own or to order actions by the trustee. The trust beneficiary's ability to use the trust principal for support and maintenance, together with his or her equitable ownership in the trust principal, makes the trust principal a resource to the trust beneficiary.

   The trust beneficiary's right to mandatory periodic payments may be a resource equal to the present value of the anticipated payments, unless a valid spendthrift clause or other provision prohibits transfer or sale of the beneficiary's interest in such anticipated payments. For more information on spendthrift clauses, see SI 01120.200B.13. in this section.

   While a trustee may have discretion to use the trust principal for the benefit of the trust beneficiary, the trustee is a third party and not an agent of the trust beneficiary. The actions of the trustee generally are not considered to be the actions of the trust beneficiary, unless the trust specifically states otherwise.

3. **Trustee**

   Occasionally, a trustee may have the legal authority to terminate a trust. However, the trust generally is not a resource to the trustee unless he or she becomes the owner of the trust principal upon termination. The trustee is a third party. Although the trustee has access to the

trust principal for the benefit of the trust beneficiary, this does not mean that the trust principal is the trustee's resource. If the trustee has the legal authority to withdraw the trust principal and use it for his or her own support and maintenance, the amount of the trust principal that he or she can withdraw and use is the trustee's resource for SSI purposes.

NOTE: We are not responsible for developing or reporting claims or allegations of trustee misuse of trust funds. We will get involved only if the individual or entity allegedly misusing the funds is also the representative payee. For misuse of SSI funds, see GN 00604.001.

4. **Totten trust**

   The grantor of a Totten trust has the authority to revoke the financial account trust at any time. Therefore, the funds in the account are his or her resource

2. Trusts that are not resources

If an individual does not have the legal authority to revoke or terminate the trust or to direct the use of the trust assets for his or her own support and maintenance, the trust principal **is not** the individual's resource for SSI purposes.

The revocability of a trust and the ability to direct the use of the trust principal depend on the terms of the trust agreement and on State (or Tribal) law. If a trust is irrevocable by its terms and under State law, and the trust beneficiary cannot control or direct use of the trust assets for the trust beneficiary's support and maintenance, the trust **is not** a resource.

3. Revocability of grantor trusts

Some States follow the general principle of trust law that if a grantor is also the sole beneficiary of a trust, the trust is **revocable** regardless of language in the trust to the contrary.

However, many of these States recognize that the grantor cannot unilaterally revoke the trust if the trust document names a "residual beneficiary" who would receive the trust principal upon the grantor's death or the occurrence of some other specific event.

When a grantor names heirs, next of kin, or similar individuals to receive the assets remaining in the trust upon the grantor's death, assume that they are residual beneficiaries, absent regional instructions to the contrary. In such a case, the trust generally is irrevocable, subject to the NOTE.

When a trust is established for a beneficiary who is a minor, or if a court has ordered the establishment of a trust for an incompetent beneficiary, assume absent regional instructions and subject to the NOTE, that it is acceptable for "the estate of the beneficiary" to be named as the residual beneficiary without causing the trust to be considered revocable.

A trust may state that it is a "Grantor Trust" for tax purposes. Such a designation does not necessarily mean that it is a countable resource for SSI purposes. You must still develop the trust under these instructions to determine resource status for SSI eligibility purposes.

NOTE: The policies regarding grantor trusts may or may not apply in your particular State. Field offices should consult regional Program Operations Manual System (POMS) instructions or your regional office program staff if in doubt.

E. Policy For Disbursements From Trusts

1. Trust principal is not a resource

If the trust principal is not a resource, disbursements from the trust may be income to the SSI applicant or recipient, depending on the nature of the disbursements. Regular rules to determine when income is available apply. For general income rules, see SI 00810.005.

a. Disbursements that are income

Cash paid directly from the trust to the individual is unearned income.

Disbursements from the trust to third parties that result in the trust beneficiary's receiving non-cash items (other than food or shelter) are in-kind income if the items would not be partially or totally excluded non-liquid resources if retained into the month after the month of receipt.

For example, if a trust buys a car for the trust beneficiary and the trust beneficiary's spouse already has an excluded car for SSI purposes, the disbursement to purchase the second car is income in the month of receipt since it would not be an excluded resource in the following month.

For receipt of certain noncash items, see SI 00815.550. For a list of resource exclusions, see SI 01110.210.

b. Disbursements that result in receipt of in-kind support and maintenance

Food or shelter received by the trust beneficiary as a result of disbursements from the trust to a third party is income in the form of in-kind support and maintenance (ISM) and is valued under the presumed maximum value (PMV) rule. For instructions pertaining to the PMV rule, see SI 00835.300. For rules pertaining to a home, see SI 01120.200F. in this section.

c. Disbursements that are not income

Generally, disbursements from the trust to a third party are not income to the trust beneficiary, unless otherwise stated in SI 01120.200E.1.a. and SI 01120.200E.1.b. in this section. Disbursements that do not count as income may include those made for educational expenses, therapy, transportation, professional fees, medical services not covered by Medicaid, phone bills, recreation, and entertainment. This list is illustrative and does not limit the types of distributions that a trust may permit. For bills paid by a third party, see SI 00815.400.

Disbursements made from the trust to a third party that result in the trust beneficiary's receiving non-cash items (other than food or shelter) are not income if those items would become a totally or partially excluded non-liquid resource if retained into the month after the month of receipt. For

example, if a trust purchases a computer for the trust beneficiary, the computer is not income, since we would exclude the computer from resources as a household good in the following month. For resource treatment of household goods, personal effects, and other personal property, see SI 01130.430. For receipt of certain non-cash items, see SI 00815.550. For a list of resource exclusions, see SI 01110.210.

d. Reimbursements to a third party

Reimbursements made from the trust to a third party for funds expended on behalf of the trust beneficiary are not income.

Regular income and resource rules apply to items that a trust beneficiary receives from a third party. If a trust beneficiary receives a non-cash item (other than food or shelter), it is in-kind income if the item would not be a partially or totally excluded non-liquid resource if retained into the month after the month of receipt. If a trust beneficiary receives food or shelter, it is income in the form of ISM.

2. Trust principal is a resource

a. Disbursements to or for the benefit of the trust beneficiary

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual or that result in receipt of something by the individual are not income but conversion of a resource. However, trust earnings may be income. For instructions pertaining to the conversion of resources from one form to another, see SI 01110.100. For treatment of income when the trust principal is a resource, see SI 01120.200G.2. in this section. For treatment of dividends and interest as income, see SI 00830.500.

b. Disbursements not to or for the benefit of the trust beneficiary

If the trust is established with the assets of an individual or his or her spouse and the trust (or portion of the trust) is a resource to the individual:

- any disbursement from the trust (or from the portion of the trust that is a resource) that is not made to, or for the benefit of, the individual is considered a transfer of resources as of the date of the payment and is not considered income to the individual (see SI 01150.110); and
- any foreclosure of payment (an instance in which no disbursement can be made to the individual under any circumstances) is considered to be a transfer of resources as of the date of the foreclosure. Such foreclosure is not considered income to the individual.

F. Policy For Home Ownership And Purchase Of A Home By A Trust

1. Home as a resource

If the trust is a resource to the individual, the property at issue is subject to exclusion as a home under SI 01130.100. Even though the trust holds legal title to the property, the individual, as trust beneficiary, still has an (equitable) ownership interest in it. Therefore, the property's possibly being excluded as a home under SI 01130.100 likely will depend on whether the property serves as the individual's principal place of residence.

If the trust is not a resource to the individual, then the property also is not a resource to the individual, regardless of whether the property serves as the individual's principal place of residence (that is, regardless of possible exclusion as a home under SI 01130.100), because the property is part of the trust principal that is not a resource to the individual.

2. Rent-free shelter

An eligible individual does not receive ISM in the form of rent-free shelter while living in a home in which he or she has an ownership interest. Accordingly, an individual with an "equitable ownership interest in the trust principal" does not receive rent-free shelter (see SI 01120.200F.1. in this section).

3. Receipt of income from a home purchase

Because the purchase of a home by a trust for the trust beneficiary establishes an equitable ownership interest for the trust beneficiary, the purchase results in the receipt of ISM, in the form of shelter, in the month of purchase. This ISM is valued at no more than the presumed maximum value (PMV). For ISM to one person, see SI 00835.400.

Even if the trust beneficiary has an ownership interest in the home that he or she resides in, and is not receiving ISM in the form of rent-free shelter (because shelter is rent-free when no household member has any ownership interest in, or rental liability for, the residence, see SI 00835.370B.1.). The purchase of the home or payment of the monthly mortgage by the trust is a disbursement from the trust to a third party that results in the receipt of ISM in the form of shelter (see SI 01120.200E.1.b. in this section).

a. Outright purchase of a home

If the trust, whose principal is not a resource, purchases the home outright and the trust beneficiary lives in the home in the month of purchase, the home is income in the form of ISM, and reduces the trust beneficiary's payment no more than the PMV **in the month of purchase only,** regardless of the value of the home (see SI 01120.200E.1.b. in this section).

b. Purchase by mortgage or similar agreement

If the trust, whose principal is not a resource, purchases the home with a mortgage and the trust beneficiary lives in the home in the month of purchase, the home would be ISM in the month of purchase. Each of the subsequent monthly mortgage payments results in the receipt of income in

the form of ISM to the trust beneficiary living in the house, each valued at no more than the PMV (see SI 01120.200E.1.b. in this section).

c. Additional household expenses

If the trust pays for other shelter or household operating expenses, these payments are income in the form of ISM in the month of the trust beneficiary's use. For computations of ISM from outside the household, see SI 00835.350. For countable shelter expenses, see SI 00835.465D.

If the trust pays for repairs, maintenance, improvements, or renovations to the home, such as renovations to the bathroom to make it handicapped accessible, installation of a wheelchair ramp or assistive devices, or replacement of a roof, the trust beneficiary does not receive income. Disbursements from the trust for improvements increase the value of the resource and, unlike household operating expenses, do not provide ISM. For computations of ISM from outside the household, see SI 01120.200E.1.c. in this section.

G. Policy For Earnings And Additions To Trusts

1. Trust principal is not a resource

a. Trust earnings

Trust earnings are not income to the trustee or grantor **unless** designated as belonging to the trustee or grantor under the terms of the trust; for example, as fees payable to the trustee or interest payable to the grantor.

Trust earnings are not income to the SSI applicant or recipient who is a trust beneficiary **unless** the trust directs, or the trustee makes, payments from the trust to the trust beneficiary.

b. Additions to principal

Additions to trust principal made directly to the trust are not income to the grantor, trustee, or trust beneficiary. For exceptions to this rule, see SI 01120.200G.1.c. and SI 01120.200G.1.d. in this section.

c. Payments not assignable by law

Certain payments are non-assignable by law; therefore, are income to the individual entitled or eligible to receive the payments under regular SSI income rules, unless an exclusion applies. Although a trust may be structured such that it appears that non-assignable payments are made directly into the trust, non-assignable payments may not be made directly into a trust, to avoid income counting or for any other reason.

Important examples of non-assignable payments include:

- Temporary Assistance to Needy Families (TANF)/Aid to Families with Dependent Children (AFDC);

- Railroad Retirement Board-administered pensions;
- Veterans' pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security Title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) 29 U.S.C.A., Section 1056(d)).

d. Assignment of income

A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, **unless** the assignment is irrevocable. We consider assignment of payment by court orders to be irrevocable. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income. Also, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable. For more information on SPB annuities, see SI 01120.201J.1.e.

If the assignment is revocable, the payment is income to the individual legally entitled or eligible to receive it, unless an SSI income exclusion applies. For **non-assignable payments**, see SI 01120.200G.1.c. in this section.

2. Trust principal is a resource

a. Trust earnings

Trust earnings are income to the individual for whom the trust principal is a resource, unless the terms of the trust make the earnings the property of another. For when to count income, see SI 00810.030.

b. Additions to principal

Additions to principal may be income or conversion of a resource, depending on the source of the funds. If a third party deposits funds into the trust, the funds are income to the trust beneficiary. If the trust beneficiary transfers funds into the trust from an account that he or she owns, the funds are not income but a converted resource.

H. Policy For Medicaid Trusts And Medicaid Qualifying Trusts

1. Medicaid Trusts

a. General

Medicaid trusts are trusts that are established by an individual (by a means other than a will) on or after August 11, 1993 and that are made up, in whole or in part, of assets of that individual. We consider a trust as established by an individual if it was established by:

- the individual;
- the individual's spouse; or
- a person (or a court or administrative body) with legal authority to act for the individual or spouse or who acts at the direction or request of the individual or spouse.

Medicaid trusts may contain terms such as "OBRA 1993 pay-back trust" or "trust established in accordance with 42 USC 1396" or may be mislabeled as an "MQT." Medicaid trusts must be evaluated under SI 01120.201 to determine whether they are a resource for SSI purposes.

For additional information and procedures for coding and referring these trusts to the State Medicaid agencies, see SI 01730.048.

b. State reimbursement provisions

Medicaid trusts generally have a payback provision stating that upon termination of the trust, or the death of the beneficiary, the trust will reimburse the State Medicaid agency for medical assistance paid on behalf of the individual. According to the law in most States, the State is not the residual or contingent beneficiary but is a creditor, and we consider the reimbursement to be payment of a debt, unless the trust instrument reflects a clear intent that the State is a beneficiary rather than a creditor. This law may or may not apply in your State, so consult your regional instructions or regional office.

2. Medicaid Qualifying Trusts (MQT)

An MQT is a trust or similar legal device established prior to October 1, 1993, other than by a will, under which the grantor (or spouse of the grantor) may be the beneficiary of all or part of the trust. The amount in the MQT considered available as a resource to the individual for Medicaid purposes, is the maximum amount that may be distributed under the terms of the trust to the individual by the trustee. This **Medicaid-only** provision has no effect on the income and resource determination for SSI purposes. MQTs must be evaluated under SI 01120.200 to determine whether they are a resource for SSI purposes.

NOTE: The last date to establish an MQT was September 30, 1993. Congress repealed section 1902(k) of the Social Security Act on October 01, 1993.

I. Policy For Representative Payees And Trusts

If a representative payee funds a trust with an underpayment or conserved funds, see GN 00602.075 for additional rules that may apply. Additionally, representative payees may not deposit dedicated account funds in a trust.

J. Procedure For Development And Documentation Of Trusts

1. Written trust

a. Review the trust document

Obtain a copy of the trust document (the original trust document is not required) and related documents and review the document to determine whether the:

- individual (applicant, recipient, or deemor) is the grantor, trustee, or trust beneficiary;
- trust was established on or after January 01, 2000;
- trust was funded with assets of the individual or third parties or both;
- trust is revocable or can be terminated and, if so, whether the individual has authority to revoke or terminate the trust and to use the principal for his or her own support and maintenance;
- individual has access to the trust principal;
- trust provides for or permits payments for the benefit of the individual, to the individual or on the individual's behalf;
- trust principal generates income (earnings) and, if so, whether the individual has the right to any of that income;
- trust provides for mandatory periodic payments and, if so, whether the trust contains a spendthrift clause that is valid under State law and prohibits the voluntary and involuntary alienation of any interest of the trust beneficiary in the trust payments; and
- trust is receiving payments from another source.

b. Which instructions apply when determining the resource status and income treatment of a trust

Depending on the trust's date of establishment and whose funds the trust principal contains, follow these instructions to determine the resource status and income treatment of the trust:

If the trust was established...	and contains...	follow instructions in:
on or after January 01, 2000,	any assets of the individual,	SI 01120.199, SI 01120.201 through SI 01120.204, SI 01120.225 and SI 01120.227

If the trust was established...	and contains...	follow instructions in:
	only assets of third parties,	SI 01120.200
before January 01, 2000,	assets of the individual transferred before January 01, 2000,	SI 01120.200
	any assets of the individual transferred on or after January 01, 2000,	SI 01120.199, SI 01120.201 through SI 01120.204, SI 01120.225, and SI 01120.227
	only assets of third parties,	SI 01120.200

NOTE: If the trust beneficiary adds his or her own assets to an existing third-party trust, on or after January 01, 2000, redevelop the trust under the instructions in SI 01120.199, SI 01120.201 through SI 01120.204, SI 01120.225, and SI 01120.227. For more information on mixed trusts, see SI 01120.200A.1.b and SI 01120.201I.3.

c. Consult regional instructions

Consult any regional instructions that pertain to trusts to see if there are State or Tribal laws to consider on such issues as revocability or irrevocability and grantor trusts.

d. Referring a trust issue to the regional office

If there are any unresolved issues that prevent you from determining the resource status of a trust, or there are issues for which you believe you need a legal opinion, follow your regional instructions or consult with your regional office (RO) program staff via vHelp. The RO staff can resolve many issues via vHelp. If necessary, the RO staff will seek guidance from the central office (CO) or the RCC. Do **not** contact or refer materials to the RCC directly.

NOTE: When referring a trust to the RO, make sure to include all documentation, identify the applicant or recipient, identify the source of funds or assets, and explain relevant relationships of others named in the trust.

2. Oral trusts

a. State recognizes as binding

If the State in question recognizes oral trusts as binding (see regional instructions):

- record all relevant information;

- obtain from all parties signed statements describing the arrangement; and
- unless regional instructions specify otherwise, refer the case, through the Assistant Regional Commissioner, Management and Operations Support (ARC, MOS), to the RCC.

b. State does not recognize as binding

If the State does not recognize oral trusts as binding (see regional instructions), determine whether an agency relationship (a person acting as an agent of the individual) exists and develop under regular resource-counting rules or transfer of resources rules, as applicable. For transactions involving agents, see SI 01120.020.

3. Determining the nature and value of trust property (written or oral trust)

To determine whether the trust is a resource, apply the policies in SI 01120.200D in this section and in any applicable regional instructions.

NOTE: When you are unsure about any relevant issue, do not make a determination but discuss the case with the RO programs staff. They will refer the case to the RCC, if necessary.

When trust principal is a resource and its value is material to eligibility, determine the nature of the principal and establish its value by:

- contacting the holder of the funds, if cash; or
- developing as required under the applicable POMS section for the specific type(s) of property, if the trust principal is not cash.

4. Documentation for trust evidence

Record all information used in determining whether the trust is a resource or generates income on the Trust (RTRS) page in the SSI Claims System. For more information on what trust information to record, see MS INTRANETSSI 013.005. Record your rationales, summary of supporting documentation, and conclusions on the Report of Contact (DROC) (and subsequently lock the DROC) or the Evidence (EVID) screen. When a certified electronic folder (EF) exists, fax the following into Section D (Non-Disability Development) of the Electronic Disability Collect System (EDCS):

- a copy of the trust document (original not required), along with trust attachments, amendments (if any), and exhibits;
- copies of any signed agreements between organizations making payments to the individual and the individual legally entitled to such payments, if the payments have been assigned to the trust or trustee;
- records of payments from the trust, as necessary; and
- any other pertinent documents, such as court orders, and the Form SSA-5002 (Report of Contact) that indicates the trust resource determination.

In the case of a paper folder, fax these materials into the Non-Disability Repository for Evidentiary Documents (NDRed), or record any development electronically in EVID.

For more information on trust documentation and development, see the trust review process in SI 01120.200L in this section.

NOTE: The SSI applicant or recipient as trust beneficiary generally has the right to request an accounting from the trustee to provide information about trust disbursements.

5. Medicaid trust and Medicaid qualifying trust determination

For information regarding Medicaid trusts and MQTs and the procedure to follow, consult SI 01730.048.

6. Systems input for trusts

Make the appropriate entries on the SSI Claims System Trust (RTRS) page. For more information on the SSI Claims System Trust page, see MS INTRANETSSI 013.005. You may also make a CG field entry (RE06 or RE07) per SM 01301.820. In non-SSI Claims System cases or where otherwise warranted, use Remarks (see MS MSSICS 023.003).

K. Posteligibility Changes In Trust Resource Status

If due to a change in policy, a policy clarification, or the reopening of a prior erroneous determination, a trust that was previously determined not to be a resource is determined to be a resource (or vice-versa), apply the following rules.

1. New trusts and trusts that have not previously been determined not to be a resource

A trust that either is newly created or has not previously been determined not to be a resource must meet the criteria set forth in SI 01120.200D.2. in this section for SSA to determine that it is not a resource. Do not determine that such a trust is not a resource unless the trust meets these criteria.

For a trust that was previously established but is newly discovered, reopen the prior resource determination back to the trust establishment date, subject to the rules of administrative finality (applying the shorter of the two periods). For more information on SSI administrative finality, see SI 04070.001.

A trust must have been previously determined not to be a resource in order for the 90-day amendment period to apply. If a 90-day amendment period is not applicable, then any future amendments to the trust will take effect the month following the month of amendment.

For overpayment waiver rules, see SI 02260.001.

2. Trusts that were previously determined not to be a resource under SI 01120.200

A trust that was previously determined not to be a resource under SI 01120.200 shall continue not to be a resource, provided that the trust is amended to conform with the policy requirements within 90 days. That 90-day period begins on the day SSA informs the individual or representative payee that the trust contains provisions that would require amendment in order to continue not to count as a resource under SI 01120.200.

a. New situations

Effective 04/27/18, if due to a change in policy, a policy clarification, or reopening of a prior erroneous determination, a trust that was previously determined not to be a resource under SI 01120.200 is now determined to be a resource, offer a 90-day amendment period.

b. During the 90-day period

Diary the case for follow-up in 90 days. If a trust was not previously counted as a resource, do not count the trust as a resource and do not impose an overpayment pending possible amendment within the 90-day period.

c. Good cause extension

We permit each trust that was not previously determined to be a resource only one 90-day amendment period. However, you may grant a request for an extension to the 90-day amendment period for good cause, if the individual requests it and provides evidence that the disqualifying issue cannot be resolved within the 90-day period: for example, if a court must amend the trust and there is a wait to get on the court docket. Document on the DROC screen the decision to grant the extension, the time allowed, and the reason. Diary the case for follow-up. Field office staff have discretion to provide a reasonable time period for a good cause extension depending on the situation.

d. End of the 90-day amendment period

If the trust is amended to be policy-compliant within the 90-day period (plus any extension), the trust continues not to be a resource for SSI purposes.

If the trust still fails to meet the policy requirements after expiration of the 90-day amendment period (plus any extension), count the trust as a resource beginning with the later of (1) the date when the policy change or clarification first applies to the trust or (2) the earliest date as of which the prior determination or decision is reopened and revised.

NOTE: All trust determinations made at the end of the 90-day amendment period are subject to the rules of administrative finality.

3. Reopening trust determinations

The field office may receive a request by any party to the determination, including SSA, questioning the correctness of the trust determination. The request to reopen a determination must be in writing and within the applicable time limit (see SI 04070.015. Reopening SSI Determinations).

L. Trust Review Process

Claims Specialists evaluate all trusts **that need a resource determination** (such as a new or amended trust) in all initial claims (IC) and posteligibility (PE) events. For PE events, do not reevaluate trusts that already have a resource determination, unless there is:

- an amendment to the trust,
- a change of or clarification in policy that affects the resource determination,
- a request for reopening, or
- a situation where you become aware of a prior erroneous determination. For resource status changes in PE events, see SI 01120.200K in this section.

To ensure accurate and consistent trust resource determinations:

- Claims Specialists submit their trust resource determinations and any related documentation to the Regional Trust Review Team (RTRT) for review using the Supplemental Security Income Trust Monitoring System (SSITMS) website.
- The RTRT review all trust determinations and provide a decision and any feedback to the Claims Specialists via the SSITMS website.

Claims Specialists and RTRT members can use this SSITMS (http://oestweb.ba.ad.ssa.gov/SSITM/)) link to access the website. For instructions on using the SSITMS website, visit the user guide located under the Help link on the SSITMS website.

NOTE: It is important to remember that trust determinations are subject to the rules of administrative finality. For more information on administrative finality, see SI 04070.040.

The following steps describe the trust review process for the Claims Specialists and RTRT members.

1. Claims Specialist actions

For all IC and PE cases where an applicant, recipient, or deemor alleges an interest in a trust that needs a resource determination, determine whether the trust is a countable resource. To make the trust resource determination, follow trust policy in SI 01120.200D in this section.

After making a trust resource determination:

a. Document the determination along with any references and rationale used in the decision-making process:

   - For SSI Claims System cases, use the Report of Contact (DROC) screen; and

- For non-SSI Claims System cases, use a Form SSA-5002 (Report of Contact) and fax it into the electronic folder (EF) or Non-Disability Repository for Evidentiary Document (NDRED).

b. Fax the initial trust resource determination, trust document, and any pertinent information into the appropriate EF.

Then follow these trust review process steps:

a. Submitting trust determinations for RTRT review

Follow these procedures:

- Access the SSITMS website and select the "Add New" tab. Add the applicant's or recipient's name, representative payee's name (if any), social security number, and all other relevant trust information;
- Select the appropriate type of trust in SSITMS (third party trust, special needs trust, etc.); and
- Submit the trust resource determination for RTRT review.

b. Reviewing the RTRT responses

SSITMS sends an email notification after the RTRT or regional trust lead (RTL) reviews the trust and makes a decision. To view the RTRT's response:

- Access SSITMS and select the case from the Summary page listing or use the link in the email to access the case, and
- Click on the "Details/Update" tab.

The Results field will show that the RTRT member either agreed or disagreed with the trust resource determination. When the Claims Specialist is ready to process the case, change the trust status to "FO Effectuated" using the Edit function.

NOTE: Select "FO Effectuated" only after completing all case development. Changing the Trust Status to "FO Effectuated" **locks** the case in SSITMS. Only the Remarks field will be accessible for additional comments.

c. Reevaluations of trust determinations

To request a reevaluation of a trust resource determination, access SSITMS and:

- change the Trust Status to "Referred to RTL" using the Edit function; and
- provide the rationale, a summary of supporting documentation, and appropriate references in SSITMS Remarks and select "Submit."

The RTL will select the case for review and determine if the central office (CO) or the Office of the General Counsel (OGC) needs to review the case. The RTL will respond to the request via the SSITMS

website, and SSITMS will send an email notification when the RTL completes the reevaluation process.

d. Appeals of trust determinations

When the applicant or recipient appeals the trust resource determination, the RTL must review the Claims Specialist's reconsideration decision. To request a review of the trust reconsideration determination, access SSITMS and:

- select "Recon Pending" from the Recon Trust Status dropdown using the Edit function; and
- provide pertinent information about the reason for the appeal in Claims Specialist remarks and select "Submit."

NOTE: Do not enter RO Recon Trust Determination in SSITMS Claims Specialist remarks. SSITMS will send an email notification when the RTL completes the FO reconsideration review. Do not load a recon into SSITMS until you have made a trust recon determination.

NOTE: Goldberg-Kelly payments may apply during trust reconsiderations only when the SSI recipient is already in pay.

e. RTRT return cases for further FO development

When the RTRT require additional information from the FO, they will return the case for further development. SSITMS will send to the FO mailbox an email notification about the further development requested. To view the RTRT's request, access SSITMS and:

- select the case from the Summary page listings or use the link in the email to access the case; and
- click on the "Details/Update" tab.

View the request for additional information in the Remarks field. After completing the development requested, update the Trust Status to "FO Development Completed" using the Edit button and submit.

2. Trust Reviewer (TR) actions

TRs review the Claims Specialist's trust resource determination along with any pertinent documentation in the SSI Claims System and the Claims File User Interface (CFUI). When TRs receive a trust resource determination for review in SSITMS, they select the case with "Pending" trust status from the SSITMS summary listing and:

- review the trust and associated information;
- provide feedback in the Remarks field in SSITMS;
- document the concurrence decision in a DROC screen or SSA-5002;

- indicate "agree" or "disagree" with the Claims Specialist's trust resource determination in Results;
- change the trust status to "Review Completed" after making a decision on the trust resource determination; and
- submit the response to the Claims Specialist.

Additionally, TRs refer:

- trusts back to the Claims Specialist when the case needs further development; and
- trusts established outside their region to the RTL. The RTL will refer the trust to the appropriate region.

3. Regional Trust Lead (RTL) actions

Regional Trust Leads (RTL) review trust resource determinations for all new or not previously evaluated pooled trusts, IGRA trusts, reevaluations, and appeals. When needed, RTLs request guidance from CO or the RCC and refer trusts to other regions for their input or decision. RTLs also refer trusts back to the FO when the case needs further development. Additionally, RTLs monitor the SSITMS website and add pooled trust precedents to the SSITMS SharePoint Repository for Precedents. For the pooled trust review process, see SI 01120.202C. For information on IGRA trusts, see SI 01120.195.

Follow these steps for the trust review process:

a. Reviewing trust resource determinations

Select the case from the SSITMS Summary listing page or by using the link in the email notification, and:

- click the "Details/Update" tab;
- review information provided by the Claims Specialist technician;
- determine if consultation with CO or the RCC is necessary;
- provide the review results in the Remarks field;
- update Trust Status to "Completed by RTL"; and
- indicate "agree" or "disagree" with the Claims Specialist's determination in Results and click "Submit."

b. Email notifications for reevaluation requests

RTLs will receive an email notification whenever a trust resource determination needs reevaluation. To view the reevaluation request, access the case from the SSITMS Summary page listing.

c. Reevaluate trust resource determinations

To reevaluate the trust resource determination, follow steps listed in SI 01120.200L.3.a. in this section. The specialist who submitted the case and the specialist's FO mailbox will receive an automated email notification when the RTL makes a decision. The subject line will show "Response to Trust for Reevaluation."

d. Appeal requests

SSITMS sends the RTL an email notification when he or she needs to review an FO determination on a trust reconsideration. To view appeal requests, access the case from the SSITMS Summary page listing or from the link in the email notification. To review the reconsideration determination, follow steps listed in SI 01120.200L.3.a. in this section. To address the appeal request, follow steps listed in SI 01120.200L.3.a. in this section. The specialist who submitted the case and the specialist's FO mailbox will receive an automated email notification when the RTL makes a decision. The subject line will show "Response to SSI Trust Recon for Review."

M. Procedure For Discussing SSI Trust Policy With The Public

1. What to discuss

When you discuss SSI trust policy with a member of the public, follow this guidance:

a. Do not advise an applicant, recipient, deemor, representative payee, legal guardian, or any other party on how to invest funds or hold property in trust. Remember that you are not permitted to provide legal or financial advice.

   Never recommend to an individual that he or she set up a trust or suggest that you think that a trust would be beneficial to him or her. Be aware that a trust may allow eligibility for SSI but not eligibility for Medicaid. Suggest that the individual check with the State Medicaid office.

b. Explain how trusts may affect SSI eligibility and payment amount in general terms or in terms specific to a particular trust arrangement. In the latter case, examine the trust document or a draft of the proposed trust provisions, as necessary. You can identify problematic provisions in the document and refer the individual to the POMS section related to the issue. Do not advocate specific changes to a trust.

c. Remember that an individual's ability to access and use the trust principal depends on the terms of the trust document and on State or Tribal law. The State or Tribal trust laws may be complex. Discuss the individual's documents with your regional office if you are unable to make a determination.

2. Use "SSI Spotlight" on trusts

Consider giving the individual a copy of the "SSI Spotlight" on trusts. You can get a copy of the **Spotlight on trusts** online: (http://www.socialsecurity.gov/ssi/spotlights/spot-trusts.htm).

N. Examples Of Trusts

The following examples are illustrative of situations that you may encounter. You should not rely solely on the analysis given in the examples in making determinations in a specific case, as State (or Tribal) laws vary and the language of individual trust documents may warrant different results from those given in the example. You can refer to regional instructions, if any, and consult your regional office, as necessary. You should also be aware of the possible implications the trust may have for Medicaid eligibility. For instructions on trusts and Medicaid, see SI 01730.048.

1. Trust principal is a resource

a. Example of a trust that is a countable resource

- **Situation**

The claimant is a child and the beneficiary of a trust established on her behalf by her mother, who is her legal guardian. The money used to establish the trust was inherited by the claimant directly from her grandmother, making the beneficiary the grantor. The mother is also the trustee. The trust document indicates that the trust may be revoked at any time by the grantor.

- **Analysis**

Since the grantor may revoke the trust at any time, the trust is a resource to the grantor. In this situation, the child is the grantor and the trust is her resource. This is the case because the actions of the mother, as legal guardian, are taken as an agent for the child. Be aware of situations in which the same person may serve multiple functions (such as parent, guardian, and trustee), and distinguish which specific function the person is performing in order to determine whether the person is acting as an agent for the claimant. Note that it is allowable for the same person to perform multiple functions independently of each other without acting as an agent of the claimant. For the definition of a grantor, see SI 01120.200B.3. in this section.

b. Example of a grantor trust that is a countable resource

- **Situation**

On April 21, 1998, the trust beneficiary, a 17-year-old SSI recipient, received a $125,000 judgment as the result of a car accident that left him disabled. His mother, as his legal guardian, placed the money in an irrevocable trust for the sole benefit of the recipient with his sister as trustee. The trustee has absolute discretion as to how the trust funds are to be spent, and the trust has a prohibition against the trustee's spending funds in a way or amount that would make the recipient ineligible for Federal or State assistance payments. There is no named residual beneficiary. Under

the State law, if an individual is both the grantor of a trust and the sole beneficiary, the trust is revocable, regardless of language in the trust to the contrary.

- **Analysis**

Since the recipient's mother, as his legal guardian, established the trust with funds that belonged to the recipient, we treat the recipient as having established the trust himself. Therefore, he is the grantor of the trust. Since he is also the sole beneficiary of the trust, the trust is revocable under the State law and is the recipient's resource, regardless of the language in the trust document. The recipient is ineligible due to excess resources.

2. Trust principal is not a resource

a. Example of a trust that is not a countable resource

- **Situation**

The SSI recipient is the beneficiary of an irrevocable trust created and funded by her deceased parents. Her brother is the trustee. The terms of the trust give the brother full discretionary power to withdraw funds for his sister's educational expenses. The trustee uses these funds to pay the recipient's tuition and room and board at a boarding school. The trust pays $25 of monthly interest income into a separate account that designates the recipient as owner. She has the right to use these funds in any way she wishes. The trust also contains a valid spendthrift clause that prohibits the trust beneficiary from transferring her interest in the trust payments prior to receipt.

- **Analysis**

Since the recipient, as trust beneficiary, has no authority to terminate the trust established with her parents' assets or to access the principal directly, the trust principal is not her resource. While trust disbursements for the beneficiary's benefit may be income to her, the disbursements for tuition are not income since they do not provide food or shelter in any form. However, the trust disbursements for room and board are in-kind support and maintenance valued under the PMV rule. The $25 monthly deposits of trust earnings are income when deposited into the recipient's personal account and are resources to the extent retained into the following month. The trust beneficiary's right to the stream of $25 monthly payments is not a resource because she cannot sell or assign it prior to receiving the payments because of the valid spendthrift clause. For a definition of spendthrift clauses, see SI 01120.200B.13. in this section.

NOTE: If the SSI recipient is the beneficiary of an unfunded third- party trust; for example, the trust will be funded upon the death of a parent. It is not necessary to review and submit the unfunded trust to SSITMS for SSI eligibility purposes until it is funded.

b. Example of a trust that is not a countable resource

Situation

The claimant is a minor and the beneficiary of an irrevocable trust established in 1997 with the child's annuity payment by his father, who is his representative payee. The father is also the trustee. The claimant's brothers and sisters will become the trust beneficiaries in the event of the claimant's death. In the State where the claimant lives, the grantor can revoke the trust if he is also the sole beneficiary. The brothers and sisters are "residual beneficiaries" who become the beneficiaries upon the prior beneficiary's death.

Analysis

The trust principal is not a resource to the claimant. The trust document provides that the trust is irrevocable under the general rule in SI 01120.200D.2. in this section. Although the claimant is the grantor of the trust (because the actions of the father as payee are as an agent of the claimant), the trust is not revocable under the rule for grantor trusts because the claimant is not the sole beneficiary, see SI 01120.200D.3. in this section.

3. Trust requires legal review

a. Example of a trust that requires legal input

- **Situation**

The SSI claimant is the beneficiary of a revocable trust established with her father's assets for her future care. Her father is her legal guardian. The claimant, as trust beneficiary, has no authority to terminate the trust. The claims specialist (CS) reviews the trust document to see if the claimant, through her legal guardian, has unrestricted access to the trust principal, whether the trust provides for payments on her behalf, and whether the trust principal generates income.

The trust document is very complex, and the fact that the claimant's father is grantor, trustee, and her legal guardian further complicates the situation. The CS cannot determine whether the trust principal is available to the trust beneficiary through the grantor or trustee.

- **Analysis**

Because it is not clear from the trust document whether the father, as legal guardian, "stands in the claimant's shoes" and controls the trust, the CS consults with the RO staff for possible referral through the ARC, MOS, to the RCC for an opinion.

b. Example of a trust that requires legal review

- **Situation**

The recipient is the beneficiary of an irrevocable trust. The trust document indicates that the recipient is the sole named beneficiary and also the grantor of the trust. The document also indicates that there are unnamed residual beneficiaries, the recipient's "heirs."

- **Analysis**

The adjudicator consults regional instructions on State law pertaining to grantor trusts. According to those instructions, a grantor trust may be a resource to the recipient, but the State law is unclear about the effect of the unnamed residual beneficiaries. The adjudicator consults with the RO staff for possible referral through the ARC, MOS, to the RCC.

O. References

- SI 00810.120 Income Determinations Involving Agents
- SI 00835.360 When to Charge In-Kind Support and Maintenance (ISM) from Third-Party Vendor Payments
- SI 01110.210 Excluded Resources
- SI 01120.020 Transactions Involving Agents
- SI 01120.195 Trusts Established under the Indian Gaming Regulatory Act (IGRA) for Minor Children and Legally Incompetent Adults (IGRA Trusts)
- SI 01120.201 Trusts Established with the Assets of an Individual on or After January 01, 2000
- SI 01140.200 Checking and Savings Accounts
- SI 01140.215 Conservatorship Accounts
- SI 01150.001 What is a Resource Transfer
- SI 01730.048 Medicaid Trusts
- MS INTRANETSSI 013.005 Trust

Social Security

POMS Recent Change

Identification Number:	**SI 01120 TN 52**
Intended Audience:	See Transmittal Sheet
Originating Office:	ORDP OISP
Title:	**Identifying Resources**
Type:	POMS Transmittals
Program:	**Title XVI (SSI)**
Link To Reference:	

PROGRAM OPERATIONS MANUAL SYSTEM
Part 05 - Supplemental Security Income
Chapter 011 - Resources
Subchapter 20 - Identifying Resources
Transmittal No. 52, 04/2018

Audience

FO/TSC: CS, CS TXVI, DRT, FR, OA, OS, RR, CSR, TA, CTE, TSC-CSR

Originating Component

OISP

Effective Date

April 30, 2018

Background

This transmittal provides instructions for determining the resource status for trusts established with the assets of an individual on or after 01/01/00 and it clarifies the three exceptions to the sole benefit rule for third party payments. We are updating this section to clarify which trust payments to third parties for travel expenses do not violate the sole benefit requirement and providing additional guidance.

Summary of Changes

SI 01120.201 Trusts Established with the Assets of an Individual on or after 01/01/00

We updated section headings, revised passive voice statements, and revised cross reference format throughout the instructions to meet POMS transmittal guidelines. Additionally, we made the following changes:

Subsection A - Clarified that trusts may also be established under tribal law.

Subsection B, D, E, G, and H - Proposed changes for clarity purposes.

Subsection C - Reorganized subsection for readability and clarity.

Subsection F - Clarified the three exceptions to the sole benefit rule for third party payments by providing detailed explanations for each exception.

Subsection I - Clarified that we treat trust disbursements to a trust beneficiary's personal debit card the same as cash disbursements.

Subsection J - Added subsections on how to treat assignment of Survivor Benefit Plans and direct deposits of SSI benefits to trusts.

Subsection K – Added new subsection that discusses when and how to use the 90-day amendment period

Subsection L - Reorganized references.

SI 01120.201 Trusts Established with the Assets of an Individual on or after 01/01/00

Citations:

Social Security Act as amended, Section 1613(e)

P.L. 106-169, Section 205

A. Background For Trusts Established With Assets Of An Individual On Or After 01/01/00

1. Foster Care Independence Act of 1999

On 12/14/99, the President signed into law the Foster Care Independence Act of 1999 (P.L. 106-169). Section 205 of this law provides, generally, that we consider trusts established with the assets of an individual (or spouse) as resources for Supplemental Security Inc

Social Security

POMS Recent Change

Identification Number:	**SI 01120 TN 53**
Intended Audience:	See Transmittal Sheet
Originating Office:	ORDP OISP
Title:	**Identifying Resources**
Type:	POMS Transmittals
Program:	**Title XVI (SSI)**
Link To Reference:	

PROGRAM OPERATIONS MANUAL SYSTEM
Part 05 - Supplemental Security Income
Chapter 011 - Resources
Subchapter 20 - Identifying Resources
Transmittal No. 53, 04/2018

Audience

FO/TSC: CS, CS TXVI, DRT, FR, OA, OS, RR, CSR, TA, CTE, TSC-CSR

Originating Component

OISP

Effective Date

April 30, 2018

Background

This transmittal provides the requirements for exception to counting trusts established with the individual's assets on or after January 01, 2000 and it incorporates the policy clarification published in the Administrative Message, AM-15032, regarding the establishment of special needs trusts by court orders. This transmittal also clarifies the requirement that the trust beneficiary must be disabled at the time the special needs or pooled trust is established. This transmittal also incorporates the new statutory provision published in the Emergency Message EM-16053 providing important information regarding a change in SSI trust policy as a result of the 21st Century Cures

Act (P.L. 114-255), which the President signed into law on December 13, 2016. 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. The Administrative Message AM-15032 is obsolete.

Summary of Changes

SI 01120.203 Exceptions to Counting Trusts Established on or after January 1, 2000

We updated section headings, reorganized subsections for readability and clarity, and revised cross reference format throughout the instructions to meet POMS transmittal guidelines.

Additionally, we made the following subsection changes:

- **Subsection B,** divided former subsection B into new Subsections B and C on Special Needs Trusts and D on Pooled Trusts;
- **Subsection B,** clarified that a third party can be a family member, non-family member or an entity;
- **Subsections B and D,** clarified policy that the trust beneficiary must be disabled at the time the special needs trust or pooled trust account is established and expanded on the requirement that court orders must require the creation of the special needs trust or pooled trust account by providing several examples;
- **Subsection C,** added new policy to reflect statutory change effective December 13, 2016, which 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;
- **Subsection E,** created this new subsection to discuss allowable and prohibited expenses for trusts established under Section 1917(d)(4)(A) and (C) of the Act;
- **Subsection F,** created this new subsection to discuss income trusts established under Section 1917(d)(4)(B) of the Act;
- **Subsection G,** retitled and incorporated instructions from subsection C;
- **Subsection H,** retitled and incorporated instructions from subsection G;
- **Subsection I,** retitled and incorporated instructions from subsection D;
- **Subsection J,** retitled and incorporated instructions from subsection F; and
- **Subsection K,** retitled and incorporated instructions from subsection E.

SI 01120.203 Exceptions to Counting Trusts Established on or after January 1, 2000

A. Introduction To Medicaid Trust Exceptions

We refer to the exceptions discussed in this section as **Medicaid trust exceptions** because section 1917(d)(4)(A) and (C) of the Social Security Act (Act) (42 U.S.C. § 1396p(d)(4)(A) and (C)) sets forth exceptions to the general rule of counting trusts as income and resources for the purposes of Medicaid eligibility and can be found in the Medicaid title of the Act. While these exceptions are also Supplemental Security Income (SSI) exceptions, we refer to them as Medicaid trust exceptions to distinguish them from other exceptions to counting trusts provided in the SSI program (such as undue hardship) and because the term has become a term of common usage.

The type of trust under review dictates the development and evaluation of the Medicaid trust exceptions.

There are two types of Medicaid trusts to consider:

1. Special Needs Trusts; and
2. Pooled Trusts.

CAUTION: A trust that meets the exception to counting for SSI purposes under the statutory trust provisions of Section 1613(e) must still be evaluated under the instructions in SI 01120.200 to determine if it is a countable resource. If the trust meets the definition of a resource (see SI 01110.100B.1.), it will be subject to regular resource-counting rules.

B. Policy For Special Needs Trusts Established Under Section 1917(D)(4)(A) Of The Act Before December 13, 2016

1. General rules for special needs trusts established prior to December 13, 2016

The resource counting provisions of section 1613(e) do not apply to a trust that:

- contains the assets of an individual who is **under age 65** and is **disabled**;
- is **established for the benefit of such individual through the actions of a parent, grandparent, legal guardian, or court**; and
- 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(s) Medicaid plan(s).

NOTE: Although this exception is commonly referred to as the special needs trust exception, the exception applies to any trust that meets the above requirements, even if it is not titled a special needs trust.

CAUTION: A trust that meets the exception to counting for SSI purposes under the statutory trust provisions of section 1613(e) must still be evaluated under the instructions in SI 01120.200 to

determine if it is a countable resource. If the trust meets the definition of a resource (see SI 01110.100B.1.), it will be subject to regular resource-counting rules.

2. Under age 65

To qualify for the special needs trust exception; the trust must be established for the benefit of a disabled individual under age 65. This exception does not apply to a trust established for the benefit of an individual age 65 or older. If the trust was established for the benefit of a disabled individual prior to the date the individual attained age 65, the exception continues to apply after the individual reaches age 65.

3. Additions to trust after age 65

Additions to or augmentations of a trust after age 65 (except as outlined below) are not subject to this exception. Such additions may be income in the month added to the trust, depending on the source of the funds (see SI 01120.201J.) and may count as resources in the following months under regular SSI trust rules.

Additions or augmentations do not include interest, dividends, or other earnings of the trust or any portion of the trust meeting the special needs trust exception. If the beneficiary's right to receive payments from an annuity, support payments, or Survivor Benefit Plan (SBP) payments (see SI 01120.201J.1.e.), is irrevocably assigned to the trust, and such assignment is made when the trust beneficiary was less than 65 years of age, treat the payments paid to a special needs trust the same as payments made before the individual attained age 65. Do not disqualify the trust from the special needs trust exception.

4. Disabled

To qualify for the special needs trust exception, the individual whose assets were used to establish the trust must be disabled for SSI purposes under section 1614(a)(3) of the Act at the time the trust was established.

In cases where you need to develop for disability (for example, a special needs trust beneficiary files for SSI aged benefits), obtain a disability determination from the disability determination services (DDS) following procedure in SI 01150.121D.2. Develop disability as of the date on which the trust was established (unless you need to develop for an earlier period for another purpose).

If DDS determines that the trust beneficiary was:

- disabled as of the date the trust was established, the special needs trust meets the disability requirements for exception; or
- **not** disabled as of the date the trust was established, evaluate the trust under instructions in SI 01120.201. Since the trust provisions take precedence over the transfer provisions (see SI

01150.201D.5.), depending on the terms of the trust, the trust may count as a resource or the transfer penalty may apply (see SI 01150.121.).

5. Definition of established

Under section 1613(e) of the Act, a trust is considered to have been "established by" an individual if any of the individual's (or the individual's spouse's) assets are transferred into the trust other than by will. Alternatively, under the Medicaid trust exceptions in section 1917(d)(4)(A) and (C) of the Act, a trust can be "established by" an individual who does not provide the corpus of the trust, or transfer any of his or her assets into the trust, but who takes action to establish the trust. To avoid confusion, we use the phrase "established through the actions of" rather than "established by" when referring to the individual who physically takes action to establish a special needs or pooled trust.

6. Established for the benefit of the individual

Under the special needs trust exception, the trust must be established and used for the benefit of the disabled individual. SSA has interpreted this provision to require that the trust be for the sole benefit of the individual, as described in SI 01120.201F.2. Other than trust provisions for payments described in SI 01120.201F.3. and SI 01120.201F.4., any provisions will result in disqualification from the special needs trust exception if they:

- provide benefits to other individuals or entities during the disabled individual's lifetime, or
- allow for termination of the trust prior to the individual's death and payment of the corpus to another individual or entity (other than the State(s) or another creditor for payment for goods or services provided to the individual).

Payments to third parties for goods and services provided to the trust beneficiary are allowed under the policy described in SI 01120.201F.3.a.; however, such payments should be evaluated under SI 01120.200E., SI 01120.200F., and SI 01120.201I. to determine whether the payments may be income to the individual.

NOTE: A third party can be a family member, non-family member, or an entity. Do not differentiate between third parties; anyone other than the trust beneficiary (or spouse, guardian, or representative payee) is a third party.

7. Who established the trust

The special needs trust exception does not apply to a trust established through the actions of the disabled individual himself or herself. (Remember that this instruction applies specifically to special needs trusts established under section 1917(d)(4)(A) before December 13, 2016.) To qualify for the special needs trust exception, the assets of the disabled individual must be put into a trust established through the actions of:

- the disabled individual's parent(s);

- the disabled individual's grandparent(s);
- the disabled individual's legal guardian(s); or
- a court.

In the case of a legally competent, disabled adult, a parent or grandparent may establish a "seed" trust using a nominal amount of his or her own money or, if State law allows, an empty or dry trust. After the seed trust is established, the legally competent, disabled adult may transfer his or her own assets into the trust, or a second individual with legal authority (for example, a power of attorney) may transfer the disabled individual's assets into the trust. To determine if the second individual had legal authority, see SI 01120.203B.9. in this section.

8. Court-established trusts

In the case of a trust established through the actions of a court, the creation of the trust must be required by a court order for the exception in section 1917(d)(4)(A) of the Act to apply. The special needs trust exception can be met when a court approves a petition and establishes a trust by court order, as long as the creation of the trust has not been completed before the order is issued by the court. Court approval of an already created special needs trust is not sufficient for the trust to qualify for the exception. The court must specifically either establish the trust or order the establishment of the trust. An individual is permitted to petition a court for the present establishment of a trust or may use an agent to do so. The court order establishes the trust, not the individual's petition. Petitioning a court to establish a trust is not establishment by an individual.

NOTE: An individual may petition the court with a draft document of a trust as long as it is **unsigned** and not legally binding.

a. Example of a court ordering the establishment of a trust

John is a legally competent adult who inherited $250,000 in January 2015, and is an SSI recipient. His sister, Justine, petitioned the court to create and order the funding of the John Special Needs Trust. Justine also provided the court with an unsigned draft of the trust document. A month later, the court approved the petition and issued an order requiring the creation and funding of the trust. This trust meets the requirement in SI 01120.203B.8. in this section. The fact that the trust beneficiary is a competent adult and could have established the trust himself, is not a factor in the resource determination.

b. Example of a court-established trust

Henry wins a lawsuit in the amount of $50,000. As part of the settlement, the judge orders the creation of a trust in order for Henry to receive the $50,000. As a direct result of this court order, a trust was created with Henry's settlement money. The trust document lists the $50,000 as the initial principal amount in Schedule A of the trust. This trust meets the requirement for exclusion in SI 01120.203B.8. in this section.

c. Example of a court-approved trust

Jane is ineligible for SSI benefits because she has a self-established special needs trust that does not meet the requirements for exception in SI 01120.203 in this section. Jane petitioned the court to establish an amended trust and to make the order retroactive, so that her original trust would become exempt from resource counting from the time of its creation. The court approved the petition and issued a **nunc pro tunc** order stating that the court established the trust as of the date on which Jane had previously established the trust herself. The court did not establish a new trust; it merely approved a modification of a previously existing trust. The amended trust does not meet the requirement for exclusion in SI 01120.203B.8. in this section.

d. Example of a court-approved trust

Dan is the beneficiary of a special needs trust. His sister petitioned the court to establish the Dan's Special Needs Trust and submitted to the court along with the petition Dan's special needs trust that had already been signed and funded. Although the court order states that it approves and establishes the trust, the court simply approved the existence of the already established special needs trust. This trust does not meet the requirement in SI 01120.203B.8. in this section. For an example of an unsigned and unfunded trust, see SI 01120.201B.8.a.

9. Legal authority and trusts

The person or entity establishing the trust with the assets of the legally competent disabled individual or transferring the assets of the individual to the trust must have legal authority to act with respect to the assets of the individual. Attempting to establish a trust with the assets of another individual without proper legal authority to act with respect to the assets of that individual will generally result in an invalid trust under state law.

NOTE: If you question the validity of a trust, please consult with your Regional Trust Lead (RTL) or get a Regional Chief Counsel (RCC) Opinion.

For example, John is establishing a seed trust for his adult child with his own assets, and John has legal authority over his own assets to establish the trust. John would need legal authority over his child's assets only if he actually takes action with the child's assets, for example, by transferring them into a previously established trust.

A power of attorney (POA) can establish legal authority to act with respect to the assets of an individual. However, a trust established under a POA for the trust beneficiary will result in a trust that we consider to be established through the actions of the disabled individual himself or herself because the POA merely establishes an agency relationship. A POA for the trust beneficiary may be used as the legal authority to transfer assets of the beneficiary into the trust, including, for example, a previously established seed trust.

10. State Medicaid reimbursement requirement

To qualify for the special needs trust exception, the trust must contain specific language that provides that, upon the death of the individual, the State(s) will receive all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s). The State(s) must be listed as the first payee(s) and have priority over payment of other debts and administrative expenses, except as listed in SI 01120.203D.1. in this section.

The trust must provide payback for any State(s) that may have provided medical assistance under the State Medicaid plan(s) and not be limited to any particular State(s). Medicaid payback also cannot be limited to any particular period of time; for example, payback cannot be limited to the period after establishment of the trust. If the trust does not have sufficient funds upon the beneficiary's death to reimburse in full each State that provided medical assistance, the trust may reimburse the States on a pro-rata or proportional basis.

NOTE: Merely labeling the trust as a **Medicaid payback trust**, an **OBRA 1993 payback trust**, a trust **established in accordance with 42 U.S.C. § 1396p**, or a **Medicaid qualifying trust** (MQT) is not sufficient to meet the requirements for this exception. The trust must contain specific payback language whose effect is consistent with the requirements described above. An oral trust cannot meet this requirement.

C. Policy For Special Needs Trusts Established Under Section 1917(D)(4)(A) Of The Act On Or After December 13, 2016

1. General rules for special needs trusts established on or after December 13, 2016

On December 13, 2016, the President signed into law the 21st Century Cures Act (Public Law 114-255). 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. The resource counting provisions of section 1613(e) do not apply to a trust that:

- contains the assets of an individual who is **under age 65** and is **disabled**;
- is **established for the benefit of such individual through the actions of the *individual*, a parent, a grandparent, a legal guardian, or a court**; and
- 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: Although this exception is commonly referred to as the **special needs** trust exception, the exception applies to any trust meeting the above requirements, even if it is not titled as a special needs trust.

CAUTION: A trust that meets the exception to counting for SSI purposes under the statutory trust provisions of section 1613(e) must still be evaluated under the instructions in SI 01120.200, to

determine if it is a countable resource. If the trust meets the definition of a resource (see SI 01110.100B.1.), it will be subject to regular resource-counting rules.

2. Who established the trust

The special needs trust exception applies to a trust established through the actions of:

- the individual;
- a parent(s);
- a grandparent(s);
- a legal guardian(s); or
- a court.

a. Power of attorney

We consider a trust established under power of attorney (POA) for the disabled individual to be established through the actions of the disabled individual because the POA establishes an agency relationship. For additional information on a POA, see SI 01120.203C.3 in this section.

b. Use of a seed trust

If the legally competent, disabled adult does not establish the trust, a parent or grandparent may establish a "seed" trust using a nominal amount of his or her own money or, if State law allows, an empty or dry trust. After the seed trust is established, the legally competent, disabled adult may transfer his or her own assets into the trust, or another individual with legal authority (such as a power of attorney) may transfer the individual's assets into the trust. To determine if the individual had legal authority, see SI 01120.203C.9. in this section.

NOTE: Under 1613(e) of the Act, a trust is considered to have been "established by" an individual if any of the individual's (or the individual's spouse's) assets are transferred into the trust other by will. Alternatively, under the Medicaid trust exceptions in 1917(d)(4)(A) and (C) of the Act, a trust can be "established by" an individual who does not provide the corpus of the trust, or transfer any of his or her assets into the trust, but who takes action to establish the trust. To avoid confusion, we use the phrase "established through the actions of" rather than "established by" when referring to the individual who physically takes action to establish a special needs or pooled trust.

3. Legal authority and trusts

The person or entity establishing the trust with the assets of the legally competent, disabled individual or transferring the assets of the individual into the trust must have legal authority to act with respect to the assets of the individual. Attempting to establish a trust with the assets of another

individual without proper legal authority to act with respect to the assets of the individual will generally result in an invalid trust under state law.

NOTE: If you question the validity of a trust, please consult with your Regional Trust Lead (RTL) or get a Regional Chief Counsel (RCC) Opinion.

For example, John, who is establishing with his own assets a seed trust for his adult child, has legal authority over his own assets to establish the trust. He needs legal authority over his child's assets only if he actually takes action with the child's assets, for instance by transferring them into a previously established trust.

A power of attorney (POA) can establish legal authority to act with respect to the assets of an individual. A trust established under a POA for the disabled individual will result in a trust that we consider to be established through the actions of the disabled individual himself or herself because the POA establishes an agency relationship. A third party can use the POA for the trust beneficiary as the legal authority to establish a trust or to transfer assets of the beneficiary into the trust, as long as the POA provides the proper authority to do so.

4. Additional requirements for a trust established on or after December 13, 2016

Except as noted in SI 01120.203C.1. through SI 01120.203C.3. in this section, the requirements for an exempt special needs trust remain the same as those for a trust established prior to December 13, 2016. For additional requirements and guidance, see SI 01120.203B.2. through SI 01120.203B.6., SI 01120.203B.8., and SI 01120.203B.10. in this section.

D. Policy For Pooled Trusts Established Under Section 1917(D)(4)(C) Of The Act

1. General rules for pooled trusts

A pooled trust contains the assets of many different individuals, each held in separate trust accounts and established through the actions of individuals for separate beneficiaries. By analogy, the pooled trust is like a bank that holds the assets of individual account holders. A pooled trust is established and managed by a non-profit organization. The pooled trust instruments usually consist of an overarching "master trust" and a joinder agreement that contains provisions specific to the individual beneficiary.

Whenever you are evaluating the trust, it is important to distinguish between the master trust, which is established through the actions of the nonprofit association, and the individual trust accounts within the master trust, which are established through the actions of the individual or another person or entity for the individual, through a joinder agreement.

The resource-counting provisions of section 1613(e) of the Act do not apply to a trust containing the **assets of a disabled individual** that meets the following conditions:

- The pooled trust is established and managed by a **nonprofit association**;

- **Separate accounts** are maintained for each beneficiary, but assets are pooled for investing and management purposes;
- Accounts **are established solely for the benefit of the disabled individuals;**
- The account in the trust is **established through the actions of the individual, a parent, a grandparent, a legal guardian, or a court**; and
- The trust provides that, to the extent that any amounts remaining in the beneficiary's account, upon the death of the beneficiary, are not retained by the trust, **the trust will pay to the State(s)** from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under State Medicaid plan(s).

NOTE: There is no age restriction for this exception. However, a transfer of resources into a trust for an individual age 65 or over may result in a transfer penalty (see SI 01150.121.).

CAUTION: A trust that meets the exception to counting for SSI purposes under the statutory trust provisions of 1613(e) must still be evaluated under the instructions in SI 01120.200, to determine if it is a countable resource.

2. Disabled

To qualify for the pooled trust exception, the individual whose assets were used to establish the trust account must be disabled for SSI purposes under section 1614(a)(3) of the Act at the time the trust was established. This also includes individuals age 65 and older.

In cases where you need to develop for disability (for example, a pooled trust beneficiary files for SSI aged benefits), obtain a disability determination from the Disability Determination Services (DDS) following procedure in SI 01150.121D.2. Develop disability as of the date on which the trust account was established (unless you need to develop for an earlier period for another purpose). If DDS determines that the trust beneficiary was:

- disabled as of the date the trust account was established, the trust account meets the disability requirement for exception; or
- **not** disabled as of the date the trust account was established, evaluate the trust under instructions in SI 01120.201. Since trust provisions take precedence over the transfer provisions (see SI 01120.201D.5.), depending on the terms of the trust, the trust might count as a resource or the transfer of penalty may apply (see SI 01150.121.).

3. Nonprofit association

The pooled trust must be established and maintained by the actions of a nonprofit association. For purposes of the pooled trust exception, a nonprofit association is an organization established and certified under a State nonprofit statute. For development of nonprofit associations, see SI

01120.203J. in this section. For more information on pooled trust management provisions, see SI 01120.225.

4. Separate account

A **separate account within the trust** must be maintained for each beneficiary of the pooled trust. However, for purposes of investment and management of funds, the trust may pool the funds in the individual accounts. The trust must be able to provide an individual accounting for each individual.

5. Established for the sole benefit of the individual

Under the pooled trust exception, the individual trust account must be established for the sole benefit of the disabled individual. (For a definition of sole benefit, see SI 01120.201F.2.) Other than the payments described in SI 01120.201F.2.b. and SI 01120.201F.2.c., this exception does not apply if the trust account:

- provides a benefit to any other individual or entity during the disabled individual's lifetime; or
- allows for termination of the trust account prior to the individual's death and payment of the corpus to another individual or entity. For more information on early termination provisions and trusts, see SI 01120.199.

NOTE: In general, we do not limit master trusts to allow only sub-accounts that are established by parties listed in section 1917(d)(4)(C)(iii) of the Act. As pooled trusts can have SSI and non-SSI beneficiaries, we would not count a trust solely because the master trust agreement permitted a non-SSI trust to be established by someone other than those listed in section 1917(d)(4)(C)(iii).

6. Who established the trust account

In order to qualify for the pooled trust exception, the trust **account** must have been established through the actions of:

- the disabled individual himself or herself;
- the disabled individual's parent(s);
- the disabled individual's grandparent(s);
- the disabled individual's legal guardian(s); or
- a court.

A legally competent, disabled adult who is establishing or adding to a trust account with his or her own assets has the legal authority to act on his or her own behalf. A third party establishing a trust account on behalf of a disabled individual with that individual's assets must have legal authority to act with regard to the assets of the individual. An attempt to establish a trust account by a third party with the assets of a disabled individual without the legal right or authority to act with respect

to the assets of that individual will generally result in an invalid trust under state law. If there is a question regarding authority, consult your precedents or regional chief counsel.

A power of attorney (POA) is legal authority to act with respect to the assets of an individual. A pooled trust account may be established under POA given by the individual, a parent, or a grandparent.

NOTE: A representative payee must have legal authority to establish a trust or transfer funds into a trust for the disabled individual. If a representative payee attempts to establish a trust account with the assets of a disabled individual without the legal right or authority to act with respect to the assets of that individual, this will generally result in an invalid trust under state law.

7. Court-established trusts

In the case of a trust account established through the actions of a court, the creation of the trust account must be required by a court order for the exception in section 1917(d)(4)(C) of the Act to apply. That is, the pooled trust exception can be met when courts approve petitions and establish trust accounts by court order, so long as the execution of the trust account joinder agreement and funding of the trust have not been completed before the order is issued by the court. Court approval of an already executed pooled trust account joinder agreement is not sufficient for the trust account to qualify for the exception. The court must specifically either establish the trust account or order the establishment of the trust account.

a. Example of a court ordering establishment of a trust account

John is a legally competent adult who inherited $250,000 and is an SSI recipient. His sister, Justine, petitioned the court to create and order the funding of an account in the Chesapeake Pooled Trust. Justine also provided the court with an unsigned draft of the trust document. A month later the court approved the petition and issued an order requiring the creation and funding of the trust account. This trust account meets the requirement in SI 01120.203D.6. in this section. The fact that the trust beneficiary is a competent adult and could have established the trust account himself, is not a factor in the resource determination.

b. Example of a court-established trust account

Mary, a legally incompetent SSI recipient, wins a lawsuit in the amount of $50,000. As part of the settlement, the judge orders the creation of a pooled trust account in order for Mary to receive the $50,000. As a direct result of this court order, a pooled trust account was created with Mary's settlement money. The pooled trust records and documentation of the initial deposit list the $50,000 as the initial principal amount. This trust account meets the requirement in SI 01120.203D.6. in this section.

c. Example of a court-approved trust account

Jane is ineligible for SSI benefits because she has a self-established pooled trust account that does not meet the requirements for exception in SI 01120.203D stating the pooled trust has to be established and managed by a nonprofit association. A for-profit association is managing Jane's pooled trust. The pooled trust changed management to a nonprofit association to satisfy the requirement. Jane petitioned the court to establish an amended trust account joinder agreement and to make the order retroactive, so that her original trust account would become exempt from resource counting from the time of its creation. The court approved the petition and issued a **nunc pro tunc** order stating that the court established the trust account as of the date on which Jane had previously established the trust account herself. The amended trust account joinder agreement does not meet the requirement in SI 01120.203D.6. in this section. The court did not establish a new trust account; it merely approved a modification of a previously existing trust account joinder agreement.

NOTE: Please forward all **nunc pro tunc** orders to your Regional Office for additional review and final determination.

8. State Medicaid reimbursement provision

To qualify for the pooled trust exception, the trust must contain specific language that provides that, to the extent that amounts remaining in the individual's account upon the death of the individual are not retained by the trust, the trust will pay to the State(s) from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s). To the extent that the trust does not retain the funds in the account, the State(s) must be listed as the first payee(s) and have priority over payment of other debts and administrative expenses, except as listed in SI 01120.203D.1. in this section.

The trust must provide payback to any State(s) that have provided medical assistance under the State Medicaid plan(s) and not be limited to any particular State(s). Medicaid payback also cannot be limited to any particular period of time; for example, payback cannot be limited to the period after establishment of the trust.

If the trust does not have sufficient funds upon the beneficiary's death to reimburse in full each State that provided medical assistance, the trust may reimburse the States on a pro-rata or proportional basis.

NOTE: Merely labeling the trust as a **Medicaid payback trust, an OBRA 1993 payback trust**, a **trust established in accordance with 42 U.S.C. § 1396p**, or an **MQT** is not sufficient to meet the requirements for this exception. The trust must contain specific payback language whose effect is consistent with the requirements described above. An oral trust cannot meet this requirement.

E. Allowable And Prohibited Expenses For Special Needs And Pooled Trusts Established Under Section 1917(D)(4)(A) And (C) Of The Act

The following instructions, about trust expenses and payments, apply to Medicaid special needs trusts and to Medicaid pooled trusts.

1. Allowable administrative expenses

Upon the death of the trust beneficiary, the trust may pay the following types of administrative expenses from the trust prior to reimbursement of the State(s) for medical assistance:

- Taxes due from the trust to the State(s) or Federal government because of the death of the beneficiary;
- Reasonable fees for administration of the trust estate, such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust.

2. Prohibited expenses and payments

Upon the death of the trust beneficiary, the following are examples of some of the types of expenses and payments not permitted prior to reimbursement of the State(s) for medical assistance:

- Taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate;
- Inheritance taxes due for residual beneficiaries;
- Payment of debts owed to third parties;
- Funeral expenses; and
- Payments to residual beneficiaries.

NOTE: For the purpose of prohibiting payments prior to reimbursement of the State(s) for medical assistance, a pooled trust is not considered a residual or remainder beneficiary. Remember that a pooled trust has the right to retain funds upon the death of the beneficiary.

3. Applicability

This restriction on payments from the trust applies upon the death of the beneficiary. Payments of fees and administrative expenses during the life of the beneficiary are allowable as permitted by the trust document and are not affected by the State Medicaid reimbursement requirement.

F. Income Trusts Established Under Section 1917(D)(4)(B) Of The Act

Income trusts, sometimes called *Miller* trusts (named after a court case), established under section 1917(d)(4)(B) of the Act are **not** considered exceptions to trust rules for SSI purposes. However,

some States may exclude these trusts from counting as a resource for Medicaid purposes. This type of trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust).

G. Policy For Waiver For Undue Hardship

1. Definitions

a. Undue hardship

For purposes of the trust provisions of section 1613(e) of the Act, undue hardship exists in a month if:

- failure to receive SSI payments would deprive the individual of food or shelter; **and**
- the individual's available funds do not equal or exceed the Federal benefit rate (FBR) plus any federally administered State supplement.

NOTE: Inability to obtain medical care does not constitute undue hardship for SSI purposes, although it may under a State Medicaid plan. Also, the undue hardship waiver does not apply to a trust counted as a resource under SI 01120.200. It applies only to trusts counted under section 1613(e) of the Act (see SI 01120.201. through SI 01120.203.).

b. Loss of shelter

For purposes of undue-hardship waiver in the context of section 1613(e) of the Act, an individual would be deprived of shelter if:

- he or she would be subject to eviction from his or her current residence, if SSI payments were not received; and
- there is no other affordable housing available, or there is no other housing available with necessary modifications for the disabled individual.

2. Application of the undue hardship waiver

a. Applicability

We will consider the possibility of undue hardship under this provision only when:

- counting an **irrevocable** trust as a resource results in the individual's ineligibility for SSI due to excess resources;
- the individual alleges (or information in the file indicates) that not receiving SSI would deprive him or her of food or shelter; and

- the trust specifically prohibits disbursements, or prohibits the trustee from exercising his or her discretion to disburse funds, from the trust for the individual's support and maintenance.

NOTE: If the trust is revocable by the individual, the requirements for undue hardship cannot be met because the individual can access the trust funds for his or her support and maintenance.

b. Suspension of resource counting

An irrevocable trust is not counted as a resource in any month for which counting the trust would cause undue hardship.

c. Resource counting resumes

Resource counting of a trust resumes for any month(s) for which it would not result in undue hardship.

3. Available funds

In determining the individual's available funds, we include:

a. Income

Income includes the following:

- All countable income received in the month(s) for which undue hardship is an issue;
- All income excluded under the Act received in the month(s) for which undue hardship is an issue. For a list of unearned and earned income exclusions, respectively, provided under the Act, see SI 00830.099. and SI 00820.500.; and
- The value of in-kind support and maintenance (ISM) being charged, i.e., the presumed maximum value (PMV), the value of the one-third reduction (VTR), or the actual lesser amount.

Do not include SSI payments received or items that are not income, per SI 00815.000.

NOTE: The receipt of ISM, in and of itself, does not preclude a finding of undue hardship.

b. Resources

Resources include the following:

- All countable liquid resources as of the first moment of the month(s) for which undue hardship is at issue (for a definition of liquid resources, see SI 01110.300.); and
- All liquid resources excluded under the Act as of the first moment of the month(s) for which undue hardship is at issue (for a list of resource exclusions under the Act, see SI 01130.050.).

SSI benefits retained into the month following the month of receipt are counted as a resource for purposes of determining available funds.

Do not include non-liquid resources or assets determined not to be a resource, per SI 01120.000.

4. Example

Frank filed for SSI in 3/2017 as an aged individual. In 2/2017, he received an insurance settlement from an accident that was placed in an irrevocable trust. After determining that he met the other requirements for undue hardship (including a prohibition on the trustee from disbursing any funds for Franks' support and maintenance), the claims specialist (CS) determined Franks' available funds. He receives $450 in title II benefits per month. His only liquid resource is a bank account that has $500 in it. The total of $950 in available funds ($450 in title II benefits and $500 in the bank account) means that undue hardship does not apply in 3/2017, because that amount exceeds the FBR of $735. (His State has no federally administered State supplement.)

Frank comes back into the office in 6/2017. He presents evidence that he has spent down the $500 in his bank account on living expenses in the past three months. As of 6/2017, he has no liquid resources, and his income total of $450 is below the FBR. Frank meets the undue hardship test for 6/2017 (which is his E02 month). The trust does not count as his resource in that month. If his situation does not change, he qualifies for an SSI payment in 7/2017.

H. Procedure For Follow-Up To A Finding Of Undue Hardship

1. When to use this procedure

Use this procedure when it is necessary to determine whether an individual who established a trust continues to be eligible for SSI based on undue hardship. Since undue hardship is a month-by-month determination, recontact the individual to redevelop undue hardship periodically.

2. Recontact period

The recontact period may vary depending on the individual's situation. If the individual alleges, and information in the file indicates, that the individual's income and resources are not expected to change significantly, and the individual is continuously eligible for SSI because of undue hardship, recontact the individual **no less than every six months**. If the individual's income and resources are expected to fluctuate, or the file indicates a history of such fluctuation, the recontact period should be shorter, even monthly in some cases.

3. Documentation

At each recontact:

- Obtain on a DROC the individual's statement, either signed or recorded, that failure to receive SSI would have deprived the individual of food or shelter for any month not covered by a prior allegation;

- Determine whether total income and liquid resources exceeded the FBR plus any State supplement for each prior month;
- If undue hardship continued for the prior period and is expected to continue in the future period, continue payment and tickle the case for the next recontact, per SI 01120.203H.4. in this section; and
- If undue hardship did not continue through each month, clear the **excluded amount** and **exclusion reason** entries on the **ROTH** screen for each month that undue hardship did not apply. Process the excess resources overpayment for those months. If undue hardship stops due to a continuing change in the individual's situation, such as income or resources, do not tickle the file to follow up. The individual must recontact SSA and make a new allegation of undue hardship.

4. Recontact controls

For SSI Claims System cases, use the DWO1 and establish a tickle to control the case for recontact when the individual is eligible for SSI based on undue hardship. (Use the Modernized Development Worksheet (MDW) for non-SSI Claims System cases.) If MDW is applicable, set up an MDW screen using instructions in MSOM MDW 001.001 and the following MDW inputs:

- In the **ISSUE** field: input TRUST;
- In the **CATEGORY** field: input T16MISC;
- In the **TICKLE** field: input the date by which the individual should be recontacted to redevelop undue hardship; and
- In the **MISC** field: input information (up to 140 characters) about the trust undue hardship issue including issues to be aware of and anything else the CS deems appropriate. If additional space is needed, use **REMARKS**.

I. Procedure For Developing Exceptions To Resource Counting

1. Special needs trusts under section 1917(d)(4)(A) of the Act before December 13, 2016

The following is a summary of special needs trust development presented in step-action format. Refer to the policy cross-references for complete requirements:

STEP	ACTION

STEP	ACTION
1	Does the trust contain the assets of an individual who was under age 65 when the trust was established? (See SI 01120.203B.2. in this section.) • If **yes**, go to **Step 2**. • If **no**, go to **Step 9**.
2	Does the trust contain the assets of a disabled individual? (See SI 01120.203B.4. in this section.) • If **yes**, go to **Step 3**. • If **no**, go to **Step 9**.
3	Is the disabled individual the sole beneficiary of the trust? (See SI 01120.203B.5. in this section.) • If **yes**, go to **Step 4.** • If **no**, go to **Step 9.**
4	Did a parent, grandparent, legal guardian, or court establish the trust? (See SI 01120.203B.6. in this section.) • If **yes**, go to **Step 5**. • If **no**, go to **Step 9.**
5	Does the trust provide specific language to reimburse any State(s) for medical assistance paid upon the individual's death as required in SI 01120.203B.9. in this section? • If **yes**, go to **Step 6**. • If **no**, go to **Step 9**.
6	Verify if the trust contains any early termination provisions as described within SI 01120.199. If the trust does not contain any early termination provisions, go to Step 7. If the trust contains any early termination provisions, does it meet the early termination criteria in SI 01120.199F that would make early termination acceptable? • If **yes**, go to **Step 7**. • If **no**, go to **Step 9**.

STEP	ACTION
7	The trust meets the special needs trust exception to the extent that the assets of the individual were put in trust prior to the individual's attaining age 65. Any assets placed in the trust after the individual attained age 65 are not subject to this exception, except as provided in SI 01120.203B.3. in this section. Go to **Step 8** for treatment of assets placed in trust prior to age 65. Go to **Step 9** for treatment of assets placed in trust after attaining age 65.
8	Evaluate the trust under SI 01120.200D.1.a. to determine if it is a countable resource.
9	The trust (or portion thereof) does not meet the requirements for the special needs trust exception. Consider if the pooled trust exception in SI 01120.203D in this section applies. If neither exception applies, determine whether the undue hardship waiver applies under SI 01120.203K in this section.

2. Special needs trusts under Section 1917(d)(4)(A) of the Act on or after December 13, 2016

STEP	ACTION
1	Does the trust contain the assets of an individual who was under age 65 when the trust was established? (See SI 01120.203B.2. in this section.) • If **yes**, go to **Step 2**. • If **no**, go to **Step 9**.
2	Does the trust contain the assets of a disabled individual? (See SI 01120.203B.4. in this section.) • If **yes**, go to **Step 3**. • If **no**, go to **Step 9**.
3	Is the disabled individual the sole beneficiary of the trust? (See SI 01120.203B.5. in this section.) • If **yes**, go to **Step 4.** • If **no**, go to **Step 9.**

STEP	ACTION
4	Did the individual, a parent, a grandparent, a legal guardian, or a court establish the trust? (See SI 01120.203B.6. in this section.) • If **yes**, go to **Step 5**. • If **no**, go to **Step 9.**
5	Does the trust provide specific language to reimburse any State(s) for medical assistance paid upon the individual's death as required in SI 01120.203B.9. in this section? • If **yes**, go to **Step 6**. • If **no**, go to **Step 9**.
6	Verify if the trust contains any early termination provisions as described in SI 01120.199. If the trust does not contain any early termination provisions, go to **Step 7**. If the trust contains any early termination provisions, does it meet the early termination criteria in SI 01120.199F that would make early termination acceptable? • If **yes**, go to **Step 7**. • If **no**, go to **Step 9**.
7	The trust meets the special needs trust exception to the extent that the assets of the individual were put in trust prior to the individual's attaining age 65. Any assets placed in the trust after the individual attained age 65 are not subject to this exception, except as provided in SI 01120.203B.3. in this section. Go to **Step 8** for treatment of assets placed in trust prior to age 65. Go to **Step 9** for treatment of assets placed in trust after attaining age 65.
8	Evaluate the trust under SI 01120.200D.1.a. to determine if it is a countable resource.
9	The trust (or portion thereof) does not meet the requirements for the special needs trust exception. Consider if the pooled trust exception in SI 01120.203D in this section applies. If neither exception applies, determine whether the undue hardship waiver applies under SI 01120.203K in this section.

3. Pooled trusts established under Section 1917(d)(4)(C) of the Act

The following is a summary of pooled trust development presented in step-action format. Refer to the policy cross-references for complete requirements.

STEP	ACTION

STEP	ACTION
1	Does the trust account contain the assets of a disabled individual? (See SI 01120.203C.2. in this section.) • If **yes**, go to **Step 2**. • If **no**, go to **Step 8**.
2	Is the pooled trust established and managed by a nonprofit association? (See SI 01120.203C.1., SI 01120.203C.3., and development instructions in SI 01120.203F in this section.) • If **yes**, go to **Step 3**. • If **no**, go to **Step 8**.
3	Does the trust pool the funds yet maintain an individual account for each beneficiary, and can it provide an individual accounting? (See SI 01120.203C.4. in this section.) • If **yes**, go to **Step 4**. • If **no**, go to **Step 8**.
4	Is the disabled individual the sole beneficiary of the trust account? (See SI 01120.203C.5. in this section.) • If **yes**, go to **Step 5**. • If **no**, go to **Step 8**.
5	Did the individual, (a) parent(s), (a) grandparent(s), (a) legal guardian(s), or a court establish the trust account? (See SI 01120.203C.1. and SI 01120.203C.6. in this section.) • If **yes**, go to **Step 6**. • If **no**, go to **Step 8**.
6	Does the trust provide specific language to reimburse any State(s) for medical assistance paid upon the individual's death from funds not retained by the trust as required in SI 01120.203C.8. in this section? • If **yes**, go to **Step 7**. • If **no**, go to **Step 8**.
7	The trust meets the Medicaid pooled trust exception; however, the trust still should be evaluated under SI 01120.200D.1.a. to determine if it is a countable resource.
8	The trust does not meet the requirements for the Medicaid pooled trust exception. Determine if the undue hardship waiver applies under SI 01120.203I. in this section.

J. Procedure To Verify Nonprofit Associations When Evaluating Pooled Trusts

When a trust is alleged to be established through the actions of a nonprofit or a tax-exempt organization, consult the pooled trust precedent in SSITMS. If none exists, follow policy and procedure for verifying the tax-exempt status of organizations found at SI 01130.689E. "Gifts to children with life-threatening conditions."

K. Procedure For Development Of Undue Hardship Waiver

The following is a summary of development instructions for undue hardship presented in step-action format. Refer to cross-references for complete instructions:

STEP	ACTION
1	Is the trust irrevocable? • If **yes**, go to **Step 2**. • If **no**, go to **Step 8**.
2	Would counting the trust result in excess resources? • If **yes**, go to **Step 3**. • If **no**, go to **Step 8**.
3	Does the individual allege, or information in the file indicate, that not receiving SSI would deprive the individual of food or shelter according to SI 01120.203G in this section? • If **yes**, go to **Step 4**. • If **no**, go to **Step 8**.

STEP	ACTION
4	Obtain the individual's signed statement (on the DPST screen in the SSI Claims System or, in non-SSI Claims System cases, on a SSA-795 faxed into NDRed) as to whether: • Failure to receive SSI payments would deprive the individual of food or shelter; • The individual's total available funds are less than the FBR plus any federally administered State supplement; • The individual agrees to report promptly any changes in income and resources; and • The individual understands that he or she may be overpaid if, for any month, available funds exceed the FBR plus any State supplement or if other situations change. • Go to **Step 5**.
5	Does the trust contain language that specifically prohibits the trustee from making disbursements for the individual's support and maintenance or that prohibits the trustee from exercising discretion to disburse funds for the individual's support and maintenance? • If **yes**, go to **Step 6**. • If **no**, go to **Step 8**.
6	Add up all of the individual's income, both countable and excludable (see SI 01120.203G.3.a. in this section). Do not include any SSI payments received or items that are not income, per SI 00815.000. If the individual is receiving ISM, include as income the ISM being charged (the PMV, VTR, or actual amount, if less). Add up all of the individual's liquid resources, both countable and excludable (see SI 01120.203G.3.b. in this section). Does the total of the income and the liquid resources equal or exceed the FBR plus any federally administered State supplement? • If **yes**, go to **Step 8.** • If **no**, go to **Step7**.

STEP	ACTION
7	Suspend counting of the trust as a resource for any month in which all requirements above are met (see SI 01120.203G.2. in this section). • In the SSI Claims System, document the findings of undue hardship and applicable months on the **DROC** screen. • On paper forms, document the information in the **REMARKS** section. For further documentation, see SI 01120.202C and SI 01120.202D; and for follow-up instructions, see SI 01120.203H in this section. **STOP**.
8	Undue hardship does not apply. However, in some instances where income and resources are currently too high, unless the trust is revocable, undue hardship may apply in future months.

Social Security

POMS Recent Change

Identification Number:	**SI 01120 TN 54**
Intended Audience:	See Transmittal Sheet
Originating Office:	ORDP OISP
Title:	**Identifying Resources**
Type:	POMS Transmittals
Program:	**Title XVI (SSI)**
Link To Reference:	

PROGRAM OPERATIONS MANUAL SYSTEM
Part 05 - Supplemental Security Income
Chapter 011 - Resources
Subchapter 20 - Identifying Resources
Transmittal No. 54 , 04/2018

Audience

FO/TSC: CS, CS TXVI, DRT, FR, OA, OS, RR, CSR, TA, CTE, TSC-CSR

Originating Component

OISP

Effective Date

April 30, 2018

Background

This transmittal clarifies procedure regarding the review of pooled trusts for Supplemental Security Income (SSI) purposes. We provide guidelines to establish pooled trust precedents in the SharePoint Repository. We provide new examples of pooled trust reviews as guidance for evaluating pooled trusts. This transmittal incorporates the emergency message "Guidelines on Reviewing and Establishing Pooled Trust Precedents" published on February 12, 2016. EM-16006 is obsolete.

Summary of Changes

SI 01120.202 Development and Documentation of Trusts Established on or After 01/01/00

We made the following changes:

Subsection A –

- Clarified procedure for when to evaluate trust documents and when to reopen cases
- added instructions to include certain information in denial manual notices.

Subsection B and C – Moved from subsection B to C the instructions on pooled trust reviews and establishing and managing SSITMS SharePoint files.

Subsection C – Added instructions for reviewing pooled trusts, and establishing and managing files in the SSITMS SharePoint.

Subsection D – Made minor changes for clarity.

Subsection H – Added examples for reviewing and evaluating pooled trusts.

Subsection I – Reorganized relevant references.

SI 01120.202 Development and Documentation of Trusts Established on or After 01/01/00

A. Procedure For Trust Development

1. General development for written trusts

a. When to evaluate trust documents

Evaluate all trusts where an applicant, recipient, or spouse alleges an interest in a trust that needs a resource determination (such as a new or amended trust) in all initial claims (IC) and posteligibility (PE) events.

For PE events, do not reevaluate the trust resource determination (of a trust that has previously been reviewed) unless there is new and material evidence, such as an amendment to the trust or a clarification or change in policy that may affect the trust resource determination. However, evaluate all potential income implications, such as those of trust distributions and payments. For resource status changes in PE events, see SI 01120.201K.

b. Review the trust document

Obtain a copy of the trust document (the original trust document is not required) and related documents and review the document to determine whether the:

- individual is the grantor, trustee, or trust beneficiary;

- trust was established before, on, or after 01/01/00;
- assets were transferred into the trust before, on, or after 01/01/00;
- trust was funded with assets of the individual or third parties or both;
- trust is revocable or can be terminated and, if so, whether the individual has authority to revoke or terminate the trust and to use the principal for his or her own support and maintenance;
- individual has access to the trust principal;
- trust provides for or permits payments to the individual or on the individual's behalf for the benefit of the individual;
- trust principal generates income (earnings) and, if so, whether the individual has the right to any of that income;
- trust provides for mandatory periodic payments and, if so, whether the trust contains a spendthrift clause that is valid under State law and prohibits the voluntary and involuntary alienation of any interest of the trust beneficiary in the trust payments; and
- trust is receiving payments from another source.

c. Which instructions apply when determining the resource status and income treatment of a trust

Depending on the trust's date of establishment and whose funds the trust principal contains, follow these instructions to determine the resource status and income treatment of the trust:

If the trust was established...	And contains...	Then follow instructions in:
On or after 01/01/00	Any assets of the individual	SI 01120.199, SI 01120.201 through SI 01120.204, SI 01120.225 and SI 01120.227
	Only assets of third parties	SI 01120.200
Before 01/01/00	Assets of the individual transferred before 01/01/00	SI 01120.200
	Any assets of the individual transferred on or after 01/01/00	SI 01120.199, SI 01120.201 through SI 01120.204, SI 01120.225, and SI 01120.227
	Only assets of third parties	SI 01120.200

NOTE: If the trust beneficiary adds his or her own assets to an existing third party trust on or after 01/01/00, redevelop the trust under the instructions in SI 01120.199, SI 01120.201 through SI

01120.204, SI 01120.225 and SI 01120.227. For more information on mixed trusts, see SI 01120.200A.1.b. and SI 01120.201I.3.

d. Consult regional instructions

Consult any regional instructions that pertain to trusts to see if there are any State or Tribal laws to consider on such issues as revocability or irrevocability and grantor trusts. You may also consult the Title XVI Regional Chief Counsel (RCC) Precedents. For RCC precedents on trusts, see PS 01825.000.

e. Referring a trust issue to the Regional Office (RO)

If there are unresolved issues that prevent you from determining the resource status of a trust, or there are issues that you believe need a legal opinion, follow your regional instructions or consult with your RO program staff via vHelp. If necessary, the RO staff will seek guidance from the central office (CO) or the Regional Chief Counsel (RCC). Do **not** contact or refer materials to the RCC directly.

NOTE: When referring a trust issue to the RO, make sure to include all documentation and an SSA-5002 (Report of Contact), if necessary, identifying the individual, source of the funds or assets, relevant relationships of others named in the trust, and a brief summary of the unresolved issue(s).

f. Reopening trust determinations

The field office may receive a request by any party to the determination, including SSA, questioning the correctness of the trust determination. The request to reopen a determination must be in writing and within the applicable time limit. For information on reopening SSI determinations, see SI 04070.015.

g. Manual notices

When applicable, issue a manual notice for trusts established with an individual's assets on or after 01/01/00 as required per SI 01120.204. For such notices, specify using free-form text each reason the trust is countable (that is, why it does not meet the relevant exception(s) or requirements). In the notice, you must cite:

- the applicable section of the trust (or any joinder agreement, if applicable) containing the problematic language or issue; and
- the Program Operations Manual System (POMS) citation that contains the policy requirements on that subject.

Additionally, provide the following language indicating where the POMS can be found on-line: "You can find the Program Operations Manual System (POMS) on the Social Security website at https://secure.ssa.gov/poms.nsf/Home?readform." For examples of manual notice language, see SI 01120.204.

NOTE: You should not provide legal advice or attempt to explain how to remedy the problem. For guidance on discussing trust policy with the public, see SI 01120.200M.

2. General development for oral trusts

a. State recognizes as binding

If the State in question recognizes oral trusts as binding (see regional instructions):

- record all relevant information;
- obtain from all parties signed statements describing the arrangement; and
- unless regional instructions specify otherwise, refer the case to your RO staff. The RO will refer the case, through the Assistant Regional Commissioner, Management and Operations Support (ARC, MOS), to the Regional Chief Counsel.

NOTE: The special needs trust and pooled trust exceptions do not apply in the case of an oral trust since these exceptions require written evidence as part of the trust document. For more information on the special needs trust and pooled trust exceptions, see SI 01120.203.

b. State does not recognize as binding

If the State does not recognize oral trusts as binding (see regional instructions), determine whether an agency relationship (a person or entity acting as an agent of the individual) exists and develop under regular resource-counting rules or transfer of resources rules, as applicable. For transactions involving agents, see SI 01120.020.

3. Determining whether a trust is revocable or irrevocable

Determine whether a trust is revocable or irrevocable based on the terms of the trust and State or Tribal law considerations (grantor trust rules). For revocability of grantor trusts, see SI 01120.200D.1.b and SI 01120.200D.3.

4. Determining if a self-funded trust established on or after 01/01/00 is a resource

When determining whether a trust is a resource, apply the policies in regional instructions and SI 01120.201C and SI 01120.201D For instructions on determining the resource status of third party trusts and self-funded trusts established prior to 01/01/00, see SI 01120.200. If the individual used his or her assets to establish a trust on or after 01/01/00, and the trust is:

- revocable, count the trust corpus as a resource **unless one of the exceptions in SI 01120.203 applies.**

  NOTE: The exceptions in SI 01120.203A only apply to counting a trust under the statutory provisions of section 1613(e) of the Act. A trust that meets the exception to counting for SSI

purposes under the statutory trust provisions of Section 1613(e) must still be evaluated under the instructions in SI 01120.200 to determine if it is a countable resource.

- irrevocable, count as a resource any portion of the trust attributable to the individual's assets and from which the trust can make payments to or for the benefit of the individual or the individual's spouse under any circumstance **unless one of the exceptions in SI 01120.203 applies**.
- irrevocable, and if the trust cannot make payments to or for the benefit of the individual or the individual's spouse under any circumstance, develop the establishment of the trust for a potential transfer of resources penalty using instructions in SI 01150.100.

  NOTE: If you determine that the trust is a resource, you must determine if an exception or waiver in SI 01120.203 applies.

5. Developing legal instruments and devices similar to a trust

a. Which legal instruments and devices to develop

Obtain any written documentation and review the legal instrument or device to determine if it meets the requirements in SI 01120.201G.

If it does, determine whether the arrangement created by the legal instrument or device is a countable resource under regular SSI resource counting rules. If the resource is:

- countable, develop the legal instrument or device under the other applicable resource rules.
- not countable, develop the legal instrument or device following the procedures for developing trusts.

NOTE: Review only a legal instrument or device established with the individual's assets on or after 01/01/00. Do **not** develop legal instruments and devices similar to a trust established with the individual's assets prior to 01/01/00 under instructions in SI 01120.200. However, transfers to such arrangements created by a legal instrument or device may be subject to the transfer of resources provisions. For instructions on transfer of resources, see SI 01150.100.

b. Referral to the RO

If you are unsure of whether the arrangement is one that you should develop as a legal instrument or device similar to a trust, refer the matter to the RO via the vHelp system. If necessary, the RO staff will seek guidance from the central office (CO) or the RCC.

B. Trust Review Process For Trusts Established On Or After 01/01/00

Claims Specialists evaluate all trusts **that need a resource determination** (such as a new or amended trust) in all IC and PE events. For PE events, do not reevaluate trusts that have a resource determination, unless there is:

- an amendment to the trust,
- a change of or clarification in policy that affects the resource determination,
- a request for reopening, or
- a situation where you become aware of a prior erroneous determination.

For resource status changes in PE events, see SI 01120.200K.

To ensure accurate and consistent trust resource determinations:

- Claims Specialists submit their trust resource determinations and any related documentation to the Regional Trust Review Team (RTRT) for review using the Supplemental Security Income Trust Monitoring System (SSITMS) website.
- The RTRT reviews all trust determinations and provide concurrence and any feedback to the Claims Specialists via the SSITMS website. After the Field Office (FO) receives the RTRT concurrence, Claims Specialists can adjudicate the case.

Claims Specialists and RTRT members can use this SSITMS (http://oestweb.ba.ad.ssa.gov/SSITM/default.aspx) link to access the website. SSITMS is a tool for SSA internal communication. Do not share information, including the precedents, with non-SSA personnel. For instructions on using the SSITMS website, visit the user guide located under the Help link on the SSITMS website.

NOTE: It is important to remember that trust determinations are subject to the rules of administrative finality. For more information on administrative finality, see SI 04070.040.

The following steps describe the trust review process for the Claims Specialists and RTRT members for reviewing trusts established with the assets of an individual on or after 01/01/00.

For the trust review process for trusts established prior to 01/01/00, third party trusts, or trusts not subject to Section 1613(e) of the Act, see SI 01120.200L. For instructions on the trust review process of Indian Gaming Regulatory Act (IGRA) trusts, see SI 01120.195.

1. Claims Specialists actions

For all IC and PE cases in which an individual alleges an interest in a trust established on or after 01/01/00 with his or her own (or spouse's) funds and which needs a resource determination, determine whether the trust is a countable resource. To make the trust resource determination, follow the appropriate trust policies in SI 01120.199, SI 01120.201, SI 01120.203, SI 01120.204, SI 01120.225, and SI 01120.227. Additionally, for pooled trusts follow instructions in SI 01120.202C. in this section.

After making a trust resource determination:

· Document the determination along with any references and rationale used in the decision-making process.

Ø For SSI Claims System cases, use the Report of Contact (DROC) screen.

Ø For non-SSI Claims System cases, use a Report of Contact form (SSA-5002) and fax it into the electronic folder (EF) or Non-Disability Repository for Evidentiary Document (NDRED).

· Fax the initial trust resource determination, trust document, and any pertinent information into the appropriate EF.

Follow the trust review process steps in SI 01120.202B.1.a. through SI 01120.202B.1.e. in this section.

a. Submitting trust determinations for RTRT review

To submit your trust determination for RTRT review:

- Access the SSITMS website and select the "Add New" tab. Add the applicant or recipient's name, representative payee's name (if any), social security number, and all other relevant trust information.
- Select the appropriate type of trust in SSITMS (for example, third party trust or special needs trust).
- Add remarks describing your determination and rationale.
- Submit the trust resource determination for RTRT review.

b. Reviewing the RTRT responses

SSITMS sends an email notification after the trust reviewer (TR) or regional trust lead (RTL) reviews the trust and provides a response. To view the RTRT's response:

- Access SSITMS and select the case from the Summary page listing or use the link in the email to access the case, and
- Click on the "Details/Update" tab.

The "Results" field will show that the RTRT member either agreed or disagreed with the trust resource determination. When the Claims Specialist is ready to process the case, change the trust status to "FO Effectuated" using the "Edit" function. The RTRT member may provide feedback in the remarks field.

NOTE: Select "FO Effectuated" only after completing all case development. Changing the Trust Status to "FO Effectuated" **locks** the case in SSITMS. Only the Remarks field will be accessible for additional comments.

c. Reevaluations of trust determinations

To request a reevaluation of a trust resource determination, access SSITMS and:

- Change the Trust Status to "Referred to RTL" using the "Edit" function.
- Provide the rationale, a summary of supporting documentation, and appropriate references in SSITMS remarks and select "Submit."

The RTL will select the case for review and determine if the central office (CO) or the Regional Chief Counsel (RCC) needs to review the case. The RTL will respond to the request via the SSITMS website, and SSITMS will send an email notification when the RTL completes the reevaluation process.

d. Appeals of trust determinations

When the applicant or recipient appeals the trust resource determination, the RTL must review the FO's reconsideration determination. To request a review of the trust reconsideration determination, access SSITMS and:

- select "Recon Pending" from the Recon Trust Status dropdown using the "Edit" function, and
- provide pertinent information about the reason for the appeal in FO remarks and select "Submit."

NOTE: Do not load a recon into SSITMS until you have made a trust recon determination. SSITMS will send an email notification when the RTL completes the FO reconsideration determination review.

NOTE: Goldberg-Kelly payments may apply during trust reconsiderations only when the SSI recipient is already in pay.

e. RTRT returns cases for further FO development

When the RTRT require additional information from the FO, they will return the case for further development. SSITMS will send an email notification about the further development requested to the FO mailbox. To view the RTRT's request, access SSITMS and:

- select the case from the Summary page listings or use the link in the email to access the case, and
- Click on the "Details/Update" tab.

View the request for additional information in the Remarks field. After completing the development requested, update the Trust Status to "FO Development Completed" using the "Edit" function and submit.

2. Trust Reviewer (TR) actions

Trust reviewers (TR) review the Claims Specialist's trust resource determination along with any pertinent documentation in the Supplemental Security Income Claims System (SSI Claims System), eView, and the Claims File User Interface (CFUI). When TRs receive a trust resource determination for

review in SSITMS, TRs select the case with "Pending" trust status from the SSITMS Summary listing or from the link in the email notification, and:

- Review the trust and associated information.
- Provide feedback in the Remarks field in SSITMS.
- Document the decision in a Report of Contact (DROC) screen or SSA-5002 .
- Indicate "agree" or "disagree" with the Claims Specialist's trust resource determination in Results.
- Change the trust status to "Review Completed" after making a decision on the trust resource determination.
- Submit the response to the FO.

Additionally, TRs refer:

- trusts back to the FO when the case needs further development.
- pooled trusts to the RTL for review and inclusion in the precedent file.
- trusts established outside their region, including pooled trusts with a precedent established in another region, to the RTL. The RTL will refer the trust to the appropriate region.

3. Regional Trust Lead (RTL) actions

Regional Trust Leads (RTL) review trust resource determinations for all pooled trusts, reevaluations, and appeals. When needed, RTLs request guidance from CO or the RCC, and refer trusts to other regions for their input or decision. RTLs also refer trusts back to the FO when the case needs further development. Additionally, RTLs monitor the SSITMS website and add pooled trust precedents to the SSITMS SharePoint Repository for Precedents. For instructions on establishing pooled trust precedents, see SI 01120.202C.3. in this section.

RTLs follow the trust review process steps in SI 01120.202B.3.a. to SI 01120.202B.3.d. in this section.

a. Reviewing pooled trust resource determinations

Select the case from the SSITMS Summary listing page or the link in the email notification and:

- Click the "Details/Update" tab.
- Review information provided by the Claims Specialist.
- Determine if consultation with CO or the RCC is necessary.
- Submit pooled trust documents to the RCC for a legal opinion when necessary.
- Provide the review results in the Remarks field.
- Update Trust Status to "Completed by RTL."

- Indicate "agree" or "disagree" with the FO's determination in Results and click "Submit."

NOTE: Add a precedent to the SSITMS SharePoint Repository for Precedents for all pooled trusts that do not have a precedent on file. Use the SSITMS "Help" link to access the precedent library on the SharePoint site.

For instructions on referring pooled trusts to the RCC and establishing and managing pooled trust precedent files, see SI 01120.202C.3. in this section.

b. Email notifications for reevaluation requests

RTLs will receive an email notification whenever a trust resource determination needs reevaluation. To view the reevaluation request, access the case from the SSITMS Summary page listing.

c. Reevaluate trust resource determinations

To reevaluate the trust resource determination, follow the steps listed in SI 01120.202B.3.a in this section. The Claims Specialist who submitted the case and the Claims Specialist's FO mailbox will receive an automated email notification when the RTL makes a decision. The subject line will show "Response to Trust for Reevaluation."

d. Appeal requests

SSITMS sends the RTL an email notification when he or she needs to review an FO determination on a trust reconsideration. An RTL who did not review the initial trust determination should review the FO reconsideration determination. To view appeal requests, access the case from the SSITMS Summary page listing or from the link in the email notification. To address the appeal request, follow the steps listed in SI 01120.202B.3.a. in this section.

The Claims Specialist who submitted the case and the Claims Specialist's FO mailbox will receive an automated email notification when the RTL makes a decision. The subject line will show "Response to SSI Trust Recon for Review."

C. Procedure For Reviewing Pooled Trusts And Establishing Precedent Files

To determine the resource status of a pooled trust, review the most recent version available of the master pooled trust for compliance with the requirements of section 1917(d)(4)(C) of the Act. Do not review prior versions of the master pooled trust agreement.

EXCEPTION: If the master trust has been amended, but the amendment does not cover the entire period of review, you may need to review the prior version(s) of the trust. See examples in SI 01120.202H.8.d. in this section.

For all IC and PE cases where an individual alleges establishment of a pooled trust subject to SI 01120.203:

- Review a copy of the master trust agreement, associated documents (such as any amendments) and his or her joinder agreement; and
- Determine whether a precedent for the pooled trust exists. Use the SSITMS "Help" link to access the SSI Trust Precedent SharePoint site that houses the precedent library.
- Review the precedent, if one exists. Trust precedents contain information to help you with evaluation of the pooled trust.

IMPORTANT: Do not share copies of trust precedents, RCC opinions, or other materials in the SSITMS SharePoint precedent file with the public, attorneys, or non-SSA personnel. The only precedents available to the public are in the PS part of the POMS instructions.

1. Procedure for reviewing pooled trusts that have not been amended and amended pooled trusts whose amendment applies to all prior versions

a. The pooled trust precedent is current and there has not been a policy change since the precedent was established

If the precedent in SSITMS SharePoint is for the most current version of the master pooled trust, and the applicant or recipient submits a trust agreement that is the same version or an older version of the master agreement amended by the current version, you do not need to review the master agreement submitted to make your determination. Use the resource determination in the precedent file. However, review the joinder agreement for SI 01120.203 compliance. Additionally, note that, before using the resource determination in the precedent file, you should check to make sure that there have been no policy changes since the precedent determination that would affect the trust resource determination.

After determining the resource status of the master pooled and joinder agreements:

- Document your determination and fax the master agreement and joinder agreement into the appropriate EF.
- Continue the trust review process in SI 01120.202B in this section. See the example of a current precedent for a pooled trust in SI 01120.202H.8.a. in this section.

b. The pooled trust precedent is current but there has been a policy change since the precedent was established

If the precedent in SSITMS SharePoint is for the most current version of the master pooled trust, but there has been a policy change since the precedent was established that may affect the resource determination for the master pooled trust, review the master agreement and joinder agreement for SI 01120.203 compliance, and take the following actions:

- Document your determination and fax the master agreement and joinder agreement into the appropriate EF.

- Continue the trust review process in SI 01120.202B. See the example of a current precedent for a pooled trust in SI 01120.202H.8.a. in this section.

c. The pooled trust precedent is not for the current version of the trust or there is no precedent

If the applicant or recipient submits a new or amended version of a pooled trust master agreement and/or the precedent in the SSITMS SharePoint is not for the most current version of the trust or no precedent exists, review the master pooled agreement and joinder agreement for SI 01120.203 compliance. Then take the following actions:

- Document your determination and fax the master agreement and joinder agreement to the appropriate EF.
- Continue the trust review process in SI 01120.202B in this section. See the example of an outdated precedent for a pooled trust in SI 01120.202H.8.b. in this section.

NOTE: RTLs submit the pooled trust documents to the Regional Chief Counsel (RCC) for a trust resource evaluation and update or establish a precedent in SSITMS SharePoint.

2. Procedure for reviewing amended pooled trusts whose amendment does not apply to all prior versions

If you encounter a situation where an applicant or recipient submits a pooled trust and the pooled trust manager established a new version of the master agreement that does not amend prior versions, take the following actions:

- If there is a precedent for the version of the agreement submitted, follow instructions in SI 01120.202C.1.a. in this section.
- If there is not a precedent for the version of the agreement submitted, follow instructions in SI 01120.202C.1.b. and SI 01120.202C.3. in this section. See example SI 01120.202H.8.c. in this section.
- Submit all versions of the pooled trust to the RTL by using SSITMS, including those with precedents.

3. Procedure for RTLs for establishing pooled trust precedents

a. Information in pooled trust precedents

Before adding or updating a pooled trust precedent in SSITMS SharePoint, RTLs must consult with the RCC. After the RCC evaluates the pooled trust documents, RTLs upload the trust precedent and related documents to the SharePoint site. Pooled trust precedents in SSITMS must contain the following information:

- A copy of the master trust agreement;
- A sample of a joinder agreement;
- A copy of the RCC evaluation of the pooled trust; and
- A precedent summary sheet containing the following information:
    a. Title of the pooled trust.
    b. Establishment date.
    c. Amendment dates.
    d. Resource determination (whether the master pooled trust agreement meets the requirements for exception) and date.
    e. Evaluation of whether the master pooled trust meets each of the requirements in SI 01120.203B.2. State in the summary the specific reason why the pooled trust does not meet any requirement.
    f. Conflicting trust provisions that render the trust countable: for example, a noncompliant early termination provision.

IMPORTANT: Do not share copies of trust precedents, RCC opinions, or other materials in the SSITMS SharePoint precedent file with the public, attorneys, or non-SSA personnel. The only precedents that are available to the public are in the PS Part of the POMS instructions.

b. Regional Chief Counsel (RCC) reviews all pooled trusts

RTLs must consult with the RCC before establishing and updating trust precedents in SSITMS SharePoint. The RCC reviews all pooled trusts and provides a written evaluation on whether they meet the requirements for exception in section 1917(d)(4)(C) of the Act.

c. RTLs manage the precedent files on the SSITMS SharePoint site

After consulting with the RCC, RTLs add precedents to SSITMS SharePoint for all pooled trusts that do not have a precedent on file and update the precedents when pooled trusts have been amended.

1. **Amended trusts that amend all prior versions**

For amended trusts that amend all prior versions, update the precedent summary sheet with the most recent information for the pooled trust and note that the amendments apply to all prior versions of the trust. For example:

- Add an amendment date and any reasons why the amended pooled trust is or is not in compliance.
- Add to SSITMS the most recent versions of the master pooled trust and joinder agreement.

- Do not delete prior versions of the pooled trust. Instead, identify them as "for historical purposes only."

2. **Amended trusts that do not amend all prior versions**

For amended trusts that do not amend all prior versions, keep a precedent for each version of the master agreement. For example, keep and update the prior version of a precedent summary sheet, a copy of the master trust agreement, and a copy of the RCC evaluation for each version of the pooled trust.

D. Summary For Trust Development

1. Trust development

The following is a summary of trust development presented in step-action format (for full development instructions, see SI 01120.202A in this section):

STEP	ACTION
1	Obtain and review a copy of the trust and all related documents. For instructions on the trust review process for Indian Gaming Regulatory Act (IGRA) trusts, see SI 01120.195.
2	Does the trust contain **any** assets of the individual? • If **no**, follow instructions in SI 01120.200. **STOP.** **NOTE:** If the individual adds any of his or her assets to a third party trust on or after 01/01/00, redevelop the trust per SI 01120.201 through SI 01120.204. • If **yes**, go to **Step 3**.
3	Determine the date the individual transferred his or her assets to the trust. To know which instruction to follow, see SI 01120.201C.1. and SI 01120.202A.1.c. in this section. • If the individual transferred any of his or her assets prior to 01/01/00, follow instructions in SI 01120.200. **STOP.** • If the individual transferred his or her assets in the trust only on or after 01/01/00, go to **Step 4**.

STEP	ACTION
4	Consult national and regional instructions to determine if the trust is revocable or irrevocable (for determining revocability of a trust, see SI 01120.202A.3. in this section and SI 01120.200D): • If you are unable to make a determination, consult with your RO programs staff. • If the trust is revocable, go to **Step 5**. • If the trust is irrevocable, go to **Step 6**. For policy on irrevocable trusts, see SI 01120.201D.2.
5	The trust is a resource unless an exception applies. To see if an exception applies, go to SI 01120.203. For treatment of revocable trusts, see SI 01120.201D.1. Issue a manual notice per SI 01120.204 and include the following information: • The applicable section of the trust (or any joinder agreement, if applicable) containing the problematic language or issue; • The POMS citation that contains the policy requirements on that subject; and • The following language indicating where the POMS can be found on-line – "You can find the Program Operations Manual System (POMS) on the Social Security website at https://secure.ssa.gov/poms.nsf/Home?readform."
6	For the policy on irrevocable trusts see SI 01120.201D.2. Does the trust also contain assets of a third party? • If **yes**, determine the amounts in the trust attributable to the individual and the third party. Develop resource treatment of the portion attributable to the third party under SI 01120.200. Go to **Step 7** for the portion of the trust attributable to the individual. • If **no**, go to **Step 7**.
7	Are there **any** circumstances that would allow payment from the trust to or for the benefit of the individual? • If **no**, the trust is not a resource. To see if a transfer penalty is applicable, refer to SI 01150.100. • If **yes**, the trust is a resource in the amount that the trust can pay out from the portion attributable to the individual unless an exception applies. To see if an exception applies, go to SI 01120.203. Issue a manual notice as instructed in **Step 5** in this table.

2. FO actions during the trust review process

The following is a summary of FO actions during the trust review process presented in step-action format (for full development instructions, see SI 01120.202A and SI 01120.202B.1. in this section):

Step	Action
1	Determine whether the trust is a countable resource. To help you evaluate the trust, follow the steps in SI 01120.202D.1. in this section. Additionally, for pooled trusts, follow instructions in SI 01120.202C in this section. Go to **step 2.** For instructions on the trust review process for Indian Gaming Regulatory Act (IGRA) trusts, see SI 01120.195.
2	Submit your trust resource determination to the RTRT for review using the SSITMS website. Follow instructions in SI 01120.202B.1.a. in this section. Go to **step 3.**
3	When SSITMS sends the automated notification that the RTRT completed review of the trust, access SSITMS to review the results. Go to **step 4**
4	Do you agree with the RTRT's review of the trust? • If yes, change the trust status in SSITMS to "FO effectuated" at the point when you are ready to adjudicate the IC or close the PE event. Do not change the status until all issues within the IC or PE event are resolved. **STOP.** • If not, request a reevaluation of the trust. For information on how to request a reevaluation, see SI 01120.202B.1.c. in this section. **NOTE**: You have to wait for the reevaluation's results to adjudicate your claim event.

3. RTRT actions during the trust review process

The following is a summary in step-action format indicating the RTRT's actions in the trust review process (for full development instructions, see SI 01120.202B.2. in this section):

STEP	ACTION
1	Access SSITMS to select the case with "pending" trust status or from the link in the email notification. Go to **step 2.** For instructions on the trust review process for Indian Gaming Regulatory Act (IGRA) trusts, see SI 01120.195.

STEP	ACTION
2	Is the trust a pooled trust? • If yes, refer to RTL for review. STOP. • If not, go to **step 3.**
3	Review the FO's trust resource determination. Use information documented in the SSI Claims System, eView, and CFUI to help with your review of the trust. Go to **step 4.**
4	Determine whether you agree or disagree with the FO's determination and provide feedback in the remarks section of SSITMS and document the decision on a DROC or SSA-5002 . Go to **step 5.**
5	Select "Edit" to change the trust status to "Review Completed" and indicate in "Results" whether you agree or disagree with the Claims Specialist's trust resource determination. Go to **step 6.**
6	Submit your response. **STOP.**

4. RTL actions during the trust review process

The following is a summary in step-action format indicating the RTL's actions in the trust review process (for full development, see SI 01120.202B.3. and SI 01120.202C in this section):

STEP	ACTION
1	Access SSITMS to select the case from the SSITMS listing or from the link in the email notification. Go to **step 2.** For instructions on the trust review process for Indian Gaming Regulatory Act (IGRA) trusts, see SI 01120.195.
2	Is this a reevaluation request? If yes, go to **step 3.** If no, go to **step 6.**
3	A RTL who did not review the initial determination reviews the FO and TR determinations and the remarks section to see the reason for the disagreement. Go to **step 4.**

STEP	ACTION
4	Determine if CO or RCC consultation is necessary to resolve the disagreement. Contact CO or the RCC if necessary and go to **step 5** once you are ready to make a decision. If CO or RCC input is not necessary, go to **step 5.**
5	Make a determination on the reevaluation and submit your response via SSITMS. **STOP.**
6	Is the trust established outside your region? • If yes, refer the trust to the appropriate region for input. • If not, go to **step 7.**
7	Review the FO's trust resource determination for the pooled trust. **NOTE:** If the trust determination is for a new pooled trust, add a new precedent to SharePoint. For pooled trusts, you must consult with the RCC before establishing and updating a precedent in SharePoint. Contact the RCC or CO if you need input while evaluating the trust. Go to **step 8.**
8	Determine whether you agree or disagree with the FO's determination and provide feedback in the remarks section of SSITMS and document the decision on a DROC or SSA-5002 . Go to **step 9.**
9	Select "Edit" to change the status to "Completed by RTL" and indicate in "Results" whether you agree or disagree with the Claims Specialist's trust resource determination. Go to **step 10.**
10	Submit your response. **STOP.**

E. Procedure For Documenting Trusts

1. Documenting trusts in the SSI Claims System

Document the existence of a trust in the SSI Claims System by answering **Yes** on the Resource Selection (RMEN) page to the **Trusts** question. A **Yes** answer will bring the **Trust (RTRS) page** into the path.

- Complete the applicable trust questions on the Trust page.

- Enter the value of a trust that does not count as a resource in **excluded amount,** if an exception applies, and select the exclusion type, for example, meets special needs trust requirements or undue hardship, from the **exclusion reason** drop down menu.
- Record all information used in determining whether the trust is a resource and whether it generates income in the Trust page in the SSI Claims System. For more information on what information to record, see MS INTRANETSSI 013.005.
- Record your conclusion and rationale on the **DROC** screen or SSA-5002 and fax to NDRED.

2. Documenting trust on paper forms

Document the existence of a trust on the appropriate resources question on the form or in Remarks. Record all information used in determining whether the trust is a resource and whether it generates income. Record your rationale and determination on an SSA-5002 , and fax to NDRED. For non-SSI Claims Systems cases, document evidence on the **EVID** screen. For information on electronic evidence documentation and retention, see GN 00301.286.

3. Documentation requirements in all cases

Include in the file:

- A copy of the trust document;
- Copies of any signed documents between organizations making payments to the individual and the individual legally entitled to such payments, if the payments have been assigned, either revocably or irrevocably, to the trust or trustee;
- Source of assets funding the trust;
- Records of any payments or disbursements (such as ledgers and bank statements) from the trust, as necessary; and
- Any other pertinent documents, such as court documents.

F. Procedure For Coding Trusts

1. Coding Medicaid trusts on paper

Code a **Q** and the date of establishment of the trust in the Third party Liability (PT) field of the Supplemental Security Record (SSR) if the trust qualifies as a Medicaid Trust.

2. Coding the CG field

Code **RE06** or **RE07**, as applicable in the CG (case characteristics) field to indicate a revocable or irrevocable trust, respectively. For a list of CG code entries, see SM 01301.820.

G. Procedure For Medicaid Determination

1. When not to make Medicaid eligibility determination

If the individual resides in a section 1634 State (in which SSA makes Medicaid determinations on behalf of the State), do not attempt to make a Medicaid eligibility determination since the Medicaid determination regarding the trust may differ from the SSI eligibility determination. For a discussion of Section 1634 States, see SI 01715.010A.3.

2. Prepare manual notice

Posteligibility discovery of a trust in a section 1634 State will not result in a correct automated notice paragraph. Suppress any automated notice and prepare a manual notice using Medicaid Paragraph 1147 in NL 00804.110.

NOTE: If the individual is blind or visually impaired, see instructions on the special blind or visually impaired notice options in NL 01001.010.

3. Send trust information to State

a. 1634 States

Copy the trust information and send it to the same address used for assignment of rights (AOR) and third party liability (TPL) information. See regional instructions or contact your RO staff for the correct address.

b. 209(b) and SSI criteria States

In States where SSA does not have an agreement to make the Medicaid eligibility determination:

- copy the trust information and see, as applicable, regional instructions SI NY01150.110, SI DEN01150.110, and SI BOS01150.110; or
- contact your RO staff for the correct address to send the information. For a discussion of section 209(b) and SSI criteria States, see SI 01715.010A.1. and SI 01715.010A.2.

H. Examples Of Trust Evaluations

1. Example of when the trust principal is a resource

a. Situation

A 20-year-old SSI claimant is the beneficiary of an irrevocable trust. The court established the trust in 02/2014 with the proceeds of the settlement of a lawsuit. The claimant lives with her parents, who support her fully. Her parents filed a medical malpractice suit on her behalf against her doctor. The

doctor's insurance company settled the lawsuit before it went to trial for $400,000. The court approved the settlement agreement, whereby the insurance company placed the money in an irrevocable trust for the claimant, naming her parents as trustees. The trust permits payments for the claimant's special needs other than support and maintenance. The trust does not provide for reimbursement of Medicaid expenditures to the State on behalf of the claimant.

b. Analysis

The trust was established with assets of the claimant. Although she never received them directly, the settlement proceeds meet the definition of assets in SI 01120.201B.2. Her parents, acting on her behalf, agreed to the settlement that established the trust. The court directed the proceeds to establish the trust after 01/01/00, so the instructions in SI 01120.201 apply. Although the trust is legally irrevocable under State law, it may be a resource because it permits disbursement of all the funds in the trust to or for the benefit of the claimant. The trust does not meet the exception for a special needs trust under SI 01120.203 because it does not require reimbursement of expenditures to the State(s) that provided medical assistance. Therefore, the trust is a resource in its full amount, $400,000. The claimant is ineligible due to excess resources.

2. Example of when the individual's assets form only part of the trust

See the example of when the individual's assets form only a part of the trust in SI 01120.201C.2.c.

3. Example of when part of the individual's assets in the trust is countable

a. Situation

Bill Murray is an SSI recipient. His wife, who is not eligible, won $150,000 in the State lottery, of which she received $85,000. She used the money to establish the Murray Family Irrevocable Trust. The trust stipulates that she must use $40,000 for their daughter's college education. She can use the remainder of the money for a number of purposes, including supplemental needs for Bill and income payments to herself, at the discretion of the trustee.

b. Analysis

Since Mrs. Murray established the trust with her assets and she can only pay $45,000 to or for the benefit of Mr. Murray, we will count $45,000 as a resource. We consider the remaining $40,000 in the trust a transfer of resources that we must evaluate under SI 01150.100.

4. Example of when a third party trust is not a resource

a. Situation

Woody King is a disabled young adult. In 08/2014, his parents established an irrevocable special needs trust on his behalf with $100,000 of their own funds. Prior to attaining age 18, he was ineligible because of the income and resources of his parents through deeming. Now that he has attained age 18, he is reapplying for SSI.

b. Analysis

Mr. King's resources do not include the trust established by his parents since he was not the grantor of the trust and it is irrevocable. The trust is not a countable resource for SSI purposes. However, payments from the trust, to or for the benefit of Mr. King, may be income.

NOTE: A third party trust can be revocable and not count as a resource as long as the trust beneficiary does not have the legal authority to revoke the trust or direct the use of the trust assets.

NOTE: If the SSI recipient is the beneficiary of an unfunded third party trust, — for example, the trust will be funded upon the death of a parent — it is not necessary to review and submit the unfunded trust to SSITMS for SSI eligibility purposes until it is funded.

5. Example of when the trust is self-established but no payment can be made to or for the benefit of the individual

a. Situation

Arnie Becker is permanently disabled due to an injury he suffered in an automobile accident. Mr. Becker received a $3.5 million dollar insurance settlement that he put into two irrevocable trusts. The first trust is a discretionary trust providing $2.5 million for the education and welfare of his children. The second trust is a charitable trust containing $1 million. The trustee must distribute annually the earnings on the trust in the form of scholarships for students at a nearby college.

b. Analysis

Although Mr. Becker's trusts constitute a very large amount of money, none of the trust assets can be disbursed to him or to provide for his or his spouse's needs. SSA does not count the trusts as resources for SSI purposes. However, the establishment of the trusts is a transfer of resources under SI 01150.100. Mr. Becker will likely be ineligible for SSI for at least 36 months.

6. Example of a burial trust

a. Situation

Mattie Walker, an SSI recipient, wishes to plan her funeral through a prepaid agreement. In the State where she lives, recipients of public assistance, including SSI, must place the funds for their prepaid agreement into a funeral trust. Ms. Walker enters into a contract for a casket and vault valued at $5,000, and the funeral services she wants are valued at $1,500. She places the full amount in a

revocable trust. As required by State law, the trust shows Ms. Walker as the grantor and the funeral home as the trust beneficiary.

b. Analysis

The revocable funeral trust is a resource under SSI burial trust policy in SI 01120.201H.2. This is the case because Ms. Walker is the grantor of the trust and the trust is revocable. The purpose of the trust is irrelevant for purposes of trust policy (see SI 01120.201C.2.d.).

However, since the trust is a resource, the SSI resource exclusions for burial spaces and funds apply. We exclude the vault and the casket as burial spaces. We exclude the $1,500 for funeral services under the $1,500 burial funds exclusion. Therefore, we exclude the total value of the trust. If the amount of funds for funeral services exceeds $1,500 (other than interest or appreciation), we would exclude up to $1,500, and the remaining amount would be countable.

For the burial space exclusion, see SI 01130.400, and for the burial fund exclusion, see SI 01130.409 through SI 01130.425.

NOTE: If a trust does not permit the use of the funds in the trust for burial, the burial exclusions are generally not applicable. Upon the individual's death, the individual would no longer be a beneficiary of the trust, unless the trust specifically provides otherwise. Therefore, individuals cannot designate $1,500 of an otherwise countable trust as a burial fund, unless the trust permits such a use. If you are unable to make this determination, consult with your RO programs staff using vHelp.

7. Example of a trust that includes an excluded resource

a. Situation

Armand Gonzales is a disabled adult SSI recipient. Mr. Gonzales received an award of $250,000 in a lawsuit in 06/2010 and the money went directly into a trust for his benefit. The trust does not meet any of the exceptions to the general SSI trust policy, so the trust would be a countable resource for SSI purposes. As a result, Mr. Gonzales has excess resources in 07/2010 (the month after the month in which the trust was established). The trustee uses all of the money in the trust to purchase a house for Mr. Gonzales (the trust holds the property title), and he moves into the home in 01/2011, when construction is completed. He contacts SSA and informs us of what has happened.

b. Analysis

Mr. Gonzales is ineligible due to excess income in 06/2010 and excess resources from 07/2010 to 01/11. When he moves into the house in 01/2011, we consider him to be living in his own home because he has an equitable ownership interest under a trust. The house qualifies for the home exclusion as of 02/2011, and if Mr. Gonzales meets all other SSI eligibility requirements, we will reinstate his benefits. For information on the home resource exclusion, see SI 01120.200F.1.

8. Examples of pooled trusts

a. Pooled trust precedent is current

Andy Smith filed for SSI benefits on 04/21/09. During his initial interview, he provided The Brothers of Townsville Master Pooled Trust and his joinder agreement for our evaluation. The master agreement states that the trust was established on 11/12/07 and there is no evidence that it has been amended.

The precedent summary sheet in SSITMS SharePoint shows that the trust was established on 11/12/07 and that it does not have any amendment dates. It also states that the master pooled trust meets the requirements of SI 01120.203 for exception.

Since SSITMS SharePoint has a current precedent on file for The Brothers of Townsville Master Pooled Trust, and there have not been any trust policy changes since 11/12/07 that would affect the resource determination in the precedent, we adopt the precedent determination for Mr. Smith's pooled trust, evaluate the joinder agreement for compliance, document the DROC, and submit our request for RTRT review via SSITMS.

b. Pooled trust precedent is not current

During Paul Baker's redetermination (RZ) on 06/02/10, he provided The Brothers of Townsville Master Pooled Trust and his joinder agreement for our evaluation.

The master agreement states the trust was established on 11/12/07 and amended on 10/24/09.

The precedent summary sheet in SSITMS SharePoint shows the trust was established on 11/12/07, but does not indicate any amendments.

The precedent in SSITMS SharePoint is not up-to-date. Therefore, we evaluate the master and joinder agreements for compliance, document our determination, and submit our determination via SSITMS for review.

Once the RCC evaluates the amended trust agreement, the RTL updates the precedent summary sheet in SSITMS SharePoint with the new determination information and a copy of the amended trust and updates all other trust-related documents.

c. No pooled trust precedent on file

Janet Moore reports during her RZ interview on 10/08/15 that she is a trust beneficiary of the Greater Los Angeles Master Pooled Trust. Her account was established in 07/2015. Ms. Moore submits her trust documents for our evaluation. We do not have a precedent in SSITMS SharePoint for the Greater Los Angeles Master Pooled Trust.

The Greater Los Angeles Master Pooled Trust was established on 05/15/08 and amended 06/04/12. The amendments do not apply to the prior version. We do not need to evaluate the 05/15/08 version of the master agreement to make a determination in Ms. Moore's case, because her trust was established under the 06/04/12 amended version of the trust. Therefore, we evaluate the 06/04/12 amended master trust agreement and joinder agreement for compliance and submit our determination via SSITMS for review.

Once the RCC evaluates the trust, the RTL creates a precedent for the Greater Los Angeles Master Pooled Trust that includes all the items listed in SI 01120.202C.3. in this section.

If another applicant who has a trust established under the original 2008 version of the trust submits a copy later (because the 2012 amendments do not apply to the 2008 version), establish a separate precedent for the 05/15/08 version of the trust.

d. Reviewing the most recent version of a master pooled trust

Scenario A: trust precedent is not current and 90-day trust amendment period does not apply

Gary Thompson has been a trust beneficiary of The Brothers of Townsville Master Pooled Trust since 02/01/08 and an SSI recipient since 2003. He reported the trust for the first time during an RZ interview in 08/20/15 and submitted his master and joinder trust documents. The Brothers of Townsville Master Pooled Trust has been amended three times, on 10/24/09, 03/18/12, and 02/15/13, and the amendments apply to prior versions. Our precedent file is not current because it shows that the master trust meets the requirement for exception based on the amended version of 03/18/12.

During Mr. Thompson's RZ, we evaluate the 02/15/13 amended version of the master pooled trust, because it is the most recent, and his joinder agreement. The RCC finds that the 02/15/13 version does not meet the requirements for exception. We document the trust determination and count the balance of the trust as a resource back to the start of the period of review based on administrative finality.

NOTE: Mr. Thompson does not qualify for a 90-day trust amendment period because his trust was not previously excepted from resource counting. A trust that either is newly formed or was not previously excepted from resource counting for that individual must meet all of the criteria in SI 01120.199 through SI 01120.203 and SI 01120.225 through SI 01120.227, to be excepted under section 1917(d)(4)(A) or 1917(d)(4)(C). Do not except such a trust from resource counting unless the trust meets all of these requirements.

Scenario B: trust precedent is not current and 90-day trust amendment period applies

Gary Thompson has been a trust beneficiary of The Brothers of Townsville Master Pooled Trust since 02/01/08 and an SSI recipient since 2003. We first excepted his pooled trust from resource counting in 03/2008. During an RZ interview on 08/20/15, Mr. Thompson submitted a copy of 02/15/13 amended master and joinder trust documents. The Brothers of Townsville Master Pooled Trust has been amended three times, on 10/24/09, 03/18/12, and 02/15/13, and the amendments apply to prior versions. Our precedent file is not current because it shows that the trust meets the requirements for exception as a resource based on the amended version of 10/24/09.

During Mr. Thompson's RZ, we evaluate the 02/15/13 version of the master pooled trust, because it is the most recent, and his joinder agreement. The RCC finds that the 02/15/13 version does not meet the requirements for exception because the early termination provision is noncompliant.

Since we had previously excepted The Brothers of Townsville Master Pooled Trust in Mr. Thompson's record (in 03/2008), we follow instructions in SI 01120.199 and offer him 90 days to

amend the trust. On 11/11/15, the trust is amended and becomes compliant. Since the trust was amended during the amendment period, the trust remains excepted from resource counting during the amendment period and continuing.

Scenario C: trust amendments do not cover the entire period of review

Gary Thompson has been a trust beneficiary of The Brothers of Townsville Master Pooled Trust since 02/16/08 and an SSI recipient since 2003. We first excepted his pooled trust from resource counting in 03/2008. During an RZ interview on 08/20/15, Mr. Thompson submitted a copy of 12/15/13 amended master and joinder trust documents. The Brothers of Townsville Master Pooled Trust has been amended three times, on 10/24/09, 03/18/12, and 12/15/13. Our precedent file is not current because it shows that the trust meets the requirements for exception as a resource based on the amended version of 10/24/09.

Mr. Thompson's RZ period of review is 08/13 through 08/15. We evaluate the 12/15/13 version of the master pooled trust because it is the most recent and covers the period 12/13 to 08/15 and the 03/18/12 version of the trust because it is applicable to the other part of the period of review (08/13 – 12/13). (The 12/15/13 version of the trust amended the 03/18/12 version of the trust, but only after 12/15/13. The 12/15/13 amendment is not retroactive to 03/18/12.) We also evaluate his joinder agreements. The RCC finds that the 03/18/12 version of the trust is compliant, but the 12/15/13 version does not meet the requirements for exception because the early termination provision is noncompliant.

Since we had previously excepted The Brothers of Townsville Master Pooled Trust in Mr. Thompson's record (in 03/2008), we follow instructions in SI 01120.199, and offer him 90 days to amend the trust. On 11/11/15, the trust is amended and becomes compliant. Since the trust was amended during the amendment period, the trust remains excepted from resource counting during the amendment period and continuing.

I. References

- SI 01120.199 Early Termination Provisions and Trusts
- SI 01120.201 Trusts established with the assets of an individual on or after 1/1/00
- SI 01120.202 Development and Documentation of Trusts Established on or After 01/01/00
- SI 01120.203 Exceptions to Counting Trusts Established on or after 1/1/00
- SI 01120.204 Notices for Trusts Established on or after 1/1/00
- SI 01120.225 Pooled Trusts Management Provisions
- SI 01120.227 Null and Void Clauses in Trust Documents

Bonin v Wells, Jaworski & Liebman, LLP
2017 NY Slip Op 32097(U)
October 4, 2017
Supreme Court, New York County
Docket Number: 153167/2016
Judge: Kathryn E. Freed
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various state and local government websites. These include the New York State Unified Court System's E-Courts Service, and the Bronx County Clerk's office.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. KATHRYN E. FREED PART 2
Justice

----------X

DELINDA BONIN,

Plaintiff,

- v -

WELLS, JAWORSKI & LIEBMAN, LLP, ANNMARIE PALERMO-SMITS

Defendant.

INDEX NO. 153167/2016

MOTION DATE

MOTION SEQ. NO. 001

DECISION AND ORDER

----------X

The following e-filed documents, listed by NYSCEF document number 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24,

were read on this application to/for Dismissal

Upon the foregoing documents, it is ordered that **the motion is granted and the complaint is dismissed.**

Defendants Wells, Jaworski & Liebman, LLP and Annmarie Palermo-Smits, Esq. move, pursuant to CPLR 3211 (a) (1), (a) (5), and (a) (7) and 3016 (b), for an order dismissing the complaint as barred by the relevant statutes of limitations and the documentary evidence.

FACTUAL AND PROCEDURAL BACKGROUND

In the complaint, plaintiff Delinda G. Bonin alleges that she and her husband, Carl J. Bonin ("Carl Bonin"), now deceased (collectively "the Bonins"), initially retained defendants to sell certain inherited real property. Subsequently, by written retainer

agreement executed October 10, 2007, the Bonins retained defendants to prepare an irrevocable trust to avoid having their assets, consisting primarily of the proceeds of that sale, affect their future eligibility for the Nursing Home Medicaid Program, in the event that either of them should require nursing home care in the future, and to prepare powers of attorney and living wills.

On December 14, 2007, the Bonins executed a trust agreement between them, as Grantors, and their son, nonparty Carl Gordon Bonin (a/k/a Gordon Carl Bonin), as the Trustee, prepared by defendants. The trust agreement created the Irrevocable Supplemental Benefits Trust (the Trust).

Plaintiff alleges that, in 2007, defendants advised the Bonins that the transfer of their assets into the Trust would insulate those assets from Medicaid's consideration after expiration of the 60-month look-back period. She further alleges that defendants advised the Bonins that, upon expiration of that period in 2013, they would be able to apply for institutional Medicaid, without being subject to a penalty period of ineligibility.

The Bonins funded the Trust in December 2007 and July 2008 by transferring $227,269 into the same, allegedly with defendants' advice and assistance.

Plaintiff alleges that defendants improperly drafted and structured the Trust and that, therefore, Medicaid would have considered the entire Trust property as an available resource upon a Medicaid benefits application filed by either of the Bonins. Plaintiff alleges that, because the Trust was self-settled, the principal of the Trust property would be considered by Medicaid as an available resource of the Bonins, citing 42 USC § 1396p (d) (3) (B) and 18 NYCRR § 360-4.5 (b) (1) (ii). She also alleges that the structure of the

Trust would permit discretionary payments for the benefit of either of the Bonins to be considered by Medicaid as available income, upon an application for Medicaid benefits by either, citing 18 NYCRR § 360-4.5 (b) (1) (iii).

Plaintiff further alleges that the trust agreement cites to New Jersey law in one instance, although the Bonins were New York residents, and although the Trust was to be administered in accordance with the laws of New York. She further alleges that one provision of the trust agreement is void as against public policy, citing EPTL § 7-3.1 [c]). Additionally, plaintiff alleges that the Trust cannot be a supplemental benefits/needs trust, as promised by defendants, because the relevant law does not allow self-settled supplemental benefits/needs trusts for individuals over the age of 65.

Plaintiff maintains that, had the Trust been properly drafted by defendants, she could have filed an application for Community Medicaid in-home benefits, without the 60-month look-back period, and could have made such application in 2011, four years after the Trust was created.

She alleges that, in 2009, in furtherance of legal advice previously provided by defendants to the Bonins, defendants prepared a gift tax return, reflecting both the transfer of their assets to the Trust, and Carl Bonin's transfer of his interest in the Bonins' residence to plaintiff.

Plaintiff alleges that, in 2011, she hired home health aides to care for Carl Bonin, paying the cost from the Bonins' checking account and with at least one distribution from the Trust.

In February 2013, plaintiff allegedly sought Medicaid planning assistance from an attorney specializing in elder care, nonparty Martin Hersh, Esq., who advised her by letters dated February 21 and 27, 2013 that the Trust assets would not be insulated for purposes of Medicaid eligibility because the trust agreement prepared by defendants was not properly structured. Plaintiff alleges that Hersh also advised that any attempt to amend the trust agreement or transfer the Trust property would subject the Bonins to a penalty period.

Plaintiff maintains that defendants never advised her that the Community Medicaid Program would have paid the Bonins benefits, without subjecting their assets to a look-back period, in the event that the Trust were broken.

By letter dated March 6, 2013, plaintiff, through the Trustee, forwarded Hersh's letters to defendants, and requested a response to Hersh's legal opinion about the structuring of the Trust.

By letter dated April 15, 2013, defendants advised plaintiff that the Trust estate plan was a good plan, and that the assets placed in the Trust would not be considered for purposes of Medicaid because the Trust was a "gifting trust," pursuant to which the Bonins gave up total control of the Trust assets. Defendants recommended that plaintiff file a Medicaid application as originally contemplated in 2007.

Plaintiff took Hersh's advice, rather than defendants'. She broke the Trust, transferred the assets to herself, and subsequently secured Medicaid benefits for Carl Bonin.

Plaintiff claims that, as a result of defendants' misconduct and improper legal advice, she incurred additional and unnecessary legal expenses to obtain proper Medicaid

planning and home health care for Carl Bonin, while waiting for the five-year look-back period to expire. She also alleges that, should she require nursing home care within the five-year period ending in 2020, Medicaid will assess a penalty against her, and she will be required to spend her assets on her medical care.

On April 13, 2016, plaintiff commenced the instant action, in which she asserts causes of action against defendants for legal malpractice, breach of contract, fraud, and violations of General Business Law (GBL) §§ 349, 349-c, and 350. She seeks to recover monetary damages in an amount to be determined at trial, together with court costs, disbursements, and reasonable attorneys' fees incurred in connection with prosecuting this action.

MOTION TO DISMISS

Defendants now seek to dismiss the complaint on numerous grounds, including that the complaint is barred by the relevant statutes of limitations and by the documentary evidence.

Section 3211 (a) (5) of the CPLR permits dismissal of a claim that is barred by the applicable statute limitations.

> "In moving to dismiss a cause of action pursuant to CPLR 3211 (a) (5) as barred by the applicable statute of limitations, a defendant bears the initial burden of demonstrating, prima facie, that the time within which to commence the action has expired. The burden then shifts to the plaintiff to raise an issue of fact as to whether the statute of limitations was tolled or was otherwise inapplicable, or whether it actually commenced the action within the applicable limitations period"

(*City of Yonkers v 58A JVD Indus., Ltd.*, 115 AD3d 635, 637 [2d Dept 2014] [internal quotation marks and citations omitted]).

On a motion addressed to the sufficiency of the pleadings, the court must accept each and every allegation in the complaint as true, and liberally construe those allegations in the light most favorable to the pleading party (*Leon v Martinez*, 84 NY2d 83, 87-88 [1994]; *see* CPLR 3211 [a] [7]). "We . . . determine only whether the facts as alleged fit within any cognizable legal theory" (*Leon v Martinez*, 84 NY2d at 87-88).

"[W]here a written agreement . . . unambiguously contradicts the allegations supporting a litigant's cause of action for breach of contract, the contract itself constitutes documentary evidence warranting the dismissal of the complaint pursuant to CPLR 3211 (a) (1), regardless of any extrinsic evidence or self-serving allegations offered by the proponent of the claim" (*150 Broadway N.Y. Assoc., L.P. v Bodner*, 14 AD3d 1, 5 [1st Dept 2004]; *see* CPLR 3211 [a] [1]).

The Legal Malpractice Claim Is Time-Barred

Defendants contend that the legal malpractice claim is time barred pursuant to CPLR 214 (6).

In opposition, plaintiff contends that the claim is timely asserted on the ground that the continuous representation doctrine tolled the running of the limitations period.

The legal malpractice claim is not timely asserted. An action to recover for attorney malpractice is governed by a three-year statute of limitations, regardless of whether the underlying theory is based on contract or tort (*McCoy v Feinman*, 99 NY2d 295, 301

[2002]; *see* CPLR 214 [6]). The three-year limitations period accrues "when the malpractice is committed, not when the client discovers it" (*Williamson v PriceWaterhouseCoopers LLP*, 9 NY3d 1, 7-8 [2007]). This is true even where the plaintiff is unaware of any malpractice, damages, or injury (*McCoy v Feinman*, 99 NY2d at 300-301).

For statute of limitations purposes, plaintiff's legal malpractice claim accrued no later than July 2008, when the Trust was fully funded. A legal malpractice claim accrues when the alleged injury to the client occurs, such as when the trust agreement was funded, regardless of the client's awareness of the malpractice (*Johnson v Proskauer Rose LLP*, 129 AD3d 59, 67 [1st Dept 2015]; *Pace v Raisman & Assoc. Esqs., LLP*, 95 AD3d 1185, 1187-1188 [2d Dept 2012]). Therefore, the legal malpractice claim should have been asserted no later than July 2011 for it to have been timely commenced. However, plaintiff commenced this action on April 13, 2016, almost five years after expiration of the limitations period.

Contrary to plaintiff's argument, the continuous representation doctrine is not applicable here because, once the Trust was funded, the attorney/client relationship between the Bonins and defendants ended.

The continuous representation doctrine tolls the accrual of the malpractice claim until completion of the professional's ongoing representation concerning the matter out of which the malpractice claim arises (*Shumsky v Eisenstein*, 96 NY2d 164, 168 [2001]). The doctrine "recognizes that a person seeking professional assistance has a right to repose confidence in the professional's ability and good faith, and realistically cannot be expected

to question and assess the techniques employed or the manner in which the services are rendered" (*Shumsky v Eisenstein*, 96 NY2d at 167 [internal citation and quotation marks omitted]). Where the doctrine is applied, the limitations period does not expire until the termination of the representation in connection with the subject matter of the alleged malpractice (*Droz v Karl*, 736 F Supp 2d 520, 527 [ND NY 2010] [applying New York law]; *Glamm v Allen*, 57 NY2d 87, 93-94 [1982]).

To toll the legal malpractice limitations period on a theory of continuous representation, the plaintiff must establish that there existed a mutual understanding between the attorney and client of the need for further representation on the specific subject matter underlying the malpractice alleged; a clear indication of an ongoing, continuous, developing, and dependent relationship between them pertaining specifically to the representation from which the alleged malpractice stems, that is not sporadic or intermittent; and a continuing relationship of trust and confidence between the attorney and the client (*Matter of Merker*, 18 AD3d 332, 332-333 [1st Dept 2005]).

Plaintiff has failed to plead any facts that suggest the existence of a continuing attorney/client relationship between defendants and herself. After the funding of the Trust in July 2008, no contact regarding the trust agreement is alleged to have occurred between the Bonins and defendants, until the Trustee's letter dated March 6, 2013, almost five years after the funding of the Trust and 1 ½ years after the expiration of the statutory limitations period. For purposes of the statute of limitations, an attorney/client relationship cannot be revived after the limitations period has expired (*see Droz v Karl*, 736 F Supp 2d at 527 [applying New York law]; *Maurice W. Pomfrey & Assoc., Ltd. v Hancock & Estabrook*,

50 AD3d 1531, 1533 [4th Dept 2008]). Therefore, the correspondence exchanged by the parties in 2013 does not constitute evidence of a continuing relationship, and cannot revive the relationship.

Defendants' reassurances that the Trust was properly created do not demonstrate the existence of a continuous representation. Repeated assurances by attorneys that they provided accurate advice and that they did nothing wrong do not constitute continuous representation, particularly where there exists no mutual understanding to maintain a professional relationship (*Arnold v KPMG LLP*, 543 F Supp 2d 230, 236 [SD NY 2008], *affd* 334 Fed Appx 349 [2d Cir], *cert denied* 558 US 901 [2009] [applying New York law]).

Plaintiff's consultation with Hersh demonstrates, at the very least, the absence of the required continuing relationship of trust and confidence.

Defendants' failure to advise in writing in 2013 that the attorney/client relationship had ended is not dispositive. The continuous representation doctrine does not provide that an attorney/client relationship continues indefinitely unless formally terminated in writing by either party.

Defendants' preparation of gift tax returns for the Trust in 2009 cannot establish the existence of a continuing relationship. Such preparation and legal representation was not related to the creation of the Trust, and, therefore, is not relevant to the issues raised here. Subsequent legal advice to an estate regarding tax liabilities is separate and distinct from the alleged negligence underlying the malpractice claim, and, therefore, cannot demonstrate the existence of a continuing relationship (*Pace v Raisman & Assoc. Esqs. LLC*, 95 AD3d at 1185).

In any event, the preparation of those returns would not render the legal malpractice claim timely commenced. Defendants prepared those returns more than three years prior to the commencement of this action in April 2016.

For the foregoing reasons, that branch of defendants' motion to dismiss the legal malpractice claim as untimely is granted, and that claim is dismissed.

Time-Barred Contract and Fraud Claims

The breach of contract and fraud claims are similarly time-barred.

Plaintiff cannot evade the three-year limitations period by re-characterizing the legal malpractice claim as one sounding in contract or fraud. Where the contract or fraud claim arises out of the same facts as does the legal malpractice claim, and does not seek to recover damages distinct from that claim, then the plaintiff may not benefit from the limitations periods applicable to contract or fraud claims (*Matter of R.M. Kliment & Frances Halsband, Architects [McKinsey & Co., Inc.*], 3 NY3d 538, 542-543 [2004]; *Farage v Ehrenberg*, 124 AD3d 159, 169-170 [2d Dept 2014]; *see* CPLR 214 [2], 214 [8]).

The factual allegations underlying the contract and fraud claims are identical to those underlying the legal malpractice claim. In the contract claim, plaintiff alleges that she and Carl Bonin retained defendants "to prepare . . . an irrevocable trust, to take advantage of the maximum tax savings and asset protection techniques relative to Medicaid planning" (complaint, ¶ 31), and that defendants breached the retainer agreement by "performing legal services in a sub-standard, sloppy and deficient manner" (*id.*, ¶ 35). In the fraud claim, plaintiff alleges that defendants held themselves out as "experienced

attorneys with a substantial expertise in the areas of . . . trusts and estate planning and that they would assist the Bonins to take advantage of the maximum tax savings and asset protection techniques relative to Medicaid planning" (*id.*, ¶¶ 56 [internal quotation marks omitted]).

In addition, the breach of contract claim is time barred, without reference to the legal malpractice claim. A contract claim must be brought within six years after the alleged breach (CPLR 214 [2]). As held above, the breach occurred no later than July 2008, when the Trust was fully funded. Plaintiff commenced this action on April 13, 2016, almost eight years later.

The contract claim is also fatally defective on the ground that it duplicates the legal malpractice claim in all respects. "[A] breach of contract claim premised on the attorney's failure to exercise due care or to abide by general professional standards is nothing but a redundant pleading of the malpractice claim" (*Sage Realty Corp. v Proskauer Rose*, 251 AD2d 35, 38-39 [1st Dept 1998]; *Xiong Ping Tang v Marks*, 133 AD3d 455, 456 [1st Dept 2015]).

The fraud claim is also time-barred, having been asserted more than six years after the fraud was allegedly committed in 2008, and more than two years from the time that the alleged fraud could have been discovered with due diligence, whichever is longer (*see Ghandour v Shearson Lehman Bros., Inc.*, 213 AD2d 304, 305 [1st Dept 1995]; CPLR 213 [8]). Here, plaintiff discovered the fraud no later than April 2013, upon her consultation with Hersh.

For the foregoing reasons, those branches of defendants' motion to dismiss the fraud and contract claims are granted, and those claims are dismissed.

Duplicity of Fraud And Legal Malpractice Claims

Defendants contend that the fraud claim is also fatally defective on the ground that it is duplicative of the legal malpractice claim.

In opposition, plaintiff contends that the fraud claim arises out of tortious conduct independent of the conduct giving rise to the malpractice claim.

A fraud claim that arises within the context of a legal malpractice claim will be dismissed as duplicative where it arises from the same facts as does the malpractice claim and does not allege separate and distinct damages (*Dinhofer v Medical Liab. Mut. Ins. Co.*, 92 AD3d 480, 481 [1st Dept 2012]; *Carl v Cohen*, 55 AD3d 478, 478-479 [1st Dept 2008]). No separate cause of action for fraud will lie where the plaintiff's allegations essentially "consist of accusations that defendants committed malpractice" (*Kaiser v Van Houten*, 12 AD3d 1012, 1014 [3d Dept 2004]).

Here, the fraud claim is duplicative of the legal malpractice claim. In both claims, plaintiff alleges that defendants failed to do what the Bonins allegedly hired them to do, i.e., create a trust that would allow the Bonins to take advantage of the maximum tax savings and asset protection techniques available with respect to Medicaid planning, and to discharge their duties in an expert, skillful, and knowledgeable manner (*see* complaint, ¶¶ 8, 11, 38-47, 56-57).

In both claims, plaintiff seeks to recover monetary damages of no less than $100,000, incurred solely as a result of defendants' failure to properly discharge their duties with respect to creating a trust that would protect the Bonins' assets, in the event that either of the Bonins decided to apply for Medicaid benefits in the future (*see id.*, ¶¶ 46, 48, 57, 61). Plaintiff alleges that those monetary damages consist of additional and unnecessary legal expenses and disbursements incurred in obtaining Medicaid planning a second time and home care for Carl Bonin, while waiting for the five-year look-back period to expire, and health care expenses and Medicaid penalties to be incurred in the future, should plaintiff herself require nursing home care within the five-year period ending in 2020. Plaintiff also seeks to recover all sums that the Bonins paid to defendants for their estate and trust planning legal services.

The fraud claim is also fatally defective on the ground that the elements of fraud are not pleaded with the specificity and particularity required by CPLR 3016 (b).

To state a legally viable claim of fraud, a plaintiff must allege "a representation of a material existing fact, falsity, *scienter*, deception and injury" (*New York Univ. v Continental Ins. Co.*, 87 NY2d 308, 318 [1995] [internal quotation marks and citation omitted]; *Nicosia v Board of Mgrs. of Weber House Condominium*, 77 AD3d 455, 456 [1st Dept 2010]). "Where a cause of action or defense is based upon misrepresentation, fraud, mistake, willful default, breach of trust, or undue influence, the circumstances constituting the wrong shall be stated in detail" (CPLR 3016 [b]). The allegations must be sufficiently particularized to give adequate notice to the court and to the parties of the transactions and occurrences intended to be proved (*Accurate Copy Serv. of Am., Inc. v Fisk Bldg. Assoc.*

L.L.C., 72 AD3d 456, 456 [1st Dept 2010]; *Foley v D'Agostino*, 21 AD2d 60, 63-64 [1st Dept 1964], citing CPLR 3013, 3016 [b]). Mere conclusory language is insufficient to state a fraud claim (*Daly v Kochanowicz*, 67 AD3d 78, [2d Dept 2009]).

A fraud claim asserted against multiple defendants must include specific and separate allegations for each defendant, or it will be dismissed (*Aetna Cas. & Sur. Co. v Merchants Mut. Ins. Co.*, 84 AD2d 736, 736 [1st Dept 1981]).

Here, plaintiff has failed to plead any actionable misrepresentation or material omission of fact by either defendant.

Plaintiff's allegations that defendants misrepresented their legal expertise in estate and trusts planning are not sufficient to support a legally viable fraud claim. A law firm's alleged statements regarding its attorneys' familiarity and expertise in an area of law are mere puffery and opinion, and, as such, are not actionable as fraud (*Schonfeld v Thompson*, 243 AD2d 343, 343 [1st Dept 1997]). Mere puffery regarding professional experience is promissory in nature, and, therefore, is not actionable as fraud (*Sheth v New York Life Ins. Co.*, 273 AD2d 72, 74 [1st Dept 2000]; *Schonfeld v Thompson*, 243 AD2d at 343).

Further, plaintiff's allegation that defendants misrepresented their future intent to keep their promise to provide competent legal assistance regarding Medicaid planning is similarly insufficient. A fraud claim cannot be predicated upon statements which are promissory in nature at the time that they are made, and which relate to future actions or conduct (*P. Chimento Co. v Banco Popular de Puerto Rico*, 208 AD2d 385, 385 [1st Dept 1994]). A fraud claim "may not be based on disappointment that a promised future benefit did not materialize" (*Satler v Merlis*, 252 AD2d 551, 552 [2d Dept 1998]).

Plaintiff failed to allege any facts that might establish that defendants had a present intent to deceive her. A conclusory allegation of present intent is not adequate to plead sufficient details regarding the essential element of scienter (*Zanett Lombardier, Ltd. v Maslow*, 29 AD3d 495, 495 [1st Dept 2006]). Plaintiff's allegations that defendants never intended to assist her as promised are completely belied by the facts as alleged in the complaint and by the documentary evidence. Defendants created a Trust for the Bonins. As discussed above, plaintiff's current disappointment with that service is not actionable.

For the foregoing reasons, the branch of defendants' motion to dismiss the fraud claim is granted, and that claim is dismissed.

General Business Law Claims

Plaintiff's GBL §§ 349, 349-c, and 350 claims are time-barred, pursuant to CPLR 214 (2).

A claim based upon a liability created or imposed by statute is subject to a three-year limitations period (*Gaidon v Guardian Life Ins. Co. of Am.*, 96 NY2d 201, 209 [2001]; *see* CPLR 214 [2]). A claim for a violation of either GBL § 349 or § 350 accrues when the plaintiff sustains injury as the result of a deceptive act or practice violating the statute (*Gaidon v Guardian Life Ins. Co. of Am.*, 96 NY2d at 209).

Bonin's GBL §§ 349 and 350 claims accrued when plaintiff executed and funded the Trust in July 2008 because that was the point at which she allegedly sustained injury. Plaintiff alleges that, when she funded the Trust, the assets were not insulated from Medicaid, and her "expectations were not met" (complaint, ¶¶ 63-65). She commenced

this action on April 13, 2016, almost eight years later. Therefore, the GBL claims are time-barred.

The GBL § 349 claim is also fatally defective on the ground that plaintiff has not alleged that defendants engaged in consumer-oriented conduct that was deceptive or misleading in a material way. Nor can she demonstrate that she was injured as a result of such conduct. GBL § 349 provides, in relevant part, that "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful" (GBL § 349 [a]).

Plaintiff's claim for violations of GBL § 349 is not legally cognizable. To state a claim for relief under GBL § 349, a plaintiff must allege "first, that the challenged act or practice was consumer-oriented; second, that it was misleading in a material way; and third, that the plaintiff suffered injury as a result of the deceptive act" (*Stutman v Chemical Bank*, 95 NY2d 24, 29 [2000]).

The GBL's "threshold requirement of consumer-oriented conduct is met by showing that acts or practices have a broader impact on consumers at large in that they are directed to consumers or potentially affect similarly situated consumers"
(*Cruz v NYNEX Info. Resources*, 263 AD2d 285, 290 [1st Dept 2000] [internal quotation marks and citations omitted]).

Bonin's GBL § 349 claim is not based on a transaction that affects the consuming public at large. Instead, it is based on an alleged breach of a retainer agreement unique to the parties. A private contract dispute, such as the dispute here, does not come within the scope of GBL §§ 349 and 350 (*Canario v Gunn*, 300 AD2d 332, 333 [2d Dept 2002]).

Contrary to plaintiff's contention, the Rules of Professional Conduct prohibiting false advertising by an attorney (*see* 22 NYCRR 1200.0, Rules 7.1 [a] [1], 7.3 [a] [2]) do not create a private cause of action, nor may violations of those rules form the basis of claims under the GBL. "The violation of a disciplinary rule does not, without more, generate a cause of action" (*Schwartz v Olshan Grundman Frome & Rosenzweig*, 302 AD2d 193, 199 [1st Dept 2003]).

Plaintiff's GBL § 350 claim for false advertising is fatally defective on that ground as well. False advertising is defined by the statute as "advertising, including labeling, of a commodity, or of the kind, character, terms or conditions of any employment opportunity, if such advertising is misleading in a material respect" (GBL § 350-a). The provision of legal services does not involve any commodity, product, or employment opportunity.

Finally, plaintiff's GBL § 349-c claim is defective on its face. Section 349-c of the GBL does not support an independent cause of action, but, instead, imposes an additional civil penalty for violations of sections 349 and 350 of the GBL, when the plaintiff is 65 years of age or older (*see* GBL § 349-c). Inasmuch as plaintiff's claims asserted under GBL §§ 349 and 350 are fatally defective, the GBL § 349-c claim is also fatally defective.

For the foregoing reasons, those branches of defendants' motion to dismiss the claims for violations of GBL §§ 349, 349-c, and 350 are granted, and those claims are dismissed.

Therefore, in light of the foregoing, it is hereby:

ORDERED that defendants' motion to dismiss the complaint is granted, and the complaint is dismissed in its entirety as against each defendant, with costs and disbursements to each defendant, as taxed by the Clerk of the Court, and the Clerk is directed to enter judgment accordingly in favor of each defendant; and it is further

ORDERED that this constitutes the decision and order of the court.

10/4/2017
DATE

KATHRYN E. FREED, J.S.C.

CHECK ONE:	[X]	CASE DISPOSED	[ ]	DENIED	[ ]	NON-FINAL DISPOSITION	
	[X]	GRANTED			[ ]	GRANTED IN PART	[ ] OTHER
APPLICATION:	[ ]	SETTLE ORDER			[ ]	SUBMIT ORDER	
CHECK IF APPROPRIATE:	[ ]	DO NOT POST			[ ]	FIDUCIARY APPOINTMENT	[ ] REFERENCE

Jimenez v Concepts of Independence, Inc.
2018 NY Slip Op 30257(U)
February 14, 2018
Supreme Court, New York County
Docket Number: 653161/2016
Judge: Melissa A. Crane
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 15

JANETH JIMENEZ, on behalf of herself and all others similarly situated

Plaintiffs,

-against-

CONCEPTS OF INDEPENDENCE, INC.,

Defendant.

Index No.: 653161/2016

Mot. Seq. No. 001

MELISSA A. CRANE, J.S.C.:

Defendant Concepts of Independence, Inc. moves, pursuant to CPLR 3211 (a) (7), to dismiss plaintiff Janeth Jimenez's complaint for failure to state a cause of action.

Background

Defendant is a not-for-profit enterprise that employs aides to care for elderly and disabled people in New York through the Consumer Directed Personal Assistance Program ("CDPAP") (class action complaint, ¶ 1). Plaintiff alleges that she is a home care aide whom defendant employs. Defendant contracts with Independence Care Systems, Inc. to provide human resources and payroll services for the aides (*id.*, ¶ 2). Plaintiff alleges that she and other aides work 24-hour shifts and earn roughly $5.71 per hour, approximately half the minimum wage in New York (*id.*, ¶ 3). Moreover, they also work more than 40 hours per week without receiving any overtime pay (*id.*, ¶ 5). These shifts take place at the homes of individual elderly or infirm persons, defined as consumers (18 NYCRR 505.28 [b] [1]), but the aides live in their own homes, where they return after each shift (class action complaint, ¶ 4).

CDPAP is a statewide Medicaid program that allows consumers to choose their own aides, and how care will be provided (*id.*, ¶¶ 12-14). These services include "personal care services, home health aide tasks, or skilled nursing tasks" (*id.*, ¶ 16). More specifically, plaintiff

alleges that her duties included assistance with practically every facet of day to day living, scheduling appointments, acting as emotional support, and staying awake and alert during overnight shifts (*id.*, ¶¶ 25-30). Defendant then arranged for plaintiff's wages, taxes, other withholdings, and benefits. Defendant also maintained relevant records and coordinated reimbursement from the New York State Department of Health ("DOH"). Plaintiff received her pay and other various administrative assignments from DOH (*id.*, ¶¶ 31-37).

Plaintiff alleges that, from July 18, 2015 through August 28, 2015, she generally worked between three and five 24-hour shifts every week, for which she was only paid for 12 of the 24 hours, plus a per diem payment of $16.95 (*id.*, ¶¶ 10, 42, 44-45). Plaintiff further alleges that defendant under-paid her and other putative class members, despite requiring them to be present at each consumer's house to provide services for the entire 24-hour shift (*id.*, ¶ 41). Plaintiff claims that the entirety of each shift were compensable work hours (*id.*, ¶ 46). Moreover, she alleges that defendant had a policy and practice of not paying overtime for any hours over 40 worked in a given week (*id.*, ¶ 48). These practices allegedly violate various statutory and regulatory provisions (*id.*, ¶¶ 51-53, 59). Plaintiff claims that she attempted to discuss these discrepancies with defendant by phone, to no avail (*id.*, ¶ 50).

On June 15, 2016, plaintiff brought this class action on behalf of all individuals defendant employed as home care aides in New York City since March 1, 2012, and in Westchester, Nassau, and Suffolk Counties since March 1, 2013 (*id.*, ¶ 56). The complaint alleges six causes of action: failure to pay minimum wage, pursuant to Labor Law § 652 and 12 NYCRR § 142-3.1 (first cause of action); failure to pay overtime, pursuant to Labor Law § 650, *et seq.*, and 12 NYCRR § 142-3.2 (second cause of action); failure to pay spread-of-hours pay, pursuant to Labor Law § 650, *et seq.*, and 12 NYCRR § 142-3.4 (third cause of action); failure to pay wages

due and owing, pursuant to Labor Law § 663 (fourth cause of action); breach of contract for failure to comply with Public Health Law § 3614-c (the Wage Parity law) (fifth cause of action); and, unjust enrichment (sixth cause of action). Defendant now moves to dismiss the complaint for failure to state a cause of action.

Discussion

"On a motion to dismiss pursuant to CPLR 3211, the pleading is to be afforded a liberal construction" (*Leon v Martinez*, 84 NY2d 83, 87 [1994]). "[The court] accept[s] the facts as alleged in the complaint as true, accord[ing] plaintiffs the benefit of every possible favorable inference, and determin[ing] only whether the facts as alleged fit within any cognizable legal theory" (*id.* at 87-88). "[W]here . . . the allegations consist of bare legal conclusions, as well as factual claims either inherently incredible or flatly contradicted by documentary evidence, they are not entitled to such consideration" (*Ullmann v Norma Kamali, Inc.*, 207 AD2d 691, 692 [1st Dept 1994]).

For the most part, defendant does not direct its motion at the individual causes of action themselves. Instead, defendant raises broader arguments that apply to multiple individual claims. In order to address these arguments, it is necessary to analyze the wage scheme under which the parties operated.

Under the Labor Law, an employee is "any person employed for hire by an employer in any employment" (Labor Law § 190 [2]). An employer is "any person, corporation, limited liability company, or association employing any individual in any occupation, industry, trade, business or service" (Labor Law § 190 [3]). Employment is not defined. However, the Labor Law does define "employed" quite broadly as "permitted or suffered to work" (Labor Law § 2 [7]).

During the time that plaintiff worked for defendant, employers were required to pay their employees a minimum wage of $8.75 per hour (Labor Law § 652 [1]). In addition, and subject to certain provisions of the Fair Labor Standards Act, employers must pay employees one and one-half times their regular rate for any hours worked over 40 hours per week (12 NYCRR 142-3.2), and an additional hour's worth of pay where the "spread-of-hours" worked exceeds 10 hours (12 NYCRR 142-3.4).[1] Not-for-profit entities, such as defendant, may exempt themselves from the statutory minimum wage and related regulations, provided they certify that their employees are paid "a wage, exclusive of allowances, of not less than the minimum wage" (Labor Law § 652 [3] [b]). This exemption lasts either until 60 days after the entity informs the Commissioner of the Department of Labor that it wishes these provisions to apply to it, or "immediately upon the issuance of an order by the commissioner finding that such institution has failed to pay" these wages (*id.*, § 652 [3] [c]).

In addition to the statutory and regulatory provisions cited above, the parties reference an opinion of the Counsel for the New York State Department of Labor regarding the number of hours for which live-in employees must receive payment. Specifically, live-in employees, whether residential or, like plaintiff, living off the premises,

> must be paid not less than for thirteen hours per twenty-four hour period provided they are afforded at least eight hours for sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals. If an aide does not receive five hours of uninterrupted sleep, the eight-hour sleep period exclusion is not applicable and the employee must be paid for all eight hours. Similarly, if the aide is not actually afforded three work-free hours for meals, the three-hour meal period exclusion is not applicable

(NY St Dept of Labor, Op No. RO-09-0169 at 4 [Mar. 11, 2010]). The Appellate Division, First

[1] "The spread of hours is the interval between the beginning and end of an employee's workday. The spread of hours for any day includes working time plus time off for meals plus intervals of duty" (12 NYCRR 142-3.16)

and Second Departments, have recently considered the application of this opinion letter to the minimum wage law. In *Tokhtaman v Human Care, LLC* (149 AD3d 476 [1st Dept 2017]), the court affirmed the trial court's denial of the defendant's motion to dismiss. The plaintiff, a home health care attendant, had alleged similar Labor Law violations to those in this case (*id.* at 476). The court held that the opinion letter, in failing to distinguish between residential and non-residential employees, conflicted with the Labor Law (*id.* at 477). Further, the court held that the plaintiff, as a non-residential employee, could recover unpaid wages for hours worked in excess of 13 hours, and that the defendant was not entitled to dismissal of her minimum wage, overtime, spread-of-hours, and failure to pay wages claims (*id.*). Similarly, in *Andryeyeva v New York Health Care, Inc.* (153 AD3d 1216 [2d Dept 2017]), the Second Department upheld class certification of home health care attendants raising similar claims. The court found that, because the plaintiffs, who were non-residential employees, had to remain at their clients' residences and perform services if necessary, "they were entitled to be paid the minimum wage for all 24 hours of their shifts, regardless of whether they were afforded opportunities for sleep and meals" (*id.* at 1219).[2]

After these appellate decisions, the Department of Labor issued an Emergency Rule amending the minimum wage orders, effective October 6, 2017 (2017 NY REG TEXT 471959 [NS]). Specifically, the Department of Labor amended 12 NYCRR 142-3.1 [b] as follows:

> Notwithstanding the above, this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more

(12 NYCRR 142-3.1 [b] [2]). 29 CFR 785.22 provides that an employer and employee may

[2] On the same day, the Second Department also reversed the denial of a motion for class certification in *Moreno v Future Care Health Servs., Inc.* (153 AD3d 1254 [2d Dept 2017]) on similar grounds.

agree to exclude bona fide meal and sleeping periods from the required wage, provided that sleeping facilities are "furnished by the employer" and that "the employee can usually enjoy an uninterrupted night's sleep" (29 CFR 785.22 [a]). In the absence of an agreement, meal and sleeping periods "constitute hours worked" (*id.*).

Against this backdrop, defendant makes three broad arguments. First, it argues that it has made the required certification, pursuant to Labor Law § 652 (3) (b), that it pays at least minimum wage and is therefore exempt from the statutory and regulatory minimum wage and related provisions. Second, it asserts that plaintiff is only entitled to thirteen hours of pay per day, pursuant to the Department of Labor's opinion that the eleven hours set forth for meals and sleep are not working hours, and, therefore, the court must dismiss plaintiff's claims based on 24 hours of work. Third, it claims that it is not plaintiff's employer, but rather the consumer is, and, accordingly, cannot be liable for plaintiff's allegedly unpaid wages.

Regarding the election under Labor Law § 652 (3) (b), defendant argues that because it has elected to exempt itself from the minimum wage requirements, plaintiff's claims, for failure to pay the minimum wage and overtime, are not viable. Moreover, 14 NYCRR 142-3.4 (a), that provides the spread-of-hours requirement, does not apply to nonprofits that have made the election. In opposition, plaintiff argues that defendant has not, in fact, paid her "not less than the minimum wage," pursuant to Labor Law § 652 (3) (b). Thus, defendant has not complied with the conditions of the election. Accordingly, plaintiff asserts that the requirements of minimum wage must apply.

Defendant attaches a copy of its request to be exempt from the minimum wage orders (Mischke Aff dated 10/7/16, exhibit 1, Statement of Non-Profitmaking Institutions dated 1/14/80 [election form]). The Labor Law is clear that its provisions and related wage orders apply to

entities like defendant under two circumstances: (1) sixty days after the entity notifies the commissioner that it wishes these provisions to apply to it, or (2) immediately upon the commissioner finding that the entity has failed to pay "a wage, exclusive of allowances, of not less than minimum wage" (Labor Law §§ 652 [3] [b], [c]). Plaintiff has not alleged that defendant requested that the wage orders apply to it, or that the commissioner has found that defendant has failed to pay the required wage. Thus, unlike the defendants in *Tokhtaman* and *Andryeyeva*, defendant here is not subject to the minimum wage regulations and related wage orders. Accordingly, the court dismisses plaintiff's second and thirds causes of action, for failure to pay overtime and spread-of-hours pay, respectively.

However, that defendant may not be required to pay overtime or spread-of-hours pay does not mean that plaintiff is not entitled to her regular pay for every hour that she works. While plaintiff argues that she is making below minimum wage, her argument is better understood as defendant was simply not paying her for her full day's work. Plaintiff's own allegations show that defendant paid $10 per hour on weekdays and $11.10 per hour on the weekend, respectively $1.25 and $2.35 more than the minimum wage in effect during plaintiff's employment with defendant (class action complaint, ¶ 44). Thus, the hourly rate is, in fact, not less than the minimum wage. However, the issue remains whether plaintiff has been paid for the correct number of hours, and that issue stands regardless of whether defendant's election remains in effect (*see Andryeyeva*, 153 AD3d at 1218-1219; *Tokhtaman*, 149 AD3d at 477 [allowing plaintiff's minimum wage claims to proceed]).

Defendant argues that the opinion letter and, by extension, the regulations it interprets, limit plaintiff to thirteen hours of pay per shift. Defendant points out that the client for whom plaintiff cared was only approved for "live-in 24-hour consumer directed personal assistance,"

that the regulations define as "the provision of care . . . for a consumer . . . whose need for assistance is sufficiently infrequent that an [aide] would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep" (18 NYCRR 505.28 [b] [12]). This is as opposed to "continuous consumer directed personal assistance," which is "the provision of uninterrupted care . . . for a consumer who, . . . needs assistance with such frequency that a live-in 24-hour [aide] would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep" (18 NYCRR 505.28 [b] [4]). Accordingly, defendant claims that plaintiff is only entitled to thirteen hours of pay per shift under the regulations, because she was not providing continuous care. Moreover, defendant asserts that plaintiff has not sufficiently pleaded that she was required to work during her breaks. In opposition, plaintiff states that she had to be present in the consumer's home for the entirety of her 24-hour shift, on call, awake and able to provide services. Accordingly, she asserts that she is entitled to pay for all of those hours, as she did not in reality receive any meal or sleep breaks.

Both the opinion letter and the current regulations require certain conditions before it is possible to exempt time set aside for meals and for sleeping from required wages. The opinion letter requires setting aside time for meals, and for at least five hours of regularly uninterrupted sleep, in order to qualify as "breaks" (NY St Dept of Labor, Op No,. RO-09-0169 at 4 [Mar. 11, 2010]). The newly amended regulation requires that the employer and employee must agree to exclude sleep and meal periods from regular pay, and, in the case of sleeping periods, the employer must furnish "adequate sleeping facilities" (12 NYCRR 142-3.1 [b]; 29 CFR 785.22 [a]). Moreover, *Tokhtaman* and *Andryeyeva* both hold that a non-residential employee, such as plaintiff, is entitled to a full day's pay if she is required to be at the consumer's residence (*Andryeyeva*, 153 AD3d at 1218-1219; *Tokhtaman*, 149 AD3d at 476). Here, plaintiff has

adequately alleged that she was a nonresidential employee, that the consumer required her presence at the consumer's home for the entirety of each 24-hour shift, and that she was required to remain alert and be prepared to render service throughout her shift (complaint, ¶¶ 4, 30, 41).

Relying on federal case law, defendant argues that plaintiff must plead wage and hour claims under the Labor Law with particularity. Accordingly, defendant claims that plaintiff's allegations are insufficient to show the extent that she was required to work during her breaks. Defendant, however, misapplies case law interpreting the Fair Labor Standards Act and the Labor Law. Regardless of whether the analysis is the same under either statute, defendant cites no New York State authority that Labor Law claims in state court are evaluated under the federal standard for purposes of a motion to dismiss. With the exception of fraud, defamation, and certain other claims and actions, a pleading need only "give the court and parties notice of the transactions, occurrences, or series of transactions or occurrences, intended to be proved and the material elements of each cause of action or defense" (CPLR 3013). The federal standard for pleadings derives from *Bell Atlantic Corp. v Twombly* (550 US 544, 570 [2007]) and *Ashcroft v Iqbal* (556 US 662, 678 [2009]). Subsequent to those two decisions, the New York courts have adhered to New York's lower notice pleading standard (*e.g. MatlinPatterson ATA Holdings LLC v Federal Express Corp.*, 87 AD3d 836, 839 [1st Dept 2011]; *Vig v New York Hairspray Co., L.P.*, 67 AD3d 140, 144 [1st Dept 2009]; *see also Torchlight Loan Services, LLC v Column Fin., Inc.*, 42 Misc 3d 1236[A], 2014 NY Slip Op 50376[U], *5 [Sup Ct, NY County 2014] ["At the outset, the court notes that *Torchlight* only asserts breach of contract claims, which are subject to New York's notice pleading standards, not CPLR 3016(b), the Federal Rules of Civil Procedure, or *Iqbal* and *Twombly*"]). Thus, the court finds defendant's argument that plaintiff insufficiently pleaded its remaining Labor Law claims unavailing. Regardless, the factual issues surrounding

plaintiff's work schedule are "not suited to resolution on a motion to dismiss" (*see Williams v Citigroup, Inc.*, 104 AD3d 521, 522 [1st Dept 2013]).

Defendant argues that, pursuant to the "economic reality" test (*Irizarry v Catsimatidis*, 722 F3d 99, 105 [2d Cir 2013]), defendant cannot have been plaintiff's employer because in the CDPAP, the consumer controls the hiring, scheduling, training, supervision, and termination of plaintiff and the other putative class members. Defendant argues its role as fiscal intermediary is primarily administrative. If it were an employer, defendant asserts that nonprofits would fuel the CDPAP, such as defendants, rather than the consumers. Nonprofits would then intrude upon consumer decision-making to avoid the kind of liability that plaintiff seeks to impose.

In opposition, plaintiff argues that whether defendant was her employer is a fact intensive question, ill-suited to resolution on a motion to dismiss. Moreover, she asserts that the complaint adequately alleges, at minimum, a joint employer relationship between defendant and the consumers that is sufficient to hold defendant liable for the alleged Labor Law violations.

In determining whether an entity is an employer for purposes of the Labor Law, New York courts have adopted the economic reality test set forth by the federal courts (*see Bonito v Avalon Partners, Inc.*, 106 AD3d 625, 626 [1st Dept 2013]; *Ponce v Lajaunie*, 2015 NY Slip Op 31216[U], *4-5 [Sup Ct, NY County 2015). The test has four factors: "whether the alleged employer (1) had the power to hire and fire the employees, (2) supervised and controlled employee work schedules or conditions of employment, (3) determined the rate and method of payment, and (4) maintained employment records" (*Irizarry*, 722 F3d at 105).

Courts will also consider whether an entity is a joint employer under the "immediate control" test (*Brankov v Hazzard*, 142 AD3d 445, 445–46 [1st Dept 2016]). "[A] joint employer relationship may be found to exist where there is sufficient evidence that the defendant had

immediate control over the other company's employees, and particularly the defendant's control over the employee in setting the terms and conditions of the employee's work" (*id.* at 446 [internal quotation marks omitted]). Relevant factors include "commonality of hiring, firing, discipline, pay, insurance, records, and supervision" (*id.* [internal quotation marks omitted]; *see Sanchez v Brown, Harris, Stevens*, 234 AD2d 170, 170 [1st Dept 1996]). "A complaint will survive a motion to dismiss in this context as long as the facts set forth in the Complaint plausibly suggest a degree of control and involvement by [the defendant] in Plaintiff's employment" (*Zuccarini v PVH Corp.*, 2016 NY Slip Op 30350[U], *4 [Sup Ct, NY County 2016] [internal quotation marks and citations omitted]). Indeed, whether a joint employer relationship exists is "essentially [a] factual question[s] that cannot be disposed of on a motion to dismiss" (*Dias v Community Action Project, Inc.*, 2009 WL 595601, at *6, 2009 US Dist LEXIS 17562, at *20 [EDNY, Mar. 6, 2009, No. 07-CV-5163 (NGG)(RER)]).

Here, plaintiff alleges that defendant established her wages, processed payroll and deductions (class action complaint, ¶¶ 24, 32-34), and maintained personnel records (complaint, ¶ 36). However, the CDPAP's governing regulations provide that the consumer is responsible for hiring, firing, training, supervision, and scheduling (18 NYCRR 505.28 [g] [1]). Thus, plaintiff has not adequately alleged that defendant was her sole employer (*Irizarry*, 722 F3d at 105).

However, plaintiff has alleged enough to suggest that a joint employer relationship is plausible. As set forth above, the complaint alleges, and the regulations confirm, that while the consumer is responsible for hiring, retention, training, and supervision (18 NYCRR 505.28 [g] [1]), defendant is responsible for maintaining records for both aides and consumers (*id.* at [i] [1] [iii-iv]), for monitoring aides' health statuses and aides' compliance with applicable regulations

(*id.* at [i] [1] [ii]), for monitoring the abilities of consumers or their designated representatives to comply with the CDPAP requirements (*id.* at [i] [1] [v]), and for establishing appropriate wages (*id.* at [i] [1] [i]). A similar division of responsibility existed in *Sanchez* where the plaintiff concierge was paid by the condominium in which she worked, but was hired, supervised, and fired by the condominium's managing agent (*Sanchez*, 234 AD2d at 170). The Appellate Division, First Department, denied summary judgment to the managing agent, holding that there was sufficient evidence to raise an issue of fact about whether the condominium and its managing agent employed the plaintiff, especially given the "evidence of the managing agent's day-to-day control over both plaintiff and the [condominium] superintendent" (*id.*). Here, there is a similar division of authority, and defendant's responsibilities under the governing regulations suggest the necessary "degree of control and involvement" with plaintiff's employment to survive this motion (*Zuccarini*, 2016 NY Slip Op 30350[U] at *4). Whether defendant is plaintiff's employer, and what that means for plaintiff, are fact intensive questions that the court cannot readily decide on a motion to dismiss. Further, if the consumer assumes responsibility, rather than the employer, for plaintiff's unpaid hours, plaintiff is left with no recourse for the alleged underpayment because the consumer is not responsible for plaintiff's wages.

Finally, defendant alleges that the Wage Parity Act (the "Act") does not apply to it, and, therefore, the court must dismiss the fifth cause of action (*see* NY Public Health Law 3614 [c]). Defendant asserts that, because the Act does not cover it, defendant is not part of any contract requiring compliance with the Act. Therefore, defendant cannot claim to be a third-party beneficiary of a contract under the Act. In opposition, plaintiff argues that she has sufficiently alleged that defendant was party to contracts requiring compliance with the Act, that plaintiff was a third-party beneficiary, and that defendant breached those contracts.

At the time defendant allegedly employed plaintiff, the Wage Parity Act forbade government agencies from making payments to "certified home health agencies, long term home health care programs or managed care plans" for care that home care aides provide who are compensated at less than an established minimum rate (former Public Health Law § 3614-c [2]). The CDPAP was only included in the statute as of July 1, 2017 (Public Health Law § 3614-c [2], as amended by L 2017, ch 57). Where a statute expressly provides a list of items to which it applies, a court can infer anything not on that list has been purposefully excluded (*e.g. Matter of Awe v D'Alessandro*, 154 AD3d 932, 932 [2d Dept 2017]). Because the Wage Parity Act did not cover CDPAP at the time that plaintiff worked for defendant, defendant cannot be liable for breaching any contractual requirement to comply with it.

Accordingly, the court grants that branch of defendant's motion to dismiss the fifth cause of action for breach of contract for failure to comply with the Wage Parity Law. The court has examined the remaining contentions of the parties and found them without merit.

Accordingly, it is hereby

ORDERED that the court grants the motion to dismiss to the extent that the second, third, and fifth causes of action of the complaint are dismissed; and it is further

ORDERED that the court directs defendant to serve an answer to the complaint within 20 days after service of a copy of this order with notice of entry; and it is further

ORDERED that the court directs counsel to appear for a preliminary conference in Room 304, 71 Thomas Street, on February 15, 2018, at 10:00AM.

Dated: February 14, 2018

ENTER:

HON. MELISSA A. CRANE, J.S.C.

Matter of Wellner v Jablonka

2018 NY Slip Op 02701 [160 AD3d 1261]

April 19, 2018

Appellate Division, Third Department

Published by New York State Law Reporting Bureau pursuant to Judiciary Law § 431.

As corrected through Wednesday, May 30, 2018

[*1]

In the Matter of Vaira Wellner, Petitioner,
v
Kary Jablonka, as Commissioner of Social Services of Columbia County, et al., Respondents.

Guterman Shallo & Alford, PLLC, Hudson (Matthew D. Cabral of counsel), for petitioner.

Carole Ann Kinnaw, Columbia County Department of Social Services, Hudson, for Commissioner of Social Services of Columbia County, respondent.

Eric T. Schneiderman, Attorney General, Albany (Kathleen M. Treasure of counsel), for Commissioner of Health, respondent.

Garry, P.J. Proceeding pursuant to CPLR article 78 (transferred to this Court by order of the Supreme Court, entered in Columbia County) to review a determination of the Department of Health finding petitioner ineligible for Medicaid benefits for a certain period of time.

Petitioner suffers from a progressive neurological disorder and resides in a nursing home. Until October 2014, she had resided with her spouse and received home health care assistance. Petitioner and her spouse have a son to whom, in 2010, the spouse transferred funds in exchange for a promissory note obliging the son to repay the loan in five annual installments. The son made only two of the payments, resulting in an unpaid balance. In February 2013, the spouse loaned him an additional and significantly greater sum in return for a 30-year mortgage on a newly-purchased residence for the son in New Jersey. Approximately three months following petitioner's entry into the nursing home, in January 2015, she submitted an application for Medicaid to the Columbia County Department of Social Services (hereinafter DSS). DSS denied the application and imposed a 45-month penalty period of ineligibility on the ground that the spouse had transferred assets for less [*2]than full market value during the 60-month period before the application.[FN1]

Acting as petitioner's attorney-in-fact, the spouse requested a fair hearing. The Department of Health (hereinafter DOH) upheld the determination following the hearing, finding petitioner ineligible for Medicaid because of the transfers, but reduced the length of the penalty period by crediting the sum of the mortgage payments that had been made by the son. Petitioner thereafter commenced this CPLR article 78 proceeding.

When an institutionalized applicant for Medicaid—or the applicant's spouse—transfers assets for less than fair market value during the 60-month "look-back period" before the date of the application, the applicant may be found to be ineligible for benefits for a period of time based upon the amount of the transfer (Social Services Law § 366 [5] [e] [3]; *see Matter of Whittier Health Servs., Inc. v Pospesel*, 133 AD3d 1176, 1177 [2015]). When such a transfer has occurred, a presumption arises that the transfer "was motivated, in

part if not in whole, by anticipation of a future need to qualify for medical assistance," and it is the applicant's burden to establish his or her eligibility for Medicaid by rebutting the presumption (*Matter of Mallery v Shah*, 93 AD3d 936, 937 [2012] [internal quotation marks, ellipsis and citations omitted]; *accord Matter of Krajewski v Zucker*, 145 AD3d 1252, 1253 [2016]). As pertinent here, an applicant may do so by demonstrating that he or she intended to receive fair consideration for the transfers or that the transfers were made exclusively for purposes other than qualifying for Medicaid (*see* Social Services Law § 366 [5] [e] [4] [i], [ii]).

Here, petitioner contended both that the spouse expected the note and mortgage to be repaid in full, and, in the alternative, that the transfers were made exclusively for purposes other than qualifying for Medicaid. DOH rejected these contentions. Upon review, we find the determinations to be supported by substantial evidence. At the fair hearing, the spouse testified that he made the 2010 loan to the son for the sole purpose of assisting in the purchase of a house in Columbia County, and that it would be "unrealistic" to believe that he knew then that petitioner would someday need to qualify for Medicaid assistance. Notably, however, he also testified that petitioner had begun to display symptoms of her progressive condition "many years" before this loan was made. She had been required to use a walker due to her symptoms, and, for several years before her 2014 nursing home admission, she had required care by home health aides during workdays and by the spouse at night and on weekends. She entered the nursing home in 2014 because the spouse was no longer able to handle her care. This testimony contrasts with the primary case that petitioner relies upon in this proceeding, in which the applicant, although of advanced age, had only relatively minor health concerns at the time of the transfers (*see Matter of Collins v Zucker*, 144 AD3d 1441, 1443 [2016]).[FN2]

The spouse testified that, at the time of the 2013 loan and mortgage, the son, who was [*3]an attorney, had recently left his employment in a law firm to establish his own practice and was thus unable to qualify for a bank loan. The spouse stated that he drafted the mortgage himself, without legal assistance, and included a 30-year term because he believed that this time period was customary. He further asserted that he expected the son to apply for and receive a conventional mortgage loan and make repayment in full within the next five years. However, there was no documentation supporting this expectation.

Assets conveyed through a note or a mortgage during the look-back period are considered to be transfers for full market value when the underlying loan is actuarially sound based upon the lender's life expectancy, provides for equal payments throughout the life of the loan—with no deferrals or balloon payments—and includes a provision prohibiting cancellation upon the lender's death (*see* Social Services Law § 366 [5] [e] [3] [iii]; 42 USC § 1396p [c] [1] [I]). Here, the mortgage was not actuarially sound, as its 30-year repayment term significantly exceeded the anticipated life expectancy of the spouse, who was 76 years old at the time of the transfer. After the rejection of petitioner's Medicaid application, the spouse executed an amended mortgage that reduced the repayment term to five years. However, this amended mortgage provided for the same monthly payment as had the original document, with a balloon payment at the end of the five-year term; it thus did not comply with the separate requirement for equal payments throughout the life of the loan. Moreover, neither the original nor the amended version of the mortgage included the required provision prohibiting cancellation upon the spouse's death; the 2010 note likewise included no such provision. Accordingly, substantial evidence supports DOH's determination that neither transaction

was made for fair market value (*see* 42 USC § 1396p [c] [1] [I]; *Matter of Rivera v Blass*, 127 AD3d 759, 762 [2015]).

A presumption thus arose in favor of DOH, and petitioner bore the burden of establishing her eligibility for Medicaid. As for the spouse's claim that he expected to be repaid in full, his testimony at the fair hearing established that the son made no payments on the 2010 loan after 2012, but that the spouse took no action to collect the balance due until after petitioner was found to be ineligible for Medicaid. He testified that he had expected the son to repay the balance of the 2010 loan in full upon the sale of the Columbia County house that had been purchased with his assistance, but acknowledged that the son had sold that house without repaying the loan. In December 2015, a week before the fair hearing, the spouse wrote to the son demanding payment of the remaining balance of the 2010 loan if there were adequate funds available upon the sale of the New Jersey residence, or otherwise within six months—thus deferring the deadline for final payment six months beyond the end of the original term. Proof was submitted that the New Jersey residence had been listed for sale, but there was no evidence of a contract of sale. In view of the entire record, including the spouse's belated efforts to collect the balance due on the promissory note, his provision of the 2013 loan and mortgage despite the son's default on the 2010 note, and the failure of the mortgage to comply with Medicaid requirements even after the spouse amended it, we find that substantial evidence supports DOH's determination that petitioner did not establish that the spouse expected to be fully repaid for the note and the mortgage.

As for whether the transfers were made solely for purposes other than qualifying for Medicaid, DOH declined to credit the spouse's testimony that he did not contemplate that petitioner might require nursing home placement at the time of the transfers, and this Court defers to such assessments (*see*

Matter of Mallery v Shah, 93 AD3d at 938-939). In view of the progressive nature of petitioner's condition and her poor health at the time of both transfers, substantial evidence supports DOH's conclusion that petitioner did not rebut the presumption that the transfers were made, at least in part, for the purpose of qualifying for Medicaid (*see Matter of Burke*, 145 AD3d 1588, 1589-1590 [2016]; *Matter of Corcoran v Shah*, 118 AD3d [*4]1473, 1473-1474 [2014]; *Matter of Mallery v Shah*, 93 AD3d at 938-939; *compare Matter of Collins v Zucker*, 144 AD3d at 1441; *Matter of Rivera v Blass*, 127 AD3d at 762-763).

McCarthy, Devine, Mulvey and Rumsey, JJ., concur. Adjudged that the determination is confirmed, without costs, and petition dismissed.

Footnotes

Footnote 1: The assessment also included a 2012 gift that the spouse made to the son. Petitioner concedes that this gift was properly treated as an uncompensated transfer subject to a penalty period of ineligibility, and raises no related challenges in this proceeding.

Footnote 2: Petitioner did not appear at the hearing due to the severity of her condition at that time; she was no longer able to walk at all, and was suffering certain cognitive difficulties.

Tara Anne Pleat

From: Ira Salzman via New York State Bar Association <Mail@ConnectedCommunity.org>
Sent: Tuesday, February 06, 2018 7:55 AM
To: Tara Anne Pleat
Subject: [Elder] : Interesting Article 81 Fee Case

Elder Law and Special Needs Section

Post New Message

Interesting Article 81 Fee Case

Reply to Group | Reply to Sender

Feb 6, 2018 7:55 AM
Ira Salzman, Esq.

In this case the 4th Dept. held that the trial court erred when it determined to appoint a guardian and at the same time ordered the petitioner to pay the fees of the court evaluator and the court appointed counsel.

Matter of Buttiglieri (Ferrel J.B.), 2018 N.Y. App. Div. LEXIS 648

Copy Citation

Supreme Court of New York, Appellate Division, Fourth Department

February 2, 2018, Decided; February 2, 2018, Entered

1400 CA 17-00589

Reporter
2018 N.Y. App. Div. LEXIS 648 * | 2018 NY Slip Op 00738 **

[**1] IN THE MATTER OF THE APPLICATION OF MARK BUTTIGLIERI, DESIGNEE OF THE CHIEF EXECUTIVE OFFICER OF UPSTATE UNIVERSITY HOSPITAL OF THE STATE UNIVERSITY OF NEW YORK, PETITIONER-APPELLANT, FOR THE APPOINTMENT OF A GUARDIAN OF THE PERSON AND PROPERTY PURSUANT TO ARTICLE 81 OF THE MENTAL HYGIENE LAW FOR FERREL J.B., AN ALLEGED INCOMPETENT PERSON, RESPONDENT. M. KATHLEEN LYNN, ESQ., RESPONDENT. (APPEAL NO. 2.)

Notice:
THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

evaluator, appoint, directing, court erred, services, legal services, mental hygiene, court-appointed, incapacitated, orders, reasonable compensation, well settled, inasmuch, indigent, provides, vacate

Counsel: **[*1]** ERIC T. SCHNEIDERMAN, ATTORNEY GENERAL, ALBANY (KATHLEEN M. TREASURE OF COUNSEL), FOR PETITIONER-APPELLANT.

M. KATHLEEN LYNN, RESPONDENT, Pro se, FAYETTEVILLE.

Judges: PRESENT: SMITH, J.P., CARNI, LINDLEY, CURRAN, AND TROUTMAN, JJ.

Opinion

Appeal from an order of the Supreme Court, Onondaga County (James P. Murphy, J.), entered May 26, 2016 in a proceeding pursuant to Mental Hygiene Law article 81. The order, insofar as appealed from, directed petitioner to pay M. Kathleen Lynn, Esq. certain attorneys' fees.

It is hereby ORDERED that the order insofar as appealed from is unanimously reversed on the law without costs and the language in the ordering paragraph ", and is to be paid by Petitioner as an administrative expense" is vacated.

Memorandum: In this proceeding in which petitioner sought the appointment of a guardian of the person and property of an alleged incapacitated person (AIP), petitioner appeals from two orders that, respectively, directed petitioner to pay the fees for services submitted by the court-appointed attorney for the AIP and by the court evaluator (collectively, respondents). We agree with petitioner that Supreme Court erred in directing it to pay those fees.

Petitioner contends in appeal No. 2 that the court erred **[*2]** in directing it to pay attorney fees for the court-appointed attorney. We agree. Article 81 of the Mental Hygiene Law provides that the court may appoint an attorney to represent the AIP, and that petitioner may be directed to pay for such services where the petition is dismissed or the AIP dies before the proceeding is concluded (*see* § 81.10 [f]). In all cases, "[t]he court shall determine the reasonable compensation for the mental hygiene legal service or any attorney appointed pursuant to" that statute (*id.*). Nevertheless, "the statute is silent as to the source of funds for payment of counsel [where, as here,] the AIP is indigent" (*Matter of St. Luke's-Roosevelt Hosp. Ctr. [Marie H.-City of New York]*, 89 N.Y.2d 889, 891, 675 N.E.2d 1209, 653 N.Y.S.2d 257 [1996]; *see Hirschfeld v Horton*, 88 AD3d 401, 403, 929 N.Y.S.2d 599 [2d Dept 2011], *lv denied* 18 N.Y.3d 804, 962 N.E.2d 287, 938 N.Y.S.2d 862 [2012]). Despite that silence, it is well settled that "the Legislature, by providing for the assignment of counsel for indigents in the Mental Hygiene Law, intended, by necessary implication, to authorize the court to compensate counsel" (*St. Luke's-Roosevelt Hosp. Ctr.*, 89 NY2d at 892), and it is likewise well settled that the court should direct that requests for such compensation should be determined "in accordance with the procedures set forth in County Law article 18-B" (*id.; see Matter of Rapoport v G.M.*, 239 AD2d 422, 422-423, 657 N.Y.S.2d 748 [2d Dept 1997]). Thus, the court erred in directing petitioner to pay those fees.

We also agree with the contention of petitioner in appeal No. **[*3]** 3 that the court erred in directing it to pay the fees requested by the court evaluator. Where, as here, a court appoints a court evaluator pursuant to Mental Hygiene Law § 81.09 (a) and then "grants a petition, the court may award a reasonable compensation to a court evaluator, including the mental hygiene legal service, payable by the estate of the allegedly incapacitated person" (§ 81.09 [f]). The statute further provides that a court may direct petitioner to pay for the services of a court evaluator only where the court "denies or dismisses a petition," or the AIP "dies before the determination is made in the petition" (§ 81.09 [f]). Therefore, "notwithstanding Supreme Court's broad discretion to award reasonable fees in Mental Hygiene Law article 81 proceedings . . . , [inasmuch as] petitioner was successful

[and the AIP is alive], the court was without authority to ascribe responsibility to petitioner for payment of the court evaluator's fees" (*Matter of Charles X.*, 66 AD3d 1320, 1321, 887 N.Y.S.2d 731 [3d Dept 2009]). Contrary to petitioner's contentions, although the court had discretion to appoint Mental Hygiene Legal Services as attorney for the AIP and to dispense with a court evaluator (*see* Mental Hygiene Law § 81.10 [g]), under the circumstances presented here "the court did not abuse its discretion as a matter of law in failing to do so" (*St. Luke's-Roosevelt Hosp. Ctr.*, 89 NY2d at 892 n). Nevertheless, **[*4]** inasmuch as the court properly made the "determination that [the AIP] is incapacitated within the meaning of Mental Hygiene Law article 81, and [in] the absence of evidence that the petitioner commenced this proceeding in bad faith, it was an improvident exercise of discretion for . . . Supreme Court to direct the petitioner to pay the fees of the court-appointed evaluator and the attorney it appointed to represent [the AIP] in the proceeding" (*Matter of Loftman [Mae R.]*, 123 AD3d 1034, 1036-1037, 999 N.Y.S.2d 166 [2d Dept 2014]; *cf. Matter of Samuel S. [Helene S.]*, 96 AD3d 954, 958, 947 N.Y.S.2d 144 [2d Dept 2012], *lv dismissed* 19 N.Y.3d 1065, 979 N.E.2d 802, 955 N.Y.S.2d 542 [2012]). We therefore reverse, insofar as appealed from, the orders in appeal Nos. 2 and 3, and we vacate the language in each order directing petitioner to pay the respective fees for services rendered.
Entered: February 2, 2018

Ira Salzman
Goldfarb Abrandt Salzman & Kutzin LLP
350 Fifth Avenue - Suite 4310
New York, New York 10118
Tel. 212-387-8400 ext. 231
Fax 212-387-8404
Web Site www.seniorlaw.com

Cited
As of: March 6, 2018 8:15 PM Z

Matter of KeyBank N.A.

Surrogate's Court of New York, Saratoga County

September 25, 2017, Decided

2016-769

Reporter
58 Misc. 3d 235 *; 67 N.Y.S.3d 407 **; 2017 N.Y. Misc. LEXIS 3800 ***; 2017 NY Slip Op 27321 ****

[**1]** In the Matter of the Application of KeyBank National Association, Kenneth F. ***Tyrrell*** and Polly E. ***Tyrrell***, Pursuant to SCPA § 2101.

Notice: THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION. THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

beneficiary, social services, eligibility, regulations, venue, surrogate's court, amend, modification, reformation, modified, grantor, social services department, disabled, trusts, drafting, requests, terms, remainder interest, parties, health department, set forth, accounting, provisions, proper venue, provides, marital deduction, observations, supplemental, recipient, comports

Counsel: **[***1]** For (KeyBank National Association, Kenneth and Polly ***Tyrrell***), Petitioners: Edward V. Wilcenski, Esq., Wilcenski & Pleat, Clifton Park, NY.

For Saratoga County Department of Social Services, Objectant: Hugh G. Burke Esq., Saratoga County Attorney's Office, Ballston Spa, NY.

Judges: HON. RICHARD A. KUPFERMAN, SARATOGA COUNTY SURROGATE.

Opinion by: Richard A. Kupferman

Opinion

[*236] **[**409]** Richard A. Kupferman, S.

Against the backdrop of a myriad of complex Federal and State statutes and regulations governing Medicaid eligibility, this case analyzes the extent and limitations of the authority of a local department of social services in an application to modify or reform a supplemental needs trust.

Kevin J. ***Tyrrell*** (the "Beneficiary") was the plaintiff in a personal injury/medical malpractice action commenced on his behalf by his parents, Kenneth F. ***Tyrrell*** and Polly E. ***Tyrrell*** in Albany County Supreme Court. By Stipulation of Settlement dated January 15, 2001 the underlying litigation was settled in the Albany County Supreme Court. Thereafter, by Agreement dated February 15, 2001 a Special Needs Trust ("SNT") was established for the benefit of the Beneficiary by his parents as lawful grantors. A review of the original SNT at the time **[***2]** of its creation establishes the Beneficiary's parents as co-Trustees along with KeyBank as the third (corporate) Trustee and repository of the Trust assets. Further, the beneficiary of the SNT **[*237]** (Kevin J. Tyrell) was (and remains) under sixty-five (65) years of age and (2) was (and remains) an individual with a disability thus eligible for the establishment of a SNT, and that (3) the SNT was being established by the beneficiary's parents and (4) the SNT provides the State as a Medicaid remainderman beneficiary **[**410]** upon the death of the Beneficiary. Thus, there appears to be no issue that the SNT as originally written comports with and had no negative effect upon the trust beneficiary's eligibility for Medicaid and is thus a lawfully created SNT.

By Order dated February 27, 2001 the Albany Court Supreme Court approved the terms of the above-referenced settlement and directed that the Beneficiary's share of the settlement be periodically paid into the SNT as established above. Pursuant to the terms of the Order, on March 20, 2001 the parties executed a Stipulation of Discontinuance and filed same with the Albany County Supreme Court. Upon the filing of the

Stipulation of Discontinuance, the **[***3]** matter in the Albany County Supreme Court was concluded and the parties (the Beneficiary and his parents) had no further dealings in the Albany County Supreme Court and relocated soon thereafter to Saratoga County.

By Verified Petition dated January 5, 2017 to this Court, Kenneth and Polly ***Tyrrell*** (the Beneficiary's parents, Grantors and Trustees) as well as KeyBank National Association commenced the instant action seeking permission to amend the terms of the February 27, 2001 SNT pursuant to *Surrogate's Court Procedure Act Section 2101*. Specifically, the SNT provides under Article II that upon the death of the Beneficiary, the Trust will terminate and the Trustee shall divide and distribute the remaining principal and accrued and undistributed income in the Trust Estate as follows:

> A. In the event that the probate estate of Kevin J. ***Tyrrell*** shall contain insufficient assets to cover all funeral expenses and debts of Kevin J. ***Tyrrell***, administration expenses of his Estate, or applicable estate taxes, the Trustee is authorized to distribute from the Trust Estate herein, to the extent of such insufficiency, such amounts as are necessary to pay said funeral expenses, debts, administration expenses and estate taxes of Kevin J. ***Tyrrell***. **[***4]**
>
> B. The Trustee shall reimburse the State of New York and/or any other state which has provided **[*238]** Medicaid assistance to Kevin J. ***Tyrrell*** during his lifetime, in an amount equal to the Medicaid assistance rendered to or paid on behalf of Kevin J. ***Tyrrell*** by such state or states. If Kevin J. ***Tyrrell*** received Medicaid assistance in more than one state, then the amount distributed to each state shall be based upon each state's proportionate share of the total amount of Medicaid assistance paid by all states on behalf of Kevin J. ***Tyrrell***.

As written, the provision that permits the payment of funeral expenses after death of the beneficiary and prior to reimbursement to the State is now inconsistent with *42 USC Section 1396p(d)(4)(A)*, which authorizes the use of a SNT by Social Security and Medicaid recipients. *See also*, Social Security Administration's Program Operations Manual ("POMS") Sections SSI SI 01120.203(B)(3)(a). The SNT in its current form renders the Beneficiary ineligible to receive Supplemental Security Income (SSI).

Thus, in order to render the Beneficiary eligible to qualify for SSI, the Petitioners have made this application seeking amendment of Article II of the SNT. Specifically, the Petitioners seek to **[***5]** amend the language of Article II to provide that upon the death of the Beneficiary that the Trustee may only pay those expenses enumerated in the Social Security Administration's Program Operations Manual ("POMS") Sections SSI SI 01120.203(B)(3)(a) prior to reimbursement to the Medicaid program for all medical assistance provided to the Beneficiary during his lifetime.

[411]** After receiving the instant Petition, the Court issued a Citation returnable on January 31, 2017 to the parties and to the local social services district; e.g. the Saratoga County Department of Social Services (the "Department"). Upon return of the Citation on January 31, 2017, counsel for the Petitioners appeared as well as the Saratoga County Attorney's Office on behalf of the Department. At this appearance, the Department asked for additional time to review the instant petition and trust. The Court then directed the Department to submit any objections (if so **[****2]** inclined to object) to the relief requested within thirty (30) days and then the Petitioner would have seven (7) days within receipt upon which to respond.

Thereafter and by letter dated February 13, 2017, the Department provided its objection to the Petition and **[***6]** its **[*239]** request to amend the terms of the SNT.[1] Specifically, the Department objected to the proposed language relative to the prepaid funeral expenses, and proceeded to make several "observations" and requests to amend the language of further sections of the Trust document. In support of its position, the Department posited that the filing of the application to amend an existing SNT subjects the language of the *entire* document to modification.

In response thereto, by letter dated February 22, 2017, counsel for the Petitioners submitted a reply to the specific objection of the Department, as well as replies to the Department's "observations" and requests to amend language as well as the Department's position relative to its right to have a seat at the drafting (or in the instant case, redrafting) table of the SNT. Specifically to address the Department's objection to the language of the pre-paid funeral expenses, the Petitioners identified that the language of the existing SNT rendered the Beneficiary ineligible for SSI and the

[1] While not captioned as formal objections, the Court chose to accept the Department's February 13, 2017 letter as such.

proposed amendment merely brought the language into the eligibility standards set forth in the Social Security Administration's Program Operations Manual ("POMS") **[***7]** and under relevant federal and state guidelines for SSI eligibility. In its reply, the Petitioners acknowledged that the Department does have a role in the formation and reformation of an SNT, but that role is limited to that which is specifically laid out in federal and state statutes. Specifically, to review a SNT to confirm that it meets the statutory criteria under *42 USC Section 1396p(d)(4)(A)* and *NY Social Services Law Section 366(2)(b)(2)(iii)* and to confirm that the SNT is being administered (and that the State's right as a remainderman under the terms of same is being upheld) consistent with statutory law and Social Services regulations.

The Petitioners identify that nothing in the Department's objections or observations suggests that the instant SNT as written (pre and post amendment) fails to comply with the federal and state statutory language governing same. The Petitioners likewise identify that nothing in the authority governing the drafting and approval of a SNT enlarges the role and responsibility of the Department beyond that which is expressly codified.

Thereafter, correspondence flowed between the parties, and the Court encouraged counsel for both parties to work collaboratively **[*240]** at resolving the issues and disagreement between them. By letter **[***8]** dated April 19, 2017, counsel for the Petitioners submitted a proposed Decree to **[**412]** the Court with a request for the Court to sign same and accompanying therewith a letter which outlined that the parties had yet to reach common ground on certain issues and identified the remaining issues of disagreement. The Court then scheduled a conference on the issues raised above and directed the parties to submit Memoranda of Law detailing their respective positions. Counsel for both sides submitted Memoranda of Law. The Court held a telephone conference on May 11, 2017 whereupon counsel for the Department acknowledged that issues remained in disagreement, that he objected to the terms of the proposed Decree and for the first time raised the issue that the entire proceeding in the Saratoga County Surrogate's Court was improperly venued.

With the issue of venue having been raised for the very first time at the May 11, 2017 **[****3]** telephone conference, the Court directed counsel for the Department to file (should he so choose to do so) a Motion for Change of Venue by May 31, 2017 and a response (by Cross-Petition or Answer) to the relief requested in the Petition by May 17, 2017. Counsel for the Petitioners **[***9]** was given until June 21, 2017 to respond to both the Department's Motion for Change of Venue and Answer/Cross-Petition.

Counsel for the Department filed an Answer and Cross-Petition and Motion to Change Venue and for dismissal of the Petition for failure to recite grounds for relief under *CPLR Section 2214(a) en toto* on May 17, 2017. The Court thereafter instructed counsel to segregate his papers into a Motion to Change Venue and an Answer with Cross-Petition as had been previously directed at the May 11, 2017 telephone conference. Counsel for the Department thereafter filed a Notice of Motion and Affirmation in Support of Motion to Change Venue on May 31, 2017 along with amendments to its original submission which the Court shall consider as its Answer and Cross-Petition for affirmative relief to enable the Court to implement its (the Department's) recommendations to the SNT.

In its Notice of Motion, the Department asserts that the Petitioners' application should properly be venued in Albany County as the court of original and continuing jurisdiction from the initial 2001 drafting of the SNT. The Department moved for a transfer of proceedings pursuant to *SCPA §§207, 209, 501*; *CPLR §503(b)* and for dismissal of the Petition on **[*241]** jurisdictional **[***10]** grounds for failure to recite grounds for relief sought under *CPLR §2214(a)*.[2]

Further, in its Answer and assuming that the Court retains venue over the matter, the Department nevertheless requests that the Court implement the modifications asserted in the Cross-Petition as set forth in its correspondence of February 13, 2017. In response thereto, counsel for the Petitioner filed papers in opposition to the Department's motion to transfer and dismiss, and also filed a Cross-Motion seeking Attorney's Fees pursuant to *22 NYCRR §130-1.1(c)(3)*. Thereafter, counsel for the Department filed a Cross-Motion seeking sanctions against Petitioners pursuant to *22 NYCRR §130-1.1(c)(1)*.

[2] Upon return of the Motion at oral argument on July 19, 2017, the Department conceded that the Court has jurisdiction to hear and preside over the matter, thus rendering the CPLR argument to dismiss relative to jurisdiction moot. In view of the same and of the Department's acknowledgment of jurisdiction, the Court will consider the issue of jurisdiction settled and will not address the Department's motion to dismiss and will consider it withdrawn.

Oral argument was held on July 19, 2017 before the Court. After significant argument **[**413]** by counsel for both parties, the Petitioner's motion for an award of Attorney's fees pursuant to *22 NYCRR §130-1.1(c)(3)* and the Department's motion for sanctions were dismissed, leaving before the Court the issue of venue as well as the Department's role in the drafting and reformation of the SNT. The Court shall first address the question of venue, and then consider the authority or lack thereof to modify or reform a SNT in turn herein.

In its Motion for Change of Venue, the Department asserts that the petition is **[***11]** improperly venued in this Court. At the oral argument of July 19, 2017, counsel for the Department acknowledged and stipulated that jurisdiction was not in contest, merely venue. In support of its position, the Department first identifies that the institutional trustee (KeyBank) is listed as having its principal place of business in Albany County and that the location of the assets of the trust are thus in Albany County as well. The Department further avers that as the original **[****4]** proceeding giving rise to the instant SNT began in Albany County Supreme Court, the proper venue is with Albany County. The Petitioner objects, and notes that the Beneficiary and the Grantor/Trustees (the Beneficiary's parents) all reside in Saratoga County, that there is no pending matter in the Albany County Supreme Court upon which to continue **[*242]** venue and/or jurisdiction, and that venue and jurisdiction has been properly acquired by the Saratoga County Surrogate's Court upon the commencement of the instant proceeding under *Sections 201*, *203* and *207 of the Surrogate's Court Procedure Act*.

As it relates to the Saratoga County Surrogate's Court as an appropriate venue, *Surrogate's Court Procedure Act Section 207(1)* states that;

> a proper venue for a proceeding is (a) the county where the assets of the trust are located, **[***12]** (b) the county where the grantor is domiciled at the time of the commencement of a proceeding or (c) the county where a trustee then acting resides. *NY SCPA Section 207(1)*

There is no argument that the Grantors/Trustees (the Beneficiary's parents) reside in Saratoga County, and did so at the *commencement* of the instant proceeding. A proceeding has been commenced concerning the Trust and the Grantors/Trustees are domiciled in Saratoga County, thus making the Saratoga County Surrogate's Court an appropriate venue pursuant to *NY SCPA Sections 207(1)(b)* and *(c)*.

Here, the Court acknowledges that the institutional Trustee (KeyBank) has its principal place of business located within Albany County and which would make Albany County an appropriate venue under *NY SCPA Section 207(1)(c)* as the Department suggests. The Court finds no merit in the Department's position that Albany County is an appropriate venue under *SCPA Section 207(1)(a)* because the "assets of the trust" are located at the office of the institutional Trustee in Albany County. The Court takes note that KeyBank is a national banking and lending institution with offices and branches throughout Saratoga County and specifically in Clifton Park, the town of residence for the Grantor/Trustees. The Court likewise notes that the "assets **[***13]** of the trust" are funds deposited into the trust account, and given the electronic nature of modern banking readily accessible at other locales as opposed to solely from the Albany County branch.

Even if the Court were to find the assets to be located in Albany County, in *Matter of Myers (45 AD3d 955, 845 N.Y.S.2d 510 [3rd Dept. 2007])*, the Appellate Division Third Department reconciled a similar question of venue. In that case, the subject **[**414]** property of the trust was located in Steuben County and the trustee resided in Chemung County. The Appellate Division found that venue for the proceeding was properly in Chemung county as the county of residence of the trustee (as opposed to the location of the assets of the trust) under *SCPA Section 207(1)(c)*. *NYS SCPA Section 207(1)*; *See also, Matter of Kelly, 17 AD3d 791, 794 N.Y.S.2d 458 (3rd Dept. 2005)*.

[*243] Two of the three Trustees (the Beneficiary's parents) reside in Saratoga County, the third and corporate Trustee (KeyBank) while having its principle office physically located in Albany County has joined in filing the instant application. In view of the same, Saratoga County is a proper venue under *NY SCPA Section 207(1)(c)*.

Under the facts of the instant case, venue would appropriately be in both Saratoga County and Albany County. Accordingly, the analysis must then turn to a reading of NY SCPA **[****5]** *Section 207(2)*.[3]

In the instant proceeding, there exists **[***14]** before the

[3] Ignoring, parenthetically, that the Albany County Trustee joined in the Petitioner's request for the petition and proceeding to be held in Saratoga County.

Court a duly filed Petition and commensurately proper proceeding under SCPA Section 203. As set forth above, the Court acknowledges that both Albany County and Saratoga County are proper venues for the filing of this petition under SCPA Section 207(1). Under SCPA Section 207(2) "where proper venue may lie in more than one county under the provisions of subdivision one, the court where *a proceeding* is first commenced with proper venue shall retain jurisdiction" (emphasis added).

In Surrogate's Court, all proceedings are special proceedings commenced by the filing of a petition and pursuant to New York Surrogate's Court Procedure Act Section 203. In addition, NY SCPA Section 301(a) provides that a proceeding is commenced with the filing of a petition, provided process is issued and service on all respondents is completed within 120 days. *See,* Matter of DeMaio, 13 Misc 3d 190, 819 N.Y.S.2d 648 (Sup. Ct., Kings Co. 2006).

Here, a Verified Petition was filed with the Court on January 5, 2017, and the Department having been duly served and appeared before the Court on the return date of January 31, 2017. The Court having acknowledged jurisdiction over the matter without objection from either party, including the Department. In view of the same, the instant matter represents an active and pending proceeding before the Saratoga County Surrogate's Court, and is the first and only proceeding **[***15]** seeking to address the relief requested in the Petition. There is no pending proceeding in the Albany County Supreme Court and there has never been a commensurate proceeding commenced in the Albany County Surrogate's Court.

Even assuming, *arguendo*, that there was an open proceeding or that the proceeding remained open in the Albany County **[*244]** Supreme Court, the law is well settled that a supreme court will defer to the surrogate's court on matters where the surrogate's court has expertise. H & G Operating Corp. v. Linden, 151 AD2d 898, 542 N.Y.S.2d 868 (3rd Dept. 1989). The review and administration of trusts is one of the experiential hallmarks of a surrogate's court. Even assuming (again, *arguendo*) that a subsequent proceeding were to be commenced in the Albany County Surrogate's Court, the Saratoga County Surrogate's Court would still retain possession of the matter as the "first" court upon which the proceeding was commenced. *See,* NY SCPA Section 207(2).

[415]** Accordingly, the Court finds that the Saratoga County Surrogate's Court is the proper venue for this matter and that there is no basis to remove this proceeding from the Saratoga County Surrogate's Court and transfer it to the Albany County Supreme Court. Therefore, the Department's motion for a change of venue is hereby denied.

The Court **[***16]** now directs its analysis to the true issue in contention between the Petitioner and the Department, specifically what, if any authority the local social services district has to seek modification or reformation of an existing SNT.

To begin, the Court notes that a SNT is a "discretionary trust established for the benefit of a person with a severe and chronic or persistent disability [*EPTL 7-1.12(a)(5)*] that is designed to enhance the quality of the disabled individual's life by providing for special needs without duplicating services covered by Medicaid or destroying Medicaid eligibility." Cricchio v Pennisi, 90 NY2d 296, 683 N.E.2d 301, 660 N.Y.S.2d 679 (1997); Matter of Abraham XX, 11 NY3d 429, 900 N.E.2d 136, 871 N.Y.S.2d 599 (2008). A SNT is a **[****6]** planning device authorized by federal and state law to insulate assets of a chronically ill and severely disabled individual "for the dual purpose of securing or maintaining eligibility for state-funded services, and enhancing the disabled person's quality of life with supplemental care paid by his or her trust assets." Abraham XX, 11 NY3d at 434; see also Matter of Morales, 1995 NY Misc. LEXIS 726, 214 N.Y.L.J. 19 (NY Sup. Ct. Kings Co. July 28, 1995).

Under the pertinent statutes, 42 USC §1396p(d)(4)(A) and Social Services Law §366(2)(b)(2)(iii), neither the corpus nor the income of a SNT is considered a resource or income available to the beneficiary. *See,* Abraham XX, 11 NY3d at 435, Cricchio, 90 NY2d at 303; *see also* 18 NYCRR 360-4.5(b)(5)(i)(a). Rather, the SNT is designed to "address the unique and **[*245]** difficult situation faced by severely disabled individuals **[***17]** with assets that are sufficient to end their Medicaid eligibility but insufficient to account for their medical costs." (*Id. at 437*).

Such treatment is extended to a SNT as long as the trust documents setting up same conform to the language and the requirements of *EPTL 7-1.12(a)(5)* as well as the applicable regulations of the Department of Health. *see* Cricchio, 90 NY2d at 303, *see also* Social Services Law § 366(2)(b)(2)(iii),(iv). Specifically, a SNT is exempted from the general rules governing available resources and Medicaid eligibility when (1) the recipient is "disabled" as that term is defined at 42 USC §

1382c(a)(3), and (2) the SNT contains the following provision:

> The assets of such a disabled individual and was established for the benefit of the disabled individual while such individual was under sixty-five years of age by 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. Social Services Law § 366(2)(b)(2)(iii).

The relationship between the SNT, its beneficiary and the State is set forth in its clearest form by the Court of Appeals decision of Abraham XX, specifically that:

> The SNT is available only to applicants under the age of **[***18]** 65 with severe disabilities as defined by statute. Unless the **[**416]** applicant placed excess assets in the Medicaid SNT for supplemental care, he or she would no longer be eligible for Medicaid, thus relieving the State of a substantial financial burden. In order to further Medicaid's purpose of providing medical assistance to needy persons, the State agrees to continue paying Medicaid costs, in instances where it would otherwise be relieved of this obligation, in exchange for the possibility of reimbursement upon the recipient's death. The State in a sense is like an insurer calculating risk. For every recipient who depletes the trust before death, the State can expect some trusts to have sufficient assets upon a recipient's death to offset the additional cost of continuing Medicaid payments **[*246]** for these severely disabled individuals who otherwise would be ineligible. Moreover, the State's right to reimbursement occurs only upon the death of the beneficiary, at a time when the life-enhancing purpose of the trust can no longer be effectuated. The Medicaid SNT reflects a policy decision to balance the needs of the severely disabled and the State's needs for funds to sustain the system. Abraham XX, 11 NY3d at 436-437.

The State **[***19]** thus has a statutory role within the establishment and maintenance of a SNT. Specifically, the State's role is twofold; first to determine the SNT beneficiary's continued eligibility for Medicaid by ensuring that the proposed SNT comports with existing Federal and State Medicaid Law and second by protecting the State's ultimate remainder interest.

Under the Federal Medicaid statute, it is the individual state departments of health that are tasked with this particular review. In New York State, it is the Department of Health that is bound by these regulations, and the responsibility for its administration falls to the local social services district of each county as the individual Medicaid provider. Specifically, the local social services district (through the Department of Social Services) is to evaluate an applicant's interest in irrevocable trusts for purposes of Medicaid eligibility.

To this end, within the framework of the SNT statutes, there are safeguards are in place to protect both the beneficiary and the remainder interest. Specifically, Social Services Law §366(2)(b)(2)(iv) clearly seeks to protect 'the remainder interest' of the State by authorizing the promulgation of regulations to assure fulfillment of the **[***20]** trustee's fiduciary obligations. Further, Social Services Law §366(2)(b)(2)(iv) directs in relevant part that "the department [of health] shall promulgate such regulations as may be necessary to carry out the provisions of this [section, and such] regulations shall include provisions for assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this [section] to legal instruments and other devices **[*247]** similar to trusts, in accordance with applicable federal rules and regulations."[4] In addition to the aforementioned, there are numerous other safeguards and oversights prescribed under the Surrogate's Court Procedure Act, the Estates Powers and Trusts Law, the Social Services Law and Executive Law Section 63.

The statutory safeguards outline the responsibilities and procedural remedies of **[**417]** the State in its review of proposed SNTs. The role of the State is clearly defined and relates specifically to the review of proposed SNTs for its comport to the relevant statutes, Medicaid eligibility and protection of the State's remainder interest. There is nothing in the Federal Medicaid statute, the New York State Social Services law and regulations that **[***21]** expands the responsibility of the State or its local social services departments beyond its statutory role, e.g. the

---

[4] It is important to distinguish at this point in the analysis that the New York State Department of Health is a distinct and separate entity from the Department. That the Department in and of itself has no independent authority to promulgate regulations absent the procedures found in NYS Social Services Law Section 20(3)(a).

assessment and determination of an applicant's initial and continuing eligibility for Medicaid. The State and its local social services departments are responsible for the *review* of a SNT and have not been granted any formal authority in the *drafting* of a SNT, as such responsibility is left with the creators of the SNT.

For as the State has a statutory role in the establishment and maintenance of the SNT, so to do the trustees and fiduciaries responsible for the SNT. The responsibilities of these individuals are set forth in *Article 11 of the Surrogate's Court Procedure Act* and at *18 NYCRR §360-4.5(b)(5)(iii)* and require a trustee of a SNT to fulfill not only their fiduciary obligation to the SNT beneficiary but also their concomitant fiduciary obligations with respect to the State's remainder interest in the trust. Specifically, under *18 NYCRR §360-4.5(b)(iii)* the trustee must, by way of example;

> a. notify the appropriate social services district of the creation or funding of the trust for the benefit of an MA applicant/recipient;
> b. notify the social services district of the death of the beneficiary of the trust;
>
> c. notify the social services district in advance of any **[***22]** transactions tending to substantially deplete the principal of the trust, in the case of a trust **[*248]** valued at more than $100,000; for purposes of this clause, the trustee must notify the district of disbursements from the trust in excess of the following percentage of the trust principal and accumulated income: five percent for trusts over $100,000.00 up to $500,000; 10 percent for trust valued over $500,000.00 up to $1,000,000.00; and 15 percent for trusts over $1,000,000.00;
> d. notify the social services district in advance of any transactions involving transfers from the trust principal for less than fair market value; and
> e. provide the social services district with proof of bonding if the assets of the trust at any time equal or exceed $1,000,000.00, unless that requirement has been waived by a court of competent jurisdiction, and provide proof of bonding if the assets of the trust are less than $1,000,000.00, if required by a court of competent jurisdiction.

Thus, the SNT represents a "bargain struck between the SNT beneficiary and the State" whereby the eligibility rights of the SNT beneficiary for social services are preserved, and the pecuniary remainder rights of the State are **[***23]** protected. *See, Matter of Abraham XX, 11 NY3d 429, 900 N.E.2d 136, 871 N.Y.S.2d 599 (2008).*

In addition to the roles of the State and the SNT parties, the Court likewise has a role in this process. The Court's role is to strike a balance to protect both the beneficiary and the State's remainder interest, thereby seeking also to protect public interest to fulfill "the ultimate goal of Medicaid [is] that the program 'be the payor of last resort." *See, Cricchio, 90 NY2d at 305.*

As it relates to the Court's role and responsibilities regarding a SNT, the following **[**418]** opinion most clearly defines same, specifically that:

> It is appropriate for the court to seek assurance that a proposed supplemental needs trust complies with the controlling laws and rules regarding Medicaid eligibility. This is consistent with the function of the court to assure that the best interests of the incapacitated person are promoted. It would be a clear dereliction of that duty for the court to deliberately overlook provisions of a proposed supplemental needs trust if such provisions were inconsistent with statutory guidelines and thus would bar an incapacitated person from **[*249]** receiving Medicaid benefits by its establishment. To do so would permit diverting of assets from the ownership or title of the incapacitated person **[***24]** to another legal entity with no consequent benefit to the incapacitated person." *Matter of McMullen, 166 Misc 2d 117, 632 N.Y.S.2d 401 (Sup Ct. Suffolk Co., 1995).*

These provisions, however, should not be read as obviating any additional controls required by the court since the regulations promulgated by the State are for the protection of its own remainder interest whereas the court is primarily concerned with the protection of the disabled person and likewise to assure fulfillment of the establishment of a SNT, in the inherent exercise of its power, the court may fashion or condition the exercise of that privilege in such manner as it believes will sufficiently protect the interest of the disabled person." *In Re Goldblatt, 162 Misc 2d 888, 618 N.Y.S.2d 959 (Sur Ct. Nassau Co., 1994).*

Turning to the instant matter, the Petitioners have come before this Court and seek the approval of a modification with respect to the SNT for Kevin ***Tyrrell***. The Department has reviewed the proposed modification to the SNT and has presented certain "observations" relative to same, as well as requests to modify certain language within the SNT. The Department has not raised any challenge that the SNT as written has any negative effect upon the beneficiary's

[****7] financial eligibility for Medicaid, nor that the application and SNT should be denied.[5]

There is no dispute [***25] that the beneficiary (Kevin ***Tyrrell***) is disabled and under sixty-five (65) years of age. Likewise, the Petitioners, as parents of the beneficiary, are lawful grantors under Social Services Law §366(2)(b)(2)(iii) and possess the requisite skill and competency to serve as Trustees. The language of the proposed SNT is in conformance with *EPTL §§7-1.12,7-3.1*; SSL §366(2)(b)(2)(iii) and 42 USC §§1396p(d)(4)(A); 1382b(e)(5) and provides the State of New York (e.g. Saratoga County Department of Social Services) with the remainder interest as described in and required by Social Services Law §366(2)(b)(2)(iii)(A).

[*250] There likewise appears to be no dispute that the SNT as written comports with, and has no negative effect upon, the trust beneficiary's eligibility for Medicaid. Thus, the Court finds that (1) the beneficiary of the SNT (Kevin ***Tyrrell***) is under sixty-five (65) years of age and (2) is an individual with a disability thus eligible for the establishment of a SNT, and that (3) the SNT is being established by the beneficiary's parents and guardians and (4) the SNT provides the State as a Medicaid remainderman beneficiary upon the death of Kevin ***Tyrrell***.

[**419] The Department's papers and accompanying brief avers that the terms to modify the SNT must be guided by *EPTL 7-1.9(a)*, and specifically "upon the written consent, acknowledged or proved in [***26] the manner required by the laws of this state for the recording of a conveyance of real property, of all the persons beneficially interested in a trust of property, heretofore or hereafter created, the creator of such trust may revoke or amend the whole or any part thereof." The Department believes that their consent as a beneficially interested party is necessary for the grantor to amend the trust. In support of its position, the Department relies on *EPTL 7-1.9(a)* and cites the case of Perosi v. LiGreci (98 AD3d 230, 948 N.Y.S.2d 629 (2nd Dept. 2012)) in its papers. The Court acknowledges that the Department is a person beneficially interested in a trust of property for purposes of *EPTL 7-1.9(a)* and therefore their consent to amend said trust would be necessary.

However, the Department's reliance on *EPTL 7-1.9(a)* is inapposite with regard to *this* specific SNT. *EPTL 7-1.9(a)* does not apply in this case, because Article VI of the SNT states that; "this Agreement and Trust created hereby are irrevocable. The Grantor shall have no right in any respect to later, amend, revoke, or terminate this Agreement or the Trust created hereby without *approval by a court of competent jurisdiction*" (emphasis added). Likewise, the holding in Perosi can be readily distinguished. In Perosi, the approval of the local social [***27] services department was required to amend the terms of the trust because the subject trust was silent on the issue of amendment. Here, Article VI of the subject SNT does set forth an amendment procedure by application to a court of competent jurisdiction for approval of same.

The Petitioners have exercised the specific procedure laid out in the SNT to seek an amendment by the filing of the instant [*251] proceeding with the Court. Therefore, taking this grant of express authority to amend the SNT, the Court will now set upon the analysis of judicial powers and limitations with regard to modification or reformation of a SNT. Reformation is generally available to correct mistakes in inter vivos instruments so that the written instrument accurately expresses the settlor's actual intent. As the court noted in *Matter of Dickinson v Bates* (NYLJ, Aug. 4, 1999, at 22, col 6, *affd* 273 AD2d 89, 709 N.Y.S.2d 69 [2000]), reformation may not be [****8] used to change the terms of a trust to effectuate what the settlor would have done had the settlor foreseen a change of circumstances that has occurred.

Similar to the facts in Dickinson, the Petitioner herein seeks to correct an element of the trust so as to allow the Beneficiary to maximize the availability of benefits. [***28] Courts have the power not only to ascertain the "validity, construction or effect" of language in a testamentary instrument (NY SCPA Section 1420), but also to reform such instrument and to add, excise, change or transpose language to effectuate a decedent's intent. *See e.g.*, Matter of Snide, 52 NY2d 193, 418 N.E.2d 656, 437 N.Y.S.2d 63 (1981).

Whether construction and/or reformation is sought in the context of an estate, the paramount duty of the court is to determine the intent of the testator from a reading of the will in its entirety Matter of Bieley, 91 NY2d 520, 695 N.E.2d 1119, 673 N.Y.S.2d 38 (1998); Matter of Snide, 52 NY2d 193, 418 N.E.2d 656, 437 N.Y.S.2d 63 (1981).

[5] In court and on the record, the Department has repeatedly supported the proposed modification to the SNT (although desires that different language be used) and has stated that there would be no financial harm to the Department as a remainderman by the Court's acceptance of same.

Courts have reformed instruments so that estates could take full advantage of available tax deductions and exemptions, but only if the literal application of an instrument's provisions **[**420]** would frustrate testator's actual intent as reflected in the court's review of the entire document. *In re Estate of Martin, 146 Misc 2d 144, 549 N.Y.S.2d 592 (Sur Ct. New York Co., 1989)*; *Matter of Choate, 141 Misc 2d 489, 533 N.Y.S.2d 272 (Sur Ct. New York Co., 1988)*; *In re Estate of Lepore, 128 Misc 2d 250, 492 N.Y.S.2d 689 (Sur Ct. Kings Co., 1985)*.

Of specific relevance to the Court's instant analysis is the holding of *In re Estate of Lepore (128 Misc 2d 250, 492 N.Y.S.2d 689, supra)*. In *Lepore*, the court permitted the reformation of a will so that certain "inadvertently excluded words" could be added to the document's definition of the marital deduction (*id. at 253*). In *Lepore*, the original will defined the marital deduction under prior law, which had limited the amount of the marital deduction to the greater of $250,000 or one-half the adjusted gross estate, **[***29]** instead of the unlimited marital deduction under current law. The court found that the complete reading of the will **[*252]** made it clear that the testator had intended to give his wife the largest possible bequest by use of the maximum available marital deduction, and in view thereof the court allowed reformation of the instrument to ensure that the entire residuary estate would qualify for the unlimited marital deduction.

In this case, the Petitioner's intent in seeking a modification to the terms of the SNT is clearly to ensure that the Beneficiary receives and is eligible for the maximum government entitlements, namely Medicaid and SSI, that are available to him. *In re Estate of Lepore, 128 Misc 2d 250, 492 N.Y.S.2d 689 (Sur Ct. New York Co., 1985)*; *Matter of Carcanagues, 2016 NY Misc. LEXIS 3436 (Sur Ct. New York Co., 2016)*.

Explicitly throughout the Department's moving papers and oral argument was reliance on the concept of the "bargain" as espoused in *Abraham XX* to elevate its status in the drafting and redrafting process of the SNT. It appears to the Court that through its "observations" and requests to amend the language of certain provisions of the SNT, the Department seeks to expand its role beyond that of Medicaid eligibility review and into the actual drafting process of the SNT. The Department posits that as a result the "bargain" between **[***30]** the beneficiary and the State as a Medicaid eligibility remainderman that it is due a seat at the drafting table.

The Department's interpretation of the Court of Appeal's rationale of a how the SNT represents a "bargain" is misguided. The bargain in an SNT represents the priority interest in the balance of the SNT upon the beneficiary's death in exchange for the Beneficiary's receipt of Medicaid. This is contrary to the Department's assertion that the Court of Appeals language in *Abraham XX* should be read to expand and somehow broaden the "bargain" and thereby authorize the Department to require additional modifications/reformations beyond the relief sought by the **[****9]** Petitioners. The Department's interpretation is also contrary to the plain language of *Abraham XX* and of the statutory authority governing SNTs.

Further, that the Department considers a SNT to be a "special" type of trust and thus seeks to broaden its authority into the dictation of the terms of a SNT or for that matter insert itself into the drafting process is likewise misplaced. This Court shares the opinion of Surrogate Czygier in "that a supplemental needs trust trustee should not be treated differently than a testamentary **[***31]** or *inter vivos* trustee there are safeguards in place to protect the lifetime beneficiary and DSS." **[*253]** *Matter of Kaidirmouglou*, NYLJ November 5, 2004 at Page 28 (Sur. Ct. Suffolk **[**421]** Co., 2004) There is nothing "special" about an SNT that would separate it from other types of trusts and thus grant an expansion of the authority of the State and its local social services department beyond that which is already provided for. To treat a SNT differently from similarly fashioned trusts without the authority to do so would setting same upon the precipice of a slippery slope towards an overreach of State authority.

The Court observed from its review of *Abraham XX* that nothing within that decision suggests an intention to deviate from established state law of trusts or to expand the rights given to the state agency in court proceedings. Likewise, the Court notes that there is nothing in the authority governing a SNT (the Federal Medicaid statute, the New York State Social Services law and regulations) that increases or broadens the role of the Department beyond one of assessment and determination of an applicant's initial and continuing eligibility for Medicaid. The clearly defined role of the Department **[***32]** is to determine whether the SNT as written comports with and affects the trust beneficiary's eligibility for Medicaid.

The State and its local social services department cannot exceed that authority which has been set forth in its own regulations. The local social services

department is subordinate to the State Department of Health. DOH is authorized to "supervise the local social services department and in exercising such supervision *shall approve or disapprove* rules, regulations and procedures made by local social services officials within thirty days after filing of same with the commissioner; such rules, regulations and procedures shall become operative immediately upon approval or on the thirtieth day after such submission to the commissioner unless the commissioner shall specifically disapprove said rule, regulation or procedure as being inconsistent with law or regulations of the department." *See*, NYS Social Services Law §20(3)(a).

The Court can not reach the Department's position that a local social services department, acting without the approval of the Department of Health, would have the unilateral authority **[*254]** to make its own rules and regulations. To do so would invite every local social services district **[***33]** across the State to implement rules that may not necessarily be cohesive or comport with existing regulations promulgated by the Department of Health.

As observed by the Court of Appeals in the matter of Beaudoin v Toia, 45 NY2d 343, 380 N.E.2d 246, 408 N.Y.S.2d 417 (1978), "inasmuch as the local commissioners are agents of the State Department they may not substitute their interpretations of the regulations of the State Department for those of the State Department or the State Commissioner. To recognize any such right would be to undermine the supervisory authority of the State commissioner and to invite administrative chaos." *Matter of Samuels v. Berger, 55 AD2d 913, 390 N.Y.S.2d 445 (2nd Dept. 1971); Matter of Bonfanti v. Kirby, 54 AD2d 714, 387 N.Y.S.2d 461 (2nd Dept. 1976); Matter Barbaro v. Wyman, 32 AD2d 647, 300 N.Y.S.2d 856 (2nd Dept. 1969).*

The Department misinterprets its role in this proceeding. The Department has no authority to impose demands for reformation for that which is neither mandated by statute and **[****10]** regulations nor in keeping with the grantors' intent. To echo the opinion of Surrogate Preminger in Matter of Rubin, 4 Misc 3d 634, 781 N.Y.S.2d 421 (Sur Ct. New York Co., 2004), "to reform the trust in the manner requested would stretch the doctrine of reformation beyond recognition."

[422]** Here, as the SNT meets the statutory requirements for approval as written, the Court will not consider and review each and every one of the Department's "observations" and requests for modification relative to same. The Court notes that none of **[***34]** the Department's proposed changes to the SNT has anything to do with the Beneficiary's eligibility (or ineligibility) for Medicaid. Many of the Department's requested modifications are duplicative to the language of the SNT,[6] unnecessary as already covered under statute[7] or in direct contravention to **[*255]** existing authority.[8] It is not necessary to mandate that which is not required by statute and regulations.[9]

It is well settled that New York courts have historically been reluctant to reform or modify the terms of a trust other than in very limited circumstances. Because a proceeding such as this seeks to modify documents which were established by a grantor based upon a set of facts and circumstances that existed at the time of creation, a court should use this form of relief sparingly. Modification, although intended to be used sparingly, is appropriate to achieve a specific objective. *Matter of Carcanagues*, 2016 NY Slip Op 31765(U)(Sur. Ct. New York Co., 2016). Here, modification of the terms of the SNT are appropriate to achieve the specific intent and objective sought by the Petitioners, specifically the maximization of the Beneficiary's eligibility for benefits.

---

[6] The Department requests that Article VIII be amended to reflect that the Trustees are required to file a formal accounting for judicial approval and settlement with the Court. The SNT as drafted already provides that the Trustees are required to submit a final accounting for judicial settlement and the proposed amendment is duplicative.

[7] The Department requests that Article V be modified to reference that the Trustees are liable as per EPTL 11-1.7 and not exonerated for failure to use reasonable care. The existence of the statute already imposes said liabilities.

[8] The Department requests that Article II(b) be modified to provide notice to the local social services district within thirty (30) days of the beneficiary's death. 18 NYCRR 360-4.5(b)(iii)(b) directs that a trustee must notify the local social services department of the death of the trust beneficiary within a reasonable time. The Department has no authority to mandate that the SNT exceed or further define that which is already in the regulation.

[9] The Department requests that Articles IX(b), IX(d) and XI be modified to require that all trustees (including the corporate Trustee) acquire and serve with a bond. 18 NYCRR 360-4.5 directs that no bond is required from the trustees. The Department has no authority to mandate that the SNT exceed that which is already set forth under the regulation or requested by the grantor.

In view of the same, the Court will direct that Article II(A) of the SNT be modified to require the **[***35]** Trustee to pay those administrative expenses enumerated in the Social Security Administration Programs Operations Manual System (POMS) SI 01120.203(B)(3)(a).

Further, in the Court's discretionary role to "balance" the interests of the State with that of the **[****11]** Beneficiary, the Court directs that Article VII be modified to require that the Trustee shall prepare an annual accounting of the Trust and file same with the local social services district, or other appropriate Medicaid entity, responsible for determining the Beneficiary's Medicaid eligibility at the time of the accounting. *See, Matter of Goldblatt, 162 Misc 2d 888, 618 N.Y.S.2d 959 (Sur Ct. Nassau Co., 1994)*; *Matter of Morales*, NYLJ, Jul. 28, 1995 at 25, col1 (Sur Ct. Kings Co., 1995). The SNT as written directs the Trustee to file its annual accounting specifically with Albany County, and the Court will amend the SNT accordingly to **[*256]** permit **[**423]** the Trustees to file their annual accounting with their local social services department or other appropriate Medicaid servicing entity.

It is therefore so

ORDERED, that Article II, paragraph (A) of the Trust Agreement for the Benefit of Kevin J. ***Tyrrell*** dated February 15, 2001 be modified as follows: "(A) The Trustee shall pay those administrative expenses enumerated in the Social Security **[***36]** Administration Programs Operations Manual System (POMS) SI 01120.203(B)(3)(a); and it is further

ORDERED, that Article VII of the Trust Agreement for the Benefit of Kevin J. Tyrell dated February 15, 2001 be modified as follows: "The Trustee shall prepare an annual accounting of the Trust and file same with the local social services district, or other appropriate Medicaid entity, responsible for determining Kevin J. Tyrell's Medicaid eligibility at the time of the accounting; and it is further

ORDERED, that all other motions not specifically addressed herein are dismissed; and it is

SO ORDERED.

DATED: September 25, 2017

HON. RICHARD A. KUPFERMAN

SARATOGA COUNTY SURROGATE

End of Document

Cronin

Surrogate's Court of New York, Kings County

December, 2017, Decided; January 19, 2018, Published

1980-4246/A/B

Reporter
2017 NYLJ LEXIS 3753 *

Cronin

(Matter of ***Cronin***, NYLJ, Jan. 19, 2018 at 42)

Core Terms

guardian, appointed, beneficiary's, cross-petitioner

Judges: **[*1]** Judge: Surrogate Margarita Lopez Torres

Opinion

Cross-petitioner Nicholson sought to be appointed ***Cronin***'s guardian after his mother, Mildred died May 1, 2017, and prior thereto renounced and consented to appointment of Nicholson--***Cronin***'s cousin. A guardian ad litem was appointed for ***Cronin***. A hearing was held; the court heard testimony from ***Cronin***, among others, finding that even with support, he demonstrated a want of understanding arising from his intellectual disability resulting in an inability to manage his affairs, including any financial or medical decisions. As such, the court was satisfied ***Cronin*** remained a person in need of a guardian under SCPA Article 17-A, and it was in his best interest to appoint Nicholson. During the proceeding, a $100,000 trust created in 2009 for ***Cronin***'s benefit was revealed, yet the court found it troubling that no money was ever expended on ***Cronin***'s behalf until three years ago, stating it was unacceptable for trustees to sit back and do nothing until a request was made. It directed that moving forward trust assets would continue to be spent for its intended purpose--to enhance ***Cronin***'s quality of life in proactive consultation with him and his guardian.

Full Case Digest **[*2]** Text

DECISION

***1**

Before the court is a cross-petition by Pam-Eve Nicholson (the cross-petitioner) seeking to be appointed guardian of the person of Andrew ***Cronin*** (Andrew). Andrew's mother and legal guardian, Mildred ***Cronin***[1] (Mildred), died on May 1, 2017. Before her death, Mildred ***Cronin*** renounced and consented to the appointment of the cross-petitioner, who is Andrew's cousin. A guardianship petition initially filed by NYSARC was withdrawn upon the filing of the cross-petition. Jurisdiction is complete and a guardian ad litem was appointed for Andrew. Letters of guardianship of Andrew and of his post-deceased twin brother, Douglas ***Cronin***, who was also intellectually disabled, had been issued to Mildred on September 5, 1980. Subsequently, by decree dated July 2, 1996, NYSARC was appointed stand-by guardian for Andrew. A hearing was held on February 1, 2017, continued onto March 8, 2017, and September 27, 2017, during which testimony was adduced from various witnesses, including Andrew, Mildred, the cross-petitioner, and the individuals whom Andrew fondly refers to as "my staff:" Donatella Horavath, Andrew's medicaid service coordinator, and Rosetta Williams, the manager at the AHRC supported **[*3]** residence where Andrew lives. The Court had the opportunity to observe the demeanor of Andrew, finding Andrew to be an extremely personable individual who is able to express his preferences and desires, and who enjoys robust support from his family and the staff at the residential facility wherein he resides. However, even with support, it is also clear that

[1] The Court wishes to express deep gratitude for the assistance of Dominic Famulari, Esq., who served as counsel to Mildred, and to Jill Kupferberg, Esq., who served as guardian ad litem, for their exemplary representation and invaluable insights.

Andrew demonstrates a want of understanding arising from his intellectual disability that results in the inability to manage his own affairs, including making medical and financial decisions. Upon the record, the Court is satisfied that Andrew continues to be a person in need of a guardian pursuant to Article 17-A of the Surrogate's Court Procedure Act, and that it is in his best interest that the cross-petitioner be appointed the guardian of his person. Decisions by the guardian for Andrew shall be made in meaningful consultation with Andrew, taking into consideration his wants and preferences.

During the course of this proceeding, the existence of a trust created for the benefit of Andrew, which NYSARC believed was administered by NYSARC or AHRC (the trust), was revealed. The court requested NYSARC to furnish information about the trust, including the amount in the trust and what **[*4]** disbursements had been made. Questioned further, it was revealed that Andrew's trust account was valued at almost $100,000.00,[2] yet up until three

***2**

months ago, not a single dollar had been spent on Andrew's behalf since its creation in 2009. Ms. Williams testified that she was unaware of trust monies that could benefit Andrew, that Andrew, whose source of income is social security benefits of which AHRC is the designated payee, lives on food stamps and has a clothing allowance of $250.00 for the year, with Mildred or the cross-petitioner providing some spending money in a nominal amount. Andrew, who is 51 years old, testified that he does not have money to go to the movies, that he is unable to attend sports games or to buy his favorite and coveted sports jerseys. He further testified that he mostly eats food that his elderly mother[3] shared with him out of her "Meals on Wheels" ration, stating "we divide the meals — with me and for her. And we have to divide each," explaining that they split the food containers among themselves.

It is deeply troubling that over the course of seven years since the establishment of the trust, no steps had been taken by the trustees whatsoever to ascertain **[*5]** or meet the needs of Andrew, despite the clear intention of the trust that it be used for Andrew's benefit. The duty of trustees to act in the best interest of the trust beneficiary carries with it the concomitant obligation that trustees make themselves knowledgeable about a beneficiary's condition and needs.

Trustees, institutional and individual alike, bear an affirmative obligation to ascertain the beneficiary's educational, medical, or quality of life needs in order to use trust money for the enhancement of the beneficiary's life, regardless of whether the trust is pooled[4] or otherwise.

Indeed, the plain language of Andrew's trust states that its purpose "is intended to provide, in the sole and absolute discretion of the Trustees, extra and supplemental items for the best interests of the Designated Beneficiary including, without limitation, the care, comfort, education and training of the Designated Beneficiaries..."[5] It is unacceptable for trustees to simply sit back and do nothing until a request is made. In serving as trustee over a beneficiary living with disabilities, a fiduciary's responsibility is "something stricter than the mere morals of the marketplace...but a punctilio **[*6]** of honor most sensitive," *In re JP Morgan Chase, NA, 38 Misc 3d 363* (Sur Ct New York County2012) citing *Meinhard v. Salmon, 249 NY 458, 464 (1928)* (Cardozo, C.J.). "Both case law and basic principles of trust administration and fiduciary obligation requires the trustees to take appropriate steps to keep abreast of [the beneficiary's] condition, needs, and quality of life, and to utilize trust assets for his actual benefit," In re JP Morgan Chase, supra at 868. See also *Matter of Mark C.H., 28 Misc 3d 765 (Sur Ct, New York County 2010)* The trustees bear an affirmative duty to inquire with diligence into the quality of Andrew's life and to apply trust income towards significantly improving it.

At the final hearing date in September 2017, the Court was pleased to learn that a list of items had finally been provided from Andrew's trust for Andrew's benefit, including a watch, an electric shaver, bedding, sneakers, and a desktop computer. Moving forward, it is expected that Andrew's trust assets will continue to be

---

[2] According to counsel for AHRC, a trust account was established for Andrew's benefit on July 7, 2009, under the AHRC New York City Foundation, Inc. Community Trust II, in the sum of $77,769.56. Inclusive of interest, the value of the trust as of December 16, 2016, was $99,579.00.

[3] In the course of this proceeding, Andrew's mother passed away.

[4] Funds contained in pooled special needs trusts are to be used during the individuals' lifetime to enhance their life and upon their death the funds remain in the special needs trust for the benefit of other trust beneficiaries.

[5] Paragraph 2 (B), AHRC New York City Foundation Inc. Community Trust II, as amended July 2, 2014

spent for its intended purpose, that is to enhance Andrew's quality of life in proactive consultation with Andrew and his guardian to determine his needs and preferences.

*3

The cross-petition is hereby granted, the petition by NYSARC is withdrawn, and letters of guardianship of the person of Andrew ***Cronin*** shall issue to Pam-Eve **[*7]** Nicholson, upon duly qualifying according to law.

Dated: December, 2017

Brooklyn, New York

New York Law Journal

End of Document

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Medicaid Managed Care Transition for Enrollees Gaining Medicare
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Upstate (518) 473-6397 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the Medicaid Managed Care (MMC) transition process for enrollees who gain Medicare eligibility.

1. Transition from MMC to MLTC

To ensure that enrollees who are receiving long term services and supports (LTSS) do not experience a lapse in services when they are disenrolled from MMC due to receipt of Medicare, New York Medicaid Choice (NYMC) will process *all* managed care transfers and disenrollments for recipients with Medicare, including recipients residing in non-enrollment broker counties. Each month, NYMC performs an electronic search to identify MMC enrollees with current Medicare or Medicare that will become effective within the next 60 days. Once identified, NYMC contacts the Medicaid managed care plans to have the plans identify those enrollees in receipt of LTSS. If in receipt of LTSS, NYMC will enroll eligible recipients into a managed long-term care (MLTC) plan. If a recipient is receiving LTSS and is excluded from MLTC, NYMC will disenroll the consumer from MMC and notify the MMC plan that the recipient is excluded from MLTC. The MMC plan is required to provide the current service authorization plan to the local district managed care coordinator to coordinate the delivery of LTSS through fee-for-service Medicaid.

The monthly Medicare disenrollment report produced by NYMC is available on MoveIt. Local district managed care coordinators and other designated staff have access to this report. The report identifies transfers and disenrollments for recipients with Medicare. The name of the report is the "Medicare Disenrollment and Transfer Report [County Name] _ Effective MMDDYYYY.xls."

2. Individuals Turning Age 65 and Enrollment in Medicare

In many cases, enrollment in Medicare will coincide with the recipient turning age 65. For adults in the Modified Adjusted Gross Income (MAGI) category who are turning age 65, and who are not a parent or caretaker relative, Medicaid eligibility must be redetermined under the individual's non-MAGI category of assistance (SSI-related). If the individual is receiving coverage through NY State of Health (NYSOH), the individual will be transitioned to the district the month prior to the individual's 65th birthday for a redetermination of eligibility. Medicaid coverage must continue while eligibility is being redetermined. To avoid a gap in enrollment for individuals receiving LTSS, enrollment from a MMC plan to a MLTC can occur pending the district's redetermination of eligibility.

Ideally, the district should have information concerning an individual's disenrollment from MMC or transition to MLTC (due to receipt of Medicare) in time to redetermine eligibility and issue a timely notice concerning the individual's on-going eligibility by the first day of the month following the individual's 65th birthday. However, if the district does not have the necessary MMC information concerning the individual's disenrollment or transition to a MLTC plan, the district should contact

NYMC to obtain this information prior to taking any action on the eligibility redetermination. The resource documentation requirements will be different for an individual transitioning to MLTC or needing community-based long-term care than the requirements will be for a person who is not in need of long-term care services. If the district is not able to make the new eligibility determination and provide timely notice by the first day of the month following the individual's 65th birthday, Medicaid coverage must be extended until timely notice is provided.

3. Individuals Under Age 65 with Medicare

Individuals under age 65 who gain Medicare eligibility remain in the MAGI category of assistance until their Medicaid renewal due to continuous coverage. Parents and caretaker relatives remain in the MAGI category regardless of Medicare eligibility. If these MAGI recipients are enrolled in MMC through NYSOH and are receiving LTSS, the individual will be transitioned to the district for enrollment in MLTC or for the delivery of services through fee-for-service Medicaid. The transition to the district is facilitated by staff in the Department of Health (DOH).

4. Reimbursement of Medicare Premiums

NYSOH Medicaid recipients newly in receipt of Medicare will have their Medicare Part B premiums reimbursed by DOH through the Medicare Insurance Premium Payment (MIPP) process. For Medicare beneficiaries who are referred to the local district on the daily NYSOH "referral file," MIPP payments will be made through the end of the month, following the month of referral, for upstate recipients and through the month of referral, plus two prospective months, for New York City (NYC) recipients.

Note: For Medicare beneficiaries who are referred to the district by DOH staff for LTSS (MLTC or fee-for-service Medicaid), MIPP payments will be made through the end date of the NYSOH authorization for upstate recipients (month of referral) and for the month of referral, plus three prospective months, for NYC recipients.

For Medicaid recipients in receipt of Medicare who have coverage through the local district, the district is responsible for determining eligibility for the Medicare Savings Program (MSP). For adults in a MAGI category, the district should do a "scratchpad" MSP budget to determine eligibility for the Buy-in. If income is equal to or over 120% of the federal poverty level (FPL), reimbursement of the Part B premiums should be made through MIPP payments for the months the individual remains eligible under the MAGI category/budget. If income is below 120% of the FPL, the individual should be added to the Buy-in. For individuals transitioning from MIPP payments for reimbursement of Medicare Part B premiums to the Buy-in, the Buy-in begin date should be the first day of the month following the last MIPP payment. Recipients should never receive a MIPP payment and the Buy-in payment in the same month. MIPP payment dates are viewable on the eMedNY resource page.

Effective immediately, dually eligible MMC enrollees who are transitioning to MLTC, or fee-for-service Medicaid, are entitled to have their Medicare premiums paid or reimbursed. It had been DOH's policy to not reimburse individuals their Medicare Part B premiums for months in which the individual was enrolled in MMC. Due to efforts to transition individuals who gain Medicare eligibility and who require LTSS, individuals may not be disenrolled from MMC upon receipt of Medicare. To facilitate the transition and not disadvantage the recipient, the Medicaid program is approving reimbursement of Part B premiums for enrollees in MMC.

5. District MMC Dis-enrollment

It should be noted that there are instances when the local district managed care coordinator or designated staff will need to process MMC dis-enrollments. This occurs when there is insufficient Medicaid eligibility in the system. For example, NYMC is unable to process a January 1, 2017 disenrollment if eligibility does not extend beyond December 31, 2016, which can occur at the end of an authorization period. In the case where a MLTC transfer is required, the district must re-determine eligibility and extend coverage, if the individual is determined eligible for MLTC or if additional time is needed to complete the eligibility re-determination for MLTC. The district will need to coordinate the MLTC enrollment with the eligibility change. The district has the option to either notify NYMC to process the enrollment, or the district can process the enrollment. For any actions processed by local district staff, the local district must either send managed care disenrollment/enrollment notices or advise NYMC to send the notice. If a MMC enrollee with Medicare is not found on the report, the local district managed care coordinator should contact NYMC so that NYMC can conduct outreach to the plan.

Please direct any questions concerning this message to your local district liaison.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Treatment of New York Achieving a Better Life Experience (ABLE) Accounts
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 advise local departments of social services (LDSS) of the treatment of accounts established pursuant to the federal Achieving a Better Life Experience Act of 2014 (ABLE Act) in determining eligibility for Medicaid. The ABLE Act allows individuals with disabilities the opportunity to set aside funds in an account established pursuant to Section 529A of the Internal Revenue Code for disability-related expenses, with limited impact on their eligibility for Medicaid. For Modified Adjusted Gross Income (MAGI) and non-MAGI based eligibility determinations, funds in an ABLE account, earnings on funds in the account, contributions to an ABLE account from a third party, and distributions from the account for qualified disability expenses (QDEs) are disregarded, as reflected in Section 366(2)(a)(11) of the Social Services Law. Individuals must meet certain disability criteria to be eligible for participation in an ABLE program, however the treatment of funds in an ABLE account is not contingent upon the individual being certified disabled.

Designated beneficiaries of an ABLE account can contribute their own income to their ABLE account but it does not reduce the amount of income that is countable for purposes of determining Medicaid eligibility, or reduce the amount of income that the beneficiary (Medicaid applicant/recipient) may be required to contribute toward the cost of medical care. Resources that are used to fund an ABLE account are subject to resource counting rules until the funds are deposited into an ABLE account. Assets in an ABLE account are available to the account owner to meet his/her QDEs; therefore, funds deposited to the account by the beneficiary (Medicaid applicant/recipient) him or herself are not considered a transfer of assets.

Distributions from an individual's ABLE account are not counted as income for purposes of determining Medicaid eligibility, or for purposes of post-eligibility treatment of income, provided the funds are used to pay for QDEs. For SSI-related individuals, ABLE account distributions retained after the month of receipt continue to be disregarded unless the money is used for a non-qualifying expense. If the individual uses the distribution for a non-QDE, the distribution would be subject to treatment as a countable resource in the month the distribution is spent. Since resources are reviewed as of the first day of the month to determine eligibility for an SSI-related individual, a distribution spent after the first day of the month is not considered a countable resource. For MAGI eligibility, distributions which exceed the QDEs incurred by the beneficiary in a taxable year are taxable and therefore included in determining MAGI-based income eligibility. Individuals may self-attest to this taxable income, if any.

The ABLE Act allows States the option to file a claim for reimbursement of Medicaid costs from funds remaining in an ABLE account upon death of the designated beneficiary. New York has implemented this right pursuant to 2 NYCRR Section 156.5. If such a claim is not filed, and funds remaining in the ABLE account become part of the decedent's estate, the funds are subject to Medicaid estate recovery.

In New York (NY), the ABLE program is authorized by Article 84 of the Mental Hygiene Law and is administered by the Office of the State Comptroller in accordance with regulations at 2 NYCRR Part 156. The policy for the treatment of ABLE accounts applies to accounts established with the New York ABLE Program, and to accounts established through ABLE programs administered by other states.

Information about the NY ABLE Program can be found at:
https://www.osc.state.ny.us/savings/able.htm and https://www.mynyable.org/home.html.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2018 Federal Poverty Levels
EFFECTIVE DATE:	January 1, 2018
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 (LDSS) of the revised federal poverty levels (FPLs). The revised FPLs are effective January 1, 2018, as published in the Federal Register.

The new FPLs should be used for all transactions with a January 1, 2018 MBL/eligibility "From" date. The revised figures will be available on MBL on March 19, 2018. For all new and pending applications, income must be compared to the 2018 FPLs.

Due to the increase in the FPLs, some Specified Low-Income Medicare Beneficiaries (SLIMB) may be income eligible for the Qualified Medicare Beneficiary (QMB) benefit and some Qualified Individuals-1 (QI-1) may become eligible for SLIMB. In such cases, staff must complete a 99-change transaction on the eMedNY Buy-in span, with the effective date of January 1, 2018, and change the Medicare Savings Program (MSP) code appropriately. For NYC, the change in MSP level can be transmitted via an undercare case transaction.

To assist districts with evaluating possible necessary changes, the following will occur:

- Upstate will perform a limited Mass Re-Budget (MRB) on March 17, 2018. The cases to be re-budgeted and have a 2018 Cost of Living Adjustment (COLA) applied are those that are included in the Aged, Blind, Disabled (ABD) or Medicare Savings Program (MSP) Automated Renewal Process. Upstate will not perform a MRB on any other budgets. Districts are required to manually update all other affected budgets at next contact or at renewal.

- New York City will perform a MRB on April 7, 2018 on Budget Types 01 - 07 for qualified budgets on open Case Type 20. The MRB will only impact cases with Social Security income. A closing transaction will be established for cases as appropriate. The MRB Reports of Exclusions and Exceptions will be created for the following budgets:

    - Budget 01 with EEC Code of "M";
    - Budget 04 with EEC codes of "E", "A", "H";
    - Budget 04, 05, 06, 07 with Buy-In Indicator = "A"; and
    - Budget 04 for MBI-WPD cases with MA RESP area code = "WD" or "PD".

The Human Resources Administration must evaluate and take appropriate action on these cases.

Medicare Part B Premium

In 2018, there is a COLA of 2% for Social Security benefits. Under a "hold-harmless" provision of federal law, basic Medicare Part B premiums in any year cannot rise higher than that year's COLA.

Many people were held harmless in 2017 because the COLA for that year (0.3%) was not large enough to cover the full amount of the increased Part B premium ($134.00).

In 2018, most of those who will be held harmless, will pay the full Part B premium. In other words, the 2% COLA will generate enough increased income for them to pay $134.00 without reducing their net Social Security benefits.

For the remainder of those held harmless, their 2% Social Security COLA increase will not be sufficient to cover the entire Part B premium. They will pay a range of smaller Part B premiums, based on their 2018 COLAs.

The "hold-harmless" provision does not apply to all beneficiaries. The Medicare Part B premium for individuals in the following categories will pay the standard premium of $134.00 (or higher) in 2018:

- Individuals whose income is above $85,000, or a married individual when the couple's combined income is over $170,000, will pay the standard premium and an Income Related Monthly Adjustment Amount (IRMAA);
- New Medicare Part B beneficiaries. Since these individuals did not pay the Medicare Part B premium in 2017, the "hold harmless" provision does not apply; and
- Individuals who do not have the Medicare Part B premium deducted from their Social Security benefit. This includes individuals who are enrolled in the Medicare Savings Program. These individuals will not be directly affected; the increased premium will be paid by Medicaid.

If a person has chosen to pay the Medicare Part B premium to reduce excess income, the actual premium that is paid must be used in calculating the individual's budget.

Family Member Allowance

As a result of the increase in the FPLs, the amount used in the Family Member Allowance (FMA) formula increased to $2,058. The maximum monthly FMA increased to $686. All spousal impoverishment cases involving a family member entitled to the family member allowance, which were active on or after January 1, 2018, and which were budgeted using the 2017 Family Member Allowance, must be re-budgeted using the 2018 Family Member Allowance. In addition, the increased Family Member Allowance must be used effective January 1, 2018, in determining any requested contribution of income from a community spouse or from a spouse living apart from an SSI-related applicant/recipient. Budget adjustments should be made at next contact or renewal.

If a district determines that a previously budgeted case has been negatively affected due to use of the 2017 FPL, or a case is brought to the district's attention, the case should be re-budgeted using the revised FPLs. If eligible, covered medical expenses paid by an individual as a result of an improper calculation, must be reimbursed pursuant to 10 OHIP/ADM-9, "Reimbursement of Paid Medical Expenses Under 18 NYCCR §360-7.5(a)."

Charts with the 2018 FPLs for the various categories of Medicaid eligibility are attached to this GIS.

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, 2018

HOUSE HOLD SIZE	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		185% FPL		200% FPL		250% FPL		RESOURCES	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY		
ONE	10,100	842	12,140	1,012	14,568	1,214	16,147	1,346	16,389	1,366	18,210	1,518	22,459	1,872	24,280	2,024	30,350	2,530	15,150	1
TWO	14,800	1,233	16,460	1,372	19,752	1,646	21,892	1,825	22,221	1,852	24,690	2,058	30,451	2,538	32,920	2,744	41,150	3,430	22,200	2
THREE	17,020	1,418	20,780	1,732			27,638	2,304			31,170	2,598	38,443	3,204	41,560	3,464				3
FOUR	19,240	1,603	25,100	2,092			33,383	2,782			37,650	3,138	46,435	3,870	50,200	4,184				4
FIVE	21,460	1,788	29,420	2,452			39,129	3,261			44,130	3,678	54,427	4,536	58,840	4,904				5
SIX	23,680	1,973	33,740	2,812			44,875	3,740			50,610	4,218	62,419	5,202	67,480	5,624				6
SEVEN	25,900	2,158	38,060	3,172			50,620	4,219			57,090	4,758	70,411	5,868	76,120	6,344				7
EIGHT	28,120	2,343	42,380	3,532			56,366	4,698			63,570	5,298	78,403	6,534	84,760	7,064				8
NINE	30,340	2,528	46,700	3,892			62,111	5,176			70,050	5,838	86,395	7,200	93,400	7,784				9
TEN	32,560	2,713	51,020	4,252			67,857	5,655			76,530	6,378	94,387	7,866	102,040	8,504				10
EACH ADD'L PERSON	2,220	185	4,320	360			5,746	479			6,480	540	7,992	666	8,640	720				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,090.00	$123,600
Institutionalized Spouse	$50	$15,150
Family Member Allowance	$2,058 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $686.	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$417	Northeastern	$467	Northern Metropolitan	$935
Rochester	$424	Long Island	$1,274		
Western	$365	New York City	$1,305		

*In determining the community resource allowance on and after January 1, 2018, 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 $123,600. 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 January 30, 2018

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	842	1,233	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	842	1,233	15,150	22,200	Household size is always one or two.
Qualified Medicare Beneficiary (QMB)	AT OR BELOW 100% FPL	1,012	1,372	NO RESOURCE TEST		Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100% FPL	1,012	1,372	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185% FPL	1,872	2,538	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED DISABLED & WORKING INDIVIDUAL	200% FPL	2,024	2,744	4,000	6,000	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMBS)	OVER 100% BUT BELOW 120% FPL	1,012	1,372	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
		1,214	1,646			
QUALIFIED INDIVIDUALS (QI-1)	GREATER THAN OR EQUAL TO 120% BUT LESS THAN 135% FPL	1,214	1,646	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
		1,366	1,852			
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250%	2,530	3,430	20,000	30,000	Countable retirement accounts are disregarded as resources effective 10/01/11.

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

New York State Income Standards for MAGI Population
Effective January 1, 2018

House Hold Size	LIF LEVEL		100% FPL		110% FPL		138% FPL		154% FPL		155% FPL		223% FPL	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY
One	12,211	1,018	12,140	1,012	13,354	1,113	16,754	1,397	18,696	1,558	18,817	1,569	27,073	2,257
Two	15,504	1,292	16,460	1,372	18,106	1,509	22,715	1,893	25,349	2,113	25,513	2,127	36,706	3,059
Three	18,691	1,558	20,780	1,732	22,858	1,905	28,677	2,390	32,002	2,667	32,209	2,685	46,340	3,862
Four	21,897	1,825	25,100	2,092	27,610	2,301	34,638	2,887	38,654	3,222	38,905	3,243	55,973	4,665
Five	25,195	2,100	29,420	2,452	32,362	2,697	40,600	3,384	45,307	3,776	45,601	3,801	65,607	5,468
Six	27,848	2,321	33,740	2,812	37,114	3,093	46,562	3,881	51,960	4,330	52,297	4,359	75,241	6,271
Seven	30,594	2,550	38,060	3,172	41,866	3,489	52,523	4,377	58,613	4,885	58,993	4,917	84,874	7,073
Eight	33,851	2,821	42,380	3,532	46,618	3,885	58,485	4,874	65,266	5,439	65,689	5,475	94,508	7,876
Nine	36,117	3,010	46,700	3,892	51,370	4,281	64,446	5,371	71,918	5,994	72,385	6,033	104,141	8,679
Ten	38,385	3,199	51,020	4,252	56,122	4,677	70,408	5,868	78,571	6,548	79,081	6,591	113,775	9,482
Each Add't Person	2,269	190	4,320	360	4,752	396	5,962	497	6,653	555	6,696	558	9,634	803

Revised January 30, 2018

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	3,059	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spenddown to become eligible for presumptive eligibility.
PREGNANT WOMEN	223% FPL	N/A	3,059	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. If 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	2,257	3,059	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	1,558	2,113	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	1,113	1,509	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	1,558	2,113			
PARENTS/CARETAKER RELATIVES	138% FPL	1,397	1,893	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	1,397	1,893	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	1,569	2,127			
SINGLE/CHILDLESS COUPLES AND 19 AND 20 YEARS LIVING ALONE	100% FPL	1,012	1,372	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	1,397	1,893			
FAMILY PLANNING PROGRAM	223% FPL	2,257	3,059	NO RESOURCE TEST		Eligibility determined using only applicant's income.

Section 503 of Public Law 94-566, referred to as the Pickle Amendment, protects Medicaid eligibility for all recipients of Retirement Survivors and Disability Insurance (RSDI) who were previously eligible for SSI benefits concurrently. These recipients are individuals who would be eligible for SSI, if all RSDI Cost of Living Allowances (COLAs) received since they were last eligible for and receiving RSDI and SSI benefits concurrently, were deducted from their countable income. (See 85 ADM-35 for further information). The reduction factors in the chart below, "REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT", should be used when determining Medicaid eligibility for individuals who are entitled to a reduction to their countable SSI Income.

If SSI was terminated during this period:	Multiply 2018 Social Security income by:	If SS was terminated during this period:	Multiply 2018 Social Security income by:	If SSI was terminated during this period:	Multiply 2018 Social Security income by:
May – June 1977	0.240	Jan. 1990 – Dec. 1990	0.515	Jan. 2003 – Dec. 2003	0.736
July 1977 – June 1978	0.254	Jan. 1991 – Dec. 1991	0.542	Jan. 2004 – Dec. 2004	0.752
July 1978 – June 1979	0.270	Jan. 1992 – Dec. 1992	0.562	Jan. 2005 – Dec. 2005	0.772
July 1979 – June 1980	0.297	Jan. 1993 – Dec. 1993	0.579	Jan. 2006 – Dec. 2006	0.804
July 1980 – June 1981	0.339	Jan. 1994 – Dec. 1994	0.594	Jan. 2007 – Dec. 2007	0.830
July 1981 – June 1982	0.377	Jan. 1995 – Dec. 1995	0.611	Jan. 2008 – Dec. 2008	0.849
July 1982 – Dec. 1983	0.405	Jan. 1996 – Dec. 1996	0.627	Jan. 2009 – Dec. 2011	0.899
Jan. 1984 – Dec. 1984	0.420	Jan. 1997 – Dec. 1997	0.645	Jan. 2012 – Dec. 2012	0.931
Jan. 1985 – Dec. 1985	0.434	Jan. 1998 – Dec. 1998	0.659	Jan. 2013 – Dec. 2013	0.947
Jan. 1986 – Dec. 1986	0.448	Jan. 1999 – Dec. 1999	0.667	Jan. 2014 – Dec. 2014	0.961
Jan. 1987 – Dec. 1987	0.454	Jan. 2000 – Dec. 2000	0.684	Jan. 2015 -Dec 2016	0.977
Jan. 1988 – Dec. 1988	0.473	Jan. 2001 – Dec. 2001	0.708	Jan. 2017 - Dec. 2017	0.980
Jan. 1989 – Dec. 1989	0.492	Jan. 2002 – Dec. 2002	0.726		

Note: This updates the Reduction Factors included in the Medicaid Reference Guide (MRG). The MRG table should no longer be used.

Revised January 30, 2018

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Treatment of Income of Dependents Under MAGI-like Rules, 2018 Update
ATTACHMENT:	Dependent Income Counting Worksheet 2018
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 inform local departments of social services (LDSS) of an update regarding the treatment of a dependent's income under Modified Adjusted Gross Income (MAGI) rules.

CMS (Centers for Medicare & Medicaid Services) has advised that due to the Tax Cuts and Jobs Act of 2017, the threshold that determines whether a tax dependent is required to file a tax return has been updated, and should be used in MAGI determinations immediately.

As per GIS 15 MA/08 "Treatment of Income of Dependents Under MAGI-like Rules," this income threshold is used to determine if the income of a child or tax dependent is included in the MAGI-like budget. This information is generally released via IRS publication 501, which is not yet available. Attached to the GIS is a worksheet to assist in calculating whether a dependent's income is countable.

The income threshold for dependents for tax year 2018 is $12,000 for earned income and $1,050 for unearned income.

- If a dependent has earned income only and it exceeds $12,000, the dependent must file a return.
- If a dependent has unearned income only and it exceeds $1,050, the dependent must file a return.
- If a dependent has both earned and unearned income and one income type exceeds the IRS threshold, the dependent must file a return.
- In addition, if a dependent has both earned and unearned income and each is less than the applicable threshold, the dependent, nevertheless, must file a return if the combined (gross) income exceeds the larger of $1,050 or the amount of the dependent's earned income (up to $11,650) plus $350.

If a district determines that a previously budgeted case has been negatively affected due to use of the 2017 threshold, or a case is brought to the district's attention, the case should be re-budgeted using the revised threshold level. If eligible, covered medical expenses paid by an individual as a result of an improper calculation, must be reimbursed pursuant to 10 OHIP/ADM-9, "Reimbursement of Paid Medical Expenses Under 18 NYCCR §360-7.5(a)."

Please direct any questions to your Local District Support Liaison.

Counting children's (< 21) income for MAGI-like ("M") budgeting

If child has:	*Income should be:*
Title II income only	Excluded
Earned Income only	Counted if over IRS threshold ($12,000)*
Unearned Income only	Counted if over IRS threshold ($1050)*
Earned and Unearned Income	Counted if one or both are over the applicable thresholds
Earned and Unearned Income	If both are under the applicable thresholds, refer to worksheet below
Title II and other Income (earned or unearned)	Title II and other are counted if other income is over applicable threshold
Title II and other Income (earned and unearned)	If earned and unearned are both under the applicable thresholds, refer to worksheet below

Earned and Unearned income Worksheet

Line		Amount
1	Enter dependent's earned income plus $350	
2	Minimum amount	$1050*
3	Compare lines 1 and 2. Enter the **larger** amount	
4	Maximum amount	$12,000 *
5	Compare lines 3 and 4. Enter the **smaller** amount	
6	Enter the dependent's gross income (earned+unearned). If line 6 is more than line 5, the dependent **must file** an income tax return, and all their income is countable.	

*Yearly figures are for tax year 2018, refer to IRS publication 501 for updates [section: Filing requirements for dependents]

5/7/18

WGIUPD **GIS 17 MA/16**	**GENERAL INFORMATION SYSTEM** **DIVISION:** Office of Health Insurance Programs	10/27/17 **PAGE** 1

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2017 Update to the Actuarial Life Expectancy Table
ATTACHMENT:	2017 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.

2017 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	76.33	81.11	30	47.86	52.06
1	75.81	80.54	31	46.93	51.10
2	74.84	79.57	32	46.00	50.13
3	73.86	78.59	33	45.07	49.17
4	72.88	77.60	34	44.15	48.21
5	71.89	76.61	35	43.22	47.25
6	70.90	75.62	36	42.29	46.29
7	69.91	74.63	37	41.37	45.34
8	68.92	73.64	38	40.44	44.39
9	67.93	72.64	39	39.52	43.44
10	66.94	71.65	40	38.60	42.49
11	65.94	70.66	41	37.68	41.55
12	64.95	69.66	42	36.76	40.61
13	63.96	68.67	43	35.85	39.67
14	62.97	67.68	44	34.95	38.74
15	61.99	66.69	45	34.04	37.81
16	61.02	65.70	46	33.15	36.88
17	60.05	64.72	47	32.26	35.96
18	59.08	63.73	48	31.38	35.05
19	58.13	62.75	49	30.51	34.14
20	57.18	61.77	50	29.64	33.24
21	56.24	60.80	51	28.79	32.34
22	55.30	59.82	52	27.94	31.45
23	54.37	58.85	53	27.11	30.57
24	53.44	57.87	54	26.29	29.70
25	52.51	56.90	55	25.47	28.83
26	51.58	55.93	56	24.67	27.96
27	50.65	54.96	57	23.87	27.10
28	49.72	53.99	58	23.09	26.25
29	48.79	53.03	59	22.32	25.40

2017 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	21.55	24.56	90	4.08	4.85
61	20.79	23.72	91	3.79	4.50
62	20.04	22.89	92	3.52	4.18
63	19.30	22.07	93	3.27	3.88
64	18.57	21.25	94	3.05	3.61
65	17.84	20.44	95	2.85	3.37
66	17.12	19.63	96	2.68	3.16
67	16.40	18.84	97	2.53	2.96
68	15.70	18.06	98	2.39	2.79
69	15.01	17.29	99	2.27	2.63
70	14.32	16.53	100	2.15	2.48
71	13.66	15.78	101	2.04	2.33
72	13.00	15.05	102	1.93	2.19
73	12.36	14.34	103	1.83	2.06
74	11.73	13.63	104	1.73	1.93
75	11.11	12.94	105	1.63	1.81
76	10.51	12.26	106	1.54	1.69
77	9.93	11.60	107	1.45	1.58
78	9.36	10.96	108	1.36	1.47
79	8.81	10.33	109	1.28	1.37
80	8.28	9.73	110	1.20	1.27
81	7.76	9.14	111	1.13	1.18
82	7.27	8.58	112	1.05	1.09
83	6.80	8.04	113	0.98	1.01
84	6.34	7.52	114	0.92	0.93
85	5.91	7.01	115	0.86	0.86
86	5.50	6.53	116	0.79	0.79
87	5.11	6.08	117	0.74	0.74
88	4.74	5.64	118	0.68	0.68
89	4.40	5.23	119	0.63	0.63

necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

§ 438.402 General requirements.

(a) *The grievance system.* Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

(b) *Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) *Timing.* The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.

(3) *Procedures.* (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

§ 438.404 Notice of action.

(a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.

(b) *Content of notice.* The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 25, 2017
[redacted]
AGENCY: Erie
FH #: 7618249Z

In the Matter of the Appeal of

[redacted]

from a determination by the Erie 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 March 21, 2018, in Erie County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Candace O'Toole, Fair Hearing Representative

ISSUE

Was the Agency's August 31, 2017 determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services for 16.2805 months, commencing April 1, 2017 because he transferred assets for less than fair market value correct?

FINDINGS OF FACT

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 May 15, 2017, an application for Medicaid was made by or on behalf of the Appellant. The Appellant was [redacted] years of age at the time of application.

2. The Appellant was admitted to a skilled nursing facility for long-term care in June 2016 and remained there until his death on October 14, 2017.

3. The Appellant is seeking coverage retroactive to April 1, 2017.

4. The Appellant's spouse is deceased.

5. The Appellant has no minor or disabled children.

6. The Agency calculated the sanction based on the following uncompensated transfers:

August 24, 2012: $1,022.60 -1/2 the value of a bank account transferred to son
October 23, 2012: $2,000.00- cash withdrawal without proof of what it was spent on
April 24, 2013: $18,850.00- car purchase for son
September 4, 2013: $3,500.00- paid lawyer fees for son
June 5, 2014: $5,000.00- cash withdrawal without proof of what it was spent on
October 10, 2014: $3,500.000- cash withdrawal without proof of what it was spent on
February 27, 2015: $2,500- cash withdrawal without proof of what it was spent on
April 16, 2015: $4,000.00- cash withdrawal without proof of what it was spent on
March 27, 2017: $57,708.86- gift to son
March 21, 2007: $105,363.86—annuity purchased without listing the State as a remainder beneficiary; amount is value of annuity on March 31, 2017.

Total Uncompensated Transfers:	$203,444.74
Minus Returned Assets:	(1,661.09)
Minus Promissory Note dated March 27, 2017	($37,708.28)
Net Uncompensated Transfers:	$164,075.37

7. By notice dated August 31, 2017, the Agency determined that the Appellant was not eligible under Medicaid for nursing facility services because the Appellant transferred assets valued at $164,075.37 for less than market value. This amount was divided by the regional nursing home rate of $10,078.00 which resulted in a 16.2805-month sanction being imposed, commencing April 1, 2017.

8. On September 25, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Sections 360-4.1 and 360-4.8(b) of 18 NYCRR (herein referred to as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Under Section 360-4.4 of the Regulations, "Resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or

behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid-qualifying trust, as described in Section 360-4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

Section 366.5(d) of the Social Services Law and Section 360-4.4(c)(2) of the Regulations govern Transfers of Assets made by an applicant or recipient or his or her spouse) on or after August 11, 1993. Section 366.5(e) governs transfers made on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, either as an in-patient in a nursing facility (including an intermediate care facility for the mentally retarded), as an in-patient in a medical facility at a level of care such as is provided in a nursing facility, or as a recipient of care, services, or supplies at home pursuant to a waiver under section 1915(c) of the federal Social Security Act ("waivered services"), any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

For applications filed on or after August 1, 2006, for Medical Assistance coverage of nursing facility services, the "look-back period" is the period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical Assistance. Beginning in February 1, 2009 the look back period will increase from 36 months to 37 months and each month thereafter it will increase by one month until February 1, 2011 when a 60-month look-back period will be in place for all types of transfers of assets. 06 OMM/ADM-5. The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(e).

Effective August 1, 2006 if an applicant or recipient seeking coverage for nursing facility services purchased an annuity on or after February 8, 2006 the State must be named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the State must be named in the second position after a community spouse or minor or disabled child and must be named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value. If the applicant/recipient or applicant or recipient's spouse fails or refuses to so name the State as the remainder beneficiary the purchase will be considered a transfer of assets for less than fair market value. In addition, if an annuity is purchased by or on behalf of an applicant or recipient, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

- an annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986, or

- purchased with the proceeds from an account described in subsection (a), (c), (p) of Section 408 of such Code; a simplified employee pension within the meaning of Section 408(k) of such Code; or a Roth IRA described in section 408A of such Code; or

the annuity is:

- irrevocable and non-assignable;
- is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and
- provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions. Social Services Law 366.5(e), 06 OMM/ADM-5

Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if:

(a) the asset transferred was other than a homestead and was a disregarded or exempt asset under Section 360-4.4(d), 360-4.6, and/or 360-4.7 of the Regulations; or

(b) the asset transferred was a home, and title to the home was transferred to:

(1) the individual's spouse; or

(2) the individual's child, who is blind, disabled, or under the age of 21; or

(3) the individual's sibling, who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date the person became an institutionalized individual, or

(4) the individual's child, who was residing in the home for a period of at least two years immediately before the date the person became an institutionalized individual, and who provided care to the person which permitted her or him to continue residing at home rather than enter into an institution or facility; or

(c) the asset was transferred:

(i) to the individual's spouse or to another for the sole benefit of the spouse; or

(ii) from the individual's spouse to another for the sole benefit of the spouse; or

(iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or

(iv) to a trust established solely for the benefit of a disabled person under 65 years of age.

(d) a satisfactory showing is made that:

(i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or

(ii) the asset was transferred exclusively for a purpose other than to qualify for Medicaid; or

(iii) all assets transferred for less than fair market value have been returned to the individual.

In addition, Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if denial of eligibility will result in an undue hardship. Section 360-4.4 of the Regulations provides that denial of eligibility will result in an undue hardship if:

(i) the individual is otherwise eligible for Medicaid;

(ii) said person is unable to obtain appropriate medical care without the provision of Medicaid; and

(iii) despite his or her best efforts, said person or his or her spouse is unable to have the transferred asset returned or to receive fair market value for the asset. Best efforts include cooperating, as deemed appropriate by the commissioner of the social services district, in efforts to seek the return of the asset.

For transfers made on or after February 8, 2006, section 366.5(e)(4)(iv) of the Social Services Law provides that an individual shall not be ineligible for services solely by reason of any such transfer to the extent that denial of eligibility would cause an undue hardship such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter or other necessities of life. The Department of Health in 06 OMM/ADM-5 has incorporated in addition to the deprivation of food, clothing, shelter or other necessities of life as set forth in the statute, the regulatory grounds set forth in Section 360-4.4 of the Regulations as stated above.

A transfer for less than fair market value, unless it meets one of the above exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. The average regional rate is updated each January first.

For uncompensated transfers made on or after February 8, 2006, the penalty period starts the first day of the month during or after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible individual is receiving services for which Medical Assistance would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. Social Services Law 366.5(e).

DISCUSSION

The Agency's August 31, 2017 determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services for 16.2805 months commencing April 1, 2017 because he transferred assets for less than fair market value was correct.

At the outset it will be noted that the Appellant's attorney only disputed that part of the Agency determination that sought to impose a transfer penalty on the Appellant's purchase of an annuity that did not include the State as a named beneficiary. The Appellant's attorney stipulated and waived the right to a hearing on the remaining transfers totaling $58,711.51, and therefore the imposition of a penalty on the transfer of these assets is sustained.

Turning to the sole issue in dispute, the record showed that on March 21, 2007, the Appellant purchased an annuity contract #[redacted], from [redacted] through an Individual Retirement Account (IRA) rollover and that the annuity at issue is an IRA held Annuity. The Appellant is the annuitant. The Appellant's deceased spouse and son are listed as the sole beneficiaries. It is undisputed that New York State was not named as a beneficiary. As of March 31, 2017, the Appellant's purchase payments since issue totaled $116,349.55, the Appellant's withdrawals since issue totaled $40,470.74, and the total value of the annuity was $105,363.86.

The Agency maintains that the value of the annuity as of the date the Appellant was seeking Medicaid coverage of nursing facility services ($105,363.86) must be considered an uncompensated transfer because the annuity was purchased after February 8, 2006, that subsequent additions to principal and elective withdrawals have been made in the annuity, and the State has not been named as a remainder beneficiary for at least the amount of Medicaid paid on the Appellant's behalf. In response, the Appellant argues that the annuity at issue is not an

"asset" subject to a Medicaid transfer penalty, and therefore the requirement to name the State as a remainder beneficiary does not apply.

The Deficit Reduction Act of 2005 (DRA) added new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006. These new requirements impact the annuity at issue herein, which was purchased by the Appellant on March 21, 2007. Specifically, Section 6012(b) of the DRA added a new section 1917(c)(1)(F) to the Social Security Act, which provided that the purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named as a remainder beneficiary. See, 42 U.S.C. Section 1396p(c)(l)(F). In addition, Section 6012(c) of the DRA amended section 1917(c)(1) of the Social Security Act by adding a new subparagraph (G) which provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services shall be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria. See, 42 U.S.C. Section 1396p(c)(l)(G). One of the criterion exempts an annuity described in subsection (b) of Internal Revenue Code Section 408. See, 42 U.S.C. Section 1396p(c)(l)(G)(i)(I).

The Appellant's attorney argues that the annuity under review is one described in subsection (b) of section 408 of the Internal Revenue Code of 1986, and therefore is not an asset that can be subject to a Medicaid transfer penalty. The Appellant's attorney made the annuity contract part of the record, which is titled as an IRA annuity, and includes an endorsement that indicates the annuity contract was issued under the Internal Revenue Code of 1986, as amended, IRS Code Section 408(b). The Agency did not otherwise challenge this evidence, and for purposes of this decision, the annuity contract at issue will be found to be an asset exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(l)(G).

The Appellant's attorney next argued that because the annuity at issue is exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(l)(G), it must also be exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(l)(F), even if the State is not named as a remainder beneficiary. In support of this position, the attorney cited *In the Matter of the Application of Virginia Entz v Reed*, Index No. 2009-10454, from Monroe County Supreme Court, decided on March 10, 2010, where a Department of Health (DOH) determination to impose a transfer penalty for an IRA annuity where the State was not named as the remainder beneficiary was reversed. In *Entz*, the court analyzed the provisions of 42 U.S.C. Section 1396p(c)(l)(F) and 42 U.S.C. Section 1396p(c)(l)(G), concluding that DOH policy requiring adherence to both Sections (F)and (G) was incorrect. In its analysis the Court stated: 'This court reads (c)(l)(G) not conjunctively with (c)(l)(F), but explicitly excluding from the term "assets" the qualified retirement annuities and IRAs described in section (G). Therefore, to give fair credence to federal law, the State must be named as remainder beneficiary of an annuity unless the annuity is accepted by the requirements of (c)(l)(G)'.

The Appellant's argument, as supported by the *Entz* decision from the [redacted] County Supreme Court, is unpersuasive in the context of the present hearing. The Centers for Medicare and Medicaid Services (CMS) issued a "Dear State Medicaid Director" letter on July 27, 2006

that clarified the interplay between paragraphs (c)(1)(F) and (c)(1)(G) at issue herein. Specifically, enclosure 6012 II(c) of that letter clarifies the requirement under subparagraph (G) "is in addition to those specified in 1917(c)(1)(F) pertaining to the State's position as a remainder beneficiary". The CMS letter further distinguishes the two sections by pointing out that 1917(c)(1)(F) applies to annuities purchased by an applicant or a spouse, while 1917(c)(1)(G) applies only to annuities purchased by an applicant. The interpretation of CMS is entitled to significant deference with regard to Medicaid law and policy, and supports the conjunctive interpretation followed in State law and policy. See, Social Services Law 366.5(e)(3)(i)'s use of the conjunctive "and" to separate the two annuity requirements, and 06 OMM/ADM-5's use of the designator "in addition" to separate the two annuity requirements. Based on the foregoing, the Appellant's argument that a Medicaid applicant's IRA annuity need not designate the State as a remainder beneficiary to avoid the imposition of a transfer penalty is rejected.

It was undisputed that the annuity at issue failed to designate the State as a remainder beneficiary. Consequently, the Agency determination to impose a transfer penalty based upon the full purchase value of the annuity is sustained. The Appellant did not dispute the full purchase valuation used by the Agency ($105,363.86), and therefore the determination to impose a transfer penalty on this amount is also sustained. Coupled with the otherwise undisputed uncompensated transfers of $58,711.51, the Agency's determination that the Appellant transferred assets totaling $164,075.37 for less than fair market value was correct. The record showed that the Agency properly divided these uncompensated transfers by the applicable nursing home regional rate of $10,078.00, which resulted in a 16.2805-month sanction being imposed as of April 1, 2017. The Agency determination under review was correct.

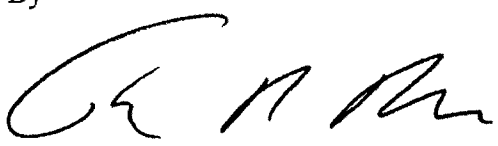
DECISION

The Agency's August 31, 2017 determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services for 16.2805 months commencing April 1, 2017 because he transferred assets for less than fair market value was correct.

DATED: Albany, New York
04/12/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee

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

SMD# 18-004

RE: Penalty period start date for certain HCBS waiver participants

April 17, 2018

Dear State Medicaid Director:

The purpose of this letter is to provide guidance on the proper start date of an asset transfer penalty period under section 1917(c) of the Social Security Act (the Act) for certain Medicaid applicants who are seeking eligibility for Home and Community-Based Services (HCBS) delivered through waivers approved under section 1915(c) of the Act.

Background. Section 1917(c)(1)(A) of the Act requires that states apply a coverage penalty against certain individuals when such individuals have transferred assets for less than fair market value on or after the "look back date," which is the date that precedes by 60 months the point at which an individual has both applied for Medicaid and is an "institutionalized individual." The coverage penalty applies to nursing facility services, a level of care in an institution equivalent to that of nursing facility services, and HCBS provided under a section 1915(c) waiver ("waiver services"). The length of the penalty period is calculated by dividing the total amount transferred for less than fair market value by the average monthly cost of nursing facility services in the state (or locality in which the individual is located). The quotient is the number of months the individual will be denied institutional or waiver services.

For purposes of penalties, an "institutionalized individual" is defined in section 1917(h)(3) of the Act as an inpatient of a nursing facility or similar medical institution or individuals who are eligible for Medicaid under section 1902(a)(10)(A)(ii)(VI) of the Act, implemented at 42 CFR §435.217 (referred to as the "217" group). The 217 group provides Medicaid coverage to individuals who need HCBS to avert institutional placement, who would be eligible for Medicaid under another eligibility group if they were in an institution, and who receive waiver services.

The Deficit Reduction Act of 2005 (Pub. L. No. 109-171, "DRA") amended section 1917(c)(1)(D) of the Act to make the asset transfer penalty start date (for post-DRA transfers) the later of (1) the month during or after which a transfer is made or (2) "the date on which the individual is eligible for medical assistance under the State plan and *would otherwise* be receiving institutional level [of] care services" but for the penalty. (Emphasis added.)

Prior Guidance. In an enclosure to the State Medicaid Director Letter (SMDL) published on July 27, 2006 (SMDL #06-018), we explained that the penalty start date for post-DRA transfers is the later of the month during or after which a transfer is made or "the date on which the

individual is eligible for Medicaid and *is receiving* institutional level of care services" but for the penalty.[1] (Emphasis added.)

The substitution of "is receiving institutional level care services" for "would otherwise be receiving institutional level [of] care services" has had unintended consequences for 217 group applicants. This is because, in contrast to nursing facility services and other institutional services, HCBS received by an individual only become "waiver services" once the individual is enrolled in the state's 1915(c) waiver program and Medicaid is providing coverage.

For example, the personal care services an individual is receiving under the Medicaid state plan prior to placement in a 1915(c) waiver, and which become part of the individual's service plan under the relevant 1915(c) waiver after placement in the waiver, only become *waiver* services after the individual's waiver enrollment. Thus, for 217 group applicants who are subject to an asset transfer penalty period, the penalty period does not begin to run until the individual begins *receiving* HCBS waiver services, but the individual cannot begin to receive waiver services until the penalty period has run.

The result under the prior guidance is an infinite penalty period. Under the interpretation of the DRA's changes expressed in our July 27, 2006, guidance, an individual would have to enter an institution to begin the penalty period. We do not believe that this result is supported by the language or intent of the DRA.

Revised Guidance. We are revising our earlier guidance to be consistent with the statute. Under the revised interpretation, the penalty period start date for a 217 applicant is no later than the point at which a 217 applicant *would otherwise* be receiving HCBS waiver coverage based on an approved application for such care but for a penalty. For a 217 group applicant, this would be at the point at which a state has: determined that the applicant meets the financial and nonfinancial requirements for Medicaid eligibility and the level-of-care criteria for the 1915(c) waiver; developed for the individual a person-centered service plan; and identified an available waiver slot for the individual's placement. The penalty period for a 217 group applicant begins no later than the date on which a state has confirmed that all of these requirements are met. Transfers that would be subject to a penalty would be those that were made on or after the 60 months preceding this same date.[2]

[1] See State Medicaid Director Letter, #06-018 (July 27, 2006), Enclosure, "Sections 6011 and 6016 – New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005."

[2] Under section 1917(c)(1)(B) of the Act, the look-back period is "the first date as of which the individual is both an institutionalized individual and has applied for medical assistance. . . ." As indicated above, an "institutionalized individual" is one who is actually in an institution or who "is described in section 1902(a)(10)(A)(ii)(VI)." An individual is not described in section 1902(a)(10)(A)(ii)(VI) of the Act unless and until he or she is eligible to actually receive services under the 217 group. This means that, for individuals seeking coverage under the 217 group, the look-back period dates back from the point at which the state has confirmed all of the requirements for coverage under that group are met.

If you have any questions about this guidance, please contact Gene Coffey at 410-786-2234, or gene.coffey@cms.hhs.gov, or contact your SOTA team lead.

Sincerely,

/s/

Timothy B. Hill
Acting Director, CMCS

TRACK 1

Overview of Tax Planning for the Elder Law Practitioner

and

TRACK 4

Advanced Tax: Understanding the New Tax Laws

Presented By:
Vincent J. Russo, Esq.

NEW YORK STATE BAR ASSOCIATION

Elder Law and Special Needs Section
July 12-14, 2018

Part 1: Overview of Tax Planning for the Elder Law Practitioner
Part 2: Advanced Tax: Understanding the New Tax Laws

Presented by:

Vincent J. Russo

J.D., LL.M. in Tax, CELA, CAP

Offices: Long Island and New York City
Phone: 800-680-1717 | www. vjrussolaw.com

Table of Contents

I.

Overview of Tax Planning for the Elder Law Practitioner – Part 1

Presented by:

Vincent J. Russo
J.D., LL.M. in Tax, CELA, CAP

RUSSO LAW GROUP, P.C.
Estate Planning, Elder Law & Special Needs

Offices: Long Island and New York City
Phone: 800-680-1717 | www. vjrussolaw.com

Today's Workshop: Basic Tax Planning

- Income Taxation
- Deductibility of Expenses
- SNTs and Grantor Trusts
- Estate and Gift Taxation

General Income Tax Rules

2018 Federal Income Tax Brackets

Tax Rate	Single	Married-Joint	Estate or Trust
10%	$ 0 – 9,525	$ 0 – 19,050	N/A
12%	$ 9,526 – 38,700	$ 19,051 – 77,400	$ 0 – 2,550
22%	$ 38,701 – 82,500	$ 77,401 – 165,000	N/A
24%	$ 82,501 – 157,500	$ 165,001 – 315,000	$2,551 – 9,150
32%	$157,501 – 200,000	$ 315,001 – 400,000	N/A
35%	$416,701 – 418,400	$ 416,701 – 470,700	$9,151 – 12,500
37%	$500,001 + over	$600,001 + over	over $12,500

Reporting of Income and Expenses

- Sources of Income
  - Income Earned
  - Passive Income
  - Trust payments to or for the benefit of the Individual
    - May be subject to reporting as Income
- Types of Expenses
  - Itemize versus Standard Deduction
  - Medical Expense Deduction

2018: Income Taxation

- Tax Cuts and Jobs Act
  - 2017 Tax Act or Reconciliation Act of 2017
- Most provisions
  - Effective January 1, 2018
  - Sunset at the end of 2025 – in eight years.

2018: Will You Pay More or Less in Taxes

- What Tax Bracket will you be in and at what rate?
- Will you benefit from the Standard Deduction?
- Will you be hurt by the Elimination of Certain Itemized Deductions?

2018: Will You Pay More or Less in Income Taxes

- Lower Tax Rates
- Increased Standard Deduction
  - Plus the Blind and Elderly Deduction
- Eliminated the Personal Exemption
- Child Tax Credit and the Dependent Tax Credit

2018: If You Itemize…

- Elimination of Most Itemized Deductions
- Mortgage Interest - modified
- State and Local Taxes - limited
- Charitable Deductions - modified (plus)
- Medical Deduction – modified (plus)

If You Itemize… Medical Expense Deduction

Adjusted Gross Income	$ 60,000
Medical Expenses	$ 15,000
7 ½ % of AGI	4,500
Deduction Amount	**$ 10,500**

(Medical Expenses less 7.5% of the AGI)

IRAs, Retirement Accounts and Trusts

Early Withdrawal of IRAs

- General Rule: Withdrawal before age 59 ½ - 10% Penalty
- Exception to the General Rule
  - Annuity – 72(t) payments
  - Excess Medical Expense
  - Health Insurance
  - Permanent Disability

Income: Qualified Retirement Funds

- Reporting of the Income
  - Amount and Timing
- Use of Special Needs Trusts as Beneficiary of IRAs
- Qualifying for the Stretch Pay Out

Retirement Death Benefits

- Annual Distributions over Life Expectancy of Designated Beneficiary
- Beneficiary may be a Trust for Purposes of the Minimum Distribution Rules

Two Types of "See Through" Trusts

- Conduit Trust
  - Trustee has no Power to Accumulate Plan Distributions
- Accumulation Trust
  - Trustee has the Discretion to Pay Out or Accumulate the Plan Distributions

"See Through" Trusts as Beneficiary

- Benefits are Distributed to the Trust
  - in Annual Installments
  - over the Life Expectancy of the Oldest Trust Beneficiary (referred to as the "Applicable Distribution Period")
- Just as if left Outright to the Designated Beneficiary

Third Party Designation of SNT as IRA Beneficiary

- Bob' has three Children
  - Daughter - Krista, is 35 years old and has CP
- Options to Fund SNT with 1/3: Bob creates:
  - A Living Third Party SNT for Krista
  - A Revocable Trust with SNT for Krista
  - A Will with SNT for Krista
- Bob Designates the Trust, Sub-Trust or his Estate as the Beneficiary with a Provision for 1/3 to SNT for Krista

Taxation of Trusts

Taxation of Trusts: Overview

- Federal Income Tax Return – Form 1041
- Trust Tax Rates
- Type of Trust for Tax Purposes
  - Grantor Trust
    - Informational Statement of Income and Expenses
    - Taxpayer Identification Number or Social Security Number
  - Non-Grantor Trust
    - Schedule K-1 issued to the Beneficiary
    - Taxpayer Identification Number

Reporting of Trust Income

- Must be Reported on the Trust Income Tax Return (unless an exception is met)
- If Exception is met,
  - All income may be reported on the grantor's personal income tax return
  - All or part of the income may be reported on the beneficiary's personal income tax return
  - All or part of the income may be reported on the trust income tax return

2018 Federal Income Tax Brackets

Tax Rate	Single	Married-Joint	Estate or Trust
10%	$ 0 – 9,525	$ 0 – 19,050	N/A
12%	$ 9,526 – 38,700	$ 19,051 – 77,400	$ 0 – 2,550
22%	$ 38,701 – 82,500	$ 77,401 – 165,000	N/A
24%	$ 82,501 – 157,500	$ 165,001 – 315,000	$2,551 – 9,150
32%	$157,501 – 200,000	$ 315,001 – 400,000	N/A
35%	$416,701 – 418,400	$ 416,701 – 470,700	$9,151 – 12,500
37%	$500,001 + over	$600,001 + over	over $12,500

2018 Income Tax Traps

Taxable Income	Single	Married- Joint	Estate or Trust
$10,000	$1,009.50	$1,000.00	$2,136.50
$20,000	$2,209.50	$2,019.00	$5,786.50
$50,000	$6,939.50	$5,619.00	$16,886.50
$100,000	$18,289.50	$13,879.00	$35,386.50
$200,000	$45,689.50	$36,579.00	$72,386.50
$10,000	$1,009.50	$1,000.00	$2,136.50

Taxation of Grantor Trusts

Income Taxes: Examples of Grantor Trusts

- All
  - Revocable Third Party Special Needs Trusts
  - First Party Special Needs Trust [D(4)(a) Trust]
- Optional
  - Medicaid Asset Protection Trust
  - Third Party Irrevocable Special Needs Trust

Income Taxes: Grantor Trust (Taints)

- Reversionary Interest in the Trust (IRC § 673)
- Power to Add Beneficiaries (IRC § 674)
- Grantor may Exchange Property of Equivalent Value in Non-Fiduciary Capacity (IRC § 675)
- Use Trust Income to Pay Premiums of Insurance on Life of Grantor / Grantor's Spouse (IRC § 677)

Income Taxes: Grantor Trust (Taints)

- Power to Revoke (IRC § 676)
  - Do not use the Power to Revoke if a First Party Special Needs Trust (where the beneficiary is accessing or seeking to qualify for Supplemental Security Income and/or Medicaid)
- Income Payable by Grantor or Non-Adverse Party (Trustee) to the Grantor (IRC § 677)
  - Without the consent of an Adverse Party (Trustee)
    - any person who has a substantial beneficial interest in the trust which would be adversely affected (IRC § 672)

Medicaid Asset Protection Trust as a Grantor Trust - Taint

- **Power of Substitution***
  - While I am living, I may direct my Trustee to transfer any property of my trust to me in exchange for property of equivalent value. My Trustee must follow any such directive.

** Excerpt from Elderdocx (Eldercounsel, LLC)*

Medicaid Asset Protection Trust as a Grantor Trust - Taint

- **Power to Add Charities as Beneficiaries**
  - While I am living, I may add beneficiaries to my trust by designating any charitable organization described in Section 170 of the Internal Revenue Code, other than any charitable organization to which I am indebted, as an additional beneficiary of the net income or principal of the trust. After designating any additional charitable beneficiary, my Trustee may distribute trust income or principal to the designated charitable beneficiary in amounts and proportions determined in my Trustee's sole and absolute discretion. However, if my Trustee is an adverse party, as defined in Section 672(a) of the Internal Revenue Code, then I may direct my Trustee to distribute net income or principal to the additional charitable beneficiary in amounts and proportions determined in my sole and absolute discretion, and my Trustee must follow such direction.

** Excerpt from Elderdocx (Eldercounsel, LLC)*

Taxation of Non-Grantor Trusts

Income Taxes: Non-Grantor Trusts

- All
  - Testamentary Trusts
  - Qualified Disability Trust
- Optional
  - Third Party Irrevocable Special Needs Trusts
  - MAPT

Taxation of Non – Grantor Trusts Distributable Net Income (DNI)

- Distributable net income (DNI) is used to Allocate Income between a Trust and its Beneficiaries.
  - Trusts are allowed to deduct the lesser of DNI or the sum of the trust income required to be distributed and other amounts "properly paid or credited or required to be distributed" to beneficiaries.
  - The Beneficiary will be taxed on the DNI amount and any amount above will be tax-free.

Income Taxes: Advantages of a Grantor Trust

- Income Tax Consequences stay with the Grantor
- Consider the Tax Bracket of the Grantor
  - Single Individual reaches 37% at $500,001 for 2018
  - Trust reaches 37% bracket at $12,501 for 2018
- Simpler Tax Filings
- Easier to Explain to the Client

Income Taxes: Advantages of a Non-Grantor Trust

- Grantor does not have to come up with funds to pay tax on "phantom income"
- Spread out the income tax consequences
- Beneficiary who receives the income pays the income tax in beneficiary's tax bracket
- Exemption Amount as a "Qualified Disability Trust"

Income Taxes: Disadvantages of a Non-Grantor Trust

- If not Careful, Higher Overall Taxes
- Beneficiary does not Understand that they need to come up with Income Tax Payments
- More Complicated
  - Trustee needs to pay attention to calendar year-end distributions

Gift and Estate Taxation

Estate and Gift Tax System

- Unified Federal Tax System
- Exemption Amount
  - $11,180,000
- Tax Rate
  - 40%

NYS Estate Tax System

- Estate Tax Rate
  - Estate tax rates start at five percent, and goes up to 16%, subject to the "estate tax cliff"
  - Exemption Amount
    - $5,250,000 for Decedents dying on or after 4/1/2017 and before 1/01/2019
    - $5,600,000 (est.) for Decedents dying on or after 1/1/2019
- No Gift Tax

Medicaid Planning and Estate and Gift Taxation

- Asset Transfers
- Gift Tax Consequences
  - Carryover in Basis v. Step Up in Basis

Sale of Primary Residence

Case Study – Sale of Residence

House purchased in 1970 for $60,000

Improvements of $40,000

FMV in 2018: $500,000

Capital Gain Exclusion on a Sale of Primary Residence

- Capital Gain Exclusion of $250,000 or $500,000 (if married – filing joint)
- You must own and Live in (used) the residence as your principal residence an aggregate of 2 out of the last 5 years before the sale
- Available once every two years

Income Taxation – Sale of a Primary Residence

- Sold During Lifetime
  - Outright Ownership
  - Owned in a MAPT
  - Owned by Donee
- Sold After Death
  - Owned Outright
  - Owned by Donee
  - Owned by MAPT

Case Study
Sale of Primary Residence During Lifetime

	Sale by Senior	Sale by MAPT	Sale by Donee
Selling Price	$ 500,000	$ 500,000	$ 500,000
Less: Basis	$ 100,000	$ 100,000	$ 100,000
Gain	$ 400,000	$ 400,000	$ 400,000
Less Capital Gain Exclusion	$ 250,000	$ 250,000	$ 0
Gain for Tax Purposes	$ 150,000	$ 150,000	$ 400,000
Tax at 27%*	**$ 40,500**	**$ 40,500**	**$ 108,000**

**Assumes a combined tax rate of 27%*

Case Study
Sale of Residence After Death

	Sale by the Estate	Sale by MAPT	Sale by Donee
Selling Price	$ 500,000	$ 500,000	$ 500,000
Less: Basis	$ 500,000	$ 500,000	$ 100,000
Gain	$ 0	$ 0	$ 400,000
Less Capital Gain Exclusion	$ 0	$ 0	$ 0
Gain for Tax Purposes	$ 0	$ 0	$ 400,000
Tax at 27%*	**$ 0**	**$ 0**	**$ 108,000**

**Assumes a combined tax rate of 27%*

Obtaining Grantor Trust Status Over Principal

- Important Trust Provisions when Dealing with Appreciated Assets
  - To allow the Grantor to Maintain IRC § 121 exemption on sale of primary residence
  - To ensure that individual capital gains tax rates apply when trust assets are sold
    - For example, Sale of Stock and Bonds

Sale of Residence with a Retained Life Estate: Capital Gain Exclusion

- The Capital Gain Exclusion will only apply to the sale proceeds determined by the value of the life estate interest
- This is a disadvantage when compared to a Sale during life time of the residence from a MAPT (with grantor trust status for tax purposes)

In Summary

Comprehensive Planning for Seniors and Individuals with Disabilities…

…Requires Consideration of the Tax Implications when Planning for Medicaid and SSI Benefits

Questions

Overview of Tax Planning for the Elder Law Practitioner – Part 1

Stay Tuned for Part 2
Have a Great Day!

RUSSO LAW GROUP, P.C.
Estate Planning, Elder Law & Special Needs

Offices: Long Island and New York City
Phone: 800-680-1717 | www. vjrussolaw.com

II.

Advanced Tax: Understanding the New Tax Laws – Part 2

Presented by:

Vincent J. Russo
J.D., LL.M. in Tax, CELA, CAP

RUSSO LAW GROUP, P.C.
Estate Planning, Elder Law & Special Needs

Offices: Long Island and New York City
Phone: 800-680-1717 | www. vjrussolaw.com

Today's Workshop: Advanced Tax Planning

- Tax Cuts and Jobs Act
- Qualified Disability Trusts
- New Business Tax Options
- Planning Options Available under the New Federal Income Tax Structure

Tax Cuts and Jobs Act

Individual Income Tax Changes

- Tax Rates Reductions
- Standard Deduction - 12k single, 24k for married
- Personal Exemption - eliminated, except:
  - for Dependent exemption is zero
  - for Elderly and Blind still available;
  - for Qualified Disability Trust still available
- Credit for Qualifying Dependents
  - $500, Non-Refundable (in addition to the Child Care Tax Credit)

2018 Federal Income Tax Brackets

Tax Rate	Single	Married-Joint	Estate or Trust
10%	$ 0 – 9,525	$ 0 – 19,050	N/A
12%	$ 9,526 – 38,700	$ 19,051 – 77,400	$ 0 – 2,550
22%	$ 38,701 – 82,500	$ 77,401 – 165,000	N/A
24%	$ 82,501 – 157,500	$ 165,001 – 315,000	$2,551 – 9,150
32%	$157,501 – 200,000	$ 315,001 – 400,000	N/A
35%	$416,701 – 418,400	$ 416,701 – 470,700	$9,151 – 12,500
37%	$500,001 + over	$600,001 + over	over $12,500

Income Tax: Changes

- Capital Gain Exclusion for Sales of Primary Residence
  - Home sale exclusion test remains two out of the last five years
- Medical Expense Deduction
  - Medical expenses: 7.5% of AGI limit through 2018
- Health Care
  - Individual Mandate under Affordable Care Act
    - repealed after 2018

Income Tax: Changes

- Elimination of Most Itemized Deductions
- Limit on the State and Local Tax (SALT) Deduction
  - Up to $10,000 ($5,000 married filing separately)
- Limit on Mortgage Interest Deduction - $750K
  - No deduction for Home Equity Loans
- Charitable Contributions
  - Continues with a 60 percent of AGI limit (increased from 50%)

Income Tax: Able Accounts

- Increased Contribution Limits to ABLE accounts through 2025
  - The total annual contribution limit to an ABLE account will be increased from $14,000 per tax year to $15,000 per tax year beginning in 2018
- Section 529 Rollover to an Able Account
  - Permit rollovers from 529 plans to ABLE accounts through 2025

Small Business Owners

- 20% Deduction in Flow Thru Business Income
  - Includes rental income
  - Formula for calculating the 20 percent deduction from qualified business income
- Limitation on Service Businesses
  - List includes: Law, Accounting, Financial Services
  - Any business where principal asset is reputation and skill of employees or owners

Trusts and Estates Tax Considerations

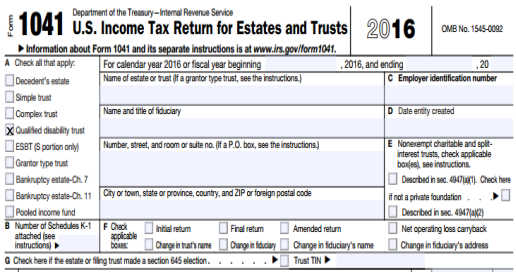
- Kiddie Tax – *Applies Trust Tax Rates*
- Personal Exemption for Trusts *Retained*
- State and Local Tax Deduction Limitation *Applies*
- Executor and Trustee Fees allowed – *Not Clear*
- Excess Deductions on Termination *Eliminated*
- Deduction for Estate Taxes Attributable to Income in Respect of a Decedent *Retained*

Qualified Disability Trusts

Qualified Disability Trust

- Requirement for Qualified Disability Trust (QDisT)
  - Disability Trust – sole benefit for beneficiaries who are under age 65
  - All of the beneficiaries must be disabled
  - Must be a Non-Grantor Trust for tax purposes
- Qualifies for an Exemption
  - $4,150 for 2018 (indexed for inflation)
- Exempts Income from the Kiddie Tax
  - Treated as earned income

Qualified Disability Trust Election



Form **1041** Department of the Treasury—Internal Revenue Service
U.S. Income Tax Return for Estates and Trusts 2016 OMB No. 1545-0092

▶ Information about Form 1041 and its separate instructions is at *www.irs.gov/form1041.*

A Check all that apply:
- ☐ Decedent's estate
- ☐ Simple trust
- ☐ Complex trust
- ☒ Qualified disability trust
- ☐ ESBT (S portion only)
- ☐ Grantor type trust
- ☐ Bankruptcy estate-Ch. 7
- ☐ Bankruptcy estate-Ch. 11
- ☐ Pooled income fund

For calendar year 2016 or fiscal year beginning , 2016, and ending , 20

Name of estate or trust (If a grantor type trust, see the instructions.) | C Employer identification number

Name and title of fiduciary | D Date entity created

Number, street, and room or suite no. (If a P.O. box, see the instructions.) | E Nonexempt charitable and split-interest trusts, check applicable box(es), see instructions.
- ☐ Described in sec. 4947(a)(1). Check here if not a private foundation . . ▶ ☐
- ☐ Described in sec. 4947(a)(2)

City or town, state or province, country, and ZIP or foreign postal code

B Number of Schedules K-1 attached (see instructions) ▶

F Check applicable boxes: ☐ Initial return ☐ Final return ☐ Amended return ☐ Net operating loss carryback ☐ Change in trust's name ☐ Change in fiduciary ☐ Change in fiduciary's name ☐ Change in fiduciary's address

G Check here if the estate or filing trust made a section 645 election . . . . . ▶ ☐ Trust TIN ▶

QDisT Case Study - Exemption

	Non-Grantor Trust	QDisT	Beneficiary
Income	$ 22,500	$ 22,500	$ 22,500
Exemption	$ 100	$ 4,150	$ 0
Standard Deduction	$ 0	$ 0	$ 12,000
Taxable Income	$ 22,400	$ 18,350	$ 10,500
Tax	$ 6,675	$ 5,176	$ 1,070

QDisT Exemption Benefit

- If $4,150 of Trust Income is Offset by the Exemption and Hence not Taxed, then
  - With a 7% return over a 14 year period, the fund would be over $95,000 (which would be available for the benefit of the beneficiary)
- The QDisT can be a Good Vehicle as a Beneficiary of IRAs
  - Due to the exemption amount and beneficiary's tax Bracket

Steven J. Silverberg blog on QDisT

QDisT and the Kiddie Tax

- Three Prong Test for the Kiddie Tax to Apply
- Taxed at the Trust Rates and the Parents' Rates
- Treatment of the Income Distributed to the Beneficiary as Earned Income
  - Not subject to the Kiddie Tax

Capital Gains – 2018 Tax Rates

QDisT Trust Tax Rates	
If Income is:	Capital Gain Tax Rate
Up to $ 2,600	0%
$ 2,601 to $ 12,700	15%
Over $ 12,700	20%

QDiST Beneficiary Tax Rates	
If Income is:	Capital Gain Tax Rate
Up to $ 38,600	0%
$ 38,601 to $ 425,800	15%
Over $ 425,800	20%

The 65 Day Rule

65 Day Rule

- If within the first 65 days of any taxable year of an estate or a trust, an amount is properly paid or credited, such amount shall be considered paid or credited on the last day of the preceding taxable year.
- Section 663(b) Election Requirements
  - I.R.C. § 663. Special rules applicable to sections 661and 662

Section 663(b) Election Form 1041 Page 2

	Other Information	Yes	No
1	Did the estate or trust receive tax-exempt income? If "Yes," attach a computation of the allocation of expenses. Enter the amount of tax-exempt interest income and exempt-interest dividends ▶ $		
2	Did the estate or trust receive all or any part of the earnings (salary, wages, and other compensation) of any individual by reason of a contract assignment or similar arrangement?		
3	At any time during calendar year 2016, did the estate or trust have an interest in or a signature or other authority over a bank, securities, or other financial account in a foreign country? See the instructions for exceptions and filing requirements for FinCEN Form 114. If "Yes," enter the name of the foreign country ▶		
4	During the tax year, did the estate or trust receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," the estate or trust may have to file Form 3520. See instructions		
5	Did the estate or trust receive, or pay, any qualified residence interest on seller-provided financing? If "Yes," see the instructions for required attachment		
6	If this is an estate or a complex trust making the section 663(b) election, check here. See instructions ▶	X	
7	To make a section 643(e)(3) election, attach Schedule D (Form 1041), and check here. See instructions ▶		
8	If the decedent's estate has been open for more than 2 years, attach an explanation for the delay in closing the estate, and check here ▶		
9	Are any present or future trust beneficiaries skip persons? See instructions		
10	Was the trust a specified domestic entity required to file Form 8938 for the tax year (see the instructions for Form 8938)?		

Form 1041 (2016)

Benefits of the 65 Day Rule: Case Study

- Trust has Taxable Income of $30,000 in 2017, but only $10,000 was Paid out to Beneficiaries in 2017.
- Under the 65 Day Rule, the Trustee can Distribute up to $20,000 more to the Beneficiaries in February of 2018 and Elect to Treat that Amount as Having been Distributed on December 31st of the Prior Year for Income Tax Purposes.

ABLE Accounts

Able Account

- Eligibility
  - Disabled (prior to age 26)
- Funding
  - $15, 000 per year (in 2018)
- Qualified Expenses
  - Any expenses related to the beneficiary
- Tax Benefits
  - Income Tax free growth for qualified expenses

Estate and Gift Tax

Estate and Gift Tax Changes

- Doubling of Estate and Gift Tax Exemption Amount after 12/31/2017
  - Projected to be $11,180,000 (subject to inflation adjustment)
  - Sunset Provision: Expires after 2025
- Paradigm Shift
- Planning: Revise Estate Plans

Review Formula Clauses

- Review Credit Shelter / Marital Trust Planning
  - For estates under the Estate Tax Exemption, does the client want to fully fund a Credit Shelter Trust?
    - Also, may generate New York State Estate Taxes

Testamentary Planning

- Couples with Assets under $5.5 million
  - Address assets outright to spouse or in trust
- Couples with Assets over $5.5 million but less than $11 million
  - Consider Disclaimer / Clayton Provisions
- Couples with Assets over $11 million
  - Consider Disclaimer / Clayton Provisions
  - Also consider gifting of assets outright or to trusts

NYS State Estate Tax System

- Estate Tax Rate
  - Estate Tax rates start at five percent, and goes up to 16%, subject to the "Estate Tax Cliff"
  - Exemption Amount
    - $5,250,000 for Decedents dying on or after 4/1/2017 and before 1/01/2019
    - $5,600,000 (est.) for Decedents dying on or after 1/1/2019
- No Portability for a Surviving Spouse
- No Gift Tax

Generation Skipping Transfer Tax

- GST Tax is still Applicable
- GST Exemption Allocation
  - Proper allocation of GST Trusts
  - Review automatic allocation
  - Review trusts not fully GST-Exempt for additional allocation

Section 199A

The New Section 199A - 20% Small Business Deduction

- Deduction for 20% of Domestic Qualified Business Income for Pass Through Businesses
  - Available for a "trade or business"
- Effectively, a 29.6% Tax Rate
- Applies to Individuals, Trusts and Estates
  - The deduction cannot exceed taxable income (reduced by the net capital gains) of the taxpayer

Business Owners

- All Business Owners except owners of C Corps
- For Example,
  - Sole Proprietorships
  - Interest in LLCs
  - Interest in S- Corps
  - Interest in Partnerships
- Owner Must use Allocable Share for the 20% Deduction Calculations

Business Classifications

Type of Business	Threshold Amount Married – Joint	Threshold Amount - Other
Service / Non- Service	< $ 315,000	< $ 157,500
Service / Non- Service	> $ 315,000 up to $415,000	> $ 207,500 up to $ 257,500
Service	> $ 415,000	> $ 257,500

Specified Service Business

- Any trade or business involving the performance of services in the fields of health, law, accounting, actuarial science, performing arts, consulting, athletics, financial services, brokerage services, or any trade or business where the principal asset of such trade or business is the reputation or skill of 1 or more of its employees.
  - Exception: Architects and Engineers

Modified Deduction

- Deduction Equals the Lesser of:
  - QBI x 20% or
  - The greater of:
    - 50% of W-2 wages of with respect to the qualified trade or business, or
    - 25% of W-2 wages with respect to the qualified trade or business plus 2.5% of unadjusted basis immediately after acquisition of all qualified property
      - W-2 Wages - S-Corp may be preferable
      - Wages do not include guaranteed payments or payments to independent contractors

Qualified Property

- The term “qualified property” means, with respect to any qualified trade or business for a taxable year, tangible property of a character subject to the allowance for depreciation undersection 167—
  - (i) which is held by, and available for use in, the qualified trade or business at the close of the taxable year,
  - (ii) which is used at any point during the taxable year in the production of qualified business income, and
  - (iii) the depreciable period for which has not ended before the close of the taxable year.

Depreciable Period

- The term "depreciable period" means, with respect to qualified property of a taxpayer, the period beginning on the date the property was first placed in service by the taxpayer and ending on the later of—
  - (i) the date that is 10 years after such date, or
  - (ii) the last day of the last full year in the applicable recovery period that would apply to the property undersection 168(determined without regard to subsection (g) thereof).

Formula Definitions - Clarifications

- Qualified Property
  - Does not include land
  - Depreciation period is the latter of the regular depreciation period or 10-years
- Unadjusted Basis for Tangible Property
  - Equal to basis immediately after acquisition
  - Not adjusted for depreciation

Phase Out Formulas

- MFJ
  - (1 – taxable income–$315,000/$100,000) X QBI X 20%
- All others
  - (1 – taxable income–$157,500/$50,000) X QBI X 20%

Planning Approaches: Maximizing the 20% Deduction

- Split the Business into Separate Entities
  - Service Business v. Office Building /Equipment /Non-Legal Services
- Add Owners to the Business
  - Moving Property into Non-Grantor Trusts or to individuals
- Use Retirement Accounts to Reduce Income
  - Defined Benefit or Contribution Plan

199A - In Summary

- NOW, Estate Tax Planning Should Consider how to Minimize Income Taxation on Qualified Business Income
  - This is an opportunity to work closely with your client and your client's accountant

Questions

Advanced Tax: Understanding the New Tax Laws – Part 2

Have a Great Day!

RUSSO LAW GROUP, P.C.
Estate Planning, Elder Law & Special Needs

Offices: Long Island and New York City
Phone: 800-680-1717 | www. vjrussolaw.com

II. Taxes

20:1. Overview

This chapter covers the basic federal tax concepts and issues encountered in an elder law practice, including income taxes, real estate taxes, gift taxes and estate taxes. Although many topics are addressed in detail, the practitioner must consider the specific facts surrounding any transaction and, where relevant, refer to the New York State Tax Code. However, as a general rule, New York's Tax Code follows the Internal Revenue Code.

The Internal Revenue Code of 1986 ("I.R.C."), the tax laws of New York State, and those of local jurisdictions often contain age-linked provisions designed to reduce the tax burdens of the elderly. In addition, there are other specific tax provisions which, while not age-linked, offer important planning opportunities to reduce or eliminate income, gift and estate taxes.

Identifying the need for estate and tax planning is a necessary step in the representation of elder law clients. The attorney must be familiar with various planning alternatives and the tools available to meet the client's objectives and be able to explain in a clear and understandable manner the purpose and necessity for the plan, the tools to implement the plan and the alternatives that are available to the client. A client who understands his or her objectives and how they can be met will be better able to make intelligent choices among various alternatives. This will result in an estate and tax plan that is the client's plan as well as the attorney's plan.

IRS Circular 230. In June 2005, the IRS promulgated Circular 230,[1] and instituted procedures designed to ensure that tax practitioners comply with rules governing written tax advice. Under these rules, a failure to comply with the IRS procedures could result in sanctions up to and including disbarment from practice before the IRS. Included within the ambit of "written tax advice" was covered opinions, limited scope opinions and marketed opinions. The IRS's rationale for these rules, collectively known as "Circular 230,"" was to regulate tax shelter advisors and promoters. However, the practical effect of the Circular 230 regulations has been the inclusion of innocuous and routine tax advice within its restriction, subjecting the elder law attorney to onerous procedures for composing a simple summary letter to a client. Compliance with the new procedures could convert a simple letter into a complicated and expensive formal tax memorandum.

Tax practitioners concerned about their letters and informal tax advice being characterized as "listed opinions" have routinely included, at the end of their correspondence and emails, the following suggested "opt-out" language:

> IRS Circular 230 Disclosure: In order to ensure compliance with IRS Circular 230, we must inform you that any U.S. tax advice contained in this transmission and any attachments hereto is not intended or written to be used and may not be used by any person for the purpose of (i) avoiding any penalty that may be imposed by the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any tax-related matter(s) addressed herein.

However, on June 12 2014, the IRS issued final regulations *(Reference: Circular No. 230 (Rev. 6-2014)* under Circular 230 modifying, among other things, the rules for practitioners

[1]2005-4 I.R.B. 357, 69 Fed. Reg. 75839.

providing written tax advice. The preamble to the regulations clarify the Treasury's intent to eliminate practitioners' use of Circular 230 disclaimers in e-mail and other written client communication. Furthermore, the IRS Office of Professional Responsibility issued formal announcements that practitioners no longer have to include the Circular 230 disclaimers in client communications stating that the detailed "covered opinion" rules for tax opinions under Circular 230 contributed to overuse as well as misleading use of disclaimers on most practitioner communications. Notwithstanding, practitioners are encouraged to provide reasonable limitations when providing written advice, where applicable.

Under the new regulations, the covered opinion rules have been abandoned and replaced with more practical written advice rules. Under the new rules, practitioners are required to base all written advice on "reasonable factual and legal assumptions; exercise reasonable reliance on the statements, representations, finding, agreements, and advice of taxpayers and others; and consider all relevant facts that the practitioners know or reasonably should know".

20:2. 2011-2018 Federal Gift and Estate Tax Laws

The New Law. On December 22, 2017, President Trump signed into law the Tax Cuts and Jobs Act (TCJA). *(Reference: Public Law Number 115-97, H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, commonly referred to as the 'Tax Cuts and Jobs Act of 2017', the 'Tax Cuts and Jobs Act', the 'TCJA').* The new law made broad changes to the Federal tax code. Notably, the Tax Cuts and Jobs Act increased the federal estate and gift tax exemption to $10,000,000 (indexed for inflation) per person beginning January 1, 2018. Under the new law, it is expected that for 2018 the inflation adjusted exemption will be approximately $11,200,000 per person, or $22,400,000 for a married couple. *(Reference: 26 U.S.C. §2010(c)(3), as amended by the Tax Cuts and Jobs Act).*

The Tax Cuts and Jobs Act left in effect certain provisions previously included in the American Taxpayer Relief Act of 2012.[2] The step up in basis rules in IRC 1014 which had been restored in 2011, remain in effect under the new law. The highest marginal federal gift and estate tax rate also remained at 40 percent.

The 2013 Law.[1] On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012.[2] This law permanently extended the estate and gift tax exclusion amounts set at $5 million for tax year 2011.

This amount was adjusted for inflation, as follows:

Tax Year 2012, $5,120,000
Tax Year 2013, $5,250,000
Tax Year 2014, $5,340,000
Tax Year 2015, $5,430,000
Tax Year 2016, $5,450,000
Tax Year 2017, $5,490,000

[1]Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

[2]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

Tax Year 2018, $11,200,000 *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed).*

The step up in basis rules in IRC 1014 which had been restored in 2011, remain in effect under the new law. The law also raised the highest marginal gift and estate tax rate from 35% to 40%.[4]

The new law continues the portability of the spousal estate tax exemption (called Deceased Spouse Unused Exemption Amount or "DSUEA"); that is, if a predeceased spouse did not fully utilize his or her $11,180,000 (for 2018) estate tax exemption, the surviving spouse could utilize the unused exemption of her predeceased spouse.[5]

Estate, Gift and Generation-Skipping Transfer (GST) Tax Exemptions and Rates. Under the new law, in 2018, the estate, gift and GST exemptions amounts will increase to $11,200,000 for individuals and $22,400,000 for married couples, with the highest marginal tax rate remaining at 40%.[6]

For 2010, the gift tax exemption remained at $1 million with a 35% tax rate, but the GST exemption was reinstated at $5 million with a 0% tax rate for 2010 only. The gift and GST exemption was $5 million for 2011 and $5,120,000 for 2012 with a top rate of 35%. For the year 2012, the gift, estate and GST tax exemptions were unified again, with the exemption set at $5,120,000 and the tax rate at 35%. For 2013, the unified exemption was $5,250,000 and for 2014, $5,340,000. The unified exemption was $5,430,000 for 2015, $5,450,000 for 2016, $5,490,000 for 2017 and $11,200,000 *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed for 2018).*

Portability of Estate Tax Exemptions Between Spouses. For individuals dying after 2010, the executor of the estate may elect to transfer any unused estate tax exemption to a surviving spouse by filing a timely estate tax return.

Only the last deceased spouse's unused exemption may be used by the surviving spouse, which could impact the decision of a surviving spouse to remarry because, if the new spouse should die first, the unused exemption of the second deceased spouse, if any, would replace that of the first deceased spouse.[7]

Tax Year 2010. Prior to the enactment of the Tax Relief, Unemployment Insurance

[4]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

[5]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

[6]26 U.S.C.A. §2001(c), Public Law Number 115-97, H.R.1 – An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, commonly referred to as the "Tax Cuts and Jobs Act of 2017" the "TCJA"; see Tax Cuts and Jobs Act, Pub. L. No. 115-97 H.R.; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[7]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

Reauthorization, and Job Creation Act of 2010,[8] the estate tax had been repealed for tax year 2010. Notwithstanding the retroactive reinstitution of the estate tax for 2010, the new law allows the estates of decedents who died in 2010 the opportunity to elect out of the new estate tax law which provided a $5,000,000 federal estate tax exemption and a full step up in basis, and elect that the prior tax law which provided no federal estate tax and a carryover basis regime be applied instead.

20:3. Overview-- Primary goals of the senior client

This chapter addresses tax ramifications of the planning techniques available to meet the needs of elderly clients.

Seniors have multiple concerns when implementing a health care and estate plan. Often, the goals of the senior client are:

1. protecting and preserving assets;
2. minimizing taxes;
3. financing of long term care; and
4. disposing of assets upon demise in an appropriate manner.

Clearly, these goals are interrelated. It is essential that estate tax planning be part of an overall plan for the senior. Depending upon the value of the senior's assets and his or her particular health and personal situation, estate tax planning may be the first priority or it may be a lesser priority.

When planning for seniors, the planner should always review the estate plan in the context of potential estate tax liability. Since the federal estate tax applicable exemption amount is $11,200,000 for 2018,[1] this amount is an identifiable threshold amount in the context of federal estate tax planning. For estates over $11,200,000 in 2018, there is a significant need for the senior to implement estate tax planning. Under the Tax Cuts and Jobs Act, each dollar over $11,200,000 will be taxed at a rate of 40% in 2018.[2] For estates under $10 million, there is typically no need for the senior to implement estate tax planning for the purpose of minimizing federal estate taxes. However, one should be aware of potential state estate tax and income tax issues (such as income taxes on highly appreciated assets).

The planner must also not ignore the impact of the estate tax laws of New York State, even though the New York State gift tax law was repealed effective January 1, 2000. The New York State applicable exclusion amount for estate tax is $3,125,000 (for decedent's dying on or after April 1, 2015 and before April 1, 2016). The New York State applicable exclusion amount for estate tax is $4,187,500 (for decedent's dying on or after April 1, 2016 and before April 1, 2017). The New York State applicable exclusion amount for estate tax is $5,250,000 (for

[8]Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010[0], Pub. L. No. 111-312, §303, 124 Stat 3296.

[1]The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed; *See supra* §20:2; *See infra* §§20:20 and 20:76 for Federal and N.Y.S. Gift and Estate Tax Applicable Exclusion Amount Schedule.

[2]The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed; *See supra* §20:2; *See infra* §20:76 for Federal Unified Transfer Tax Schedule.

decedent's dying on or after April 1, 2017, and on or before December 31, 2018). The New York State applicable exclusion amount for estate tax is scheduled on January 1, 2019 to equal the amount of the Federal estate tax exemption as determined under the Federal rules in effect prior to the enactment of the Tax Cuts and Jobs Act. Both New York State applicable exclusion amounts are in contrast to the federal estate tax exemption of $11,200,000 (in 2018).[3]

For an estate of $5,490,000 with the decedent dying on or after January 1, 2017 through March 31, 2017, a New York State estate tax of $449,600 will be due, despite the fact that the same estate will not be subject to federal estate taxes. But if the $5,490,000 estate consists of $1,302,500 in taxable gifts (made more than three years prior to the date of death) then this results in a $4,187,500 New York taxable estate, and no New York State estate tax will be due.[4]

For an estate of $5,490,000 with the decedent dying on or after April 1, 2017, through December 31, 2018, a New York State estate tax of $435,830 will be due, despite the fact that the same estate will not be subject to federal estate taxes. But if the $5,490,000 estate consists of $240,000 in taxable gifts (made more than three years prior to the date of death) then this results in a $5,250,000 New York taxable estate, and no New York State estate tax will be due.[5]

For New York estates under $5 million ($6 million on or after April 1, 2017), there is typically no need for the senior to implement estate tax planning. However, this is not to say that there are no tax issues with which the senior must be concerned (such as income taxes on highly appreciated assets).

20:4. Overview-- Planning techniques to minimize or eliminate estate taxes

There are a number of estate tax planning techniques which should be explored with the client. Depending upon the client's objectives, one or more of these approaches or a combination of them may be appropriate. This chapter will briefly refer to a few of the more popular techniques and provide sample language the planner can provide to the senior for his or her consideration.[1]

20:5. Overview-- Inter-relationship of tax and Medicaid planning

During the early stages of estate and tax planning, the client's need for long term care must be determined. Because Medicaid is the primary provider of long term care, and because Medicaid is a means-tested program,[1] planning for long term care, which typically involves asset transfers, may not be good estate or tax planning.

The elder law attorney must therefore analyze with the client the probable duration and cost of the long term care, as compared to what transfers for Medicaid eligibility will cost the

[3]The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed; *See supra* §20:2.

[4]N.Y. Tax Law §952.

[1]*See infra* §§20:72, 20:73, 20:74, and 20:75 for form letters to seniors regarding estate tax planning.

[1]*See supra* Medicaid Income, Resources, Transfers and Spousal Impoverishment Ch 14.

client in taxes. If the client must divest himself or herself of assets to become Medicaid eligible, and such divestment will create a tax liability during lifetime or at the time of death, then the client should be advised of the extent of the tax liability as compared to the probable savings on long term care, so that an informed choice may be made. A client whose life expectancy is six (6) months and who is in need of long term care, may be better advised to favor estate and tax planning to achieve tax savings which will be in excess of the cost of medical care for six (6) months. Hence, the elder law attorney must be familiar with the tax and the long term care aspects of elder law to properly advise his or her clients.

20:6. Overview-- Estate tax planning tools and resources

It is important that the planner utilize available resources such as treatises and software to assist him or her in the tax analysis for the senior. In addition, these tools can also assist the planner in the presentation of the tax analysis and the overall estate plan to the senior.

20:7. Income taxation considerations-- Overview (Federal)

When implementing estate and long term care planning, income taxes must be considered, both at the federal and state level. Restructuring assets can impact on whether income taxes will have to be paid, by when and by whom.

20:8. Income taxation considerations-- Tax return requirements

Seniors must file federal income tax returns if their income is above the basic standard deduction amount, and any additional standard deduction.[2] The standard deduction depends upon the taxpayer's filing status.[3] Two additional deductions are available for a senior who is both elderly and blind.[4] A taxpayer, who reaches age 65 at any time during the tax year or on December 31 of the prior year, qualifies for the additional standard deduction. The Tax Cuts and Jobs Act has repealed all personal exemptions for tax years beginning December 31, 2017, and before January 1, 2026. *(Reference: Code Sec. 151(d)(5), as added by the Tax Cuts and Jobs Act).*

The following is a summary of the filing thresholds and deductions for taxable years beginning 2018:[5]

Filing Status	**Item**	**Amount**	**2018 Thresholds**
Single,	Standard Deduction	12,000	
65 or over	Additional Standard	1,600	

[2]26 U.S.C.A. §6012.

[3]26 U.S.C.A. §§151(d) and 63(c).

[4]Note that each deduction is equal to $ 1,300. These amounts are increased to $1,600 if the individual is also unmarried and not a surviving spouse.

[5]*See* Sec. 11041(f) of the Tax Cuts and Jobs Act.

	Deduction		
Blind	Additional Standard Deduction	1,600	
FILING THRESHOLD:			$15,200
Married,	Standard Deduction	24,000	
Both age 65or older	Additional Standard Deduction	2,600	
FILING THRESHOLD:			$26,600
Married,	Standard Deduction	24,000	
One age 65 or older	Elderly Deduction	1,300[6]	
FILING THRESHOLD:			$25,300

One should note that the personal exemption has been repealed under the Tax Cuts and Jobs Act. Historically, the personal exemption was phased out based on the level of adjusted gross income.[7] For tax year 2017, the exemption amount was phased out based on the taxpayer's adjusted gross income ("AGI"). For every $2,500 of AGI (or portion thereof) above the beginning phase out amount depended upon your filing status, the $4,050 exemption was reduced by 2%.[8]

The Federal Income Tax rates in 2018 are listed in the Tables as follows:[10]

[6]There is an additional $1,250 deduction if one of the married taxpayers is blind, $2,500 if married taxpayers are both blind. The additional deduction (for an elderly or blind taxpayer) increases to $1,550 if the taxpayer is unmarried and not a surviving spouse.

[7]I.R.C. §151.

[8]IRS Publication 501 (2016).

[10]Rev. Proc. 2017-58, 2016-45 I.R.B. 707.

TABLE 1--Section 1(a)--Married Individuals Filing Joint Returns and Surviving Spouses

If Taxable Income is:	The Tax Is:
Not over $19,050	10% of the taxable income
Over $19,050 but not over $77,400	$1,905 plus 12% of the excess over $19,050
Over $77,400 but not over $165,000	$8,907 plus 22% of the excess over $77,400
Over $165,000 but not over $315,000	$28,179 plus 24% of the excess over $165,000
Over $315,000 but not over $400,000	$64,179 plus 32% of the excess over $315,000
Over $400,000 but not over $600,000	$91,379 plus 35% of the excess over $400,000
Over $600,000	$161,379 plus 37% of the excess over $600,000

TABLE 2--Section 1(b)--Heads of Households

If Taxable Income Is:	The Tax Is:
Not over $13,600	10% of the taxable income
Over $13,600 but not over $51,800	$1,360 plus 12% of the excess over $13,600
Over $51,800 but not over $82,500	$5,944 plus 22% of the excess over $51,800
Over $82,500 but not over $157,500	$12,698 plus 24% of the excess over $82,500
Over $157,500 but not over $200,000	$30,698 plus 32% of the excess over $157,500
Over $200,000 not over $500,000	$44,298 plus 35% of the excess over $200,000
Over $500,000	$149,298 plus 37% of the excess over $500,000

TABLE 3--Section 1(c)--Unmarried Individuals (other than Surviving Spouses and Heads of Households)

If Taxable Income Is:	The Tax Is:
Not over $9,525	10% of the taxable income
Over $9,525 but not over $38,700	$952.50 plus 12% of the excess over $9,525

Over $38,700 but not over $82,500	$4,453.50 plus 22% of the excess over $38,700
Over $82,500 but not over $157,500	$14,089.50 plus 24% of the excess over $82,500
Over $157,500 but not over $200,000	$32,089.50 plus 32% of the excess over $157,500
Over $200,000 not over $500,000	$45,689.50 plus 35% of the excess over $200,000
Over $500,000	$150,689.50 plus 37% of the excess over $500,000

TABLE 4--Section 1(d)--Married Individuals Filing Separate Returns

If Taxable Income Is:	The Tax Is:
Not over $9,525	10% of the taxable income
Over $9,525 but not over $38,700	$952.50 plus 12% of the excess over $9,525
Over $38,700 but not over $82,500	$4,453.50 plus 22% of the excess over $38,700
Over $82,500 but not over $157,500	$14,089.50 plus 24% of the excess over $82,500
Over $157,500 but not over $200,000	$32,089.50 plus 32% of the excess over $157,500
Over $200,000not over $300,000	$45,689.50 plus 35% of the excess over $200,000
Over $300,000	$80,689.50 plus 37% of the excess over $300,000

TABLE 5--Section 1(3)--Estates and Trusts

If Taxable Income Is:	The Tax Is:
Not over $2,550	10% of the taxable income
Over $2,550 but not over $9,150	$255 plus 24% of the excess over $2,550
Over $9,150 but not over $12,500	$1,839 plus 35% of the excess over $9,150
Over $12,500	$3,283 plus 37% of the excess over $12,500

20:9. Income taxation considerations-- Medical expense deductions

As a general rule, medical expenses are deductible by seniors who are younger than 65 years old and who itemize their deductions, where non-reimbursed medical expenses exceed 10% of the taxpayer's adjusted gross income (formerly 7.5% prior to 2013). However, the threshold to claim an itemized deduction for taxpayers 65 years old and older is reduced to 7.5% of adjusted gross income for tax years beginning after December 31, 2016 and before January 1, 2019. In 2019, the threshold is scheduled to go up to 10% of adjusted gross income.[1]

The term "medical expense" is broadly defined to include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease and amounts paid for the purpose of affecting any structure or function of the body. While this section does not provide a comprehensive checklist of all types of expenses which qualify for deduction, the elder law practitioner should be aware of the tax status of the following deduction categories:[2]

Qualified Long Term Care Services. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") clarified the deduction of the cost of "qualified long term care services"[3] as a medical expense under I.R.C. §213 for tax years after 1996. Qualified long term care services are deductible from gross income as an itemized deduction, subject to the limitation that when added to any other un-reimbursed medical expenses for the year, only that amount which exceeds 7.5% of adjusted gross income (or 10% for taxpayers younger than 65 years of age) is an itemized deduction.

Qualified long term care services are defined as "necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and personal care services, which (A) are required by a chronically ill individual, and (B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner."

A chronically ill individual is defined as someone who is unable to perform (without substantial assistance from another individual) at least two out of five activities of daily living (ADLs) for a period of at least 90 days (in the future) due to a loss of functional capacity, or requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. The individual must be certified each year as meeting such requirements by a licensed health care practitioner.

The congressional conference committee report indicates those individuals with cognitive impairment such as Alzheimer's disease, but who are physically able should be treated similarly to an individual who is unable to perform (without substantial assistance) at least two ADLs.

Residence Expenses Incurred to Accommodate the Condition of a Physically Handicapped Person. Seniors may deduct the cost of home modifications made to accommodate their own physical handicaps or those of a handicapped person residing with them for the following:[4]

[1]*See* Sec. 11027(c) of the Tax Cuts and Jobs Act; 26 U.S.C.A. §213. These deductions are not subject to the 2% floor on miscellaneous itemized deductions. *See* 26 U.S.C.A. §67(b).

[2]The deduction calculation appears on Schedule A, Internal Revenue Service ("IRS") Form 1040.

[3]26 U.S.C.A. §7702B.

[4]Rev. Rul. 87-106, 1987-2 C.B. 67; Committee Reports to Pub. L. No. 99-154.

1. constructing entrance or exit ramps;
2. widening doorways at entrances or exits;
3. widening or otherwise modifying hallways and interior doorways;
4. installing railing, support bars, or other modifications to bathrooms;
5. lowering or making other modifications to kitchen cabinets and equipment;
6. altering the location of or otherwise modifying electrical outlets and fixtures;
7. installing porch lifts and other forms of lifts (generally, this does not include elevators), as they may add to the fair market value of the residence and any deduction would have to be decreased to that extent;[5]
8. modifying fire alarms, smoke detectors, and other warning systems;
9. modifying stairs;
10. adding handrails or grab bars whether or not in bathrooms;
11. modifying hardware on doors;
12. modifying areas in front of entrance and exit doorways; and
13. grading of ground to provide access to the residence.

Capital Expenditure as Medical Expense. Generally, capital expenditures are not deductible for federal income tax purposes.[6] However, an expenditure which otherwise qualifies as a medical expense under I.R.C. §213 shall not be disqualified merely because it is a capital expenditure. For example, the following items are deductible: eyeglasses, a wheelchair, crutches,[7] an inclinator or an air conditioner which is detachable from the property purchased only for the use of a sick person.[8]

Transportation Expenses. Medical expenses include amounts paid for transportation "primarily for and essential to medical care" which includes ambulance hire, taxi, train, bus, and airplane fares to and from the point of treatment.[9] Other medical expense deductions include expenditures for handicap controls[10] and for automobile equipment to accommodate wheelchair passengers.[11]

Accident and Health Insurance, Medical Insurance. Where a medical insurance contract (such as accident and health insurance) provides for the payment of benefits for other than medical care, such as an income benefit for the loss of income due to the loss of life, sight or limb, no medical deduction is allowable unless a separately stated premium for medical

[5]26 C.F.R. §1.213-1(e)(1)(iii).

[6]26 U.S.C.A. §263; 26 C.F.R. §1.213-1(e)(1)(iii).

[7]*See* 26 C.F.R. §1.213-1(e)(1)(iii).

[8]26 C.F.R. §1.213-1(e)(1)(iii).

[9]26 U.S.C.A. §213(d)(1)(B).

[10]Weinzimer v. C. I. R., T.C. Memo. 1958-137, T.C.M. (P-H) 58137, 17 T.C.M. (CCH) 712, 1958 WL 796 (T.C. 1958).

[11]Rev. Rul. 70-606, 1970-2 C.B. 66; Priv. Ltr. Rul. 8024169, CCH IRS Letter Rulings Reports.

coverage is provided.[12]

Medical Care Insurance Premiums. Medical care insurance premiums paid by a taxpayer are added to the taxpayer's other medical expenses which are deductible to the extent they exceed 7.5% of the adjusted gross income. This threshold increased to 10% of the taxpayer's adjusted gross income in January 2013 for taxpayers younger than 65 years old, but will remain at 7.5% through 2018 for taxpayers 65 years old and older. *(Reference: 26 U.S.C.A. §213(f) as amended by the Tax Cuts and Jobs Act)*. The exemption will also apply where only one spouse is age 65 or older.[13]

In addition, premiums paid during the taxable year before the taxpayer reaches 65, which cover expenses after he or she reaches 65, are deductible when paid if the premiums are payable (on a level payment basis) under a contract for either: (i) a period of 10 years or more; or (ii) a period lasting until the year in which the taxpayer reaches age 65 (but in no case for a period of less than five years).[14]

Medicare Part B payments, which provide supplementary insurance, are deductible. Medicare part A premiums are deductible when paid by a taxpayer otherwise ineligible for coverage.[15] Amounts withdrawn from wages for Medicare hospital insurance under the Social Security program or from self-employment income are not deductible.[16]

The Health Insurance Portability and Accountability Act of 1996 allows for premiums paid for "a qualified long term care insurance contract" to be deductible as a medical expense effective for taxable years after December 31, 1996. For 2018, the deduction is limited as follows: $420 for those 40 years of age or less, $780 for those 41 through 50 years of age, $1,560 for those between 51 through 60, $4,160 for those 61 through 70 years of age and $5,200 for those over 70.[17] These limitations are indexed for inflation each year. These expenses will be combined with other medical expenses and the amount in excess of 10% of adjusted gross income will be deductible.

Nursing Home Care Costs. Since nursing home care costs often exceed 7.5% or 10% of AGI, as the case may be, and are usually not reimbursed by private insurers, it is important to determine whether fees and expenses incurred by or on behalf of a resident are deductible medical expenses. The deductibility of fees paid to institutions other than hospitals depends upon the facts.[18] Where a senior is a nursing home resident because his or her condition is such that

[12]26 U.S.C.A. §213(d)(6); Rev. Rul. 68-212, 1968-1 C.B. 91.

[13]*See* I.R.C. §213; *See supra* §18:36.

[14]26 U.S.C.A. §213(d)(7); 26 C.F.R. §1.213-1(e)(4)(i)(b).

[15]Rev. Rul. 79-145, 1979-1 C.B. 117.

[16]Rev. Rul. 66-216, 1966-2 C.B. 100.

[17]Rev. Proc. 2017-58, 2016-45 I.R.B. 707.

[18]26 C.F.R. §1.213-1(e)(1)(v)(a).

the availability of medical care is *a*, as opposed to *the* principal reason for his or her presence there, and meals and lodging are furnished as a necessary incident to that care, the entire cost of the medical care, meals and lodging is deductible.[19]

In *Havey v. C.I.R.*,[20] the following tests were set forth: (i) Was the expense incurred at the direction or suggestion of a physician? (ii) Did the attendance or the treatment at the place bear such a direct or proximate therapeutic relation to the bodily condition as to justify a reasonable belief that it would be efficacious? (iii) Was the attendance or the treatment so proximate in time to the onset or recurrence of the disease or condition as to make the expense specifically related to the individual's physical or mental improvement?

In *Counts v. C.I.R.*,[21] the taxpayer sought to deduct the nursing home care costs of his father, who suffered from high blood pressure and a gall bladder condition. The father was not ambulatory and he required nursing assistance for bathing and took his meals in bed. The nursing home itemized charges for medical items such as drugs, injections and dressings and rendered a lump sum "maintenance" charge that included the costs of nursing services, food and room fees. Residents of the home had available the services of registered and practical nurses. The maintenance fee was found to be incidental to medical care and deductible.

Where a senior is in an institution and his or her condition is such that the availability of medical care is not a principal reason for his or her presence, then only the cost for care which is attributable to medical care or nursing attention furnished to him or her is deductible.[22]

When the taxpayer is unable to establish medical reasons as a primary reason for his or her nursing home residency, but where there is a demonstrable percentage of the budget of the facility devoted to medical and nursing services that are guaranteed to residents, both lump-sum and periodic fees will be deductible on a consistent basis. In Rev. Rul. 75-302, 1975-2 C.B. 86, the taxpayer was able to demonstrate that 30% of the lifetime care fees were historically budgeted for the cost of nursing and medical care. There was no mention of the taxpayer's physical condition except to note that he was 78 years old. The IRS ruled that a 30% deduction allocation was permissible, even though the services would be provided in future years, if at all.[23]

20:10. Income taxation considerations-- Credit for the elderly and disabled

I.R.C. §22 provides for a tax credit for any senior who has attained the age of sixty-five (65) before the close of the taxable year or who retired on disability before the close of the taxable year and who, when he or she retired, was permanently and totally disabled. Proof of disability must be provided.[1] The tax credit is equal to 15% of the senior's "Section 22 amount" which is defined by the Code Section.

[19]26 C.F.R. §1.213-1(e)(1)(v)(a).

[20]Havey v. C.I.R., 12 T.C. 409, 1949 WL 172 (T.C. 1949).

[21]Counts v. C. I. R., 42 T.C. 755, 1964 WL 1230 (T.C. 1964), acq., 1964-2 C.B. 3.

[22]26 C.F.R. §1.213-1(e)(1)(v)(b).

[23]In Rev. Ruls. 68-525, 1968-2 C.B. 112 and 81, 1976-2 C.B. 82, the deduction for fees allocable to construction costs was denied.

[1]See Part II to the Instructions of IRS Form 1040, Schedule R.

The maximum base amount on which the credit is applied is $5,000 for a single senior or a married couple with only one spouse eligible for the credit, $7,500 for a married couple with both spouses eligible for the credit, and $3,750 for a married couple filing separate returns.[2] For seniors under age 65, the maximum base amount will be further limited to the amount of disability income.[3]

The base amount is further reduced by one-half of the excess of adjusted gross income over $7,500 for a single senior, $10,000 for a married couple filing joint and $5,000 for a married couple filing separate returns.[4]

In addition, the base amount is reduced by the amount of any pension, annuity, or disability benefit received under the Social Security Act, the Railroad Retirement Act of 1974, or a law administered by the Veterans Administration, which is excluded from gross income, or which is excluded under any other provision of law.[5]

20:11. Income taxation considerations-- Dependent credit and exemption

Family members may receive an income tax benefit for supporting and/or taking care of their parents.

Child and Dependent Care Expense Credit. Often, family members, such as children, will pay for the care of parents who live in their households, thus allowing the children to be gainfully employed.

I.R.C. §21 allows for a nonrefundable credit for the portion of dependent care expenses paid for the purpose of allowing a taxpayer to be gainfully employed. The dependent senior will be considered a dependent even if he or she has income above the tax exemption amount ($4,150 per annum in 2018), where the taxpayer could have claimed the person as a dependent except for the income aspect (i.e., over one-half of the dependent's support must have been furnished by the taxpayer, he or she must be a citizen, and must not have filed a joint return with his or her spouse). For tax year 2018, the exemption amount is phased out based on adjusted gross income (AGI).[1]

Hence, this credit is sometimes available where a dependent parent has working adult care-provider children who hire household assistance, or pay for respite or community care to enable them to work.[2] The credit is equal to 35% of employment related expenses for taxpayers with AGIs of $15,000 or less. The credit is reduced by one percentage point for each $2,000 of AGI (or fraction thereof) over $15,000 until it decreases to twenty percent (20%) for taxpayers with AGIs of over $45,000. Employment related expenses are limited to $3,000 for one qualifying person receiving care, and $6,000 for two or more qualifying persons receiving care.

[2]26 U.S.C.A. §22(c)(2)(A).

[3]26 U.S.C.A. §22(c)(2)(B).

[4]26 U.S.C.A. §22(d).

[5]26 U.S.C.A. §22(c)(3).

[1]Rev. Proc. 2017-58, 2016-45 I.R.B. 707.

[2]*See* 26 U.S.C.A. §21; The credit is claimed on IRS Form 2441.

Amounts cannot be taken as both a medical expense and a dependent care expense credit if they qualify as a medical expense.

Support of a Dependent. An individual may be able to take an additional exemption on his or her personal income tax return of $4,150 (in 2018) for each dependent.[3] A child may take a dependency exemption for a parent if he or she meets certain requirements.

20:12. Income taxation considerations-- Taxation of benefits from retirement plans

Generally, distributions from qualified retirement plans are subject to income tax when received by the participant of the plan. Distributions before age 591/2 from qualified plans including annuity plans and individual retirement accounts ("IRAs") are subject to a 10% excise tax for early withdrawal.[1]

There are exceptions to the excise tax, including distributions upon the death or disability of the participant and distributions on account of certain medical expenses under I.R.C. §213.[2] However, the medical expense exception does not apply to withdrawals from IRAs.[3] The definition of disability[4] is being unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration. This is essentially the same definition used in qualifying for the credit for the elderly or disabled.[5]

Minimum Required Distributions must be taken from the qualified retirement plan or IRA by the participant or IRA owner by April 1 of the year following the year that the individual reaches age 701/2.[6] Under the Treasury Regulations, revocable trusts can be used as beneficiaries of an IRA without adverse tax consequences, similar to Irrevocable Trusts, as long as certain conditions are met.[7]

The regulations require that:

[3]26 U.S.C.A. §§151 and 152. Rev. Proc. 2017-58, 2016-45 I.R.B. 707.

[1]26 U.S.C.A. §72(t)(1). Please note that the tax, and the exception to the tax, are reported on IRS Form 5329.

[2]26 U.S.C.A. §72(t)(2)(A)(i)-(vi). Medical expenses allowable under Section 213 are those incurred by the taxpayer, the taxpayer's spouse or dependents, which are not compensated for by insurance or otherwise, to the extent the expenses exceed 10% of the taxpayer's adjusted gross income.

[3]26 U.S.C.A. §72(t)(3)(A).

[4]26 U.S.C.A. §72(m)(7).

[5]*See supra* §20:10.

[6]Please note that in accordance with section 201 of the Worker, Retiree and Employer Recovery Act of 2008, no minimum distributors were required to be taken in 2009.

[7]Treas. Reg. §1.401(a)(9)-1.

1. The trust becomes irrevocable upon the IRA's owner's death.

2. A copy of the trust must be provided to the plan administrator.

3. The IRA owner must agree to provide the plan administrator with any future trust amendments.

4. The trust beneficiaries must be identifiable.

5. All trust beneficiaries must be individuals.

6. The trust must be valid under state law.

The 15% excise tax on excess distributions (received after December 31, 1996) and the 15% excise tax on excess retirement accumulations (applicable to estates of decedents who die after December 31, 1996) from qualified retirement plans, tax-sheltered annuities and IRAs have been repealed.[8]

20:13. Income taxation considerations-- Taxation of accident and health plan benefits

I.R.C. §105(a) requires the inclusion as income of benefits paid under accident or health plans for personal injuries or sickness, attributable to employer contributions, to the extent that: (i) the contributions from the employer to an insurance plan were not includable in the gross income of the employee; or (ii) are paid directly by the employer. An exclusion as to income applies to medical care payments that are made to reimburse the taxpayer, not only for the taxpayer's own medical expenses, but also for the medical expenses of a spouse or any dependents. Where a portion of the contributions is paid by the employer and a portion by the employee, a consistent proportion of taxable and nontaxable benefits should be computed.[1]

20:14. Income taxation considerations-- Step up in basis concept

For income tax purposes, the basis of property acquired from a decedent is its fair market value ("FMV") at the time of death,[1] or, if subject to the alternate valuation date election, the alternate valuation authorized.[2] This is referred to as a step up in basis. It is important to recognize that the income tax benefit is a corollary to estate planning valuation considerations.

For individuals dying in 2010, there is an option for the Executor to elect by September 17, 2011, that the estate will not be subject to estate tax. However, if this election is made, the modified carryover basis rules instead of the step up in basis rules will apply.[3]

Where a husband and wife own property as tenants by the entirety, one-half of the property is included in the deceased spouse's estate, resulting in a step up in basis as to one-half of the property.[4] This rule has been in effect since 1982 and replaced the "contribution" rules

[8]Taxpayer Relief Act of 1997 §1073(a) to (c).

[1]26 C.F.R. §1.105-1(c). *See supra* §20:2.

[1]26 U.S.C.A. §1014.

[2]26 U.S.C.A. §2032; *see infra* §20:30.

[3]*See supra* §20:2.

[4]26 U.S.C.A. §2040(b)(1).

which required tracing of interests.[5]

There is an exception to the above rules when real estate jointly owned between spouses was acquired prior to 1977. Such real property is fully includable in the estate of the first spouse to die, which inclusion results in a full step up in basis.[6]

Where there is a joint tenant other than a husband or wife, for example, a son or daughter, there is full-inclusion in the estate of the first to die, and a corresponding 100% income tax step-up, unless the property had been inherited by the decedent and the survivor as joint tenants with right of survivorship and their interests had been specified by law, or the survivor can prove he or she supplied part or all of the consideration.[7] For income tax purposes, when a non-spouse joint tenant is added, the tracing rule must be used to establish the basis of joint tenant holders.

Where an owner reserves a life estate in real property and transfers the remainder to another party, there is a 100% tax step-up in basis upon the life tenant's demise.[8]

20:15. Income taxation considerations-- Sale of residence

Effective for transactions after May 6, 1997, taxpayers who sell property that they owned and occupied as a principal residence for at least two of the last five years preceding the sale can elect a $250,000 exclusion of gain subject to income tax.[1]

There is an exception to the two out of five-year rule for taxpayers who are "physically or mentally incapable of self-care" who reside in a licensed care facilities (e.g., a nursing home). In such case, the taxpayer need only reside in his or her primary residence for one out of five years preceding the sale or exchange.[2]

The amount of excludable gain is increased to $500,000 for a married couple filing jointly if: (1) either spouse meets the ownership test; or (2) both spouses meet the use test; and (3) neither spouse is ineligible for exclusion due to a sale of a primary residence within the last two years.[3]

A pro rata amount of $250,000 (or $500,000) will be allowed if a taxpayer does not meet

[5]26 U.S.C.A. §2040(b)(1); *see infra* §20:30; 26 U.S.C.A. §2040(b) which makes the amount eligible for the stepped-up basis rules under 26 U.S.C.A. §1014(b)(9); *see also* Gallenstein v. U.S., 975 F.2d 286, 92-2 U.S. Tax Cas. (CCH) P 60114, 70 A.F.T.R.2d 92-5683 (6th Cir. 1992).

[6]*See* Gallenstein v. U.S., 975 F.2d 286, 92-2 U.S. Tax Cas. (CCH) P 60114, 70 A.F.T.R.2d 92-5683 (6th Cir. 1992), followed by Patten v. U.S., 96-1 U.S. Tax Cas. (CCH) 60231, 77 A.F.T.R.2d 96-1877, 1996 WL 303257 (W.D. Va. 1996), aff'd, 116 F.3d 1029, 80 A.F.T.R.2d 97-5108 (4th Cir. 1997); Marvin H. Anderson, Richard G. Anderson v. U.S., 96-2 U.S. Tax Cas. (CCH) 60235, 78 A.F.T.R.2d 96-6555, 1996 WL 809449 (D. Md. 1996).

[7]26 U.S.C.A. §2040(a).

[8]26 U.S.C.A. §1014(a).

[1]Taxpayer Relief Act of 1997 §312(a) to (e) and IRS Form 8853.

[2]26 U.S.C.A. §121(d)(7) (applying to sales or exchanges occurring after May 6, 1997).

[3]26 U.S.C.A. §121(b)(2) (applying to sales or exchanges occurring after May 6, 1997).

the ownership or use requirements due to a change in place of employment, health or unforeseen circumstances.

This exclusion of gain replaces the rollover of gain provision[4] and the one-time $125,000 exclusion for taxpayers age 55 or older.[5]

20:16. Income taxation considerations-- Taxation of long term care benefits

Benefit payments received under a qualified long-term care insurance contract are excluded from an individual's gross income in an amount of up to $360[1] per day. Amounts in excess of $360 per day may also be excluded to the extent that the individual has incurred actual costs for qualified long-term care services[2] that were not covered by other insurance.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), long-term care insurance contracts issued before 1997 are automatically grandfathered as "Qualified Long Term Care Insurance Contracts."

Most policies approved by a state after January 1, 1997, will highlight on the first page that the policy "is intended to be a qualified policy under HIPAA."

20:17. Income taxation considerations-- Capital gains and net investment tax

Capital Gains. Taxpayers may benefit from the sale of certain assets by a lower tax rate being applied to the gain on the sale (referred to as a "capital gain"), if certain requirements are met, such as the holding period.

For tax years 2013 and 2014 the maximum capital gain tax rate is 0% for individuals in the 10% and 15% income tax brackets, 15% in the 25% and 35% brackets and 20% for the 39.6% bracket.[1] For tax years 2015 and 2016 the maximum capital gain tax rate is 0% for individuals in the 10% and 15% income tax brackets, 15% in the 25%, 28%, 33% and 35% brackets, 20% for individuals in the 39.6% income tax bracket, 25% for certain gains under I.R.C. Section 1250, and 28% for collectibles gain and certain gains under I.R.C. Sections 1202 and 1250.

Net Investment Tax. For 2013 and thereafter, there is a new tax: the net investment tax. Please note that the 3.8% tax will be added to this bracket for taxpayers whose modified adjusted gross income exceeds certain amounts. The calculation of the tax is 3.8% of the lesser of the taxpayer's investment income and the excess of the taxpayer's modified adjusted gross income over $200,000 (single or head of household), $250,000 (married filing jointly or qualifying widow(er) with dependent child) or $125,000 (married filing separately).[2] The tax also applies to

[4]26 U.S.C.A. §1034.

[5]Former 26 U.S.C.A. §121 (predates the Taxpayer Relief Act of 1997).

[1]*See* I.R.C. §213(d)(10), I.R.C. §7702B(b), Rev. Proc. 2017-58, 2014-47 I.R.B. 831.

[2]*See supra* §20:9.

[1]See I.R.C. §1(h)(1)(B) to (h)(1)(F).

[2]*See* I.R.C. §1411(a)(1).

estates and trusts.[3]

20:18. Unified gift and estate tax system

Since 1976 there has been a Federal Unified Gift and Estate Tax System.[1] One tax is imposed on all transfers, lifetime or testamentary.[2] New York Gift and Estate Tax Law is based on the gift and tax provisions of the I.R.C., with modifications for New York purposes.

20:19. Unified gift and estate tax system-- Unified tax rate

The federal gift and estate tax is computed under a unified graduated rate schedule applicable to both gifts during lifetime and transfers at death on a cumulative basis.[1]

For transfers made in 2013-2018--the top rate is 40%, in 2010-2012 the top rate is 35%, in 2007-2009--18% to 45%, in 2006--18% to 46%, in 2005--18% to 48%, in 2004--18% to 48%, in 2003--18% to 49%, in 2002--18% to 50%.

For transfers made between 1983 and 2001, the rate ranged from 18% to 55% with the highest rate applying to transfers of $3 million or more.[2]

20:20. Unified gift and estate tax system-- Unified credit against federal gift and estate tax

Under the Tax Cuts and Jobs Act, for estates of decedents dying and gifts made after 2017 and before 2026, the applicable exclusion amount for federal estate and gift tax will be doubled from $5,000,0000 to $10,000,000, before being adjusted for inflation. As a result, the applicable federal exclusion for estates is $11,200,000 for 2018 (Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed), $5,490,000 for 2017, $5,450,000 for 2016,1 $5,430,000 for 2015, $5,340,000 in 2014,2 $5,250,000 for 2013,3 and $5,120,000 for 2012.4 Between 2002-2010, the gift tax exclusion equivalent remained constant at $1 million while the estate tax exclusion equivalent rose in stages from $1,500,000 in 2005 to $5,120,000 in 2012. The

[3]I.R.C. §1411(a)(2).

[1]26 U.S.C.A. §§2001 and 2501.

[2]26 U.S.C.A. §§2001(c) and 2502(a).

[1]26 U.S.C.A. §§2001(c) and 2502(a).

[2]26 U.S.C.A. §2001(c).*See infra* §20:76 for Federal Unified Transfer Tax Schedule.

[1]Rev. Proc. 2017-58, 2016-45 I.R.B. 707. Applicable exclusion for 2018 was calculated based on the inflation adjusted amount of $5,600,000.

[2]Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, Pub. L. No. 111-312, §303, 124 Stat 3296. Rev. Proc. 2014-61.

[3]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

[4]*See supra* §20:2.

applicable exclusion amount and applicable credit amount has been phased in from 1998 to 2009.[5]

The gift tax exemption equivalent for years 2012 through 2018 are as follows:

$11,200,000 in 2018, *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed).*

$5,490,000 in 2017,
$5,450,000 in 2016,
$5,430,000 in 2015,
$5,340,000 in 2014,
$5,250,000 in 2013, and
$5,120,000 in 2012.

For gifts made after December 31, 1997, and estates of decedents who die after December 31, 1997, the previous unified credit of $192,800, which was the equivalent of a $600,000 exemption, has been replaced by an "applicable credit amount."[6] The applicable credit amount is the amount of the tentative tax that would be determined under the rate schedule in I.R.C. §2001(c) if the amount with respect to which such tentative tax is to be computed were the "applicable exclusion amount."[7]

20:21. Unified gift and estate tax system-- New York unified gift and estate tax system

The New York State Estate Tax Return is filed on Form ET-706 for estates of individuals dying on or after February 1, 2000. The New York State estate tax return (Form ET-706) must be filed and estate taxes must be paid within nine months after the decedent's death, unless an extension of time to file and pay is granted by New York State Tax Department. The one major difference between the federal and New York State gift and estate tax laws is that the New York State gift tax law was repealed effective January 1, 2000.

For New York residents dying on or after April 1, 2015, and before April 1, 2016, the New York State estate tax exclusion amount is $3,125,000. For New York residents dying on or after April 1, 2016, and before April 1, 2017, the New York State estate tax exclusion amount is $4,187,500. For New York residents dying on or after April 1, 2017, and on or before December 31, 2018, the New York State estate tax exclusion amount is $5,250,000.[1] On January 1, 2019, the New York State estate tax exclusion amount is scheduled to equal the Federal estate tax exemption amount as determined under the Federal rules in effect prior to the enactment of the Tax Cuts and Jobs Act. *(Reference: Rev. Proc. 2017-58, 2016-45 I.R.B. 707. Prior to the enactment of the Tax Cuts and Jobs Act, the federal estate exemption was expected to be $5,600,000).*

[5]*See infra* §20:77 for a schedule of New York State estate and Federal Estate and Gift Applicable Exclusion Amounts.

[6]26 U.S.C.A. §2010 (applicable to gifts made after December 31, 1997 and estates of decedents dying after December 31, 1997).

[7]26 U.S.C.A. §2010(c) (applicable to gifts made after December 31, 1997, and estates of decedents dying after December 31, 1997).

[1]See §20:77 for the Schedule--Federal and NYS Exclusion Amounts.

Prior to April 1, 2014, the New York's gift and estate taxes are computed under a unified rate schedule applicable to both gifts and transfers resulting from death on a cumulative basis.[2] This system is similar in concept to the federal gift and estate tax system.[3]

The New York State estate tax is equal to the maximum amount allowable against the federal estate tax, as a *credit for state death taxes* under §2011 of the Internal Revenue Code. This type of estate tax is sometimes referred to as a pickup tax, sponge tax, or sop tax, since the tax picks up or absorbs the portion of the federal estate tax allowed as a credit when paid to a state, that would otherwise be paid to the federal government if the state did not impose a tax on the estate.[4]

Generally, when a state imposes a pickup tax the total tax liability (federal and state combined) of the estate is no more than the federal estate tax liability before the credit for state death taxes. In 2005, the state death tax credit was replaced by a deduction reducing the federal taxable estate. The practical effect of this phase out in New York, in the absence of new state legislation, is that New York decedents will pay estate tax on estates that are valued at less than the federal applicable exclusion.

20:22. Gift tax considerations-- Overview (Federal)

Under the Tax Cuts and Jobs Act, gifts made after December 31, 2017 and before January 1, 2026, are subject to the same gift tax rate of 40% as applicable for calendar years 2013**-**2016.[1] For calendar years 2010**-**2012, the gift tax rate is equal to the highest individual tax rate which is 35%.[2]

The gift tax is an excise tax imposed upon the lifetime transfer of property, measured by the value of the property transferred in excess of the value of any consideration received therefor.[3]

The gift tax is paid by the donor who makes the gift.[4] If the donor fails to pay the tax when due, the donee is also liable for the tax to the extent of the value of the gift.[5]

Any transfer of property gratuitously bestowed is a gift. The general requirements are the following:

[2]*See infra* §20:37 for a further explanation of the New York State estate tax and §20:28 for a further explanation of the New York State gift tax.
[3]*See supra* §20:19.

[4]New York Tax Law §952.

[1]American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 H.R. 8, 126 Stat. 2313.

[2] Economic Growth and Tax Relief Reconciliation Act of 2001 Pub. L. No. 107-16 §511, 115 Stat. 38.

[3]26 U.S.C.A. §§2501 through 2524.

[4]26 U.S.C.A. §2501(a).

[5]26 U.S.C.A. §6324(b).

1. a competent donor,
2. a donee capable of taking the gift,
3. a clear intent on the part of the donor to divest himself of control of the gift,
4. an irrevocable transfer of legal title barring further control by the donor,
5. a delivery to the donee of the gift or evidence of title, and
6. acceptance of the gift by the donee.[6]

There are exclusions,[7] deductions and credits[8] for federal gift tax purposes which must be considered.

20:23. Gift tax considerations-- Use of the gift tax exclusion

For gifts made during the calendar year 2018, the annual gift tax exclusion amount is $15,000 per donee per calendar year. *(Reference: Rev. Proc. 2017-58, 2016-45 I.R.B. 707)*; For gifts made during the calendar years 2013-2017, the annual gift tax exclusion amount is $15,000 per donee per calendar year.[1]

The annual exclusion amount is indexed annually for inflation.[2] The annual gift exclusion amount will be rounded to the next lowest multiple of $1,000.

To qualify for the annual exclusion however, the gift must be of a "present interest" and not of a "future interest."[3]

There is also an exclusion from gift tax for payment of tuition (not books, room, board, etc.) to a qualifying educational institution and payments for medical care directly to a provider or for medical insurance.[4] The gift tax does not apply to gifts to political organizations.[5] No gift tax return need be filed for these education or medical gifts or for gifts under the annual exclusion of $15,000 in 2018[6] because there is no taxable gift.[7]

In addition, contributions made to a qualified state college tuition program (sometimes referred to as a “Section 529 Plan”) which exceed $15,000 in 2018 can be excluded over a five-year period as annual exclusion gifts. Thus, an aggregate of $70,000 (equal to five annual

[6]*See, e.g.* the cases cited at 62 N.Y Jur. 2d §27.

[7]*See infra* §20:23.

[8]*See infra* §§20:24 and 20:25.

[1]26 U.S.C.A. §2503(b); Rev. Proc. 2016-55, 2016-45 I.R.B. 707.

[2]Taxpayer Relief Act of 1997 §501(c), amending 26 U.S.C.A. §2503(b).

[3]26 C.F.R. §25.2503-3.

[4]26 C.F.R. §25.2503-6(b) and (c).

[5]26 C.F.R. §25.2501-1(a)(5).

[6]Rev. Proc. 2016-55, 2016-45 I.R.B. 707.

[7]26 C.F.R. §§25.2503-6(b)(2), (3), 25.2503-2. *See* I.R.C. §§2503(e)1, 2503(e)(2). *But see infra* §20:25 for split annual exclusion gifts.

exclusions) can be excluded from gift tax, if the donor so elects.[8]

Limited Powers of Withdrawal. In order to qualify a gift for the annual exclusion, the gift must be of a present interest. If assets are contributed into an Irrevocable Trust, they do not automatically qualify for the annual exclusion.

One method of qualifying the gift is to give the beneficiary(ies) of the trust the right to withdraw the funds contributed to the trust. For example, in order to qualify the money contributed to an Irrevocable Life Insurance Trust as a present interest gift,[9] so the trustees can pay the insurance premiums, a trust beneficiary can be given a limited power of withdrawal that permits the beneficiary to elect to withdraw his or her proportionate share of the contributions made to the trust each year (but not exceeding $15,0000).[10] This power can qualify the gifts for the $15,000 annual exclusion per year.[11]

Gifts to Grandchildren. Often, seniors are interested in making gifts to grandchildren. For example, if the senior has a taxable estate, he or she may want to reduce the estate by taking advantage of the $15,000 annual exclusion by making gifts to grandchildren. There are several options as to the manner of the gift.

1. The senior can make outright gifts directly to each grandchild. If the grandchild is a minor, then the senior can make the gift to the minor grandchild by placing the asset in the parent's name as custodian under the Uniform Transfer to Minors Act. The grandchild will have a right to access the asset at age 21 in New York.[12]

2. The senior can set up individual trusts for each grandchild. This type of trust is known as a "Minor's Trust" or a "2503(c) Trust" and the trust must meet certain requirements under §2503(c) of the Internal Revenue Code. Typically, the primary purpose will be to pay for a college education. The parent of the grandchild can be the trustee. The grandchild will have a right to access the asset at age 21. This trust will automatically qualify the gifts to the trust for the annual $15,000 gift tax exclusion each year.[13]

3. The senior can also set up one trust ("with separate shares") for each of his or her grandchildren with the trustee disbursing the funds for the benefit of each grandchild, in his or her discretion. There are additional administrative requirements as to this trust to qualify the gifts for the $15,000 annual exclusion.[14] The grandchildren must receive the balance of the funds as

[8]*See* I.R.C. §529(c)(2)(B).

[9]*See infra* §21:31.

[10]26 U.S.C.A. §2514(e).

[11]*See supra* §20:20 for gifts made after December 31, 1997.

[12]*See* EPTL §§7-6.1-7-6.26.

[13]26 U.S.C.A. §2503(c).

[14]Crummey v. C.I.R., 397 F.2d 82, 68-2 U.S. Tax Cas. (CCH) P 12541, 22 A.F.T.R.2d 6023 (9th Cir. 1968); Estate of Cristofani v. C. I. R., 97 T.C. 74, Tax Ct. Rep. (CCH) 47491, Tax Ct. Rep. Dec. (P-H) 97.5, 1991 WL 137858 (1991), acquiescence in result only recommended, AOD-1992-9, 1992 WL 794826 (I.R.S. AOD 1992) and acq., 1992-2 C.B.1 and acquiescence in result

provided for in the trust, for example, at a stated age or upon the occurrence of a stated event.[15]

20:24. Gift tax considerations-- Gift tax deductions and credits

Deductions. A marital deduction is allowed for all gifts between U.S. citizen or resident spouses.[1] There is also a charitable deduction for gifts, similar to those qualifying for an income tax deduction, except that deductible gifts are not limited to gifts to or for the use of U.S. recipients.[2]

Credits. After the tentative gift tax liability for a year has been computed, the donor's gift tax liability is determined by subtracting the available federal unified estate and gift tax credit.[3]

Valuation of Gifts. Where the gift is of an annuity, a life interest, a remainder or a reversion, the IRS requires that the gift's present value be determined according to IRS tables. Between December 1983 and May 1989, the tables were based on a 10% interest factor.[4] Thus one can give a gift of a future interest and value it below its true present value for tax purposes. Beginning in May 1989, the IRS published new tables with values that are dependent upon the interest rate at the time of the gift. The values on the table still afford the opportunity for some savings, but this is limited by the closer approximation of interest rates and the regular adjustment to the current index.[5]

Disclaimers. With respect to transfers made after December 31, 1976, a "Qualified Disclaimer"[6] can be made in which the property will be treated as if the interest had never been transferred to the person disclaiming. If a qualified disclaimer[7] is made, the disclaimed interest is treated as if there had never been a transfer to the person who made the disclaimer.

A qualified disclaimer means an irrevocable and unqualified refusal by a person to accept an interest in property but only if:[8]

only recommended, AOD-1996-10, 1996 WL 390089 (I.R.S. AOD 1996) and acq., 1996-2 C.B.1.

[15]Additionally, see I.R.C. §2503(c). A trust with separate shares for each grandchild may qualify for the annual exclusion from generation skipping tax. See I.R.C. §2642(c).

[1]26 U.S.C.A. §2523.

[2]26 U.S.C.A. §2522.

[3]26 U.S.C.A. §2505.

[4]26 C.F.R. §20.2031-7A(d).

[5]If the gift is of a remainder interest and a related party retains a life estate, the valuation of the gift will be made at the fair market value. The IRS will value at zero the transferor's retained interest. I.R.C. §2702.

[6]26 U.S.C.A. §2518.

[7]26 U.S.C.A. §2518(b).

[8]26 U.S.C.A. §2518(b).

1. Such refusal is in writing;

2. Such writing is received by the transferor, his or her legal representative or holder of the legal title to property to which the interest relates, not later than the date which is 9 months after the later of:

3. The date on which the transfer creating the interest in such person is made or;

4. The day on which such person attains the age of 21;

5. Such person has not accepted the interest or any of its benefits; and

6. As a result of such refusal, the interest passes without any direction on the part of the person making the disclaimer and passes either:

a. To the spouse of the decedent; or

b. To a person other than the person making the disclaimer.

20:25. Gift tax considerations-- Spousal gifts

For gifts made after September 30, 1983, there is an unlimited marital deduction for gifts between U.S. citizen or resident spouses.[1]

QTIP Living Trust. As an alternative to an outright gift to the spouse qualifying for the marital deduction, the donor spouse can make a gift to a living trust which meets the Qualified Terminable Interest Property ("QTIP") requirements so that the gift qualifies for the marital deduction.[2] The donor must make this QTIP election on the gift tax return.

Split Gifts. With the consent of one's spouse, a donor may "split" the gift with the spouse so that it will be treated as having been given one-half by each.[3] Since each spouse has a $15,000 annual exclusion per donee, the $15,000 can in effect be doubled. This can be extremely helpful when taxable gifts are made which can be offset by the exemption as well. For example, if a husband makes a gift of $810,000 to his son, and husband and wife split their gifts, the taxable gift of $780,000 is offset by the federal gift tax exclusion amount of $11,200,000 (in 2018) for each spouse leaving an unused exclusion of $10,810,000 ($11,200,000-$390,000) for each spouse. If the gift were only made by the husband, then the unused exclusion amount for the husband would be $10,420,000 ($11,200,000-$780,000).

With respect to gifts made after December 31, 1981, or before January 1, 1971, the spouse's consent may be signified (on a gift tax return) at any time following the close of the calendar year, subject to the following limitation:[4]

1. The consent may not be signified after the 15th day of April following the close of the calendar year, unless before such 15th day, no return has been filed for the year by either spouse, in which case the consent may not be signified after a return for the year is filed by either spouse;[5] and

[1]26 U.S.C.A. §§2056 and 2056A.

[2]*See infra* §20:31.

[3]26 U.S.C.A. §2513.

[4]26 C.F.R §25.2513-2(b)(1).

[5]26 C.F.R. §25.2513-2(b)(1)(i).

2. The consent may not be signified for a calendar year after a notice of deficiency in gift tax for that year has been sent to either spouse in accordance with §6212(a).[6]

20:26. Gift tax considerations-- Tax return filing requirements

If a reportable gift has been made, a federal gift tax return must be filed by April 15 of the year following the year of the gift.[1] A reportable gift is one that is not excluded by the marital deduction or the annual exclusion.[2] Form 709 is used to report the gifts to the federal government.

20:27. Gift tax considerations-- Interrelationship with income and estate taxation

Gift tax considerations should be tied in with income and estate tax considerations. The gift of high income producing property to a person in a lower income tax bracket may reduce the income taxes owed. Obviously many smaller estates can be transferred during the donor's lifetime (so as to qualify for Medicaid benefits in the future) and escape all taxation. Applicable state law must be reviewed for purposes of ascertaining the gift taxes which may be applicable to transfers during life. One should also consider planning in regard to clients who have residences in different states.

20:28. Gift tax considerations-- New York State gift taxation (Repealed)

One should always consider whether the taxpayer is subject to state gift taxation in the state in which the taxpayer resides. The New York State gift tax has been repealed without replacement for gifts made on or after January 1, 2000.[1] This allows taxpayers to implement a gifting program to minimize estate tax consequences without adverse New York State gift tax consequences.[2]

New York State did impose a gift tax for transfers by gift on or after January 6, 1972, and before January 1, 2000, by resident and nonresident individuals.[3] In the case of a New York resident, the gift tax did not apply to gifts of out-of-state real or tangible property.[4] In the case of a nonresident, the tax only applied to gifts of real or tangible personal property located in New York or intangible personal property within New York employed in carrying on any business in New York by the donor.[5]

[6]26 C.F.R. §25.2513-2(b)(1)(ii).

[1]26 U.S.C.A. §6075.

[2]26 U.S.C.A. §6019(a). If a spouse makes annual exclusion gifts and gift splitting is elected, then a gift tax return must be filed.

[1]New York State Budget Bill of 1997 Chapter 389, S. 5785, A. 6781.

[2]*See infra* §20:37.

[3]NYTL §§1001 to 1004.

[4]NYTL §1003(a)(1).

[5]NYTL §1003(a)(2).

New York State followed the federal rules as to exclusions and deductions. The New York State gift tax credit amount was similar to the New York State estate tax credit.[6]

20:29. Estate Tax Considerations-- Overview (Federal)

The federal estate tax is imposed on the transfer of a person's property at death.[1] The value of the gross estate is the aggregate fair market value of the various items of property included in the gross estate.[2] For this purpose, "fair market value" is defined as the price at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of all relevant facts,[3] and with the highest and best use of the property being considered. Certain property, such as farm business real estate, may be valued based upon its actual use rather than its highest and best use.[4]

20:30. Estate Tax Considerations-- Gross estate

The value of all property whether real or personal, tangible or intangible, and wherever situated, in which a United States citizen or resident decedent has a beneficial interest at death is includable in the gross estate.[1] This includes life insurance owned by the decedent, joint accounts and retirement plans.

This valuation is made at the date of the decedent's death, but an alternate valuation date of six months later may be elected if certain requirements are met.[2]

20:31. Estate Tax Considerations-- Deductions from gross estate

Certain deductions from the gross estate are available in calculating the taxable estate. These deductions include: expenses, debts, and casualty losses of the estate,[1] transfers to a charity,[2] and transfers to a surviving spouse.[3]

Expenses, Debts, and Casualty Losses of the Estate.[4] "Reasonable" and "bona fide"

[6]*See supra* §20:21.

[1]26 U.S.C.A. §2001(a).

[2]26 U.S.C.A. §2031.

[3]26 C.F.R. §2031-1(b).

[4]26 U.S.C.A. §2032A.

[1]26 U.S.C.A. §§2033 to 2046.

[2]26 U.S.C.A. §2032.

[1]26 U.S.C.A. §§2053 and 2054.

[2]26 U.S.C.A. §2055.

[3]26 U.S.C.A. §2056.

[4]26 U.S.C.A. §§2053 and 2054.

expenses attributable to the decedent's funeral and the administration of the decedent's estate, claims against the decedent's estate, mortgages on and debts due with respect to property included in the gross estate, and casualty losses of property included in the gross estate during administration are fully deductible.[5]

Charitable Deduction.[6] Bequests to qualifying charitable organizations are fully deductible from a decedent's gross estate for federal estate tax purposes.[7] The amount of the deduction is not limited to any portion of the estate, and charitable bequests can be used to avoid any estate tax. However, there are limitations when certain types of partial interests are transferred,[8] for example, when there are non-charitable and charitable interests in the same property.[9] In addition, special rules apply for the allowance of charitable deductions to exempt organizations, family or private foundations and nonexempt charitable trusts.

The same types of organizations which qualify as charities for income tax purposes also qualify for estate tax purposes,[10] so that transfers to the United States, a state, a local government, the District of Columbia, or a U.S. possession for exclusively public purposes, and transfers to a corporation, trust or community chest, fund or foundation, created or organized in the United States, and organized and operated exclusively for religious, charitable, scientific, literary or educational purposes are deductible.

The Marital Deduction.[11] The "marital deduction" is a deduction from the value of the gross estate in an amount equal to the value of property which passes from the decedent to his or her surviving spouse. If the surviving spouse is not a United States citizen, property passing to the surviving spouse is not deductible,[12] unless the property passes to a "Qualified Domestic Trust" for the benefit of the surviving spouse, whereupon it becomes fully deductible.[13] Accordingly, the citizenship of both spouses must be ascertained at the onset of any planning, and specialized planning may be required if either or each of them is not a United States citizen.

If property does not pass outright to the surviving spouse, then certain requirements must be met. The most common form of transfer is a special form of life income interest[14] given to a surviving spouse which qualifies for the marital deduction. This interest is referred to as a

[5]26 U.S.C.A. §§2053 and 2054.

[6]26 U.S.C.A. §2055.

[7]26 U.S.C.A. §2055.

[8]26 U.S.C.A. §2055(e).

[9]26 U.S.C.A. §2055(e)(2).

[10]26 U.S.C.A. §2055(a).

[11]26 U.S.C.A.§§2056 and 2056A.

[12]26 U.S.C.A. §2056(d).

[13]26 U.S.C.A. §§2056(d) and 2056A.

[14]26 U.S.C.A. §2056(b)(7).

"QTIP" or qualified terminable interest property.

If this type of life income is to qualify for the marital deduction, the following conditions must be met:[15]

1. the surviving spouse must be entitled to all of the income from the property payable at least annually for his or her life or have a usufruct interest for life in the property;

2. a QTIP interest in property not placed in trust must provide the survivor with rights to income that are sufficient to satisfy the rules applicable to marital deduction trusts;

3. there must be no power in anyone (including the spouse) to appoint any part of the property to any person other than the spouse during the spouse's life; and

4. the executor must elect on the decedent's estate tax return to have the interest treated as a QTIP.

The marital deduction is also available if the surviving spouse is entitled to the income of a specific portion of a trust for life, payable under like terms, and is possessed of like powers as to the specific portion.[16] The deduction applies only to that specific portion.

Another method of qualifying for the marital deduction is the general power of appointment.[17] This permits a life interest arrangement to qualify, whether it is in trust or not, if the survivor is entitled to all the income (payable at least annually) and has the power to appoint the property to herself (i.e., in the case of a trust, power to direct the trustee to pay her all of the principal) or has the power to appoint the property to her estate, (i.e., has a general power of appointment).

20:32. Estate Tax Considerations-- Credits against the estate tax

The federal tentative tax computed on the taxable estate may be reduced by the Unified Credit,[1] and various credits allowable for other taxes such as death taxes paid to the state (for decedents dying before 2005),[2] taxes paid on gifts made prior to 1977,[3] taxes on prior transfers,[4] and foreign death taxes.[5]

The Unified Credit.[6] Each person is allowed an applicable credit amount (the "Unified

[15]26 U.S.C.A. §2056(b)(7).

[16]26 U.S.C.A. §2056(b)(7).

[17]26 U.S.C.A. §2056(b)(5).

[1]26 U.S.C.A. §2010.

[2]26 U.S.C.A. §2011 as amended by Economic Growth and Tax Relief Reconciliation of 2001, 115 Stat. 38.

[3]26 U.S.C.A. §2012.

[4]26 U.S.C.A. §2013.

[5]26 U.S.C.A. §2014.

[6]26 U.S.C.A. §2010.

Credit") against federal estate taxes,[7] which corresponds to an applicable exclusion amount ($11,200,000 for estates of decedents dying in calendar year 2018)This means that $11,200,000 can pass free of federal estate tax.[8] *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed).* The amount of the credit cannot exceed the amount of the estate tax.[9]

Please note that, for spouses who die in 2018, the estate of the deceased spouse can elect to have any unused federal estate tax applicable exclusion carried over to the estate of the surviving spouse ("portability"), subject to certain restrictions.[10] In order to take advantage of this "portability," a United States Estate (and Generation-Skipping Transfer) Tax Return (IRS Form 706) for the deceased spouse must be filed timely with the portability election affirmatively taken.[11] This is true regardless of whether there is a federal estate tax due for the spouse who died in 2018.

In connection with planning for a married couple, it is important that each spouse take advantage of his or her unified credit. For example, if the first spouse to die (in 2018) has an estate of $8.47 million, and the surviving spouse has an estate of $2.51 million and the first spouse leaves the entire estate to the surviving spouse, then upon the death of the first spouse, the $8.47 million estate of the first spouse will not be subject to any federal estate taxes, because of the unlimited marital deduction. Assuming asset levels remain unchanged, and the second spouse dies in 2018, the second spouse to die will leave an estate of $10,980,000 which will be protected by the federal unified credit. Assuming the second spouse died on or before March 31, 2018, the second spouse's estate will have a zero federal estate tax but a New York estate tax of approximately $1,223,600. By leaving the entire estate outright to the second spouse, the first spouse failed to take advantage of his New York State unified credit, resulting in this example in the unnecessary payment of approximately $774,000 New York State estate taxes.

Credit for State Death Taxes.[12] Prior to 2005, with certain limits and restrictions, death

[7]Taxpayer Relief Act of 1997 §501(a), amending 26 U.S.C.A. §2010.

[8]26 U.S.C.A. §2001. The amount of the Unified Credit shall be reduced by any gifts which were made between September 9, 1976 and December 31, 1976 which were offset by the pre-1977 $30,000 exemption, but only to the extent of 20% of the amount of the exemption. This law was enacted as a transitional rule so that individuals did not benefit under the old and new tax systems by receiving the $30,000 exemption under the old system while receiving the post-1976 Unified Credit.

[9]26 U.S.C.A. §§2010(b) and 2010(c).

[10]*See supra* §20:2.

[11]26 U.S.C.A. §2010(c)(5)(A).

[12]In 2005, the credit for state death tax was eliminated and replaced by a deduction for state taxes actually paid. The $510,800 deduction for estate taxes actually paid to New York State reduces a $6 million taxable estate to $5,489,200. See Sanford J. Schlesinger and Dana L. Mark, "Changes in Estate and Gift Taxes Will Increase Exemption Amounts and Lower Federal Rates, 74 - SEP N.Y.S.B.J. 37, 51.

taxes imposed by any state on a decedent's estate may be credited against the decedent's federal estate taxes.[13]

Although New York State also permits an unlimited marital deduction, in the example above, in addition to the federal estate tax consequences, the estate of the second spouse to die would also be liable for New York State estate taxes since the value of the estate is in excess of $4,187,500 (for dates of death of January 1-March 31, 2017) and in excess of $5,250,000 (for dates of death of April 1, 2017-December 31, 2018). New York State does not have the deceased spouse unused estate tax applicable exclusion (DSUEA).

Credit for Gift Tax Paid.[14] Property may be included in a decedent's gross estate even though the decedent transferred it prior to death and paid a gift tax. For gifts made after 1976, the unified gift and estate tax system accounts for any gift tax paid on property included in the gross estate, and a separate credit is allowed for gift tax paid on gifts made prior to 1977.[15] Certain specific requirements apply with regard to the valuation of the gift at the time of the transfer or the decedent's death[16] and to gifts split between the decedent and his or her spouse.[17]

Credit for Tax on Prior Transfers.[18] Property which a decedent received by gift or transfer at the death of another will be included and taxed in the decedent's gross estate even if a gift or estate tax was paid on that earlier transfer to the decedent. To ameliorate the effect of this multiple taxation, a credit is allowed for prior estate taxes paid by another.[19]

If the decedent dies within two years after the death of the prior transferor, a credit is allowed in the amount of the full federal estate tax paid by the transferor with respect to the prior transferred property. If the decedent dies more than two years after the prior transferor, the credit is reduced by twenty percent (20%) for each two-year period, such that no credit is allowed after 10 years. Thus, if the decedent dies more than 10 years after the prior transferor, no credit is allowed.[20]

Credit for Foreign Death Taxes.[21] With certain limits and restrictions, death taxes imposed by a foreign country on a decedent's estate may be credited against the decedent's federal estate tax.[22]

[13]26 U.S.C.A. §2001.

[14]26 U.S.C.A. §2012.

[15]26 U.S.C.A. §2012.

[16]26 U.S.C.A. §2012(b).

[17]26 U.S.C.A. §2012(c).

[18]26 U.S.C.A. §2013.

[19]26 U.S.C.A. §2013.

[20]26 U.S.C.A. §2013(a)(1)-(4).

[21]26 U.S.C.A. §2014.

[22]26 U.S.C.A. §2014.

20:33. Estate Tax Considerations-- Federal estate tax computation

The tax is imposed on the "taxable estate" which is calculated as the value of the "gross estate" (the total property owned and transferred at death plus the value of other property considered to be transferred at death)[1] reduced by various deductions.[2]

There are five steps in computing the federal estate tax:

Step #1 Determine the value of the gross estate.

Step #2 Compute the taxable estate by reducing the gross estate by allowable deductions[3] including:[4]

a. funeral and administration expenses and claims against the estate, including certain taxes and charitable pledges;

b. losses from casualty or theft during the administration of the estate;[5]

c. transfers to public, charitable, and religious uses;[6]

d. certain bequests to the surviving spouse (the "marital deduction");[7] and

e. state death taxes.

Step #3 Calculate the "Adjusted Taxable Estate" as the sum of the Taxable Estate plus the aggregate value of all of the gifts made by the decedent after 1976 and not otherwise included in the gross estate.

Step #4 Calculate the "Tentative Tax" by applying the appropriate estate tax rate to the Adjusted Taxable Estate.[8] Reduce the Tentative Tax by the aggregate amount of gift taxes paid on gifts made by the decedent after 1976, including those gifts includable in the gross estate.[9]

Step #5 Calculate the "Net Estate Tax" by reducing the tentative tax by applicable tax credits,[10] including:

a. the applicable credit amount (the "unified credit"),[11]

b. any credit for gift tax paid on gifts made before 1977,[12]

[1]26 U.S.C.A. §§2031, et seq.; *see supra* §§20:30 and 20:31.

[2]26 U.S.C.A. §2051.

[3]26 U.S.C.A. §2051; *see supra* §20:31.

[4]26 U.S.C.A. §2053.

[5]26 U.S.C.A. §2054.

[6]26 U.S.C.A. §2055.

[7]26 U.S.C.A. §2056.

[8]26 U.S.C.A. §2001.

[9]26 U.S.C.A. §2001.

[10]*See supra* §20:32.

[11]26 U.S.C.A. §2010, *see also supra* §20:20.

[12]26 U.S.C.A. §2012.

c. any credit for prior transfers, or[13]

d. any foreign death tax credit.[14]

20:34. Estate Tax Considerations-- Federal estate tax liability

The federal estate tax is due at the place for filing the return[1] nine months after date of death.[2] A district director may extend the time for payment of estate taxes in two situations:

1. For reasonable cause (illiquidity, for example) for up to 12 months from date fixed for payment,[3] or

2. For "special" reasonable cause for up to 10 years from date fixed for payment, i.e., undue hardship.[4] For example, a sale of property at a sacrifice price or in a depressed market would constitute undue hardship, but mere inconvenience would not.[5]

The IRS may also assess penalties under certain circumstances. There is a penalty for failure to pay an amount shown as tax due on the estate tax return in the amount of 1/2% of the tax per month up to a 25% maximum, unless failure to pay is due to a reasonable cause and not willful neglect.[6] There is also a penalty of 5% per month up to a 25% maximum for failure to file an estate tax return.[7] If the estate is subject to a 5% penalty for failure to file a return and to a 1/2% penalty for failure to pay tax in the same month, the 5% failure to file penalty is reduced by the amount of the failure to pay penalty of 1/2%,[8] thus, resulting in a maximum of total combined penalties of 5% per month.

20:35. Estate Tax Considerations-- Paying the federal tax

An extension of the time for payment of the federal estate tax may also be elected by the Executor if he or she meets certain requirements. This election must be made by letter to the Internal Revenue Service ("IRS") filed with a timely return for tax attributable to the following interests:

[13]26 U.S.C.A. §§2013.

[14]26 U.S.C.A. §2014.

[1]The place for filing is the IRS center where the decedent was domiciled at death. 26 U.S.C.A. §6091(b)(3).

[2]26 C.F.R. §§20.6151-1, 20.6075-1, and 20.6091-1.

[3]26 U.S.C.A. §6161(a)(1); *see* IRS Form 4768.

[4]26 U.S.C.A. §6161(a)(2); *see* IRS Forms 4768 and 1127.

[5]26 C.F.R. §20.6161-1(a)(2).

[6]26 U.S.C.A. §6651(a)(2). Penalties are not imposed if a valid extension is filed. 26 U.S.C.A. §6651(a)(1).

[7]26 U.S.C.A. §6651(a)(1).

[8]26 U.S.C.A. §6651.

1. For reversionary or remainder interests,[1] until six months after termination of the prior interest, which may be extended for an additional three years.

2. For estates of decedents dying after 1981, if the value of a farm or closely held business exceeds 35% of the adjusted gross estate, the estate taxes attributable to that interest may be deferred up to 15 years with the estate making annual interest payments (4%) for the first five years, and paying the balance in 10 annual installments of principal and interest.[2] A protective election may be made if it is not certain at the time of filing whether the estate qualifies.

The IRS will assess interest on the late payment of federal estate tax at a fluctuating rate as determined by the Secretary.[3]

If the estate of a decedent dying after August 5, 1997, is denied relief under I.R.C. §6166, the estate is entitled to seek a declaratory judgment before the U.S. Tax Court as to the estate's eligibility to make installment payments. This will be very helpful to estates that are at a financial disadvantage due to a lack of liquidity, since this judicial review is available without first paying the estate taxes due.[4]

20:36. Estate Tax Considerations-- Federal tax return filing requirements

If the value on the date of death of the gross estate of a decedent in a given year exceeds the applicable exclusion amount[1] ($11,200,000 in 2018, $5,490,000 in 2017, $5,450,000 in 2016, $5,430,000 in 2015, $5,430,000 in 2014, $5,250,000 in 2013 and $5,120,000 in 2012), then the representative of the estate must file a federal estate tax return. The threshold amount is reduced by post-1976 lifetime taxable gifts.[2]

20:37. Estate Tax Considerations-- New York State estate taxation

Estates after April 1, 2014. On April 1, 2014, the Executive Budget of 2014**-**2015 was signed into law by Governor Andrew Cuomo. This new law significantly altered the estate tax

[1]26 U.S.C.A. §§6163 and 6601(j).

[2]26 U.S.C.A. §6166.

[3]26 U.S.C.A. §6621(a)(2).

[4]Taxpayer Relief Act of 1997 §505, adding 26 U.S.C.A. §7479.

[1]26 U.S.C.A. §2010; *see also supra* §20:20; NYTL §971(a); The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[2]For decedents dying in 2012, for estates exceeding $5,120,000, an estate tax return must be filed, unless the executor, within 9 months of the enactment of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 Pub. L. No. 111-312 (Sept. 17, 2011) (extended to September 19, 2011, as September 17 is a Saturday) has elected the no-federal-estate-tax option for 2010. If such an election is made (presumably on Form 8939 Allocation of Increase in Basis for Property Acquired from a Decedent) this election must also be made by September 19, 2011.

structure in New York.[1]

The new law immediately increased the New York State estate tax exemption from $1 million to $2,062,500 for the period of April 1, 2014 to March 31, 2015. Thereafter the exemption amount is set to increase gradually until January 1, 2019, when the New York exemption amount will equal the federal exemption amount as calculated prior to the enactment of the Tax Cuts and Jobs Act and increased each year for inflation.

Time Period	**New York Basic Exclusion Amount from Estate Tax**
Prior to the 2014-2015 NYS Budget	$1,000,000
April 1, 2014-March 31, 2015	$2,062,500
April 1, 2015-March 31, 2016	$3,125,000
April 1, 2016-March 31, 2017	$4,187,500
April 1, 2017-December 31, 2018	$5,250,000
On or after January 1, 2019	Same as federal exemption amount (indexed for inflation)

However, the new tax law is not without its disadvantages. The most significant disadvantage is that the law entirely eliminates the use of the New York estate tax exemption for estates that are valued at more than 5% of the exemption amount (105% of the estate tax exemption level).[2] This is commonly referred to as the "5% cliff."

In addition to this 5% cliff, New York's top estate tax rate of 16% still exists under the new law.[3] Another significant issue with the new law is that, unlike the federal law, there is no portability provision allowing a surviving spouse to shelter double the exemption.

Estates after December 31, 2004. For estates of decedents dying after December 31, 2004, the state death tax credit was phased out and the credit has been replaced by a deduction on the federal estate tax return for New York estate tax. The phase out of the state death tax credit has resulted in a higher tax bill for New York estates.

[1]N.Y. Tax Law §952.

[2]N.Y. Tax Law §952(c).

[3]N.Y. Tax Law §952(b).

Estates after January 31, 2000 to December 31, 2004. For estates of decedents dying after January 31, 2000, through December 31, 2004, the New York estate tax is equal to the state death tax credit under federal law.[4] Thus, the total amount of New York estate tax paid was deductible from any federal estate tax that may be payable. In 2004, the state death tax credit was 25% of the New York estate tax.

In addition to New York estate tax liability, real property owned by a decedent in another state may be subject to estate taxation by that state. Elder law attorneys are often required to interpret provisions of the Internal Revenue Code in light of local laws. Many legal questions need interpretation such as: domicile, effect of community property, and statutory rights of spouses.

Estates from October 1, 1998, to January 31, 2000. For estates of decedents dying from October 1, 1998, to January 31, 2000, the New York State Estate Tax is based upon the adjusted gross estate for federal estate taxes with certain modifications. The tax rates range from 2% to 21%.[5] The maximum rate applies to estates of $10,100,000 and over.[6] The estate tax credit is from $500 to $10,000 depending upon the preliminary tentative tax.

In addition, New York has an estate tax deduction of up to $250,000 for a principal residence for estates of decedents who died after June 9, 1994, and before February 1, 2000.[7]

20:38. Planning for the residence-- Overview

The residence is typically the most significant asset owned by the senior. In order to protect the residence in the context of a catastrophic illness, the senior may consider transferring the residence, and in such event, the tax consequences of such a transfer must be addressed.

The elder law attorney should advise the senior of the following considerations:

1. Ownership and Control. Is the senior comfortable giving up ownership and control? Should the senior retain a life estate, *i.e.*, the legal right to live in the residence for the senior's lifetime?

2. Income Taxes. The income tax consequences if the residence is sold during or after the senior's lifetime.[1]

3. Real Estate Taxes. The Senior Citizen's, Veteran's and/or the STAR exemption of real property taxes may be lost under certain circumstances if the property is transferred.

4. Gift and Estate Taxes. The tax consequences of transferring the residence during the senior's lifetime or upon his or her death. Will there be gift taxes due? What are the income tax consequences on a later sale of the residence?

20:39. Planning for the residence-- Outright transfers

There are several disadvantages of an outright transfer of a residence in the context of asset protection and tax planning:

[4]*See supra* §20:32.

[5]NYTL §952(a)(6).

[6]NYTL §952(a)(6).

[7]NYTL §955(f), (as amended in S.5279, sec.91, June 2, 1995).

[1]*See supra* §20:15.

1. There is no right to live in the house.

2. The donee obtains the donor's carryover basis.

3. There is the loss of the step up in basis upon the demise of the donor.

4. There is the loss of the senior's $250,000 exclusion from capital gains on a later sale of the residence during the donor's lifetime.[1]

5. There is the loss of any Senior Citizen's, Veteran's or School Tax Relief Exemption of real property taxes.

20:40. Planning for the residence-- Transfer to a Medicaid Asset Protection Trust

Another alternative is for the senior to transfer the residence to a Medicaid Asset Protection Trust.[1] This will also typically provide more protection and security for the senior and provide for preferential tax treatment.

20:41. Planning for the residence-- Comparison of residential transfers

When comparing a transfer of a residence with a retained life estate versus a transfer to a Medicaid Asset Protection Trust,[1] there are several advantages and disadvantages:

1. Unlike a transfer of a residence with a retained life estate, the funding of an Irrevocable Trust (containing a limited power of appointment)[2] with a residence would not constitute a taxable gift because of the incomplete nature of the transfer. This is not critical if the creator of the trust dies in 2018 with an estate of under $11,200,000.[3]

2. In the Medicaid Asset Protection Trust, the residence is still considered part of the grantor's estate subject to estate taxation.[4] The residence would receive a step up in basis for income tax purposes at the grantor's death.[5] With a retained life estate, upon the demise of the Grantor/Life Tenant, the transferee obtains a step up in basis.

3. If the residence is in the Medicaid Asset Protection Trust and is sold while the grantor is in a nursing home, then the sale proceeds would not be an available resource for purposes of Medicaid eligibility. A portion of the proceeds would be an available resource if the residence were transferred with a retained life estate.[6]

20:42. Use of Revocable Living Trusts-- Overview

[1]*See supra* §20:15.

[1]*See infra* §21:25.

[1]*See infra* §20:54 for a detailed discussion of the Medicaid Asset Protection Trust.

[2]*See infra* §21:22 regarding Medicaid consequences.

[3]*See supra* §20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[4]*See* I.R.C. §2036(a)(2).

[5]See I.R.C. §1014.

[6]*See supra* §14:31.

A Revocable Living Trust (sometimes referred to as a "Lifetime Trust" is a trust in which the grantor or the settlor (the individual establishing the trust)) reserves the right to revoke or amend the trust.[1] This reserved power causes the trust assets to be treated as the grantors for income[2] and estate tax purposes.[3]

The proper use of revocable living trusts can provide many advantages, such as:

1. Asset Management. The trustee can protect the assets, invest the principal and implement a sound investment policy.

2. Lower Estate Settlement Costs. The trust assets are not subject to a probate proceeding. Filing fees and legal fees may be reduced.

3. Delays in Distribution Avoided. The disposition of trust assets will not be prolonged by delays involved in estate settlement.

4. Assures Privacy. The trust is a private agreement and is not a public document.

5. Avoids Disputes. Unlike wills, dispositions of trust assets are more difficult to challenge on the grounds of incapacity and undue influence. The grantor's actions subsequent to the trust being set up will be evidence to support that: (i) the settlor had requisite capacity; and (ii) was not under any undue influence.

6. Tax Benefits. The trust may be drafted to achieve estate tax savings upon the demise of the grantor. For example, the trust may be divided upon the death of the grantor into a By Pass and Marital Trust which can reduce overall estate taxes for a married couple.[4]

7. Grantor Can Observe Estate Plan in Action. The grantor can observe and make modifications by actual personal experience.

20:43. Use of Revocable Living Trusts-- Income taxation

The grantor of a Revocable Living Trust will be treated as the owner for purposes of income taxation.[1] All of the income, deductions and expenses of the Trust are reported on the grantor's own personal income tax returns.

Upon the demise of the grantor, both the estate's executor and the trustee of the decedent's qualified revocable trust may make an irrevocable election to tax the revocable trust as part of the estate for federal income tax purposes.[2]

20:44. Use of Revocable Living Trusts-- Gift taxation

There is no federal gift tax due upon funding of a Revocable Trust,[1] Although a gift tax

[1]*See infra* §21:2.

[2]26 U.S.C.A. §676.

[3]26 U.S.C.A. §2038.

[4]*See infra* §20:60.

[1]26 U.S.C.A. §676.

[2]26 U.S.C.A. §646.

[1]26 C.F.R. §25.2511-2(c).

return asserting that no tax is due appears to be required,[2] it is the authors' view that no return should be required because the transfer is a mere change of identity.

Distribution of trust assets may be subject to gift taxation. Uncompensated transfers made by the grantor to any person other than himself or herself will be treated as a completed gift by the grantor for gift tax purposes. A transfer becomes a completed gift when and if, during the lifetime of the grantor, the property ceases to be subject to the grantor's power to revoke. This can occur if the grantor simply releases the retained power or if the grantor holds the power as trustee and resigns from office. It can also occur if another person exercises a power of appointment that distributes or vests the property in such a way that the grantor's retained powers are negated or cancelled. Most commonly, a distribution from the trust to a beneficiary will place the distributed property beyond the control of the grantor. Thus, any distribution of income or corpus from a Revocable Trust is a completed gift by the original grantor.[3]

20:45. Use of Revocable Living Trusts-- Estate taxation

The assets of a Revocable Trust are included in the grantor's estate.[1] Hence, there are no estate tax benefits to placing assets in a Revocable Trust. Notwithstanding, a trust which provides for a Unified Credit Shelter Trust and a Marital Trust upon the demise of the grantor[2] can be a means of implementing estate tax planning for the benefit of a grantor's surviving spouse and family.

The trust may be set up so as to avoid a second death tax on the death of its beneficiaries.[3] For example, a Revocable Trust is set up for the senior's lifetime and then upon his or her death, the trust will terminate and the assets will be distributed to the senior's child. Then, upon the child's death, the former trust assets still held by the child will be subject to estate tax (a second estate tax) in her estate before passing to her children (the senior's grandchildren).

An alternative approach would be for the Revocable Trust to continue for the benefit of the child for her lifetime and then pass to the grandchildren. The trust assets would not be included in the child's estate upon her demise. Hence, a second estate tax would be avoided. This approach can result in significant estate tax savings, but must also take into account the generation skipping transfer tax.[4]

For example, if the senior has $11,200,000 in his living Revocable Trust (effectively all of his/her assets) and the child also has $11,200,000 of his/her own assets, and the trust provides for the assets to pass to the child, then there would be no federal estate tax on the death of the parent (in 2018). But if the child then passes away in 2018 with $22,400,000 as his/her taxable

[2]26 C.F.R. §25.2511-2(j).

[3]26 C.F.R. §25.2511-2(f).

[1]26 U.S.C.A. §2038.

[2]*See infra* §20:60.

[3]*See infra* §20:68; *see also infra* Living Trusts Ch 21.

[4]*See infra* §20:68.

estate, the child would be subject to both a federal and New York estate tax in 2018.[5]

In the alternative approach, where the trust continues for the benefit of the child during his/her lifetime, the child would only have $11,200,000 as his/her taxable estate because the $11,200,000 of trust assets would not be included in his/her estate. The federal estate tax *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed)* on the senior's estate and the child's estate would be zero. A New York estate tax of $1,258,800 (in 2018) would be due upon the death of each of the senior and the child.

In an elder law practice, it is not uncommon to have clients in their eighties and nineties with children who are in their sixties. Thus it is very important to consider intergenerational estate planning. In addition to the estate tax savings, the elder law attorney should also consider asset protection planning for both generations in light of the high cost of long term care.[6] This approach must also take into account the generation skipping transfer tax.

There had been an issue as to whether gifts from the Revocable Trust to third parties made within three years of the grantor's demise are included in the grantor's estate for estate tax purposes.[7] In recent years there have been a number of case decisions and IRS private letter rulings which have not been consistent in the treatment of this issue. The IRS has basically taken a position that lifetime gifts made directly from the Trust are includable in the grantor's estate for estate tax purposes.[8] Inclusion of the gift for estate tax purposes can be avoided by the grantor withdrawing the trust property and then making a gift directly of the withdrawn property.

For estates of decedents who died after August 5, 1997, this issue has been resolved in favor of the taxpayer. Transfers from a revocable trust within three years of the decedent's death will be treated as if made directly by the decedent and, thus, the value of such transfers will not be includable in the decedent's gross estate.[9]

20:46. Use of Revocable Living Trusts-- Joint Revocable Living Trust

A Joint Revocable Living Trust is a Trust created by two persons (typically set up by a husband and wife) who are both grantors and trustees. This single Trust agreement provides for management of the Trust assets for the lifetime of both grantors and estate planning as well.

There are several advantages to this type of trust:

1. Ongoing management in the event of a disability; access by either spouse to all marital assets; and simplicity of asset management.
2. Estate planning, including avoidance of probate and tax planning.

[5]*See infra* §21:18.

[6]*See supra* Nursing Homes and Alternatives Ch 19.

[7]26 U.S.C.A. §2038.

[8]26 U.S.C.A. §§2035(d)(2) and 2038(a)(1). *See also* Estate of Barton v. C.I.R., T.C. Memo. 1993-583, T.C.M. (RIA) 93583, 66 T.C.M. (CCH) 1547 (1993); McNeely v. U.S., 16 F.3d 303, 94-1 U.S. Tax Cas. (CCH) 60155, 73 A.F.T.R.2d 94-2339 (8th Cir. 1994) Priv. Ltr. Rul. 9343003; Priv. Ltr. Rul. 9343004; TAM 9413002.

[9]Taxpayer Relief Act of 1997 §1310, amending 26 U.S.C.A. §2035.

However, there may be adverse consequences of this type of trust in the context of Medicaid eligibility.[1]

The following discussion provides a tax analysis of Joint Revocable Living Trusts in both non-taxable and in taxable estates.

Tax Analysis of Nontaxable Estates. A nontaxable estate is defined as a married couple's combined estate of $22,400,000 or less (in 2018).[2] Since $22,400,000 can pass federal[3] estate tax free to the beneficiaries of the estate due to the applicable exclusion amount, the federal estate tax consequences of such a trust for a couple both passing away in 2018 can be basically ignored. Notwithstanding, in 2018 there will be New York estate tax consequences on a combined estate of more than $4,187,500 for January 1, 2017, through March 31, 2017. There will be New York estate tax consequences on a combined estate of more than $5,250,000 for estates on or after April 1, 2017, through December 31, 2018.

For example, if the combined estate was $22,400,000, then upon the demise of both spouses in 2018 there are potential combined New York estate taxes of approximately $2,500,000 for both estates.

Typically, a husband and wife create a Joint Revocable Living Trust in which they are co-trustees and each has access to either income or principal during their lifetime. Upon the death of the first spouse, the trust continues for the benefit of the surviving spouse. Upon the demise of the second spouse, the assets pass to the children of the husband and wife. Upon the funding of the trust, property held as tenants by the entirety will be transferred. Ownership will be in the name of the trustees, as fiduciaries.

It may be important to consider how much is contributed by each spouse for gift and estate tax purposes. For example, the husband may contribute 75% of the property and the wife may contribute 25% of the property. This will be relevant if the funding of the trust is treated as a taxable gift.[4] A gift may be incurred because the husband and wife have transferred assets to the trust with a contingent remainder interest, which is dependent on surviving the other spouse even though they have retained a life estate in the trust property.[5]

Gift Taxation. As a general rule, any transfer to a trust in which someone other than the grantor has an interest creates the potential for a gift.[6] In order for a gift to be taxable, the transfer must be complete. A gift in trust is generally incomplete to the extent that the donor reserves a power over the distribution of trust assets.[7] A donor is not considered to have such a

[1]*See infra* §21:20.

[2]*See supra* §§20:2, 20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[3]*See supra* §20:21.

[4]*See supra* §15:21.

[5]*See* TAM 9308002.

[6]26 C.F.R. §25.2511-1.

[7]26 U.S.C.A. §2036.

retained power if it is exercisable only in conjunction with a person having a substantial adverse interest in the disposition of property.[8] A transfer to a trust which provides that the husband and wife jointly direct the distribution of trust income and principal during their lives, without the power to change the beneficiaries during their lifetimes, is a completed gift.[9]

There are also other potential gift tax problems with Joint Trusts. For example, if the trust provides that upon the demise of the first spouse the trust becomes irrevocable and the surviving spouse has limited access to principal based upon ascertainable standards, then the surviving spouse has made a completed gift of the remainder interest of that spouse's share of the trust property to their children.

One solution would be for the trust to provide that upon the demise of the first spouse, the trust remains revocable or, in the alternative, the surviving spouse retains a limited testamentary power of appointment. With either solution, there is no completed gift and, hence, no gift taxes. Note that the gift will not qualify for the marital deduction because the donor-spouse may enjoy the trust property after the demise of the donee-spouse.[10] The gift does not qualify for the QTIP treatment because: (i) the spouse is not entitled to all the income from the trust property; and (ii) the trust principal can be distributed to the other spouse.

Since each spouse has an interest in one-half of the income from the property contributed by the other spouse, and a remainder interest in the property if the spouse survives the other, these interests can be valued using applicable IRS valuation tables. The value of the interest will be based upon the value of property contributed and the age of each spouse.[11] If the value of the gift is less than the gift tax applicable exclusion amount of $11,200,000 (in 2018) *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed),* there would be no federal gift tax due. The trust can be drafted so that the funding of the trust will be treated as an incomplete gift. The following are some examples:

1. The trust provides that each spouse has the right to withdraw all of the trust assets, without the consent of the other spouse.
2. The trust provides that each spouse has the right to withdraw his or her separate contributions to the trust at any time, without the consent of the other spouse.
3. Husband and wife create separate shares within the Joint Trust for each spouse's contributions.

Estate Taxation. The trust assets may be included in the estate of the first spouse to die because he or she retained an interest in the trust.[12] Under I.R.C. §2036, a decedent's estate includes property to the extent of any interest therein of which the decedent has retained for his/her life or for any period not ascertainable without reference to his/her death or for any period which does not in fact end before his or her death: (1) the possession or enjoyment of, or the

[8]26 C.F.R. §25.2511-2(e).

[9]26 C.F.R. §25.2511-2(f).

[10]26 C.F.R. §25.2523(b)-(1)(c).

[11]26 U.S.C.A. §7520.

[12]26 U.S.C.A. §§2036 and 2038.

right to income from, the property; *or* (2) the right, either alone or in conjunction with any person, to designate the persons who shall possess or enjoy the property or the income therefrom. Since the deceased spouse retained an interest under I.R.C. §2036, the Trust assets would be includable in his or her estate.

In addition, under I.R.C. §2038, a decedent's estate includes property as to which the decedent made a transfer and retained "alone or ... in conjunction with any other person" the power to amend or revoke. Since the deceased spouse had the right to amend or revoke the trust, the trust assets would be includable in his or her estate.

There may be some relief available to offset the inclusion of trust assets due to the contributions of assets to the trust by the surviving spouse.[13] For example, if the surviving spouse contributed 25% of the trust assets, then 25% of the trust assets should not be includable in the estate of the first spouse to die.

Assuming the estate is less than the applicable exclusion amount ($11,200,000 in 2018), there are no federal estate taxes due, and the surviving spouse will receive a step up in basis,[14] as to the appreciated trust assets to the extent that they are included in the estate of the first spouse to die.[15] Hence, there are potential income tax savings to the surviving spouse on the later sale of Trust assets.

However, there may be potential estate tax problems. For example, if the value of the trust assets appreciates to an amount in excess of the applicable exclusion amount ($11,200,000 in 2018) *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed),* then there may be federal and New York estate taxes due.[16] Additionally, if the Trust provides that the grantor's powers are limited upon disability, or, if the trust provides that the trust becomes irrevocable upon the death of the first spouse then the transfer will not qualify for the marital deduction.[17] At the death of the first spouse, there may also be a gift by the surviving spouse of his/her remainder interest if the trust restricts his/her control under certain conditions.[18]

These problems can be avoided by drafting appropriate trust provisions. For example, the husband and wife could create separate trust shares for each spouse, providing each spouse with control over his or her respective share.

Income Taxation. As a general rule, a Joint Trust will be treated as a Grantor Trust for income tax purposes. In the event the husband and wife file separate returns, then it is necessary to allocate the trust income between the husband and wife in some manner. The grantors should

[13]26 C.F.R. §20.2038-1(a).

[14]*See supra* §§20:2, 20:14; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[15]26 U.S.C.A. §1014.

[16]*See supra* §20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[17]*See supra* §20:31.

[18]*See* 26 C.F.R. §25.2511-2(f).

still retain benefits of ownership, such as deductions for real estate and mortgage interest and qualifications for the $250,000 ($500,000 for a married couple) exclusion of capital gain on the sale of the residence.[19]

Since all of the trust property is included in the estate of the first spouse to die, there is a step up in basis for the full value of the trust assets,[20] unless the trust is drafted so that only part of the trust assets are includable in the estate of the first spouse to die. In this respect, the Joint Trust operates like community property (a full step up notwithstanding ownership of only one-half of the community property). Hence, a Joint Trust may result in a full step-up in basis, while joint tenancy allows for only one-half of the value of the trust property to be increased to its fair market value.

If the contributions of the husband and wife to a Joint Trust are not segregated and each spouse has retained interests or powers over the entire trust, then all trust assets may be included in the estate of both spouses, with a full step up in basis in each estate. There may be some uncertainty as to the application of §§2036 and 2038 of the I.R.C. to both estates.

One solution may be for the trust to provide the first to die with a testamentary general power of appointment over all of the trust property. All of the trust assets would be included in the decedent's estate[21] and the trust assets would acquire a full step up in basis. This solution may backfire if the trust assets appreciate in value and exceed the applicable exclusion amount ($11,200,000 in 2018)[22] at the demise of the first spouse. The excess amount over the applicable exclusion amount ($11,200,000 in 2018) would result in federal and New York estate tax liability since this amount would not qualify for the marital deduction.[23]

Tax Analysis of Taxable Estates. A federal taxable estate is defined as a married couple's combined estate which exceeds the federal applicable exclusion amount ($11,200,000 in 2018).[24] Typically, the husband and wife create a Joint Revocable Living Trust in which they are co-trustees and each has access to either income or principal during their lifetime. Upon the demise of the first spouse, the trust provides that an amount up to the applicable exclusion amount be first funded into a separate irrevocable "Family Trust" (sometimes referred to as a By Pass or Unified Credit Shelter Trust) and the remaining assets be administered as a Revocable Trust for the surviving spouse. Upon the demise of the surviving spouse, the assets pass to the children. The entire Joint Revocable Living Trust assets will be included in the estate of the first spouse to die. The entire Trust may also be included in the estate of the surviving spouse upon his or her death.[25] The on-going revocable trust will not qualify for the marital deduction in the

[19]26 U.S.C.A. §121.

[20]26 U.S.C.A. §1014.

[21]26 U.S.C.A. §2041.

[22]*See supra* §20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[23]*See supra* §§20:2 and 20:31.

[24]*See supra* §20:20 and §20:2; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.
[25]26 U.S.C.A. §2036.

estate of the first spouse to die, if the trust provides that the surviving spouse lacks a mandatory income interest, permits distributions to children or others, or puts restrictions on the surviving spouse, if disabled.[26]

The Joint Revocable Living Trust can be drafted to avoid subjecting the trust assets to estate taxation in both estates. One alternative is to qualify for the marital deduction by providing the surviving spouse with a mandatory income interest in the revocable trust portion or whatever is necessary to qualify the trust as a QTIP trust or a general power of appointment trust.[27]

Another alternative would be to create a Joint Trust with separate shares for each spouse. In effect, a married couple will have one Revocable Trust document, but each will have a separate Revocable Trust.[28]

Income Taxation. During the lifetimes of the husband and wife, the income tax consequences of the joint Revocable Trust will be the same as in a nontaxable estate. Upon the demise of the first spouse, the Unified Credit Shelter Trust would be treated as a separate taxpayer for income tax purposes.

In an effort to simplify a married couple's estate plan by using a single Revocable Trust, the elder law attorney must be careful to create a Joint Trust which takes into account income, gift and estate tax consequences. Such a trust may end up being more complex for the client than two separate revocable Trusts.[29]

20:47. Use of Revocable Living Trusts-- Convertible Trusts

A Convertible Trust is a Revocable Trust which becomes an Irrevocable Trust upon the incompetency or disability of the grantor.[1] If the grantor is the trustee, then he/she is replaced with a successor trustee and the grantor relinquishes all ability to revoke or amend the trust upon triggering the conversion. The trust typically provides for a definition of "disability." The trust should contain a medical procedure for establishing the existence of a "disability" and a procedure for the successor trustee to step in, if not already a co-trustee with the grantor.

Upon conversion, the trust would be treated as an Irrevocable trust for gift, income and estate tax purposes. For example, trust assets will be treated as a completed gift for gift tax purposes.[2] There may also be Medicaid eligibility consequences upon the conversion.[3]

[26]26 U.S.C.A. §2056(b)(5).

[27]*See supra* §20:31 for a discussion of qualifying the Trust for the marital deduction.

[28]In community property states, the need to maintain separate shares may be less compelling because the joint Trust probably will not change the ownership character of the Trust under state law.

[29]*See* Roy M. Adams, Thomas W. Abendroth, The Joint Trust: Are You Saving Anything Other Than Paper? Trusts and Estates, 8/92, vol.131, p.39.

[1]*See infra* §21:15.

[2]26 C.F.R. §25.2511-2(f).

[3]*See infra* §21:4 for a discussion of Trigger Trusts and §21:27 for Convertible Trusts.

20:48. Irrevocable Living Trusts-- Overview

An Irrevocable Living Trust is defined as a trust in which the grantor has no power to revoke or amend the Trust. This type of trust is often set up in the context of estate tax planning, but it can also be set up in the context of asset protection planning in the event of a catastrophic illness. The latter is the major concern of elder law clients.[1]

20:49. Irrevocable Living Trusts-- Income taxation

A trust is a separate taxable entity or a conduit through which income is passed to the beneficiaries. Income generated by the trust assets is taxable to the trust, the grantor or other beneficiaries of the trust, depending upon how the trust has been structured.[1]

Income is taxable to the trust if it is accumulated by the trust. The trust can be set up so that part of the income is taxable to the trust and part taxable to the beneficiaries. Income is generally taxable to the beneficiaries to the extent that the trust actually distributes the income to them or makes it available to them. Notwithstanding the above, the grantor may be taxed on trust income in accordance with any of the Grantor Trust rules.[2] The rationale is that the grantor is considered the owner of all or a portion of the trust and thus must pay tax on the trust's income.[3] In a Medicaid asset protection context, the Irrevocable Trust is typically drafted so that the trust is treated as a "Grantor Trust."[4] This is helpful when the grantor is in a lower income tax bracket than other beneficiaries named in the trust.

20:50. Grantor trusts-- Income taxation

If a grantor retains certain powers in a trust with respect to the property transferred to the trust as provided for in the Internal Revenue Code Sections 671 to 679, then the grantor will be treated as the owner of the trust property for federal income tax purposes. This type of trust is known as "Grantor Trust."[1] The grantor will report items of income, deduction and credit associated with the trust property on his or her own individual income tax return because the trust will not be treated as an independent taxpayer.[2]

Oftentimes the tax identification number of a Grantor Trust is the social security number of the grantor in lieu of an independent tax identification number for the trust.

A grantor includes any person to the extent such person either creates a trust, or directly or indirectly makes a gratuitous transfer of property to a trust.[3] The grantor can be a beneficiary

[1]*See infra* §21:26.

[1]26 U.S.C.A. §671; *see also* Ann I. Weber, Tax Consequences of the Use of Grantor and Non-Grantor Trusts in Medicaid Planning, The Elder Law Report, 1/92, vol. III, no.6.
[2]26 U.S.C.A. §§671 to 677.

[3]I.R.C. §§671 to 677.

[4]I.R.C. §§671, 672, 674, 675.

[1]*See supra* §20:49.

[2]I.R.C. §671.

[3]Treas. Reg. §1.672-2(e)(1).

of the trust who furnishes the trust funds, even if he or she is not the grantor in the trust agreement.[4] Therefore in the context of a trust set up for the purposes of Medicaid asset protection, the Medicaid recipient does not necessarily need to be named as grantor of the Trust agreement in order to obtain Grantor Trust status. In effect, the beneficiary is deemed to be the "grantor" of a Grantor Trust.

To determine if a trust qualifies as a Grantor Trust for income tax purposes the Elder Law attorney should review and be familiar with the Internal Revenue Code Sections 673 through 679. Each code section first sets out the general rule that must be followed in order to result in Grantor Trust status and then provides exceptions to the general rule.

There are four key terms relevant to Grantor Trusts:

1. Adverse Party--any person having a substantial beneficial interest in the trust which would be adversely affected by the exercise or nonexercise of the power which he possesses respecting the trust. A person having a general power of appointment over the trust property shall be deemed to have a beneficial interest in the trust.[5]

2. Nonadverse party--any person who is not an adverse party.[6]

3. Related or subordinate party--any nonadverse party who is (a) the grantor's spouse if living with the grantor and (b) any one of the following: the grantor's father, mother, issue, brother or sister, an employee of the grantor, a corporation or any employee of a corporation in which the stock holdings of the grantor and the trust are significant from the viewpoint of voting control; a subordinate employee of a corporation in which the grantor is an executive.[7]

4. Spouse--the grantor shall be treated as holding any power or interest held by: (a) any individual who was the spouse of the grantor at the time of the creation of such power or interest; or (b) any individual who became the spouse of the grantor after the creation of such power or interest, but only with respect to periods after such individual became the spouse of the grantor.[8]

a. Any individual legally separated from his spouse under a decree of divorce or of separate maintenance shall not be considered as married.[9]

The amount of the grantor's income, deductions, and credits, and the manner in which they are reported generally depends on the ownership of the Grantor Trust assets. There are three basic types of ownership:

Grantor as owner of entire trust--If the grantor or another person is treated as the owner of an entire trust (corpus and income), then all income, deductions and credits related to the trust

[4]Rev. Rul. 85-13, 1985-C.B. 184.

[5]I.R.C. §672(a).

[6]I.R.C. §672(b).

[7]I.R.C. §672(c).

[8]I.R.C. §672(e)(1).

[9]I.R.C. §672(e)(2).

assets are reported on his individual income tax returns.[10]

Grantor as owner of specific trust property--If the grantor treats as owning only a portion of the trust property and income related to such property, then he takes into account only the income, deductions, and credit against tax, and all capital gain or loss directly related to that specific property. Any income, deductions and credits derived from assets not related to the grantor or another person are reported on the trust's income tax return.[11]

Grantor as owner of undivided fractional interest--If the portion of a trust as owned by a grantor or another person consists of an undivided fractional interest in the trust, or of an interested represented by a dollar amount, a pro rata share of each item, deduction, and credit is normally allocated to the portion.[12] The treasury regulations under Section 671 provide details as to the calculation of allocation of these amounts.

Whether or not the Elder Law attorney actually prepares the income tax returns for the grantor or the trustee of the Grantor Trust, it is important to be familiar with the various types of income tax reporting methods available to a Grantor Trust which are detailed in Treasury Regulation Section 1.671-4 “Method of reporting.” This familiarity with the relevant regulations will allow the Elder Law attorney to provide comprehensive advice to clients about the administration of Grantor Trusts and will help when drafting key provisions to the Grantor Trust.

Upon the death of the grantor there is a deemed transfer of the assets held by the Grantor Trust to a non-grantor trust. At that time the trust will need to obtain a tax identification number if it does not already have one and all income, deductions, and credits will be reported under the new tax identification number. In the year in which the grantor dies the trust or the portion of the trust deemed to have been owned by the deceased grantor continues to report in the manner previously used for the taxable year that ends with the deceased grantor's death.[13]

The income, deductions, capital gains or losses will be attributed to the trust's tax identification number and the trustee of the non-grantor trust will need to file federal and relevant state fiduciary income tax returns for each year the trust income meets the filing threshold until the trust is terminated.

20:51. Irrevocable Living Trusts-- Gift taxation-- Funding of the Trust

Upon funding of the trust, there may be gift tax consequences, depending upon the terms of the trust.[1] If there is a completed gift, then the trust beneficiaries, rather than the trust or trustee, are treated as the donees. For example, once the grantor has parted with dominion and control over the property so that the grantor cannot change its disposition, the gift is deemed completed.[2]

[10]Treas. Reg. §1.671-3(a)(1).

[11]Treas. Reg. §1.671-3(a)(2).

[12]Treas. Reg. §1.671-3(a)(2).

[13]26 C.F.R. §1.671-4(h)(2).

[1]26 U.S.C.A. §2501.

[2]26 C.F.R. §25.2511-2(b).

A gift is incomplete in every instance in which the donor reserves the power to re-vest the beneficial title of the property to him/herself. A gift is also incomplete if and to the extent that the grantor reserves a power to name new beneficiaries or a power to change the interests of the beneficiaries as between themselves, unless the power is a fiduciary power limited by a fixed or ascertainable standard.

If the grantor retains a power over the disposition of the assets, such as a testamentary limited power of appointment over the remainder upon death, then no portion of the transfer is considered a completed gift.[3] Therefore, gift taxes can be avoided upon funding of the trust or at the time a Revocable Trust becomes Irrevocable by providing for a limited power of appointment.[4] This also results in the trust assets being part of the grantor's estate.[5]

20:52. Irrevocable Living Trusts-- Gift taxation-- Distributions from the Trust

If the transfers of assets funding the trust were classified as "completed gifts" subject to gift tax, then the distributions from the trust are not "gifts."[1]

If the transfers funding the trust were classified as "incomplete gifts" and hence not subject to gift tax, then the distributions from the trust are treated as "gifts."[2]

20:53. Irrevocable Living Trusts-- Estate taxation

If the gift is incomplete or if the grantor has retained powers over the transferred property under I.R.C. §§2035 to 2042, such property will be included in the grantor's estate at death.[1]

For example, if the grantor retains a limited right to change the beneficiaries of the trust property, then the trust property will be includable in the estate.[2] Another example is if the grantor reserves an income interest for his/her life, then the trust will be fully includable in the grantor's gross estate for estate tax purposes.[3] In such event, the beneficiaries will receive the property with a full step up in basis.

20:54. Medicaid Asset Protection Trust

Income Tax. A Medicaid Asset Protection Trust can be structured as a Grantor Trust for income tax purposes under Internal Revenue Code §§671 to 678. The two most common provisions which will taint the trust as a Grantor Trust are the following:

1. The power to add charitable beneficiaries (I.R.C. §674).

[3]26 C.F.R. §25.2511-2(c).

[4]*See supra* §20:30 regarding Medicaid consequences.

[5]*See supra* §20:53.

[1]*See generally* 26 C.F.R. §25.2511-2(b).

[2]26 C.F.R. §25.2511-2(f).

[1]26 U.S.C.A. §§2035 to 2042.

[2]*See supra* §20:51.

[3]26 U.S.C.A. §2036(a)(1).

2. The power to substitute property of equivalent value under Internal Revenue Section 675(4)(C).

Please note that either of these power provisions may be challenged by the local Medicaid agency as to disqualifying the Trust; thus rendering the trust assets available for purposes of Medicaid eligibility, even though the authors do not believe that such a challenge will prevail. From a drafting standpoint, it may be less aggressive to choose on provision versus both provisions which create Grantor Trust status for income tax purposes.

Gift Tax. A Medicaid Asset Protection Trust can be used to achieve eligibility for Medicaid while protecting assets (subject to the Medicaid transfer penalty rules) without gift tax consequences. This can be achieved by having the grantor retain a testamentary right to change the beneficiaries of the trust, limited to a class of beneficiaries, excluding the grantor, the grantor's estate and creditors of the grantor or the grantor's estate.

Medicaid Asset Protection Trusts may also be used to achieve Medicaid eligibility subject to the gift tax laws. Contributions to the trust (i.e., gifts) may qualify for the $15,000 annual exclusion in 2018,[1] as long as the present interest requirement is satisfied. There are several methods of satisfying this requirement, such as: (i) providing for "Crummey Powers" in the trust wherein the beneficiary is given the right to demand an amount of corpus equal to the annual gift tax exclusion;[2] or (ii) mandating the distribution of income to the beneficiary of the trust.[3] However, such contributions will be considered transfers for Medicaid eligibility purposes.[4]

Contributions to the trust (i.e., gifts) may also qualify for the marital deduction if any distribution to a spouse constitutes qualified terminable interest property (QTIP).[5]

Estate Tax. A Medicaid Asset Protection Trust can be structured so that the trust assets are included in the estate of the grantor for federal and New York State estate taxes.[6] This will allow the beneficiary of the trust assets to receive a step up in basis which can save capital gains taxes on the sale of the assets.[7]

[1]*See supra* §15:21.

[2]*See* Crummey v. C.I.R., 397 F.2d 82, 68-2 U.S. Tax Cas. (CCH) 12541, 22 A.F.T.R.2d 6023 (9th Cir. 1968); Estate of Cristofani v. C. I. R., 97 T.C. 74, Tax Ct. Rep. (CCH) 47491, Tax Ct. Rep. Dec. (P-H) 97.5, 1991 WL 137858 (1991), acquiescence in result only recommended, AOD-1992-9, 1992 WL 794826 (I.R.S. AOD 1992) and acq., 1992-2 C.B.1 and acquiescence in result only recommended, AOD-1996-10, 1996 WL 390089 (I.R.S. AOD 1996) and acq., 1996-2 C.B.1.

[3]*See* Swetland v. C.I.R., T.C. Memo. 1978-47, T.C.M. (P-H) 78047, 37 T.C.M. (CCH) 249, 1978 WL 2754 (1978), recommendation regarding acquiescence, AOD-1983-65, 1983 WL 203726 (I.R.S. AOD 1983).

[4]*See supra* §14:28.

[5]26 U.S.C.A. §2523.

[6]26 U.S.C.A. §§2035 to 2038.

[7]26 U.S.C.A. §1014.

20:55. Use of Special Needs Trusts under OBRA 1993-- Overview

Dramatic changes were made with regard to the treatment of trusts for Medicaid eligibility purposes when the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93") was signed into law by President Clinton on August 10, 1993.[1] Many elder law practitioners considered this law to be an attack on trusts, since many restrictions were placed on the use of trusts within the context of the elder law practice.

The Special Needs Trust is a trust funded with the assets of a disabled individual under the age of 65 which is established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court, provided the state receives all amounts remaining in the trust upon the death of the disabled individual, up to an amount equal to the total medical assistance paid on behalf of the individual.[2]

The use of the Special Needs Trust can be an important planning tool to protect damages recovered in personal injury and medical malpractice lawsuits. This type of Trust can also be useful in the context of inheritances or to protect the assets possessed by a disabled senior at the time the disability is incurred.

Elder law attorneys are often asked by personal injury and medical malpractice attorneys to assist them in the structuring of the settlements of tort actions with the objective of optimizing the disabled person's recovery by maintaining eligibility for government programs such as Medicaid. This analysis must not only address entitlement planning, but also tax planning. The income, gift and estate tax implications of structured settlements need to be determined when the payments are made to a Special Needs Trust.[3]

It will be important for the elder law attorney to have a complete understanding of the tax and entitlement issues surrounding Special Needs Trusts. It is equally important to understand that the use of these trusts under OBRA '93 presents a wonderful opportunity for all elder law practitioners to advocate on behalf of the disabled and insure them a better quality of life.

20:56. Use of Special Needs Trusts under OBRA 1993-- Income taxation

Settlement Payments to an Individual. When an individual is to receive payment of a monetary award, whether as a lump sum or as periodic payments, as a result of damages received from a personal injury or medical malpractice action, how is such an award to be treated for income tax purposes? Generally, gross income includes all income from whatever source derived.[1] However, gross income does not include any damages received due to personal injury or sickness.[2]

[1]*See infra* §21:20.

[2]*See* 42 U.S.C.A. §1396p(d)(4)(A).

[3]Hindert, Rehner, Hindert, Structured Settlements and Periodic Payment Judgments, (1994) (Law Journal Seminars-Press, originally published in 1986); and Howard J. Atlas and Vincent J. Russo, The Tax Implications of the OBRA-93 Disability Trust, (May 1995) (The ElderLaw Report, Volume VI, Number 10).

[1]26 U.S.C.A. §61(a).

[2]26 U.S.C.A. §104(a)(2).

Periodic payments can provide the individual with disabilities with an opportunity for federal income tax savings that does not exist with a lump sum settlement, since the interest realized from investing the lump sum is not excluded from gross income.[3] Periodic payments, which include investment interest, are "exempt income" and thus are excluded from income taxation.[4] One issue for the practitioner to consider is whether or not an assignment of the periodic payments to a trust taints the tax-exempt status of the payments.[5] If payments are made to a "Grantor Trust" the payments should continue to be excluded because the disabled individual is treated as the owner of the trust for income tax purposes.[6]

Punitive damages recovered in a case not involving physical injury or sickness may not be excluded.[7] The law is currently unsettled however, as to whether punitive damages recovered in a case involving physical injury or sickness may be excluded from income. The IRS and the Tax Court have taken contrary positions. The IRS has stated that punitive damages are always included in gross income,[8] while a federal district court in Alabama and the Tax Court have ruled that all punitive damages are excludable regardless of whether they are compensatory or not, as long as the underlying claim qualifies as a personal injury pursuant to I.R.C. §104(a).[9] There is a small, but growing number of cases supporting this exclusion.[10]

Settlement Payments to the Special Needs Trust. Once the payments from the settlements are funded into the Special Needs Trust,[11] counsel must consider who will be taxed on the interest and dividends that the Trust assets generate. From a tax planning standpoint, under most circumstances, it is preferable for the tax to be reported by the disabled individual, instead of the Trust itself, since under current tax law the trust's higher tax brackets apply at lower levels of taxable income than for individuals.[12] The 2018 federal income tax rates range from 10% to 37% for individuals and 10% to 37% for trusts. An individual filing with the single filing status (i.e., other than surviving spouses and heads of household) will reach a 37% tax

[3]*See* Rev. Rul. 65-29, 1965-1 C.B. 59.

[4]26 U.S.C.A. §104(a)(2).

[5]26 U.S.C.A. §104(a)(2).

[6]26 U.S.C.A. §104(a)(2).

[7]26 U.S.C.A. §104(a).

[8]Rev. Rul. 84-108, 1984-2 C.B. 32.

[9]*See* Burford v. U.S., 642 F. Supp. 635, 86-2 U.S. Tax Cas. (CCH) 9724, 58 A.F.T.R.2d 86-5821 (N.D. Ala. 1986).

[10]*See* Horton v. C.I.R., 100 T.C. 93, Tax Ct. Rep. (CCH) 48856, Tax Ct. Rep. Dec. (RIA) 100.8, 1993 WL 28557 (1993), aff'd, 33 F.3d 625, 94-2 U.S. Tax Cas. (CCH) 50440, 74 A.F.T.R.2d 94-5934, 1994 FED App. 0301P (6th Cir. 1994).

[11]*See infra* §21:10.

[12]26 U.S.C.A. 1§(j), as added by the Tax Cuts and Jobs Act.

bracket at $500,000 of taxable income (in 2018), while a trust will reach the same bracket at a taxable income of only $12,500 (in 2018).[13]

In order for the trust income to be considered taxable to the disabled individual at the lower tax rate, the trust must be considered a "Grantor Trust" for income tax purposes.[14] To ensure Grantor Trust treatment, the disabled individual need not be named as grantor of the Trust document. The grantor of a trust can be the disabled beneficiary of the trust who furnishes the trust funds, not necessarily the individual named as grantor in the trust agreement.[15]

A Grantor Trust can be best described as a trust under which the individual has retained some level of interest or control in the trust which causes that individual to be considered the owner of the trust property. To ensure that the disabled individual is taxed on the trust income, it is critical that the trust be drafted in accordance with the Grantor Trust rules.[16]

The following are two suggestions for provisions the practitioner may want to utilize within the trust document to secure Grantor Trust status:

1. The trust may include a provision that would allow the disabled individual an unrestricted power to remove, substitute or add trustees and to designate any person including himself or herself as the replacement trustee. This type of power is deemed to be a "right to control the beneficial enjoyment of the trust property."[17] With this power, income will be taxed to the grantor.[18]

2. The trust may provide the disabled individual with a certain administrative power, such as the power to reacquire trust corpus by substituting other property of equal value.[19] With this administrative power, the trust income will be taxed to the grantor.[20]

Furthermore the IRS has held that for income tax purposes a minor will be treated as the owner of a trust which is created for the minor's benefit by court order as a result of a personal injury suit filed on the minor's behalf, if the trust contains provisions that fall under the Grantor Trust rules.[21]

20:57. Use of Special Needs Trusts under OBRA 1993-- Gift taxation

[13]26 U.S.C.A. §1(j), as added by the Tax Cuts and Jobs Act..

[14]26 U.S.C.A. §§671 to 677.

[15]*See* Blackman v. U.S., 98 Ct. Cl. 413, 48 F. Supp. 362, 43-1 U.S. Tax Cas. (CCH) 10010, 30 A.F.T.R. (P-H) P 846 (1943); *see also* Priv. Ltr. Rul. 9004007.

[16]26 U.S.C.A. §§671 to 677.

[17]26 C.F.R. §1.674(d)-2.

[18]26 U.S.C.A. §674.

[19]26 U.S.C.A. §675(4).

[20]26 U.S.C.A. §675.

[21]26 U.S.C.A. §§671 to 677; *see also* Rev. Rul. 83-25, 1983-1 C.B. 116; Priv. Ltr. Ruls. 9502019, 9502020, 9502024, 9502029, and 9502031.

With regard to gift tax liability, one must determine upon the payment of settlement proceeds into the Special Needs Trust whether a completed gift has been made by the person with disabilities. Generally, the essential elements of a valid *inter vivos* gift are:

1. a donor competent to make the gift;
2. a clear and unmistakable intention on his or her part to make it;
3. a donee capable of accepting the gift;
4. a conveyance, assignment, or transfer sufficient to vest the legal title in the donee, without power of revocation at the will of the donor; and
5. a relinquishment of dominion and control of the subject matter by delivery to the donee.[1]

The transfer of property constitutes a completed gift to the extent that the donor has parted with dominion and control of the property so as to leave him or her without a power to change the disposition, whether for his or her own benefit, or for the benefit of another.[2]

Since the Special Needs Trust must provide for a pay back to the State for Medicaid paid during the individual's lifetime, the funding of the trust with the assets of the individual will be treated as an incomplete gift. Under Rev. Rul. 76-103, when a trust allows for the grantor's creditor to be paid from the trust, then the funding of the trust is an incomplete gift. In addition, if the Special Needs Trust provides for the trust assets to pass to the grantor's estate on his or her demise, then the trust assets will be treated as an incomplete gift due to this reversion.[3]

To avoid the gift question entirely, the attorney should draft the trust document properly to insure that the funding of the Trust is not a completed gift. If the individual who is disabled retains a power over the disposition of trust assets, such as a testamentary power of appointment over the remainder upon death, then no portion of the funding should be considered a completed gift.[4]

Even if the individual who is disabled does not have the requisite legal capacity to execute a Last Will and Testament and thus, cannot exercise the limited power of appointment, the funding of the trust can still be considered an incomplete gift. Current case law and an IRS Revenue Ruling have taken the position that the mere possession at death of the power, rather than the exercise of, or inability to exercise the power, is the proper criterion to examine whether the transfer to the Trust is an incomplete gift.[5]

20:58. Use of Special Needs Trusts under OBRA 1993-- Estate taxation

Generally, if the individual who is disabled has retained an interest in the trust or sufficient powers over the trust property, then the trust will be included in the estate of the person

[1]Edson v. Lucas, 40 F.2d 398, 8 A.F.T.R. (P-H) 10743 (C.C.A. 8th Cir. 1930).

[2]26 C.F.R. §25.2511-2(b).

[3]Treas. Reg. §20-2511-2(c).

[4]26 C.F.R. §25.2511-2(b), *see also* Priv. Ltr. Rul. 9437034.

[5]*See* Boeving v. U.S., 650 F.2d 493, 81-2 U.S. Tax Cas. (CCH) P 13415, 48 A.F.T.R.2d 81-6248 (8th Cir. 1981).

with disabilities.[1] All assets in which an individual has an interest at the time of death, are part of his or her gross estate for purposes of estate taxation.[2] Conversely, if the individual who is disabled has retained no interest in, or control over the trust property, the funding of the trust could be considered a completed gift subject to gift tax and not part of the estate for estate tax purposes. As a result, the drafting of the trust agreement can have a significant impact on the gift and estate tax consequences of the trust.

Assets of the Special Needs Trust will be included in the estate of the individual who is disabled if: (i) the trust assets will be distributed to his or her estate;[3] or (ii) that individual retains a limited power of appointment over the trust assets. Drafting the trust to allow the individual who is disabled the power to determine who will receive the remainder of the trust property at his or her death, would cause estate inclusion pursuant to I.R.C. §2036(a)(2).

The IRS has officially agreed with this position in a private letter ruling.[4] This private letter ruling involved a personal injury settlement paid into an Irrevocable Trust for the benefit of a child who is disabled. The IRS held that the trust assets were includable in the disabled child's estate since the decedent child retained a special testamentary power of appointment over the trust (the power to alter the disposition of the trust corpus at his death). Thus, the transfer of the funds into the trust constituted an incomplete gift[5] and the trust corpus was includable in the child's estate.[6]

In Technical Advice Memorandum 9506004, issued November 1, 1994, the Internal Revenue Service took the position that the settlement proceeds of a tort action brought on behalf of a minor and placed in two irrevocable trusts by his guardians were includable in the minor's gross estate for estate tax purposes. The proceeds were includable not only under I.R.C. §2038 due to a testamentary power of appointment, but also under I.R.C. §2036 because the trust corpus could be consumed for the minor's needs. Under the terms of the trust agreement, the trustees had broad discretion to distribute income or principal for the minor. In a recent U.S. Court of Claims case, the court held that the trust assets of a Supplemental Needs Trust were included in the decedent's estate for estate tax purposes.[7]

If the estate of an individual who is disabled is valued under the applicable exclusion

[1]26 U.S.C.A. §§2033 to 2041.

[2]26 U.S.C.A. §2033.

[3]I.R.C. §2037

[4]Priv. Ltr. Rul. 9437034.

[5]26 U.S.C.A. §2511.

[6]26 U.S.C.A. §2038.

[7] Arrington v. U.S., 34 Fed. Cl. 144, 95-2 U.S. Tax Cas. (CCH) 60212, 76 A.F.T.R.2d 95-6762 (1995), aff'd, 108 F.3d 1393, 97-1 U.S. Tax Cas. (CCH) 60260, 79 A.F.T.R.2d 97-1341 (Fed. Cir. 1997).

amount ($11,200,000 in 2018),[8] then there is no federal estate tax.[9] If the date of death value of the trust is over the applicable exclusion amount, then the attorney must consider debts and expenses which will reduce the gross estate subject to tax. These include the claim of the state for medical reimbursement under the Medicaid program, as well as other debts and administrative expenses, which will reduce the gross estate[10] subject to estate taxation. If the estate is reduced to the applicable exclusion amount ($11,200,000 in 2018)[11] or less, then there would be no federal estate tax to be paid because of the applicable federal applicable exclusion.[12]

Estate Inclusion--Future Periodic Payments. If a personal injury lawsuit settlement is structured so that annuity payments continue to be paid to a disabled individual's parents upon his or her demise, the present value of the annuity payments to be received by the parents (the remainder beneficiaries) is included in the decedent's estate.[13]

Since the remaining annuity payments are includable in the disabled individual's estate, the continued payment stream must be valued. There are three potential approaches to valuing the amount to be included in the decedent's estate:

1. The cost of a commercial annuity;[14]
2. The value based on discounting future payments at 120% of the average federal midterm rate[15] on the date of death;[16] or
3. The price a willing buyer would pay a willing seller for the right to receive future payments.[17]

Although not involving periodic payments of personal injury settlements, two Tax Court

[8]*See supra* §20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[9]26 U.S.C.A. §2010. *See supra* §20:2.

[10]26 U.S.C.A. §2053.

[11]*See supra* §20:20 and §20:2; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[12]Please note that an estate of $11,200,000 would generate a New York State estate tax of $1,258,800 for estates from April 1, 2017, through December 31, 2018.

[13]26 U.S.C.A. §2039.

[14]26 C.F.R. §20.2031-7.

[15]The federal midterm rate is promulgated on a monthly basis. *See* Rev. Rul. 2017-2, for January 2017 Rates. This rate is to assist in valuations for gift and estate tax purposes. 26 U.S.C.A. §§7520 and 1274(d)(1).

[16]26 U.S.C.A. §7520.

[17]26 C.F.R. §20.2031-1(b).

cases valued continuing annuity payments at the cost of a commercial annuity and not pursuant to the willing buyer/willing seller rule.[18] It is likely that the IRS will utilize the commercial annuity valuation or at a minimum, the valuation specified under I.R.C. §7520 and resist applying the willing buyer/willing seller approach.

If the settlement is structured as a payment stream which continues paying the deceased disabled individual's family over a number of years, there may be insufficient trust assets to pay the estate tax which is due within nine months after the decedent's death. Under this scenario, the estate may request that the estate tax be paid in installments over time.[19] If the IRS grants this request, there will be no penalty for not paying the estate tax within nine months from the decedent's date of death, but interest will have to be paid on each installment.[20]

20:59. Third-Party Trusts

Third-Party Trusts are set up by the grantor for the benefit of a third party. Typical situations in which Third-Party Trusts are used in an elder law practice would be where: (a) a spouse sets up a trust for the benefit of the other spouse;[1] (b) a child sets up a trust for his or her elderly or disabled parent; or (c) a parent sets up a trust for the special needs of a disabled child.[2] The trust usually provides for discretionary powers in the trustee to utilize income or principal for the benefit of a primary beneficiary, without replacing any government benefits. This type of trust is sometimes referred to as a "Third-Party Supplemental Needs Trust." This type of trust can be invaluable in protecting assets in the event that the third-party/beneficiary requires long term care.[3]

All of the trust tax rules apply to the Third-Party Trust.[4] Hence, taxation may depend upon on a number of factors such as grantor retained powers.

20:60. Use of Bypass/Marital Trusts

One common estate planning technique for married couples is to have wills or Living Trusts which contain Marital and/or Bypass Trusts (sometimes referred to as A/B Trusts

[18]Estate of Bell v. U.S., 80-2 U.S. Tax Cas. (CCH) 13356, 46 A.F.T.R.2d 80-6148, 1980 WL 1700 (E.D. Wash. 1980); Estate of Raimondi v. C.I.R., T.C. Memo. 1970-25, T.C.M. (P-H) 70025, 29 T.C.M. (CCH) 70, 1970 WL 1529 (1970).

[19]26 U.S.C.A. §6166.

[20]*See supra* §20:34.

[1]*See infra* §22:4.

[2]*See infra* §22:7.

[3]Estates, Powers and Trust Law §7-1.12 (McKinney's 1996 Interim Update); *see also* Estate of Escher, 94 Misc. 2d 952, 407 N.Y.S.2d 106 (Sur. Ct. 1978), decree aff'd by, 75 A.D.2d 531, 426 N.Y.S.2d 1008 (1st Dep't 1980), order aff'd, 52 N.Y.2d 1006, 438 N.Y.S.2d 293, 420 N.E.2d 91 (1981).

[4]*See supra* §§20:42 to 20:54 and *infra* §20:60.

respectively).[1]

In this type of plan, the first applicable exclusion amount ($11,200,000 in 2018) is first placed in the Bypass Trust which is subject to estate tax but is offset by the applicable credit amount,[2] which is the equivalent of $11,200,000. This allows the assets in the Bypass Trust to pass free of federal estate tax to the family upon the surviving spouse's demise.

The assets in excess of the applicable exclusion amount ($11,200,000 in 2018) are placed in the Marital Trust.[3] One type of Marital Trust is the Qualified Terminable Interest Property ("QTIP") Trust. This is the most commonly used form of Marital Trust. If a QTIP election is made by the executor of the estate of the first spouse to die, then the Marital Trust is not subject to estate tax, but will be taxed in the estate of the surviving spouse.[4] This amount can then be offset by the surviving spouse's federal applicable exclusion amount ($11,200,000 in 2018).[5] If certain requirements are met, the tax treatment above can be achieved with both trusts structured for the primary benefit of the surviving spouse during his or her lifetime.

This plan will allow a married couple to pass $11,200,000 (in 2018) of assets free of federal estate tax.[6]

Often, there must be a restructuring of ownership of the married couple's assets in order to achieve these estate tax savings. In a joint estate of $22,400,000 or more (in 2018), each spouse must have at least $11,200,000 in his or her name in order to maximize the use of the $11,200,000 federal exclusion amount *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed)* in the estate of the first spouse to die. Notwithstanding the above, for spouses who die in 2018, the estate of the deceased spouse can elect to have any unused applicable estate exclusion carried over to the estate of the surviving spouse (“portability”), subject to certain restrictions.[7]

20:61. Use of Bypass/Marital Trusts-- Bypass Trusts: Overview

[1]*See infra* §21:16.

[2]26 U.S.C.A. §§2010 and 2505; *see supra* §20:20;The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[3]26 U.S.C.A. §2056, *see infra* §20:62 for definition of Marital Trust; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[4]26 U.S.C.A. §2056(b)(7); 26 U.S.C.A. §2044.

[5]*See supra* §§20:2 and 20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[6]*See supra* §§20:20 and 20:37; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[7]*See supra* §20:2.

The purpose of a Bypass Trust[1] is to allow assets to be available to a beneficiary such as a surviving spouse, without the assets being included in his or her estate. A Bypass Trust (sometimes referred to as a "Credit Shelter Trust") can be funded while the grantor is alive through the use of a Living Trust or upon the grantor's demise under his or her last Will and Testament. This device is typically used when there is a spouse and should be considered when the estate is over the federal applicable exclusion amount ($11,200,000 in 2018).[2]

Instead of passing the federal applicable exclusion amount ($11,200,000 in 2018) *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed)* outright to a beneficiary (other than a spouse), the amount is placed in a trust, typically for the benefit of a surviving spouse. This trust can be wholly discretionary or provide for mandatory distributions of income or a portion of the principal to the trust beneficiaries.

20:62. Use of Bypass/Marital Trusts-- Marital Trusts: Overview

A Marital Trust can be defined as a trust set up for the benefit of the surviving spouse, which qualifies for the marital deduction.[1] This trust can be a Living Trust or a Testamentary Trust under a Last Will and Testament. Typically, the trust will provide for the surviving spouse to have a lifetime income interest and a limited power of appointment to alter the beneficiaries to a limited class of beneficiaries, excluding the surviving spouse and his or her estate and respective creditors. Upon the demise of the surviving spouse, the trust property is distributed to settlor's children.

The gift will qualify for the marital deduction if the trust property is "Qualified Terminable Interest Property" ("QTIP"). The grantor spouse must elect to qualify such interest and certain other prerequisites must be met:[2]

1. First, the spouse must be entitled, for a period measured solely by the spouse's life, to all of the income from the entire interest, or all of the income from a specific portion thereof, payable annually or at more frequent intervals. A usufruct interest in property will also qualify. An income interest granted for a term of years, or life estates subject to termination upon remarriage or the occurrence of a specified event, will not qualify.
2. Second, there must be no power in any person (including the spouse) to appoint any part of the property to any person other than the spouse during the spouse's life.

If these tests are met, then the surviving spouse has a "qualifying income interest for life."

The trustee may be permitted to invade corpus for the benefit of the spouse, but the value of property distributed to the spouse is subject to estate tax upon the spouse's death (or gift tax if

[1]*See infra* §21:29 for a detailed discussion of Bypass Trusts and *see infra* §20:68 for an example of the use of the Bypass Trusts in the context of generation skipping.

[2]*See supra* §§20:2 and 20:20; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[1]26 U.S.C.A. §2523.

[2]26 U.S.C.A. §§2056 and 2523; *see also* Estate of Lamude, 4/8/2002 N.Y.L.J. 31, col. 4 (Surr. Ct. Queens County).

the spouse makes an earlier disposition). The settlor can create or retain powers over all or a portion of the corpus, provided such powers are exercisable only at or after the death of a spouse.

A QTIP trust may provide that the principal of the trust can be utilized for supplemental needs of the spouse without adversely affecting government benefits.[3]

Property which the settlor elects to be treated as qualified terminable interest property will be subject to transfer taxes at the earlier of: (1) the date on which the donee spouse disposes (either by gift, sale or otherwise) of all or part of the qualifying income interest for life; or (2) upon the donee spouse's death.

20:63. Use of Bypass/Marital Trusts-- Will versus Living Trust format

There are advantages and disadvantages to using a Will versus a Living Trust. Each case must be analyzed on an individual basis.[1] There can be different tax and Medicaid consequences.

20:64. Use of Bypass/Marital Trusts-- Trusts set up by a well spouse for a dying spouse

Where a well spouse has assets in excess of the federal applicable exclusion amount ($11,200,000 in 2018)[1] and a dying spouse has no assets, the objective is to maximize the applicable exclusion of the dying spouse for estate tax purposes.

Trust Provisions. The well spouse can set up a trust for the benefit of the dying spouse which qualifies for the marital deduction under I.R.C. §2523. For example, the trust could be funded with the assets in excess of the federal applicable exclusion amount ($11,200,000 in 2018).[2] The dying spouse will be given a lifetime income interest and a limited power of appointment to alter the beneficiaries to a limited class of beneficiaries excluding the dying spouse and his or her estate and respective creditors. Upon the demise of the dying spouse, the trust property is distributed to Settlor's children.

Marital Deduction. The gift will qualify for the marital deduction if the property is "Qualified terminable interest property" ("QTIP").

The grantor spouse must elect to qualify such interest and certain other prerequisites must be met.[3]

[3]*See* T.A.M. 199932001.

[1]*See infra* Living Trusts Ch 21 and Wills, Waivers and Renunciations Ch 22.

[1]*See supra* §20:20 for an explanation of the credits against federal gift and estate taxes and *infra* §20:77 for a schedule of Federal and N.Y.S. Gift and Estate Applicable Exclusion Amounts. *See also supra* §20:2 for 2010 federal estate tax repeal and carryover basis rules; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[2]*See supra* §20:20 for an explanation of the credits against federal gift and estate taxes and *infra* §20:77 for a schedule of Federal and N.Y.S. Gift and Estate Applicable Exclusion Amounts. *See also supra* §20:2 for federal estate tax changes for years 2010 through 2018; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[3]*See supra* §20:62.

The trustee may be permitted to invade corpus for the benefit of the spouse, but depending on the scope of the trustee's discretion, there may be adverse Medicaid consequences.

For decedent's dying in 2011 and thereafter, for example, if both spouses die in 2015, then the estate of the first spouse can elect to have the unused applicable exclusion amount carried over to the estate of the second spouse to die.[4]

20:65. Planning for the wealthy senior

It is critical for seniors with taxable estates to consider estate tax planning to minimize estate taxes. In addition to the use of Bypass/Marital Trusts,[1] there are a number of other planning techniques available. This chapter briefly highlights a few of the more popular ones. In addition to those mentioned, the use of family limited partnerships, private annuities and self-cancelling installment notes are also available as planning techniques to reduce estate taxes.

20:66. Planning for the wealthy senior-- Use of Grantor Retained Trusts

The senior can reduce his/her estate subject to tax by leveraged gifts to a particular type of Living Irrevocable Trust (referred to as a "Grantor Retained Trust"). There are several types of Grantor Retained Trusts available under Chapter 14 of the Internal Revenue Code, including the Grantor Retained Annuity Trust ("GRAT"), the Grantor Retained Unitrust ("GRUT"), the Personal Residence Trust ("PRT") and the Qualified Personal Residence Trust ("QPRT").[1]

GRATs and GRUTs. A Grantor Retained Annuity Trust ("GRAT") is an Irrevocable Trust in which the grantor retains the right to receive a fixed return on an annual basis for a fixed period of time (the "term").[2] Certain requirements must be met in order to reduce the value of the transfer by the value of the remainder interest for gift tax purposes.[3]

For example, the grantor can retain the right to receive a 5% annual return on the value of the trust for a ten-year term. Upon the expiration of the term, the grantor would no longer have an interest in the trust. At that point, the trust assets would not be includable in the grantor's estate because he would no longer retain an interest in the trust.[4]

The gift would be discounted because of the senior's term interest in the trust. The assets in the trust would be includable in the senior's estate if the senior does not outlive the fixed term (i.e., 10 years).[5] The trust can provide for a payout of the remaining term which may result in less than the full value of the trust being included in the estate. The amount included is the amount of GRAT principal that is needed to obtain the annuity payment that has been made on

[4]*See supra* §20:2. 26 U.S.C.A. §2010(c)(5)(A). *See* http://www.irs.gov/pub/irs-drop/n-2011-82.pdf.

[1]*See supra* §20:60.

[1]*See infra* §21:9.

[2]26 U.S.C.A. §2702(b).

[3]26 C.F.R. §25.2702-3.

[4]26 C.F.R. §25.2702-3.

[5]26 U.S.C.A. §7520.

the date of the settlor's death, using the §7520 rate that is in effect on the date of settlor's death.[6]

If a senior (age 72) funds the trust with $1,570,192 in liquid income producing assets and the term is eight years with a 5% annual return and a §7520 rate[7] of 2.20%, then the value of the assets contributed to the trust for gift tax purposes is $1 million.[8] If the senior survives the term, $400,000 in federal and New York State estate taxes would be saved by the establishment of the GRAT. The estate tax savings calculation assumes the current top estate tax rates and the state death tax deduction. The tax savings may be even greater if a combination of trust income and the trust asset appreciation exceeds a rate of 2.2% per annum.[9]

The tax benefits of a Grantor Retained Unitrust ("GRUT") are similar to those of a GRAT.[10] The trusts differ in that the GRUT must provide the grantor with a fixed annual (or more frequent) payment based upon a fixed percentage of the fair market value of the trust, valued annually.[11] The amount paid will, therefore, vary depending on the value of the trust assets. Whereas the GRAT pays a fixed return, without regard to the actual performance of the trust investments, the GRUT is market sensitive and varies the payment to the grantor according to the value of the trust assets. The GRUT will set a fixed percentage of value that is paid each year, and this fixed percentage is generally based upon the anticipated income of the trust. The GRUT provides a little more flexibility than the GRAT, in that payments to the grantor will increase or decrease as the value of the trust assets increase or decrease. Because this is a Grantor Retained Trust, a value is placed on the income retention provisions, which is then used to reduce the value of the gift created by funding the trust. The value is computed in the same way the value is computed for the annuity trust.

In the GRUT (similar to the GRAT), the trustee must make payments to the grantor for a defined period of time. If the grantor outlives the defined period, the assets in the trust will not be considered part of his or her estate for tax purposes. If the grantor does not survive the defined period established by the trust, the assets remain part of his or her estate subject to estate taxes. The tax results may vary depending on the trust provisions.

Once again, the maximum gift tax reduction is obtained by a combination of a higher percentage of payout to the grantor and a longer defined period. Obtaining the maximum gift tax reduction must be balanced against the actual earnings and value of the trust and the life expectancy of the grantor. Establishing the appropriate defined benefit period includes a degree of guess work. In order to keep the assets out of the grantor's estate, most elder law attorneys will

[6]I.R.B. 2007-28, REG-119097-05.

[7]The federal mid-term rate is calculated on a monthly basis. The §7520 rate is 120% of the applicable federal mid-term rate; 26 U.S.C.A. §§7520 and 1274(d)(1).

[8]Note: the applicable exclusion amount for federal gift tax purposes is $11,200,000 (estimated) for 2018; however, the actual inflation adjusted amount has not yet been confirmed . *See supra* §20:20.

[9]*See infra* §20:70 for a GRAT Worksheet.

[10]*See supra* §20:66.

[11]26 U.S.C.A. §2702(b)(2).

lean toward a shorter rather than a longer defined benefit period. However, the shorter the period, the lower the gift tax reduction, and the lower the savings to the grantor and his estate. As with all Grantor Retained Trusts, a balance must be achieved to maximize the federal gift and estate tax benefits. For example, a five-year term is likely more appropriate than a 10-year term for an individual aged seventy (70).

When estate tax planning involves the senior's residence, counsel must consult Chapter 14 of the I.R.C. which provides for the PRT and QPRT, discussed below. The QPRT tends to be more flexible because the trustee can sell the residence and convert the Trust to a GRAT.

QPRT. A Qualified Personal Residence Trust ("QPRT") is an Irrevocable trust which allows a senior to place his/her residence in trust for his/her use during a fixed period of time (the "term").[12] Certain requirements must be met in order to reduce the value of the transfer for gift tax purposes. For example, the residence must be held for the grantor's primary use and is not to be occupied by any other person (other than a spouse or a dependent), and the residence is to be available at all times for the grantor's use.[13]

The value of the gift (i.e., the residence) is reduced by the value of the grantor's term interest for gift tax purposes. If the grantor lives through the end of the term, an additional savings is achieved because the residence will not be considered part of the grantor's estate.[14] If the grantor fails to survive the term, the residence may be included in his or her estate. This necessitates a balancing when selecting an appropriate term. When the QPRT has a longer term, the value of the gift to the QPRT will be smaller. The smaller gift results in a greater reduction of the gift tax. However, the length of the term must be balanced against the grantor's life expectancy, because unless he or she outlives the term, there may be no estate tax savings.

If the trust is properly structured as a Grantor Trust, the residence can qualify for the $250,000 exclusion of capital gain (assuming the grantor satisfies the requirements under I.R.C. §121 and the trust is a grantor type trust as to income and principal).

Charitable Remainder Trust (CRT). This type of trust, as defined in I.R.C. §664, is designed for the individual who is interested in supporting a charity and who has significant income tax liability or highly appreciated assets. The trust must provide for the distribution of a specified payment, at least annually, to one or more persons (at least one of which is a non-charitable beneficiary).

The payment period must be for the life or lives of the individual beneficiaries (all of whom must be living at the time the Trust is created) or for a term of years, not in excess of 20 years.

Upon the termination of the non-charitable interest or interests, the remainder must either be held in continuing trust for charitable purposes or be paid to or for the use of one or more organizations described in I.R.C. §170(c).

[12]*See* 26 C.F.R. §25.2702-5(c). For an example of the gift and estate tax consequences of a Qualified Personal Residence Trust, *see* §20:71 for a QPRT worksheet.

[13]*See* 26 C.F.R. §25.2702-5(c). For an example of the gift and estate tax consequences of a Qualified Personal Residence Trust, *see* §20:71 for a QPRT worksheet.

[14]*See* 26 C.F.R. §25.2702-5(c). For an example of the gift and estate tax consequences of a Qualified Personal Residence Trust, *see* §20:71 for a QPRT worksheet.

A qualified Charitable Remainder Trust is exempt from income tax, and the grantor is entitled to a charitable, income, gift, and/or estate tax deduction based on the present value of the remainder interest ultimately passing to charity. The present value is calculated at the time of funding the trust.

There are two types of Charitable Remainder Trusts:

1. a Charitable Remainder Annuity Trust; and
2. a Charitable Remainder Unitrust.

In order to qualify as a Charitable Remainder Trust, certain requirements must be met.[15]

20:67. Planning for the wealthy senior-- Irrevocable Life Insurance Trusts

A senior can remove the proceeds of life insurance policies from his or her estate through the transfers of the insurance policies to an Irrevocable Life Insurance Trust ("ILIT"). In order to achieve the tax benefit of this trust, certain requirements must be met. This planning tool is very useful when the senior owns a significant amount of insurance or when the senior is interested in purchasing insurance to fund the payment of the estate tax.[1]

If the senior's estate is subject to tax and/or the senior is seeking to have liquidity in his or her estate, an Irrevocable Trust funded with insurance may be established to avoid the problems associated with an illiquid estate (e.g., desperation sales of real property or other types of property which are not readily marketable, such as business assets), provide for asset management, and exempt life insurance proceeds from federal estate taxation so that the insurance proceeds would be available for the benefit of the senior's spouse and children. This type of trust can play an important part in the senior's estate plan to achieve the maximum benefits available.

The trustee can purchase the policy from an insurance company or the senior can contribute an existing policy to the trust. An alternative to an Irrevocable Life Insurance Trust is for the senior to irrevocably transfer the ownership of the policy to a third party such as the senior's children.

If the policy is transferred into the trust or to the senior's children outright, then after the passage of three years the insurance would not be includable in the senior's estate.[2] However, depending upon the cash value of the policy, there may be gift tax consequences.

The use of *Crummey* powers will permit gifts to the trust to qualify for the $15,000 annual exclusion in 2018.[3] The planner must carefully review use of *Crummey* powers in the context of gift and estate taxes.[4]

[15]A Charitable Remainder Trust must meet all of the requirements set forth in 26 U.S.C.A. §664, and the requirements in Rev. Rul. 72-395, 1972-2 C.B. 340; as modified by Rev. Rul. 80-123, 1980-1 C.B. 205; Rev. Rul. 82-128, 1982-2 C.B. 71; and Rev. Rul. 88-81, 1988-2 C.B. 127.

[1]*See infra* §21:31.

[2]26 U.S.C.A. §2035(d)(2).

[3]*See supra* §20:54.

[4]*See supra* §20:23.

20:68. Planning for the wealthy senior-- Generation skipping

The federal generation-skipping transfer tax ("GSTT") is a tax imposed on three types of transfers:[1] taxable terminations, taxable distributions and direct skips. The GSTT is a separate tax imposed along with the gift or estate tax ordinarily due upon a transfer. It is applied at a flat rate (not a graduated rate) equal to the highest federal estate tax rate applicable at the time of the transfer.[2] The highest federal estate tax rate is 40% in 2017.[3] So any generation-skipping transfer will incur a GSTT at 40% (in 2017) of its value in addition to the ordinary gift or estate tax due.

Exemptions. A direct skip outright transfer which is exempt for federal gift tax because it falls within the $15,000 annual exclusion is also exempt from the GSTT.[4] However, a transfer in trust which qualifies for the annual gift tax exclusion will not necessarily qualify for the GST exemption, unless the trust was set up for the sole benefit of the grandchild and the trust proceeds will be includable in the grandchild's estate if the grandchild predeceases the settlor.[5] In addition, a transfer which is exempt from federal gift tax because it falls within the tuition or medical exclusion is also exempt from the GSTT.[6]

Furthermore, in 2018 every transferor has a $11,200,000 lifetime exemption,[7] (the "generation-skipping tax exemption" or "GST tax exemption").

One technique to minimize tax liability is to use generation-skipping Trusts funded with up to $11,200,000 (in 2018) *(Reference: The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed)* which will allow the senior to pass estate assets to grandchildren, and hence, avoid estate taxation upon the death of the children. This technique can be used either during lifetime or at death.

Application of GST Tax. The GSTT applies to any transfer to a "Skip Person."[8] A Skip Person is defined as: a person who is two or more generations removed from the transferor or as a trust in which all of the interests are held by Skip Persons or in which no person holds an

[1]26 U.S.C.A. §§2601 to 2663.

[2]26 U.S.C.A. §§2602 and 2641.

[3]26 U.S.C.A. §2001(c).

[4]26 U.S.C.A. §2642(c).

[5]26 U.S.C.A. §2642(c)(2).

[6]26 U.S.C.A. §2611(b).

[7]26 U.S.C.A. §2631(a); Rev. Proc. 2002-70, 2002-46 I.R.B. 845; The federal estate tax exemption for 2018 will be $11,200,000 (estimated); however, the actual inflation adjusted amount has not yet been confirmed.

[8]26 U.S.C.A. §§2601 et seq.

interest but at no time can any distribution be made other than to a Skip Person.[9]

Types of Generation-Skipping Transfers. A Generation-Skipping Transfer can take any of three forms:

1. a Direct Skip;
2. a Taxable Distribution; or
3. a Taxable Termination.

A "Direct Skip" occurs upon an outright transfer for the benefit of a person at least two generations below the transferor or a transfer to a trust for one or more such beneficiaries (i.e., a "Skip Person").[10]

A "Taxable Distribution" is any distribution from a trust to a Skip Person which is other than a taxable termination or a direct skip.[11]

A "Taxable Termination" occurs upon the expiration of an interest in a trust if the transfer is not subject to federal gift or estate tax and if, after the termination, all interests in the property are held by Skip Persons and no subsequent distribution from the trust can be made to a Skip Person.[12]

The generation-skipping transfer tax rules are quite complex, and great care must be used in implementing any plan which includes generation skipping.

[9]26 U.S.C.A. §2613.

[10]26 U.S.C.A. §2612(c).

[11]26 U.S.C.A. §2612(b).

[12]26 U.S.C.A. §2612(a).

III. List of Internal Revenue Code Sections (Excerpts)

Medical Expense Deduction

Reg. Section 1.213-1(e)(1)(v) Medical, dental, etc., expenses.

(v) The cost of in-patient hospital care (including the cost of meals and lodging therein) is an expenditure for medical care. The extent to which expenses for care in an institution other than a hospital shall constitute medical care is primarily a question of fact which depends upon the condition of the individual and the nature of the services he receives (rather than the nature of the institution). A private establishment which is regularly engaged in providing the types of care or services outlined in this subdivision shall be considered an institution for purposes of the rules provided herein. In general, the following rules will be applied:

(a) Where an individual is in an institution because his condition is such that the availability of medical care (as defined in subdivisions (i) and (ii) of this subparagraph) in such institution is a principal reason for his presence there, and meals and lodging are furnished as a necessary incident to such care, the entire cost of medical care and meals and lodging at the institution, which are furnished while the individual requires continual medical care, shall constitute an expense for medical care. For example, medical care includes the entire cost of institutional care for a person who is mentally ill and unsafe when left alone. While ordinary education is not medical care, the cost of medical care includes the cost of attending a special school for a mentally or physically handicapped individual, if his condition is such that the resources of the institution for alleviating such mental or physical handicap are a principal reason for his presence there. In such a case, the cost of attending such a special school will include the cost of meals and lodging, if supplied, and the cost of ordinary education furnished which is incidental to the special services furnished by the school. Thus, the cost of medical care includes the cost of attending a special school designed to compensate for or overcome a physical handicap, in order to qualify the individual for future normal education or for normal living, such as a school for the teaching of braille or lip reading. Similarly, the cost of care and supervision, or of treatment and training, of a mentally retarded or physically handicapped individual at an institution is within the meaning of the term "medical care".

(b) Where an individual is in an institution, and his condition is such that the availability of medical care in such institution is not a principal reason for his presence there, only that part of the cost of care in the institution as is attributable to medical care (as defined in subdivisions (i) and (ii) of this subparagraph) shall be considered as a cost of medical care; meals and lodging at the institution in such a case are not considered a cost of medical care for purposes of this section. For example, an individual is in a home for the aged for personal or family

considerations and not because he requires medical or nursing attention. In such case, medical care consists only of that part of the cost for care in the home which is attributable to medical care or nursing attention furnished to him; his meals and lodging at the home are not considered a cost of medical care.

(c) It is immaterial for purposes of this subdivision whether the medical care is furnished in a Federal or State institution or in a private institution.

Grantor Trust Rules
§671 - §678

26 U.S. Code § 671 - Trust income, deductions, and credits attributable to grantors and others as substantial owners

Where it is specified in this subpart that the grantor or another person shall be treated as the owner of any portion of a trust, there shall then be included in computing the taxable income and credits of the grantor or the other person those items of income, deductions, and credits against tax of the trust which are attributable to that portion of the trust to the extent that such items would be taken into account under this chapter in computing taxable income or credits against the tax of an individual. Any remaining portion of the trust shall be subject to subparts A through D. No items of a trust shall be included in computing the taxable income and credits of the grantor or of any other person solely on the grounds of his dominion and control over the trust under section 61 (relating to definition of gross income) or any other provision of this title, except as specified in this subpart.

26 U.S. Code § 672 - Definitions and rules

(a) Adverse party

For purposes of this subpart, the term “adverse party” means any person having a substantial beneficial interest in the trust which would be adversely affected by the exercise or nonexercise of the power which he possesses respecting the trust. A person having a general power of appointment over the trust property shall be deemed to have a beneficial interest in the trust.

(b) Nonadverse party

For purposes of this subpart, the term “nonadverse party” means any person who is not an adverse party.

(c) Related or subordinate party

For purposes of this subpart, the term "related or subordinate party" means any nonadverse party who is—

(1) the grantor's spouse if living with the grantor;

(2) any one of the following: The grantor's father, mother, issue, brother or sister; an employee of the grantor; a corporation or any employee of a corporation in which the stock holdings of the grantor and the trust are significant from the viewpoint of voting control; a subordinate employee of a corporation in which the grantor is an executive.

For purposes of subsection (f) and sections 674 and 675, a related or subordinate party shall be presumed to be subservient to the grantor in respect of the exercise or nonexercise of the powers conferred on him unless such party is shown not to be subservient by a preponderance of the evidence.

(d) Rule where power is subject to condition precedent

A person shall be considered to have a power described in this subpart even though the exercise of the power is subject to a precedent giving of notice or takes effect only on the expiration of a certain period after the exercise of the power.

(e) Grantor treated as holding any power or interest of grantor's spouse

(1) In general

For purposes of this subpart, a grantor shall be treated as holding any power or interest held by—

(A) any individual who was the spouse of the grantor at the time of the creation of such power or interest, or

(B) any individual who became the spouse of the grantor after the creation of such power or interest, but only with respect to periods after such individual became the spouse of the grantor.

(2) Marital status

For purposes of paragraph (1)(A), an individual legally separated from his spouse under a decree of divorce or of separate maintenance shall not be considered as married.

(f) Subpart not to result in foreign ownership

(1) In general

Notwithstanding any other provision of this subpart, this subpart shall apply only to the extent such application results in an amount (if any) being currently taken into account (directly or through 1 or more entities) under this chapter in computing the income of a citizen or resident of the United States or a domestic corporation.

(2) Exceptions

(A) Certain revocable and irrevocable trusts

Paragraph (1) shall not apply to any portion of a trust if—

(i) the power to revest absolutely in the grantor title to the trust property to which such portion is attributable is exercisable solely by the grantor without the approval or consent of any other person or with the consent of a related or subordinate party who is subservient to the grantor, or

(ii) the only amounts distributable from such portion (whether income or corpus) during the lifetime of the grantor are amounts distributable to the grantor or the spouse of the grantor.

(B) Compensatory trusts

Except as provided in regulations, paragraph (1) shall not apply to any portion of a trust distributions from which are taxable as compensation for services rendered.

(3) Special rules

Except as otherwise provided in regulations prescribed by the Secretary—

(A) a controlled foreign corporation (as defined in section 957) shall be treated as a domestic corporation for purposes of paragraph (1), and

(B) paragraph (1) shall not apply for purposes of applying section 1297.

(4) Recharacterization of purported gifts

In the case of any transfer directly or indirectly from a partnership or foreign corporation which the transferee treats as a gift or bequest, the Secretary may recharacterize such transfer in such circumstances as the Secretary determines to be appropriate to prevent the avoidance of the purposes of this subsection.

(5) Special rule where grantor is foreign person

If—

(A) but for this subsection, a foreign person would be treated as the owner of any portion of a trust, and

(B) such trust has a beneficiary who is a United States person,

such beneficiary shall be treated as the grantor of such portion to the extent such beneficiary has made (directly or indirectly) transfers of property (other than in a sale for full and adequate consideration) to such foreign person. For purposes of the preceding sentence, any gift shall not be taken into account to the extent such gift would be excluded from taxable gifts under section 2503 (b).

(6) Regulations

The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection, including regulations providing that paragraph (1) shall not apply in appropriate cases.

26 U.S. Code § 673 - Reversionary interests

(a) General rule

The grantor shall be treated as the owner of any portion of a trust in which he has a reversionary interest in either the corpus or the income therefrom, if, as of the inception of that portion of the trust, the value of such interest exceeds 5 percent of the value of such portion.

(b) Reversionary interest taking effect at death of minor lineal descendant beneficiary

In the case of any beneficiary who—

(1) is a lineal descendant of the grantor, and

(2) holds all of the present interests in any portion of a trust,

the grantor shall not be treated under subsection (a) as the owner of such portion solely by reason of a reversionary interest in such portion which takes effect upon the death of such beneficiary before such beneficiary attains age 21.

(c) Special rule for determining value of reversionary interest

For purposes of subsection (a), the value of the grantor’s reversionary interest shall be determined by assuming the maximum exercise of discretion in favor of the grantor.

(d) Postponement of date specified for reacquisition

Any postponement of the date specified for the reacquisition of possession or enjoyment of the reversionary interest shall be treated as a new transfer in trust commencing with the date on which the postponement is effective and terminating with the date prescribed by the postponement. However, income for any period shall not be included in the income of the grantor by reason of the preceding sentence if such income would not be so includible in the absence of such postponement.

26 U.S. Code § 674 - Power to control beneficial enjoyment

(a) General rule

The grantor shall be treated as the owner of any portion of a trust in respect of which the beneficial enjoyment of the corpus or the income therefrom is subject to a power of disposition, exercisable by the grantor or a nonadverse party, or both, without the approval or consent of any adverse party.

(b) Exceptions for certain powers

Subsection (a) shall not apply to the following powers regardless of by whom held:

(1) Power to apply income to support of a dependent

A power described in section 677 (b) to the extent that the grantor would not be subject to tax under that section.

(2) Power affecting beneficial enjoyment only after occurrence of event

A power, the exercise of which can only affect the beneficial enjoyment of the income for a period commencing after the occurrence of an event such that a grantor would not be treated as the owner under section 673 if the power were a reversionary interest; but the grantor may be treated as the owner after the occurrence of the event unless the power is relinquished.

(3) Power exercisable only by will

A power exercisable only by will, other than a power in the grantor to appoint by will the income of the trust where the income is accumulated for such disposition by the grantor or may be so accumulated in the discretion of the grantor or a nonadverse party, or both, without the approval or consent of any adverse party.

(4) Power to allocate among charitable beneficiaries

A power to determine the beneficial enjoyment of the corpus or the income therefrom if the corpus or income is irrevocably payable for a purpose specified in

section 170 (c) (relating to definition of charitable contributions) or to an employee stock ownership plan (as defined in section 4975 (e)(7)) in a qualified gratuitous transfer (as defined in section 664 (g)(1)).

(5) Power to distribute corpus

A power to distribute corpus either—

> **(A)** to or for a beneficiary or beneficiaries or to or for a class of beneficiaries (whether or not income beneficiaries) provided that the power is limited by a reasonably definite standard which is set forth in the trust instrument; or
>
> **(B)** to or for any current income beneficiary, provided that the distribution of corpus must be chargeable against the proportionate share of corpus held in trust for the payment of income to the beneficiary as if the corpus constituted a separate trust.

A power does not fall within the powers described in this paragraph if any person has a power to add to the beneficiary or beneficiaries or to a class of beneficiaries designated to receive the income or corpus, except where such action is to provide for after-born or after-adopted children.

(6) Power to withhold income temporarily

A power to distribute or apply income to or for any current income beneficiary or to accumulate the income for him, provided that any accumulated income must ultimately be payable—

> **(A)** to the beneficiary from whom distribution or application is withheld, to his estate, or to his appointees (or persons named as alternate takers in default of appointment) provided that such beneficiary possesses a power of appointment which does not exclude from the class of possible appointees any person other than the beneficiary, his estate, his creditors, or the creditors of his estate, or
>
> **(B)** on termination of the trust, or in conjunction with a distribution of corpus which is augmented by such accumulated income, to the current income beneficiaries in shares which have been irrevocably specified in the trust instrument.

Accumulated income shall be considered so payable although it is provided that if any beneficiary does not survive a date of distribution which could reasonably have been expected to occur within the beneficiary's lifetime, the share of the deceased beneficiary is to be paid to his appointees or to one or more designated alternate takers (other than the grantor or the grantor's estate) whose shares have been irrevocably specified. A power

does not fall within the powers described in this paragraph if any person has a power to add to the beneficiary or beneficiaries or to a class of beneficiaries designated to receive the income or corpus except where such action is to provide for after-born or after-adopted children.

(7) Power to withhold income during disability of a beneficiary

A power exercisable only during—

(A) the existence of a legal disability of any current income beneficiary, or

(B) the period during which any income beneficiary shall be under the age of 21 years,

to distribute or apply income to or for such beneficiary or to accumulate and add the income to corpus. A power does not fall within the powers described in this paragraph if any person has a power to add to the beneficiary or beneficiaries or to a class of beneficiaries designated to receive the income or corpus, except where such action is to provide for after-born or after-adopted children.

(8) Power to allocate between corpus and income

A power to allocate receipts and disbursements as between corpus and income, even though expressed in broad language.

(c) Exception for certain powers of independent trustees

Subsection (a) shall not apply to a power solely exercisable (without the approval or consent of any other person) by a trustee or trustees, none of whom is the grantor, and no more than half of whom are related or subordinate parties who are subservient to the wishes of the grantor—

(1) to distribute, apportion, or accumulate income to or for a beneficiary or beneficiaries, or to, for, or within a class of beneficiaries; or

(2) to pay out corpus to or for a beneficiary or beneficiaries or to or for a class of beneficiaries (whether or not income beneficiaries).

A power does not fall within the powers described in this subsection if any person has a power to add to the beneficiary or beneficiaries or to a class of beneficiaries designated to receive the income or corpus, except where such action is to provide for after-born or after-adopted children. For periods during which an individual is the spouse of the grantor (within the meaning of section 672 (e)(2)), any reference in this subsection to the grantor shall be treated as including a reference to such individual.

(d) Power to allocate income if limited by a standard

Subsection (a) shall not apply to a power solely exercisable (without the approval or consent of any other person) by a trustee or trustees, none of whom is the grantor or spouse living with the grantor, to distribute, apportion, or accumulate income to or for a beneficiary or beneficiaries, or to, for, or within a class of beneficiaries, whether or not the conditions of paragraph (6) or (7) of subsection (b) are satisfied, if such power is limited by a reasonably definite external standard which is set forth in the trust instrument. A power does not fall within the powers described in this subsection if any person has a power to add to the beneficiary or beneficiaries or to a class of beneficiaries designated to receive the income or corpus except where such action is to provide for after-born or after-adopted children.

26 U.S. Code § 675 - Administrative powers

The grantor shall be treated as the owner of any portion of a trust in respect of which—

(1) Power to deal for less than adequate and full consideration

A power exercisable by the grantor or a nonadverse party, or both, without the approval or consent of any adverse party enables the grantor or any person to purchase, exchange, or otherwise deal with or dispose of the corpus or the income therefrom for less than an adequate consideration in money or money's worth.

(2) Power to borrow without adequate interest or security

A power exercisable by the grantor or a nonadverse party, or both, enables the grantor to borrow the corpus or income, directly or indirectly, without adequate interest or without adequate security except where a trustee (other than the grantor) is authorized under a general lending power to make loans to any person without regard to interest or security.

(3) Borrowing of the trust funds

The grantor has directly or indirectly borrowed the corpus or income and has not completely repaid the loan, including any interest, before the beginning of the taxable year. The preceding sentence shall not apply to a loan which provides for adequate interest and adequate security, if such loan is made by a trustee other than the grantor and other than a related or subordinate trustee subservient to the grantor. For periods during which an individual is the spouse of the grantor (within the meaning of section 672 (e)(2)), any reference in this paragraph to the grantor shall be treated as including a reference to such individual.

(4) General powers of administration

A power of administration is exercisable in a nonfiduciary capacity by any person without the approval or consent of any person in a fiduciary capacity. For purposes of this paragraph, the term "power of administration" means any one or more of the following powers:

(A) a power to vote or direct the voting of stock or other securities of a corporation in which the holdings of the grantor and the trust are significant from the viewpoint of voting control;

(B) a power to control the investment of the trust funds either by directing investments or reinvestments, or by vetoing proposed investments or reinvestments, to the extent that the trust funds consist of stocks or securities of corporations in which the holdings of the grantor and the trust are significant from the viewpoint of voting control; or

(C) a power to reacquire the trust corpus by substituting other property of an equivalent value.

26 U.S. Code § 676 - Power to revoke

(a) General rule

The grantor shall be treated as the owner of any portion of a trust, whether or not he is treated as such owner under any other provision of this part, where at any time the power to revest in the grantor title to such portion is exercisable by the grantor or a non-adverse party, or both.

(b) Power affecting beneficial enjoyment only after occurrence of event

Subsection (a) shall not apply to a power the exercise of which can only affect the beneficial enjoyment of the income for a period commencing after the occurrence of an event such that a grantor would not be treated as the owner under section 673 if the power were a reversionary interest. But the grantor may be treated as the owner after the occurrence of such event unless the power is relinquished.

26 U.S. Code § 677 - Income for benefit of grantor

(a) General rule

The grantor shall be treated as the owner of any portion of a trust, whether or not he is treated as such owner under section 674, whose income without the approval or consent of any adverse party is, or, in the discretion of the grantor or a nonadverse party, or both, may be—

(1) distributed to the grantor or the grantor's spouse;

(2) held or accumulated for future distribution to the grantor or the grantor's spouse; or

(3) applied to the payment of premiums on policies of insurance on the life of the grantor or the grantor's spouse (except policies of insurance irrevocably payable for a purpose specified in section 170 (c) (relating to definition of charitable contributions)).

This subsection shall not apply to a power the exercise of which can only affect the beneficial enjoyment of the income for a period commencing after the occurrence of an event such that the

grantor would not be treated as the owner under section 673 if the power were a reversionary interest; but the grantor may be treated as the owner after the occurrence of the event unless the power is relinquished.

(b) Obligations of support

Income of a trust shall not be considered taxable to the grantor under subsection (a) or any other provision of this chapter merely because such income in the discretion of another person, the trustee, or the grantor acting as trustee or co-trustee, may be applied or distributed for the support or maintenance of a beneficiary (other than the grantor's spouse) whom the grantor is legally obligated to support or maintain, except to the extent that such income is so applied or distributed. In cases where the amounts so applied or distributed are paid out of corpus or out of other than income for the taxable year, such amounts shall be considered to be an amount paid or credited within the meaning of paragraph (2) of section 661 (a) and shall be taxed to the grantor under section 662.

26 U.S. Code § 678 - Person other than grantor treated as substantial owner

(a) General rule

A person other than the grantor shall be treated as the owner of any portion of a trust with respect to which:

> **(1)** such person has a power exercisable solely by himself to vest the corpus or the income therefrom in himself, or
>
> **(2)** such person has previously partially released or otherwise modified such a power and after the release or modification retains such control as would, within the principles of sections 671 to 677, inclusive, subject to grantor of a trust to treatment as the owner thereof.

(b) Exception where grantor is taxable

Subsection (a) shall not apply with respect to a power over income, as originally granted or thereafter modified, if the grantor of the trust or a transferor (to whom section 679 applies) is otherwise treated as the owner under the provisions of this subpart other than this section.

(c) Obligations of support

Subsection (a) shall not apply to a power which enables such person, in the capacity of trustee or co-trustee, merely to apply the income of the trust to the support or maintenance of a person whom the holder of the power is obligated to support or maintain except to the extent that such income is so applied. In cases where the amounts so applied or distributed are paid out of corpus or out of other than income of the taxable year, such amounts shall be considered to be an

amount paid or credited within the meaning of paragraph (2) of section 661 (a)and shall be taxed to the holder of the power under section 662.

(d) Effect of renunciation or disclaimer

Subsection (a) shall not apply with respect to a power which has been renounced or disclaimed within a reasonable time after the holder of the power first became aware of its existence.

(e) Cross reference

For provision under which beneficiary of trust is treated as owner of the portion of the trust which consists of stock in an S corporation, see section 1361 (d).

Subchapter S

§ 1361

26 U.S. Code § 1361 - S corporation defined

(a) S corporation defined

(1) In general

For purposes of this title, the term “S corporation” means, with respect to any taxable year, a small business corporation for which an election under section 1362 (a) is in effect for such year.

(2) C corporation

For purposes of this title, the term “C corporation” means, with respect to any taxable year, a corporation which is not an S corporation for such year.

(b) Small business corporation

(1) In general

For purposes of this subchapter, the term “small business corporation” means a domestic corporation which is not an ineligible corporation and which does not—

(A) have more than 100 shareholders,

(B) have as a shareholder a person (other than an estate, a trust described in subsection (c)(2), or an organization described in subsection (c)(6)) who is not an individual,

(C) have a nonresident alien as a shareholder, and

(D) have more than 1 class of stock.

(2) Ineligible corporation defined

For purposes of paragraph (1), the term "ineligible corporation" means any corporation which is—

(A) a financial institution which uses the reserve method of accounting for bad debts described in section 585,

(B) an insurance company subject to tax under subchapter L,

(C) a corporation to which an election under section 936 applies, or

(D) a DISC or former DISC.

(3) Treatment of certain wholly owned subsidiaries

(A) In general

Except as provided in regulations prescribed by the Secretary, for purposes of this title—

(i) a corporation which is a qualified subchapter S subsidiary shall not be treated as a separate corporation, and

(ii) all assets, liabilities, and items of income, deduction, and credit of a qualified subchapter S subsidiary shall be treated as assets, liabilities, and such items (as the case may be) of the S corporation.

(B) Qualified subchapter S subsidiary

For purposes of this paragraph, the term "qualified subchapter S subsidiary" means any domestic corporation which is not an ineligible corporation (as defined in paragraph (2)), if—

(i) 100 percent of the stock of such corporation is held by the S corporation, and

(ii) the S corporation elects to treat such corporation as a qualified subchapter S subsidiary.

(C) Treatment of terminations of qualified subchapter S subsidiary status

(i) In general For purposes of this title, if any corporation which was a qualified subchapter S subsidiary ceases to meet the requirements of subparagraph (B), such corporation shall be treated as a new corporation acquiring all of its assets (and assuming all of its liabilities) immediately before such cessation from the S corporation in exchange for its stock.

(ii) Termination by reason of sale of stock If the failure to meet the requirements of subparagraph (B) is by reason of the sale of stock of a corporation which is a qualified subchapter S subsidiary, the sale of such stock shall be treated as if—

(I) the sale were a sale of an undivided interest in the assets of such corporation (based on the percentage of the corporation's stock sold), and

(II) the sale were followed by an acquisition by such corporation of all of its assets (and the assumption by such corporation of all of its liabilities) in a transaction to which section 351 applies.

(D) Election after termination

If a corporation's status as a qualified subchapter S subsidiary terminates, such corporation (and any successor corporation) shall not be eligible to make—

(i) an election under subparagraph (B)(ii) to be treated as a qualified subchapter S subsidiary, or

(ii) an election under section 1362 (a) to be treated as an S corporation, before its 5th taxable year which begins after the 1st taxable year for which such termination was effective, unless the Secretary consents to such election.

(E) Information returns

Except to the extent provided by the Secretary, this paragraph shall not apply to part III of subchapter A of chapter 61 (relating to information returns).

(c) Special rules for applying subsection (b)

(1) Members of a family treated as 1 shareholder

(A) In general

For purposes of subsection (b)(1)(A), there shall be treated as one shareholder—

(i) a husband and wife (and their estates), and

(ii) all members of a family (and their estates).

(B) Members of a family

For purposes of this paragraph—

(i) In general The term "members of a family" means a common ancestor, any lineal descendant of such common ancestor, and any spouse or former spouse of such common ancestor or any such lineal descendant.

(ii) Common ancestor An individual shall not be considered to be a common ancestor if, on the applicable date, the individual is more than 6 generations removed from the youngest generation of shareholders who would (but for this subparagraph) be members of the family. For purposes of the preceding sentence, a spouse (or former spouse) shall be treated as being of the same generation as the individual to whom such spouse is (or was) married.

(iii) Applicable date The term "applicable date" means the latest of—

(I) the date the election under section 1362 (a) is made,

(II) the earliest date that an individual described in clause (i) holds stock in the S corporation, or

(III) October 22, 2004.

(C) Effect of adoption, etc.

Any legally adopted child of an individual, any child who is lawfully placed with an individual for legal adoption by the individual, and any eligible foster child of an individual (within the meaning of section 152 (f)(1)(C)), shall be treated as a child of such individual by blood.

(2) Certain trusts permitted as shareholders

(A) In general

For purposes of subsection (b)(1)(B), the following trusts may be shareholders:

(i) A trust all of which is treated (under subpart E of part I of subchapter J of this chapter) as owned by an individual who is a citizen or resident of the United States.

(ii) A trust which was described in clause (i) immediately before the death of the deemed owner and which continues in existence after such death, but only for the 2-year period beginning on the day of the deemed owner's death.

(iii) A trust with respect to stock transferred to it pursuant to the terms of a will, but only for the 2-year period beginning on the day on which such stock is transferred to it.

(iv) A trust created primarily to exercise the voting power of stock transferred to it.

(v) An electing small business trust.

(vi) In the case of a corporation which is a bank (as defined in section 581) or a depository institution holding company (as defined in section 3(w)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1813 (w)(1)), a trust which constitutes an individual retirement account under section 408 (a), including one designated as a Roth IRA under section 408A, but only to the extent of the stock held by such trust in such bank or company as of the date of the enactment of this clause.

This subparagraph shall not apply to any foreign trust.

(B) Treatment as shareholders

For purposes of subsection (b)(1)—

(i) In the case of a trust described in clause (i) of subparagraph (A), the deemed owner shall be treated as the shareholder.

(ii) In the case of a trust described in clause (ii) of subparagraph (A), the estate of the deemed owner shall be treated as the shareholder.

(iii) In the case of a trust described in clause (iii) of subparagraph (A), the estate of the testator shall be treated as the shareholder.

(iv) In the case of a trust described in clause (iv) of subparagraph (A), each beneficiary of the trust shall be treated as a shareholder.

(v) In the case of a trust described in clause (v) of subparagraph (A), each potential current beneficiary of such trust shall be treated as a shareholder; except that, if for any period there is no potential current beneficiary of such trust, such trust shall be treated as the shareholder during such period.

(vi) In the case of a trust described in clause (vi) of subparagraph (A), the individual for whose benefit the trust was created shall be treated as a shareholder.

(3) Estate of individual in bankruptcy may be shareholder

For purposes of subsection (b)(1)(B), the term "estate" includes the estate of an individual in a case under title 11 of the United States Code.

(4) Differences in common stock voting rights disregarded

For purposes of subsection (b)(1)(D), a corporation shall not be treated as having more than 1 class of stock solely because there are differences in voting rights among the shares of common stock.

(5) Straight debt safe harbor

(A) In general

For purposes of subsection (b)(1)(D), straight debt shall not be treated as a second class of stock.

(B) Straight debt defined

For purposes of this paragraph, the term "straight debt" means any written unconditional promise to pay on demand or on a specified date a sum certain in money if—

(i) the interest rate (and interest payment dates) are not contingent on profits, the borrower's discretion, or similar factors,

(ii) there is no convertibility (directly or indirectly) into stock, and

(iii) the creditor is an individual (other than a nonresident alien), an estate, a trust described in paragraph (2), or a person which is actively and regularly engaged in the business of lending money.

(C) Regulations

The Secretary shall prescribe such regulations as may be necessary or appropriate to provide for the proper treatment of straight debt under this subchapter and for the coordination of such treatment with other provisions of this title.

(6) Certain exempt organizations permitted as shareholders

For purposes of subsection (b)(1)(B), an organization which is—

(A) described in section 401 (a) or 501 (c)(3), and

(B) exempt from taxation under section 501 (a),

may be a shareholder in an S corporation.

(d) Special rule for qualified subchapter S trust

(1) In general

In the case of a qualified subchapter S trust with respect to which a beneficiary makes an election under paragraph (2)—

(A) such trust shall be treated as a trust described in subsection (c)(2)(A)(i),

(B) for purposes of section 678 (a), the beneficiary of such trust shall be treated as the owner of that portion of the trust which consists of stock in an S corporation with respect to which the election under paragraph (2) is made, and

(C) for purposes of applying sections 465 and 469 to the beneficiary of the trust, the disposition of the S corporation stock by the trust shall be treated as a disposition by such beneficiary.

(2) Election

(A) In general

A beneficiary of a qualified subchapter S trust (or his legal representative) may elect to have this subsection apply.

(B) Manner and time of election

(i) Separate election with respect to each corporation An election under this paragraph shall be made separately with respect to each corporation the stock of which is held by the trust.

(ii) Elections with respect to successive income beneficiaries If there is an election under this paragraph with respect to any beneficiary, an election under this paragraph shall be treated as made by each successive beneficiary unless such beneficiary affirmatively refuses to consent to such election.

(iii) Time, manner, and form of election Any election, or refusal, under this paragraph shall be made in such manner and form, and at such time, as the Secretary may prescribe.

(C) Election irrevocable

An election under this paragraph, once made, may be revoked only with the consent of the Secretary.

D) Grace period

An election under this paragraph shall be effective up to 15 days and 2 months before the date of the election.

(3) Qualified subchapter S trust

For purposes of this subsection, the term “qualified subchapter S trust” means a trust—

(A) the terms of which require that—

(i) during the life of the current income beneficiary, there shall be only 1 income beneficiary of the trust,

(ii) any corpus distributed during the life of the current income beneficiary may be distributed only to such beneficiary,

(iii) the income interest of the current income beneficiary in the trust shall terminate on the earlier of such beneficiary’s death or the termination of the trust, and

(iv) upon the termination of the trust during the life of the current income beneficiary, the trust shall distribute all of its assets to such beneficiary, and

(B) all of the income (within the meaning of section 643(b)) of which is distributed (or required to be distributed) currently to 1 individual who is a citizen or resident of the United States.

A substantially separate and independent share of a trust within the meaning of section 663 (c) shall be treated as a separate trust for purposes of this subsection and subsection (c).

(4) Trust ceasing to be qualified

(A) Failure to meet requirements of paragraph (3)(A)

If a qualified subchapter S trust ceases to meet any requirement of paragraph (3)(A), the provisions of this subsection shall not apply to such trust as of the date it ceases to meet such requirement.

(B) Failure to meet requirements of paragraph (3)(B)

If any qualified subchapter S trust ceases to meet any requirement of paragraph (3)(B) but continues to meet the requirements of paragraph (3)(A), the provisions of this subsection shall not apply to such trust as of the first day of the first taxable year beginning after the first taxable year for which it failed to meet the requirements of paragraph (3)(B).

(e) Electing small business trust defined

(1) Electing small business trust

For purposes of this section—

(A) In general

Except as provided in subparagraph (B), the term "electing small business trust" means any trust if—

(i) such trust does not have as a beneficiary any person other than

(I) an individual,

(II) an estate,

(III) an organization described in paragraph (2), (3), (4), or (5) of section 170 (c), or (IV) an organization described in section 170(c)(1) which holds a contingent interest in such trust and is not a potential current beneficiary,

(ii) no interest in such trust was acquired by purchase, and

(iii) an election under this subsection applies to such trust.

(B) Certain trusts not eligible

The term "electing small business trust" shall not include—

(i) any qualified subchapter S trust (as defined in subsection (d)(3)) if an election under subsection (d)(2) applies to any corporation the stock of which is held by such trust,

(ii) any trust exempt from tax under this subtitle, and

(iii) any charitable remainder annuity trust or charitable remainder unitrust (as defined in section 664 (d)).

(C) Purchase

For purposes of subparagraph (A), the term "purchase" means any acquisition if the basis of the property acquired is determined under section 1012.

(2) Potential current beneficiary

For purposes of this section, the term "potential current beneficiary" means, with respect to any period, any person who at any time during such period is entitled to, or at the discretion of any person may receive, a distribution from the principal or income of the trust (determined without regard to any power of appointment to the extent such power remains unexercised at the end of such period). If a trust disposes of all of the stock which it holds in an S corporation, then, with respect to such corporation, the term "potential current beneficiary" does not include any person who first met the requirements of the preceding sentence during the 1-year period ending on the date of such disposition.

(3) Election

An election under this subsection shall be made by the trustee. Any such election shall apply to the taxable year of the trust for which made and all subsequent taxable years of such trust unless revoked with the consent of the Secretary.

(4) Cross reference

For special treatment of electing small business trusts, see section 641 (c).

IV. Internal Revenue Service Private Letter Ruling # 200620025

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

200620025

TAX EXEMPT AND
GOVERNMENT ENTITIES
DIVISION

FEB 2 1 2006

UICs: 691.00-00
691.01-00
401.06-00
401.06-02

SE:T:EP:RA:T3

LEGEND:

Taxpayer A:

Taxpayer B:

Taxpayer C:

Bank N:

Court T:

State W:

Date 1:

Date 2:

Date 3:

Date 4:

Date 5:

Trust T:

IRA X:

IRA Y:

Dear :

This is in response to the request for letter ruling submitted by your authorized representative on your behalf, as supplemented by correspondence dated

, , , , and , in which your authorized representative requests letter rulings under sections 401(a)(9) and 691(a)(2) of the Internal Revenue Code ("Code"). The following facts and representations support your ruling request.

Taxpayer A died on Date 1, at age 69 prior to attaining his required beginning date as that term is defined in Code section 401(a)(9)(C). Taxpayer B is one of his four surviving sons. At his death, Taxpayer A owned an individual retirement account (IRA X) with Bank N of which his four sons were equal named beneficiaries pursuant to a beneficiary designation dated Date 2, . Taxpayer B is disabled, and his mother, Taxpayer C, is his legal guardian ("Guardian"). Taxpayer B is eligible to receive Medicaid and other public benefits, and it is represented that such eligibility could lapse if he directly owned a portion of IRA X.

The IRA X custodian set aside the shares of Taxpayer B's three brothers in separate sub-IRAs (separate accounts) for their benefit on or about Date 4, . The shares of Taxpayer B's three brothers were not distributed as part of said set aside. Taxpayer B's share has not been distributed from IRA X except for required minimum distribution(s) (RMD(s)) made to the Guardian since calendar year on his behalf. It has been represented that the subdivision of IRA X into three separate IRAs (shares) for Taxpayer B's three brothers (with Taxpayer B's share remaining in IRA X) was done on an equal, pro rata, basis.

A State W court, Court T, a court of competent jurisdiction, acting on a petition by the Guardian, issued an order dated Date 3, , authorizing the creation of a trust for the Taxpayer's benefit, intended to qualify as a "special needs trust" ("Trust T") under state and federal law. It is represented that if Trust T qualifies as a "special needs trust," the trust assets will not be considered as assets of Taxpayer B in determining his eligibility to receive public benefits.

The terms of Trust T provide that the Guardian is the trustee and Taxpayer B is the sole beneficiary of Trust T during his lifetime. The Guardian may distribute to or apply for the benefit of Taxpayer B so much of the net income and principal of Trust T as appears advisable in her sole discretion. The Guardian may accumulate any or all of Trust T income; income not distributed in the current year shall be added to principal. Upon Taxpayer B's death, the balance of Trust T shall be distributed to the State W Department of Children and Families to the extent necessary to satisfy the total medical assistance paid for Taxpayer B's benefit by that department during his life. The remaining balance shall be distributed to Taxpayer B's heirs at law under the State W law of intestacy (in a manner and proportion provided in Trust T). The Guardian has disclaimed her contingent remainder interest (as one of Taxpayer B's heirs at law) in Trust T by means of a disclaimer dated Date 5, . For purposes of this letter ruling, the Service will assume that said disclaimer falls within Code section 2518.

The Guardian proposes to transfer, with state court approval, Taxpayer B's share, as ¼ beneficiary thereof, of IRA X to an IRA benefiting Trust T and the beneficiary(ies) thereof. It has been represented that, pursuant to said transfer, IRA X shall be re-titled IRA Y.

Based on the above facts and representations, you, through your authorized representative, request the following letter rulings:

1. That the transfer of IRA X (as described above) to Trust T will be disregarded for Federal income purposes, and will not be considered a transfer under Code section 691(a)(2); and

2. the trustee of Trust T, Guardian, may calculate the annual distributions required under Code section 401(a)(9) (made applicable to IRAs X and Y pursuant to Code section 408(a)(6)), to be made to Trust T from IRA Y using Taxpayer B's life expectancy.

With respect to your first letter ruling request, section 691(a)(1) of the Code provides that the amount of all items of gross income in respect of a decedent (IRD) which are not properly includible in respect of the taxable period in which falls the date of the decedent's death or a prior period (including the amount of all items of gross income in respect of a prior decedent, if the right to receive such amount was acquired by reason of the death of the prior decedent or by bequest, devise, or inheritance from the prior decedent) shall be included in the gross income, for the taxable year when received, of: (A) the estate of the decedent, if the right to receive the amount is acquired by the decedent's estate from the decedent; (B) the person who, by reason of the death of the decedent, acquires the right to receive the amount, if the right to receive the amount is not acquired by the decedent's estate from the decedent; or (C) the person who acquires from the decedent the right to receive the amount by bequest, devise, or inheritance, if the amount is received after a distribution by the decedent's estate of such right.

Section 691(a)(2) provides that if a right, described in § 691(a)(1), to receive an amount is transferred by the estate of the decedent or a person who received such right by reason of the death of the decedent or by bequest, devise, or inheritance from the decedent, there shall be included in the gross income of the estate or such person, as the case may be, for the taxable period in which the transfer occurs, the fair market value of such right at the time of such transfer plus the amount by which any consideration for the transfer exceeds such fair market value. For purposes of this paragraph, the term "transfer" includes sale, exchange, or other disposition, or the satisfaction of an installment obligation at other than face value, but does not include transmission at death to the estate of the decedent or a transfer to a person pursuant to the right of such person to receive such amount by reason of the death of the decedent or by bequest, devise, or inheritance from the decedent.

Revenue Ruling 92-47, 1992-1 C.B. 198, holds that a distribution to the beneficiary of a decedent's IRA that equals the amount of the balance in the IRA at the decedent's death, less any nondeductible contributions, is IRD under Code section 691(a)(1) that is includable in the gross income of the beneficiary for the taxable year the distribution is received.

Section 671 provides that where it is specified in subpart E of Part I of subchapter J that the grantor or another person shall be treated as the owner of any portion of a trust, there shall then be included in computing the taxable income and credits of the grantor or the other person those items of income, deductions, and credits against tax of the trust which are attributable to that portion of the trust to the extent that such items would be taken into account under chapter 1 in computing taxable income or credits against the tax of an individual.

Section 677(a) provides that the grantor shall be treated as the owner of any portion of a trust, whether or not he is treated as such owner under Code section 674, whose income without the approval or consent of any adverse party is, or, in the discretion of the grantor or a nonadverse party, or both, may be (1) distributed to the grantor or the grantor's spouse; (2) held or accumulated for future distribution to the grantor or the grantor's spouse; or (3) applied to the payment of premiums on policies of insurance on the life of the grantor or the grantor's spouse.

Rev. Rul. 85-13, 1985-1 C.B. 184, concludes that if a grantor is treated as the owner of a trust, the grantor is considered to be the owner of the trust assets for federal income tax purposes. Therefore, a transfer of the grantor's assets to the trust is not recognized as a sale or disposition for federal income tax purposes.

Based solely on the facts and representations submitted, we conclude, with respect to your first ruling request, that Trust T is currently a grantor trust all of which is treated as owned by Taxpayer B under §§ 671 and 677(a). Therefore, the transfer of Taxpayer B's share of IRA X to Trust T is not a sale or disposition of said share of the IRA for federal income tax purposes and is not a transfer for purposes of § 691(a)(2).

With respect to your second ruling request, Code section 401(a)(9)(A) provides, in general, that a trust will not be considered qualified unless the plan provides that the entire interest of each employee-

(i) will be distributed to such employee not later than the required beginning date, or

(ii) will be distributed, beginning not later than the required beginning date, over the life of such employee or over the lives of such employee and a designated

beneficiary or over a period not extending beyond the life expectancy of such employee or the life expectancy of such employee and a designated beneficiary.

Code section 408(a)(6) provides that, under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) and the incidental death benefit requirements of section 401(a) shall apply to the distribution of the entire interest of an individual for whose benefit the trust is maintained.

Code § 401(a)(9)(B)(ii) provides, in general, that if a plan participant (IRA holder) dies before the distribution of his interest has begun in accordance with subparagraph (A)(ii) (prior to his required beginning date), then his entire interest must be distributed within 5 years of his death.

Code § 401(a)(9)(B)(iii) provides, in general, that if any portion of the interest of a deceased plan participant (IRA holder) is payable to (or for the benefit of a designated beneficiary), such portion will be distributed beginning not later than 1 year after the date of the deceased's death (or a later date as prescribed by the Secretary under Regulations) in accordance with regulations over the life of the designated beneficiary (or a period not extending beyond the life expectancy of the beneficiary).

Code § 401(a)(9)(C) provides, in relevant part, that, for purposes of this paragraph, the term "required beginning date" means April 1 of the calendar year following the calendar year in which the employee attains age 70 1/2.

Code section 401(a)(9)(E) defines "designated beneficiary" as any individual designated as a beneficiary by the employee (IRA holder).

With further respect to your second ruling request, "Final" Income Tax Regulations under Code sections 401(a)(9) and 408(a)(6) were published in the Federal Register at 67 Federal Register 18987-19028 (April 17, 2002), and in the Internal Revenue Bulletin at 2002-19 I.R.B. 852 (May 13, 2002). The Preamble to the "Final" Regulations, in relevant part, provide that the regulations apply for determining required minimum distributions for calendar years beginning after January 1, 2003. For determining required distributions for calendar year , taxpayers may rely on the 1987 proposed regulations, the 2001 proposed regulations, or the "Final" Regulations..

In addition, the "Final" Regulations have been modified in part (See 2004-26 I.R.B. 1082, 1098 (June 28, 2004)). The modification to the "Final" Regulations may also be relied upon with respect to required distributions for the calendar year.

Section 1.401(a)(9)-3 of the "Final" regulations, Q&A-3(a) provides, in general, that, with respect to the life expectancy exception to the 5-year rule described in Code § 401(a)(9)(B)(iii), and in A-1, distributions are required to begin to a non-spouse beneficiary on or before the end of the calendar year immediately following the calendar year in which the employee died. This rule also applies if another individual is a designated beneficiary in addition to the employee's (IRA holder's) surviving spouse.

Section 1.401(a)(9)-3 of the "Final" regulations, Q&A-4(a), provides, in relevant part, that in the absence of a plan provision to the contrary, with respect to an individual who dies prior to reaching his required beginning date, if said individual has designated a beneficiary, distributions from his plan or IRA are to be made in accordance with the life expectancy rule of Code sections 401(a)(9)(B)(iii) and (iv).

Section 1.401(a)(9)-5 of the "Final" regulations, Q&A-5(b), provides, in general, that if an employee dies before his required beginning date, in order to satisfy the requirements of Code § 401(a)(9)(B)(iii) or (iv) and the life expectancy rule described in A-1 of § 1.401(a)(9)-3, the applicable distribution period for distribution calendar years after the distribution calendar year containing the employee's date of death is determined in accordance with paragraph (c) of this A-5.

Section 1.401(a)(9)-5 of the "Final" regulations, Q&A-5(c)(1), provides, in general, that, with respect to a non-spouse beneficiary, the applicable distribution period measured by the beneficiary's remaining life expectancy is determined using the beneficiary's age as of the beneficiary's birthday in the calendar year immediately following the calendar year of the employee's death. In subsequent calendar years, the applicable distribution period is reduced by one for each calendar year that has elapsed after the calendar year immediately following the calendar year of the employee's death.

Section 1.401(a)(9)-4 of the "Final" regulations, Q&A-1, provides, in relevant part, that a designated beneficiary is an individual who is designated as a beneficiary under a plan either by the terms of the plan or by an affirmative election by the employee. Q&A-1 further provides that a person who takes under a will or otherwise under applicable state law will not be a designated beneficiary unless that individual also takes under a plan.

Section 1.401(a)(9)-5 of the "Final" regulations, Q&A-7(a) provides, in summary, that except as otherwise provided in paragraph (c) of this A-7 (not pertinent to this ruling request), if more than one individual is designated as a beneficiary with respect to an employee as of the applicable date for determining the designated beneficiary, the named beneficiary with the shortest life expectancy will be the designated beneficiary for purposes of determining the applicable distribution period.

Section 1.401(a)(9)-4 of the "Final" regulations, Q&A-4, provides, in relevant part, that in order to be a designated beneficiary, an individual must be a beneficiary as of the date of the employee's death. Generally, an employee's designated beneficiary will be determined based on the beneficiaries designated as of the date of death who remain beneficiaries as of September 30 of the calendar year following the calendar year of death. Q&A-4 further provides, that "consequently, any person who was a beneficiary as of the date of the employee's (IRA holder's) death, but is not a beneficiary as of that September 30 (e.g. because the person receives the entire benefit to which he is entitled before that September 30) is not taken into account in determining the distribution period for required minimum distributions after the employee's death. Accordingly, if a person disclaims entitlement to the employee's benefit pursuant to a disclaimer that satisfies section 2518 by that September 30 thereby allowing other beneficiaries to receive the benefit in lieu of that person, the disclaiming person is not taken into account in determining the person's designated beneficiary".

Section 1.401(a)(9)-8 of the "Final" regulations, Qs&As-2 and 3 provide the rules that apply if the IRA of a deceased IRA holder is divided into separate accounts for purposes of Code section 401(a)(9).

Section 1.401(a)(9)-8 of the "Final" regulations, Q&A-2(a)(2), provides that if an employee's (IRA holder's) benefit in a defined contribution plan is divided into separate accounts and the beneficiaries with respect to one separate account differ from the beneficiaries with respect to the other separate accounts of the employee under the plan, for years subsequent to the calendar year containing the date as of which the separate accounts were established, or date of death if later, such separate account under the plan is not aggregated with the other separate accounts under the plan in order to determine whether the distributions from such separate account under the plan satisfy section 401(a)(9). However, the applicable distribution period for each such separate account is determined disregarding the other beneficiaries only if the separate account is established on a date no later than the last day of the year following the calendar year of the employee's (IRA holder's) death.

Section 1.401(a)(9)-8 of the "Final" regulations, Q&A-3, defines separate accounts for purposes of Code section 401(a)(9), as separate portions of an employee's benefit reflecting the separate interests of the employee's beneficiaries under the plan as of the date of the employee's death for which separate accounting is maintained. The separate accounting must allocate all post-death investments, gains and losses, contributions, and forfeitures for the period prior to the establishment of the separate accounts on a pro rata basis in a reasonable and consistent manner among the separate accounts.

Section 1.401(a)(9)-9, of the "Final" Regulations, Q&A-1, sets forth the "Single Life Table" used to compute the life expectancy of an individual.

As previously noted, taxpayers must compute minimum required distributions for calendar years beginning with calendar year in accordance with the "Final" regulations referenced above.

With respect to your second ruling request, based on the facts contained herein, the Service believes that the "separate account" requirements of section 1.401(a)(9)-8 of the "Final" regulations, Qs&As-2, have been met for years subsequent to calendar year . Additionally, based on the facts contained herein, the representation that Trust T is intended to qualify as a "special needs trust" under state and federal law to preserve Taxpayer B's eligibility to receive public benefits, and with reference to the conclusion reached on the first ruling regarding the status of Trust T as a grantor trust, the Service believes that it is appropriate to calculate the annual distributions required under Code section 401(a)(9) (made applicable to IRAs X and Y pursuant to Code section 408(a)(6), made to Trust T from IRA Y by using Taxpayer B's life expectancy.

Our conclusion to this second ruling request does not change even after Taxpayer B's share of Taxpayer A's IRA X is transferred, by means of a trustee to trustee transfer, to IRA Y, an IRA set up and maintained in the name of Taxpayer A to benefit Taxpayer B through Trust T.

Thus, with respect to your second ruling request, the Service concludes as follows:

> the trustee of Trust T, Guardian, may calculate the annual distributions required under Code section 401(a)(9) (made applicable to IRAs X and Y pursuant to Code section 408(a)(6)), to be made to Trust T from IRA Y by using Taxpayer B's life expectancy.

This ruling letter is based on the assumption that IRA X either has met, is meeting, or will meet the requirements of Code § 408(a) at all times relevant thereto. Furthermore, it assumes that IRA Y will also meet the requirements of Code section 408(a) at all times relevant thereto. It also assumes that Trust T is valid under the laws of State W as represented. Finally, it assumes that the disclaimer referenced herein met the requirements of Code section 2518.

No opinion is expressed as to the tax treatment of the transaction described herein under the provisions of any other section of either the Code or regulations, which may be applicable thereto.

200620025

This letter is directed only to the taxpayer who requested it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

The original of this letter has been sent to your authorized representatives in accordance with a power of attorney on file in this office.

If you wish to inquire about this ruling, please contact , Esquire (ID: -)) at either - (Phone) or - (FAX). Please address all correspondence to SE:T:EP:RA:T3.

Sincerely yours,

Frances V. Sloan

Frances V. Sloan, Manager,
Employee Plans Technical Group 3

Enclosures:
Deleted copy of ruling letter
Notice of Intention to Disclose

V. Internal Revenue Service Private Letter Ruling # 201117042

Based on the above facts and representations, you, through your authorized representative, request the following letter rulings:

1. That, pursuant to section 408(d)(3)(I) of the Internal Revenue Code, the 60-day rollover period found at section 408(d)(3)(A) of the Code applicable to the distribution made on or about Date 3, 2008, from IRA X is waived; and

2. that Taxpayer A, is granted a period not to exceed 60 days as measured from the date of this ruling letter to roll over an amount not to exceed Amount U into an IRA.

Section 408(d)(1) of the Code provides that, except as otherwise provided in section 408(d), any amount paid or distributed out of an IRA shall be included in gross income by the payee or distributee, as the case may be, in the manner provided under section 72 of the Code.

Section 408(d)(3) of the Code defines, and provides the rules applicable to IRA rollovers. Section 408(d)(3)(A) of the Code provides that section 408(d)(1) of the Code does not apply to any amount paid or distributed out of an IRA to the individual for whose benefit the IRA is maintained if (i)the entire amount received (including money and any other property) is paid into an IRA for the benefit of such individual not later than the 60th day after the day on which the individual receives the payment or distribution; or (ii) the entire amount received (including money and any other property) is paid into an eligible retirement plan (other than an IRA) for the benefit of such individual not later than the 60th day after the date on which the payment or distribution is received, except that the maximum amount which may be paid into such plan may not exceed the portion of the amount received which is includible in gross income (determined without regard to section 408(d)(3)).

Section 408(d)(3)(B) of the Code provides that section 408(d)(3) does not apply to any amount described in section 408(d)(3)(A)(i) received by an individual from an IRA if at any time during the 1-year period ending on the day of such receipt such individual received any other amount described in section 408(d)(3)(A)(i) from an IRA which was not includible in gross income because of the application of section 408(d)(3).

Section 408(d)(3)(D) of the Code provides a similar 60-day rollover period for partial rollovers.

Code section 408(d)(3)(E) provides, in summary, that this paragraph does not apply to any amount required to be distributed in accordance with subsection (a)(6) or (b)(3) (Code section 401(a)(9) required distributions).

Section 408(d)(3)(I) of the Code provides that the Secretary may waive the 60-day requirement under sections 408(d)(3)(A) and 408(d)(3)(D) of the Code where the failure to waive such requirement would be against equity or good conscience, including casualty, disaster, or other events beyond the reasonable control of the individual subject to such requirement. Only distributions that occurred after December 31, 2001, are eligible for the waiver under section 408(d)(3)(I) of the Code.

Revenue Procedure 2003-16, 2003-4 I.R.B. 359, (January 27, 2003), provides that in determining whether to grant a waiver of the 60-day rollover requirement pursuant to section 408(d)(3)(I), the Service will consider all relevant facts and circumstances, including: (1) errors committed by a financial institution; (2) inability to complete a rollover due to death, disability, hospitalization, incarceration, restrictions imposed by a foreign country or postal error, (3) the use of the amount distributed (for example, in the case of payment by check, whether the check was cashed); and (4) the time elapsed since the distribution occurred.

The facts submitted in support of this ruling request indicate that, during calendar year 2008, Amount U was transferred from IRA X into an account set up and maintained in the name of Trust T. Company N, the financial institution which accomplished the transfer, correctly noted that an individual retirement account cannot be set up and maintained in the name of a trust, and appropriately issued a federal Form 1099 treating the Date 3, 2008 transfer as a taxable distribution.

The facts submitted in support of this ruling request indicate that Taxpayer A's financial advisor, acting on behalf of Taxpayer A, and on behalf of Trustee B, the trustee of Trust T, requested the IRA X distribution. The Service notes that although the financial advisor's instruction to Company N was based on a Court T order, a taxable event did occur as a result of the transfer and as a result of the actions of Taxpayer A's financial advisor.

Thus, under the facts outlined above, the Service, pursuant to Code section 408(d)(3)(I), waives the 60-day rollover period applicable to the Date 3, 2008 distribution from IRA X. Therefore, with respect to your ruling requests, the Service concludes as follows:

1. That, pursuant to section 408(d)(3)(I) of the Internal Revenue Code, the 60-day rollover period found at section 408(d)(3)(A) of the Code applicable to the distribution made on or about Date 3, 2008, from IRA X is waived; and

2. that Taxpayer A is granted a period not to exceed 60 days as measured from the date of this ruling letter to roll over an amount not to exceed Amount U into an IRA.

This ruling letter is based on the assumption that IRA X either has met, is meeting, or will meet the requirements of Code section 408(a) at all times relevant thereto.

No opinion is expressed as to the tax treatment of the transaction described herein under the provisions of any other section of either the Code or regulations, which may be applicable thereto.

This letter is directed only to the taxpayer who requested it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

The original of this letter has been sent to your authorized representatives in accordance with a power of attorney on file in this office.

If you wish to inquire about this ruling, please contact me XXXXXX

Sincerely yours,

Frances V. Sloan

Frances V. Sloan, Manager,
Employee Plans Technical Group 3

Enclosures:
Deleted copy of ruling letter
Notice of Intention to Disclose

VI. Internal Revenue Service Private Letter Ruling # 201116005

Internal Revenue Service

Number: **201116005**
Release Date: 4/22/2011
Index Number: 677.00-00, 691.01-00

Department of the Treasury
Washington, DC 20224

Third Party Communication: None
Date of Communication: Not Applicable

Person To Contact:
, ID No.
Telephone Number:

Refer Reply To:
CC:PSI:B01
PLR-129484-10
Date:
December 15, 2010

X =

A =

Trust =

D1 =

State =

Dear :

This letter responds to the letter dated April 5, 2010, and subsequent correspondence, submitted on behalf of X by X's authorized representative, requesting a ruling under the Internal Revenue Code.

FACTS

The information submitted states that X is disabled and eligible to receive public benefits. X's father, A, died D1. A owned two individual retirement accounts (IRAs) of which X and X's siblings are the designated beneficiaries. X proposes to transfer X's share of the IRAs to a newly established IRA benefitting Trust and the beneficiaries thereof.

Trust is intended to be a special needs trust. The terms of Trust provide that X is the sole beneficiary of Trust during X's lifetime. The trustee shall apply so much of the net income of Trust for the use of X as the trustee in its sole discretion shall determine is beneficial to X taking into consideration the best interest and welfare of X. If the income from Trust, together with any other income and resources possessed by X, including all governmental benefits, is insufficient to provide for the benefit of X, in the sole opinion of the trustee of Trust, the trustee is authorized to invade the principal for X's benefit. In general, however, the trustee may not invade the principal if such act will serve to deny, discontinue, reduce, or eliminate any government entitlement or payment which X would otherwise receive. The trustee shall accumulate and add to principal any net income not so paid or applied. Upon X's death, any remaining principal and undistributed income of Trust shall be distributed to State as reimbursement for assistance provided during X's lifetime. After reimbursement to the State, all remaining principal and undistributed income will be distributed to X's issue or, if there are no issue, to X's siblings, then to their issue by representation.

LAW AND ANALYSIS

Section 691(a)(1) of the Code provides that the amount of all items of gross income in respect of a decedent (IRD) which are not properly includible in respect of the taxable period in which falls the date of the decedent's death or a prior period (including the amount of all items of gross income in respect of a prior decedent, if the right to receive such amount was acquired by reason of the death of the prior decedent or by bequest, devise, or inheritance from the prior decedent) shall be included in the gross income, for the taxable year when received, of: (A) the estate of the decedent, if the right to receive the amount is acquired by the decedent's estate from the decedent; (B) the person who, by reason of the death of the decedent, acquires the right to receive the amount, if the right to receive the amount is not acquired by the decedent's estate from the decedent; or (C) the person who acquires from the decedent the right to receive the amount by bequest, devise, or inheritance, if the amount is received after a distribution by the decedent's estate of such right.

Section 691(a)(2) provides that if a right, described in § 691(a)(1), to receive an amount is transferred by the estate of the decedent or a person who received such right by reason of the death of the decedent or by bequest, devise, or inheritance from the decedent, there shall be included in the gross income of the estate or such person, as the case may be, for the taxable period in which the transfer occurs, the fair market value of such right at the time of such transfer plus the amount by which any consideration for the transfer exceeds such fair market value. For purposes of this paragraph, the term "transfer" includes sale, exchange, or other disposition, or the satisfaction of an installment obligation at other than face value, but does not include transmission at death to the estate of the decedent or a transfer to a person pursuant to

the right of such person to receive such amount by reason of the death of the decedent or by bequest, devise, or inheritance from the decedent.

Section 1.691(a)-4(a) of the Income Tax Regulations provides that if a right described in § 691(a)(1) is disposed of by gift, the fair market value of the right at the time of the gift must be included in the gross income of the donor.

Rev. Rul. 92-47, 1992-1 C.B. 198, holds that a distribution to the beneficiary of a decedent's IRA that equals the amount of the balance in the IRA at the decedent's death, less any nondeductible contributions, is IRD under § 691(a)(1) that is includable in the gross income of the beneficiary for the taxable year the distribution is received.

Section 671 provides that where it is specified in subpart E of Part I of subchapter J that the grantor or another person shall be treated as the owner of any portion of a trust, there shall then be included in computing the taxable income and credits of the grantor or the other person those items of income, deductions, and credits against tax of the trust which are attributable to that portion of the trust to the extent that such items would be taken into account under chapter 1 in computing taxable income or credits against the tax of an individual.

Section 677(a) provides that the grantor shall be treated as the owner of any portion of a trust, whether or not he is treated as such owner under § 674, whose income without the approval or consent of any adverse party is, or, in the discretion of the grantor or a nonadverse party, or both, may be (1) distributed to the grantor or the grantor's spouse; (2) held or accumulated for future distribution to the grantor or the grantor's spouse; or (3) applied to the payment of premiums on policies of insurance on the life of the grantor or the grantor's spouse.

Rev. Rul. 85-13, 1985-1 C.B. 184, concludes that if a grantor is treated as the owner of a trust, the grantor is considered to be the owner of the trust assets for federal income tax purposes. A grantor's receipt of the corpus of a trust in exchange for an unsecured promissory note was treated as an unsecured borrowing of the trust corpus which caused the grantor to be treated as the owner of the trust under § 675(3). The transfer of the trust assets in exchange for the note was not recognized as a sale for federal income purposes.

CONCLUSIONS

Based solely on the facts and representations submitted, we conclude that Trust will be treated as owned by X under §§ 671 and 677(a). Therefore, assuming the transfer of X's share of the IRAs to the Trust is not a gift by X, such transfer will not be a sale or disposition for federal income tax purposes or a transfer for purposes of § 691(a)(2).

Except as specifically set forth above, we express or imply no opinion concerning the federal tax consequences of the facts described above under any other provision of the Code. Specifically, we express or imply no opinion under § 401(a)(9).

This ruling is directed only to the taxpayer requesting it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

Pursuant to a power of attorney on file with this office, a copy of this letter is being sent to X's authorized representatives.

Sincerely,

Faith P. Colson
Faith P. Colson
Senior Counsel, Branch 1
Office of the Associate Chief Counsel
(Passthroughs & Special Industries)

Enclosures (2)
Copy of this letter
Copy for § 6110 purposes

cc:

VII.

26 U.S. Code § 199A - Qualified business income

(a)**In General** In the case of a taxpayer other than a corporation, there shall be allowed as a deduction for any taxable year an amount equal to the sum of—

(1) the lesser of—

(A) the combined qualified business income amount of the taxpayer, or

(B) an amount equal to 20 percent of the excess (if any) of—

(i) the taxable income of the taxpayer for the taxable year, over

(ii) the sum of any net capital gain (as defined in section 1(h)), plus the aggregate amount of the qualified cooperative dividends, of the taxpayer for the taxable year, plus

(2)the lesser of—

(A) 20 percent of the aggregate amount of the qualified cooperative dividends of the taxpayer for the taxable year, or

(B) taxable income (reduced by the net capital gain (as so defined)) of the taxpayer for the taxable year.

The amount determined under the preceding sentence shall not exceed the taxable income(reduced by the net capital gain (as so defined)) of the taxpayer for the taxable year.

(b)**COMBINED QUALIFIED BUSINESS INCOME AMOUNT** For purposes of this section—

(1)IN GENERALThe term “combined qualified business income amount” means, with respect to any taxable year, an amount equal to—

(A) the sum of the amounts determined under paragraph (2) for each qualified trade or business carried on by the taxpayer, plus

(B) 20 percent of the aggregate amount of the qualified REIT dividends and qualified publicly traded partnership income of the taxpayer for the taxable year.

(2)**DETERMINATION OF DEDUCTIBLE AMOUNT FOR EACH TRADE OR BUSINESS** The amount determined under this paragraph with respect to any qualified trade or business is the lesser of—

(A) 20 percent of the taxpayer's qualified business income with respect to the qualified trade or business, or

(B)the greater of—

(i) 50 percent of the W–2 wages with respect to the qualified trade or business, or

(ii) the sum of 25 percent of the W–2 wages with respect to the qualified trade or business, plus 2.5 percent of the unadjusted basis immediately after acquisition of all qualified property.

(3)**MODIFICATIONS TO LIMIT BASED ON TAXABLE INCOME**

(A)Exception from limit

In the case of any taxpayer whose taxable income for the taxable year does not exceed the threshold amount, paragraph (2) shall be applied without regard to subparagraph (B).

(B)Phase-in of limit for certain taxpayers

(i)In general If—

(I) the taxable income of a taxpayer for any taxable year exceeds the threshold amount, but does not exceed the sum of the threshold amount plus $50,000 ($100,000 in the case of a joint return), and

(II) the amount determined under paragraph (2)(B) (determined without regard to this subparagraph) with respect to any qualified trade or business carried on by the taxpayer is less than the amount determined under paragraph (2)(A) with respect such trade or business,

then paragraph (2) shall be applied with respect to such trade or business without regard to subparagraph (B)

thereof and by reducing the amount determined under subparagraph (A) thereof by the amount determined under clause (ii).

(ii)Amount of reduction The amount determined under this subparagraph is the amount which bears the same ratio to the excess amount as—

(I) the amount by which the taxpayer's taxable income for the taxable year exceeds the threshold amount, bears to

(II) $50,000 ($100,000 in the case of a joint return).

(iii)Excess amount For purposes of clause (ii), the excess amount is the excess of—

(I) the amount determined under paragraph (2)(A) (determined without regard to this paragraph), over

(II) the amount determined under paragraph (2)(B) (determined without regard to this paragraph).

(4)**WAGES, ETC**

(A)In general

The term "W–2 wages" means, with respect to any person for any taxable year of such person, the amounts described in paragraphs (3) and (8) of section 6051(a) paid by such person with respect to employment of employees by such person during the calendar year ending during such taxable year.

(B)Limitation to wages attributable to qualified business income
Such term shall not include any amount which is not properly allocable to qualified business income for purposes of subsection (c)(1).

(C)Return requirement
Such term shall not include any amount which is not properly included in a return filed with the Social Security Administration on or before the 60th day after the due date (including extensions) for such return.

(5)ACQUISITIONS, DISPOSITIONS, AND SHORT TAXABLE YEARS

The Secretary shall provide for the application of this subsection in cases of a short taxable year or where the taxpayer acquires, or disposes of, the major portion of a trade or business or the major portion of a separate unit of a trade or business during the taxable year.

(6)**QUALIFIED PROPERTY** For purposes of this section:

(A)**In general** The term "qualified property" means, with respect to any qualified trade or business for a taxable year, tangible property of a character subject to the allowance for depreciation under section 167—

(i) which is held by, and available for use in, the qualified trade or business at the close of the taxable year,

(ii) which is used at any point during the taxable year in the production of qualified business income, and

(iii) the depreciable period for which has not ended before the close of the taxable year.

(B)**Depreciable period** The term "depreciable period" means, with respect to qualified property of a taxpayer, the period beginning on the date the property was first placed in service by the taxpayer and ending on the later of—

(i) the date that is 10 years after such date, or

(ii) the last day of the last full year in the applicable recovery period that would apply to the property under section 168 (determined without regard to subsection (g) thereof).

(c)**QUALIFIED BUSINESS INCOME** For purposes of this section—

(1)**IN GENERAL**

The term "qualified business income" means, for any taxable year, the net amount of qualified items of income, gain, deduction, and loss with respect to any qualified trade or business of the taxpayer. Such term shall not include any qualified REIT dividends, qualified cooperative dividends, or qualified publicly traded partnership income.

(2)**CARRYOVER OF LOSSES**

If the net amount of qualified income, gain, deduction, and loss with respect to qualified trades or businesses of the taxpayer for any taxable year is less than zero, such amount shall be treated as a loss from a qualified trade or business in the succeeding taxable year.

(3)**QUALIFIED ITEMS OF INCOME, GAIN, DEDUCTION, AND LOSS** For purposes of this subsection—

(A)**In general** The term "qualified items of income, gain, deduction, and loss" means items of income, gain, deduction, and loss to the extent such items are—

(i) effectively connected with the conduct of a trade or business within the United States (within the meaning of section 864(c), determined by substituting "qualified trade or business (within the meaning of section 199A)" for "non-resident alien individual or a foreign corporation" or for "a foreign corporation" each place it appears), and

(ii) included or allowed in determining taxable income for the taxable year.

(B)Exceptions The following investment items shall not be taken into account as a qualified item of income, gain, deduction, or loss:

(i) Any item of short-term capital gain, short-term capital loss, long-term capital gain, or long-term capital loss.

(ii) Any dividend, income equivalent to a dividend, or payment in lieu of dividends described in section 954(c)(1)(G).

(iii) Any interest income other than interest income which is properly allocable to a trade or business.

(iv) Any item of gain or loss described in subparagraph (C) or (D) of section 954(c)(1)(applied by substituting "qualified trade or business" for "controlled foreign corporation").

(v) Any item of income, gain, deduction, or loss taken into account under section 954(c)(1)(F) (determined without regard to clause (ii) thereof and other than items attributable to notional

principal contracts entered into in transactions qualifying under section 1221(a)(7)).

(vi) Any amount received from an annuity which is not received in connection with the trade or business.

(vii) Any item of deduction or loss properly allocable to an amount described in any of the preceding clauses.

(4)**TREATMENT OF REASONABLE COMPENSATION AND GUARANTEED PAYMENTS** Qualified business income shall not include—

(A) reasonable compensation paid to the taxpayer by any qualified trade or business of the taxpayer for services rendered with respect to the trade or business,

(B) any guaranteed payment described in section 707(c) paid to a partner for services rendered with respect to the trade or business, and

(C) to the extent provided in regulations, any payment described in section 707(a) to a partner for services rendered with respect to the trade or business.

(d)**QUALIFIED TRADE OR BUSINESS** For purposes of this section—

(1)**IN GENERAL** The term "qualified trade or business" means any trade or business other than—

(A) a specified service trade or business, or

(B) the trade or business of performing services as an employee.

(2)**SPECIFIED SERVICE TRADE OR BUSINESS** The term "specified service trade or business" means any trade or business—

(A) which is described in section 1202(e)(3)(A) (applied without regard to the words "engineering, architecture,") or which would be so described if the term "employees or owners" were substituted for "employees" therein, or

(B) which involves the performance of services that consist of investing and investment management, trading, or dealing in securities (as defined in section 475(c)(2)), partnership interests, or commodities (as defined in section 475(e)(2)).

(3)**EXCEPTION FOR SPECIFIED SERVICE BUSINESSES BASED ON TAXPAYER'S INCOME**

(A) **In general** If, for any taxable year, the taxable income of any taxpayer is less than the sum of the threshold amount plus $50,000 ($100,000 in the case of a joint return), then—

(i) any specified service trade or business of the taxpayer shall not fail to be treated as a qualified trade or business due to paragraph (1)(A), but

(ii) only the applicable percentage of qualified items of income, gain, deduction, or loss, and the W–2 wages and the unadjusted basis immediately after acquisition of qualified property, of the taxpayer allocable to such specified service trade or business shall be taken into account in computing the qualified business income, W–2 wages, and the unadjusted basis immediately after acquisition of qualified property of the taxpayer for the taxable year for purposes of applying this section.

(B) **Applicable percentage** For purposes of subparagraph (A), the term "applicable percentage" means, with respect to any taxable year, 100 percent reduced (not below zero) by the percentage equal to the ratio of—

(i) the taxable income of the taxpayer for the taxable year in excess of the threshold amount, bears to

(ii) $50,000 ($100,000 in the case of a joint return).

(e)**OTHER DEFINITIONS** For purposes of this section—

(1)**TAXABLE INCOME**

Taxable income shall be computed without regard to the deduction allowable under this section.

(2)**THRESHOLD AMOUNT**

(A) In general

The term "threshold amount" means $157,500 (200 percent of such amount in the case of a joint return).

(B)Inflation adjustment

In the case of any taxable year beginning after 2018, the dollar amount in subparagraph (A) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting “calendar year 2017” for “calendar year 2016” in subparagraph (A)(ii) thereof.

The amount of any increase under the preceding sentence shall be rounded as provided in section 1(f)(7).

(3)**QUALIFIED REIT DIVIDEND** The term “qualified REIT dividend” means any dividend from a real estate investment trust received during the taxable year which—

(A) is not a capital gain dividend, as defined in section 857(b)(3), and

(B) is not qualified dividend income, as defined in section 1(h)(11).

(4)**QUALIFIED COOPERATIVE DIVIDEND** The term “qualified cooperative dividend” means any patronage dividend (as defined in section 1388(a)), any per-unit retain allocation (as defined in section 1388(f)), and any qualified written notice of allocation (as defined in section 1388(c)), or any similar amount received from an organization described in subparagraph (B)(ii), which—

(A) is includible in gross income, and

(B) is received from—

(i) an organization or corporation described in section 501(c)(12) or 1381(a), or

(ii) an organization which is governed under this title by the rules applicable to cooperatives under this title before the enactment of subchapter T.

(5)**QUALIFIED PUBLICLY TRADED PARTNERSHIP INCOME** The term “qualified publicly traded partnership income” means, with respect to any qualified trade or business of a taxpayer, the sum of—

(A) the net amount of such taxpayer's allocable share of each qualified item of income, gain, deduction, and loss (as defined in subsection (c)(3) and determined after the application of subsection (c)(4)) from a publicly traded partnership (as defined in section 7704(a)) [1] which is not treated as a corporation under section 7704(c), plus

(B) any gain recognized by such taxpayer upon disposition of its interest in such partnership to the extent such gain is treated as an amount realized from the sale or exchange of property other than a capital asset under section 751(a).

(f)**SPECIAL RULES**

(1)**APPLICATION TO PARTNERSHIPS AND S CORPORATIONS**

(A) In general In the case of a partnership or S corporation—

(i) this section shall be applied at the partner or shareholder level,

(ii) each partner or shareholder shall take into account such person's allocable share of each qualified item of income, gain, deduction, and loss, and

(iii) each partner or shareholder shall be treated for purposes of subsection (b) as having W–2 wages and unadjusted basis immediately after acquisition of qualified property for the taxable year in an amount equal to such person's allocable share of the W–2 wages and the unadjusted basis immediately after acquisition of qualified property of the partnership or S corporation for the taxable year (as determined under regulations prescribed by the Secretary).

For purposes of clause (iii), a partner's or shareholder's allocable share of W–2 wages shall be determined in the same manner as the partner's or shareholder's allocable share of wage expenses. For purposes of such clause, partner's or shareholder's allocable share of the unadjusted basis immediately after acquisition of qualified property shall be determined in the same manner as the partner's or shareholder's allocable share of depreciation. For purposes of this subparagraph, in the case of an S

corporation, an allocable share shall be the shareholder's pro rata share of an item.

(B)Application to trusts and estates

Rules similar to the rules under section 199(d)(1)(B)(i) (as in effect on December 1, 2017) for the apportionment of W–2 wages shall apply to the apportionment of W–2 wages and the apportionment of unadjusted basis immediately after acquisition of qualified property under this section.

(C)Treatment of trades or business in Puerto Rico

(i)In general

In the case of any taxpayer with qualified business income from sources within the commonwealth of Puerto Rico, if all such income is taxable under section 1 for such taxable year, then for purposes of determining the qualified business income of such taxpayer for such taxable year, the term "United States" shall include the Commonwealth of Puerto Rico.

(ii)Special rule for applying limit

In the case of any taxpayer described in clause (i), the determination of W–2 wages of such taxpayer with respect to any qualified trade or business conducted in Puerto Rico shall be made without regard to any exclusion under section 3401(a)(8) for remuneration paid for services in Puerto Rico.

(2)**COORDINATION WITH MINIMUM TAX**

For purposes of determining alternative minimum taxable income under section 55, qualified business income shall be determined without regard to any adjustments under sections 56through 59.

(3)**DEDUCTION LIMITED TO INCOME TAXES**

The deduction under subsection (a) shall only be allowed for purposes of this chapter.

(4)**REGULATIONS** The Secretary shall prescribe such regulations as are necessary to carry out the purposes of this section, including regulations—

(A) for requiring or restricting the allocation of items and wages under this section and such reporting requirements as the Secretary determines appropriate, and

(B) for the application of this section in the case of tiered entities.

(g)**DEDUCTION ALLOWED TO SPECIFIED AGRICULTURAL OR HORTICULTURAL COOPERATIVES**

(1)**IN GENERAL** In the case of any taxable year of a specified agricultural or horticultural cooperative beginning after December 31, 2017, there shall be allowed a deduction in an amount equal to the lesser of—

(A) 20 percent of the excess (if any) of—

(i) the gross income of a specified agricultural or horticultural cooperative, over

(ii) the qualified cooperative dividends (as defined in subsection (e)(4)) paid during the taxable year for the taxable year, or

(B) the greater of—

(i) 50 percent of the W–2 wages of the cooperative with respect to its trade or business, or

(ii) the sum of 25 percent of the W–2 wages of the cooperative with respect to its trade or business, plus 2.5 percent of the unadjusted basis immediately after acquisition of all qualified property of the cooperative.

(2)**LIMITATION**

The amount determined under paragraph (1) shall not exceed the taxable income of the specified agricultural or horticultural for the taxable year.

(3)**SPECIFIED AGRICULTURAL OR HORTICULTURAL COOPERATIVE** For purposes of this subsection, the term “specified agricultural or horticultural cooperative” means an organization to which part I of subchapter T applies which is engaged in—

(A) the manufacturing, production, growth, or extraction in whole or significant part of any agricultural or horticultural product,

(B) the marketing of agricultural or horticultural products which its patrons have so manufactured, produced, grown, or extracted, or

(C) the provision of supplies, equipment, or services to farmers or to organizations described in subparagraph (A) or (B).

(h)**ANTI-ABUSE RULES** The Secretary shall—

(1) apply rules similar to the rules under section 179(d)(2) in order to prevent the manipulation of the depreciable period of qualified property using transactions between related parties, and

(2) prescribe rules for determining the unadjusted basis immediately after acquisition of qualified property acquired in like-kind exchanges or involuntary conversions.

(i)**TERMINATION**

This section shall not apply to taxable years beginning after December 31, 2025.

(Added Pub. L. 115–97, title I, § 11011(a), Dec. 22, 2017, 131 Stat. 2063.)

---

[1] So in original. Probably should be "7704(b))".

TRACK 2
Using the CPLR:
Advanced Practice in Article 81 Guardianship

Presented By:
Joseph A. Greenman, Esq.
and
Richard L. Weber, Esq.

USING THE CPLR:
ADVANCED PRACTICE IN ARTICLE 81 GUARDIANSHIP

Presentation to the Elder Law and Special Needs Section of the New York State Bar Association
July 12 – 14, 2018

Bond, Schoeneck & King, PLLC
Joseph A. Greenman, Esq. and Richard L. Weber, Esq.

TABLE OF CONTENTS

PURPOSE OF ARTICLE 81

In enacting Article 81 of New York State's Mental Hygiene Law, the legislature declared:

> The legislature declares that it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desire of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.

N.Y. Mental Hygiene L. § 81.01. In accordance with this purpose, Article 81 is the least restrictive means of guardianship, and "[a]ny guardian appointed under this article shall be granted only those powers which are necessary to provide for personal needs and/or property management of the incapacitated person in such a manner as appropriate to the individual and which shall constitute the least restrictive form of intervention . . ." N.Y. Mental Hygiene Law § 81.02(a)(2).

APPOINTING A GUARDIAN

The Court must determine: (1) "the appointment is necessary to provide for the personal needs of the[e] person"; and (2) the person either (a) agrees to the appointment, or (b) is incapacitated. See N.Y. Mental Hygiene L. § 81.02(a).

Incapacity depends on a showing, by clear and convincing evidence, that a "person is likely to suffer harm because: (1) the person is unable to provide for personal needs and/or property management; and (2) the person cannot adequately understand and appreciate the nature and consequences of such inability." See N.Y. Mental Hygiene L. § 81.02(b). This showing consists of a number of components, including a required court evaluator report, the resources available to the allegedly incapacitated person, and the functional level and limitations of a person. See N.Y. Metal Hygiene L § 81.02(c)-(d).

JURISDICTION & VENUE

JURISDICTION

Pursuant to N.Y. Mental Hygiene L. § 81.04:

> If after a hearing or trial in accordance with the provisions of this article it is determined that relief under this article is necessary, the supreme court, and the county courts outside the city of New York, shall have the power to provide the relief set forth in this article:
>
> ***

1. for a resident of the state;

2. for a nonresident of the state present in the state;

3. for a nonresident of the state pursuant to section 81.18[1] of this article.

***

Notwithstanding the provisions of subdivision (a) of this section, when it appears in any proceeding in the surrogate's court that a person interested in an estate is entitled to money or property as a beneficiary of the estate, or entitled to the proceeds of any action as provided in section 5-4.1 of the estates, powers and trusts law, or to the proceeds of a settlement of a cause of action brought on behalf of an infant for personal injuries, and that the interested person is a resident of, is physically present, or has any property in, the county in which the proceeding is pending and is allegedly incapacitated with respect to property management under the provisions of this article, and the surrogate's court is satisfied after a hearing or trial in accordance with the provisions of this article that the interested person is incapacitated with respect to property management, the surrogate's court shall have the power to order relief for that person with respect to property management in accordance with the provisions of this article.

See In re Verna HH., 756 N.Y.2d 300 (App. Div. 2003) (trial court erred in dismissing underlying petition based on Petitioner's lack of property in the state, as mere physical presence is all that is required).

See In re Vaneria, 712 N.Y.2d 221 (App. Div. 2000) (petition dismissed because the alleged incapacitated person resided in MA and was not physically present nor did they own property within the state).

See In re Mary S., 651 N.Y.2d 81 (App. Div. 1996) (judgment affirmed because although the AIP resided in Maryland, she had personal connections and property in the state).

VENUE

An Article 81 proceeding shall be brought "in the supreme court within the judicial district, or in the county court of the county in which the person alleged to be incapacitated resides, or is

[1] "Where the person alleged to be incapacitated is not present in the state and a guardian, by whatever name designated, has been duly appointed pursuant to the laws of any other country where the person alleged to be incapacitated resides to assist such person in property management, the court in its discretion, may make an order appointing the foreign guardian under this article with powers with respect to property management within this state on the foreign guardian's giving such security as the court deems proper." N.Y. Mental Hygiene L. § 81.18.

physically present, or in the surrogate's court having jurisdiction pursuant to subdivision (b) of section 81.04 of this article." See N.Y. Mental Hygiene L. § 81.05(a). If the person alleged to be incapacitated lives, or is cared for, in a facility, then the location of the facility is considered the proper venue. See id. If the person alleged to be incapacitated cannot be located or does not live in the state, then the location of his/her property is considered the proper venue. See id.

Generally, a proceeding to modify a prior order shall be brought in the court where the prior order was issued, unless the incapacitated person lives, or is cared for, in a facility – under those circumstances, the proceeding should be brought where the facility is located. See N.Y. Mental Hygiene L. § 81.05(b).

For either type of proceeding, if the facility's location is inconvenient, an interested party may move to change the venue. See N.Y. Mental Hygiene L. § 81.05.

See In re Davis, 866 N.Y.S.2d 91 (Sup. Ct. Queens Cty. 2008) (venue improper because alleged incapacitated person lived in Queens County in the Veteran's Home).

See In re S.A.W., 841 N.Y.S.2d 823 (Sup. Ct. Rockland Cty. 2007) (change of venue improper because the petitioner failed to sustain burden of establishing convenience of material witnesses nor that the ends of justice would be promoted by a change of venue).

WHO COMMENCES THE PROCEEDING?

Article 81 proceedings may be brought by seven (7) categories of individuals:

1. The person alleged to be incapacitated (the "AIP"). See In re Kufeld, 889 N.Y.S.2d 882 (Sup. Ct. Bronx Cty. 2009) (AIP commenced the proceeding via self-petition to have a guardian appointed to manage his personal needs and property).

2. The presumptive distributee of the AIP, i.e., any person entitled to take or share in the property of a decedent under the statutes governing descent and distribution.

3. The executor or administrator of an estate of which the AIP is or may be a beneficiary. See In re Curran, 781 N.Y.S.2d 334 (App. Div. 2004) (both the preliminary executor of the estate and the sole beneficiary of the estate were proper parties to petition).

4. The trustee of a trust for which the AIP is or may be the grantor or beneficiary.

5. The individual with whom the AIP resides.

6. A person (including a corporation, public agency, social services, etc.) "otherwise concerned with the welfare" of the AIP. See In re Azzi, 36 N.Y.S.3d 336 (App. Div. 2016) (petitioner's adult siblings are persons otherwise concerned with the welfare of the AIP).

7. The CEO of a facility where the AIP is a patient or resident. See In re C.K., 839 N.Y.S.2d 432 (Sup. Ct. Nassau Cty. 2007) (hospital where the AIP is admitted is an entity that can initiate the proceedings).

"A proceeding under [Article 81] shall be commenced upon the filing of a petition." See N.Y. Mental Hygiene L. § 81.07(a).

ORDER TO SHOW CAUSE

How Should the Order to Show Cause Look and What Information Should it Contain?

The Order to Show Cause must be written in: (1) large type; (2) plain language; and (3) in a language other than English if necessary to adequately inform the alleged incapacitated person (the "Person") of her/his rights. See N.Y. Mental Hygiene L. § 81.07(c).

The Order to Show Cause must include: (1) the date, time, and hearing of the Petition; (2) a clear, easily readable statement of the Person;[2] (3) the name, address, and phone number of the court evaluator;[3] (4) the name, address, and phone number of an appointed attorney, if any; (5) a list of the powers the guardian would have if the Petition were granted; and (6) a legend in size 12 or larger, bold, double-spaced type.[4] See N.Y. Mental Hygiene L. § 81.07(c)-(d).

What Does the Court Do Upon Receipt of the Order to Show Cause?

1. Set the date on which the Order to Show Cause will be head – no more than twenty-eight (28) days from date of signing Order (more or less for good cause shown);

2. List the name, address, and phone number of the Court Evaluator in the Order;

3. Require the Order to be served, with a copy of the Petition and supporting papers, on: (a) Alleged Incapacitated Person; (b) Court Evaluator; and (2) Counsel for Alleged Incapacitated Person; and

4. Require Notice of the Proceeding and a Copy of the Order to Show Cause to individuals identified in N.Y. Mental Hygiene L. § 81.07(g)(1).

See N.Y. Mental Hygiene L. § 81.07(b).

A sample Order to Show Cause satisfying these requirements is attached hereto as **Exhibit A**.

VERIFIED PETITION

The Petition must be verified under oath. See N.Y. Mental Hygiene L. § 81.08(a).

[2] See N.Y. Mental Hygiene L. § 81.11.
[3] See N.Y. Mental Hygiene L. § 81.09.
[4] See N.Y. Mental Hygiene L. § 81.07(d).

Verification is a written statement under oath that asserts the truth of allegations in a pleading.[5]

The Verified Petition must include[6], at least, the following:

1. Name, address, and phone number of:

    a. AIP;

    b. Anyone with whom AIP resides, and of anyone on whom service of the Order to Show Cause will be made;

    c. Presumptive distributees of AIP;

    d. Petitioner; and

    e. Any proposed Guardian or Standby Guardian.

2. Description of AIP's functional level;

3. Powers sought with respect to AIP's personal needs – specific, particularized, duration;

4. Powers sought with respect to AIP's property management needs – specific, particularized, duration;

5. Approximate value and description of financial resources of AIP;

6. Nature and amount of claims, debts, etc. of AIP;

7. Relief sought pursuant to N.Y. Mental Hygiene L. § 81.23; and

8. Available resources considered by Petition and opinion as to sufficiency and reliability.

See In re Schneider, 852 N.Y.S.2d 769 (App. Div. 2008) (petition dismissed for lack of specific factual allegations of personal actions or financial transactions demonstrating capacity).

See In re Buffalino, 960 N.Y.S.2d 627 (Sup. Ct. Suffolk Cty. 2013) (petition dismissed because it did not allege the unavailability of other alternatives or resources).

A sample Verified Petition satisfying these requirements is attached hereto as **Exhibit B**.

[5] See N.Y. C.P.L.R. § 3020 (2018).
[6] See N.Y. Mental Hygiene L. § 81.08(a).

SERVICE V. NOTICE

The Order to Show Cause (etc.) must be served on AIP, AIP's attorney, and the Court Evaluator.[7]

Service Methods for AIP[8]:

1. Personal Delivery to the AIP, not less than 14 days prior to the hearing date of the Order to Show Cause; or

2. Alternate method of service if the petitioner demonstrated to the court's satisfaction that the AIP has refused to accept service

Service Methods for AIP's attorney and Court Evaluator[9]:

1. By facsimile; or

2. Personal delivery; or

3. Overnight delivery service within three business days following the appointment of the Court Evaluator and the appearance of the AIP's attorney

In re Hammons 645 N.Y.S.2d 392 (established the principles for determining what constitutes refusal of service; same as CPLR 308 some type of affirmative act which evidences a deliberate attempt to resist service)

Notice of the Proceeding (etc.) must be mailed to the following, no less than fourteen (14) days prior to the Hearing Date[10]*:*

- Spouse of AIP;
- Parents of AIP;
- Adult Children of AIP;
- Adult Siblings of AIP; and
- Anyone with whom AIP Resides; or
- If none of the above, then "at least one and not more than three of the living relatives of [AIP] in the nearest degree of kinship who are known to Petitioner or whose existence and address can be ascertained by Petitioner with reasonably diligent efforts."

[7] See N.Y. Mental Hygiene L. § 81.07(d).
[8] See N.Y. Mental Hygiene L. § 81.07(e).
[9] *Id.*
[10] See N.Y. Mental Hygiene L. § 81.07(g).

❖ In addition to the above, others enumerated in N.Y. Mental Hygiene L. § 81.07(g)(1)(iii)-(viii) – very fact specific.

See In re Gabr, 961 N.Y.S.2d 736 (Sup. Ct. Kings Cty. 2013) (petition dismissed for failure to provide notice to the spouse of the AIP as spouse and as a person with whom the AIP resided).

NOTICE OF APPEARANCE

A sample Notice of Appearance is attached hereto as **Exhibit C**.

THE PROCEEDING

DISCLOSURE DEVICES

After commencement of an action, there are seven ways to obtain information under the CPLR:

- ❖ Depositions upon oral questions;
- ❖ Depositions without the state upon written questions;
- ❖ Interrogatories;
- ❖ Demands for addresses;
- ❖ Discovery and inspection of documents or property;
- ❖ Physical and mental examinations; and
- ❖ Requests for Admission.

See N.Y. C.P.L.R. § 3102(a).

If a party's disclosure device causes "unreasonable annoyance, expense, embarrassment, disadvantage, or other prejudice," then the party receiving the disclosure request may move for a protective order. See N.Y. C.P.L.R. § 3103(a).

Subpoena Duces Tecum

A subpoena duces tecum may be served on any person once an action has been commenced. See N.Y. C.P.L.R. § 3120(1). The subpoena may request the ability to inspect, copy, test, or photograph designated document and things. See N.Y. C.P.L.R. § 3120(1)(i).

The subpoena duces tecum must specify:

1. The time (not less than twenty (20) days after service thereof), place, and manner of making the inspection, etc.;

2. The items to be inspected, etc.; and

3. A description of the items, with reasonable particularity.

See N.Y. C.P.L.R. § 3120(2).

The subpoena duces tecum must be served on all parties. See N.Y. C.P.L.R. § 3120(3). Service is the same for the subpoena as it is for a summons. See N.Y. C.P.L.R. § 2303(a).

Within five (5) days of compliance therewith, the requesting party must notify all parties that there has been a production and provide an opportunity for them to inspect, etc. See N.Y. C.P.L.R. § 3120(3).

If a party wishes to issue a subpoena duces tecum to a public entity, such as a department of the state, then a **motion** must be made, on notice to the department, to a judge. See N.Y. C.P.L.R. §§ 2307; 3120(4).

A sample subpoena duces tecum and order to a department of the state is attached hereto as **Exhibit D**.

Failure to comply with a judicial subpoena is punishable as a contempt of court. See N.Y. C.P.L.R. § 2308(a). If a party fails to comply with any other subpoena, then the issuing party must move in the supreme court to compel compliance and obtain relief. See N.Y. C.P.L.R. § 2308(b)(1).

SEALING ORDERS

Governing Rule: 22 N.Y.C.R.R. § 216

Part 216 of the Uniform Rules for the New York State Trial Courts permits Courts to seal court records in civil actions in the trial courts for good cause shown:

> Except where otherwise provided by statute or rule, a court shall not enter an order in any action or proceeding sealing the court records, whether in whole or in part, except upon a written finding of good cause, which shall specify the grounds thereof. In determining whether good cause has been shown, the court shall consider the interests of the public as well as of the parties. Where it appears necessary or desirable, the court may prescribe appropriate notice and opportunity to be heard.
>
> ***
>
> For purposes of this rule, "court records" shall include all documents and records of any nature filed with the clerk in connection with the action. Documents obtained through disclosure and not filed with the clerk shall remain subject to protective orders as set forth in CPLR 3103(a).

See 22 N.Y.C.R.R. § 216.1.

How to Obtain a Sealing Order

Before engaging in motion practice, a party desiring a Sealing Order should meet and confer with opposing counsel. Often, these Orders may be stipulated to by the Parties, requiring only a "So Ordered" by the Judge.

If a stipulation cannot be reached, then a party desiring a Sealing Order should make a motion comprised of: (1) a notice of motion; (2) an affidavit explaining why there is good cause for a sealing order; (3) a memorandum of law explaining why there is good cause of a sealing order; and (4) a proposed sealing order.

See In re A.J., 781 N.Y.S.2d 623 (Sup. Ct. Kings Cty. 2004) (good cause to seal file in guardianship proceeding found where AIPs and potential witnesses were afraid to speak to court evaluator for fear of retribution from the AIPs abusive son).

See In re Astor, 824 N.Y.S.2d 755 (Sup. Ct. N.Y. Cty. 2006) (file sealed only with respect to medical, mental health and nursing records pertaining to AIP and all of the court examiner's reports).

A sample Sealing and Confidentiality Order is attached hereto as **Exhibit E**.

KEY RULES OF EVIDENCE

In an Article 81 proceeding, any party has the right to: (1) present evidence; (2) call witnesses, including expert witnesses; (3) cross-examine witnesses; and (4) be represented by counsel of his or her choice. See N.Y. Mental Hygiene L. § 81.11. "The court may, for good cause shown, waive the rules of evidence." See N.Y. Mental Hygiene L. § 81.12(b).

See In re Mary WW., 4 N.Y.S.3d 381 (App. Div. 2015) (good cause for relaxing rules of evidence and considering hearsay where AIP suffered from severe dementia and could not attend the modification hearing).

See In re Marie H., 811 N.Y.S.2d 708 (App. Div. 2006) (§ 81.12(b) only applies in uncontested proceedings).

If a court does not waive the rules of evidence, a few specific provisions arise frequently in the context of Article 81 proceedings: (1) hearsay; (2) the Dead Man Statute; and (3) privilege (discussed infra).

Hearsay

An out of court statement being offered for the truth of the matter asserted. See People v. John, 52 N.E.3d 1114 (N.Y. 2016).

N.Y. C.P.L.R. § 4518. Business Records Exception: Any writing or record, whether in the form of an entry in a book, a memorandum or record of any act, transaction or occurrence, shall be admissible in evidence in proof of that act if the judge finds that it was made in the regular course of any business and that is was the regular course of such business to make it.

N.Y. C.P.L.R. § 4520. Certificate or Affidavit of Public Officer. A certificate or affidavit to a fact ascertained or an act performed, made and filed or deposited in a public office of the state by a public officer, as required or authorized by a special provision of law, in the course of his official duty, is prima facie evidence of the facts stated therein.

Dead Man's Statute

N.Y. C.P.L.R. § 4519. Personal transaction or communication between witness and decedent or mentally ill person. A person deriving his title or interest from, through or under a deceased person or mentally ill person, by assignment or otherwise, concerning a personal transaction or communication between the witness and the deceased person or mentally ill person shall not be examined as a witness in his own behalf or interest, except where the testimony of the mentally ill person or deceased person is given in evidence, concerning the same transaction or communication.

PRIVILEGE

Physician Privilege	**Psychologist Privilege**	**Social Worker Privilege**
N.Y. C.P.L.R. § 4504	N.Y. C.P.L.R. § 4507	N.Y. C.P.L.R. § 4508
"Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing, licensed practical nursing, dentistry, podiatry or chiropractic shall not be allowed to disclose any information which [s]he acquired in attending a patient in a professional capacity, and which was necessary to enable [her] to act in that capacity."	"The confidential relations and communications between a psychologist registered under the provisions of [N.Y. Educ. L. § 153] are placed on the same basis as those provided by law between attorney and client, and nothing in such article shall be construed to require any such privileged communications to be disclosed."	"A person licensed as a licensed master social worker or a licensed clinical social worker under the provisions of [N.Y. Educ. L. § 154] shall not be required to disclose a communication made by a client, or his or her advice given thereon, in the course of his or her professional employment . . ."
See In re BM, 19 N.Y.S.3d 393 (N.Y. Cty. Ct. 2015) (the physician-patient privilege applies to Article 81).	See People v. Rivera, 33 N.E.3d 465 (N.Y. 2015) (under Article 81 a Court Evaluator may apply for permission to inspect medical and **psychiatric** records of the AIP)	See In re Allers, 961 N.Y.S.2d 356 (Sup. Ct. Duchess Cty. 2012) (by affirmatively placing his mental condition in issue by opposing the petition for the appointment of a guardian, the AIP has waived privilege under §4508)

The court evaluator may apply to the court for permission to inspect these typically privileged records. See N.Y. Mental Hygiene L. § 81.09(d).

EXHIBIT A

SAMPLE ORDER TO SHOW CAUSE

At an IAS part of the Supreme Court of the State of New York held in and for the County of Onondaga at the Onondaga Supreme and County Court, on the ___ day of _____, 2020

PRESENT: HON.
Justice, Supreme Court

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

Petitioner,

v.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

ORDER TO SHOW CAUSE AND REQUEST FOR TEMPORARY RELIEF

Index No.

RJI No.

IMPORTANT

An application has been filed in Court by JANE A. DOE, who believes you may be unable to take care of your personal needs or financial affairs. JANE A. DOE is asking that someone be appointed to make decisions for you. With this paper is a copy of the application to the Court showing why JANE A. DOE believes you may be unable to take care of your personal needs and financial affairs. Before the Court makes the appointment of someone to make decisions for you, the Court holds a hearing at which you are entitled to be present and to tell the Judge if you

do not want anyone appointed. This paper tells you when the Court hearing will take place. If you do not appear in Court, your rights may be seriously affected.

You have the right to demand a trial by jury. You must tell the Court if you wish to have a trial by jury. If you do not tell the Court, the hearing will be conducted without a jury. The name and address, and telephone number of the clerk of the Court is:

Patricia J. Noll

Onondaga County & City of Syracuse Criminal Courthouse

505 S. State Street Rm. 110, Syracuse, NY 13202

Phone: 315-671-1030

The court will appoint a Court Evaluator to explain this proceeding to you and to investigate the claims made in the application. The Court may give the Court Evaluator permission to inspect your medical, psychological, psychiatric, or financial records. You have the right to tell the Judge if you do not want the Court Evaluator to be given that permission. The Court Evaluator's name, address and telephone number are:

_____

(Name)

_____

(Address)

_____

(Telephone number)

You are entitled to have a lawyer of your choice represent you. If you want the Court to appoint a lawyer to help you and represent you, the Court will appoint a lawyer for you. You will be required to pay the lawyer unless you do not have the money to do so.

NOTICE TO ALLEGED INCAPACITATED PERSON

Pursuant to Article 81 of the Mental Hygiene Law, a hearing will be held on the return date of this Order to Show Cause. At this hearing, you shall have the right to:

1. Present evidence;

2. Call witnesses, including expert witnesses;

3. Cross-examine witnesses, including witnesses called by the Court;

4. Be represented by a lawyer of your choice;

5. Have the hearing conducted in your presence, either at the Courthouse or your residence (if you cannot physically come or be brought to the Courthouse); and

6. Have this case tried by a jury, unless you fail to demand it.

On reading and filing of the annexed Petition of JANE A. DOE, duly verified on the ___ day of January, 2020, from which it appears that JOHN B. DOE, an alleged incapacitated person, residing at 123 Main Street, Rochestercuse, New York, #####, located in the County of Monronondaga, State of New York, is a person likely to suffer harm because he is unable to provide for his personal needs and property management and that he cannot adequately understand and appreciate the nature and consequences of such incapacity,

ORDERED that, JOHN B. DOE, the Alleged Incapacitated Person ("AIP"), **SHOW CAUSE** before a Justice of this Court to be held at Onondaga County & City of Syracuse Criminal Courthouse, 505 S. State Street, Syracuse, NY 13202 at an IAS Part ___ Room ____ on the ___day of January, 2020, or as soon thereafter as counsel can be heard, why an Order should not be entered:

APPOINTING JANE A. DOE, an appropriate person, Guardian for the Personal Needs and Property Management of JOHN B. DOE, an AIP, upon the Guardian qualifying in accordance with the statutes of the State of New York in such cases made and provided;

AUTHORIZING JANE A. DOE to exercise the following powers on behalf of AIP if the relief sought in the Petition is granted:

A. Authority to take possession and control of all property of AIP, both real and personal, including but not limited to those properties listed in the annexed petition;

B. Authority to apply AIP's assets and income as necessary for the comfort, support, maintenance and well-being of the alleged incapacitated person;

C. Authority to make reasonable expenditures therefrom for the purpose of providing AIP with necessities or preserving the property of AIP;

D. Authority to provide for the extraordinary expenses in respect to the proper care and maintenance of AIP, and to pay the providers of the same, including physicians, hospital nurses, aides, nursing homes, if any;

E. Authority to pay all just debts of AIP and to protect and account for AIP's property and financial resources, including but not limited to retroactive payment of any debt to Medicaid;

F. Authority to invest surplus funds in investments eligible by law for the investment of trust funds, to dispose of investments so made and to reinvest the proceeds as so authorized;

G. Authority to maintain, in her own name and official title, any civil judicial proceeding which AIP might have maintained were he competent;

H. Authority to retain counsel provided that any fees paid to such counsel shall be subject to the approval of the Court;

I. Authority pursuant to Section 81.36(e) of the Mental Hygiene Law upon the death of AIP to pay for the reasonable funeral expenses of AIP;

J. Authority upon the death of AIP to pay the bills of AIP, incurred prior to the death of AIP, provided that the guardian would otherwise have had the authority to pay such bills;

K. Such authority as may be granted by any statute of the United States of America or the State of New York to a guardian of the property, conservator, or committee of the property unless any such statute specifically requires the permission of the Court before the exercise of the power granted;

L. Authority to exercise such other powers necessary and sufficient to manage the property and financial affairs of AIP;

M. Authority to pay for the care and maintenance of AIP in accordance with the plan outlined in the petition;

N. Authority to provide for proper living arrangements for AIP and to choose the place of his residence;

O. Authority to determine who will provide personal care or assistance to AIP;

P. Authority to determine who will provide medical care and treatment to AIP;

Q. Authority to access and release all of AIP's confidential medical records in order to provide for his proper medical treatment and power to access and release all of AIP's confidential financial records in order to provide for his continued care and to make any necessary application for governmental and private assistance and to participate in any governmental administrative hearings or other related activities;

R. Authority to consent to or refuse generally accepted routine medical or dental treatment, including administration of medications, if any, consistent with the findings herein and Section 81.15 of the Mental Hygiene Law;

S. Authority to consent to or refuse life sustaining measures including surgery, antibiotics, cardiac resuscitation, respiratory support and artificially administered feeding and fluids, in accordance with AIP's religious and moral beliefs, as known to petitioner;

T. Authority to make decisions regarding AIP's environment and other social aspects of his life;

U. Authority to apply for all government and private benefits including Medicaid, and participate in all related activities including but not limited to governmental administrative agency hearings on behalf of AIP;

V. Authority to determine whether AIP has a will, determine the location of any will and the appropriate persons to be notified in the event of the death of the alleged incapacitated person and in the event of the death of the alleged incapacitated person, to notify those persons

W. Authority to determine whether AIP should travel; and

X. Authority to act with respect to all retirement accounts and retirement assets of AIP, including but not limited to:

i. The authority to apply for all retirement benefits;

ii. The authority to conduct all retirement benefit transactions

iii. The authority to apply for all service retirement for AIP;

iv. The authority to withdraw from or enroll in any retirement plan;

v. The authority to choose any retirement option and/or death benefit option offered; and

vi. The authority to file any and all financial institution related paperwork with regard to AIP's retirement plan or death benefit; and

GRANTING Petitioner such other and further relief as this Court may deem just and proper; and it is further

ORDERED that, pending the hearing and determination of the application to appoint a Guardian, JANE A. DOE is appointed Temporary Guardian with the authority to:

A. Access all bank and financial accounts; and make withdrawals, deposits, and use the account(s) to pay necessary bills of JOHN B. DOE at the Temporary Guardian's discretion. If the financial institution, whether or not specifically named herein, fails or refuses to comply with the direction of the Temporary Guardian, a representative of the financial institution shall appear in Court on the return date to explain its refusal to comply with this Court Order; and

B. Act with respect to all retirement accounts and retirement assets of JOHN B. DOE, including but not limited to:

i. Applying for all retirement benefits;

ii. Conducting all retirement benefit transactions;

iii. Applying for all service retirement for JOHN B. DOE;

iv. Withdrawing from or enroll in any retirement plan;

v. Choosing any retirement option and/or death benefit option offered;

vi. Filing any and all financial institution related paperwork with regard to JOHN B. DOE's retirement plan or death benefit; and

C. Make all medical decisions for JOHN B. DOE.

SUFFICIENT CAUSE APPEARING THEREFORE, it is

ORDERED, that _____ of _____ be and is hereby appointed Court Evaluator herein to investigate the allegations made in the petition, to explain this proceeding to the alleged incapacitated person or to his family or representatives, and to report to the Court, the functional abilities and functional limitations of the alleged incapacitated person in this proceeding, and it is further

ORDERED, that _____ of _____be and hereby is appointed counsel to represent JOHN B. DOE, in this proceeding, and it is further

ORDERED, that service by personal delivery of a copy of this Order and of the papers upon which it is based upon JOHN B. DOE at least 14 days prior to the return date be deemed good and sufficient service; and it is further

ORDERED, that a copy of this Order to Show Cause and the petition shall be left with a person of suitable age and discretion at the residence of the person alleged to be incapacitated, if he is not served there; and it is further

ORDERED, that service of a copy of this Order and of the papers upon which it is based upon the Court Evaluator and Counsel herein by personal delivery to their offices or by overnight delivery service or by facsimile, within 3 business days of the date of this order or on or before the ____ day of _____, 2020, be deemed good and sufficient; and it is further

ORDERED, that pursuant to Mental Hygiene Law § 81.07 a conformed copy of the Order to Show Cause and a Notice of the Proceeding shall be served by regular mail, not less

than fourteen (14) days prior to the hearing date in the Order to Show Cause to the following: Jack C. Doe, 123 Oak Street, Albuffalo, New York, #####; Jessica D. Doe, 123 Maple Lane, Watertutica, New York #####; and City Center Hospital; and it is further

ORDERED, that the Court award fees to be paid from JOHN B. DOE's income/assets as administrative costs and expenses of the Guardianship Proceeding to Petitioner's Counsel for legal services rendered and costs/expenses incurred; and it is further

ORDERED, that any Guardian appointed herein shall be ordered to repay/reimburse the Medicaid program for funds expended to the extent that the income and resources of JOHN B. DOE exceed the Medicaid eligibility level at the time such assistance was granted; and it is further

ORDERED, that to the extent JOHN B. DOE is placed or is continued on Medicaid, ordering all costs and expenses in connection with this proceeding including legal fees, and nursing home care costs be deemed as administrative costs and expenses of the Guardianship Proceeding and paid from net available monthly income (NAMI) and/or excess available resources, as a spend down under Medicaid chronic care budgeting standards; and it is further

ORDERED, that the Court Evaluator be given access to the medical records of AIP, from City Center Hospital, and be allowed to discuss AIP's medical the medical, psychological and/or psychiatric records and condition with the medical and social worker and staff at City Center Hospital and furthermore allow the Court Evaluator access to the financial records that may be maintained by City Center Hospital and be allowed to discuss with Sutton Park Center's financial department issues surrounding AIP's financial records and governmental benefits; and further permission to inspect, review and copy any financial, banking, government, retirement, legal and other records of AIP, which are in the care and custody of City Center Hospital,

including, but not limited to, his Last Will and Testament, Powers of Attorney/Health Care Proxy, if any contained in AIP's file on the ground that said records and information are likely to assist the Court Evaluator in his or her report to the Court; and it is further

ORDERED, that any appointee herein shall comply with Section 36.3 of the Rules of the Chief Judge by filing OCA Form 830.1 with the Office of the Court Administration and OCA form 830.3 with the appointing Justice. Any subsequent affidavit or affirmation of service submitted to this Court must contain a statement indicating such compliance and be accompanied by a properly completed OCA Form 830.

Dated: January __, 2020

_____
Hon. _____
Justice, Supreme Court

ENTER

EXHIBIT B

SAMPLE VERIFIED PETITION

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

Petitioner,

v.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

VERIFIED PETITION

Index No.

RJI No.

Petitioner, JANE A. DOE, by and through Counsel, being duly sworn, states as follows:

1. JANE A. DOE, ("Petitioner") brings this Petition seeking immediate appointment as the Temporary Guardian of JOHN B. DOE's property and subsequent appointment as Guardian of JOHN B. DOE's person and for purposes of property management. Throughout this Petition, JOHN B. DOE will be referred to as the Alleged Incapacitated Person ("AIP"). Petitioner requests that she is authorized to act pursuant to her appointment.

2. Petitioner is AIP's wife. Petitioner resides at 123 Main Street, Rochestercuse, New York, #####, located in the County of Monronondaga, State of New York. Petitioner's telephone number is (___) ___-____.

3. Petitioner has standing to bring this Petition pursuant to New York's Mental Hygiene Law ("MHL") § 81.06(a)(2) and (6) as a presumptive distributee of AIP and as a person otherwise concerned with the welfare of the person alleged to be incapacitated.

4. Upon information and belief, no previous application for the relief herein requested has been made to this or any other Court.

ALLEGED INCAPACITATED PERSON

5. AIP is _____ (__) years of age. He was born on _____.

6. AIP's permanent address is 123 Main Street, Rochestercuse, New York, #####, located in the County of Monrononda ga, State of New York.

7. AIP's home telephone number is (___) ____-____.

8. I am AIP's spouse. We have __ children.

9. AIP's presumptive distributees are Petitioner, and his children, _____.

10. AIP is under no obligation of support with respect to any third party.

11. AIP sustained a heart attack, which has left him severely cognitively impaired (in a coma) and unable to advocate for himself or manage his financial affairs.

BACKGROUND

12. Petitioner is AIP's spouse.

13. On _____, 2019, AIP suffered a massive heart attack leaving him cognitively impaired.

14. AIP's parents are deceased.

15. AIP has an adult son, Jack C. Doe, 123 Oak Street, Albuffalo, New York, #####.

16. AIP has an adult sister, Jessica D. Doe, 123 Maple Lane, Watertutica, New York #####.

17. Petitioner is the only person who visits AIP on a daily basis.

18. Due to the sudden onset of AIP's current condition, he has an immediate need for assistance with his financial affairs requiring a temporary guardian of his property.

AVAILABLE RESOURCES

19. AIP does not have a power of attorney or health care proxy.

20. To Petitioner's knowledge and belief, AIP's estimated financial resources and monthly income are as follows, as of January 2017:

Assets	**Ownership**	**Approximate Value as of January 2020**
Checking Account	AIP	
Personal effects	AIP	
Monthly Income	**Recipient**	**Amount**
	AIP	
	AIP	

NEED FOR GUARDIAN OF THE PROPERTY OF JOHN B. DOE

21. AIP is likely to suffer harm because he cannot manage his most basic finances; he cannot adequately understand and appreciate the nature and consequences of his inability to handle his property management needs.

22. AIP's assets, as set forth in this Petition, could be subject to waste if not adequately protected or looked after.

23. Due to AIP's comatose state and current condition, his functional level with regard to his financial affairs is non-existent.

24. AIP is unable to tend to his most basic property management needs, much less understand immediate medical costs or other financial and investment affairs.

25. It is unknown how long AIP will remain unconscious. Indications from treating medical professionals have inferred that it could be permanent. Even if AIP were to become

conscious, it is unclear what capacity he would have immediately and if he would be able to adequately recover at all.

26. Without an appointment of a guardian of the property, AIP will not be able to meet his basic financial obligations. Furthermore, the immediacy of the situation and the nature of his circumstances put his health and welfare in danger if a temporary guardian cannot be appointed.

27. Petitioner understands the nature of her husband's condition and is the logical choice for guardian.

28. Petitioner also requests the immediate appointment of herself as Temporary Guardian pursuant to MHL § 81.23(a)(1) to serve until the scheduled hearing by the Court may be completed.

29. Petitioner is aware of the forms of public assistance (SSD and Medicaid), which AIP currently receives and easily manage her husband's finances.

30. Petitioner is unaware of any other health-related or financial factors or concerns beyond what have been set forth herein.

31. AIP, in his current condition, has no understanding or appreciation of his inability to manage his daily property management tasks. If appointed Guardian, Petitioner intends to marshal and consolidate AIP's various assets, manage and invest AIP's assets appropriately, pay all of AIP's bills in a timely fashion, and file tax returns on AIP's behalf, until such time as the Court may hold a hearing on the proposed guardianship, if Temporary Guardian, or until AIP recovers from his condition and is capable of understanding and maintaining his daily property management tasks on his own.

PROPERTY-NEEDS POWERS SOUGHT

32. The guardianship powers sought are those as set forth in section 81.21 of the Mental Hygiene Law, and as set forth in the Order to Show Cause, to include the following.

a. Authorize access to or release of confidential records;

b. Marshall all income and assets, and necessary incidental powers to effectuate such power including but not limited to the power to redirect and open any and all mail directed to the incapacitated person;

c. Transact any banking business including establishing checking accounts, savings accounts, retirement accounts, certificates of deposit, collecting, negotiating, depositing, withdrawing, endorsing checks, drafts, or any negotiable instrument and any incidental powers related thereto, and further including the establishment of a Guardianship Account;

d. Create revocable or irrevocable trusts of property of the estate which may extend beyond the incapacity or life of the incapacitated person;

e. Endorse, collect, negotiate, deposit and withdraw Social Security, disability, pension or annuity benefit checks;

f. Represent the rights of AIP and file legal actions for negligence, medical malpractice and personal injury giving rise to AIP's current physical and mental health conditions;

g. Pay such bills as may be reasonably necessary for the proper care and maintenance of AIP, and to pay the providers of the same, including physicians, hospital nurses, aides, nursing homes, if any;

h. Pay bills after the death of the incapacitated person provided the authority existed to pay such bills prior to death until a temporary administrator or executor is appointed;

i. Purchase, sell, hypothecate, assign and pledge stocks, bonds, mutual funds, stock rights, stock dividends, coupons and all securities;

j. Retain attorneys, accountants, investment counselors, brokers, and similar professionals concerning the incapacitated person's personal and real property, and to pay the necessary disbursements and fees for such individuals;

k. Prepare, complete, and sign all tax returns, and pay the tax due as shown by said returns; appear on behalf of the incapacitated person before Federal, State and local taxing authorities; prosecute, defend and settle all tax claims, litigation, assessments and levies relating to any taxing authority or any type of tax;

l. File, prosecute, compromise and settle all personal and property insurance claims and all incidental powers related thereto necessary to effectuate this power, including without limitation to surrender insurance policies for cash value;

m. Exercise rights to elect options and change beneficiaries under insurance and annuity policies and to surrender the policies for their cash value;

n. Renounce or disclaim any interest by testate or intestate succession or by inter vivos transfer consistent with paragraph (c) of section 2-1.11 of the estates, powers and trusts law;

o. Apply for government or private benefits;

p. Engage in Estate and Medicaid planning on behalf of the incapacitated person; and

q. Any other power that the Court in its discretion shall deem appropriate to meet the incapacitated person's property needs.

INTERESTED PARTIES

33. The interested parties herein are:

Name and Address	Telephone Number	Relationship to AIP
Jack C. Doe, 123 Oak Street, Albuffalo, New York, #####	(___) ___-____	AIP's Son
Jessica D. Doe, 123 Maple Lane, Watertutica, New York #####	(___) ___-____	AIP's Adult Sibling.

DURATION OF POWERS BEING SOUGHT

34. Based on AIP's current condition, it is requested that the powers granted by the Court to the Temporary Guardian continue until a hearing is conducted for appointment of a guardian of the property for AIP.

35. Should the Court find after the hearing that a guardianship of the property is warranted, it is requested that the powers granted by the Court to the Guardian be for an indefinite period.

36. Petitioner requests that she be authorized to use the powers granted to them by the Court separately and independently so as to ensure efficient and immediate protection and use of AIP's property for his benefit.

WHEREFORE, Petitioner respectfully requests that the Court:

A. Issue an Order to immediately appoint JANE A. DOE, Temporary Guardian of the Property for JOHN B. DOE and vest her with the powers requests herein;

B. Sign the annexed Order to Show Cause;

C. Appoint some proper person to serve as Court Evaluator, pursuant to N.Y. Mental Hygiene L. § 81.09;

D. Declare that JOHN B. DOE is incapacitated as that term is defined by N.Y. Mental Hygiene L. § 81.02(b);

E. Appoint Petitioner as Guardian and vest her with the powers requests herein; and

F. Grant such other and further relief as the Court deems just and proper.

Dated: January __, 2020

LAW FIRM, PLLC

By:_____
Attorney, Esq.
Address 1
Address 2
Syracuse, New York 13202-1355
Telephone: (315) 555-1234
Fax: (315) 555-1234
Email: attorney@lfpllc.com

VERIFICATION

STATE OF _____)
) ss.:
COUNTY OF _____)

JANE A. DOE being duly sworn, deposes and says that deponent is the mother and presumptive distributee of the alleged incapacitated person, a Petitioner in the within action; that deponent has read the foregoing Verified Petition and knows the contents thereof; that the same is true to deponent's own knowledge, except as to the matters therein stated to be alleged on information and belief, and that as to those matters deponent believes them to be true. The grounds of deponent's belief as to all matters not stated upon deponent's knowledge are as follows: personal relationship with the alleged incapacitated person, the alleged incapacitated person's documents and records.

_____
JANE A. DOE

Sworn to before me this
___ day of _____, 2020.

_____

Notary Public

EXHIBIT C

SAMPLE NOTICE OF APPEARANCE

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

Petitioner,

v.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

NOTICE OF APPEARANCE

Index No.

RJI No.

PLEASE TAKE NOTICE that Attorney, Esq., of Law Firm, PLLC, hereby appears as attorney for Petitioner Jane A. Doe in the above-captioned matter.

Dated: January __, 2020

LAW FIRM, PLLC

By:_____
Attorney, Esq.
Address 1
Address 2
Syracuse, New York 13202-1355
Telephone: (315) 555-1234
Fax: (315) 555-1234
Email: attorney@lfpllc.com

EXHIBIT D

SAMPLE SUBPOENA DUCES TECUM FOR TESTIMONY

SAMPLE ORDER FOR SUBPOENA DUCES TECUM

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

JUDICIAL SUBPOENA

Petitioner,

Index No.

v.

RJI No.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

TO: Jake B. Doe, Commissioner
Onodonroe County Department of Human Services
111 Rochecuse Rd.
Syrochester, New York 14633

YOU ARE HEREBY COMMANDED to appear at the New York State Supreme Court, County of ONODONROE, at the Onodonroe County Courthouse, 123 Hall of Justice, Syrochester, New York, ten (10) days from the date this subpoena is served, or at any recessed or adjourned date, and to bring with you copies of the documents identified in the attached schedule of documents in your possession, custody or control.

Your failure to comply may be punishable as a contempt of this Court.

_____

Hon. Judge _____

Dated:

SCHEDULE OF DOCUMENTS

1 Public assistance records, limited to applications for housing assistance, correspondence, leases, landlord statements, payment vouchers or invoices, child care requests, tenant billing authorization forms, schedules and other similar documents reflecting the addresses where each of the following individuals resided or leased property, or received child care or other babysitting services during the time period 1994 through 2004, and the time period when each person resided and/or was cared for at each address:

a. Jeffery Z. Doe, date of birth 1/30/50

b. Jaqueline Y. Doe, date of birth 2/3/04

2. Records reflecting the schedule of payments made to all building owners, landlords, and/or child care service providers in connection with the residency or tenancy and/or receipt of child care services of/by any of the following individuals during the time period 1994 through 2004:

a. Jeffery Z. Doe, date of birth 1/30/50

b. Jaqueline Y. Doe, date of birth 2/3/04

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

ORDER

Petitioner,

Index No.

v.

RJI No.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

Defendant John Doe, having submitted a request for the attached Judicial Subpoena Duces Tecum directed to the ONODONROE County Commissioner of Human Services for records material and necessary to the defense of this action, and there is no objection to the form of the attached Subpoena, and the ONODONROE County Attorney's Office on behalf of the ONODONROE County Department of Human Services having raised no objection to the form of the attached Subpoena Duces Tecum, it is hereby

ORDERED, that the attached Judicial Subpoena Duces Tecum shall issue from this Court and may be served upon Jane A. Doe, ONODONROE County Commissioner of

Human Services, 111 Rochecuse Rd., Syrochester, New York 14633 forthwith; and it is further

ORDERED, that all attorneys of record in the above matter are permitted to check out the Department of Human Services records from the ONODONROE County Supreme Court Clerk's Office for copying for all counsel; and it is further

ORDERED, that said records must be returned to the ONODONROE County Supreme Court Clerk's Office within one (1) business day of checkout by any attorney of record.

Dated: January __, 2020

_____
Hon. _____
Justice, Supreme Court

ENTER

EXHIBIT E

SAMPLE SEALING AND CONFIDENTIALITY ORDER

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

Petitioner,

v.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

SEALING AND CONFIDENTIALITY ORDER

Index No.

RJI No.

THIS MATTER, having come before the Court upon the application of Legal Firm, PLLC, attorneys for Petitioner Jane A. Doe (the "Petitioner"), for a Confidentiality Agreement and Protective/Sealing Order (the "Order"), sealing the court records in this proceeding and requiring the parties to keep confidential all information exchanged during the courts of this proceeding, and the Court having found there is good cause shown for the issuance of this Order under 22 N.Y.C.R.R. § 216.1, it is hereby:

ORDERED as follows:

1. The parties to the above-captioned action (the "Parties") will not disclose the financial, medical, psychological, or psychiatric information filed along with or related to this proceeding (the "Confidential Information"), to any third parties, including, but not limited to, any member of the press or media, any internet web site, and any other third party not specified in paragraphs 5(a) through 5(d) below.

2. This Protective/Sealing Order shall also apply to the Confidential Information and/or other similar types of personnel information.

3. Either party may designate information, documents, and items produced in discovery as Confidential Information, which shall be so marked in advance of their production or disclosure. If the opposing party objects to the designation of a document as Confidential Information, it may, if good faith negotiations prove unsuccessful, apply to this Court for a ruling that the document shall not be so treated, giving notice to the other party. Until this Court enters an Order changing the designation, the document shall be treated as Confidential Information in accordance with this Protective/Sealing Order.

4. Any document to be filed with the Court that contains Confidential Information, including, but not limited to, the complaint in this action, shall be filed under seal in an envelope on which a statement substantially in the following form shall be written: "CONFIDENTIAL -- This envelope contains documents and/or information that are subject to a Protective/Sealing Order entered by the Court." All such material so filed shall be maintained by the Court Clerk separate from the public records in this action and shall not be released.

5. All Confidential Information produced during the course of discovery, and all subsequent discovery, testimony, and other litigation referring to such Confidential Information, shall be maintained in confidence by the parties to be used solely for the purpose of this action. The parties shall not disclose Confidential Information to any third party other than the following:

a. counsel of record for the parties and regular employees of such counsel assisting in the conduct of this action;

b. experts or consultants retained or employed by the parties or their counsel, as long as they have signed a copy of the Certification annexed to this Protective/Sealing Order;

c. witnesses or other persons from whom testimony is taken or may be taken in this action, as well as any stenographer who has been hired to produce a transcript of any deposition taken in this action, as long as they have signed a copy of the Certification annexed to this Protective/Sealing Order; and

d. the Court, jury, or other court personnel in this action.

6. Nothing in this Protective/Sealing Order, nor any action taken in compliance with it, shall operate as an admission by any party that any particular document or information is or is not confidential. Further, nothing in this Protective/Sealing Order shall affect the admissibility or non-admissibility of documents or other evidence at trial. Any document designated as Confidential Information may be offered into evidence unless the opposing party obtains a separate protective order from the Court, and may be admitted into evidence unless the opposing party states a valid evidentiary objection.

7. Within 30 days after the conclusion of this action (including any appeals), all Confidential Information and all copies thereof shall be returned to counsel for the party that produced the Confidential Information.

Dated: January __, 2020

_____

Hon. _____
Justice, Supreme Court

ENTER

EXHIBIT F

FRANCES L. PANTALEO, BLEAKLEY PLATT & SCHMIDT, LLP, "LESSONS FROM ASTOR, CLARK, AND REDSTONE: THE INCAPACITATED CLIENT- IS GUARDIANSHIP THE ANSWER?" NYSBA TRUSTS AND ESTATES SECTION ANNUAL MEETING (JANUARY 2017)

Printed and distributed with the generous permission of the author.

Bond

Using the CPLR: Advanced Practice in Article 81 Guardianship

Joseph A. Greenman, Esq.
Richard L. Weber, Esq.

BOND SCHOENECK & KING ATTORNEYS
Commitment · Service · Value · Our Bond

Purpose of Article 81

The legislature declares that it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes into account the personal wishes, preferences and desire of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.

BOND SCHOENECK & KING

Appointment is necessary to provide for the personal needs of a person.

The person agrees to the appointment; or

The person is **incapacitated**.

Clear and convincing evidence that the person is likely to suffer harm because:

- The person is unable to provide for personal needs and/or property management; and
- The person cannot adequately understand and appreciate the nature and consequences of such inability.

BOND SCHOENECK & KING

Jurisdiction & Venue

- Supreme Court, county courts outside NYC
  - Resident of NYS;
  - Non-resident present in NYS;
  - Nonresident, pursuant to 81.18.
- Surrogate's Court has the power to order relief for specifically enumerated individuals with respect to property management in accordance with Article 81.
- Supreme or County Court
  - Surrogate's Court – limited 81.04(b)
- Where alleged incapacitated resides or is physically present
  - If resides/cared for in facility, then location of facility
  - If not present in state, then where property is situated
- Modify order
  - Court originally granted
  - If facility, then location of facility

BOND SCHOENECK & KING

BOND SCHOENECK & KING

Order to Show Cause

- Order to Show Cause Format
  - Large Type
  - Plain Language
  - English (or Other)
- Order to Show Cause Must Include
  - Date, Time, and Hearing of petition
  - Clear, Readable Statement
  - Name, Address, Phone: Court Evaluator; Attorney
  - List of Potential Guardian Powers
  - Legend
- Next Steps
  - Court Signs OTSC
  - Name, Address, Phone: Court Evaluator
  - Serve OTSC on AIP, Court Evaluator, Counsel for AIP
  - Notice of the Proceeding to Certain Individuals

BOND SCHOENECK & KING

Service of OTSC

- AIP, AIP's Attorney, Court Evaluator
- N.Y. C.P.L.R. § 308

Notice of Proceeding

- AIP's Souse, Parents, Adult Children/Siblings, Fellow Residents, Other
- N.Y. Mental Hygiene L. 81.07(g)(1)

BOND SCHOENECK & KING

Verified Petition

- Name, Address, Phone
  - AIP; Fellow residents; Presumptive distributees; Petitioner; Proposed Guardian/Stand-by
- Description of AIP's functional level
- Powers sought with respect to AIP's personal, property management needs
- Approximate value/description of AIP's financial resources (and debts, claims, etc.)
- Relief sought
- Available resources

BOND SCHOENECK & KING

STATE OF NEW YORK
SUPREME COURT COUNTY OF ONONDAGA

In the Matter of the Application of
JANE A. DOE,

Petitioner,

v.

For an Order of Appointment of a Guardian for the Person and Property of
JOHN B. DOE,

An Alleged Incapacitated Person Pursuant to Article 81 of the Mental Hygiene Law.

NOTICE OF APPEARANCE

Index No.

RJI No.

PLEASE TAKE NOTICE that Attorney, Esq., of Law Firm, PLLC, hereby appears as attorney for Petitioner Jane A. Doe in the above-captioned matter.

Dated: January __, 2020

LAW FIRM, PLLC

By:_____
Attorney, Esq.
Address 1
Address 2
Syracuse, New York 13202-1355
Telephone: (315)555-1234
Fax: (315)555-1234
Email: attorney@lfpllc.com

Notice must be mailed to the following, no less than 14 days prior to the hearing date:
- Spouse of AIP
- Parents of AIP
- Adult siblings of AIP
-Anyone with whom AIP resides

* If none of the above then "at least one and not more than three of the living relatives of [AIP] in the nearest degree of kinship who are known to Petitioner or whose existence and address can be ascertained by Petitioner with reasonably diligent efforts."

BOND SCHOENECK & KING

Disclosure Devices

BOND SCHOENECK & KING

Subpoena Duces Tecum

- Can be served on ANY person; must be served on all parties
- Must contain:
  - Time (not less than 20 days after service), place, and manner of making the inspection
  - Items to be inspected, with description
- After compliance, 5 days to notify other parties and provide access
- Failure to Comply
  - Contempt, Motion to Compel

- Specific rules for public entities
  - Must submit proposed order and judicial subpoena to court for the Judge's signature
  - Must file the signed order and judicial subpoena with the county clerk
  - Contents of the judicial subpoena are the same

See N.Y. C.P.L.R. 2307; 3120(4).

BOND SCHOENECK & KING

Sealing Orders

- 22 N.Y.C.R.R. 216.1.
- Stipulated → So Ordered
- Motion
  - Notice of Motion
  - Affidavit explaining Good Cause
  - Memo of Law, if Necessary
  - Proposed Sealing Order

BOND SCHOENECK & KING

BOND SCHOENECK & KING

HEARSAY: An Out of Court Statement Offered for the Truth of the Matter Asserted

CPLR 4518	• Business Records
CPLR 4520	• Public Officers
CPLR 4519	• Dead Man

BOND SCHOENECK & KING

PRIVILEGE: A Court Evaluator May Be Able to Circumvent

CPLR 4504	• Physicians
CPLR 4507	• Psychologists
CPLR 4508	• Social Workers

BOND SCHOENECK & KING

TRACK 3
Planning and Skills for Chronic Care Medicaid
Part 1

Presented By:
James R. Barnes, Esq.

TRACK 3

Planning and Skills for Chronic Care Medicaid: Part I

New York State Bar Association
Elder Law and Special Needs Section
Summer Meeting
Niagara-on-the-Lake, Ontario, Canada
July 12, 2018

James R. Barnes, Esq.
Burke & Casserly, P.C.
255 Washington Ave. Ext., Suite 104
Albany, NY 12205
Phone: (518) 452-1961
Fax: (518) 452-4230
E-mail:jbarnes@burkecasserly.com
www.burkecasserly.com

Medicaid Overview

To determine whether or not your client needs Medicaid, you first need to understand what Medicaid is, its various benefits, and why it may be an appropriate program for an individual or family. At its core, Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. The Medicaid system is a joint program of the federal government and the states. It is administered by the states according to federal requirements. The program itself is funded jointly by states and the federal government.

States establish and administer their own Medicaid programs and determine the type, amount duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program.

States have the option to charge premiums and establish out-of-pocket (cost sharing) requirements for Medicaid enrollees. Out-of-pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Maximum out-of-pocket costs are limited, but states can impose higher charges for targeted groups of somewhat higher income people. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs, and copayments and coinsurance cannot be charged for certain services.

The Medicaid program allows for the coverage of long-term care services through several vehicles and over a continuum of settings. This includes institutional care and home and community-based long-term services and supports. Medicaid covers certain inpatient, comprehensive services as institutional benefits. In Medicaid coverage,

institutional services refer to specific benefits authorized in the Social Security Act. These services include:

- Hospital services;
- Intermediate care facilities for people with intellectual disabilities;
- Nursing facility;
- Preadmission screening and resident review;
- Inpatient psychiatric services for individuals under age 21; and
- Services for individuals age 65 or older in an institution for mental diseases.

Institutional benefits share the following characteristics:

- Institutions are residential facilities, and assume total care of the individuals who are admitted.
- The comprehensive care includes room and board. Other Medicaid services are specifically prohibited from including room and board.
- The comprehensive service is billed and reimbursed as a single bundled payment. (States vary in what is included in the institutional rate, versus what is billed as a separately covered service; for example, physical therapy may be reimbursed as part of the bundle or as a separate service).
- Institutions must be licensed and certified by the state, according to federal standards.
- Institutions are subject to survey at regular intervals to maintain their certification and license to operate.

- Eligibility for Medicaid may be figured differently for residents of an institution, and therefore access to Medicaid services for some individuals may be tied to need for institutional level of care.

Basic Medicaid Eligibility Criteria

Medicaid is a multi-faceted program which provides the primary source for long-term care services in New York State. Medicaid can provide benefits for care in the community and in skilled nursing facilities. Eligibility rules for these programs have significant differences. For community-based Medicaid, eligibility factors include medical need, income standards, and resource standards. For skilled nursing facility benefits (i.e., chronic care Medicaid), those three factors are considered, but importantly, a complete financial review of the prior sixty (60) months of transactional activity is also required. This may cause problems for some people who became eligible for community-based benefits, and later need to transition to a skilled nursing facility. It also raises an issue, such that having minimal financial resources does not absolutely qualify someone for coverage. The impact of any transfers and potential period of ineligibility should be evaluated by an elder law attorney as early as possible.

Managed Long-Term Care (MLTC) is a system that streamlines the delivery of long-term care services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen. Enrollment in a

MLTC is mandatory for those who are dual eligible (i.e., eligible for both Medicare and Medicaid) and over 21 years of age and need community-based long-term care services for more than 120 days.

Medicaid eligibility for community-based Medicaid programs is similar to chronic care (nursing home) Medicaid eligibility in some ways, and yet different in others. While a single individual receiving chronic care Medicaid benefits may retain $50 of income per month, a single individual receiving Medicaid residing in the community may retain $842/month* of income for 2018 (*plus $20 disregard). For married couples, chronic care income budgeting permits the Medicaid recipient to retain $50/month of income, with the Community Spouse permitted to retain $3,090/month. Should the Community Spouse have personal income in excess of that figure, he or she may typically be requested to contribute approximately 25% of the excess towards the cost of his or her spouse's care expenses. For traditional community-based Medicaid, a married couple may retain $1,233/month* of income (*plus $20 disregard). Any income over that amount must be spent on medical care before Medicaid will begin paying for care at home. For many community-based Medicaid applicants/recipients, the use of a pooled trust is a tremendous tool in satisfying the required "spend-down" for his or her excess income. It is important to note that the income allowances discussed above apply for traditional community-based Medicaid recipients. The election of spousal impoverishment budgeting may in some cases provide a married couple with more favorable income treatment, which will be discussed later.

The asset level for community-based Medicaid is also different from that of chronic care Medicaid applicants in some instances. While a single individual may retain

$15,150 in countable assets whether he or she is applying for community-based Medicaid or chronic care Medicaid, a married couple has different asset thresholds in community based Medicaid cases. Unless Managed Long Term Care or the NHTD program is being applied for (again, electing for spousal impoverishment treatment), a married couple seeking community-based Medicaid coverage for one spouse may retain no more than $22,200 of assets. This is vastly different than the $74,820-$123,600* (*the $123,600 is the spousal share, meaning that a Community Spouse may retain up to one-half of the couple's resources up to $123,600) Community Spouse Resource Allowance that the Community Spouse of a chronic care Medicaid applicant is permitted to retain.

The Deficit Reduction Act and Look-Back Period

The federal provisions governing Medicaid benefits and eligibility are codified in the Social Security Act under Chapter 7, Subchapter XIX of Title 42 of the United States Code. The Social Security Act was amended by the Deficit Reduction Act (the "DRA") of 2005, which was signed into law on February 8, 2006. The State of New York has codified the law pertaining to Medicaid benefits and eligibility under Title 11 of the Social Services Law. New York adopted the provisions of the DRA and applied the provisions to all Medicaid applications made on or after August 1, 2006. In 06 OMM/ADM-5, the New York State Department of Health advised local departments of social services of the long-term care Medicaid eligibility provisions of the DRA, which, among other things, changed asset transfer rules.

Following the DRA, the look-back period was increased to sixty (60) months for individuals applying for Medicaid coverage of nursing facility services. Previously, only trust-related transfers were subject to a sixty month look-back evaluation.

Importantly, for transfers of assets made on or after February 8, 2006, the begin date of the period of ineligibility is the first day of the month after which assets have been transferred for less than fair market value, or the date on which the otherwise eligible individual is receiving nursing facility services for which Medicaid coverage would be available but for the imposition of a transfer penalty, whichever is later, and which does not occur during any other penalty period. Multiple transfers made during the look-back period, including transfers that would otherwise result in a fractional penalty, are accumulated into one total amount to determine the penalty period.

Calculating the Ineligibility Period

Once a local department of social services (LDSS) determines that a Medicaid applicant for skilled nursing home care meets the eligibility standards for medical need, income eligibility, and resource eligibility, it will conduct the financial review of the past 60 months. If the LDSS then determines that transfers were made for less than fair market value, a penalty period will be imposed. The penalty period is the period of time in which a Medicaid applicant is ineligible for Medicaid benefits. It is calculated by dividing the value of the transfer(s) (i.e., gift(s)) by the regional rate of care.

Currently, refer to GIS 17 MA/019: "Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2018," to obtain the relevant regional rate. In 2018, the average regional nursing home rates in New York State are as follows:

- Northeastern - $10,719;
- Western - $10,239;
- Rochester - $11,692;
- Central - $9,722;
- NYC - $12,319;
- Long Island - $13,053; and
- Northern Metropolitan - $12,428.

The LDSS must use the regional rate in effect on the date the institutionalized individual applies or requests an increase in coverage. For example, an application in February 2018 for coverage retroactive to November 2017, would utilize the 2018 rates as set forth in GIS 17 MA/019. It is also important to note that the rate must be utilized in the region where the facility is located, not necessarily where the application is made (based on residency).

A simple example illustrates the calculation of the penalty period. If it is deemed that an applicant has transferred $105,000 during the relevant 60 month look-back period, and the regional rate for Western New York is used, the penalty period is determined as follows:

$105,000/$10,239 = 10.25 months.

Again, the penalty period begins to run on the later of: (1) the date when (a) the Medicaid applicant: (i) is resource eligible; (ii) is income eligible; (iii) requires nursing home level care; and (iv) has filed a Medicaid application and (b) no other period of Medicaid eligibility is outstanding; or (2) the first day of the month after which assets have been transferred.

Now that the penalty period has been imposed, the applicant will be ineligible for Medicaid benefits for the relevant determined period of months, meaning that the applicant will be required to continue privately paying during that time period.

Exempt vs. Countable Assets

The New York State Medicaid Reference Guide defines resources as property of all kinds, including real, personal, tangible, and intangible. All resources of an SSI-related applicant/recipient ("A/R") are reviewed to determine their availability and value as of the first day of the month for which the A/R is applying for or receiving Medicaid. This review will be important for both an individual, and for a married couple.

Assets may include both available assets, as well as assets which the applicant, or applicant's spouse, is entitled to, but does not obtain because of action or inaction (i.e., renunciation of inheritance, waiver of right of election, etc.). Certain assets may be considered resources, unless certain elections are made, such as in the case of individual retirement accounts which are not in "pay-out status."

Certain resources may be considered as "exempt" in a Medicaid determination. For a single individual, exempt resources made include irrevocable pre-paid funeral and burial arrangements, tangible personal property, and certain limited life insurance (i.e., life insurance with a face value not exceeding $1,500 designated for a burial allowance). For a married couple, the Medicaid applicant/recipient may again retain the same exempt resources, as previously mentioned for a single A/R. The Community Spouse may also retain those exempt items. Additionally, the Community Spouse may retain his or her residence (with equity up to $858,000) and an automobile.

Methods of Calculation and Allocation of Income and Resources

For chronic care Medicaid for a single person, use countable Medicaid income, deduct $50, and arrive at the "spend-down" (income contribution required to be paid toward cost of care). For chronic care Medicaid for a married couple, the Community Spouse is permitted to retain $3,090 of income per month, which is the Minimum Monthly Maintenance Needs Allowance (MMMNA). In each case, health insurance costs are permitted disregards. If the Community Spouse ("CS") has income of his or her own exceeding $3,090, he or she will be asked to contribute 25% of excess towards the cost of the medically needy spouse's care. An example illustrates the way income is budgeted, and also the importance of which spouse is requiring care. We can look at a married couple with two scenarios, and in each case the Husband has $3,775/month of countable income and the Wife has $1,500/month of countable income. In the first scenario, the Wife is the A/R and the Husband is the CS.

$1,500	Wife's Income	$3,775	Husband's Income
($50)	Income Allowance	($3,090)	MMMNA
$1,450	Wife's Contribution to Care	$685	Husband's Excess Income

In this example, the Husband will be typically required to contribute 25% of his excess income to the Wife's care, or $171.25/month. The total family monthly income contribution to care is $1,621.25.

In scenario two, Husband is the A/R and Wife is the CS. Wife/CS does not have sufficient income to bring her up to the MMMNA level of $3,090. Wife/CS will be deemed income from Husband/A/R up to the MMMNA level.

$3,775	Husband's Income	$1,500	Wife's Income
($50)	Income Allowance	$1,590	Income from H
($1,590)	H's Inc. deemed to Wife	_____	
$2,135	H's Contribution to Care	$0	Wife's Excess Income

In this example, the total family monthly income contribution to care is $2,135. While the Community Spouse/Wife will be deemed income from her Husband, the impact to the family is different than in the first scenario.

The calculation of resources for the chronic care Medicaid applicant is fairly straightforward, following the rules provided in earlier sections. By way of review, as resources are evaluated, the single Medicaid A/R may have resources valuing $15,150 or less. For married couples, spousal impoverishment guidelines are utilized, such that the A/R spouse's resources must be $15,150 or less, while the CS' resources may not exceed $74,820-$123,600, depending on the method chosen. See GIS 17 MA/020: "2018 Medicaid Levels and Other Updates."

For a single person in a community-based Medicaid situation, you are typically looking at a straightforward calculation of income based on a threshold value of $862/month (includes disregard), and countable resources of $15,150.

For spousal budgeting in a community-based Medicaid situation, there are some variations to consider. For income purposes, under traditional community-based Medicaid, the couple is allotted $1,253 of income/month (includes disregard) and

resources not to exceed $22,200. However, if spousal impoverishment budgeting is chosen, utilizing either a waivered program or MLTC, then both income and resource thresholds change significantly. With spousal impoverishment budgeting, the CS may keep the Community Spouse Monthly Income Allowance (CSMIA) income purposes, or $3,090/month, while the A/R spouse may keep $391.00/month as the personal needs allowance. This results in total combined monthly income for the couple of $3,481/month.

Prior to 16 ADM-02, a married person applying for Medicaid to enroll in a MLTC had to initially apply using traditional community based Medicaid rules. However, based on an application for "Immediate Need" Medicaid in an MLTC case, spousal impoverishment budgeting may be utilized from the outset. In cases where "Immediate Need" cannot be met, then the application may be approved under traditional community-based income budgeting in the first month, with a request then being made immediately upon approval to proceed with spousal impoverishment budgeting in the second month. Finally, if spousal impoverishment budgeting is not helpful, as in cases where the CS has significant income, then the A/R may request to be evaluated as a single person for income purposes. Even if the A/R then has a high monthly spend-down, he or she may utilize a pooled trust for excess income, and the result may be the most favorable option.

In cases where spousal impoverishment budgeting is utilized for a married couple, resource thresholds also increase from the traditional community-based levels to the higher levels used in nursing home applications.

Specifically Exempt Transfers

The transfer of a homestead (i.e., the principal residence) will be exempt (meaning, no penalty period will be imposed) if transferred to:

1. The spouse;
2. The child of the A/R who us under 21;
3. A blind or disabled child, regardless of age;
4. Sibling of the A/R with an equity interest in the home, and who has resided at the home, and is using it as his or her primary residence for at least one year prior to the A/R's admission to a skilled nursing facility; or
5. The child of the A/R who has resided in the home as his or her residence for at least two years immediately prior to the A/R's admission to a skilled nursing facility and has provided care to the A/R.

The transfer of an asset other than a homestead will be considered exempt if transferred to:

1. The A/R's spouse or to another for the sole benefit of the A/R's spouse;
2. From the A/R's spouse to another for the sole benefit of the A/R's spouse;
3. Disabled child;
4. To a trust for the sole benefit of an individual under sixty-five (65) years of age who is disabled.

There are a few other scenarios when transfers will be considered exempt for Medicaid purposes;

1. Post-eligibility transfers by the Community Spouse will be considered exempt as to the A/R's continued eligibility, but will impact the CS' personal eligibility (if relevant in the future);
2. Transfers made for purposes other than qualifying for Medicaid; and
3. Undue Hardship.

Treatment of Retirement Accounts and Annuities

The most significant issue when evaluating qualified assets and retirement accounts in a Medicaid eligibility scenario is whether or not the account is in pay-out status. If it is not, then the account is considered a resource. If it is in pay-out status, then the distributions from the account are considered part of the monthly income of the A/R, or the CS. Pay-out status typically refers to taking the required minimum distribution ("RMD") from the particular account. In a Medicaid eligibility context, pay-out status is relevant whether or not the individual is required to take RMDs based on Internal Revenue Code rules. It is important for the practitioner to be aware of the local practice with respect to how a particular LDSS determines the required countable value for income purposes, as there are differences throughout New York State from county-to-county.

For guidance on the treatment of annuities, one should review the DRA guidelines as set forth in 06 OMM/ADM-5. These rules require the A/R to disclose the description of any interest the A/R or spouse has in an annuity, regardless of whether it is irrevocable or treated as an asset. If an A/R or spouse purchases an annuity after February 8, 2006, New York State must be named as a remainder beneficiary in the first position of the

purchase will be deemed a transfer of assets. If there is a Community Spouse or disabled child, New York State must be named in the second position.

If the annuity is purchased by or on behalf of an A/R, the purchase will be treated as a transfer of assets for less than fair market value unless;

- The annuity is an annuity described in subsection (b) or (q) of Section 408 of the IRC; or
- The annuity is purchased with the proceeds from an account described in subsection (a), (c), (p) of Section 408 of the Code; a simplified employee pension (within the meaning of Section 408(k) of the Code); or a Roth IRA described in 408A of the Code; or
- The annuity is:
    - Irrevocable and non-assignable;
    - Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA); and
    - Provides for payments in equal amounts with no deferral and no balloon payments made.

The criteria applies to transactions on or after February 8, 2006, with transactions including: any action to change the course of payment or that changes the treatment of the income or principal; additions of principal; elective withdrawals; requests to change the distribution of the annuity; elections to annuitize the contract, etc.

Crisis Planning With Promissory Notes

A gift-note plan is a crisis planning technique allowing a client to engage in asset protection planning while financing long term care expenses. In comparison with other planning techniques, the gift-note plan is a short-term planning strategy. An individual must be in need of institutional level of care for this plan to be utilized. The context is critical, since implementation of a gift-note plan will require the penalty period to be triggered.

A promissory note is an "unconditional promise, signed by the maker, to pay absolutely and in any event a certain sum of money either to, or to the order of, the bearer or designated person." To implement a gift-note plan, the practitioner must draft a Deficit Reduction Act (DRA) compliant promissory note to evidence the loan made by the applicant/recipient, which will be repaid with interest over a specified period of time. The DRA modified the rules governing the purchase of promissory notes, loans and mortgages. The DRA amended Social Security Act Section 1917(c)(1) by adding new rules governing the purchase of these investments (see Section 6016(c) of the DRA). New York State adopted these rules (see 06 OMM/ADM-5). Under the DRA, funds used to purchase a promissory note, loan or mortgage are considered to be a transfer of assets unless all of the following criteria are met:

(1) the repayment term is actuarially sound;

(2) the payments are made in equal amounts during the term of the loan, with no deferral of payments and no balloon payments; and

(3) the promissory note, loan or mortgage prohibits the cancellation of the balance upon the death of the lender.

A promissory note complying with the DRA criteria will be considered a bona fide transaction, and the purchase of such an asset will not be classified as a transfer of assets. Given the clear language of the DRA, the drafting practitioner will want to ensure that these criteria are met on the face of the note. It is advisable to consider including language stating that the note is non-negotiable, non-assignable, and otherwise non-transferrable by the promisee. This defeats the argument that the note could be considered a negotiable instrument, and thus an available resource to the applicant/recipient, by means of potential resale of the investment to a third party. The practitioner, in this context, may also consider the exclusion of otherwise standard note terms, including: acceleration language in the event of default, increase in interest rate upon default, authorizing the collection of attorneys' fees in the event of default, and other terms that would make the note attractive to a third party. Proper attention will also need to be given to the appropriate interest rate, which makes the note a viable investment.

Prior to implementing a gift-note plan, a significant amount of critical information is needed, including: the Medicare cut-off date, a comprehensive understanding of the individual's assets and income, a historical review of prior transactions, the private cost of care, outstanding liabilities, the need for retained assets, the liquidity of assets, the regional penalty period divisor, and the cost basis/tax considerations for liquidated and transferred assets.

The gift-note plan will first assess the need for any spend-down items, prior to implementation. Also, in preparing for the anticipated Medicaid application filing, it is important to determine if any resources were transferred for less than fair market value

during the relevant "look-back" period. If so, accommodations should be made in the plan to address the transfers. Then, resources will essentially be divided into three parts: the retained portion, the gift portion, and the loan portion (which is documented by the promissory note). Due care is needed to ensure that retained assets do not exceed the applicable resource threshold. The individual's income, including the new monthly loan payment, must not exceed medical expenses.

Once the plan is implemented, the Medicaid application should be filed to establish an "otherwise eligible" determination. Note payments should be made during the term of the plan, and a structured plan should be followed with clear expectations as to the term and eventual Medicaid "pick-up" date. The individual will private pay for skilled nursing home care expenses during the ineligibility period, with a combination of note income, and the individual's other standard income (i.e., Social Security, pension, etc.). There should also be an understanding of the ultimate goals of the plan, including the assets being protected and how those assets are to be held in the future.

Joint Tenancy and Life Estates

Typically, jointly owned assets are considered to be owned entirely by the Medicaid A/R. However, this presumption may be rebutted by evidence that the joint owner actually owns all or a portion of the property. This is most common in the case of financial institution accounts. However, brokerage accounts are evaluated differently, such that each owner is presumed to own an equal portion of the assets. If a Medicaid A/R added an individual as the joint owner of a brokerage account, for example, then it

will be presumed that the A/R transferred one-half of the value of the account to the other individual at that time, thereby also retaining one-half of the account.

If an individual transferred the remainder interest in real property (such as a personal residence, vacation property, etc.) to another person(s), thereby retaining a life estate interest, the first question in a Medicaid eligibility determination will be to consider the timing of the transfer. If the transfer occurred prior to the sixty (60) month look-back period, the life estate interest is exempt, so long as the property is not sold during the lifetime of the Medicaid A/R. If the transfer occurred during the look-back period, then the value of the remainder interest will be considered an uncompensated transfer, and thus subject to a penalty period. The value of the remainder interest will be established utilizing IRC Table S taking into account the 7520 rate as of the month of transfer. If the property is sold, the A/R should receive the proceeds of the sale equal to the life estate value, utilizing the same calculation procedures.

Irrevocable Trusts

Typically in the advance planning context, an individual or couple may consider transferring certain assets with the eventual goal of asset protection by utilizing an irrevocable income only trust. This type of trust is established by a grantor (or potentially grantors, in the context of a married couple) naming an independent trustee. This trust can hold many different types of assets, including real estate, brokerage accounts, bank accounts and other investment vehicles. The grantor will retain the right to the income generated by the trust during his or her lifetime. This allows the income generated by the trust assets to be taxed at the individual's income tax level. Another feature involves the

grantor retaining the right to use any real property owned by the trust during his or her lifetime. While the trust owns the property, the grantor is permitted to retain tax exemptions, which is often very advantageous. The grantor can also retain the right to pay all maintenance, tax, insurance and other carrying costs in the context of real property. Assets in the trust enjoy an income tax benefit known as a "step-up" in cost basis upon the death of the grantor. Thus, if the assets have appreciated in value over time, the cost basis for tax reporting purposes will change to the appreciated value on the date of death. This can provide a significant tax benefit to the trust's ultimate beneficiaries, especially in the context of real property and stock.

The grantor will only have access to trust income and will not be permitted to receive trust principal. While the trust can permit distributions of trust principal to a specified class of beneficiaries, the restriction of the grantor's access to principal is required for the purpose of asset protection. Certain provisions can be included in the trust giving the grantor some additional rights, including a limited power of appointment, the right to substitute property of an equivalent value, the right to change trustees (to someone other than the grantor), among others. If the assets held by an irrevocable income only trust are transferred 60 months prior to a Medicaid application, they will be considered exempt, but the income generated by the trust will be relevant for income budgeting purposes.

TRACK 5
Special Needs Planning: A New Take on Current Issues

Presented By:
Joan Lensky Robert, Esq.
and
Kerry M. McGrath, Esq.

Basics of Special Education
Kerry McGrath
Special Education Attorney

Overview
During the first part of our presentation I will review some of the basic terms in special education. Then we will walk through an Individualized Education Program (IEP). Our hope is that this information will provide some insight on how to use the IEP to serve your clients in your special needs practice.

Special Education Loves Acronyms
IDEA- Individuals with Disabilities Education Act (or IDEIA Individuals With Disabilities Education Improvement Act). The federal statute that requires to states that accept funding under the IDEA provide all students with disabilities a Free and Appropriate Public Education. See 34 CFR § 300.700

FAPE- A Free and Appropriate Public Education. Not the Cadillac of special education but a program that is allows the Student to make appropriate progress based on his individual circumstances. *Endrew F. ex rel. Joseph F. v. Douglas Cty. Sch. Dist. RE-1,* 137 S. Ct. 988, 197 L. Ed. 2d 335 (2017).

CPSE- The Committee on Preschool Special Education (CPSE) is responsible for identifying and arranging for the delivery of Special Education services for preschool children with disabilities from ages three to five.[1]

CSE- Committee on Special Education. The team, including the Parent, instructed to develop the IEP for the student.

- Parents/guardians of the student
- At least one regular education teacher of such student (*if the student is, or may be, participating in the regular education environment*)
- At least one Special Education teacher or one Special Education provider (*i.e., Related Service provider*) of the student
- A representative of the District who is qualified to provide/administer/supervise Special Education and who is knowledgeable about the general curriculum and the availability of resources of the District
- An individual who can interpret the instructional implications of evaluation results; may be a CSE member selected from the regular education teacher, the Special Education teacher or provider, the School Psychologist, or the District representative described above, or a person having knowledge or special expertise regarding the student as determined by the District

[1] https://schools.ahrcnyc.org/parent-resources/glossary-of-common-special-education-terms/

- At the discretion of the parents/guardians or the District, other individuals who have knowledge or special expertise regarding the student, including Related Services personnel
- When appropriate, the student with a disability
- School Psychologist
- School physician (*if requested in writing by the parents/guardians or District at least 72 hours prior to the meeting*)
- Parent member

IEP – Individualized Education Program

504 Plan- (Section 504 of the Rehabilitation Act) a plan that provides accommodations for the Student. Can be utilized to support physical disabilities as well.

IESP/ ISP- Individualized Services Plan. A plan developed when the student is attending a private school, but receiving services from the public school district. Many times the district where the private school is located will develop the services plan.

FERPA- Family Educational Rights and Privacy Act. Provides parents the right to access and review their child's educational records.

IEE- Independent Educational Evaluation. A term to refer to any evaluation the student requires in order to evaluate his needs. Can be paid for by parents, publicly funded if parents disagree with district evaluations, and can be ordered by an impartial hearing officer at a due process hearing.

IHO- Impartial Hearing Officer. The administrative law judge appointed to hear a special education case. In New York, most hearing officers have familiarity with special education and hear many cases per year.

LRE- Least restrictive environment is a concept that promotes educating students with disabilities with their typically developing peers. LRE does not override the FAPE interest.

ESY- extended school year/12-month services. Student should receive these services if, without services over the summer, she would substantially regress

ESD- extended school day services can be extra services provided after school

ABA- Applied Behavior Analysis. Type of services and methodology for changing children's behaviors

PLPS/PLOPS- Present Level of Performance. The section of the IEP that discuss the student's current levels (see section two for more information)

SETSS- Special Education Teacher Support Services. This is a type of related service that can be provided in small group or individually to help students with academics. In some districts they are called “resource room.”

RTI/AIS- Response to Intervention and Academic Intervention Services are services provided to students without IEPs. Many times districts will go through levels of RTI services before determining the student requires a special education referral. I have also heard these services referred to as “building level” services

OT- occupational therapy
PT –physical therapy

Dissecting the IEP

Page 1
The Heading
Disability Classification
The classification should reflect the disability/ies that impact the Student’s education. For example, if the Student has dyslexia and a minor visual impairment, I would suggest the learning disability classification as that will help drive the academic program he requires.

- Autism
- Deafness
- Deaf-blindness
- Emotional disturbance
- Hearing impairment
- Intellectual disability
- Learning disability
- Multiple disabilities
- Orthopedic impairment
- Other health-impairment
- Speech or language impairment
- Traumatic brain injury
- Visual impairment (which includes blindness)

The projected date IEP is to be implemented is not necessarily the date when the IEP team convened. Sometimes the meeting is held before the summer of one school year and the date to be implemented is the first day the IEP will go into effect the following year.

Projected date of annual review is usually the deadline for the IEP to meet to review the IEP. Each IEP must be reviewed and updated at least one time per year (should be based on current evaluative information).

Present levels of Performance 8 N.Y.C.R.R. § 200.4 (d)(2)(i)
Page 1-5

The Present levels should report the Student's **current** functioning

- Evaluation/assessment results. Generally the teacher(s) provide reports with anecdotes regarding the student's current performance/progress/areas of need

- The student's current functioning and individual needs in academic achievement, functional performance and learning characteristics; social development; physical development; and management needs. These considerations must include the strengths of the student and the concerns of the parent(s) for enhancing the education of the child.

- **The affect the student's disability has on the student's participation and progress in the general curricul**um (or, for preschool students, in appropriate activities); and

- Special considerations relating to behavior, communication, students with limited English proficiency, use of Braille and instruction in the use of Braille and use of assistive technology devices

- Whether the student requires a behavior intervention plan (BIP)

- Whether the Student requires assistive technology

    - The state regulations in section 200.4(d)(2)(v)(b)(6) state that the IEP shall indicate any assistive technology devices or services needed for the Student to benefit from education including the use of such devices in the student's home or in other settings.

Measurable Annual Goals
Pages 6-10

The IEP must list measurable annual goals, consistent with the student's needs and abilities, to be followed during the period in which the IEP will be in effect. For each annual goal, the IEP must indicate the evaluative criteria (the measure used to determine if the goal has been achieved), evaluation procedures (how progress will be measured) and schedules (when progress will be measured) to be used to measure progress toward meeting the annual goal.

- Goals must be measurable
- Help the student make appropriate progress
- Should address EACH area of needs mentioned in Present Levels

Recommended program and services
Pages 11-12
Spectrum of programs

- General Education with related services
- Integrated co-teaching services (one special education teacher, one general education teacher)
- 15:1 (appropriate when learning needs and behavior impact ability to attend to larger class)
- 12:1:1 or 12:1+1 (appropriate when learning needs and behavior significantly impact ability to attend in larger class) 12:1+1 means 12 students, 1 teacher, 1 paraprofessional/teacher's aide
- 8:1+1/8:1+2/6:1+1
- Special Education Teacher Support Services (SETSS) (individual or small group remedial academic support)
- Related services include speech, occupational therapy, physical therapy, counseling/social skills group, assistive technology training, parent counseling and training, parent psychological services, extended school day services

12-Month Service and/or Program
The IEP form must identify if the Committee recommends that the student receive special education services during the months of July and August. If so, the IEP must include:

- the identity of the provider of services during the months of July and August; and
- for a preschool student, the reason(s) the student requires special education programs and services during July and August.

Testing Accommodations
Page 13
The IEP must indicate the individual testing accommodations needed by the student, if any, to be used consistently by the student in his or her recommended education program, in the administration of district-wide assessments of student achievement and consistent with Department policy, in State assessments of student achievement that are needed by the student to participate in the assessment.

Coordinated Set of Transition Activities
Page 14
Beginning with the first IEP to be in effect when the student is **age 15** (and at a younger age, if determined appropriate) and updated annually, the IEP must include a statement of needed transition services. These services focus on improving the academic and functional achievement of the student with a disability to facilitate the student's movement from school to post-school activities.

- Vocational assessment starting at 12 years old
- Encouraged to invite other agencies to attend meeting and help plan

Other Items of Importance
Instructional Levels- this should give you a good idea of where at least the teacher estimates the student is currently performing. Comparing these levels is a very quick way of seeing whether the student is making progress

Promotional Criteria was recently modified so that districts cannot write in the IEPs the student will meet “50% of grade standards.” Instead, the IEP team determines whether the student should be on a
standardized or modified promotion.

Final Page, Attendance of the meeting

STUDENT NAME: Jane Doe **DATE OF BIRTH:** 7/7/2000 **LOCAL ID #:** 5555555	**DISABILITY CLASSIFICATION:** Learning Disability
PROJECTED DATE IEP IS TO BE IMPLEMENTED:02/13/2015	**PROJECTED DATE OF ANNUAL REVIEW:**05/19/2016

STUDENT NAME: Jane Doe **NYC ID:**5555555

PRESENT LEVELS OF PERFORMANCE AND INDIVIDUAL NEEDS

DOCUMENTATION OF STUDENT'S CURRENT PERFORMANCE AND ACADEMIC, DEVELOPMENTAL AND FUNCTIONAL NEEDS

EVALUATION RESULTS (INCLUDING FOR SCHOOL-AGE STUDENTS, PERFORMANCE ON STATE AND DISTRICT-WIDE ASSESSMENTS)

ELA State Exam 2014
Present Level 2
Proficiency Rating- 2.90
Growth Rate- 77%
Scale Score 300

MATHEMATICS State Exam 2014
Present Level- 2
Proficiency Rating- 2.57
Growth Rate- 24%
Scale Score- 324

ACADEMIC ACHIEVEMENT, FUNCTIONAL PERFORMANCE AND LEARNING CHARACTERISTICS

LEVELS OF KNOWLEDGE AND DEVELOPMENT IN SUBJECT AND SKILL AREAS INCLUDING ACTIVITIES OF DAILY LIVING, LEVEL OF INTELLECTUAL FUNCTIONING, ADAPTIVE BEHAVIOR, EXPECTED RATE OF PROGRESS IN ACQUIRING SKILLS AND INFORMATION, AND LEARNING STYLE:

In ELA, based on the Independent Reading Level Assessment Framework Jane Doe is reading on a 3rd grade level. This demonstrates that Jane Doe has mastered common core reading standards up to grade 3. She is currently struggling with skills that incorporate acquiring and using grade level academic language and word usage. When asked to use textual evidence to explain her ideas with a grade level text, Jane Doe demonstrates challenges to achieve this task on her own and requires supports in the form of scaffolded questions and graphic organizers. In reading, Jane Doe demonstrates challenges with making inferences and drawing conclusions. In the ICT ELA classroom, often Jane Doe demonstrates a lack of focus. She is very easily distracted and requires frequent monitoring to complete classroom tasks.

PRESENT LEVELS OF PERFORMANCE AND INDIVIDUAL NEEDS

DOCUMENTATION OF STUDENT'S CURRENT PERFORMANCE AND ACADEMIC, DEVELOPMENTAL AND FUNCTIONAL NEEDS

Jane Doe is able to work in small groups, but often requires re-direction to stay on task. When Jane Doe is focused she is able to form accurate conclusions after reading texts on her independent reading level and can respond to questions verbally and in written form. In writing Jane Doe struggles with structuring essays and short responses. Currently Jane Doe has shown progress using the R.A.C.E formula to respond to short assessment questions. Essay writing is still a challenge. Jane Doe benefits from using graphic organizers that outline where to place transition words, details and explanations within a paragraph. Jane Doe has trouble completing and turning in H.W. assignments and benefits from the reinforcement and monitoring of her school planner to stay organized and to build responsibility appropriate for middle school.

MATHEMATICS

Jane Doe is a 6th grade student who does not particularly enjoy Mathematics. Jane Doe has had difficulty grasping the grade level curriculum. Jane Doe has basic addition and subtraction skills. However, when subtracting numbers with regrouping, Jane Doe is more likely to make errors. Jane Doe still requires practice with her multiplication and division skills. Jane Doe was given flash cards to practice her multiplication and division skills. Therefore, Jane Doe was not able to master topics such as finding the GCF and LCM. Jane Doe is constantly distracted in class. Jane Doe had difficulty with fraction and decimal operations as well. Jane Doe was able to multiply simple fractions, however, when she was instructed to convert mixed numbers and improper fractions before multiplying, there were many errors. Jane Doe was able to follow the steps for dividing fractions and again, with simple fractions, she was able to display some success. Jane Doe is often distracted in class. Due to the constant lack of focus, Jane Doe struggles with task completion. Jane Doe is quite talkative in class and could show more progress if she would prioritize and stay focused.

SCIENCE

Jane Doe shows willingness to learn new concepts. She comes to science class prepared and ready to work. She greatly benefits from working one on one with a teacher or in small groups with a teacher. It is helpful for Jane Doe when instructions are broken down into clear and simple steps. Graphic organizers that chunk or section pieces of information help Jane Doe to understand complex material. Embedded questions in chunked reading material help Jane Doe to stay focused when reading. Jane Doe follows teacher instructions and explanation. Jane Doe is mostly well mannered and respectful; she remains on task with frequent teacher check-ins to ensure focus and understanding. Jane Doe benefits from additional time to complete her assignments. Jane Doe is able to comprehend scientific texts while using vocabulary reference sources like a textbook. She also benefits from diagrams and images that portray scientific ideas and concepts, as well as real world- science curriculum examples.

STUDENT STRENGTHS, PREFERENCES, INTERESTS:

PRESENT LEVELS OF PERFORMANCE AND INDIVIDUAL NEEDS

DOCUMENTATION OF STUDENT'S CURRENT PERFORMANCE AND ACADEMIC, DEVELOPMENTAL AND FUNCTIONAL NEEDS

Jane Doe enjoys school, she expresses a desire to learn and likes learning. Her favorite classes include, science, math, ELA and PE class. She feels like she enjoys the social aspect of school, she has many friends in her class. Jane Doe's extra curricular activities include dance and cheerleading. Jane Doe also enjoys spending time with her family and is looking forwards to this summer vacation as her family has planned trips. Jane Doe plays in the school orchestra and enjoys learning the viola.

ACADEMIC, DEVELOPMENTAL AND FUNCTIONAL NEEDS OF THE STUDENT, INCLUDING CONSIDERATION OF STUDENT NEEDS THAT ARE OF CONCERN TO THE PARENT:

Mom is trying to make an appointment with a psychologist but is having difficulty finding someone. Mom needs a referral for an independent psychologist.

2013, Jane Doe saw a psychologist who recommender her to not be on medication ADHD, mom feels like Jane Doe would benefit from being on medication now.

Did she receive a promotion in doubt for this year?

Jane Doe would greatly benefit from a tutor outside of school. She requires some one-to-one instruction.

Mom feels that Jane Doe is struggling at in the ICT classes with SETSS services. At home, Jane Doe becomes distracted when attempting to do homework more so then previous years. Mom would like Jane Doe to continue with ICT class and SETSS services and add medication.

SOCIAL DEVELOPMENT

THE DEGREE (EXTENT) AND QUALITY OF THE STUDENT'S RELATIONSHIPS WITH PEERS AND ADULTS; FEELINGS ABOUT SELF; AND SOCIAL ADJUSTMENT TO SCHOOL AND COMMUNITY ENVIRONMENTS:

Jane Doe gets along well her peers and the staff in the school.

STUDENT STRENGTHS:

Jane Doe is a very social young lady. Jane Doe participates in school events like the school talent show, she preformed a cheerleading routine with other girls in the school. She also participates in school concerts.

SOCIAL DEVELOPMENT NEEDS OF THE STUDENT, INCLUDING CONSIDERATION OF STUDENT NEEDS THAT ARE OF CONCERN TO THE PARENT:

Jane Doe is very socially. It is easy for her to make friends. Mom is concerned that Jane Doe play fights with other students and can get carried away but mom speaks to her about this frequently.

PHYSICAL DEVELOPMENT

THE DEGREE (EXTENT) AND QUALITY OF THE STUDENT'S MOTOR AND SENSORY DEVELOPMENT, HEALTH,

PRESENT LEVELS OF PERFORMANCE AND INDIVIDUAL NEEDS

DOCUMENTATION OF STUDENT'S CURRENT PERFORMANCE AND ACADEMIC, DEVELOPMENTAL AND FUNCTIONAL NEEDS

VITALITY AND PHYSICAL SKILLS OR LIMITATIONS WHICH PERTAIN TO THE LEARNING PROCESS:
Jane Doe has been diagnosed with Attention Deficit/ Hyperactivity Disorder (ADHD). She does not currently take medication. Jane Doe is otherwise reported to be in good health.
STUDENT STRENGTHS:
Jane Doe participates willingly in class and sports activities. She likes to dance and participates in extracurricular activities.
PHYSICAL DEVELOPMENT NEEDS OF THE STUDENT, INCLUDING CONSIDERATION OF STUDENT NEEDS THAT ARE OF CONCERN TO THE PARENT:
No concerns at this time.

MANAGEMENT NEEDS
THE NATURE (TYPE) AND DEGREE (EXTENT) TO WHICH ENVIRONMENTAL AND HUMAN OR MATERIAL RESOURCES ARE NEEDED TO ADDRESS NEEDS IDENTIFIED ABOVE:
During classroom lessons, Jane Doe requires:
-small group instructions
-repeated directions
-on-task focusing prompts
-repeated directions
-breaks
-visual aids
-scaffolding to write extended response questions
-extended time to complete questions

EFFECT OF STUDENT NEEDS ON INVOLVEMENT AND PROGRESS IN THE GENERAL EDUCATION CURRICULUM OR, FOR A PRESCHOOL STUDENT, EFFECT OF STUDENT NEEDS ON PARTICIPATION IN APPROPRIATE ACTIVITES
Jane Doe continue to in a general education setting with the structure and support provided in an ICT setting with where she can access more small group interaction and individual support throughout the day.

THIS IEP INCLUDES :
☐ Transition
☐ Interim Service Plan

NEW YORK CITY DEPARTMENT OF EDUCATION INDIVIDUALIZED EDUCATION PROGRAM

CONFERENCE INFORMATION
CSE Case# 10-33333
Home District 10 Service District 75
Date 3/22/2004
Type Annual Review

STUDENT INFORMATION *Age as of date of the conference.

Name Green, Thomas NYC ID# 333333333 Date of Birth 8/28/95 Gender Male
Address 2356 University Avenue Apt. 3F Age* 8.7
Phone (718) 444-2233 English LAB Year Spanish LAB Year Grade Ungraded
Language(s) Spoken/Mode of Communication English; picture symbols
Primary Agency with whom student is involved: Quality Services of the Autism Community
Name of Contact Janice Rogers Phone (718) 293-5809 **Agency Case #**

PARENT/GUARDIAN INFORMATION **Relationship to Student**

Name Angela Green
Address same as above
Phone (Home) same as above Phone (Work) (212) 339-3134 Interpreter Required ☐ Yes ☒ No
Preferred Language / Mode of Communication: English

427

SPECIAL MEDICAL/PHYSICAL ALERTS

(Refer to Health & Physical Development Page for additional details)

The student has ☐ medical conditions and/or ☐ physical limitations which affect his/her ☐ learning ☐ behavior and/or ☐ participation in school activities
The student requires ☐ medication and/or ☐ health care treatment(s) or procedure(s) during the school day.
Other alerts: seasonal allergies; asthma

Summary Of Recommendations

Eligibility ☒ yes ☐ no Twelve Month School year: ☒ Yes ☐ No

Recommended Services Classification of Disability:

Staffing Ratio
6:1:1

Recommended Services - Twelve Month School Year

same as above Staffing Ratio

Other Recommendations (Check all that apply) *Details are provided in relevant sections of IEP.

☐ Program Accessibility* ☒ Adapted Phys. Ed.* ☐ Bilingual Instruction
☒ Related Services* ☐ Assistive Technology* ☐ Monolingual Services with ESL
☒ Special Education Transportation -Comment mini bus, air conditioned bus

Students who are blind or visually Impaired :
Braille instruction needed ☐ Yes ☐ No

Students who are deaf or hard of hearing:
Language of Instruction
Mode of Communication

Copy For ___ CSE ___ Parent ___School ___Student ___Other

Student Green, Thomas **NYC ID#** 333333333 **Date of Conference** 3/22/2004

CSE Case# 10-33333

CONFERENCE INFORMATION

Referral type: ☐ Initial ☒ Annual Review ☐ Triennial ☐ Requested Review

Conference type: ☐ EPC ☒ Annual Review ☐ CSE Review ☐ CPSE Review

Attendance at Conference

Please note that your signature reflects your participation at the conference and does not necessarily indicate agreement with the Individualized Education Program.

Signature/Title	Role (Indicate if Bilingual)	Signature/Title	Role (Indicate if Bilingual)
Angela Green	Parent/Legal Guardian		Parent/Legal Guardian
Sybil Andrews, AP	District Representative	Amy Kravitz	Special Education Teacher or Related Service Provider
	General Education Teacher		Parent Member (CPSE/CSE)
	Student	Tom Jones	Speech Therapist Other
	Education Evaluator	Juan Hernandez	Physical Therapist Other
	School Psychologist	Jonathan Cummings	Occupational Therapist Other
	Social Worker	Erica Mitchell	Guidance Counselor Other

Use an asterisk (*) to signify the participant who interprets the instructional implications of evaluation results.
Use the letter (T) to signify participation by teleconference.

Conference Results

☐ Initiate Service ☐ Modify Service ☐ Change Program / Service Category ☒ No Change

Indicate Modifications .....

Initiation, Duration, and Review of IEP

Projected Date of Initiation of IEP: 4/5/2004 Projected Date Of Review of IEP: 3/22/2005

Duration of Services: 1 year

Contacts with Parent / Guardian

Date Notice of Meeting Sent: 3/8/2004

Date of Follow-up (if any):	Type of Follow- up	
3/15/2004	☒ Letter	☐ Telephone
	☐ Letter	☐ Telephone

Date IEP and Notice of Recommendation

☐ Given To Parent: .....

☒ Sent To Parent : 2/29/2004

Copy For : CSE ___ PARENT ___ SCHOOL ___ STUDENT ___ OTHER ___

Student Green, Thomas **NYC ID#** 333333333 **Date of Conference** 3/22/2004

CSE Case# 10-33333

CONFERENCE INFORMATION

Referral type: ☐ Initial ☒ Annual Review ☐ Triennial ☐ Requested Review

Conference type: ☐ EPC ☒ Annual Review ☐ CSE Review ☐ CPSE Review

Attendance at Conference

Please note that your signature reflects your participation at the conference and does not necessarily indicate agreement with the Individualized Education Program.

Signature/Title	Role (Indicate if Bilingual)		Signature/Title	Role (Indicate if Bilingual)	
Ronald James	1:1 Paraprofessional	Other			Other
		Other			Other
		Other			Other
		Other			Other
		Other			Other
		Other			Other
		Other			Other

Use an asterisk (*) to signify the participant who interprets the instructional implications of evaluation results.
Use the letter (T) to signify participation by teleconference.

Conference Results

☐ Initiate Service ☐ Modify Service ☐ Change Program / Service Category ☒ No Change

Indicate Modifications

Initiation, Duration, and Review of IEP

Projected Date of Initiation of IEP: 4/5/2004 Projected Date Of Review of IEP: 3/22/2005

Duration of Services: 1 year

Contacts with Parent / Guardian

Date Notice of Meeting Sent: 3/8/2004

Date of Follow-up (if any): 3/15/2004

Type of Follow- up: ☒ Letter ☐ Telephone

☐ Letter ☐ Telephone

Date IEP and Notice of Recommendation

☐ Given To Parent:

☒ Sent To Parent : 2/29/2004

Copy For : CSE ☐ PARENT ☐ SCHOOL ☐ STUDENT ☐ OTHER ☐

ACADEMIC PERFORMANCE AND LEARNING CHARACTERISTICS

Describe the student's present levels of academic achievement, language development, cognitive development and learning style in English and the other than English language for LEP students. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

PRESENT PERFORMANCE:

Thomas is following the alternate curriculum. Thomas will make eye contact only when he is told "Look at me" or "Look at the ....". He will sustain it for 2-3 seconds. Thomas communicates by gestures, crying, screaming and the use of pictures symbols as part of a formalized exchange system. He repeats certain words and phrases numerous times, beyond the point when they are meaningful to activity or situation. Thomas manipulates objects repeatedly, moving hands rapidly in a random fashion. Thomas focuses on an actvitiy only with constant redirection. He needs to attend to familiar activities for longer periods of time. When he is attending, Thomas can rote count to 100 by 1s, 2s, 5s, and 10s. He can write numbers 1-100 without a model but has difficulty staying within a boundary. He is currently learning to add single digit numbers up to 18. Thomas can recognize and write common and functional sight words. He is working on increasing his sight word vocabulary. Thomas likes to look at books about animals and sports. At times he will demonstrate inappropriate behaviors by repeatedly and

Reading And Writing

Area	Date	Test/Evaluation	Score	Instructional Level
Decoding	3/1-3/15	Teacher Observation		Alternate Performance Indicators
Reading Comprehension	3/1-3/15	Teacher Observation		Alternate Performance Indicators
Listening Comprehension	3/1-3/15	Teacher Observation		Alternate Performance Indicators
Writing	3/1-3/15	Teacher Observation		Alternate Performance Indicators

Math

Area	Date	Test/Evaluation	Score	Instructional Level
Computation	3/1-3/15	Teacher Observation		Alternate Performance Indicators
Problem Solving	3/1-3/15	Teacher Observation		Alternate Performance Indicators

ACADEMIC MANAGEMENT NEEDS

(Environmental modifications and human/material resources)

Thomas requires a highly stuctured, orderly instructional environment that utilizes discreet trial instructional methodologies. Auditory and/or tactile stimuli need to be kept to a minimum as Thomas has difficulty processing information from these sources. Sensory stimuli need to introdced very carefully. Thomas needs to wear a weighted vest to aide in keeping him centered during activities. Thomas needs to be prepared prior to transition from one activity to another. Thomas uses picture symbols as part of a formalized exchange system. Individualized instruction should be used for optimum learning. Staff need to support appropriate student to student interaction.

Social/Emotional Performance

Describe the student's strengths and weaknesses in the area of social and emotional development in English and the other than English language for LEP students. Consider the degree and quality of the student's relationships with peers and adults, feelings about self and social adjustment to school and community environments. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

Present Performance :

Thomas will greet his classmates and teachers by name only when prompted to do so. He inconsistently responds to his name and makes eye contact only when directed and re-directed during activities. Thomas is hesitant to work with another student, preferring to remain with the 1:1 paraprofessional. He does not seem to take interest in other students and will not initiate contact with his peers. At times, Thomas can be aggressive toward others, squeezing hands, pulling hair or kicking. When Thomas does not get what he wants/likes or wants to leave an activity, he begins to cry, cover his ears, screams loudly, jumps up and down and at times will throw himself to the ground. Thomas needs to develop a more consistent, appropriate way of making his needs known and demonstrate these skills across all environments. Thomas works best when he is one on one with an adult. He needs to begin to develop basic student to student interactions and become less reliant on the paraprofessional.

Behavior And The Instructional Process

- ☐ Behavior is age appropriate
- ☐ Behavior does not seriously interfere with instruction AND
- ☐ Can be addressed by General Education OR
- ☐ Can be addressed by special education teacher
- ☒ Behavior seriously interferes with instruction and requires additional adult support.
- ☐ Behavior requires highly intensive supervision.

Describe the present levels of support including personnel responsible for providing behavioral support.

1:1 paraprofessional; consistent communication system; counseling; system of positive reinforcement; weighted vest

Social Emotional Management Needs

Environmental modifications and human/material resources

Thomas requires a highly structured, orderly learning environment that utilizes discreet trial instructional methodologies, picture symbols as part of a formalized exchange system and clear physical, social and environmental boundaries. He requires support to begin interacting appropriately with peers. 1:1 paraprofessional to provide immediate reinforcement of appropriate behaviors and student to student interactions. Counseling as a means of coordinating a consistent, collaborative approach to managing and modifiying Thomas' social behaviors and responses.

A behavior intervention plan has been developed. ☒ Yes ☐ No

Student Green, Thomas NYC ID# 333333333 Date of Conference 3/22/2004

CSE Case# 10-33333

Health And Physical Development

Describe the student's health and physical development including the degree or quality of the student's motor and sensory development,health,vitality and physical skills or limitations which pertain to the learning process, behavior and participation in physical education or other school activities. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

Present Health Status And Physical Development:

Thomas suffers from seasonal allergies. Thomas also reacts to smells such as paint, colognes and perfumes by coughing and rubbing his eyes. He is not taking medication at this time. He has been diagnosed with exercize induced asthma. He should be watched during and after physical activity. Thomas should be in an air conditioned room in hot weather and when ozone alerts are issued.

Medical/Health Care Needs

During the school day, the student requires :

Oral medication ☐ Yes ☒ No

(If yes, functionally describe the condition for which medication is required.)

Treatment(s) or other health procedure(s) ☐ Yes ☒ No

(If yes, functionally describe the condition for which treatments(s) or procedure(s) are required.)

Health as a related service ☐ Yes ☒ No

(If yes, specify in related service recommendations.)

Physical Needs

The student: ☐ does ☒ does not have mobility limitations

(If yes, functionally describe the limitation(s).

Accessible program ☐ yes ☒ no

Adaptive physical education ☒ yes ☐ no

if yes indicate staffing ratio: 6:1:1

Assistive technology device(s) ☐ yes ☒ no

Assistive technology service(s) ☐ yes ☒ no

(If assistive technology device(s) or service(s) are required, specify in management needs)

Health/Physical Management Needs

(Environment modifications, human/material resources or specialized equipment)

Thomas needs to be watched during allergy season and during and after any sustained physical activity.

Copy For : CSE ___ PARENT ___ SCHOOL ___ STUDENT ___ OTHER ___

Student: Green, Thomas **NYC ID #** 333333333 **Date of Conference** 3/22/2004

ANNUAL GOALS AND SHORT-TERM OBJECTIVES

CSE Case# 10-33333

There will be 3 reports of progress this school year.

ANNUAL GOAL:

Thomas will demonstrate increased time on task for familiar activities and routines across all environments.

PROGRESS

Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
Methods of Measurement								
Report of Progress								
Progress Toward Annual Goal								
Reasons for not Meeting Annual Goal								

SHORT-TERM OBJECTIVES:

Other:

1. While seated at a table in a corner of the room, with his view obscured, and wearing a weighted vest, Thomas will attend to a familiar activity in a familiar environment for 3 minutes with 2 redirections to task, 4/5 opportunities over a 2 week period.
2. While seated at a table in a corner of the room, and wearing a weighted vest, Thomas will attend to a familiar activity in a familiar environment for 5 minutes with 1 redirection, 4/5 opportunities over a 2 week period.
3. While seated at a table and wearing a weighted vest, Thomas will attend to a familiar activity in a new environment for 5 minutes 4/5 opportunities over a 2 week period.

ANNUAL GOAL:

Thomas will demonstrate improvement in his ability to communicate his wants and needs.

433

PROGRESS

Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
Methods of Measurement								
Report of Progress								
Progress Toward Annual Goal								
Reasons for not Meeting Annual Goal								

SHORT-TERM OBJECTIVES:

Other:

1. Using picture symbols as part of a picture exchange system, Thomas will pick a preferred activity from 2 choices placed within his reach in response to the question "What do you want to do?" 4/5 opportunities over a 2 week period.
2. Using a picture symbol of a "clock" as part of a picture exchange system, Thomas will request a break before leaving an activity area by pointing to the symbol at least 5 seconds before leaving his seat, 4/5 opportunities over a 2 week period.
3. Using a picture symbol of the manual sign for "finished", Thomas will indicate that he is finished with an activity or routine before leaving his seat, 4/5 opportunities over a 2 week period.

EXPLANATION OF CODING SYSTEM

METHODS OF MEASUREMENT
1. Teacher Made Materials
2. Standardized Test
3. Class Activities
4. Portfolio(s)
5. Teacher/Provider Observations
6. Performance Assessment Task
7. Check Lists
8. Verbal Explanation
9. Other (Specify)

REPORT OF PROGRESS
1. Not applicable during this grading period
2. No progress made
3. Little progress made
4. Progress made; goal not yet met
5. Goal met

PROGRESS TOWARD GOAL
A. Anticipate meeting goal
B. Do not anticipate meeting goal (Note reason)
C. Goal met

REASONS FOR NOT MEETING GOAL
1. More time needed
2. Excessive absence or lateness
3. Assignments not completed
4. Other(Specify)

***While a review of your child's educational program occurs every year please be advised that you have a right to request a review of your child's program at any time.**

	1st	2nd	3rd	4th	5th	6th	7th	8th
The student's performance is approaching his/her promotion criteria as set forth on page 9 of the IEP:								
For students who are not anticipated to meet their annual goals and/or promotion criteria: We recommend that the IEP Team be reconvened:								

Use a Y (Yes) or N (No) in the appropriate column.

Copy For : CSE ___ PARENT ___ SCHOOL ___ STUDENT ___ OTHER ___

Student: Green, Thomas **NYC ID #** 333333333 **Date of Conference** 3/22/2004

ANNUAL GOALS AND SHORT-TERM OBJECTIVES

CSE Case# 10-33333

There will be **3** reports of progress this school year.

ANNUAL GOAL:

Thomas will demonstrate improvement in his ability to transition from one activity to another throughout the day.

PROGRESS

Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
Methods of Measurement	☐	☐	☐	☐	☐	☐	☐	☐
Report of Progress	☐	☐	☐	☐	☐	☐	☐	☐
Progress Toward Annual Goal	☐	☐	☐	☐	☐	☐	☐	☐
Reasons for not Meeting Annual Goal	☐	☐	☐	☐	☐	☐	☐	☐

SHORT-TERM OBJECTIVES:

Other:

1. Using an anticipation board with 2 picture symbols representing current and next activity, Thomas will remove the picture of the current acitivity (that was attached with velcro) and place it in the receptacle within 5 seconds of the prompt "we're finished, it's time to change" 4/5 opportunities over a 2 week period.
2. Using an anticipation board with 2 pictures representing the next 2 activities, Thomas will remove the correct picture (that was attached with velcro) and take it with him to the next activity within 5 seconds of the prompt "it's time to change, where do we go next", 4/5 opportunities over a 2 week period.
3. Using an anticipation board with picture symbols representing 4 consecutive activities, Thomas will transition from one activity to the next at the conclusion of each activity with only the naturally occurring cue (completion of the activity) 4/5 opportunities over a 2 week period.

ANNUAL GOAL:

Thomas will demonstrate improvement in his ability to interact appropriately with peers.

434

PROGRESS

Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
Methods of Measurement	☐	☐	☐	☐	☐	☐	☐	☐
Report of Progress	☐	☐	☐	☐	☐	☐	☐	☐
Progress Toward Annual Goal	☐	☐	☐	☐	☐	☐	☐	☐
Reasons for not Meeting Annual Goal	☐	☐	☐	☐	☐	☐	☐	☐

SHORT-TERM OBJECTIVES:

Other:

1. During preferred daily activities and routines involving 1 other student, with auditory stimuli kept to a minimum, Thomas (in his weighted vest) will remain seated within 1 foot of the student for at least 1 minute with hands remaining in his "space", 4/5 opportunities over a 2 week period.
2. During preferred daily activities and routines involving 1 other student, with auditory stimuli kept to a minimum, Thomas (in his weighted vest) will remain seated within 6 inches of the student for at least 3 minutes with hands remaining in his "space", 4/5 opportunities over a 2 week period.
2 During a play activity involving 1 other student, with auditory stimuli kept to a minimum, Thomas (in his weighted vest) will take turns with the student (2 turns for each student), 4/5 opportunities over a 2 week period.

EXPLANATION OF CODING SYSTEM

METHODS OF MEASUREMENT
1. Teacher Made Materials
2. Standardized Test
3. Class Activities
4. Portfolio(s)
5. Teacher/Provider Observations_____
6. Performance Assessment Task
7. Check Lists
8. Verbal Explanation
9. Other (Specify)_____

REPORT OF PROGRESS
1. Not applicable during this grading period
2. No progress made
3. Little progress made
4. Progress made; goal not yet met
5. Goal met

PROGRESS TOWARD GOAL
A. Anticipate meeting goal
B. Do not anticipate meeting goal (Note reason)
C. Goal met

REASONS FOR NOT MEETING GOAL
1. More time needed
2. Excessive absence or lateness
3. Assignments not completed
4. Other(Specify)_____

***While a review of your child's educational program occurs every year please be advised that you have a right to request a review of your child's program at any time.**

The student's performance is approaching his/her promotion criteria as set forth on page 9 of the IEP:

For students who are not anticipated to meet their annual goals and/or promotion criteria: We recommend that the IEP Team be reconvened:

1st	2nd	3rd	4th	5th	6th	7th	8th
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐

Use a Y (Yes) or N (No) in the appropriate column.

Copy For : CSE ___ PARENT ___ SCHOOL ___ STUDENT ___ OTHER ___

SCHOOL ENVIRONMENT AND SERVICE RECOMMENDATIONS

GENERAL EDUCATION ENVIRONMENT

Area of Instruction	Language(s) or Communication mode	Periods per week	Supplementary Aids and Service	Program Modifications and Supports for School Personnel

435

SPECIAL CLASS ENVIRONMENT

Area of Instruction	Language(s) or Communication mode	Periods per week	Special Class and Staffing Ratio	Supports	Reasons for Non-Participation in General Education Environment
All	English; picture symbols	All	6:1:1	Related Services 1:1 Crisis Management Paraprofessional system of positive reinforcement weighted vest	Thomas' significant academic, behavioral and language/ commuinication needs require the intensive support of a specialized school.

OTHER PROGRAMS/SERVICES CONSIDERED AND REASONS FOR REJECTION

Provide an explanation of the programs/services considered and the reason for rejection. Specify why the student cannot achieve the goals of his/her IEP within a general education program with the assistance of supplementary aids and services.

General Education with Related Services: Thomas requires staff with knowledge of and the ability to adapt and modify instruction while addressing his significant behavioral and language/communication needs.

Special Class in a Community School: Thomas' significant academic, behavioral and language/communication needs require the intensive supports of a specialized school.

436

Second language instruction: If the student is exempt from second language instruction, explain why:

Thomas is following the alternate curriculum.

PARTICIPATION IN SCHOOL ACTIVITIES, RELATED SERVICE RECOMMENDATIONS AND PARTICIPATIONS IN ASSESSMENTS

PARTICIPATION IN SCHOOL ACTIVITIES

If the student cannot participate in lunch, assemblies, trips and/or other school activities with non-disabled students, indicate the activity and reason(s) for non-participation.

Thomas can participate in all activities with his mandated supports in place. Special consideration to health issues and the impact of activities on well being.

Status*	Related Service	Language of service	Location**	Session/ week	Duration	Group size
C	Crisis Management Para	English	Separate Location	5	99+	1
C	Speech	English	Separate Location	2	30	1
C	Speech	English	Separate Location	2	30	2
C	Occupational Therapy	English	Separate Location	1	30	1
C	Counseling	English	Separate Location	1	30	1
C	Special Transportation Para	English	Separate Location	10	30	2

* Indicates status of recommendation: **I**nitiate; **C**ontinue; **M**odify; or **T**erminate ** Indicate whether service is provided outside the general education classroom

PARTICIPATION IN ASSESSMENTS

☐ The student WILL PARTICIPATE in state and local assessments. ☐ The student will participate in Alternative Assessment.

☐ Without Accommodations ☐ With Accommodations

Describe accommodations, if any that will be used consistently throughout the student's educational program:

Reason for participation in Alternative Assessment:

Thomas is following an instructional program based on The Learning Standards and Alternate Performance Indicators for Students with Severe Disabilities

In addition to Alternative Assessment, describe how the student will be assessed:

Teacher Observation, Videos, Data Collection.

Promotion ☐ Standard Criteria ☐ Modified Criteria*

Promotion * Describe the modified promotion criteria

Student Green, Thomas **NYC ID#** 333333333 **Date of Conference** 3/22/2004

CSE Case# 10-33333

Transition

LONG TERM ADULT OUTCOMES

(Beginning at age 14 or younger if appropriate, state long term outcomes based on the student's preferences, needs and interests.)

Community Integration:

Post-Secondary Placement

Independent Living

Employment:

Diploma Objective

☐ Regents Diploma ☐ Advanced Regents Diploma ☐ Local Diploma ☐ IEP Diploma

Expected High School Completion Date Credits Earned As Of Date

Transition Services

(Required for students 15 years of age and older.)

Instructional Activities

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency ○ Fall ○ Spring ○ Summer

Community Integration

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency ○ Fall ○ Spring ○ Summer

Post High School

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency ○ Fall ○ Spring ○ Summer

Independent Living

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency ○ Fall ○ Spring ○ Summer

☐ **Aquisition of Daily Living Skills** ☐ **Functional Vocational Assessment** ☐ **Needed** ☐ **Not Needed**

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency

KASSOFF, ROBERT & LERNER, LLP.
ATTORNEYS AT LAW
100 Merrick Road
West Building •Suite 508
Rockville Centre, New York 11570
(516) 766-7700
Fax (516) 766-0738

ELDER LAW AND SPECIAL NEEDS SECTION:

SUMMER MEETING: JULY, 2018

SPECIAL NEEDS PLANNING: A NEW TAKE ON CURRENT ISSUES

TRACK 5

ALPHABET SOUP:

SSI, SSD, DAC, TBI WAIVER, MBI-WPD, NHTD WAIVER

Joan Lensky Robert

I. INTRODUCTION

The Social Security Act provides an economic cushion for seniors and those with disabilities. New York State also has Medicaid waivers that provide services. The following is an overview of the Social Security benefits available to children and adults with disabilities, i.e., SSI, SSD and Adult Disabled Child's Benefits as well as the Traumatic Brain Injury Waiver, the Medicaid Buy-in for Working People with Disabilities and the Nursing Home Transition & Diversion waiver .

II. PLANNING FOR THE JONES FAMILY

DEBBIE comes to you to help plan her estate and to see if her sons are entitled to any benefits. She is a single mom. She earns $65,000.00/year. She is 50. She has just been diagnosed with MS. She intends to continue to work. She has savings of $100,000 and an IRA of $250,000.

She has two children. Son AARON is 22 and BOB is 17. Both have struggled at school. SON AARON is no longer in school. He had been in special education classes and received a local diploma. Although the school would have allowed him to stay until 21, he decided not to. He has been working at the local supermarket, earning $10/hour for a 20 hour week. They originally hired him to stock the shelves and serve as a cashier for 30 hours/ week, but after the first week he asked his hours to be reduced. The anxiety of working was too much, and he was not sleeping or eating. He seems to do okay with the shelf stocking but never got the hang of the cash register.

SON BOB is still in school. He receives special services through the resource center and is in mainstream classes. He has extended time to take his exams and is allowed to take his exams in the resource room, where he gets extra time and an aide can read the tests to him. He answers the questions on his own. He doesn't work and has never worked. This is the first time that he will take a Regents exam, and DEBBIE is very nervous that he won't be able to pass any Regents.

III. SSI: THE FEDERAL ENTITLEMENT PROGRAM FOR THOSE WITH DISABILITIES UNABLE TO WORK

A. Introduction to Supplemental Security Income

The Supplemental Security Income (SSI) program, 42 U.S.C. 1381 et seq. was signed into law in 1972 by President Nixon in order that the "worthy poor" receive a standard monthly income paid by the federal government and administered by the Social Security Administration. The SSI program is a needs based program. The federal program provides a monthly cash

stipend to the aged, blind and disabled whose available resources and income do not exceed the maximum income and resources standards of the program.

The statute addressed gaps in federal benefit coverage for the aged, blind, and disabled who had not been able to work sufficiently to be currently insured so as to receive disability benefits that existed under the Social Security Act and who were poor. 42 U.S.C. 1381. Prior to the enactment of the SSI program, only state welfare programs were available to provide monthly income to this group of "worthy poor". The federal benefit amount is $750 in 2018. States have the option of adding an optional state supplement "OSS" to the federal benefit amount That amount is $87/month in New York for those residing in their own households. As of 2014, New York State has paid this Optional State Supplement separately from the federal SSI check paid to the recipient.

SSI uses the same definition of disability as does the Social Security Disability Insurance program. A person with a disability is someone whose inability to perform substantial gainful employment is expected to last for 12 months. 20 C.F.R. § 416.905. A blind person has central visual acuity of 20/200 or less in the better eye with the use of correcting lens. 20 C.F.R.§ 416.981. An "aged" person is someone over the age of 65.

B. Children's Benefits

Until a child reaches 18, the financial eligibility of a child for SSI depends upon the economic situation of the parents. The parents' assets and income are deemed available to the child when computing eligibility for SSI for the disabled child through the month of his/her 18th birthday. 20 C.F.R. 416.1202(b)(1). A two parent household may have no more than $3000 in countable assets, while a one parent household may have only $2000.00. The parents' income must be at the poverty level.

After 18, the parents' assets and income will not be counted when an application is made for the "adult" child's own SSI benefits. Only his or her own assets and income will count.

C. Resource Transfer Rules for SSI

An SSI recipient may have no more than $2,000 in countable assets. If a child is under age 18 and lives with one parent, $2,000 of the parent's total countable resources is exempt. If the child lives with 2 parents, $3,000 of the parents' total countable resources will not count. SSI will count amounts over the parents' resource limits as part of the child's $2,000 resource limit. In general, the uncompensated transfer of resources will result in a period of ineligibility for SSI. The wait is calculated by dividing the amount of resources transferred by the monthly SSI benefit. There is a 36 month look-back, and the ineligibility period is capped at 36 months, no matter how great the transfer. 42 U.S.C. § 1382b(c)(1)(A). If $837/month is the monthly benefit, and $8,370 is transferred, there will be a 10 month ineligibility for SSI. If $83,700.00 is transferred, there will be a 36 month ineligibility. No ineligibility period will be assessed to transfers into a trust by someone under the age of 65 which provides a payback to the State for the lifetime of Medicaid provided pursuant to 42 U.S.C. § 1396p(d)(4)(A) or to a pooled trust pursuant to 42 U.S.C. § 1396p(d)(4)(C). 42 U.S.C. 1396p(c)(2)(b)(IV**)**. There is no payback for SSI benefits. 42 U.S.C. § 1382b(e)(5).

SO: WHEN THE CHILD HAS SAVINGS BONDS OR A CUSTODIAL ACCOUNT, WHAT TO DO?

1. A Special Needs Trust may be established for bonds.

2. UTMA ACCOUNTS: These become vested in the child upon his reaching the age of 21. ISSUE: May the custodian/parent establish and fund a "payback" SNT prior to the child's reaching the age of 21? In the New York Region, an opinion e-mail issued by SSA Regional

Office advised that parents holding UTMA and UGMA accounts may establish an SNT with UTMA and UGMA funds. This e-mail referenced Section 12b of UTMA Act, which has fewer limitations on investments than do other statutes concerning fiduciaries, and Section 13a, which gives the custodian all of the rights that an unmarried adult would have as to those assets.

D. Deeming of Income and Assets from Parent to Child

1. Overview

Until a child reaches 18, the financial eligibility of a child for SSI depends upon the economic situation of the parents. The parents' assets and income are deemed available to the child when computing eligibility for SSI for the disabled child through the month of his/her 18th birthday. 20 C.F.R. § 416.1202. After 18, however, the parents' assets and income will not be counted when an application is made for the "adult" child's own SSI benefits. Only his or her own assets and income will count. Id.

2. Deeming of Resources

When there is one parent living with the child with a disability, even if there are other children, the parent may have only $2,000 in countable resources. 20 C.F.R. § 416.1202(b). If the custodial parent has remarried, the resource level is $3000. See id. A parent's home, a car, household furnishings and goods, and retirement funds, such as IRAs, KEOUGHS or tax sheltered annuities, do not count as resources that are deemed available to the child. 20 C.F.R. § 416.1202(b)(1)(i).

The assets and income of a noncustodial parent are not deemed available to the child. See 20 C.F.R. § 416.1851(c), referring only to the deeming of assets of a parent living with the child. The assets and income of a stepparent are, however, deemed available for the support and maintenance of a child with a disability for SSI purposes. 20

C.F.R. § 416.1202(b)(1). A stepparent means the spouse of a natural or adoptive parent living in the same household with the parent. Id.

When a parent who does not receive SSI transfers assets, there is no penalty for the child's SSI caused by the parent's transfer of assets. "[T]he provision [of transfer of resources] does not apply to a resource transfer made by a parent who is a deemor (unless the eligible child and parent are co-owners of the resource." POMS SI 01150.110E. The SSI caseworker may not be aware of this provision.

This provision is particularly important in a personal injury context where the parent has a received a loss of services award for a child who will place his/her funds into an SNT. This provision is also important if the parent receives an inheritance. If the parent retains the funds, the child will lose SSI, notwithstanding the SNT. If the parent transfers the funds, and s/he is not a disabled person, the parent's transfer of assets to another who is not a member of the household will not affect the child's ongoing eligibility for SSI.

3. Deeming of Income

A parent's earned and unearned income is deemed available to a child for SSI purposes. Earned income includes wages and salary or income from self-employment. 20 C.F.R. § 416.1110. Gross income, not net earned income is counted. 20 C.F.R. § 416.1110(a)(1). Unearned income, such as interest, dividends or annuity payments or monthly maintenance (alimony) is also counted. 20 C.F.R. § 416.1102.

a. Child Support as Income

SSI defines child support as payments from the parent to or for the child to meet the child's needs for food and shelter. It may be voluntary or court-ordered. POMS SI

00830.420(A)(1). Child support is considered income of the child, not of the parent for SSI purposes. Id. When child support is paid to the custodial parent for a minor child with disabilities, i.e., one who is under the age of 18, **2/3 of the child support** will count as unearned income of the child that reduces the SSI payment dollar for dollar. POMS SI 00830.420(B)(1).

b. Application of Deeming

The following is the process in which to compute the deeming of income from parent to a child with a disability: If the parent has earned income, the first $85 is disregarded. Then ½ of the remaining income is deemed available to the child LESS the adult federal benefit level, currently $750/month. If the parent has only unearned income, the first $20 is disregarded. Then all of the remaining income is deemed available to the child LESS the adult disregard of $750/month. The resulting figures are deducted from the child's SSI amount. Because the SSI program is intended to encourage individuals to work, only approximately half of earned income is deducted from one's SSI, while almost all unearned income is deducted.

SO assume a parent earns $2,500/month gross income and has only one child, a minor, with a disability. The SSI amount for the child is $733/month. How will the parent's earned income affect the SSI amount?

1. Deduct $85 from $2,500 = $2,415. Deduct half of that amount = $1207.50. LESS the federal benefit level for an adult (parent not applying for SSI herself) $1207.50 - $750 = $457.50. That is the amount deducted from the child's SSI. Child will receive $258.50.

2. HOWEVER, if the income of the parent is all UNEARNED INCOME, i.e., Social Security, a pension or an immediate annuity, etc. bringing in the same $2,500/month, the figures change. Deduct only $20 (first $20 income disregard) = $2,480. Deduct the federal benefit level for an adult (parent not applying for SSI) $2,480 – 760 = $1,730. That is the amount deducted from the child's SSI. $750 - $1,730 = $0. The child will not receive any SSI.

SO IN OUR SCENARIO:

1. Is 17 year BOB disabled? Under Social Security guidelines, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of at least 12 months.

An important factor that is considered in the determination of disability is the maturation and development of the child and is it significantly less than other children his age. School source material is critically important here. The child's performance in school, coupled with his social interaction with other students and with his teachers, his behavior, his following instructions, etc. are all considered, as whether he is in mainstream classes, mainstream classes with accommodations or self-contained special education classes. In addition, IQ testing, reports from the School's Committee on Special Education and school counselors and psychologists are important evidence in the disability process.

2. If he has no money or income of his own, and if Debbie had low income and assets, he would qualify for SSI if he were found to be disabled. However, DEBBIE works and has savings. He will be eligible for SSI only at age 18 and only if he is found disabled at that time.

3. Is DEBBIE disabled? Not at this time. She is working and not receiving any assistance in working full time.

E. Applying for SSI Upon the Child's Reaching the Age of 18

1. Definition of Household

The SSI program pays a higher amount to those who live in their own household than to those who live with others or in another's household. An SSI recipient is residing in his/her own household if he or she has an "ownership interest or a life estate interest in the home," 20 CFR § 416.1132(c)(1), or pays the shelter costs in a business arrangement, id. at (c)(3), or pays "at least a pro rata share of household and operating expenses." Id. at (c)(4). In the context of a family, when the SSI applicant cannot pay a pro rata share of household and operating expenses, then the Social Security Administration considers a rental subsidy provided by the parents as income that will reduce the SSI monthly payment by 1/3.

2. Effect of Pro Rata Share Rule

The pro rata share standard in determining household living arrangements thus results in a reduction in SSI benefits for the 18 year old child whose SSI is not sufficient to pay his pro rata share of the monthly household expenses. Assung a middle class home with two parents and one 18 year old son, with a mortgage and taxes of $2,800/month and utilities of $500/month and food of $600/month, the total household expenditures are $3,900/month. The son's pro rata share of the household expenses would be $1,300/month. However, the SSI maximum payment

is $837/month. The SSA will impute the discount given by the parents to their son's portion of household expenses as income to him.

The SSI payment will be reduced to reflect the household living subsidy, called in-kind support and maintenance, provided by the parents who are not (can not) charge their child his/her pro rata share of the household expenses.

3. But Not ot in the Second Circuit: Ruppert v. Bowen and the Actual Economic Benefit Rule

In the Second Circuit, pursuant to Ruppert V. Bowen, 871 F.2d 1172 (2d Cir. 1989) and the Ruppert Acquiescence Ruling, AR 90-2(2), www.ssa.gov , no in-kind support and maintenance is being provided to an SSI recipient whose parent is charging at least 1/3 of the federal benefit monthly payment plus $20 as a flat fee for room and board, as the government presumes a business arrangement between parent and child.. So long as the parent charges at least one third of $750/month plus $20 for room and board, or $270/month, there should be no reduction in the monthly SSI benefit amount.

4. A contract for necessities may be implied rather than written.

When the now adult child with a disability cannot enter into a written lease agreement due to cognitive impairments, the contract may be implied rather than written if it is providing a necessity (room and board) to the person with a disability. Ruppert v. Bowen, 871 F.2d 1172(2d Cir. 1989). Hence no formal written lease need be presented to the Social Security Administration with the application.

5. Loans are not income for SSI purposes

Proceeds of a loan are not considered income for SSI purposes. 20 C.F.R. § 416.1103(f). Food and shelter provided as a loan do not count as in-kind income reducing the SSI benefit. Hickman v. Bowen, 803 F. 2d 1377 (5th Cir. 1986). SSR 92-8p. It is the donor's

intent, not the intent of the adult child, whether the provision of room and board is a loan to be repaid or a gift. Ruppert v. Bowen, 871 F.2d 1172(2d Cir. 1989).

Thus, during the period of time when the application is pending, the parent providing food and shelter to his child without being paid monthly for the room and board is not providing in-kind support and maintenance to reduce the SSI benefit, so long as the parent intends to be reimbursed from the retroactive SSI.

6. Tips to the Parents Applying for SSI for their 18 Year Old Son/Daughter

1. The Social Security Administration should NOT ask the parent about household expenses on the application. Answer: Not Applicable.

2. Parents MUST charge and collect the room and board in order to comply with the rules. "Cash must pass hands".

3. The contract/lease may be written but may also be an implied contract for necessities. See Ruppert v. Bowen, 871 F. 2d 1172 (2d Cir. 1989).

4. The parents will charge a flat fee for room and board.

5. When asked to list everyone in the applicant's household, list only the applicant. For household living arrangements, the child is living alone, i.e. in his own fiscal household.

6. When asked how the child is paying for the room and board while the application is pending, the parent will be making a loan of the food and shelter.

7. When the child receives the SSI payment, s/he must pay back the parent for the outstanding loan of the room and board from the first SSI payment, which will be retroactive to the application date.

F. SSI Offset for Recipients who Work:

If an SSI recipient works, s/he may still be considered disabled if s/he needs assistance in working. The salary will offset the SSI. To calculate the amount that the salary will reduce the monthly SSI payment, one first subtracts $20 from the gross monthly salary and then $65. One divides the remainder in half, and that quotient is the amount that the earned income will reduce the SSI. If one earns $1650/month, deducting $85 = $1565, and then dividing the remainder by half, one has $782.50 that will be deducted from $837. The adult's total income will be $54.50 from SSI plus $1650 in salary.

SO IN OUR SCENARIO:

1. AARON could be considered disabled if it were shown that he is not substantially gainfully employed and can work only 20 hours/week due to his disabling condition.

2. DEBBIE's income and assets would no longer be deemed available to him.

3. He should be found to be residing in his own household for an SSI benefit of $837/month if DEBBIE charges him a flat fee for room and board.

4.AARON's earned income of $800/month will offset his SSI. The first $20 and then $65 will be disregarded, bringing him to $715/month. Half of that amount, $357.50, is deducted from his $837, giving him monthly SSI of $479.50 in addition to his earnings of $800/month, for a total income of $1279.50, more than either the SSI or his earnings alone.

G. Earned Income Disregard for Full Time Students

A child with a disability under the age of 22 who is regularly attending school may exclude up to $1,820/month in earned income from computation for his/her SSI eligibility. The maximum earned income exclusion is $7,350/year. "Regularly attending school" means at least 8 hours/week at college or 12 hours/week for grades 7-12. If the school is a training course to

prepare for employment, s/he must attend school for at least 12 hours/week, and 15 if shop practice is required. 20 C.F.R. 416,1861; SI 00501.020.

H. Optional State Supplement Issue

New York provides an Optional State Supplement of $87/month to the federal SSI benefit level of $750/month for those residing in their own households. The State is bound by the decision of the Social Security Administration as to whether or not one is residing in his own household. 18 N.Y.C.R.R. 398-4.3. Notwithstanding this regulation, in recent months New York State has reduced the Optional State Supplement to $23.00/month based on its own interpretation of the State Living Arrangement.

In several cases, the State characterized 18 year old adult children paying room and board to their parents as living with others and not as living alone, even though they complied with the Ruppert household living arrangement. The State reduced their Optional State Supplement to $23/month. Requests for reconsiderations were successful, and no hearings had to be held to correct the State Supplement and bring it to $87/month.

I. SSI POMS and First Party "Payback" Trusts

Social Security POMS have addressed SSI issues with First Party SNTS. Their directives are as follow:

1. Payments made by a trustee to third parties or entities providing the beneficiary anything other than food and shelter for the beneficiary will NOT affect SSI.

2. Income from the Trust paid directly TO the beneficiary, or to his/her guardian or legal representative is countable unearned income that reduces the SSI benefit dollar for dollar. See SI 01120.203E(1)(a).

3. Use of the Trust to pay for food and shelter will result in in-kind income to the beneficiary, reducing the SSI payment by up to 1/3 of the federal benefit amount. An SNT Trustee MAY provide food and shelter for the beneficiary, but must decide whether the consequent reduction in the SSI is beneficial to the beneficiary, in the trustee's discretion, depending upon the terms of the SNT. See POMS SI 01120.200E(1)(b). www.ssa.gov.

4. Paying for restaurants is considered food rather than recreation by the Social Security Administration. Id.

5**.** An SNT may be funded with accumulated SSI. A Representative Payee may transfer SSI benefits to an SNT or fund an existing SNT, GN 00602.075(A), so long as these are not retroactive SSI benefits for a child under 18, as these must be held in dedicated accounts. GN 00603.025(B).

6. When the Representative Payee is funding an SNT, the Representative Payee must determine that the trust is in the best interest of the beneficiary, and that it will be used exclusively for him/her and that s/he is the sole beneficiary during lifetime. GN 00602.075c(1).

7. Income irrevocably assigned to the trust from an annuity or support payments made when the beneficiary was less than 65 and which continue after the age of 65 remain protected by the trust. SI 01120.200G(1)(d).

8. Disbursements that are not cash and which do not result in in-kind support and maintenance are not income. Examples given by the POMS include payments to third parties for education, therapy, medical services not covered by Medicaid, recreation, entertainment and phone bills. Payments made to third parties for items such as household goods that are not considered a resource do not result in income for the beneficiary in the month that they are paid for. SI 01120.200E(1)(c). See also SI 01120.200E(1)(c), (d).

9. Additions to trust principal made directly to the trust are not income to the beneficiary if such payments have been irrevocably assigned to the SNT. SI 01120.200G(1)(b).

10 Income that, by its own provisions, may not be irrevocably assigned to the SNT include monthly payments from Social Security, public assistance (TANF or AFDC), Veterans benefits, federal employee retirement payments, and ERISA private pensions. SI 01120.200G(1)(c).

11. Payments for credit card bills including True Link financial are not income if the credit card was used to pay for items other than food or shelter or countable assets. SI 01120.201(I)(1)(d).

12. Credit card bills paid by the trust for restaurants will result in in-kind support and maintenance, subject to a 1/3 reduction. Id.

13. If the trust assets are used to pay for gift cards and gift certificates, this will be considered unearned income in the month of receipt, even if the gift certificate is to a store that does not sell food or shelter items if the individual could sell/exchange the card for cash. SI 01120.201(I)(1)(e).

14. Household goods, i.e., items of personal property found in or near the home used on a regular basis, are not countable resources. 20 C.F.R. § 416.1216(a)(1). These items include, but are not limited to furniture, appliances, electronic equipment such as personal computers and televisions, dishes, cooking equipment, etc. 20 C.F.R. § 416.1216(a)(2).

15. Personal effects include items of personal property ordinarily worn or carried by the SSI recipient. 20 C.F.R. 416.1216(b)(2).

16. Items acquired or held for their value, such as collectibles, gems and jewelry that is not worn or owned due to family significance are countable resources. Id.

17. Credit cards issued to the beneficiary enable the trust to be used for the benefit of the beneficiary without the trustee's going shopping with the beneficiary for all items.

SO IN OUR SCENARIO:

1. If AARON inherits money from his grandparents, for example, and established a first-party SNT, or if DEBBIE established a third party SNT for him or a SOLE BENEFIT SNT, the trust would not affect his SSI eligibility if not used for food and shelter.

2. If any type of trust pays for his rent in an apartment so that he can live on his own, the use of the trust for his rent would reduce his SSI by up to 1/3 because it is providing in-kind support and maintenance.

3. If AARON uses a credit card to make his payments, he will be able to use his SSI for cash and have the trust pay his credit card bills without affecting his SSI so long as the trust does not pay for food and shelter.

4. An ABLE account , 20 U.S.C. 529-A, may pay for food and shelter without reducing SSI.

J. Effect of Home Ownership on SSI Benefits

1. Home Owned by the SSI Recipient

A home owned by an SSI recipient is an exempt asset. 42 U.S.C 1382b(a)(1), 20 § CFR 416.1210, 20 CFR § 416.1212. For SSI purposes, the value of the home is excluded as an asset. If the SSI recipient pays for the ongoing shelter costs from his/her SSI benefits, s/he is considered residing in his/her own household and will not have any reduction in SSI.

2. Home Owned by an SNT

A home owned by an SNT is not a countable resource for SSI or Medicaid purposes, even if the beneficiary does not reside in the home, as it is a trust asset. SI

01120.200F(1). If a third party, such as the SNT, pays for shelter costs of the beneficiary, that will result in in-kind support and maintenance that will reduce the monthly SSI benefit, up to 1/3 of the monthly SSI payment. Shelter costs include mortgage costs, including property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, water, sewer and garbage removal. SI 00835.465D(1). See 20 C.F.R. 416.1133(c).

If the trust owns the home but does not pay for housing costs, there is no reduction in SSI monthly benefits. SI 01120.200F(2). However, the purchase of the home by the trust will be considered in-kind support and maintenance (1/3 reduction of SSI) in the month of purchase. SI 01120.200F(3). The use of trust assets to purchase a home will not reduce Medicaid benefits in New York.

If the SNT purchases a home subject to a mortgage, and the monthly mortgage payments are made by the SNT, these monthly payments result in in-kind support and maintenance, providing Shelter expenses that reduce the SSI monthly benefit by 1/3 each month in which they are made. SI 01120.200F(3)(b). If the SNT pays for shelter or household operating expenses or household costs, this results in in-kind support and maintenance. SI 01120.200F(3)(c).

If the SNT pays for accommodations to the home to make it handicapped accessible or for renovations that increase the value of the home, this does not result in in-kind support and maintenance that results in a 1/3 reduction of the SSI monthly benefit. Id. Extra mortgage payments to reduce the principal owed and extra insurance coverage not required by the mortgagee are not household costs resulting in in-kind support and maintenance when paid by the SNT. SI 00835.465D(2),(3).

IV: SOCIAL SECURITY DISABILITY INSURANCE

A. Overview

The Social Security Act provides for Disability Insurance Benefits, 42 U.S.C. 423, which is a benefit program for workers who become disabled and are unable to work. The program provides a monthly income during a period of disability, while the individual is unable to perform substantial gainful activity, 42 U.S.C. § 423(d), (e). Substantial gainful activity means work that involves doing significant and productive physical or mental duties; and is done (or intended) for pay or profit. 20 C.F.R. § 404.1510. In 2018, substantial gainful activity = $1,180/month.

The applicant must also have insured status to qualify for eligibility under the Disability Insurance Program. 42 U.S.C. § 423 (c); 20 C.F.R. § 404.101 et seq. The disabled wage-earner must have paid into the Social Security system through a deduction from earned income pursuant to FICA (Federal Insurance Contributions Act), 42 U.S.C. § 409, the federal income tax withholding paid to the Social Security system.

To be "currently insured," 42 U.S.C. § 423 (c)(1); 20 C.F.R. § 404.120, for a period of disability and Disability Insurance Benefits, one must have sufficient quarters of coverage ("Social Security Credits"). For each calendar year, an individual can earn a maximum of four (4) credits of employment and social security taxation. An individual gains one quarter for each $1,320.00 of Social Security taxed employment earnings. Hence, if the individual earns $5,280.00 in social security taxed employment earnings for a calendar year, with a minimum of $1,320 in each quarter, that individual has secured four (4) quarters of coverage or Social Security credits.

In general, the individual must have paid taxes into (FICA) for a period of twenty (20) quarters out of the prior forty (40) quarters, i.e., five (5) years out of the ten (10) years prior to

the disability and the application for Social Security Disability Insurance Benefits. 42 U.S.C. § 423 (c)(1)(B)(i); 20 C.F.R. § 404.130. Those under the age of thirty-one (31) require fewer quarters of coverage, but never fewer than six (6) quarters for those under the age of twenty-four (24). 20 C.F.R. § 404.130 (c).

After a two year waiting period, a recipient of Social Security Disability benefits is eligible to receive Medicare, 20 C.F.R. § 406.12, even though that individual has not yet attained 65 years of age.

Unlike the SSI program, there is no asset or income eligibility threshold for SSDI.

B. Coordination with SSI

In some instances, individuals who qualify for Social Security Disability Insurance Benefits might also be eligible for Supplemental Security Income if the amount of their monthly Social Security Disability Insurance benefit is less than the monthly benefit of SSI. If, for example, the SSDI monthly payment based on the recipient's earnings record is $600/month, then the SSI program will pay $237/month in 2018 to supplement the SSDI to bring the total amount up to the maximum SSI benefit of $837/month. If, however, the SSDI will pay $1,000/month, the there is no SSI supplement. And, of course, to receive SSI, one must meet the asset ($2,000) and income tests of the SSI program.

C. The Medical Criteria for Disability Pursuant to the Social Security Act

The Social Security program of Disability Insurance Benefits provides monthly payments to a wage earner who is totally and permanently disabled. The Social Security Administration has issued a Listing of Impairments, 20 C.F.R. § 404, Subpart P, Appendix 1, Part A, and Medical Vocational Guidelines, 20 C.F.R. § 404, Subpart P, Appendix 2, which are guidelines used to establish if one is disabled. If an individual presents medical evidence that there is a

medically diagnosed impairment with the symptoms, signs, and test results that meet those identified in the Listings, then a finding of a period of disability is indicated, 20 C.F.R. § 404, Subpart P, Appendix 1, Part A. If an individual does not meet the criteria of a "listed impairment", that individual can still be entitled to benefits if the severity of their medical determinable impairment or combination of impairments rises to the level of a "listed impairment". 42 U.S.C. § 423(d), (e).

One must be totally and permanently disabled in order to receive Social Security benefits. 42 U.S.C. §§ 423 (d)(1)(A), 416 (i)(1). "Permanently disabled" refers to one who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months. Id. One is totally disabled if his/her physical or mental impairment or impairments are of such severity that he/she is not only unable to do previous work but cannot, after considering the individual's age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy. 42 U.S.C. § 423 (d)(2)(A).

The Social Security Administration must also consider the combined effects of all of the individual's impairments without regard to whether or not any such impairment, if considered separately, would be of such severity as to rise to a level that would impair the individual's ability to perform substantial gainful activity. Substantial gainful activity means work that involves doing significant and productive physical or mental duties; and is done (or intended) for pay or profit. 20 C.F.R. § 404.1510. See also 20 C.F.R. § 404.1571 et seq. The statute defines a physical or mental impairment as "an impairment that results from anatomical, physiological, or

psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques". 42 U.S.C. § 423(d)(3), 20 C.F.R. § 404.1508.

The courts have uniformly ruled that substantial gainful activity is work that is of a functional nature that the disabled individual can realistically perform in a competitive work environment. City of New York v. Heckler, 578 F. Supp. 1109 (D.C.N.Y., 1984), aff'd, 742 F.2d 729 (2d Cir., 1985), aff'd, 106 S. Ct. 2022, 476 U.S. 467, 90 L.Ed. 2d 462 (1987). The distinction between a competitive and a non-competitive work environment is generally seen with younger individuals who perform employment services in a sheltered environment. 20 C.F.R. § 404.1573(c). These workers might have been placed in employment situations through vocational rehabilitation and require the assistance of a job coach to assist them with day-to-day work activities. These individuals who require and receive oversight, supervision, job coaching and assistance in performing work activities should not be considered to be performing substantial gainful activity in a competitive work environment.

D. The Application Process for Social Security Disability Insurance

The Social Security Administration allows electronic application filings and form completions through their website, www.*ssa.gov*. The Social Security Administration provides a guide for use when one is preparing the data necessary for to file benefit applications and it is a downloadable packet from the Social Security website, www.*ssa.gov*.

The application requests information concerning the individual's personal data, including specific contact information, birth and citizenship information, family and dependent data, a summary of the physical and/or emotional impairments that prevent the individual from working, the date that the applicant last worked, the income earned by the applicant in the form of wages

for the three years prior to the application, and a section for any additional remarks that the applicant wants to make or expand on a prior answer from the application.

As part of the application process, the applicant must complete a Disability Report–Adult (SSA-3368-BK) which details the applicant's medical history regarding the claimed current disabling impairment(s). One does not need to list medical history that is independent of the current disabling impairment(s); however, a medical condition that is independent of the current disabling impairment(s), but which is a complicating factor in the applicant's treatment plan should be listed.

The application process also includes the work history of the applicant. The data is designed to provide a comprehensive work history so that the Social Security Administration can determine the vocational background of the applicant as a means to establish the individual's capacity to perform his/her past relevant work, and, if the individual cannot perform his/her past relevant work, whether the individual has the capacity to do other work. It is important to note that an individual does not have to be able to do work at the same earnings level, and in fact, a prior salary structure is not even considered by the Social Security Administration. S/he must simply be able to perform a job, any job, even if it is menial compared to the prior work that the individual was performing.

Once the practitioner is retained and representing the individual in the application process, a practitioner should secure his/her own Medical Authorizations so that the practitioner can receive a copy of any pertinent medical evidence from the applicant's treating sources directly, without having to wait for the Social Security Administration to make a copy available to the representative.

In addition, a treating source may be willing to prepare a narrative letter in support of the application for benefits, and a practitioner's Medical Authorization will enable the practitioner to request and secure a letter directly from the treating source. A narrative letter from a treating source is entitled to great weight if supported by objective medical findings.

E. The Social Security Administration's Review of a Completed Application

After the application filing process is completed, the Social Security Administration will forward the medical information regarding the application to a state agency acting as a sub-contractor with the Social Security Administration for purposes of issuing medical determinations. If the application for Social Security Disability Insurance benefits is approved, then the file is sent to the Social Security Payment Center for the processing of benefits, the issuance of a Social Security Award notice and payment of benefits.

If the application for benefits is denied, the applicant may appeal the Notice of Disapproved Claim by filing a Request for a Hearing before an Administrative Law Judge within sixty (60) days of the denial Notice.

F. Social Security Administrative Hearing

The Administrative Hearing is conducted by an Administrative Law Judge through the Office of Disability Adjudication and Review. 20 C.F.R. §§§ 404.914, 404.915 and 404.916.

All current Social Security files are electronic and therefore, access to a file to prepare for an Administrative Hearing is through the "Appointed Representative" website. ssa.gov/ar. Electronic Records Express provides access to appointed representatives to view a claimant's folder and this is critical in the preparation for an Administrative Hearing. In fact, the

appointed representative has arguably an affirmative duty to access the claimant's electronic folder to make certain that all of the supporting evidence is in the claimant folder.

At the Administrative Hearing, the duty of the Administrative Law Judge is to act as an independent fact finder to elicit any and all information that he/she deems necessary to render a full and fair determination of the individual's application for benefits. The Administrative Law Judge must review all of the evidentiary documents in the administrative record, take sworn testimony from the applicant and other witnesses and listen to any legal arguments raised by the practitioner on the Social Security Laws, Regulations and case-law on point.

The Administrative Law Judge may also elicit testimony from a Medical Expert and/or a Vocational Expert, acting as the Administrative Law Judge's own expert witnesses. These individuals are contracted providers for the Social Security Administration, and the Administrative Law Judge provides great weight to their testimony. The Administrative Law Judge is not bound by any of the prior determinations made by the Social Security Administration and will render and independent decision.

The Administrative Law Judge may either issue a favorable or unfavorable decision. The Second Circuit for the United States Court of Appeals has summarized the review procedure as follows:

> First, the Commissioner considers whether the claimant is currently engaged in substantial gainful activity. If he is not, the Commissioner next considers whether the claimant has a "severe impairment" which significantly limits his physical or mental ability to do basic work activities. If the claimant suffers such an impairment, the third inquiry is whether, based solely on medical evidence, the claimant has an impairment which is listed in Appendix 1 of the regulations. If the claimant has such an impairment, the Commissioner will consider him disabled without considering vocational factors such as age, education, and work experience; the Commissioner presumes that a claimant who is afflicted with a "listed" impairment is unable to perform substantial gainful activity. Assuming

> the claimant does not have a listed impairment, the fourth inquiry is whether, despite the claimant's impairment, he has the residual functional capacity to perform his past work. Finally, if the claimant is unable to perform his past work, the Commissioner then determines whether there is other work which the claimant could perform. Bluvband v. Heckler, 730 F.2d 886, 891 (2d Cir. 1984).

If the decision is Favorable, then the file is sent to the Social Security Payment Center for the processing of benefits. If the decision is Unfavorable, an appeal may be filed with the Appeals Council of the Office of Disability Adjudication and Review. There is generally no appearance before the Appeals Council, and the review is handled by submission. However, oral argument can be requested and a substantial showing must e made for the Appeals Council to grant a personal appearance be granted. Given the fact that oral argument before the Appeals Council is rarely held, establishing a strong case at the Administrative Hearing is critical to any chance of success in reversing the Administrative Law Judge before the Appeals Council.

The Appeals Council may decide favorably for the applicant and either reverse the Administrative Law Judge and award benefits, or remand the case back to the Office of Disability Adjudication and Review for a new Administrative Hearing. If the determination of the Appeals Council is Unfavorable, the individual may appeal an unfavorable decision to the United States District Court for the district where the applicant resides. The Commissioner of the Social Security Administration is represented by the United States Attorney's Office in the District where the lawsuit is filed.

G. Getting Paid

An attorney may receive only 25% of a successful retroactive recovery from representation before the Social Security Administration. Only a contingency fee retainer agreement is permissible, and the fee must be approved by the Social Security Administration. The representative must complete and file an Appointment of Representative Form.

H. Social Security Disability and Early Social Security Retirement

If the worker planning retirement prior to Full Retirement Age due to health reasons happens to have impairments that would be deemed to meet the Social Security criteria for Disability Insurance Benefits, then it is prudent for the individual to apply for both Retirement and Disability. 20 CFR 404.310. The Retirement benefit will be processed much more quickly than the Disability benefit, and the individual can start to receive a monthly benefit immediately.

If a retired worker is found disabled by the Social Security Administration, s/he will receive the SSDI, which is the maximum benefit at Full Retirement Age. 20 CFR 404.310. After 2 years s/he will receive Medicare. If the individual is ultimately denied Social Security Disability benefits, s/he will still continue to receive the Social Security Retirement benefits applied for. However, the practitioner must consider whether to represent the client, as an attorney may be paid only 25% of a successful recovery.

SO IN OUR CASE:

1. Although SON AARON is working, he is not performing Substantial Gainful Activity so he could be considered disabled even though he is working.

2. If he is earning $1,320/quarter and paying a FICA tax on those earnings he is earning work credits to be currently insured.

3. After as few as 6 quarters of coverage he could qualify for some Social Security Disability on his own earnings.

4. He would then qualify for Medicare after 2 years.

5. Social Security counts as unearned income. It would offset his SSI amount, as also would his earned income. If he is earning $800/month, $357.50 ($800 LESS $85 LESS ½ OF THE REMAINDER) PLUS his Social Security benefit OF $120/month, for example, OR $477.50 is deducted from his SSI OF $837/month, leaving him an SSI benefit amount of

$359.50. He would retain his earned income of $800/month PLUS his Social Security Disability payment of $120 PLUS SSI of $359.50 or a total of $1279.50.

6. If DEBBIE is no longer able to work at some point in the future, she may apply for SSDI. This will be beneficial to her, because she will receive her full retirement Social Security and after 2 years receive SSDI.

V: CHILDHOOD DISABILITY BENEFITS (ADULT CHILD BENEFITS):

When the child with a disability is over the age of 18 and his parent is retired, disabled or deceased, the adult child may be eligible to receive Social Security benefits based upon the parent's earnings. 42 U.S.C. 202(d).

A. Requirements:

1. The child must not be performing substantial gainful activity ($1,180/month earnings;);

b. must be unmarried at the time of the application;

c. must be disabled prior to age 22;

d. must be dependent upon the parent - this is presumed.

B. Medicare Entitlement

After 2 years, the adult child will receive Medicare benefits.

C. Interrelation with SSI

An adult child will receive the highest amount of either benefit, but the monthly benefits will not be added together to result in double monthly benefits. If the adult child's own SSI is $837/month, and the Childhood Disability benefit on the parent's earnings is $860/month, the client will LOSE SSI but receive the Social Security benefit. If the Social

Security benefit is $500/month, then the SSI will be added to the Social Security benefit to result in $337/month of SSI and $500/month Social Security.

ADVICE TO OUR CLIENTS:

1. The letter that the Social Security Administration sends when the adult childhood benefit begins often frightens the parent. It says that their son or daughter has lost the SSI benefit and may also lose Medicaid. It does not mention that the adult child will still be eligible for Medicaid or that a separate application must be placed for those whose Medicaid was provided automatically with the SSI. We must show that the adult child will soon qualify for 3 or even four entitlements.

2. Childhood benefits are not means tested. If the child receives Medicare and Adult Childhood benefits, then a lawsuit recovery or inheritance will not affect ongoing eligibility for these benefits. Only if the child needs Medicaid must planning such as a Special Needs Trust or gifting of assets be undertaken.

3. Although the disability must have occurred prior to the child's reaching 22, the entitlement begins only upon the parent's retirement, disability or death. Hence, many SSI recipients subsequently become eligible for this benefit and Medicare when the child is 30 - 40 years old or more.

4. There will be no Medicaid excess income if the sole reason that a former SSI recipient has lost SSI is due to the increased Adult Child benefit. However, to have no excess income, the adult child must have no more than $2000 in resources and not have made disqualifying transfers. See 95 ADM-11.

5. If the adult child wants to retain $15,150.00 and continue to receive Medicaid, then the excess income must be placed into an SNT.

SO IN OUR SCENARIO:

1. If DEBBIE applies for and receives SSD or reaches the Social Security retirement age and retires and takes Social Security, her sons could receive Disabled Adult Child Benefits at that time on DEBBIE's work record if her sons were disabled prior to age 22 and neither had worked enough to be considered to have substantial gainful activity. After 2 years they would receive Medicare. Neither benefit is means tested.

2. If they need Medicaid, however, they must meet the financial criteria for Medicaid. If they had been receiving SSI and lost the SSI solely due to the DAC benefits, and continued to have no more than $2,000.00 in their name, they would be able to receive Medicaid without an income spenddown. If they had more than $2,000, and up to $15,150 they would have Medicaid with a spenddown.

VII MEDICAID WAIVER PROGRAMS

A. TBI WAIVER

The TBI Waiver is a Home and Community Based Waiver for those who suffered a Traumatic Brain Injury. It is available for those between the ages of 18 and 64 who were injured after age 18. It provides 11 Medicaid-funded services to assist participants to live in community-based settings. They may receive rent subsidies and housing supports. It is intended to provide supports for those who need a nursing home level of care but will stay in the community.

The New York State Department of Health oversees the program. DOH contracts with Regional Resource Development Centers to manage the waiver. The Regional Resource Development Specialist oversees enrollment in the waiver and assists in developing needed services.

The services provided are service coordination, independent living skills training, day programs, substance abuse programs, behavioral intervention, community integration counseling, home and community support systems, hoe odifications, respite, assistive technology, transportation and transitional services. An approved plan identifies the services that will be provided to each participant.

B. Medicaid Buy-in Program for Working People with Disabilities

This program allows individuals with disabilities who are working and whose income exceeds the Medicaid levels to "buy into" the Medicaid program without a spenddown. The individual may earn up to $61,740 and have countable resources of $20,000. Private insurance is primary to the buy-in program, but people who need home attendants and who work but would otherwise be found disabled are eligible for this program. If someone is not receiving Social Security disability benefits, the New York State Disability Review Team, through the local DSS will arrange for a disability review.

Our clients who have been accepted to this program include an attorney earning $80,000/year but whose disability-related work expenses were so great that they brought her below the income level. In addition, one may shelter excess income in an SNT. Another client earned $56,000/year and worked from home. Both were totally paralyzed. He was accepted to the program and the needed home attendants were provided.

C. Nursing Home Transition & Diversion Waiver Program

In an effort to assist people with disabilities to reside in the community rather than in a skilled nursing facility, this waiver assists people to remain in the community or return to the community with Medicaid services that will not cost more than the cost of care for them in the facility. This Medicaid waiver is available to those between the age of 18 and 64 who have a

physical disability and are eligible for Medicaid coverage for community-based long term care services such as community Medicaid and outpatient Medicaid services. They must need a nursing home level of care. They must identify where they will be living when participating in the waiver. They must be self-directing or have a legal guardian who can direct for them. The services provided to them will be as set forth in a service plan.

VIII. SO WHAT DO WE TELL DEBBIE?

1. DEBBIE's assets do not affect SON AARON's eligibility for SSI, because he is over the age of 18.

2. If BOB is determined to have a disability, he would be eligible for SSI at age 18, when DEBBIE's assets and income will not affect his benefits.

3. Either son may qualify for Adult Disabled Child benefits if DEBBIE applies for and receives SSD or retires and receives Social Security retirement if they have been disabled prior to age 22.

4. Either son might qualify for his own SSDI if he pays enough into FICA, so long as he is considered disabled but working with supports..

5. The sons will lose Disabled Adult Child benefits if they ever marry, unless they marry someone with a disability.

6. DEBBIE should include an SNT in her estate plan for each child, and may consider an ABLE account as well.

7. DEBBIE could potentially qualify for the MBIWPD waiver or the NHTD waiver.

8. If her sons are disabled, DEBBIE may qualify for Medicaid without any ineligibility period by transferring assets into a SOLE BENEFIT TRUST for each child.

CONCLUSION

The Social Security Act and Medicaid waivers provide a safety net for those with disabilities. Knowing the entitlements for which our clients may be eligible assists in providing them with planning options to maximize their benefits and preserve assets.

TRACK 6
Elder Law Drafting: All the Clauses You Didn't Know You Needed and More

Presented By:
Richard A. Weinblatt, Esq.

ELDER LAW DRAFTING: ALL THE CLAUSES YOU DIDN'T KNOW YOU NEEDED AND MORE

NEW YORK STATE BAR ASSOCIATION
ELDER LAW AND SPECIAL NEEDS SECTION
Summer Meeting July 2018

Richard A. Weinblatt, Esq.
Haley Weinblatt & Calcagni, LLP
1601 Veterans Memorial Highway
Suite 425
Islandia, New York 11749
(631) 582-5151
raw@hwclaw.com

Medicaid Asset Protection Trust

Distribution of Income

1. **All Income to Grantor:** During Grantor's lifetime, the Trustee, after deducting the expenses of administration of the Trust, shall pay to or apply for the benefit of Grantor, all of the net income of the Trust in convenient installments, but at least so often as quarter-annually.

2. **Discretionary Income to Children:** During Grantor's lifetime, the Trustee, after deducting the expenses of administration of the Trust, may pay so much of the net income of the Trust as the Trustee shall deem proper to or for the benefit of any one or more of Grantor's children, _____, in equal or unequal amounts. Any income not so paid is to be accumulated and added to the principal at the end of each calendar year. Under no circumstances may the Trustee pay or apply the net income of the Trust for the benefit of the Grantor.

3. **Discretionary Income to Grantor and/or Children:** During Grantor's lifetime, the Trustee, after deducting the expenses of administration of the Trust, may pay so much of the net income of the Trust as the Trustee shall deem proper to or for the benefit of any one or more of Grantor and Grantor's children, _____, in equal or unequal amounts. Any income not so paid is to be accumulated and added to the principal at the end of each calendar year.

Distribution of Principal

1. **Distribution to Grantor's Children:** **(i)** During Grantor's lifetime, the Trustee may pay so much of the principal of the Trust (even to the extent of the whole) as the Trustee shall deem proper, to or for the benefit of any one or more of Grantor's children, _____, in equal or unequal amounts. Under no circumstances, however, shall the Trustee distribute residential real property (including condominiums or the shares of a cooperative apartment) used by the Grantor as a personal residence.

   (ii) Under no circumstances may the Trustee invade the principal of the Trust for the benefit of the Grantor. The Grantor directs that the provisions of Section 7-1.6 of the New York Estates, Powers and Trusts Law, or any successor statute, shall not be applied by any court having jurisdiction of an express or testamentary trust to compel the payment or application of the principal of the Trust to or for the benefit of the Grantor for any reason whatsoever. This provision is specifically intended to negate and eliminate any discretion granted to any Court by Section 7-1.6 of the New York Estates, Powers and Trusts Law.

Grantor's Use of Residence

1. **Provision for Income and Use of Residence:** During the lifetime of Grantor, the Trustee, in the Trustee's sole discretion, may distribute from time to time all or part of the net income from the Trust Estate, as follows: (i) to or for the benefit of Grantor, (ii) to or for the benefit of Grantor's children and/or grandchildren, or (iii) accumulate said income as part of the Trust Estate. Notwithstanding the foregoing, Grantor shall have the absolute right, during Grantor's lifetime, to reside in, enjoy, and occupy any and all residential property owned by the Trust, rent-free, provided that Grantor keeps the property in good condition and repair and pays and is responsible for all carrying costs of said property and expenses with regard to Grantor's use and occupancy thereof, including, but not limited to, any mortgage payments (interest and principal), real estate taxes, insurance premiums, loss, damage, maintenance and repairs, and maintain adequate casualty and liability insurance on said property. Grantor shall not be required to give any bond or other security.

2. **Use of Residence; Termination of Use:** In the event that my trust holds residential real property (including condominiums or the shares of a cooperative apartment) used by me, then I have the exclusive right to possess, occupy, and use the real property (including a cooperative apartment) for residential purposes.

   No Payment of Rent; Payment of Maintenance
   I may not be required to pay rent for such property, but will be responsible for and required to pay all of the expenses of the maintenance of the property, including taxes, insurance, utilities, mortgage payments, and normal costs of maintenance and upkeep of the property.

   Termination of Tenancy
   If I cease to use such property as a residence (permanently or seasonally), my Trustee may, in the exercise of sole and absolute discretion, either continue to hold such property as an investment or sell it. Notwithstanding the above, any purchaser of real property owned by this trust will be entitled to rely upon the authority of my Trustee to sell such real property. My Trustee may purchase or acquire substitute property or properties to be used by me for residential purposes. Any substitute property purchased shall be part of the principal of this trust.[1]

3. **Use of Residence; Reference to Property Tax Exemption:** In the event that the Trust holds residential real property, including shares in a cooperative apartment, used by the Grantor as a personal residence, Grantor shall have the right to the exclusive occupancy of

[1] This provision was derived from copyrighted material and are used for educational purposes with the express permission of the copyright holder, ElderCounsel, LLC.

said residential real property (or replacement residential real property). The Grantor shall not be responsible to pay rent for such property, but shall be responsible for and required to pay all of the expenses of the maintenance of the property, including taxes, insurance, utilities, mortgage payments and normal costs of maintenance and upkeep of the property. Such right to exclusive occupancy may be waived in writing by the Grantor or her legal representative (including the holder of a durable power of attorney). Such written waiver by Grantor may include binding instructions to the Trustee for the sale of the residential real property and/or the purchase of a replacement personal residence for the Grantor of her own choosing. It is the intent of the Grantor herein to preserve or obtain any and all types of property tax exemptions which the Grantor would otherwise have been entitled to if the property had been held by her.

4. **Use of Residence; Occupancy:** In the event that this trust holds residential real property used by me, then I have the right to occupy the real property (including a cooperative apartment) for residential purposes. Upon my request, the Trustees shall purchase substitute property or properties to be used for my dwelling purposes. Any substitute property purchased shall be part of the principal of this trust. Notwithstanding the above, any purchaser of real property owned by this trust will be entitled to rely upon the authority of the Trustees to sell the real property. I may not be required to pay rent for any property, but I am responsible for, and required to, pay all of the expenses of the maintenance of the property, including taxes, insurance, utilities, mortgage payments and normal costs of maintenance and upkeep of the property.

5. **Use of Residence; Joint Trust:** (G) As set forth in Schedule A annexed hereto, the Grantors have contributed to the Trust their interests in the real property containing their residence which is located at 123 Main Street, White Plains, New York 10601 (the "Residence"). The Trustees are hereby authorized to hold the Residence or any undivided interest in same as all of or a portion of the principal of this Trust as well as to hold any other real property or any undivided interest in same which the Grantors may contribute to the Trust at a later date, including all lands appurtenant to or used in connection with the Residence. The Trustees shall hold, manage and administer the Residence pursuant to the following terms and conditions:

(1) The Grantors retain the right of use, occupancy and possession of the Residence during their lifetimes. Accordingly, the Trustees shall permit the Grantors to occupy the Residence for so long as they shall so desire and the Trustees shall not charge the Grantors rent for such occupancy. If the Grantors cease to use the Residence, the Trustees may, in the exercise of absolute discretion, either continue to hold the Residence as an investment, or sell the Residence.

(2) The Grantors shall be responsible to pay for all maintenance and repairs, water, sewer, insurance and mortgage charges and all taxes related to the Residence which accrue. The Grantors specifically retain their entitlement to any Senior Citizen, STAR,

Veteran's benefits, or other tax exemptions concerning the Residence.

(3) Subject to the aforementioned right of the Grantors to continue to occupy the Residence during their lifetimes, the Trustees are authorized to sell or lease the Residence to any person, for such price and on such terms, including credit, as the Trustees may deem advisable, and the Trustees are authorized to but are not required to invest and reinvest the proceeds of such sale or any part thereof in other residential property, or any undivided interest therein, and the Grantors shall have the same right to occupy any residence so purchased during the term of this Trust as herein provided with respect to the Residence or an undivided interest therein.

Special Power of Appointment

1. **Lifetime Limited Power of Appointment Upon Termination of Trust:** The Grantor reserves the power, exercisable by written instrument delivered to the Trustees during the trust term, by making specific reference to, and exercise of this power to appoint any part or all of the principal of the remainder of the trust fund at the end of the trust term, outright or upon trusts, powers of appointment, conditions or limitations, to one or more persons select out of a class composed of the Grantor's issue. This power may be exercised by an agent under a duly executed statutory power of attorney and statutory gift rider.

2. **Lifetime Limited Power of Appointment over Income and/or Principal:** The Grantor hereby reserves a limited power to appoint the income and/or principal of the Trust, during the Grantor's lifetime, and a limited power to appoint the remainder of the Trust upon Grantor's death, to or among any one or more members of a class consisting of the Grantor's issue, in any degree, whether presently living or born hereafter, in such proportions and amounts, without regard to equality, outright or in further trust, as the Grantor may direct and appoint by written and acknowledged instrument executed by the Grantor, the Grantor's attorney-in-fact or a Court appointed guardian for the Grantor, making specific reference to this power of appointment. No such appointment shall be made to Grantor, her creditors, her estate or her estate's creditors, under any circumstances.

3. **Joint Lifetime Limited Power of Appointment:** The Grantors jointly reserve the power, exercisable by written instrument, executed by both Grantors, if both are living, or by the surviving Grantor, if one of the Grantors has died, and delivered to the Trustees during the lifetimes of the Grantors, to appoint any part or all of the principal or income of the Trust, outright or upon Trusts, power of appointment, conditions or limitations, to or among a class of beneficiaries limited to the Grantors' children, grandchildren and relatives by blood, marriage or adoption and any charitable organization. No exercise of this power shall exhaust it. No such appointment shall be made to either Grantor, the creditors of the Grantors, the estates of the Grantors, the creditors of the Grantors' estates, or any governmental entities or any federal, state or local subdivision, department or agency thereof. The power reserved to the Grantors under this paragraph may be exercised by a duly appointed agent under power

of attorney for a Grantor, provided that the authority to exercise the power is contained in the power of attorney or by a conservator, committee or guardian of a grantor, provided that the power to exercise such power is granted by a court of law. If both Grantors are living, the exercise of the power of appointment pursuant to this paragraph shall be made by both Grantors acting jointly or by either Grantor, with the signed and acknowledged consent of the other Grantor or the duly appointed attorney-in-fact or legal representative of the other Grantor.

4. **Testamentary Limited Power of Appointment:** The Grantors reserve the power, exercisable by the Will of either Grantor or any codicil thereto, to appoint any part or all, in any proportion, of the principal or income of the Trust, outright or upon Trusts, powers of appointment, conditions or limitations, to or among a class of beneficiaries limited to Grantor's children, grandchildren, relatives by blood, marriage or adoption and charitable organizations. No such appointment may be made to the Grantors, the creditors of the Grantors, the estates of the Grantors, the creditors of the Grantors' estates or governmental entities or any federal state or local subdivision or agency thereof. The Will of a Grantor who exercises this limited power of appointment shall specifically refer to the power of appointment granted by this Section of the Trust and must be submitted for probate within ninety (90) days of the death of the second Grantor to die, in the county of the Grantor's residence. If a Will exercising this limited power of appointment is submitted for probate in the estate of the first Grantor to die, such exercise of the limited power of appointment shall not be effective if the Will of the second Grantor to die shall be submitted for probate within ninety (90) days of the death of the second Grantor and such exercise of the limited power of appointment differs in any manner from the exercise of the power of appointment by the Will of the first Grantor to die, as the Grantors intend that the surviving Grantor shall retain the right to exercise this testamentary power of appointment over the entirety of the trust principal. If no Will of the second Grantor to die is submitted for probate within ninety (90) days after the death of the second Grantor to die, any exercise of the limited power of appointment by the Will of the first Grantor to die shall be effective.

Exercise of Special Power of Appointment

1. **Exercise of Testamentary Limited Power of Appointment:** I am the grantor of the _____ TRUST u/a/d _____, over which I have a power of appointment pursuant to ARTICLE FOUR, Paragraph A, thereof. I hereby specifically exercise my power of appointment by appointing all property therein, subject to the subsequent terms of this my Last Will and Testament.

2. **Exercise of Testamentary Power of Appointment; Another Form:** I hereby exercise the power of appointment which I have pursuant to Article IV (B) of my Irrevocable Trust, dated April 2, 2007, and give, devise and bequeath all real and personal property over which I have such power of appointment to my son, **JOE SMITH**.

3. **Lifetime Exercise of Limited Power of Appointment:** I, _____**,** residing at _____, as Grantor of the _____Asset Management Trust u/a/d _____(the "Trust"), hereby exercise the limited power of appointment reserved by me under the provisions of Article Three, Paragraph 1(a) of the Trust and direct that upon my death the Trustee distribute the remaining principal and undistributed income of the Trust (the "Trust Remainder") as follows:

(a) The Trustee shall distribute the Trust Remainder to my daughter,_____, if she is then living.

(b) In the event that my daughter, _____, is not then living, the Trustee shall distribute the Trust Remainder to the issue of my daughter, _____, who are then living, per stirpes.

The exercise of this power shall not be deemed to release my power to revoke this appointment and to reappoint the Trust Remainder to or among any one or more members of a class consisting of my issue, in any degree, whether presently living or born hereafter, in such proportions and amounts, without regard to equality, outright or in further trust, as I may direct and appoint.

Except as modified by this Exercise of the Power of Appointment, the terms and provisions of the _____Asset Management Trust executed by the undersigned on _____are hereby ratified and affirmed.

Trigger to SNT

1. **Distribution of SNT for Disabled Beneficiary:** Notwithstanding any provision of this Trust to the contrary, in the event that any share of the Trust hereunder shall become payable to a person who is a resident of a nursing facility and/or a "person with a severe and chronic or persistent disability" as such term is defined in New York Estates, Powers and Trusts Law Section 7-1.12 (the "Disabled Beneficiary"), such share shall not be distributed to such Disabled Beneficiary but instead shall be held for his or her benefit by the Trustee, IN FURTHER TRUST, to hold, manage, invest and reinvest the same, to collect and receive any income arising therefrom and, after deducting all charges and expenses properly attributable thereto, to administer and dispose of the net income and principal thereof as follows:

(a) The Trustee may pay to or apply for the benefit of the Disabled Beneficiary, so much (even to the extent of the whole) of the net income and/or principal of this trust as the Trustee shall deem advisable, in the Trustee's sole and absolute

discretion, subject to the limitations set forth below. The Trustee shall add to the principal of such trust the balance of net income not so paid or applied.

(b) It is the Grantor's intent to create a supplemental needs trust which conforms to the provisions of Section 7-1.12 of the New York Estates, Powers and Trust Law. The Grantor intends that the trust assets be used to supplement, not supplant, impair or diminish, any benefits or assistance of any federal, state, county, city, or other governmental entity for which the Disabled Beneficiary may otherwise be eligible or which the Disabled Beneficiary may be receiving. Consistent with that intent, it is the Grantor's desire that, before expending any amounts from the net income and/or principal of this trust for the benefit of the Disabled Beneficiary, the Trustee consider the availability of all benefits from government or private assistance programs for which the Disabled Beneficiary may be eligible and that, where appropriate and to the extent possible, the Trustee endeavors to maximize the collection of such benefits and to facilitate the distribution of such benefits for the benefit of the Disabled Beneficiary.

(c) None of the income or principal of this trust shall be applied in such a manner as to supplant, impair or diminish benefits or assistance of any federal, state, county, city, or governmental entity for which the Disabled Beneficiary may otherwise be eligible or which the Disabled Beneficiary may be receiving.

(d) The Disabled Beneficiary does not have the power to assign, encumber, direct, distribute or authorize distributions from this trust.

(e) Notwithstanding the provisions of Paragraphs 5(b) and 5(c) above, the Trustee may make distributions to meet the Disabled Beneficiary's need for food, clothing, shelter or health care even if such distributions may result in an impairment or diminution of the Disabled Beneficiary's receipt or eligibility for government benefits or assistance but only if the Trustee determines that (i) the Disabled Beneficiary's needs will be better met if such distribution is made, and (ii) it is in the Disabled Beneficiary's best interests to suffer the consequent effect, if any, on the Disabled Beneficiary's eligibility for or receipt of government benefits or assistance; provided, however, that if the mere existence of the Trustee's authority to make distributions pursuant to this Paragraph 5(e) shall result in the Disabled Beneficiary's loss of government benefits or assistance, regardless of whether such authority is actually exercised, this Paragraph 5(e) shall be null and void and the Trustee's authority to make such distributions shall cease and shall be limited as provided in Paragraphs 5(b) and 5(c) above, without exception.

(f) It is the Grantor's intent that the provisions of Section 7-1.6 of the New York Estates, Powers and Trusts Law, or any successor statute, shall not be applied or available to authorize any invasion of the principal of this trust by any court.

(g) Upon the death of the Disabled Beneficiary, the Trustee shall distribute the remaining principal and undistributed income of the trust to the Disabled Beneficiary's then living issue, per stirpes, or, in default of such issue, per stirpes to the then living issue of the Disabled Beneficiary's nearest lineal ancestor who was a descendant of the Grantor, or, in default of such issue, to the Grantor's then living issue, per stirpes, or in default thereof, to the legal representative of the Disabled Beneficiary's estate. In the event that any portion of the trust shall become payable to a person for whom an amount shall then be held in trust under any provision of this Trust, then, anything herein to the contrary notwithstanding, such portion shall not be paid over to such person but in lieu thereof shall be added to his or her trust to follow the disposition thereof in all respects as to both income and principal.

Revocation of Trust

1. **Partial Revocation of Trust:** This AGREEMENT is made as of the date below between _____ and _____, as Grantors and income beneficiaries, and _____, as Trustee, of The _____ Family Irrevocable Trust dated _____, and _____, _____, and _____ being the children of the Grantors and the residuary beneficiaries of said Trust.

RECITALS

WHEREAS, the Grantors and Trustee have entered into an irrevocable trust agreement entitled The _____ Family Irrevocable Trust dated _____ (hereinafter referred to as the "Trust"), with the Grantors being the income beneficiaries and the Grantors children being the residuary beneficiaries of the Trust; and

WHEREAS, the Grantors and Trustee have faithfully carried out the obligations set forth in the Trust since the funding of such Trust; and

WHEREAS, the Trust was funded with an initial transfer on _____ in the sum of _____ ($_____) and an additional transfer of _____($_____) on _____; and

WHEREAS, the Grantors now desire to partially revoke the Trust as permitted by Estates, Powers and Trust Law §7-1.9 so as to effectuate a return of _____ ($_____) to the Grantors; and

WHEREAS, the Trustee agrees to the partial revocation of the Trust as desired by the Grantors; and

WHEREAS, the Residuary Beneficiaries hereby acknowledge that they have no vested interest in said Trust and would have been entitled to no portion of the Trust corpus absent the exercise of discretion of the Trustee; and furthermore, that the Beneficiaries have no absolute right to the entirety of the Trust until such time as the Grantors die; and

WHEREAS, the Beneficiaries consent to the partial revocation of the Trust as desired by the Grantors.

NOW THEREFORE, in consideration of the foregoing and the mutual promises of the parties herein, the parties hereby agree to the partial revocation of the Trust and the return of the _____ ($_____) to the name of the Grantors, with the Trustee being directed to make such return as soon as possible after securing all required signatures on this Agreement as such authority and ownership of said property ceases as a result of said revocation.

_____

, Grantor and Income Beneficiary

_____

, as Trustee and as Remainder Beneficiary

_____

, as Remainder Beneficiary [Acknowledgment]

2. **Full Revocation of Trust:** This INSTRUMENT made this _____, by _____, residing at _____.

W I T N E S S E T H:

WHEREAS, _____, as the Grantor, created the _____ TRUST, originally dated _____, by and between _____, as the Grantor, and _____ and _____, as the Trustees (hereinafter referred to as the "Trust"); and

WHEREAS, pursuant to section 7-1.9 of New York's Estates, Powers and Trusts Law, as amended from time to time ("EPTL"), the Grantor may revoke or amend any of the terms and conditions of the aforesaid Trust agreement with the written consent of all persons beneficially interested; and

WHEREAS, the Grantor now desires to revoke the Trust in its entirety;

WHEREAS, signed simultaneously hereto are consents of the persons beneficially interested in the trust, as defined in EPTL § 7-1.9; and

NOW, THEREFORE, in consideration of the premises and by virtue of the statutory power given to the Grantor as aforesaid, the Grantor hereby directs as follows:

1. The undersigned acknowledges and agrees that the recitals above shall be incorporated into this Agreement as if same have been recited in their entirety herein.

2. The _____ TRUST u/a/d _____, is hereby revoked in its entirety.

IN WITNESS WHEREOF, the Grantor executed this Instrument this _____.

_____

[Acknowledgment]

3. **Full Revocation of Trust; Another Form:** REVOCATION OF TRUST AGREEMENT made and entered into this____ day of _____, 2018 by _____, residing at _____, as Grantor.

WHEREAS, _____made and entered into a Trust Agreement on _____, designated as the "_____ASSET MANAGEMENT TRUST", between said _____, as Grantor and said _____, as Trustee (hereinafter referred to as the "Trust"); and

WHEREAS, _____now desires to revoke the Trust in its entirety; and

WHEREAS, _____is an adult and the only living person who is or may be beneficially interested in the Trust; and

WHEREAS, by an instrument executed by _____on _____in the manner required by Section 7-1.9 of the Estates, Powers and Trusts Law of the State of New York, _____has consented to the revocation of the Trust.

NOW, THEREFORE, the Trust is hereby revoked in its entirety.

IN WITNESS WHEREOF, _____has executed this Revocation of the Trust as of the day and year first written above.

_____

Grantor [Acknowledgment]

4. **Full Revocation of Trust; Another Form:** THIS REVOCATION made on the 31st day of October, 2011, between _____ and _____.

WHEREAS, _____, as Grantor, (hereinafter sometime referred to as "Grantor"), and _____, as Trustee (hereinafter sometimes referred to as "Trustee"), entered into a Trust Agreement entitled _____, under agreement dated April 2, 2011 (hereinafter sometimes referred to as "Trust Agreement," a copy of which is annexed here as Exhibit A), and

WHEREAS, Grantor desires to revoke the Trust Agreement in accordance with the provisions of New York Estate Powers and Trusts Law Section 7-1.9, and

WHEREAS, Grantor desires to have all of the Trust Estate distributed to Grantor, and

WHEREAS Grantor has exercised the Power of Appointment under Article IV (B) of the Trust Agreement, by a Will dated October 31, 2011 (a copy of which is annexed here as Exhibit B), and has, pursuant to that Power of Appointment, given, devised and bequeathed all real and personal property subject to that power to _____; and

WHEREAS, upon the exercise of such Power of Appointment, the only persons beneficially interested in the Trust Agreement are _____ and _____ (hereinafter sometimes referred to as "Beneficiary"), who hereby consents to the revocation of the Trust Agreement.

NOW, THEREFORE, it is agreed that _____ u/a dated _____is hereby revoked as follows:

The Grantor hereby revokes _____ u/a dated _____in accordance with the provisions of New York Estates Powers and Trusts Law Section 7-1.9.

I. The Grantor and Beneficiary hereby ratify all actions of the Trustee in administering the Trust Estate up to the date of this revocation.

II. The Trustee and Beneficiary of _____ u/a dated _____hereby consent to the revocation of such Trust Agreement.

III. The Grantor directs the Trustee to distribute the Trust Estate of the Trust Agreement to the Grantor.

IN WITNESS WHEREOF, _____, as Grantor, and _____SMITH, as Trustee and Beneficiary, have signed and sealed this instrument.

_____

, Grantor [Acknowledgment]

Consent to Revocation of Trust

1. **Consent to Revocation of Trust Agreement:** THIS CONSENT dated as of _____, by _____, residing at _____, as beneficiary of the_____TRUST u/a/d _____.

W I T N E S S E T H:

WHEREAS, _____, as the Grantor, created the _____ TRUST, originally dated _____, by and between _____referred to as the "Trust"); and

WHEREAS, pursuant to section 7-1.9 of New York's Estates, Powers and Trusts Law, as amended from time to time ("EPTL"), the Grantor, with the written consent of all the persons beneficially interested in the trust, may revoke the Trust agreement by a written instrument, acknowledged or proved in like manner;

WHEREAS, by written instrument dated _____, entitled the "Revocation of the _____ Trust", a copy of which is attached hereto and made a part hereof (the "Revocation"), the Grantor revoked the Trust agreement;

WHEREAS, the current income and principal beneficiary of the Trust is _____, who would rightly be considered a person beneficially interested in the trust, as defined in EPTL § 7-1.9;

WHEREAS, other than the foregoing, and _____ and _____, who are the remainder beneficiaries of the Trust, there are no other persons beneficially interested in the trust;

WHEREAS, there are no persons beneficially interested in the trust who are minors;

WHEREAS, the undersigned now desires to give his/her consent to the Revocation;

NOW, THEREFORE, in consideration of the premises and the terms hereinafter set forth, and such other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto hereby agree as follows:

1. Recitals. The undersigned acknowledge and agree that the recitals above shall be incorporated into this Agreement as if same have been recited in their entirety herein.

2. Consent. _____, as beneficiary of the Trust, does hereby give his/her consent to the Revocation.

3. Counterparts. This Consent may be executed in counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

IN WITNESS WHEREOF, the undersigned has duly executed this Consent as of the date first above written.

_____

, Beneficiary of the Trust [Acknowledgment]

Consent to Revocation of Trust; Another Form: WHEREAS, _____did on or about _____ transfer and deliver to _____, as Trustee, certain personal property, to be held by her upon the trusts set forth in an indenture dated _____, designated as the "_____", between said _____, as Grantor and said _____, as Trustee (the "Trust"); and

WHEREAS, said Trustee has continued to act as Trustee under the Trust and now holds certain personal property hereunder,

NOW, THEREFORE, the undersigned, being an adult and the only living person who is or may be beneficially interested in the Trust, which statement shall be a representation by the undersigned to the Trustee which shall survive completion of the transaction contemplated herein, DO HEREBY CONSENT to the revocation of the Trust by said _____in its entirety.

This instrument shall operate and is intended and shall be construed as the written consent to the revocation of the Trust required by Section 7-1.9 of the Estates, Powers and Trusts Law of the State of New York.

IN WITNESSETH WHEREOF, I have executed this Consent to Revocation of Trust Agreement this ____day of _____. [Acknowledgment]

Grantor Trust Provisions

1. **Power Over Income:** It is Grantor's intention that this trust be construed as a "grantor trust" under Code Sec. 677(a). All income shall be taxable to Grantor, whether distributed or accumulated by the Trust. The Trustee may distribute to Grantor such amounts of income, but not principal, of the Trust as the Trustee deems necessary to satisfy Grantor's tax obligation, to the extent that the income of the Trust generates a tax liability for Grantor.

2. **Power of Substitution:** The Grantors retain the power, in a nonfiduciary capacity and without the approval or consent of any person in a fiduciary capacity, to reacquire all or any part of the Trust corpus by substituting other property of an equivalent value.

Disposition of Trust Remainder Upon Death of Grantor

1. **Joint Trust:** (A) Upon the death of either or both of the Grantors, if the Trustees determine, in their sole discretion, that there are no other assets of the Grantor or the Grantor's estate available to pay the following expenses, the Trustees shall pay first from the income of the Trust, and if the income of the Trust is insufficient, then from the principal of the Trust, all administration expenses, estate, inheritance and/or income taxes of any kind which shall be assessed as a result of the Grantor's death with respect to all items included in the computation of such taxes which relate to assets which are contained in the Trust at the time of the Grantor's death. After the Trustees have paid all of the taxes, expenses, and other costs hereto referenced, all income of the Trust not yet disbursed or otherwise

distributed as heretofore directed shall be accumulated, added to and become a part of the principal of the Trust (hereinafter collectively referred to as the "Trust Property").

(B) Upon the death of the first Grantor to die, the surviving Grantor shall continue to hold all rights as a beneficiary of this Trust as set forth in the preceding Article II herein.

(C) Upon the death of the second Grantor to die, any trust property remaining after payment of the expenses set forth in subparagraph (A) shall be distributed to such persons and in such proportions, in further Trust or otherwise, in fee or lesser estates as either Grantor, by either a lifetime instrument or the Grantor's Last Will and Testament duly admitted to probate, may validly appoint, which lifetime and testamentary powers of appointment are specifically limited as set forth in Article V hereof.

(D) If both Grantors shall fail to exercise the lifetime or testamentary powers of appointment set forth in Article III paragraph (C) and Article V and at least 90 days have elapsed since the death of the second Grantor to die, the Trustees shall distribute the rest, residue and remainder of the Trust property as follows:

2. **Trust for One Grantor:** Upon the death of Grantor, subject to the exercise of the limited power of appointment created by Article Three, Paragraph 1 above, the Trustee shall distribute the remaining principal and undistributed income of the Trust (the "Trust Remainder") to Grantor's then living issue, per stirpes. The foregoing notwithstanding, the share of the Trust Remainder payable to Grantor's daughter, _____, or her issue, shall be reduced by the amount of_____, and the share of the Trust Remainder payable to Grantor's son,_____, or his issue, shall be increased by the amount of _____.

Decanting

1. **Exercise of Power to Appoint Pursuant to New York Estates, Powers and Trusts Law §10-6.6:** PLEASE TAKE NOTICE that MICKEY MOUSE, authorized trustee, exercises the power to appoint all the assets of the separate trust established for the benefit of MINNIE MOUSE under Article I of the WALT DISNEY TRUST u/a dated December 27, 1996 (Invaded Trust) to the trustees of the MINNIE MOUSE IRREVOCABLE TRUST u/a dated March _____, 2018 (Appointed Trust). This power to appoint is authorized by New York Estates, Powers and Trust Law §10-6.6.

   A copy of the WALT DISNEY u/a dated December 27, 1996, which contains the Invaded Trust, is attached as Exhibit A. A copy of the MINNIE MOUSE IRREVOCABLE TRUST u/a dated March _____, 2018 is attached as Exhibit B.

This Exercise of Power to Appoint pursuant to New York Estates, Powers and Trusts Law §10-6.6 may be signed in counterpart.

PLEASE TAKE FURTHER NOTICE that the power to appoint exercised herein shall be effective thirty (30) days after service of this notice and attachments.

_____

MICKEY MOUSE [Acknowledgment]

2. **Exercise of Power to Appoint Pursuant to New York Estates, Powers and Trusts Law §10-6.6; Another Form: WHEREAS**, the provisions of Section 4.09 of Article Four of **_____ Irrevocable Life Insurance Trust u/a/d February 3, 2016** ("the Trust"), provide that during the lifetime of the Grantor, the Independent Trustee may distribute any portion of trust property to or for the benefit of the Grantor's descendants, in equal or unequal amounts, as the Independent Trustee determines advisable for any purpose and if there is no Independent Trustee, the Trustee may distribute to or for the benefit of any one or more of the Grantor's descendants, in equal or unequal amounts, as much of the trust property for the beneficiary's health, education, maintenance and support as the Trustee determines is necessary or advisable; and

WHEREAS, in accordance with the provisions of Article Five of the Trust, upon the Grantor's death, the Grantor's then living descendants, per stirpes, are the current and remainder income and principal beneficiaries of the Trust; and

WHEREAS, in accordance with NY EPTL Section 10-6.6 (b)(1), an authorized trustee with unlimited discretion to invade trust principal may appoint part or all of such principal to a trustee of an appointed trust for, and only for the benefit of, one, more than one or all of the current beneficiaries of the invaded trust (to the exclusion of any one or more of such current beneficiaries); and

WHEREAS, the successor and remainder beneficiaries of such appointed trust shall be one, more than one or all of the successor and remainder beneficiaries of such invaded trust (to the exclusion of any one or more of such successor and remainder beneficiaries); and

WHEREAS, the provisions of Article Four, Section 4.09 of **_____ Irrevocable Life Insurance Trust** dated January __, 2018, (the "New Trust") provide that during the lifetime of the Grantor, the Independent Trustee may distribute any portion of trust property to or for the benefit of the Grantor's descendants, in equal or unequal amounts, as the Independent Trustee determines advisable for any purpose and if there is no Independent Trustee, the Trustee may distribute to or for the benefit of any one or more of the Grantor's descendants, in equal or unequal amounts, as much of the trust property for the beneficiary's health, education, maintenance and support as the Trustee determines is necessary or advisable; and

WHEREAS, in accordance with the provisions of Article Five, Section 5.01 of the **New Trust**, upon the Grantor's death, the Grantor's descendants are the current and remainder income and principal beneficiaries of the Trust.

NOW THEREFORE, since _____, as Trustee of the Trust, has the unlimited discretion to invade the trust principal for the benefit of one or more or all of the Grantor's descendants, and one or more of Grantor's descendants are the remainder beneficiaries of the **New Trust**, he hereby invades the principal of the Trust and appoints all of the principal of the Trust in favor of the Trustee of the **New Trust**. In certain circumstances the appointment will begin the running of the statute of limitations that will preclude persons interested in the invaded trust from compelling an accounting by the trustees after the expiration of a given time. Said appointment of principal to the Trustee of the **New Trust** shall be effective thirty (30) days after the date of service of this document.

The Trustee of the Trust has signed this document on the ____ day of **January, 2018**.

_____

, Trustee

Miscellaneous Provisions

1. **No Invasion of Principal for Income Beneficiary:** Under no circumstances may the Trustee invade the principal of the Trust for the benefit of the Grantor. The Grantor directs that the provisions of Section 7-1.6 of the New York Estates, Powers and Trusts Law, or any successor statute, shall not be applied by any court having jurisdiction of an express or testamentary trust to compel the payment or application of the principal of the Trust to or for the benefit of the Grantor for any reason whatsoever. This provision is specifically intended to negate and eliminate any discretion granted to any Court by Section 7-1.6 of the New York Estates, Powers and Trusts Law.

2. **No Power to Adjust:** The Grantor expressly waives the application of the terms and conditions of Section 11-2.3(b)(5) of the Estates Powers and Trusts Law of the State of New York to the extent that the provisions of such statute are applicable to this Trust. The Trustee shall not make an adjustment between principal and income pursuant to the provisions of the aforesaid statute or any successor statutes. Further, no court or Administrative agency may compel the Trustee to make an adjustment between income and principal.

3. **No Power for Unitrust:** The Grantor expressly waives the application of the terms and conditions of Section 11-2.4 of the Estates Powers and Trusts Law of the State of New York. The Trustee shall not elect unitrust status for this Trust pursuant to the aforesaid statute to the extent that the provisions of said statute or any successor statute are applicable to this Trust. Further, no court or Administrative agency may compel the Trustee to elect unitrust status for this Trust. The Trustee shall have the sole discretion regarding the investment of Trust assets even if said investment decisions reduce the annual income payable to the Grantor.

4. **Unlimited Power for Trustee Distribution:** The provisions of Section 10-10.1 of the Estates, Powers and Trusts Law notwithstanding, the Trustee is authorized to make discretionary distributions of principal to himself or herself.

5. **No Power to Pay Grantor's Taxes:** The Grantors direct that the Trustees shall not have the power to pay to the Grantors, or to any taxing authority on Grantors' behalf, the income taxes charged to Grantors on any portion of the Trust Estate. This provision is specifically intended to negate and eliminate any discretion granted to the Trustees by Section 7-1.11 of the New York Estates, Powers and Trusts Law.

Last Will and Testament

Trigger to SNT

1. **Distribution to SNT for Disabled Spouse:** Any provision hereof to the contrary notwithstanding, if my husband/wife is in or becomes a resident of a nursing facility, my trustee's discretion regarding the payment of principal to or on behalf of my husband/wife is hereby limited to providing funds solely for items for the care and comfort of my husband/wife that are not available from any publicly funded program, including but not limited to Medicare, or Medicaid, or any private source including but not limited to insurance or employment benefits. The term "Nursing Facility" shall include but not be limited to any medical institution, skilled nursing facilities, health related facilities, intermediate care facilities, residential treatment facilities, small residential facilities, hostel, group home, foster home operated for the care, support, and maintenance of the beneficiary, or room and board situations eligible for reimbursement under Title XIX of the Social Security Act, or any successor statute.

   My trustee is prohibited from utilizing any trust funds from principal for the payment of any care or services that would otherwise be paid by any public, private, insurance or employment based source. It is my intention that the provision of Section 7-1.6 of the Estates, Powers and Trust Law of the State of New York, or any successor statute, shall not be applied or available to authorize any invasion of the principal of this trust by any court.

   No judge or court shall have the power to order the invasion of principal in contravention of the provisions of the foregoing paragraphs. This provision is intended to negate and eliminate any discretion granted by Section 7-1.6 of the New York Estates, Powers and Trusts Law. [2]

[2]This provision was derived from copyrighted material and are used for educational purposes with the express permission of the copyright holder, ElderCounsel, LLC. All rights reserved.

2. **Distribution to SNT for Disabled Beneficiary, Including Spouse:** Notwithstanding any provision of this Will to the contrary, any bequests payable under this Will, including distributions from any trust created under this Will, to a person, including my husband, who is a resident of a nursing facility and/or a "person with a severe and chronic or persistent disability" as such term is defined in New York Estates, Powers and Trusts Law Section 7-1.12 (the "Disabled Beneficiary"), shall not be distributed to such Disabled Beneficiary but instead shall be held for his or her benefit by the Trustee hereinafter named, IN TRUST, to hold, manage, invest and reinvest the same, to collect and receive any income arising therefrom and, after deducting all charges and expenses properly attributable thereto, to administer and dispose of the net income and principal thereof as follows:

(a) The Trustee shall pay to or apply for the benefit of the Disabled Beneficiary, so much (even to the extent of the whole) of the net income and/or principal of this trust as the Trustee shall deem advisable, in the Trustee's sole and absolute discretion, subject to the limitations set forth below. The Trustee shall add to the principal of such trust the balance of net income not so paid or applied.

(b) It is my intent to create a supplemental needs trust which conforms to the provisions of Section 7-1.12 of the New York Estates, Powers and Trust Law. I intend that the trust assets be used to supplement, not supplant, impair or diminish, any benefits or assistance of any federal, state, county, city, or other governmental entity for which the Disabled Beneficiary may otherwise be eligible or which the Disabled Beneficiary may be receiving. Consistent with that intent, it is my desire that, before expending any amounts from the net income and/or principal of this trust for the benefit of the Disabled Beneficiary, the Trustee consider the availability of all benefits from government or private assistance programs for which the Disabled Beneficiary may be eligible and that, where appropriate and to the extent possible, the Trustee endeavor to maximize the collection of such benefits and to facilitate the distribution of such benefits for the benefit of the Disabled Beneficiary.

(c) None of the income or principal of this trust shall be applied in such a manner as to supplant, impair or diminish benefits or assistance of any federal, state, county, city, or governmental entity for which the Disabled Beneficiary may otherwise be eligible or which the Disabled Beneficiary may be receiving.

(d) The Disabled Beneficiary does not have the power to assign, encumber, direct, distribute or authorize distributions from this trust.

(e) Notwithstanding the provisions of Sub-Paragraphs (b) and (c) of this Paragraph SEVENTH above, the Trustee may make distributions to meet the Disabled Beneficiary's need for food, clothing, shelter or health care even if such distributions may result in an impairment or diminution of the Disabled Beneficiary's receipt or eligibility for government benefits or assistance but only if the Trustee determines that (i) the Disabled Beneficiary's needs will be better met if such distribution is made, and (ii) it is in the Disabled Beneficiary's best interests to suffer the consequent effect, if any, on the Disabled Beneficiary's eligibility for or receipt

of government benefits or assistance; provided, however, that if the mere existence of the Trustee's authority to make distributions pursuant to this Sub-Paragraph (e) of this Paragraph SEVENTH shall result in the Disabled Beneficiary's loss of government benefits or assistance, regardless of whether such authority is actually exercised, this sub-paragraph shall be null and void and the Trustee's authority to make such distributions shall cease and shall be limited as provided in Sub-Paragraphs (b) and (c) of this Paragraph SEVENTH above, without exception.

(f) It is my intention that the provisions of Section 7-1.6 of the New York Estates, Powers and Trusts Law, or any successor statute, shall not be applied or available to authorize any invasion of the principal of this trust by any court.

(g) Upon the death of the Disabled Beneficiary, the Trustee shall distribute the remaining principal and undistributed income of the trust to the Disabled Beneficiary's then living issue, per stirpes, or, in default of such issue, per stirpes to the then living issue of the Beneficiary's nearest lineal ancestor who was a descendant of mine, or, in default of such issue, to my then living issue, per stirpes. In the event that any portion of the trust shall become payable to a person for whom an amount shall then be held in trust under any provision of this will, then, anything herein to the contrary notwithstanding, such portion shall not be paid over to such person but in lieu thereof shall be added to his or her trust to follow the disposition thereof in all respects as to both income and principal.

(h) If my husband, _____, is a beneficiary of this trust, and should make an election pursuant to EPTL 5-1.1-A, the trust created and administered pursuant to Paragraph SEVENTH of this Last Will and Testament shall, after the distribution of the statutory share to my husband, continue for the benefit of my husband, and the election pursuant to EPTL 5-1.1-A shall not result in the termination of such trust as if my husband had predeceased me, EPTL 5-1.1A(a)(4)(A) to the contrary notwithstanding.

3. **Distribution to SNT for Disabled Beneficiary; Another Form:** Notwithstanding anything contained in this Will to the contrary, if any property is to be distributed under this Will to a person who at that time is a "person with a severe and chronic or persistent disability," as defined in Section 7-1.12 of the New York Estates, Powers and Trust Law, as amended, then such distribution shall not be made to such person, but instead shall be retained by my executor, as trustee, and held, IN TRUST, as a separate supplemental needs trust (SNT), for the benefit of such person (each such person is hereinafter referred to in this paragraph as the "SNT beneficiary"). The trustee of each SNT established under this paragraph shall pay so much of the income and/or principal of the SNT to or for the benefit of the SNT beneficiary as the trustee, in the trustee's discretion, shall determine is advisable to supplement, not supplant, impair or diminish, government benefits or assistance for which the SNT beneficiary may otherwise be eligible or which the SNT beneficiary may be receiving, unless the trustee determines the SNT beneficiary's needs are better met by a distribution regardless of any consequential effect on such benefits or assistance. Upon the death of the SNT

beneficiary, any principal and accumulated income remaining shall be distributed to the SNT beneficiary's issue then surviving, per stirpes, but if there are no issue of the SNT beneficiary then surviving, according to the provisions of this Will disposing of my residuary estate, as if I had died then owning such property.

4. **Distribution to SNT for Disabled Beneficiary; Another Form:** Notwithstanding anything contained in this Will to the contrary,

(i) If any property is to be distributed under this Will to a person who at that time is a "person with a severe and chronic or persistent disability," as defined in Section 7-1.12 of the New York Estates, Powers and Trust Law (EPTL), as amended, then such distribution shall not be made to such person, but instead shall be retained by my executor, as trustee, and held, IN TRUST, as a separate supplemental needs trust (SNT), for the benefit of such person (hereinafter referred to as the "SNT beneficiary").

(ii) If, during the administration of any trust established under this Will, the current sole income beneficiary becomes a "person with a severe and chronic or persistent disability," as defined in Section 7-1.12 of the EPTL, then, the terms and conditions of such trust shall be changed to those of an SNT for the benefit of such person (hereinafter referred to as the "SNT beneficiary").

(iii) The trustee of each SNT established under this paragraph shall pay so much of the income and/or principal of the SNT to or for the benefit of the SNT beneficiary as the trustee in the trustee's discretion shall determine is advisable to supplement, not supplant, impair or diminish, government benefits or assistance for which the SNT beneficiary may otherwise be eligible or which the SNT beneficiary may be receiving, unless the trustee determines the SNT beneficiary's needs are better met by a distribution regardless of any consequential effect on such benefits or assistance. Upon the death of the SNT beneficiary, any principal and accumulated income remaining shall be distributed to the SNT beneficiary's issue then surviving, per stirpes, but if there are no issue of the SNT beneficiary then surviving, according to the provisions of this Will disposing of my residuary estate, as if I had died then owning such property (and provided, however, that in the case of any person for whose benefit a trust is then in existence under the provisions of this Will, I direct that his or her share shall be added to the principal of such trust instead of being paid over to him or her).

Appointment of Successor Executor and/or Trustee

1. **Nomination of Successor Executor or Administrator:** Subject to the foregoing, any sole executor or sole administrator of this Will (and any successor executor or administrator appointed pursuant to the provisions of this paragraph) shall have the right to nominate a successor executor or administrator, as the case may be, if a successor is not nominated by me pursuant to the foregoing paragraph. Such nomination shall be made by filing in the Surrogate's Court of the county where my Will has been admitted to probate a duly acknowledged written instrument, nominating the said successor executor or successor administrator.

2. **Nomination of Successor Executor, Administrator or Trustee:** Subject to the foregoing, any sole executor or sole administrator of this Will, and any sole trustee of any trust established under this Will (and any successor executor, administrator or trustee appointed pursuant to the provisions of this paragraph) shall have the right to nominate a successor executor, administrator or successor trustee, as the case may be, if a successor is not nominated by me pursuant to the foregoing paragraphs. Such nomination shall be made by filing in the Surrogate's Court of the county where my Will has been admitted to probate a duly acknowledged written instrument, nominating the said successor executor, successor administrator or successor trustee.

NYS Tax Provision

1. **Charitable Bequest to Prevent New York Estate Tax on a Portion of the Estate Where the Tax Is Greater than 100% of the Portion (The Cliff)**: If my New York taxable estate exceeds the New York basic exclusion amount in effect at my death, as those terms are used and defined in Article 26, Part I of the New York Tax Law (§§ 951 et seq.), then I give and bequeath an amount that will result in a reduction of my New York State estate tax, which reduction equals or exceeds the amount so distributed. Such bequest shall pass to _____CHARITY_____: In calculating the New York taxable estate for purposes of this paragraph of my Will, the amount of any charitable deduction that might be available as a result of the gifts in this paragraph of my Will shall be ignored. . In the event the beneficiary is not a charity which would qualify for the estate tax charitable deduction, then the Executors shall have authority to substitute another charity, with similar purposes, to receive this bequest. It is my intention that this bequest shall be to a charity qualified for the estate tax charitable deduction.

2. **Disclaimer to Charity to Minimize Tax:** Notwithstanding the foregoing paragraphs, if any residuary beneficiary disclaims any part of their share, said disclaimed shares shall be distributed to the following charitable organizations in equal shares:

ABLE Act Provision for Testamentary SNT

1. **Distribution to ABLE Account:** The authority of the Trustee to make distributions shall include the authority to make a distribution and deposit to an ABLE Act account pursuant to Section 529A of the Internal Revenue Code (the Stephen Beck Jr. Achieving a Better Life Experience Act) which may have been or will be established by a guardian or parent of the beneficiary of this trust even though such account may be subject to pay back to any government agency, including a state medical assistance agency under that statute. The Trustee shall be guided by the special needs of the beneficiary to determine whether the qualified disability expenses, as defined in that statute, will be better met under this trust or the ABLE Act account before making the distribution to this account.

Monitor Care of SNT Beneficiary

1. **Protecting the Interests of Disabled Beneficiary:** At least one of the Trustees designated hereunder, or their designee, shall be required to visit with the beneficiary on a quarterly basis to informally assess and determine the condition of her care and health. It is my direction that they shall also spend sufficient time in the beneficiary's residence and room to determine if it is clean, safe and well-maintained.

   (i) If no Trustee is able to conduct the quarterly visit, the Trustee may designate a family member (designee) for such purpose, or if none is available, may retain a professional advocate or care manager to conduct the visits and report back to the Trustee, in writing, regarding their observations, concerns, and findings.

   (ii) If the Trustee shall become aware of any questions or concerns regarding the health, happiness, or care of the beneficiary, or of the care and maintenance of their possessions, the Trustee shall notify, in writing, the appropriate social worker, residential director, or house manager. If these concerns are not adequately addressed or resolved by the social worker, residential director, or house manager, the Trustee is directed to contact, in writing, and by other such means necessary, the servicing agency and/or organization to inform them of said Trustee's and to pursue such concern until satisfactory resolution.

   (iii) If there shall be no satisfactory resolution, the Trustees are directed to contact the appropriate state agency including but not limited to Office of Persons with Developmental Disabilities (known as OPWDD) and the Empire Justice Center for the Protection of Persons with Special Needs. The Trustee shall be authorized to retain an attorney and to pay any legal fees from this Trust for such purpose, in the sole discretion of the Trustee.

Pour Over to Revocable Trust

1. **Pour Over of Residuary Estate to Revocable Trust:** (a) I give all the rest, residue and remainder of the property, both real and personal and wheresoever located, which I may own or to which I may be entitled at the time of my death (excluding any property over which I may have a power of appointment, it being my intention not to exercise any such power), and which is herein referred to as my "residuary estate" to the then-acting Trustee of the _____ Revocable Trust dated _____, and executed before this Will, to be added to the property of that trust. I direct that the Trustee administer the property according to the trust agreement and any amendments made prior to my death.

   (b) If the _____ Revocable Trust dated _____ is not in effect at my death, or if for any other reason the pour–over cannot be accomplished, I completely incorporate by reference all the terms of such trust into this Will by reference.

   (c) In the event that incorporation by reference is not permitted in the State in which I am domiciled at the time of my death, I dispose of my estate as follows: [insert dispositive plan]

Retirement Plans

1. **Conduit Trust as Beneficiary of Retirement Plans: (a) Distributions from Retirement Plans to Trusts** Unless specifically stated otherwise, each year, beginning with the year of my death, if any trust created under my Will becomes the beneficiary of death benefits under any qualified retirement plan, my Trustee shall withdraw from the trust's share of the plan, in each year, the required minimum distribution required under Section 401(a)(9) of the Internal Revenue Code. My Trustee may withdraw such additional amounts from the trust's share of the plan as my Trustee deems advisable; but, only if the dispositive terms of the trust authorize my Trustee to immediately distribute the withdrawn amount as provided below. My Trustee shall immediately distribute all net amounts withdrawn to:
My wife, if a beneficiary of the trust; and
If my wife is not a beneficiary of the trust, to my descendants, *per stirpes*, who are beneficiaries of the trust; and
If no descendant of mine is a beneficiary of the trust, then to the Income Beneficiaries of such trust in equal shares.
Amounts required to be withdrawn and distributed under this Section, to the extent they are withdrawn and distributed, reduce mandatory distribution amounts under other provisions of my Will that otherwise require distribution of all of the income of the trust.
The purpose of this Section is to insure that the life expectancy of the beneficiaries of the trust may be used to calculate the minimum distributions required by the Internal Revenue Code. This Section is to be interpreted consistent with my intent despite any direction to the contrary in my Will.

(b) Minimum Required Distribution

In administering any trust created under my Will, the minimum required distribution for any year will be, for each qualified retirement plan, the greater of (1) the value of the qualified retirement plan determined as of the preceding year-end, divided by the applicable distribution period; and (2) the amount that my Trustee is required to withdraw under the laws then applicable to the trust to avoid penalty.
If my death occurs before my required beginning date with respect to a qualified retirement plan, the applicable distribution period means the life expectancy of the beneficiary. If my death occurs on or after my required beginning date with respect to a qualified retirement plan, the applicable distribution period means the life expectancy of the beneficiary, or (if longer) my remaining life expectancy.
Notwithstanding the foregoing, if my death occurs on or after my required beginning date with respect to a qualified retirement plan, the minimum required distribution for the year of my death means (a) the amount that was required to be distributed to me with respect to the qualified retirement plan during the year, minus (b) amounts actually distributed to me with respect to the qualified retirement plan during the year.
Life expectancy, required beginning date and other similar terms used in this Section, will be determined in accordance with Section 401(a)(9) of the Internal Revenue Code.

(c) Qualified Retirement Plan

The term "qualified retirement plan" means a plan qualified under Section 401 of the Internal Revenue Code, an individual retirement arrangement under Section 408 or Section 408A or a tax-sheltered annuity under Section 403. The term "qualified retirement benefits" means the amounts held in or distributed pursuant to a plan qualified under Section 401, an individual retirement arrangement under Section 408 or Section 408A, a tax-sheltered annuity under Section 403 or any other benefit subject to the distribution rules of Section 401(a)(9)[3].

Cemetery Plot

1. **Specific Bequest of Cemetery Plot:** I give and devise that certain plot known and designated on the map of _____ cemetery as grave no. 2, in row 3 to my son, _____, per stirpes.

Beneficiary Designation Form

Testamentary Trust as Beneficiary

1. **Naming Testamentary Trust as Contingent Beneficiary:** If my wife, _____, survives me, I designate her as my primary beneficiary to receive 100% of the death benefit upon my death.

   If my wife, _____, survives me, but disclaims all or part of the death benefit, I designate the then acting Trustee of the Credit Shelter Trust under Article Four of my Last Will and Testament dated _____, as my contingent beneficiary, to receive the part (or all) of the death benefit so disclaimed.

   If my wife, _____, does not survive me, I designate my son, _____, per stirpes, as my contingent beneficiary.

First Party SNT

Medicare Set Aside Account

1. **Options for Medicare Set Aside Account:** If the personal injury plaintiff is receiving Supplemental Security Income, Medicaid, or other needs based governmental benefits that require a first party special needs trust compliant with the requirements of 42 U.S.C. §1396p(d)(4)(A), the MSA must be imbedded within a (d)(4)(A) trust.

---

[3]This provision was derived from copyrighted material and are used for educational purposes with the express permission of the copyright holder, WealthCounsel, LLC.

The (d)(4)(A) might provide for a separate account as follows:

OPTION ONE

Medicare Set Aside Account Pursuant to 42 U.S.C. § 1395Y(b)(2)(A):
Notwithstanding any other dispositive provision of this trust applicable during the lifetime of [Beneficiary], the [Beneficiary] Irrevocable Trust shall contain a Medicare Set Aside account (MSA) which shall be segregated from other trust assets. As soon as practicable after the receipt of the trust assets described in Schedule A to this agreement, the Trustee shall segregate from the remainder of the trust assets those funds and structured settlement annuities listed on Schedule A that are intended to fund the MSA.

Distributions During the Lifetime of [Beneficiary].
During the lifetime of [Beneficiary], both the corpus and income of the MSA, including any payments that may be received in the future from any structure settlement annuity that is purchased to fund the MSA, shall remain segregated as a part of the trust estate and separately administered as a Medicare Set Aside arrangement. Payments may be made from MSA for the sole benefit of [Beneficiary] subject, however, to the limitations set forth in Subparagraph 2 below.

Payment of Certain Medical Expenses If and As Required for Medicare Benefits. During the lifetime of [Beneficiary] both the corpus and the income from the MSA may be paid for medical services and supplies that would otherwise be reimbursable under Medicare but only if (1) such payments are necessary to entitle [Beneficiary] to Medicare coverage under the Medicare Secondary Payer Statute and (2) such payments shall be prudent in the discretion of the Trustee after considering all other benefits to which [Beneficiary] shall be entitled. Such medical expenses and supplies are hereinafter referred to as "eligible injury related medical expenses".

Engagement of Experts and Consultants. The Trustee shall engage the services of experts, including but not limited to [Name of Medicare Advisor], a Medicare claims and payment administrator, to advise and counsel the Trustee with respect to eligible injury related medical expenses. The Trustee may rely upon the written instruction and advice of such experts regarding disposition of the trust as to eligible injury related medical expenses, and payments and distributions from the MSA, made in accord with such instructions and advice of such experts, shall be conclusively deemed authorized and proper. The Trustee is specifically authorized to appoint, direct and/or remove [Name of Medicare Advisor], as an agent for the administration of the MSA and to authorize [Name of Medicare Advisor], to hold the MSA, or any portion thereof, as a part of the trust. For administrative convenience, the Trustee is authorized to revocably assign to [Name of Medicare Advisor] any payments intended to fund the MSA.

Administrative Fees, Costs and Expenses Related to Medicare Set Aside Account. Administrative fees, costs and expenses related to the MSA shall not be paid from the MSA

or its income. Any such fees, costs and expenses associated with the maintenance, management, and administration of the MSA, including but not limited to the fees of the Trustee and of [Name of Medicare Advisor] or any other Medicare claims and payments administrator or advisor, shall be paid from trust assets not contained in the MSA. The fees, costs, and expenses of experts and consultants retained in connection with the administration of the MSA shall not reduce or be paid from or as part of the compensation due the Trustee.

Distributions After the Death of [Beneficiary]. After the death of [Beneficiary], the remainder of the trust estate shall be distributed in accordance with the provisions of [Paragraph providing for the disposition of the remainder of the d4A trust after the death of the beneficiary] below.

OPTION TWO

ARTICLE II
SETTLOR'S INTENT

2.3 Additional Purpose. Because some portion of the Trust estate may represent funds received by the Beneficiary as the result of injuries for which future medical services might reasonably be necessary that would otherwise be covered by Medicare, it is the further intent of the Settlor and purpose of the Trust that such portion of the Trust estate qualify and be administered as a Medicare Set-Aside Arrangement ("MSA") pursuant to the provisions of 42 U.S.C. § 1395y and 42 C.F.R. §411.20 and all related Memoranda issued by the Centers for Medicare and Medicaid Services (herein after referred to collectively as the "Secondary Payor Act"), as provided more specifically herein, and to the extent the Beneficiary becomes and remains eligible to receive Medicare.

ARTICLE III
DEFINITIONS

3.1MSA Sub-account" means that portion of the Trust estate, if any, that is designated as a MSA because it represents funds received by the Beneficiary due to injuries for which future medical services can reasonably be expected to be needed that would otherwise be paid by Medicare but for the receipt of such funds. Just as with the entire Trust estate, no portion of the MSA Sub-account is available to the Beneficiary and shall not be considered or construed as being available for purposes of public benefits eligibility or otherwise.

ARTICLE VI
TAX PROVISIONS

6.6. Tax Attributable to MSA Sub-account. As provided by the CMS July 11, 2005 Policy Memorandum, the Trustee may pay any taxes owed on the MSA Sub-account from the MSA Sub-account as a, "cost that is directly related to the account."

ARTICLE VII
DISTRIBUTIONS DURING THE BENEFICIARY'S LIFETIME

7.11 Distributions for Medicare Related Expenses. Throughout the administration of the Trust and lifetime of the Beneficiary, the Trustee shall use the income and corpus of the

MSA Sub-account to pay directly for medical services, supplies, prescriptions, and durable medical equipment, if any, that would otherwise be paid or reimbursed by Medicare, provided however, that any such direct payments are also: a) related to the injuries suffered by the Beneficiary for which damages for future medical services were paid to the Trust; and, b) made pursuant to an allocation or other pre-prepared plan identifying the Beneficiary's injuries and future medical costs otherwise payable by Medicare but for the receipt of such damages for future medicals (hereinafter "Qualified Expenses").

7.12 Engagement of Experts or Consultants. In addition to the Trustee's general authority to engage professionals, the Trustee is specifically empowered to engage the services of experts, including but not limited to, any entity engaged in the professional administration of MSAs. The Trustee shall be entitled to rely upon the advice and written instructions of such experts, including but not limited to an allocation or other pre-prepared plan identifying the Beneficiary's Qualified Expenses, and any distributions made from the Trust for the payment of such Qualified Expenses shall be conclusively deemed as proper, necessary, and authorized

ARTICLE IX
ADMINISTRATIVE PROVISIONS

9.3 MSA Sub-account Reports. The Trustee shall provide annual reports or accountings of the MSA Sub-account to the Centers for Medicare and Medicaid Services ("CMS") within thirty (30) days of the annual accounting period for the MSA Sub-account. The annual accounting period shall be the anniversary date of the funding of the MSA Sub-account unless otherwise provided in the allocation or other pre-prepared plan identifying the Beneficiary's Qualified Expenses. The Trustee shall also provide reports or accountings to CMS upon the exhaustion of the MSA Sub-account, whether such exhaustion of funds is temporary or permanent.

9.4 MSA Sub-account Reporting Fees and Other Costs. Any fees or costs that may be associated with filing annual reports of the MSA Sub-account with CMS shall be paid from that portion of the Trust estate not constituting the MSA Sub-account. Likewise, the Trustee shall not pay any administrative fees, including Trustee compensation, costs, or other expenses related to the MSA Sub-account from the MSA Sub-account but shall instead pay all such fees, costs or expenses from that portion of the Trust estate not constituting the MSA Sub-account.

Revocable Trust

Administrative Trust Upon Death

1. **Creation of Administrative Trust:** Upon the death of the creator, this Agreement shall become irrevocable and may not be amended thereafter. During the administration of this trust after the death of the creator, this trust shall be known as "The **NAME** Administrative Trust.

Pour Over to Testamentary SNT

1. **Pourover to Testamentary Trust for Spouse:** If my husband, _____, shall survive me, my Trustee shall distribute my remaining trust property (not distributed under prior Articles of this instrument) to the then acting Trustee of the _____Supplemental Needs Trust created under Article _____ of my Last Will and Testament dated _____ to be administered and disposed of as a part thereof.

Digital Assets

Provisions for Digital Assets

1. **Provision for Power of Attorney; Can be Adopted for Will or Trust:** Online Accounts, Digital Assets, and Digital Devices
Without limiting any other provision of this Power of Attorney, and subject to the limitations of any other provision of this Power of Attorney, my Agent has the powers described in this Section.

   My Agent has full authority to deal with Online Accounts, Digital Assets, and Digital Devices of all kinds, wherever located. This authority includes, but is not limited to, the power to acquire, create, establish, access, control, modify, cancel, delete, continue, transfer, and take possession of such accounts, assets, and devices.

   However, if I have used an online tool to direct the custodian of an Online Account, Digital Asset, or Digital Device to not disclose certain information, and if the online tool allows for the modification or deletion of that direction at all times, then such direction overrides the authority granted in this Section.

   Further, even though state law might not require a custodian to disclose a deleted digital asset, my Agent is authorized to access them, and the custodian will be held harmless for doing so.
   My Agent may request and change my access credentials to any Online Account, Digital Asset, and Digital Device (such as username, password, and secret question), and any third-party dealing with my Agent in good faith will be held harmless for releasing such access credentials.
   For purposes of this Power of Attorney, the following definitions apply:

   (1) Online Accounts
   The term "Online Accounts" means accounts that are accessible through the Internet or other similar method, including, but not limited to: bank accounts; investment accounts; other financial accounts; accounts with health care providers; social media accounts (like LinkedIn, Facebook, and Twitter); gambling and poker accounts; accounts with publishers; accounts for access to employee benefits; email accounts; accounts with Internet service providers;

accounts to manage websites and website domain names; accounts with retail vendors; tax-preparation service accounts; affiliate marketing accounts; accounts with utility companies; user access accounts on third-party Digital Devices; and any other online account.

(2) Digital Assets
The term "Digital Assets" means intangible personal property related to digital technology (whether located on a Digital Device or an Online Account), including, but not limited to: emails sent or received; text messages sent or received; other digital communications sent or received; digital music; digital photographs; digital videos; software licenses; social network accounts; file sharing accounts; online access to financial accounts; domain registrations; DNS service accounts; website hosting accounts; personal and commercial websites; tax preparation service accounts; online store accounts; affiliate marketing accounts; and other types of online accounts and digital items that currently exist or may exist as technology develops.

(3) Digital Devices
The term "Digital Devices" means tangible personal property related to digital technology capable of storing Digital Assets or accessing Online Accounts, and includes, but is not limited to: desktop computers; laptop computers; tablet computing devices (tablets); other mobile computing devices; peripheral devices; hard disk drives; solid state drives; flash memory devices; other storage devices; mobile telephones; smartphones; and any other type of digital device that currently exists or may exist as technology develops.

2. **Provision for Will:** My Executor shall have the power to access, handle, distribute, and dispose of my Digital Assets, and the power to obtain, access, modify, delete, and control my passwords and other electronic credentials associated with my digital devices and Digital Assets. If I have prepared a memorandum, which may be altered by me from time to time, with instructions concerning my Digital Assets and their access, handling, distribution, and disposition, I direct my Executor and beneficiaries to follow my instructions as outlined in that memorandum, although I recognize such memorandum is not legally binding. "Digital Assets" includes the following:

    1. Files stored on my digital devices, including but not limited to, desktops, laptops, tablets, peripherals, storage devices, mobile telephones, smartphones, and any similar digital device which currently exists or may exist as technology develops; and

    2. Emails received, email accounts, digital music, digital photographs, digital videos, software licenses, social network accounts, file sharing accounts, financial accounts, banking accounts, domain registrations, DNS service accounts, web hosting accounts, tax preparation service accounts, online stores, affiliate programs, other online accounts, and similar digital items which currently exist or may exist as technology develops, regardless of the ownership of the physical device upon which the digital item is stored.

This authority is intended to constitute "lawful consent" to a service provider to divulge the contents of any communication under The Stored Communications Act (currently codified as 18 U.S.C. §§ 2701 et seq.), to the extent such lawful consent is required, and an agent acting hereunder shall be an authorized user for purposes of applicable computer-fraud and unauthorized-computer-access laws."

3. **Provision for Will or Trust; Abbreviated Form:** My Executor [Trustee] shall have the power and authorization to access, take control of, conduct, continue, or terminate my accounts on any website, including any social networking site, photo sharing site, micro blogging or short message service website or any email service website. All such websites may release my log-on credentials, including username and password, to my Executor [Trustee], and the website shall be indemnified and held harmless by my estate for any damages, causes of action or claims that may result from this disclosure. This authority is intended to constitute "lawful consent" to a service provider to divulge the contents of any communication under The Stored Communications Act (currently codified as 18 U.S.C. §§ 2701 et seq.), to the extent such lawful consent is required, and any Executor [Trustee] acting hereunder shall be an authorized user for purposes of applicable computer-fraud and unauthorized- computer-access laws. It my intent that my Executor [Trustee] shall have full authority to access my Digital Assets in accordance with New York Estates Powers and Trust Law Article 13-A.

4. **Provision for Will or Trust; Comprehensive Form:** My Executor [Trustee] may take any action (including, without limitation, changing a terms of service agreement or other governing instrument) with respect to my Digital Assets and Digital Accounts as my Executor or the Trustee shall deem appropriate, and as shall be permitted under applicable state and Federal law. My Executor [Trustee] may engage experts or consultants or any other third party as necessary or appropriate to effectuate such actions with respect to my Digital Assets or Digital Accounts, including, but not limited to, such authority as may be necessary or appropriate to decrypt electronically stored information or to bypass, reset or recover any password or other kind of authentication or authorization. If my Executor or the Trustee shall determine that it is necessary or appropriate to engage and delegate authority to an individual pursuant to this paragraph, it is my request that [DIGITAL ASSET FIDUCIARY] be engaged for this purposes. This authority is intended to constitute "lawful consent" to a service provider to divulge the contents of any communication under The Stored Communications Act (currently codified as 18 U.S.C. §§ 2701 et seq.), to the extent such lawful consent is required, and a Executor or Trustee acting hereunder shall be an authorized user for purposes of applicable computer-fraud and unauthorized-computer-access laws. The authority granted under this paragraph shall extend to all Digital Assets and Digital Accounts associated with or used in connection with the Business (as defined herein). The authority granted under this paragraph is intended to provide my Executor [Trustee] with full authority to access and manage my Digital Assets and Digital Accounts to the extent permitted under applicable state and Federal law and shall not limit any authority granted to my Executor [Trustee] under such laws. "Digital Account" means an electronic system for creating, generating, sending, sharing, communicating, receiving, storing, displaying or processing information

which provides access to a Digital Asset stored on a digital device, regardless of the ownership of such digital device. It my intent that my Executor [Trustee] shall have full authority to access my Digital Assets in accordance with New York Estates Powers and Trust Law Article 13-A.

5. **Provision for Power of Attorney; Another Form:** (___) (G) my attorney-in-fact shall have (i) the power to access, use and control my Digital Devices, including but not limited to, desktops, laptops, tablets, peripherals, storage devices, mobile telephones, smartphones, and any similar Digital Device which currently exists or may exist as technology develops or such comparable items as technology develops for the purpose of accessing, modifying, deleting, controlling or transferring my Digital Assets, and (ii) the power to access, modify, delete, control and transfer my Digital Assets, including but not limited to, my emails received, email accounts, digital music, digital photographs, digital videos, software licenses, social network accounts, file sharing accounts, financial accounts, domain registrations, DNS service accounts, web hosting accounts, tax preparation service accounts, online stores, affiliate programs, other online accounts and similar digital items which currently exist or may exist as technology develops or such comparable items as technology develops, and (iii) the power to obtain, access, modify, delete, and control my passwords and other electronic credentials associated with my Digital Devices and Digital Assets described above.

Power of Attorney

Gifting to Children

1. ____: My agent may make gifts, in any amount, to my children and more remote descendants. When a child of mine acts as agent hereunder, he or she shall be authorized to make gifts of my property, in any amounts, to any descendants of mine. Gifts to my child who is my agent and all descendants of that child shall not exceed the least amount which is gifted during the same calendar year, but previously, to any living sibling of my agent or to the descendants, collectively, of any deceased sibling of my agent. For purposes of the preceding sentence, a gift to my agent shall be the aggregate gifts to my agent and his or her descendants at the time in question and the amount which is gifted to a sibling of my agent shall be the aggregate gifts to such sibling and his or her descendants at the time in question.

Sale of Real Estate

1. ( ): This Power of Attorney is to be used in connection with the execution of all documents necessary to the sale, transfer and conveyance of any of my right, title, and interest in real property located at 1234 Main Street, Middle Village, New York 11379.

ABLE Act

1. Transfer or gift my property in cash or in kind, either: (a) outright to the recipient; (b) to a custodian under the Uniform Transfer to Minors Act; (c) to a tuition savings account or prepaid tuition plan as defined under Section 529 of the Internal Revenue Code; or (d) directly to an educational institution; or (e) to an ABLE Act account as defined under Section 529a for the benefit of a qualified disabled beneficiary.

Suggested Modifications to a New York Statutory Short Form Power of Attorney and Statutory Gift Rider

***New York Elder Law*, by David Goldfarb and Joseph Rosenberg (Lexis/Matthew Bender 2018)**

Form 2.203 Optional Modifications to Statutory Short Form Durable Power of Attorney

Insert these in (g) MODIFICATIONS (OPTIONAL):

( ) Whenever two or more powers of attorney are valid at the same time, the agents appointed on each shall act separately, unless specified differently in the documents.
( ) I grant my agent authority to make loans and execute promissory notes.
( ) Unless reasonable cause exists to require otherwise, the agent shall not be obligated by the monitor to provide financial details or accountings more frequently than annually.
( ) Reasonable Compensation shall be defined as [insert definition of reasonable compensation].

Form 2.204 Optional Modifications to Statutory Gift Rider (SGR)

[Insert these in SGR Section (b) Modifications:]

( ) I grant my agent authority to make gifts up to [a specified dollar amount];
( ) I grant my agent authority to make gifts unlimited in amount;
( ) I grant my agent authority to make gifts to any person or persons;

( ) I grant my agent authority to make the following specified transactions:
( )open, modify or terminate a deposit account in the name of the principal and other joint tenants;
( )open, modify or terminate any other joint account in the name of the principal and other joint tenants;
( )open, modify or terminate a bank account in trust form as described in section 7-5.1 of the estates, powers and trusts law, and designate or change the beneficiary or beneficiaries of such account;
( )open, modify or terminate a transfer on death account as described in part four of article thirteen of the estates, powers and trusts law, and designate or change the beneficiary or beneficiaries of such account;
( )change the beneficiary or beneficiaries of any contract of insurance on the life of the principal or annuity contract for the benefit of the principal;

( )procure new, different or additional contracts of insurance on the life of the principal or annuity contracts for the benefit of the principal and designate the beneficiary or beneficiaries of any such contract;

( )designate or change the beneficiary or beneficiaries of any type of retirement benefit or plan;

( )create, amend, revoke, or terminate an inter vivos trust; and

( )create, change or terminate other property interests or rights of survivorship, and designate or change the beneficiary or beneficiaries therein.

( ) I grant my agent authority to forgive loans.
( ) I grant my agent authority to purchase life estates.
( ) My best interests shall include planning for eligibility for a benefit, a program, or assistance under a statute or regulation.
( ) A gift or other transfer may be made outright, to a trust established or created for such individual, to a Uniform Transfers to Minors Act account for such individual (regardless of who is the custodian), or to a tuition savings account or prepaid tuition plan as defined under **section 529 of the Internal Revenue Code** for the benefit of such individual (without regard to who is the account owner or responsible individual for such account).

Form 2.205 Optional Modifications to the Statutory Gift Rider—Gifts to the Agent

[The following provisions may be added to the SGR at Section (c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE GIFTS OR OTHER TRANSFERS TO HIMSELF OR HERSELF: (OPTIONAL)]

( ) make gifts up to [a specified dollar amount];
( ) make gifts unlimited in amount;
( ) make gifts as in the modification section (b) above.

Form 2.206 Optional Springing Provision

[Insert this provision in Section (g) MODIFICATIONS]

( ) This Power of Attorney will take effect upon the occasion of the signing of a written statement by a physician or physicians named herein by me at this point:

Dr. [indicate name and address of physician(s)]
[Insert Full Name(s) and Address(es) of Certifying Physician(s)]

or if no physician or physicians are named hereinabove, or if the physician or physicians named hereinabove are unable to act, by my regular physician, or by a physician who has treated me within one year preceding the date of such signing, or by a licensed psychologist or psychiatrist, certifying that I am suffering from diminished capacity that would preclude me from conducting my affairs in a competent manner.

( ) This Power of Attorney will take effect upon the occasion of the signing of a written statement by a person or persons named herein by me at this point:

[indicate names and addresses of persons selected] CERTIFYING that the following specified event has occurred: [indicate triggering event]

Form 2.207 Additional Clause—Designation of Guardian

[Add to Statutory Short Form Power of Attorney section (g) Modifications:]

If it becomes necessary to appoint a guardian of my person or property, I hereby nominate pursuant to **New York Mental Hygiene Law §?81.17** [indicate name of nominated guardian] to serve as guardian. If [name of nominated guardian] is for any reason unable or unwilling to serve as guardian, I nominate [indicate name of alternate guardian] to serve as guardian.

Form 2.207A Additional Clause—Digital Assets

[Insert this provision in Section (g) MODIFICATIONS]

The agent shall have the following powers and authority over digital devices, digital assets, and digital passwords and credentials, which shall be considered sufficient lawful consent to service providers under applicable law, and the agent shall be an authorized user for all purposes, including but not limited to, computer fraud and unauthorized access laws:

a. To access, use, and control my digital devices, including but not limited to, computers, tablets, storage devices, cell phones, smartphones, and any similar devices, in order to access, modify, delete, control, or transfer my digital assets;
b. To access, modify, delete, control, and transfer my digital assets, including but not limited to, email accounts, social media accounts, music, photographs, videos, software licenses, file sharing accounts, financial accounts, banking accounts, domain registrations, web hosting accounts, tax preparation service accounts, online stores, and similar digital assets; and
c. To obtain, access, modify, delete, and control my passwords and other electronic credentials associated with my digital devices and digital assets.

Form 2.208 Additional Clause—Renounce Inheritance and Exercise, Waive or Release Right of Election

[This clause may be added to the Statutory Gifts Rider (SGR) in Section (b) Modifications:]

I authorize my agent to make statutory elections and disclaimers and/or renunciations, including the power to execute and deliver a valid disclaimer under the Internal Revenue Code, **New York Estates, Powers and Trusts Law §2-1.11,** and any other applicable state statutes. My agent has the power to disclaim any property, interest in property, or powers to which I am or may become entitled, whether by gift, testate or intestate succession, or right of survivorship, and to exercise, waive or release any right to claim an elective share in any estate or under any will.

[Add the following if appropriate, to the SGR Section (c): Grant of Specific Authority for an Agent to Make Gifts or Other Transfers to Himself or Herself:] I authorize my agent to make a renunciation in favor of my attorney-in-fact or the spouse or issue of my attorney-in-fact.

Acknowledgments:

The idea for this presentation came from program co-chairs Beth Polner Abrahams, Esq. and JulieAnn Calareso, Esq. Beth and JulieAnn asked me to reach out to experienced elder law attorneys and ask if they would be willing to share samples of the various provisions that they use in drafting trusts, wills and powers of attorney. At their request, I reached out to a number of experienced elder law attorneys and am pleased with the response that I received. Not surprisingly, our colleagues are always willing to share their knowledge in order to improve the quality of legal services provided to the elderly and disabled.

I would like to acknowledge and thank the following elder law attorneys who so graciously provided sample forms to be used in this presentation, as well as those who provided valuable input for the presentation:

Beth Polner Abrahams
Jeffrey A. Asher
Jill Choate Beier
Britt Burner
JulieAnn Calareso
Salvatore M. Di Costanzo
Fern J. Finkel
Daniel Fish
David Goldfarb
Martin Hersh
Howard Krooks
Robert J. Kurre
Kathryn Grant Madigan
Robert Mascali
Michael E. O'Connor
Timothy C. O'Rourke
Frances M. Pantaleo
Tara Anne Pleat
Joan Lensky Robert
Irene Villacci

Plenary Session
Mediation: Turning the Tables on Guardianship and Estate Litigation

Presented By:
Michael Burger, Esq.
and
Beth Polner Abrahams

BASICS OF MEDIATION

Presented by:

Michael A. Burger
Mediator & Attorney
1250 Pittsford Victor Rd.
Building 100, Suite 190
Pittsford, NY 14534
Tel.: (585) 203-1700
mike@neutralmediationgroup.com
www.neutralmediationgroup.com

BASICS OF MEDIATION

I. What is mediation?

A. Non-binding, party-driven, alternative dispute resolution mechanism.

II. What is the role of the mediator?

A. Neutral friend of the deal.

B. Facilitator who helps and empowers the Parties to reach a mutually satisfactory agreement.

C. Sounding board.

D. Objective Listener.

III. Who participates in mediation?

1. Parties
2. Friends, supporters
3. Attorneys: Mediation Advocates
4. Neutral Mediator

IV. Where does a mediation occur?

A. Mediation suite

B. Lawyer's office

C. Courthouse

D. Religious institution

E. Destination of your choice…

V. How does a case get to mediation?

A. Judicial referral (clause in will or trending judicial preference)

1. Mandated in some jurisdictions (e.g., United States District Court of the Southern District of New York)

B. Agreement of counsel

C. Agreement of parties

Michael A. Burger
mike@neutralmediationgroup.com

VI. Timing of Mediation on the Litigation Calendar.

A. Pre or post suit?
B. Adjunct to discovery
C. Continues to settlement or impasse
D. Pivotal moments: Risk Assessment
    1. Summary Judgment Motion
    2. Pre-Trial
    3. During Trial
    4. On appeal
    5. A good mediator never gives up

VII. Cost.

A. Mediator's rates are similar to lawyers' rates
B. Split by the parties
C. Buy in is an incentive to make the most of the process

VIII. Selection of a Mediator.

Where the Parties have a choice (sometimes Judge selects), consider:

A. Mediator's Background
    1. Rapport, rapport, rapport (will she earn trust)
    2. Formal mediation training and coursework
    3. Lawyer with litigation experience
    4. Subject matter expertise
    5. Experience on both sides of the issues (Petitioners and Respondents)
    6. High EQ – student of human behavior
    7. Flexibility
    8. Patience
    9. Sense of humor
    10. Not afraid of conflict
    11. Former Judge? Pro and con. Mediation is a different skill set.
B. Tactical considerations
    1. Who will your adversary listen to?
    2. Who will your client listen to?
    3. Transformative vs. Evaluative Approach

IX. Mediation mechanics (What to expect).

- A. Engagement and Confidentiality Agreement
- B. Pre-mediation call
  1. Dynamics
  2. Expectations
  3. Issues
  4. Discovery
- C. Mediation submissions
  1. Goals
  2. Disputes
  3. Personality dynamics
  4. Facts, law & evidence
  5. Mediator only vs Party exchange
- D. Plenary Session
  1. Optional
     - (a) Pros:
       - (1) Clients meet and are heard
       - (2) Conflict in open (yell, hug it out, etc.)
       - (3) Empowering – Smart clients figure it out
       - (4) Get lawyers out of the middle
     - (b) Cons
       - (1) Destructive intransigence
       - (2) Cause a Setback
       - (3) Emotional triggers
  2. Opening statements
     - (a) Mediator explains and promotes process
     - (b) Parties or counsel speak
       - (1) Collaborative, not incendiary
       - (2) Managing client expectations
       - (3) Client's Goals are Heard in a Positive Light
- E. Caucus
  1. Confidential unless otherwise stated or vice versa?
  2. Shuttle diplomacy
  3. Active listening
  4. Understanding goals within goals
  5. Probing for details and rationale

X. Why Mediate? (Or why not?)

A. Most cases settle eventually!
B. Cost
C. Preserve or rekindle relationships
D. Seek relief beyond what a judge can order
E. The limits of judicial intervention
F. Confidentiality
G. Rapid discovery
H. Certain, speedy, tailored, and final resolution
I. Flexibility
J. (Allocation of scarce financial resources)
K. (Revealing trial strategy or tactics)
L. (Indifferent or unrealistic parties)

XI. Becoming a lawyer Mediation Advocate to enhance your law practice (litigator or not!)

A. Another tool in the toolbox
B. Holistic lawyering
C. Build bridges
D. Not constrained by the rules of Evidence
E. (But a "BATNA" consult may be indicated)
F. The British solicitor model
G. Bibliography

1. Anatomy of a Mediation by James C. Freund (PLI 2012);
2. Bey☺nd Smart Lawyering with Emotional Intelligence by Ronda Muir (ABA Dispute Resolution Section 2017);
3. Fair is Fair: Mediation Clauses in Wills and Trusts by Michael A. Burger, 50 NYSBA T&E Section Newsletter 6 (Summer 2017)[1];
4. Getting Past No by William Ury (Bantam Books 1991);
5. Getting to Yes by Fisher and Ury (Penguin Books 2011) (3d Ed.);
6. How to Mediate Like a Pro by Mary Greenwood (iUniverse, Inc. 2012);
7. Mediation Practice Guide by Bennett G. Picker (ABA 2003) (2d Ed.);
8. Sharing a Mediator's Powers by Dwight Golann (ABA 2013);
9. Why Can't They Settle? The Psychology of Relational Disputes, *18 Cardozo J. Conflict Resol. 311*, Winter, 2017.
10. NYSBA and NYC Bar Training Seminars.

[1] Attached.

Michael A. Burger
mike@neutralmediationgroup.com

XII. Hypothetical exercises

A. In-state/out-of-state child (Contested 81/Estate/Trust)

B. Divided room—cross the aisle

MICHAEL A. BURGER

Michael Burger is a founding partner of Santiago Burger LLP, a litigation-based law firm in Rochester, NY, and he is a founding member of Neutral Mediation Group LLC. Prior to that, Mr. Burger was a partner in two Rochester, New York law firms. Before relocating to Rochester, New York, in 1999, Mr. Burger spent several years practicing law in a large non-profit New York City based public interest law firm where he handled a variety of constitutional law matters including impact litigation that successfully secured the right to a jury trial for housing court litigants city-wide.

Mike focuses his litigation practice on fiduciary relationships within New York State and Federal Trial and Appellate Courts. His representative clients run the range from businesses of various sizes and structures, trusts, estates, and individuals owed or under a fiduciary duty such as officers, directors, executors, trustees, agents under a power of attorney, and guardians. Mike also handles Election Law cases during the season for both petitioners and respondents. These practices are equally divided between representing plaintiffs and defendants, affording an alacrity with the issues and arguments attending all facets of litigated matters. The substantive areas he focuses on consists of complex commercial disputes, corporate, LLC, and partnership dissolutions and disagreements, challenges to agency authority, congested article 81 guardianship, labor and employment matters (including class and collective action experience as lead counsel), election law, campaign finance, ballot access proceedings, and civil rights impact litigation challenging laws that work a constitutional deprivation on a segment of the citizenry. Michael commonly employs mediation as a tool across disciplines as an alternative to litigation.

Mr. Burger is also a founding member of the Neutral Mediation Group, LLC which provides mediation services to parties and industries needing to mediate disputes both pre-suit and during litigation. Michael brings over 20 years of experience as a litigator to the process, as coursework, lecturing, and writing in the field of mediation dating back to law school coursework. Mr. Burger is a member of the New York State Bar Association Dispute Resolution Section and serves on the Monroe County Bar Association's Fee Arbitration Committee where he acts alternatively as mediator or arbitrator. A passionate proponent for the mediation process, Mr. Burger stresses the importance of the parties being heard and empowered to chart their own resolutions.

Mr. Burger has written and lectured before the state and local bar associations on a variety of topics within his practice concentrations, including mediation and mediation clauses. His ready rapport and ability to build bridges of trust make him a consummate friend of the honest deal.

Fair Is Fair: Mediation Clauses in Wills and Trusts

By Michael A. Burger

At the 2016 Fall Meeting, the Estate Planning Committee luncheon featured in depth discussions about thorny tax issues, trust selection, valuation, drafting and decanting strategies, a survey of local and historical practices, cutting edge legislation, and inside baseball anecdotes about the development of the Surrogate's Court bar. Acronyms and statutory section numbers proliferated like bullets in an action movie firefight. Navajo code talkers would have been impressed by the impenetrable lexicon.

All of the thoughtful practice considerations we discussed will undoubtedly facilitate clients' estate planning, but most had only occasional application. Each of the legal and taxation issues discussed, taken separately, was unlikely to frustrate a client's plans as frequently as potential strife among the client's eventual heirs or creditors.

As a trusts and estates litigator, I see the effects of postmortem litigation and the planners and heirs who call me are uniformly in distress about the prospect of a fight in Surrogate's or Supreme Court. Avoiding confusion and litigation is as much part of the estate planning practitioner's code of honor as it is a secret of their unique and ancient guild. Yet, we all wondered aloud why mediation clauses have not been employed in wills or trusts, even when carefully crafted *in terrorem* or no contest clauses increasingly proliferate.

Historically, Surrogates and their staff have ably performed a mediator-like function, albeit with the implicit threat of an adverse ruling against a recalcitrant party. In some jurisdictions they still do, but with mixed success and delays tied to calendar congestion. Some Surrogates frown on mediation due to the cost of engaging a mediator and the risk that the parties, left to their own devices, may conspire to pervert the testator's intent. But at the Spring Meeting, a panel of esteemed Surrogates discussed mediation as a dispute resolution mechanism in Surrogate's Court and all but one generally approved of the process.

A. The Pros and Cons of Mediation

Nearly all Surrogate's Court cases settle out of court. This is a powerful bit of knowledge for litigants and their counsel. If a case is statistically likely to settle eventually, why not do so as early as possible, before spending time and money on court battles? A litigation war chest can also fund a tailored, creative and even mutually beneficial compromise.

More importantly, litigants have an inherent sense of what is fair. We all do, really. Studies show that even toddlers have an innate sense of fairness.[1] As lawyers, we are primarily trained to funnel disputes over fairness into the court system. And of course Surrogate's Court, a court of equity, is uniquely oriented towards a fair result, not just a legally correct one. Still, clients are frequently disappointed by both the process and the outcome of litigated disputes, which is the reason for appellate courts. But even the smartest judges in the land, sitting on the highest courts, are not always able to agree on a fair outcome, sometimes dividing along partisan lines. Plus, the result is often a zero sum game. A "winner" and a "loser" are declared, in cold legal rhetoric.

If our clients know what is fair, why are we so quick to turn over their disputes to judges who do not know our clients or their families? In part, litigants yearn for a wise and impartial mind to resolve their troubles for them—even to vindicate them. Judges offer a keen understanding of the law and an impartial desire to see justice prevail that we naturally trust. But judges are also constrained by the contours of the matter before them, regardless of the intangible goals or overall family dynamic.

Yes, mediation involves an additional cost. But trials and appeals come at an even greater cost. Years of litigation, subpoenas, motions, depositions, hearings, trials, appeals, briefs and tens of thousands of dollars (or more) in fees. To say nothing of the emotional toll, health effects, and family turmoil attendant to a congested and procedure-laden process.[2]

The court process is, of course, a necessary and carefully constructed mechanism for producing justice, and we are fortunate to have the best and most independent judiciary in the world, but the court system is slow, expensive and necessarily limited by the rules of evidence, standing, ripeness and justiciability. And a decision by a third party—even an impartial and independent one—is no substitute for self-determination and empowerment.[3]

Independence and impartiality are essential for a neutral judge to be respected as unbiased. But with independence comes a detachment and distance from the dispute stemming from a lack of familiarity. From

Michael A. Burger, Esq., is an NYSBA member, a trusts and estates litigator, and a trained mediator. He is also a member of the Neutral Mediation Group LLC, an organization dedicated to helping litigants and their lawyers reach consensus. www.neutralmediationgroup.com

the standpoint of familiarity with the nuances of the dispute, including the intangible goals, and goals within goals, that make a possible result fair from the standpoint of a particular family—a significant and decisive factor in a court of equity. No one knows family like the family itself.

B. The Testator's Sacred Intent

What happens to the expressed intent of the testator when the parties negotiate privately, with or without a mediator?

Surrogate's Court litigation is arguably even more complex and uncertain than other litigation because there is essentially another "silent" party whose interests are paramount: the decedent or trust settlor. One of the Surrogate's solemn duties is to protect and enforce the testator's wishes. To be sure, a well-timed scowl from a wise jurist can help resolve a case.[4]

Mediation is not a substitute for the Surrogate but rather a ready and flexible supplement; an additional tool at the disposal of the Court and the litigants. If a court conference resolves a festering issue then mediation will not be necessary. But many cases soldier on past the best judicial efforts at brokering settlement.

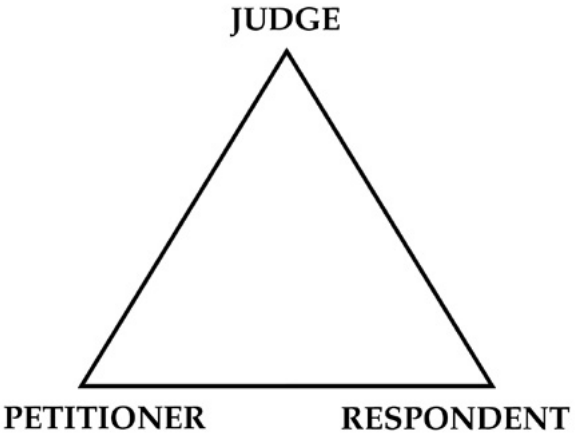
Working with seasoned counsel, the parties may find solutions not available to the Surrogate, while still scrupulously safeguarding the testator's intent. If the parties attempt to corrupt the testator's intent then the Surrogate, who will review any proposed decree, would understandably reject such a proposed decree.

Even with able and experienced counsel assisting each of the parties, common ground can be hard to find and impasse always looms as a possibility. In part, the fog of war can curtail settlement efforts, especially early on when they are most valuable. Posturing and jockeying for legal position can obscure weaknesses and hazards of litigation as counsel walk a tightrope between client relations and effective advocacy.

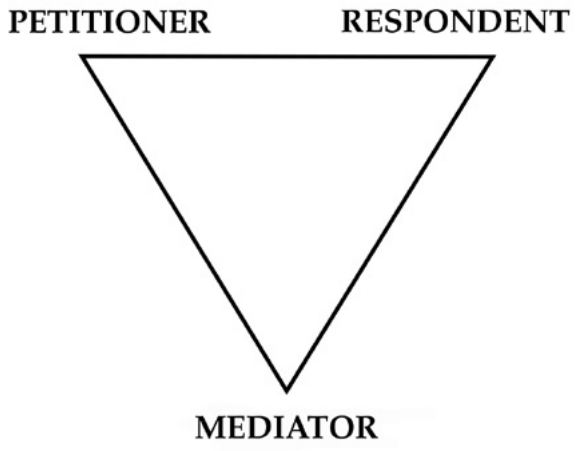
A seasoned mediator with trusts and estates experience will often be a helpmate in this regard, guiding the parties away from resolutions that will not pass judicial muster.

C. Maintaining Party Control: The Nonbinding Neutral

If we graphically display the court system as an equilateral triangle, with the Surrogate at the top point and the litigants at the bottom points, we can appreciate the power dynamics of a court-imposed result: the parties hand up the evidence and arguments supporting their opposing visions of a fair outcome, and the Surrogate hands down a mandated result.



Mediation turns this triangle paradigm on its head, allowing the litigants to fashion a mutually acceptable outcome which they dictate, subject to Surrogate approval, to the trained trust and estates mediator who helps facilitate the discussion towards the zone of possible agreement.



D. Mediation Clauses Are Valuable and Flexible Tools

Efforts to micromanage an outcome of a dispute from beyond the grave can frustrate the well-laid plans of even the most prescient testators. Mediation rewards compromise and ingenuity. And, if mediation begets impasse, litigation remains as an alternative, with mediation still available as the case progresses.

The value of earnest attempts at mediated compromise is increasingly recognized by both scholars and courts alike.[5] Early mediation has become mandatory in some courts,[6] and other courts have empaneled mediators to be available to the parties on an *ad hoc* basis.[7]

Through artful drafting the estate planning practitioner may require mediation as a condition precedent to a legacy. Together, counsel and the testator or settlor may preserve assets or corpus and empower heirs, legatees and beneficiaries to explore solutions beyond

those apparent at the time of drafting and execution. For instance, a mediation clause might be co-extensive with the safe harbor rules,[8] and be required prior to the filing of objections to a will or to an accounting.

Other essays have examined sample draft language.[9] This essay is not intended to promote a one-size-fits-all template for drafters, but rather as an informative guide to assist a drafter in tailoring dispute resolution mechanisms to the client—and the client's family. As planners who also eventually hope to assist the survivors in administering the estate, mediation also offers opportunities to foster client continuity and satisfaction.

With the foregoing primer on the mediation process, there is nothing mysterious about drafting a mediation clause. A plain vanilla mediation clause might read:

> **MANDATORY MEDIATION**: I direct that any dispute concerning my [will/trust] or [estate/trust] administration first be the subject of mandatory mediation between or among the parties to such dispute, with a trained, private neutral mediator. Only in the case of good faith mediated impasse, as determined by the mediator, may the parties seek judicial intervention. Every disposition and fiduciary appointment herein is expressly conditioned upon compliance with this directive. Any noncompliant party's appointment and/or legacy shall be deemed a nullity. The costs of the mediator shall be borne by the party or parties invoking mediation.

It is of course most advisable for the estate planning practitioner to confer with her client and craft language to meet her specific goals. One common consideration concerns the "teeth" inserted into a mediation clause, including, but not limited to, mediator selection and party recalcitrance. Some drafters may leave such possible eventualities to the sound discretion of the Surrogate, while others may wish to dictate specific remedies that are most likely to motivate those involved.

E. Contrary Views

Detractors may say that mediation is an invitation to the unscrupulous, or that the Surrogate can perform this function for free, or that the testator's intent will be frustrated. This may be so at times, and no solution is perfect. Counsel and the courts must consider the particular case, the personalities and the size and liquidity of the estate. However, a few related considerations:

- The unscrupulous contestant can also be managed with a carefully drawn *in terrorem* clause setting milestones delimiting the mediation time frame, or shifting its cost.
- The Surrogate and her staff have limited time and resources and are prone to reality testing that carries the court's imprimatur. Counsel cherish the glimpses into the fact-finder's viewpoint but simultaneously acting as a mediator and the ultimate finder of fact has its challenges.[10]
- If the Court is perceived as having a point of view as to the settlement terms, the parties' power of self-determination is curtailed. This may not be problematic from a legal point of view, but where value is placed upon preserving a relationship or encouraging the parties to take ownership of a tailored result of their own design, the "recommendation" of the ultimate finder of fact may not be ideal. Many a family fight has been resolved at the proverbial kitchen table. Perhaps as it should be.
- Where probate is at issue, the Surrogate will ultimately examine any proposed compromise anyway. This requires the parties to be thoughtful about protecting the testator's intent. A seasoned trusts and estates mediator will be watchful for this and help build safeguards into the mediation memorandum resolving the dispute. On the rare occasion that a judge rejects a proposal, the framework of a compromise remains and as the saying goes, where there is a will there is a way.
- Finally, where the dispute concerns the fiduciary's account mediation holds the prospect of a voluntary settlement of such account, thus avoiding further judicial intervention by way of a judicial settlement under the Surrogate's Court Procedure Act (SCPA) article 22. However, some accounts may require judicial intervention even where there is consensus (e.g., wrongful death *Kaiser* issues, attorney's fees under SCPA 2110, infant settlements, absent heirs, guardian ad litem recommendations, etc.).

F. Impasse Is Impermanent

Mediation is a fluid process. A good trusts and estates mediator will stay involved past the initial plenary sessions and caucuses. Additional and future shuttle diplomacy can be by telephone or separate meetings, to fit the case. Sometimes a more observant transformative process may carry the day, whereas in others gentle reality testing or decision tree analysis may be more effective. Above all, allowing the parties to be heard has profound benefits.[11]

The "top down" dynamics of a court-facilitated setting are not always suited to litigants who may be able

to resolve the matter themselves with the aid of a little humor, compassion, some food or just an alternative viewpoint.

As a trusts and estates mediator, steeped in the intricacies of Surrogate's Court practice, I have found that a litigant's opportunity to speak and be heard and feel the control of his or her own destiny can sometimes even turn an inevitable unpleasant result into a palatable one. But more often, the parties find mutually beneficial solutions that a court could not and would not order—and at far lesser cost to the parties.

Endnotes

1. *See Babies know what's fair*, 23 Psychological Science 196 (Association for Psychological Science Feb. 2012) (available online at https://www.sciencedaily.com/releases/2012/02/120218134639.htm).
2. *See* Robert D. Steele, Leona Beane, Kevin Murphy, Jill Teitel & Barbara Levitan, *The Benefits of Mediation and Arbitration for Dispute Resolution in Trusts and Estates Law*, NYSBA Dispute Resolution Law Section (Jan. 2011) (available online at https://www.nysba.org/Sections/Dispute_Resolution/Dispute_Resolution_PDFs/Trusts_estateswhitepaper12-21-2010_pdf.html).
3. *See, e.g.*, Joseph M. Lauria & Sharon S. Townsend, *A Decade of Reform in the New York State Family Courts*, N.Y. St. B.J. 46 (Jan. 2008).
4. *See* Chief Justice John Roberts, 2015 Year End Report on the Federal Judiciary, at 7.
5. *See* Jonathan G. Blattmachr, *Reducing Estate and Trust Litigation Through Disclosure, in Terrorem Clauses, Mediation and Arbitration*, 9 Cardozo J. Conflict Resol. 237 (2008).
6. *See, e.g.*, United States District Court for the Western District of New York Alternative Dispute Resolution Plan at 4 (June 24, 2011) (available online at http://www.nywd.uscourts.gov/sites/default/files/ADRPlanRevisedJune242011.pdf).
7. *See, e.g.*, Commercial Division, Supreme Court, New York County Rules and Procedures of the Alternative Dispute Resolution Program, at Rule 3 (available online at https://www.nycourts.gov/courts/comdiv/ny/PDFs/ADRCD.rulesprocs22016.pdf).
8. *See* SCPA 1404(4); *see also* EPTL 3-3.5(b)(3)(D).
9. *See* Steele et al., *supra* note 2.
10. *See* Yaraslau Kryvoi & Dmitry Davydenko, *Consent Awards in International Arbitration: From Settlement to Enforcement*, 40 Brook. J. Int'l L. 827, 843-44 (2015).
11. *See generally* James A. Beha II, *Mediation in Commercial Cases Can Be Very Effective for Clients*, N.Y. St. B.J. 10, n.1 (Sept. 2002).

BASICS OF MEDIATION

Presenter:
Michael Burger
Neutral Mediation Group LLC

RESOLVING COMPLEX LEGAL DISPUTES

NEUTRAL MEDIATION GROUP LLC

WHAT IS MEDIATION?

Mediation is an alternative dispute resolution mechanism that is:

- Voluntary.
- Non-binding.
- Party-driven.

NEUTRAL MEDIATION GROUP

WHAT IS THE ROLE OF THE MEDIATOR?

A Mediator is:

- a Neutral friend of the deal.
- a Facilitator who helps and empowers the Parties to reach a mutually satisfactory agreement.
- a Sounding Board.
- an Objective Listener.

NEUTRAL MEDIATION GROUP

WHO PARTICIPATES IN MEDIATION?

Participants can include:

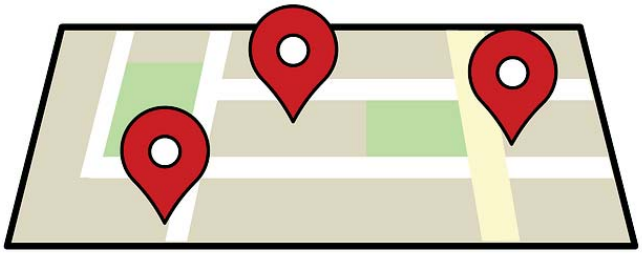
- the Parties.
- Friends and Supporters.
- Attorneys for the Parties (the Mediation Advocates).
- The Neutral Mediator.

NEUTRAL MEDIATION GROUP

WHERE DOES A MEDIATION OCCUR?

A mediation can occur in a:

- Mediation suite.
- Lawyer's office.
- Courthouse.
- Religious institution.
- Destination of your choice.



NEUTRAL MEDIATION GROUP

HOW DOES A CASE GET TO MEDIATION?

A case may get to mediation by:

- Judicial Referral:
  (Mandatory in some jurisdictions.)
- Agreement of Counsel.
- Agreement of the Parties.

NEUTRAL MEDIATION GROUP

TIMING OF MEDIATION

Mediation:

- Can occur pre or post suit.
- Can be an adjunct to discovery.
- Continues to settlement or an impasse.
- Can occur at pivotal moments | risk assessment:
  - Summary Judgment Motion
  - Pre-Trial
  - During Trial
  - On appeal
  - a good Mediator never gives up.

NEUTRAL MEDIATION GROUP

COST

The Cost of a Mediator is:

- Similar to lawyers' rates.
- Split by the Parties.
- An incentive to make the most of the process.

NEUTRAL MEDIATION GROUP

SELECTION OF A MEDIATOR

Mediator's Background:

- Rapport, rapport, rapport
- Formal mediation training and coursework
- Lawyer with litigation experience
- Subject matter expertise
- Experience on both sides of the issues
- High EQ – student of human behavior
- Flexibility
- Patience
- Sense of humor
- Not afraid of conflict
- Former Judge?

Tactical Considerations:

- Who will your adversary listen to?
- Who will your client listen to?
- Transformative vs. Evaluative Approach

NEUTRAL MEDIATION GROUP

MEDIATION MECHANICS : WHAT TO EXPECT

- Engagement and Confidentiality Agreement
- Pre-Mediation Call:
  - Dynamics
  - Expectations
  - Issues
  - Discovery
- Mediation Submissions:
  - Goals
  - Disputes
  - Personality dynamics
  - Facts, law & evidence
  - Mediator only vs. Party exchange

NEUTRAL MEDIATION GROUP

- Plenary Session : Optional

Pros – In a Plenary Session:

- Clients meet and are heard
- Conflict is in the open
- The Parties feel empowered
- The lawyers get out of the middle

Cons – But a Plenary Session May:

- Foster destructive intransigence
- Cause a Setback
- Stimulate emotional triggers

NEUTRAL MEDIATION GROUP

- Opening Statements
  - Mediator explains and promotes process
  - Parties or counsel speak
    - Collaborative, not incendiary
    - Managing client expectations
    - Client's Goals are Heard in a Positive Light

- Caucus
  - Confidential unless otherwise stated or vice versa?
  - Shuttle diplomacy
  - Active listening
  - Understanding goals within goals
  - Probing for details and rationale

NEUTRAL MEDIATION GROUP

WHY MEDIATE? (OR WHY NOT?)

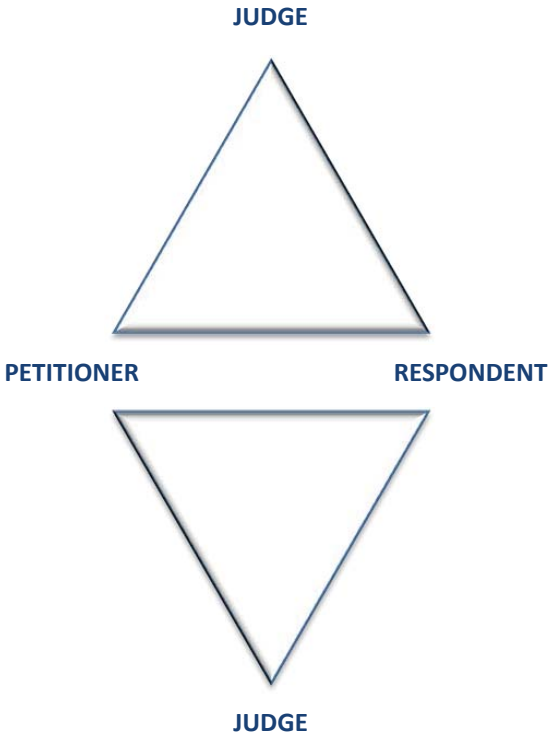
Reasons to Mediate:

- Most cases settle eventually!
- Cost
- Preserve or rekindle relationships
- Seek relief beyond what a judge can order
- The limits of judicial intervention
- Confidentiality
- Rapid discovery
- Certain, speedy, tailored, and final resolution
- Flexibility

Some Reasons Not to:

- Allocation of scarce financial resources
- Revealing trial strategy or tactics
- Indifferent or unrealistic parties

NEUTRAL MEDIATION GROUP



Mediation turns this triangle paradigm on its head, allowing the litigants to fashion a mutually acceptable outcome which they dictate.

NEUTRAL MEDIATION GROUP

ADVOCATING FOR MEDIATION

Becoming a lawyer Mediation Advocate to enhance your law practice (litigator or not!)

- Another tool in the toolbox
- Holistic lawyering
- Build bridges
- Not constrained by the rules of Evidence
- (But a “BATNA” consult may be indicated)
- The British solicitor model

NEUTRAL MEDIATION GROUP

BIBLIOGRAPHY

1. Anatomy of a Mediation by James C. Freund (PLI 2012);
2. Bey☺nd Smart Lawyering with Emotional Intelligence by Ronda Muir (ABA Dispute Resolution Section 2017);
3. Fair is Fair: Mediation Clauses in Wills and Trusts by Michael A. Burger, 50 NYSBA T&E Section Newsletter 6 (Summer 2017);
4. Getting Past No by William Ury (Bantam Books 1991);
5. Getting to Yes by Fisher and Ury (Penguin Books 2011) (3d Ed.);
6. How to Mediate Like a Pro by Mary Greenwood (iUniverse, Inc. 2012);
7. Mediation Practice Guide by Bennett G. Picker (ABA 2003) (2d Ed.);
8. Sharing a Mediator's Powers by Dwight Golann (ABA 2013);
9. Why Can't They Settle? The Psychology of Relational Disputes, *18 Cardozo J. Conflict Resol. 311*, Winter, 2017.
10. NYSBA and NYC Bar Training Seminars.

NEUTRAL MEDIATION GROUP

HYPOTHETICAL EXERCISES

- In-state/out-of-state child (Contested 81/Estate/Trust)
- Divided room—cross the aisle

NEUTRAL MEDIATION GROUP

TRACK 7
Planning and Skills for Chronic Care Medicaid
Part 2

Presented By:
Sara Meyers, Esq.

MEDICAID ADMINISTRATIVE APPEALS

Appealing a Medicaid Denial

Sara Meyers, Esq.
Enea, Scanlan & Sirignano, LLP
245 Main Street
White Plains, New York 10605
(914) 948-1500
s.meyers@esslawfirm.com

I. BACKGROUND

A. REGULATIONS

The right to a fair hearing is based upon the federal Medicaid statute and regulations. New York State codified the federal regulations in the Social Services Law and the New York Code of Rules and Regulations. Under the federal law creating the Medicaid program, states must devise a plan to provide the opportunity for a fair hearing to anyone whose claim for benefits under the program is denied or not properly acted upon. The federal law is codified in the United States Code (USC) at 42 U.S.C. §1396a(a)(3) and the federal regulations are found in the Code of Federal Regulations (CFR) at 42 C.F.R. §431.200-.250.

The implementing state statute is codified in the New York Social Services Law (SSL) at SSL §22 and the State regulations are found in the New York Code of Rules and Regulations (NYCRR)

at 18 N.Y.C.R.R. Part 358. The fair hearing regulations cited in this outline can be found at 18 N.Y.C.R.R. §358.

B. THE RIGHT TO A FAIR HEARING (§358-3.1)

The moment applicants apply for Medicaid their due process rights are triggered. Due process rights exist from the filing of the application, to the eligibility determination, through the entire period that benefits are received until the termination of benefits. Applicants/recipients (A/R) have the right to written notice of any decision affecting their benefits and the right to be heard at a hearing.

The right to notice and the opportunity to have a fair hearing are activated in these types of situations:

- denial of an application;
- failure to process an application in a timely manner;
- reduction or termination of benefits; or
- inadequacy of benefits.

The parties to a fair hearing are the Medicaid applicant or recipient, known as the appellant, and the local Medicaid agency whose decision is the subject of the fair hearing.

C. PRE-HEARING CONFERENCE (§358-2.4; 3.8)

Prior to attending a fair hearing, an A/R may attend an agency conference, an informal meeting at the local Medicaid

office. At the conference, Medicaid is required to provide a meaningful opportunity to resolve the problem.

A hearing should be requested before proceeding to a conference to preserve the right to a fair hearing. A request for a conference is not considered a request for a hearing.

Conferences are useful to solve simple clerical errors or to have some simple issues clarified. The personnel handling conferences will not be able to make substantive judgments (errors of law) and can only correct straightforward errors that were made in reviewing the original information.

II. NOTICE REQUIREMENTS (§358-3.3)

A. NOTICE OF ACTION (§358-2.15)

Medicaid must provide written notice to A/R of any action to be taken by Medicaid affecting their benefits. The notice must be both timely and adequate. (§358-2.23, 2.2).

Receiving adequate notice starts the 60-day time limit for requesting a fair hearing (see below). The Notice of Action informing the A/R of the intended action must be mailed at least ten days prior to the date the proposed action is to go into effect (the effective date). (§358-2.23)

A notice of intent has two dates:

- Notice date: the notice date is the date the notice was issued; and

- Effective date: the effective date is the date the proposed action will go into effect.

The A/R must receive the notice of intent at least ten days before the effective date.

B. NOTICE CONTENT (§358-2.2)

An adequate notice must conform to certain requirements as to content. Failure to provide proper notice to the Medicaid A/R that is, any required information is not included, renders the proposed action void, and the notice must be withdrawn. The notice must conform to the requirements set forth in the regulations and must include:

- the date the notice of intent was issued;
- the effective date of the proposed action (except in the case of initial acceptance);
- an explanation of what action the agency is taking;
- the specific laws and/or regulations upon which the action is based;
- an explanation of the right to request a conference and a fair hearing;
- the procedure for requesting a conference and fair hearing (including time limits for making the request and the address and telephone number where a request may be made);
- an explanation of how to request the continuation of services pending the fair hearing date (aid continuing);
- an explanation that individuals may be held liable to repay Medicaid for continuing services if they lose the fair hearing;
- the right of individuals to review their case records and obtain copies of documents;
- the right to be represented by a lawyer, relative, friend or other person;

- the right to call and question witnesses; and the right to present written and oral evidence.

This list is not exhaustive, and the regulations should be checked for a comprehensive list. If the notice fails to list the above information, it is considered defective, and therefore inadequate.

C. IMPROPER OR NO NOTICE

Lack of a notice or a defective notice stops the 60-day limit for filing a fair hearing request (see discussion below). For example, if the notice fails to cite the regulation(s) upon which it is based, or cites the wrong regulation, the 60-day limit is stopped until a proper notice is issued. Therefore, if the 60-day deadline has passed, a fair hearing may still be requested. At the hearing, it must be proven that the notice was defective.

III. REQUESTING A FAIR HEARING SIXTY DAY DEADLINE (§358-3.5)

A. THE FAIR HEARING REQUEST

Once A/R receives the notice of intent, they have 60 days from the date of the notice to request a fair hearing challenging the action. If A/R fails to request hearings within the 60-day time limit, they must prove that the notice was improper or that they did not receive it in a timely manner,

that therefore the 60-day time limit for requesting a fair hearing did not expire. In addition, if a fair hearing is requested within 10 days of receipt of the notice of intent, or prior to the effective date on the notice, in some cases the Medicaid A/R is entitled to aid continuing (see discussion below). Note: for Food Stamp hearings, appellants have 90 days from the notice of intent to request a fair hearing.

Anyone acting on behalf of the appellant may make the request for a fair hearing. Merely requesting a fair hearing on behalf of an individual does not obligate the requester to represent the person at a fair hearing.

1) Requesting a fair hearing (§358-3.5)

Requests may be made in writing, by telephone, by fax or in-person.

Write to:	OAH-OTDA Fair Hearing Section P.O. Box 1930 Albany, NY 12201
Fax:	(518) 473-6735
On-Line:	www.otda.state.ny.us/oah/oahforms/erequestform.asp

B. WHAT SHOULD THE REQUEST CONTAIN? (§358-3.5)

All requests for a fair hearing must contain the following information:

- name, address and telephone number of the A/R;
- Medicaid case number and Social Security number;
- the notice date and effective date of the notice;
- the action or lack of action taken by Medicaid as explained in the notice received;
- whether the appellant is homebound if a telephone hearing is requested;
- name, address, and telephone number of the representative/requester;
- request for ongoing services to continue ("aid continuing"); and
- issues the administrative law judge will be asked to consider.

C. AID CONTINUING: KEEPING SERVICES IN PLACE (§358-3.6)

In certain situations, Medicaid recipients have the right to have their Medicaid benefits and services continued unchanged until a fair hearing decision is issued. This is known as the right to aid continuing. Medicaid recipients must make this request at the time they request a fair hearing and within 10 days of receiving adequate notice of the pending change.

If services have been terminated or reduced before the Medicaid recipient has made the request for aid continuing, Medicaid must restore the services as soon as possible, but no later than five business days after being informed that the recipient is entitled to aid continuing. To get services restored call OAH at 1-800-342-3334.

Aid continuing cannot be granted if the action taken was based upon a change in State or federal law.

1. Reimbursement

If appellants do not have aid continuing and win the fair hearing, they may seek reimbursement for medical and/or home care bills incurred during the time between the application and the fair hearing. For example, if a Medicaid recipient does not have aid continuing and wins the fair hearing, reimbursement may be requested from Medicaid for costs incurred in the time that the Medicaid case was closed to the time the case is reopened.

2. New applicants

Applicants appealing a denial of eligibility on an initial application are not entitled to aid continuing. If the applicants win the appeal of the denial of eligibility, they are entitled to retroactive coverage back to the date of application and three months prior to application if eligible and retroactive reimbursement of costs incurred.

3. Medicaid recovery for benefits received

If Medicaid continues benefits pending a fair hearing appeal and the appellant loses the appeal, the appellant will have to repay Medicaid for all benefits received during the period of aid continuing.

D. FAIR HEARING CONFIRMATION

A confirmation of the fair hearing request is usually mailed to the appellant two weeks after the fair hearing request is received by OAH. Included in the notice is the fair hearing number, the aid continuing status and the issue(s) to be decided.

IV. PREPARING FOR THE FAIR HEARING

A. THE EVIDENCE PACKET (§358-3.7)

Appellants have the right to be provided with copies, at no cost, of all documents relevant to their case prior to the fair hearing. At any reasonable time before the date of the fair hearing and also at the fair hearing, the appellant or the authorized representative has the right to examine the contents of the case record and all documents to be used by Medicaid at the hearing. This request may be made orally or in writing.

The evidence packet should include the application or re-certification with supporting documents, any documents generated by Medicaid and the adverse notice. Reviewing the documents provides some idea of why and how a particular decision was made and gives an idea of what evidence is needed to support the appellant's case.

1. Requesting the evidence packet

The fair hearing evidence packet may be obtained from the Medicaid Hearing Office. Requests should either be mailed return receipt requested or faxed, keeping the confirmation of transmission.

The evidence packet request should contain the following information:

- appellant's name and address;
- case number and Social Security number;
- fair hearing number;
- fair hearing date, if known; and
- if the appellant's representative is requesting the packet, enclose a release from the client authorizing the representative to receive the information.

2. Reasonable time

If the request was made more the five days before the fair hearing, Medicaid must send the packet within a reasonable time of receipt of the request. If the request was made less than five days before the hearing, Medicaid does not have to mail the documents, but rather may provide them at the hearing. Medicaid must also provide access to the documents at the fair hearing.

3. Failure to obtain/incomplete evidence packet

If Medicaid fails to send the evidence packet, Medicaid must withdraw its notice of intent. See Rivera v. Bane, 45305/92 (Sup. Ct. N.Y. Co. December 22, 1995). At the fair hearing, it is important to demonstrate that the request for the

evidence packet was made. For example, a fax confirmation or the "return receipt" card.

The fair hearing representative can submit into evidence at the fair hearing only documents provided in the evidence packet. If a document is not included in the evidence packet, Medicaid is precluded from submitting it into evidence at the hearing.

B. REPRESENTATION (§358-3.9)

The appellant has the right to be represented by an attorney or other authorized representative at any conference and/or fair hearing. An authorized representative, except an attorney, appearing without the appellant present must have written authorization from the appellant.

C. PREPARING FOR THE FAIR HEARING

1. Theory of the case

It is important to identify the issue or issues to be resolved at the fair hearing. Once a theory is identified, both the theory of the case and the plan to support that theory through evidence must be developed.

For example, if the notice is a denial of a Medicaid nursing home application due to the transfer of resources, the appellant would introduce evidence that the gifts/transfers made

were for purposes other than to qualify the appellant for Medicaid.

D. BURDEN OF PROOF (§358-5.9(a))

The burden of proof is the obligation of a party in a legal proceeding to substantiate an issue to prove the correctness of the claim to the ALJ.

The burden of proof at a fair hearing shifts depending on the issue of the case. Any action by Medicaid to discontinue, reduce or suspend Medicaid benefits must be justified by Medicaid, who must prove the correctness of its action taken regarding the appellant. In cases where the appellant's benefits have been denied or the appellant claims that the benefits are inadequate, the appellant has the burden of proof to demonstrate either that eligibility should be established or that the benefits are inadequate. The burden of proof must be documented and corroborated by evidence.

E. DEVELOPING EVIDENCE

The formal legal rules of evidence do not apply at fair hearings. Evidence presented must be relevant to the case being heard and hearsay evidence may be used. The ALJ determines what evidence is admissible at the hearing. Prior to the hearing, appellants and their representatives must obtain records or

information in addition to the appellant's Medicaid file that will support their position.

1. Types of Evidence

Obtain records or information from sources other than HRA, such as:

- letter or affidavit from treating physician, nurse, therapist indicating Applicants health status when gifts were made, along with corresponding medical records;
- detailed information (ledgers, cancelled checks, etc.) regarding gifts such as specific amounts, to whom, and reasons why gifts were made to them (i.e. holiday gifts, birthday gifts, tuition payments, compensation for care, etc.)
- if gifts or purchases were made with cash, provide a ledger with details as to whom received the cash, amount and reasons why;
- if cash was used to pay for home care aides, provide ledger with information such days/hours worked, by whom and services provided as well as any home care agreements entered into by the applicant or their legal representative;
- if transactions were made for the benefit of applicant such as for food, shelter, clothing, equipment, home repairs, etc., provide receipts reflecting same;
- if gifts are part of a larger gifting pattern, provide evidence of same such as copies of checks made payable to others, in similar amounts, prior to the lookback period, and specify reason for gift (i.e. family members tuition payments, annual federal exclusion amount, gifts to charities, etc.;
- provide evidence (statements with balance) that applicant did not impoverish themselves by gifting and that they remained financially solvent after gifts were made;
- promissory notes and proof that monies are being paid back;
- prior hearing decisions that support your argument;

- any other evidence you feel necessary to prove and support your position.

F. STARE DECISIS

ALJs must follow determinations established in past fair hearing decisions or explain in their decision why they have not done so. This principle of administrative stare decisis is essential to guaranteeing and ensuring equal justice to those affected by fair hearing decisions.

The failure of an administrative hearing decision to conform to agency precedent requires reversal as arbitrary even where there is substantial evidence to support the determination made.

The Greater Upstate Law Project (GULP) on-line Fair Hearing Bank (FHB) allows users to search summaries of fair hearing decisions and to download or print copies of actual hearing decisions that can be used as precedent in appropriate hearings. The FHB can be found on-line at www.gulpny.org or www.wnylc.net.

The Office of Temporary Disability and Assistance (OTDA) established a Fair Hearing archive for decisions rendered after November 1, 2010. The archive can be accessed at http://www.otda.state.ny.us/oah/FHArchive.asp.

V. THE FAIR HEARING

A. NOTICE OF FAIR HEARING (§358-5.1)

At least 10 days prior to the fair hearing, the appellant will receive notice of the fair hearing. The notice includes:

- date, time, place of the hearing;
- issue(s) to be resolved;
- aid continuing status;
- ALJ number;
- right to reimbursement for transportation expenses;
- right to be represented;
- right to review case file; and
- right to a translator.

B. THE ADMINISTRATIVE LAW JUDGE (ALJ) (§358-5.6)

The hearing officer is a State official who must act as an impartial trier of fact. The ALJ is obligated to ensure that a complete record of the hearing is made. The ALJ makes findings of fact and conclusions of law. The ALJ tape-records the fair hearing.

C. THE FAIR HEARING REPRESENTATIVE

The fair hearing representative presents Medicaid's case at the fair hearing, setting forth its facts and justifying the correctness of Medicaid's actions. The representative submits Medicaid's evidence to the ALJ. If the agency representative fails to produce the appellant's entire case record at the fair hearing, Medicaid must withdraw its Notice of Intent. See Annunziata v. Blum, 81 Civ. 302 (S.D.N.Y December 15, 1982.)

D. PARTICIPATING AT THE HEARING (§358-3.4(g))

The appellant has a right to appear and participate at the fair hearing in a meaningful manner. If an appellant is homebound (§358-3.4(j)) and unable to attend the hearing at the hearing location, two options exist:

(1) a telephone hearing where the ALJ calls the appellant; or

(2) the appellant's representative appears at the hearing office and participates at the hearing without the appellant.

If the ALJ cannot render a favorable decision for the appellant after the initial telephone hearing or hearing without the appellant, homebound appellants are given the opportunity to have a hearing in their home, thus giving them a meaningful opportunity to participate at the hearing. No decision is issued after the first hearing if the appellant "loses." The hearing will simply be rescheduled for a home hearing.

E. PRESENTING EVIDENCE (§358-5.9(c))

The appellant may present any evidence which is relevant to the issue before the hearing officer. The rules of evidence do not apply at administrative hearings.

1) Opening statement

The opening statement is an oral summary of the case presented at the commencement of the hearing. This should give the ALJ the information needed to know what the case is about and present the facts in a positive and meaningful way for the appellant.

2) Presenting Evidence

An appellant has the right to bring witnesses (§358-3.4(h)) and to present written or oral evidence at the hearing. Witnesses may have their evidence or statements placed into the hearing record through an affidavit instead of appearing at the hearing.

If witnesses refuse to appear voluntarily at a fair hearing, they may be subpoenaed. The ALJ presiding over the hearing must issue a subpoena (§358-5.6(b)(8)), (§358-5.9(e)) compelling the witness to appear.

3) Closing statement

The closing statement is a restatement of the opening statement. It also summarizes the essential points and evidence presented during the hearing.

4) Requesting relief

At the fair hearing, relief can be requested. The appellant can request that the ALJ reverse Medicaid's determination; or, in the alternative, that the ALJ remand the case back to Medicaid for a new evaluation.

If the appellant presents evidence that Medicaid should have known or, if known, would have dramatically changed the original action or decision made by Medicaid, the ALJ may order Medicaid to reopen the evaluation and make another decision.

VI. THE HEARING DECISION

A. THE HEARING RECORD (§358-5.11)

The fair hearing proceedings are taped, and the transcripts, documents and other evidence submitted become part of the official record and remain confidential. The hearing record can only be reviewed by the parties to the hearing or their authorized representatives.

B. THE FAIR HEARING DECISION (§358-6.1)

The fair hearing decision must be based exclusively on the hearing record. The decision must be in writing and set forth the hearing issues, relevant facts, the applicable laws and regulations upon which the decision is made. The decision is sent to all parties concerned.

The hearing decision will either affirm, reverse or make an adjustment the initial notice sent by Medicaid. In some instances, the ALJ will remand the case back to Medicaid for further processing. The decision is binding on Medicaid and must be complied with within a reasonable time.

C. REOPENING OF THE HEARING DECISION (§358-6.6)

A review of the issued fair hearing decision is permitted to correct an error of law or fact which is substantiated and supported by the fair hearing decision. The standard procedure to have a hearing decision reopened is to have the representative write a letter to the Commissioner of OAH. The correspondence should also state what the correct decision should have been.

D. COMPLIANCE (§358-4.4; 6.4)

OAH and the local Medicaid office must render a final decision within 90 days of the request for a fair hearing. Medicaid must comply with fair hearing decision promptly. If Medicaid fails to comply with the decision in a timely manner, call the OAH Compliance Unit at (518) 474-5603.

E. JUDICIAL REVIEW OF THE DECISION

If appellants receive unfavorable decisions, they may appeal and seek court review under the Civil Practice Laws and Rules by bringing a special proceeding in New York State Supreme Court (known as an Article 78 proceeding). An Article 78 proceeding must be commenced within four months of the date of the fair hearing decision. To have a Court reverse a fair hearing decision, the appellant must demonstrate that the ALJ's decision is arbitrary, capricious or an abuse of discretion.

Gifting[1]

Applicable Regulations

Section 366.5(e) of the Social Services Law governs transfers of assets made by an A/R or his/her spouse on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, any transfer of assets for less than fair market value made by the person or his or her spouse within the "look-back period" (the 60-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical

[1] This Section has been updated and edited by Sara Meyers, Esq. and Kristine Garcia, a third-year law student at CUNY Law School and a summer intern with Enea, Scanlan & Sirignano, LLP.

Assistance (06 OMM/ADM-5)) will render the person ineligible for Medicaid to pay for the nursing facility services.

Sections 366.5(d) and (e) of the Social Services Law provides that [a penalty period will not be imposed upon]

> (d) a satisfactory showing is made that:
>
> (i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or
>
> (ii) **the asset was transferred exclusively for a purpose other than to qualify for Medicaid**; or
>
> (iii) all assets transferred for less than fair market value have been returned to the individual.

It is presumed that any transfer of resources within five years prior to an application for medical assistance is done for the purpose of qualifying for Medical Assistance. Therefore, the burden of proof is on the Appellant to show that the transfer was made "exclusively for a purpose other than to qualify for Medical Assistance."

Cases and Examples

Gifts Made for Purposes OTHER than Qualifying for Medicaid

FH # 5571655Z (Agency: Erie; Request: July 14, 2010)

The agency determined Appellant was not eligible for Medicaid for nursing facility services because the Appellant transferred assets valued at $106,652.34 for less than fair market value, imposing a 14.37-month penalty period.

At the hearing, Appellant's son and Power of Attorney sufficiently rebutted the presumption that the various transfers were done for purposes other than qualifying for Medicaid. Appellant's son testified that his mother transferred the home to him to prevent his other sibling from getting the home after his mother and brother had a disagreement regarding the handling of his father's ashes. Appellant's son also sufficiently showed a pattern of gift giving going back multiple years, as well as the fact that his mother often took out large sums of cash for herself. Appellant's son further testified that while his mother had some medical issues, she was always independent and required little to no help. She drove herself to appointments, did her own food shopping, etc. She was once admitted to the hospital but was subsequently discharged and returned home. When she returned to the nursing home for a short rehab stay, son anticipated his mother returning home and when she decided she wanted to stay there because she was happy, he requested a psychological evaluation. The documentation and testimony was found to be credible. Accordingly, based on the record, the evidence established that the transfers were made exclusively for a purpose other than qualifying for Medicaid.

Decision: The Agency's determination that Appellant was not eligible for Medicaid for nursing facility services for a period of 14.37 months because the Appellant transferred assets valued

at $106,652.34 for less than fair market value was correct when made but cannot now be implemented.

FH # 6054793P (Agency: Albany; Requested: March 2, 2012)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $42,365.48 for less than fair market value, imposing a 5-month penalty period.

Decision After Fair Hearing was issued modifying the penalty period. Appellant's son and Power of Attorney asked for reconsideration due to factual errors in the Decision. Specifically, a check in the amount of $35,000 which was to cover tuition for grandchildren ($15,000) and the other $20,000 was to compensate her son for room and board for six years. Son provided sufficient documentation to establish a pattern of gift giving, as well as the fact that he constructed an extension to his home as a "parental apartment" for his mother to live in after his father passed away. The record also supports the fact that Appellant was in good health at the time the gifts were made.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 5 months because the Appellant transferred assets valued at

$42,365.48 for less than fair market value was not correct and was reversed.

FH# 6766942N(Agency: Erie; Requested: June 30, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $44,549.79 for less than fair market value, imposing a 5.13-month penalty period.

Appellant's daughter testified that her parents were in good health and intended to die at home. Appellant's husband only went into a nursing home after an unexpected diagnosis. Letters from medical providers supported daughter's testimony. Daughter further testified that her sister lived in the upstairs flat of Appellants home and provided necessary assistance to her parents. Appellant's daughter established a pattern of gift giving and stated that monies giving to children and grandchildren was due to unemployment of one daughter and the tuition for grandchildren whose father had suddenly passed away. It was further established that after the gifts, Appellant and her husband retained another $150,000 in their bank account sufficient to cover the cost of aides in the home.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 5.13 months because the Appellant transferred assets valued

at $44,549.79 for less than fair market value cannot be sustained and is reversed.

FH# 7378581Z(Agency: Madison; Requested: September 8, 2016)

The agency determined Appellant was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $35,653.23 for less than fair market value, imposing a 2.34-month penalty.

Appellant's spouse presented evidence showing that transfers were part of ongoing gifts to help grandchildren with college expenses. Although Appellant's spouse had been diagnosed with early Alzheimer's disease in 2011, she never intended to place him in nursing home care. Appellant was living a somewhat normal lifestyle. It wasn't until 2014 that Appellants spouse left her job to care for him and their daughter would also come by and help on a daily basis. Appellant's condition did not progress and become unmanageable until 2015. Even after gifts were made to grandchildren, Appellant and his spouse were still able to maintain financial solvency.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 2.34 months because the Appellant transferred assets valued at $35,653.23 for less than fair market value was not correct and is reversed.

FH# 7515665K(Agency: Suffolk; Requested: April 17, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $51,000.00 for less than fair market value, imposing a 4.04-month penalty.

At the hearing Appellant's representative asserted that transfers were made for the purpose of helping Appellant's daughter when she fell into extreme financial trouble due to her spouse's mental health issues. Appellant's representative asserted that no other child had received gifts, and gifts made to the grandchildren had been returned. At the time the transfers were made, Appellant nor her spouse considered nursing home care, and they still had approximately $200,000 after the transfers were made. Appellant's daughter testified as to her and her spouse's situation and medical condition. Copies of checks showed that uncompensated transfer were issued directly to pay for daughter's mortgage, real estate taxes, state and federal income taxes, divorce mediation and other bills such as insurance. The evidence established that all of the transfers were made exclusively for a purpose other than qualifying for Medicaid.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period

of 4.04 months because the Appellant transferred assets valued at $51,000.00 for less than fair market value was not correct and is reversed.

FH# 7726893Q(Agency: Schenectady; Requested: March 26, 2018)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $135,615.69 for less than fair market value, imposing a 12-month penalty.

At the hearing, Appellant's nephew and POA testified as to Appellant's life before facility placement. The Appellant never married, never had children, never lived alone and never drove. Appellant lived with her sister for over a decade before entering facility placement. Even when she lived with her sister, her sister was the one who cooked, did laundry, etc. and Appellant would contribute to the monthly living expenses. Appellant was also known for gifting during special occasions or holidays but never larger sums than $100. Appellant would often leave the house daily and not return until dinner-time, but no one knew where she was going or what she was doing. The family did know Appellant always carried cash and enjoyed going on bus trips to the casino. They did not become aware of Appellant's finances or the large withdrawals until after Appellant's entry into the nursing facility. Withdrawal slips from the bank did

not contain much helpful information. The lack of information in this case is not sufficient to overcome the presumption that transfer were made for the purpose of qualifying for Medicaid. However, the evidence established Appellant was at risk of losing appropriate medical care without the provision of Medicaid as she is unable to care for herself and her remaining family is not able to provide such care. Therefore, Appellant meets the criteria for undue hardship should she be denied such benefits.

Decision: The Agency's determination that Appellant not eligible for Medicaid for nursing facility services for a period of 12 months because the Appellant transferred assets valued at $135,615.69 for less than fair market was not correct when made but can no longer be sustained.

Gifts found to have been made to qualify for Medicaid

FH# 5594426J (Agency: Fulton; Requested: August 16, 2010)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $98,360.00 for less than fair market value, imposing a 13.54-month penalty.

At the hearing Appellant was represented by her niece and POA. Appellant's niece contended that transfers were not made

for the purposes of qualifying for Medicaid. Instead Appellant's niece claimed it was an early retirement gift so that niece could retire and care for her mother (Appellant's sister) and as a gift for all she had done for her. Appellant's niece further explained that Appellant had no children of her own and was always generous with her family. Even when Appellant was advised to secure her money in a trust before entering the nursing home, she preferred to pay her own way and she did from 2003 through present.

However, without anything in writing evidencing that Appellant intended to compensate her niece and considering that Appellant had been in nursing home care since 2003 and not returned home, the transfers made after Appellant entered a nursing home (2006-2008) should not have been made.

The Agency's determination that Appellant is not eligible for nursing facility services for 13.54 months is affirmed.

FH# 6599242Z(Agency: Suffolk; Requested: January 8, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $97,600.00 for less than fair market value, imposing an 8.11 month penalty.

Appellant's counsel did not dispute the transfers or respective amounts, but instead contends that the transfers are

part of a larger pattern of gift giving. In 2004 when Appellant sold his house, he began gifting funds to his adult children, which continued through 2013, with the exception of 2008. He further argued that Appellant maintained $160,000 in assets to cover any medical expenses if necessary. Additionally, that Appellant was in good health when the transfers were made.

Appellant's counsel did not provide an explanation for the gifts other than Appellant wanted to be generous with his kids. Based on Appellant's age, his physical and mental condition at the time the gifts were made, the fact that his wife was the one who signed all the checks and naming his daughter POA showed at least an expectation of a need for nursing home care. There was also no indication that Appellant lived independently and cared for himself. Without any documentation or medical testimony to the contrary, this argument was not persuasive.

The Agency's determination that Appellant is not eligible for nursing facility services for 8.11 months is affirmed.

FH# 6728007H (Agency: Erie; Requested: May 17, 2014)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $32,000.00 for less than fair market value, imposing a 3.69-month penalty.

At the hearing Appellant's son contended that transfers were part of a larger pattern of gift giving. Son testified that Appellant wanted to give all her grandchildren money when they got married. She had done this in 2006 when she gave one of them a $2,000 but because she felt she wouldn't be around to see all of them get married, she started giving them gifts beforehand. Specifically, in 2012 she gifted $2,000 to each of her three grandchildren and $13,000 (each) to both of her children. However, gifts to the children were given under the condition that if Appellant needed nursing care the money would be returned.

The evidence presented does not establish that gifts were made for reasons other than qualifying for Medicaid. Small $50-100 gifts, and one isolated $2,000 gift prior to 2012 does not establish a pattern of gift giving. Furthermore, the condition of the gifts to the children that the money be returned should Appellant need home care demonstrate that Appellant was already considering the need for skilled nursing care.

The Agency's determination that Appellant is not eligible for nursing facility services for 3.69 months is affirmed.

FH# 7399514Z(Agency: Suffolk; Requested: October 11, 2016)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $73,383.98 for less than fair market value, imposing a 5.81-month penalty.

At the hearing, the Appellant, through her daughter, argued that transfers totaling $73,383.98, from the Appellant to her family members during the period of December 2011 to May 2014 were gifts as holiday presents as well as renovations. Renovations to the storefront and home where Appellant was residing, which Appellant's daughter owned. Furthermore, Appellant's daughter further argued that Appellant had more than $350,000.00 in assets to pay the cost of the facility and that there was no indication of a need for nursing home care.

The bank logs showed checks disbursed as holiday gifts in 2010 and 2011 but not 2009, and do not support a pattern of gift giving. Additionally, no medical documentation was provided to establish Appellant's good health or sudden medical issues. The fact that the Appellant's daughter moved the Appellant into her home in 2011 indicates some need for a higher level of care and the contemplation of the need for nursing home care. Furthermore, the evidence regarding renovations to the storefront and Appellant's daughter's home were not supported by receipts or explanation as to the medical need for such renovations for the benefit of the Appellant.

The Agency's determination that Appellant is not eligible for nursing facility services for 5.81 months is affirmed.

FH# 7657450Q(Agency: Westchester; Requested: November 27, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $28,298.21 for less than fair market value, imposing a 2.3-month penalty.

At the hearing, Appellant's daughter testified as to the transfers in question. At issue here was a transfer to Appellant's daughter in the amount of $7,320.00, which she claimed she was holding for her mother and would withdraw the funds as necessary. She could not explain the reasons for the $3,500.00 to another daughter (her sister). As for the remaining $17.478.21, she testified that Appellant was swindled (by a friend) into gifting her that money. Appellant's daughter confirmed that the signature on the withdrawal slip was Appellant's, but the name, date and withdrawal amount was not written in Appellant's handwriting. No police reports were filed.

The court found the $3,500 is an unexplained and therefore uncompensated transfer. Although Appellants daughter wrote the agency a letter indicating that she is holding the funds for her mother and would withdraw them as needed, the $7,320.00 is

attributable to Appellants daughter as an uncompensated transfer. Lastly, lack of documentation indicating Appellant was swindled makes this claim unreliable and not sufficient to rebut the presumption that funds for transferred for purpose other than qualifying for Medicaid.

The Agency's determination that Appellant is not eligible for nursing facility services for 2.3 months is affirmed.

Decisions where DOH made adjustments to penalty period

FH# 7487016Q(Agency: Chautauqua; Requested: February 27, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $22,098.29 for less than fair market value, imposing a 2.3-month penalty.

At the hearing, Appellant was represented by her son and POA. Appellant's son argued that the uncompensated transfer should be reduced to $6,185.51 because the other $15,903.78 was paid to contractor for door and window repairs in Appellant's home prior to her needing nursing facility care. The agency argued that because Appellant retained a life estate in the property, all improvements made to said property constituted uncompensated transfers.

The court found that because Appellant was in relatively good health when the transfer was made and was living independently (for several months) in the home before her unexpected need for nursing home care. That such repairs were made for the benefit Appellant to enable her to remain in her home. The court also found that Appellant was financially solvent after the transfers and payment to the nursing facility as well as burial fund.

Therefore, the Agency determination that Appellant transferred assets valued at $22,098.29 for less than fair market value, imposing a 2.3-month penalty was not correct and was revered. The Agency was directed to reduce the uncompensated transfers by $15,903.78, and to only impose a partial penalty of $6,185.51.

FH# 7459103K(Agency: Albany; Requested: January 17, 2017)

The agency determined Appellant was not eligible for Medicaid for nursing facility services, because the Appellant transferred assets valued at $125,929.00 for less than fair market value, imposing an 8.92-month penalty with a remaining penalty amount of $9,079.00.

Appellant, by her attorney, did not dispute the $87,000 withdrawal (promissory note), for which Appellant had already received $37,970.00. They did dispute the four checks made to

Appellant's church totaling $23,505.00 and the $15,424.00 cash withdrawal for the purchase of a vehicle. They argued that the transfers to the church were made for charitable purposes. The record supports a pattern of gift giving going back several years in similar amounts while maintaining financial solvency. Appellant's health and expectation of nursing care was determined by her earliest payment for nursing home care in 2014. However, the Appellant had already established a pattern of gift giving to the church. Further, withdrawal slips and bank check submitted indicate the $15,424.00 cash withdrawal was used to purchase a vehicle.

Therefore, the Agency determination that Appellant transferred assets valued at $125,929.00 for less than fair market value, imposing an 8.92-month penalty with a remaining penalty amount of $9,079.00 was not correct and was revered. The Agency was directed to reduce the uncompensated transfers by the total transfer to the church ($23,505.00), the amount used to purchase the vehicle (15,424.00) and the amount received thus far as it relates to the promissory note ($37,970.00) leaving a penalty amount of $49,030.00.

Article 78 Appeals

Rivera v. Blass, 127 A.D.3d 759 (2015)

The agency determined applicant was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $152,567.42 for less than fair market value, imposing a 14.058-month penalty. Applicant appealed, and the Commissioner of New York State Department of Health affirmed. Applicant petitioned for judicial review.

A review of the record shows that on January 2008 when petitioner was 84 years old, her husband loaned their grandson and his wife $200,000 to make home repairs. A promissory note had been executed to reflect a 15-year repayment period with a 5.5% interest rate. The grandson and wife had been making payments accordingly. In March 2009 petitioner fell, broke her hip and entered nursing home care. In August 2009 petitioner applied for Medicaid and in May 2010, the original promissory note was amended to comply with certain Medicaid rules. DDS concluded that petitioner was not eligible for Medicaid, finding the loan to be an uncompensated transfer.

At the hearing husband testified that the loan provided him a stream of income and proved that grandson had been making payments as per the promissory note, with a greater rate of return than he would have received at any bank at the time the loan was made. The petitioner concedes that the loan was not made for fair market value considering their age and 15-year repayment period. However, the evidence presented rebutted the

presumption that the transfer was motivated by an anticipation of need to qualify for Medicaid, which was supported by letter from her physician stating petitioner was in good health when the loan was made. Furthermore, evidence shows prior family loans that had been fully repaid.

Based on the substantial evidence presented in this case, the petition was granted and DOH was directed to provide retroactive Medicaid benefits for a period of 14.058 months.

Matter of Collins v. Zucker, 144 A.D.3d 1441 (2016)

The agency determined applicant (now deceased) was not eligible for Medicaid for nursing facility, because the Appellant transferred assets valued at $26,000.00 for less than fair market value, imposing a 3.04-month penalty. Applicant appealed, and the Commissioner of New York State Department of Health affirmed. Applicant petitioned for judicial review.

The record shows that applicant was in her 90s and living independently. In 2009 and 2010 she transferred $26,000.00 to her daughter for use by her grandson (a military veteran with small children and a service related disability) to purchase a home and make repairs. After the transfer, applicant retained approximately $200,000.00 in assets. In 2011 applicant broke her right femur and moved to an assisted living facility. Later that year she fractured her pelvis and entered a nursing home for

what was expected to be a temporary stay. Due to complications, she remained there. Applicant paid for the cost of her care with her own assets until June 2012 when she applied for Medicaid.

The substantial evidence in this case supports the claim that transfers where gifts to applicant's grandson for the purchase of a house and repairs, which were substantially more than the amount contributed by the applicant. While applicant had some health conditions, it wasn't until her fall in 2011 that she needed nursing home care. Transfers were made several years prior to the need for nursing home care, she retained large sums of assets and was able to live independently until then. The substantial evidence in this case adequately rebuts the presumption that transfer were made for the purpose of qualifying for Medicaid.

Therefore, respondent was directed to provide retroactive Medicaid benefits for a period of 3.04 months.

TRACK 8
Practice Management and E-Filing in Surrogate's Court: The New Frontier

Presented By:
Kathleen D. Krauza, Esq.
Joseph A. Shifflett, Esq.
Linda Stravalaci Grear, Esq.

New York State Bar Association
Elder Law and Special Needs Law Section
Summer Meeting

July 12 - 14, 2018

"Practice Management and E-Filing in Surrogate's Court: The New Frontier"

July 13, 2018

Kathleen D. Krauza, Esq.
Chief Clerk
Erie County Surrogate's Court
kkrauza@nycourts.gov

Joseph A. Shifflett, Esq.
Chief Court Attorney
Erie County Surrogate's Court
jshiffle@nycourts.gov

"Practice Management and E-Filing in Surrogate's Court: The New Frontier"

Table of Contents

I. E-Filing in Surrogate's Court

II. Electronic Discovery

(I)

E-FILING IN SURROGATE'S COURT

E-FILE

Electronic Filing
in the New York State Courts

2018

Report of the Chief Administrative Judge
to the Legislature, the Governor, and the
Chief Judge of the State of New York

"Technology is critical to our efforts to enhance the efficiency and productivity of court operations, as well as to improve our service to the public. E-filing is the centerpiece of these efforts. It reduces costs and saves time for both the court system and litigants, improves access to the courts, and sharply reduces the environmental impact of litigation. E-filing is the future of our court system, and we must expand, thoughtfully and carefully, but also diligently, the use of this powerful tool."

Janet DiFiore

Chief Judge Janet DiFiore
Chief Judge of the State of New York

I. Executive Summary

The New York State Courts Electronic Filing System ("NYSCEF") continues to make significant advances and to show itself to be both reliable and effective. A significant milestone was achieved in 2016 – the e-filing of one million cases since e-filing was first authorized in New York, a number that has since grown to more than 1.6 million cases. 2017 saw another important milestone – more than 100,000 registered users of NYSCEF, a number that will continue to grow as attorneys and others become familiar with the ease of e-filing and its many advantages. Yet another major milestone will soon be reached – after years of experience in the trial courts, e-filing will shortly debut in the appellate courts, with pilot programs in each of the four Departments of the Appellate Division beginning in the first quarter of 2018.

This steady expansion reflects a growing recognition of the many benefits of e-filing:

Convenience. A case can be commenced and subsequent documents can be filed with the court and served on opposing parties via NYSCEF from any place with Internet access at any time on any day, even when the courthouse is closed. E-filing makes case files accessible online to counsel of record at any time and anywhere and allows counsel immediate access to newly-filed papers.

Efficiency and Productivity. E-filing streamlines the mechanics of litigation. The system provides immediate e-mail notification and delivery of all filings, including court orders, judgments, and decisions, which are available online. In addition, the system automatically serves papers on all participating parties and thereby relieves attorneys and litigants of this burden.

Cost. E-filing offers significant cost savings to attorneys, litigants, County Clerks and the courts. For attorneys and litigants, it eliminates the cost of serving hard-copy papers on opposing parties. For attorneys, the courts, and County Clerks, it sharply reduces record storage and retrieval costs.

Environment. E-filing is a green initiative that not only saves vast quantities of paper each year but also sharply reduces the need to travel for the purpose of serving, filing, or retrieving papers.

E-filing is one of the most successful projects, and certainly one of the most important, ever undertaken by the New York State Unified Court System ("UCS"). E-filing is transforming very much for the better the way attorneys conduct litigation and the way the courts and County Clerk offices operate. More transformation is on the horizon.

Section II reports on the current status of the e-filing program, highlights recent progress, and sets out our plans for the future. Among other things, we outline the continued expansion of e-filing in Supreme Court and Surrogate's Court; report on efforts to bring an up-to-date case management system integrated with NYSCEF to the Supreme Court, thus achieving improvements in efficiency and labor savings for the courts and the County Clerks; set forth the plan for the imminent introduction of e-filing in the Appellate Division, thus achieving integrated e-filing in trial courts and on appeal; and summarize the status of our efforts to introduce e-filing in criminal and Family Court cases. We also describe our ongoing training and outreach efforts, and the work of the NYSCEF Resource Center.

Section III summarizes comments and suggestions about e-filing received from County Clerks, bar associations, not-for-profit entities, government agencies and other groups, individual attorneys, and members of the public, as well as our responses thereto.

Section IV sets forth the court system's proposal for legislative changes. After significant legislative reform in 2015, further major modifications are not sought at this time. There are, however, two respects in which current legislative scheme can and should be improved:

- Removal of statutory provisions that deny to the Chief Administrative Judge the authority to require attorneys to e-file in matrimonial, residential foreclosure, and consumer credit cases; and
- Extension of the September 1, 2019 sunset currently in place for the authorization for e-filing in criminal and Family Court cases.

OCA will submit to the 2018 Legislature a legislative proposal to accomplish these ends. This limited proposal (Appendix A) will improve the efficiency and effectiveness of the e-filing program, reduce some of the complexity that currently affects it, and facilitate our ongoing efforts to move the New York courts into the digital future.

ERIE COUNTY SURROGATE'S COURT
TIPS AND TOPICS FOR E-FILING
June 1, 2018

I. Essential Step Prior To E-Filing Input

Prior to inputting any information to an initial file, an inquiry should be run on the Decedent's Last Name, using the first initial to determine if a file is already open. Due to the numbering system at Surrogate's Court, an inquiry based on the file number alone may not produce accurate results.

II. Original Input of Case Information

1. An error in inputting the original case information can significantly delay the proceeding as any changes with respect to the original input cannot be made locally, but must be done at the Statewide level.

2. Case name must be entered as follows and in the order listed below:
   a. Initial entry must be identical to the signature on the Will;
   b. If the name on the death certificate is different, that becomes an "a/k/a";
   c. If the name on the Will does not match the signature, that also becomes an "a/k/a";
   d. No punctuation or spaces should be used when entering the name or the a/k/a (i.e. Mc Carthy should be input as McCarthy).

3. Most common errors
   a. Spelling
   b. Improper entry of date of death

4. Once you input a proceeding, initially, do not e-file subsequent documents until you receive a file number. Failure to do so will result in the creation of a secondary proceeding and will delay processing of your petition.

III. Other Information

1. Failure to file accurate or correct documents delays the proceeding and requires filing of amendments:

   a. Review documentation
      (1) Scanned documents should be previewed on your computer before they are sent to the Court to make sure that they scanned properly and are legible.
      (2) Documents should be scanned right side up as the Court Processor cannot correct the view of the scan.
      (3) If submitting an attorney certified death certificate, the attorney signed certification should appear on the back of the death certificate. The front and back of the death certificate should then be scanned to the court.
      (4) If the death certificate is not legible when scanned it is suggested to print the scanned death certificate and then rescan.

2. Like documents must be scanned together, for example:
   a. Waivers (except Waiver of funeral home)
   b. Releases
   c. Notices of Probate
   d. Proofs of Service

3. The order of filing the documents does not matter to the Court.

4. If the drop-down box does not have the name of the document you are looking for with respect to the proceeding you are filing, i.e. if you are filing a release prior to settlement, use the "Other Document" and explain this in the Comments Box.

5. Request for Surrogate's Court Action (see attached forms)
   a. A new Request for Surrogate's Court Action form must be completed with each filing. Do not re-use your original Request for Surrogate's Court Action. Prepare a new one for each filing with comments pertaining to what is being requested.
   b. Do not submit a blank Request for Surrogate's Court Action.

6. Credit Cards and Document Return
   a. Make sure credit limit is large enough to cover anticipated filings for at least one (1) month.
   b. To ensure rapid return of requested documents, Surrogate's Court will keep your pre-paid self-addressed envelopes on file and, when filing your Request for Surrogate's Court Action, you should indicate that the item should be returned to you in the self-addressed envelopes located at the court. If self-addressed stamped envelopes are not provided, the court will place the documents into the attorney pick-up drawer located at the main desk.
   c. There are two ways of paying for e-filing:
      1. **Pay with your credit card on e-file website**. Input credit card information directly on website. You must insert information with each filing.
      2. **Pay at court**. You may pay by attorney or estate check, cash, money order or credit card at the court. When paying at court by mailing the payment, note prominently in your cover letter that the proceeding has been e-filed, or include a copy of the NYSCEF filing receipt.

7. General
   a. Failure to make payment - the court cannot process the filing.
   b. Failure to file original Will or original or attorney certified death certificate - the court may process, but the court will not take action, i.e. granting Lettters, etc. If an attorney certified death certificate (front and back) is scanned to the court, it is not necessary for an original death certificate to be filed with the original Will.
   c. Note that there is a **drop-off bin** at the front desk for e-filed documents including original Wills, death certificates and checks.
   d. Guardian ad Litem.
      Consent, Oath & Designation must be e-filed. Reports can be e-filed.
   e. <u>When attorneys e-file, they are responsible to have the ORIGINAL DOCUMENTS in their possession.</u>

(Effective 5/1/17)

REQUEST FOR SURROGATE'S COURT ACTION

NAME OF MATTER:_____ FILE NO.: (If assigned): _____

NATURE OF PROCEEDING

[ ] **Administration**
- [ ] Temporary Letters are being sought
- [ ] Citation required
- [ ] Objection to Administration

[ ] **Probate**
- [ ] Preliminary Letters are being sought
- [ ] Citation required
- [ ] Objection to Probate

[ ] **Voluntary Administration**
- [ ] Number of Certificates requested: _____

[ ] **Accounting Proceeding**
- [ ] Estate [ ] Citation required
- [ ] Testamentary Trust [ ] Citation required
- [ ] Inter Vivos Trust [ ] Citation required

[ ] **Construction Proceeding** [ ] Citation required
[ ] **Advice and Direction** [ ] Citation required
[ ] **Answer or Objection** (other than to Probate or Administration)
[ ] **Appointment of successor fiduciary**
[ ] **Proceeding to compel accounting**
[ ] **Proceeding to continue a business**
[ ] **Proceeding to open a safe deposit box**
[ ] **Discovery Proceeding**
[ ] **Proceeding to determine the right of election**
[ ] **Application of fiduciary to resign**
[ ] **Proceeding to compel the production of a Will**
[ ] **Other:**

[ ] **Check[ ] or Cash[ ] Authorization to Use Credit Card on File [ ]**
In the amount of _____ applied as follow:
Filing fee _____ Certified Copies _____
Certificates_____ Other_____

Date: _____
Filed by Name _____
Address _____
Telephone No. _____
Email _____

Method of contact/return
[ ]telephone [ ]email [ ]SASE [ ]pickup

(Effective 5/1/17)

REQUEST FOR SURROGATE'S COURT ACTION

NAME OF MATTER:_____ FILE NO.: (If assigned): _____

NON PROCEEDING RELIEF

[ ] Reissue of Short forms - Letters Testamentary Number_____
[ ] Reissue of Short forms - Letters of Administration Number_____
[ ] Reissue of Short forms - Letters Trusteeship Number_____
[ ] Reissue of Short forms - other Number_____
describe: _____

[ ] Search of safekeeping for Will on file
Most recent address of decedent _____
_____

Prior addresses of decedent _____
_____
_____

[ ] Certification of documents
Describe the document(s) to be certified:_____
[ ] Exemplification of documents
Describe the document(s) to be exemplified:_____

[ ] Disclaimer and Renunciation
[ ] Right of Election
[ ] Inventory of Assets
[ ] Informal Closing
[ ] Releases
[ ] Other:_____

[ ] **Check[ ] or Cash[ ] Authorization to Use Credit Card on File [ ]**
In the amount of _____ applied as follow:
Filing fee _____ Certified Copies _____
Certificates_____ Other_____

Date: _____

Filed by Name _____
Address _____
Telephone No. _____
Email _____

Method of contact/return
[ ]telephone [ ]email [ ]SASE [ ]pickup

CREDIT CARD AUTHORIZATION
ERIE COUNTY SURROGATE'S COURT
92 FRANKLIN STREET
BUFFALO, NEW YORK 14202

HON. ACEA M. MOSEY
SURROGATE JUDGE

PHONE: 716-845-2560
FAX: 716-845-2700
EMAIL: Erie-Surrogate@nycourts.gov

DATE:_____, 20__

CARDHOLDER NAME:_____ PHONE: (__) _____

ADDRESS:_____

FILE NAME :_____ FILE NO :_____

New York State Surrogate's Courts will only accept VISA or MasterCard credit card payments. Use of credit or debit card payments requires the submission of an authorization signed by the payee or a duly authorized representative of the payee organization; no telephone credit card transactions can be accepted, except by fax to the court's dedicated fax number or by email to the court's dedicated email address set forth above. To do so, complete the credit card authorization below and submit this entire form.

Check as appropriate:

Credit or Debit Card* (Check One): VISA___ MasterCard___

Credit or Debit Cardholder: _____
Print Clearly - Exactly as appears on card

Credit or Debit Card Number: _____

CV2 Code: _____ Expiration Date: _____

*Debit Cards without the VISA or MasterCard Logo will NOT be accepted. Debit cards with the VISA or MasterCard logo will be processed as a credit card.

I hereby pay the fee amount(s) as set by Section 2402 of the Surrogate's Court Procedure Act or the CPLR and authorize payment thereof via the above-noted credit/debit card.

CHECK ONE
( ) I authorize the use of this credit card for all fees in connection with the above-captioned estate, guardianship or other proceeding.
( ) I authorize the use of this credit card for this transaction only in the amount of $ _____.

Cardholder Signature: _____ Date: _____

Credit/Debit card transactions rejected by your bank for failure to submit all required information will result in return charge of $20 which will be added to the outstanding balance.

ADMINISTRATIVE ORDER OF THE CHIEF ADMINISTRATIVE JUDGE OF THE COURTS

Pursuant to the authority vested in me, and in consultation with the Presiding Justices of the Appellate Divisions, upon notice by the Presiding Judge of the Court of Claims, and, as appropriate, in consultation with or with the approval of County Clerks, I hereby establish, continue, or give notice of, programs for the voluntary and mandatory use of electronic means for the filing and service of documents ("e-filing") in the manner authorized pursuant to L. 1999, c. 367, as amended by L. 2009, c. 416, L. 2010, c. 528, L. 2011, c. 543, L. 2012, c. 184, L. 2013, c. 113, L. 2015, c. 237 and L. 2017, c. 99 in the counties, courts, and cases in effect as of the date of this Order or upon the effective dates set forth in Appendix A (e-filing matters) attached hereto. Such programs shall be subject to sections 202.5-b, 202.5-bb, 206.5, 206.5-aa, 207.4-a, 207.4-aa, and 208.4-a of the Uniform Rules for the New York State Trial Courts, as well as the rules relating to matrimonial matters in Appendix B. This Order is effective May 23, 2018, and supersedes AO/116/18.

Chief Administrative Judge of the Courts

Dated: May 22, 2018

AO/192/18

APPENDIX A
E-FILING MATTERS
(Commenced on or after May 23, 2018)

SURROGATE'S COURT

Broome Cortland Dutchess Orange Orleans Queens Tompkins	**Consensual/Voluntary:** • probate and administration proceedings • miscellaneous proceedings relating thereto • such other types of proceedings as the court may permit **Mandatory:** None

SURROGATE'S COURT

Albany Allegany Cattaraugus Cayuga Chautauqua Erie Franklin Genesee Jefferson Livingston Monroe Montgomery Niagara Oneida Onondaga Ontario Orleans Oswego Schenectady Seneca Steuben Suffolk Ulster Warren Wayne Westchester Wyoming Yates	**Consensual/Voluntary:** • such types of proceedings as the court may permit **Mandatory:** • probate and administration proceedings • miscellaneous proceedings relating thereto

* For cases commenced prior to May 23, 2018, see AO/243/08, AO/244/08, AO/371/09, AO/395/10, AO/396/10, AO/507/10, AO/376/11, AO/468/11, AO/527/11, AO/529/11, AO/530/11, AO/531/11, AO/235/12, AO/236/12, AO/237/12, AO/238/12, AO/245/12, AO/112/13, AO/173/13, AO/222/13, AO/029/14, AO/64/14, AO/210/14, AO/049/15, AO/058/15, AO/194/15, AO/10/16, AO/79/16, AO/151/16, AO/224/16, AO/24/17, AO/84/17, AO/170A/17, and AO/116/18; see also, administrative orders of the Court of Claims dated 12/31/02 and 6/3/13 (www.nycourts.gov/efile).

22 NYCRR § 207.64

This document reflects those changes received from the NY Bill Drafting Commission through May 18, 2018

New York Codes, Rules, and Regulations > TITLE 22. JUDICIARY > SUBTITLE A. JUDICIAL ADMINISTRATION > CHAPTER II. UNIFORM RULES FOR THE NEW YORK STATE TRIAL COURTS > PART 207. UNIFORM RULES FOR THE SURROGATE'S COURT

§ 207.64 Omission or redaction of confidential personal information; public access to certain filings

(a) Omission or Redaction of Confidential Personal Information.

(1) Except as otherwise provided by rule or law or court order, and whether or not a sealing order is or has been sought, the parties shall omit or redact confidential personal information in papers submitted to the court for filing. For purposes of this rule, confidential personal information ("CPI") means:

(i)the taxpayer identification number of an individual or an entity, including a social security number, an employer identification number, and an individual taxpayer identification number, except the last four digits thereof; and

(ii)other than in a proceeding under Article 13 of the SCPA, a financial account number, including a credit and/or debit card number, a bank account number, an investment account number, and/or an insurance account number, except the last four digits or letters thereof.

(2) The court sua sponte or on motion by any person may order a party to remove CPI from papers or to resubmit a paper with such information redacted; order the clerk to seal the papers or a portion thereof containing CPI in accordance with the requirement of *22 NYCRR section 216.1* that any sealing be no broader than necessary to protect the CPI; for good cause permit the inclusion of CPI in papers; order a party to file an unredacted copy under seal for in camera review; or determine that information in a particular action is not confidential. The court shall consider the pro se status of any party in granting relief pursuant to this provision.

(3) Where a person submitting a paper to a court for filing believes in good faith that the inclusion of the full CPI described in Paragraph (1) of this subdivision is material and necessary to the adjudication of the proceeding before the court, he or she may apply to the court for leave to serve and file, together with a paper in which such information has been set forth in abbreviated form, a confidential affidavit or affirmation setting forth the same information in unabbreviated form, appropriately referenced to the page or pages of the paper at which the abbreviated form appears.

(4) When served with objections or a request for an inquiry or examination under *SCPA 2211* or *1404* that specifies a request for particular unredacted documents previously filed in the proceeding with respect to which the objection or request for inquiry or examination relates, the party who originally served and filed the redacted document shall serve (but not file) an unredacted version upon all parties interested in the proceeding or such portion of it to which the objection or request for inquiry or examination relates.

(b) Public Access to Certain Filings. The officers, clerks and employees of the court shall not permit a copy of any of the following documents to be viewed or taken by any other person than a party to the proceeding, or the attorney or counsel to a party to the proceeding, the Public Administrator or counsel thereto, counsel for any Federal, State or local governmental agency, or court personnel, or by order of the court or written permission of the Surrogate or Chief Clerk of the court. The standard for the grant of such permission in a contested matter shall be the same as required under *22 NYCRR 216.1* and applicable law:

(1) All papers and documents in proceedings instituted pursuant to Articles 17 or 17-A of the SCPA;

(2) Death certificates;

(3) Tax returns;

(4) Firearms Inventory; and

(5) Documents containing information protected from disclosure under other provisions of Federal or State law such as HIPAA for medical information, job protected services reports, material obtained from a state mental hygiene facility under *MHL 33.13*, and records involving alcohol or other substance abuse under *42 CFR 2.64*. These examples are not intended to be exclusive. This rule shall not preclude disclosure or copying of any index of filings maintained by the court.

Any determination by the court regarding access to any filings may be the subject of an appropriate motion for clarification or reconsideration.

Statutory Authority

Section statutory authority:

Surrogate's Court Procedure, § A13.Section statutory authority: *Surrogate's Court Procedure, § 2211*.Section statutory authority: *Surrogate's Court Procedure, § 1404*.Section statutory authority: Surrogate's Court Procedure, § A17.Section statutory authority: Surrogate's Court Procedure, § A17-A.Section statutory authority: *Mental Hygiene Law, § 33.13*

History

Added 207.64 on 3/19/14.Amended 207.64(effective 03, 01, 16) on 2/03/16.

NEW YORK CODES, RULES AND REGULATIONS

End of Document

(II)

ELECTRONIC DISCOVERY

1. Discovery Generally

- CPLR 3101 (a)

  -- "There shall be full disclosure of all matter material and necessary in the prosecution or defense of an action, regardless of the burden of proof".

- *Forman v. Henkin*, 30 NY3d 656 [2018]

  -- the terms "material and necessary" must be interpreted liberally to require disclosure, upon request, of any facts bearing on the controversy which will assist in the preparation for trial. "The test is one of usefulness and reason" (*Allen v. Crowell-Collier Publ. Co.*, 21 NY2d 403, 406 [1968]).

  -- in *Forman*, the Court of Appeals was dealing with a request to access the social media records of an injured plaintiff. The test to be applied is relevancy to the issues in the case, with the Court not allowing a wholesale "fishing expedition".

- *Hacksaw v. Mercy Med. Ctr.*, 139 AD3d 798 [2016]

  "'. . . unlimited disclosure is not mandated, and the court may deny, limit, condition, or regulate the use of any disclosure device to prevent unreasonable annoyance, expense, embarrassment, disadvantage, or other prejudice to any person or the courts' (*Diaz v. City of New York*, 117 AD3d [777,777]; see CPLR 3103[a]; *Berkowitz v. 29 Woodmere Blvd. Owners', Inc.*, 135 AD3d 798, 799). 'The supervision of disclosure and the setting of reasonable terms and conditions therefor rests within the sound discretion of the trial court . . .' (*Berkowitz v. 29 Woodmere Blvd. Owners', Inc.*, 135 AD3d at 799 [internal quotation marks omitted]; see *Gould v. Decolator*, 131 AD3d [445, 447])" (at 799-800).

- *Matter of Nugent*, 26 AD3d 892 [2006]

  -- in contested probate proceeding, Court must ensure that disclosure being sought is relevant to the actual issues involved. Thus, the Court properly granted "limited disclosure of proponent's financial records. These records may be relevant on the issue of undue influence" (at 893). However, where Will proponent had not put her "medical condition in controversy, nor has she otherwise waived the physician-patient privilege" (at 893), her medical records or information are not discoverable. "The issue in this case is the testamentary capacity of decedent", not the medical condition of the Will proponent.

- *Matter of Hoffenberg*, 2014 NY Slip Op 33429U [dec. Dec. 19, 2014, Surrogate's Court, Nassau County]

  -- "Discovery of documents is permitted even if they are not admissible in evidence, provided that the production of such documents may lead to disclosure of admissible evidence (*Fell v. Presbyterian Hospital in New York at Columbia-Presbyterian Med. Ctr.*, 98 AD2d 624, 625 [1983])" *(see also Carrillo v. Brown,* 2017 NY Slip Op 32321U [dec. Oct. 19, 2017]).

2. Electronically Stored Information [ESI]

- Uniform Civil Rules for Supreme and County Courts
  §202.12 [22 NYCRR 202.12] ["Preliminary Conference"]

  -- subd (b) sets out how to handle a case which is "reasonably likely to include electronic discovery", and subd (c) sets guidelines for dealing with, and preservation of, such possible material.

- *Irwin v. Onondaga Cty. Resource Recovery Agency*, 72 AD3d 314 [2010]

  -- decision discusses types of ESI potentially discoverable by obtaining computer records or by forensic examination of a computer hard drive, pointing out that "nearly 'every electronic document contains metadata'" (at 319);

  -- "substantive metadata" "is useful in showing the genesis of a particular document and the history of proposed revisions or changes" (at 321);

  -- "System metadata reflects automatically generated information about the creation or revision of a document, such as the document's author, or the date and time of its creation or modification. System metadata is not necessarily embedded in the document, but can be obtained from the operating system or information management system on which the document was created . . . [S]ystem metadata is most relevant if a document's authenticity is at issue, or there are questions as to who received a document or when it was received" (at 321);

  -- "Embedded metadata is data that is inputted into a file by its creators or users, but that cannot be seen in the document's display. Common types of embedded metadata include the formulas used to create spreadsheets, hidden columns, references, fields, or internally or externally linked files. Embedded metadata is often critical to understanding complex spreadsheets which lack an explanation

of the formulas underlying the output in each cell" (at 321).

- *Encore I, Inc. v. Kabcenell*, 2016 NY Slip Op 32282U [dec. Nov. 4, 2016, Supreme Court, New York County]

  -- e-mails relating to issues in a case can be the subject of a production order, and, in an appropriate case, the Court can direct that a computer be "searched" by a computer forensic expert for such e-mails. If a Court does so, it will set appropriate guidelines to govern such analysis.

- *Tener v. Cremer*, 89 AD3d 75 [2011]

  -- In a defamation action, plaintiff contended that a search of a medical center's computers was needed in order to establish who had sent out the allegedly defamatory e-mail. Even though there were hundreds of possible users of the computers in question, and even though information stored on the computers might be "deleted" in "normal business operations", the Appellate Division, First Department, pointed out that (a) relevant information might still be recoverable through forensic analysis, and (b) that plaintiff had no other way to prove her case. However, the Court said a hearing was required to look at <u>all</u> the relevant factors that would go into a decision whether to order such a forensic analysis, including a "cost-benefit" analysis.

3. <u>*Matter of Nunz* [Erie County Surrogate Court File #2012-4075/A]</u>

- *Matter of Nunz*, 53 Misc 3d 483 [2015]

  -- in probate proceeding, objectant sought forensic examination of attorney-draftsperson's computer, noting that (a) attorney-draftsperson had stated that he deleted the Will draft from computer after downloading it, and (b) there was an apparent "discrepancy" between the first and subsequent pages of the Will. Objectants said they had "a guy who thinks he can restore the hard drive and retrieve almost all of it." Finding that the application for ESI from the subject computer was proper on its face and that a forensic examination "may" provide information relevant to objectants' claims, the Court nevertheless deferred decision pending further affidavit material (a) from the prospective forensic computer examiner, and (b) the other parties. The Court also directed that the attorney-draftsperson "shall ensure that the computer on which he drafted decedent's 2012 Will at issue here is preserved and is not removed, replaced or destroyed, pending the further Order of this Court."

- *Matter of Nunz*, 52 Misc 3d 1216A [2016]

  -- following submission of additional information required by *Matter of Nunz*, 53 Misc 3d 483 [2015], the Court had ordered an evidentiary hearing on whether the requested forensic examination should be granted. This decision, following that hearing, reviewed the hearing testimony from the proposed forensic computer expert, concluded that there was a proper basis to order the requested forensic examination to try to recover ESI about the draft of decedent's Will, set out certain terms for a protocol to be followed in that examination, and set the matter down for a "protocol conference" to work out all such terms and conditions.

- *Matter of Nunz*, decided September 20, 2016

  -- Court established a detailed Protocol for the forensic examination of the attorney-draftsperson's computer.

- David Paul Horowitz, *I [Gotta] Guy [for That]*, New York State Bar Association *Journal* [November/December 2016]

- David Paul Horowitz, *What's The Guy Gonna Do?*, New York State Bar Association *Journal* [February 2017]

STATE OF NEW YORK
SURROGATE'S COURT: COUNTY OF ERIE

In the Matter of the Estate of

WILLIAM R. NUNZ, SR.,
Deceased.

File No. 2012-4075/A

JOHN RICHARD STREB, ESQ.
Attorney for Preliminary Executor Mary Jane Nunz

MICHAEL O. MORSE, ESQ.
Attorney for Objectants William Nunz, Jr., Michael Nunz, Kathleen Danheiser, and Tambra Nunz

SHELBY BAKSHI & WHITE
Attorneys for Estate of Wendy Fecher
Justin S. White, Esq., of Counsel

DEBORAH A. BENEDICT
Appearing *Pro Se*

KEITH D. PERLA, ESQ.
Appearing *Pro Se*

MEMORANDUM AND ORDER

BARBARA HOWE, J.

This is a probate proceeding in which decedent's surviving spouse is seeking to admit decedent's Last Will and Testament, dated August 17, 2012, to probate. Four of decedent's children [referred to herein as the Morse objectants] by his first wife have filed objections to probate, and discovery have been on-going.

As part of that discovery, the Morse objectants have requested that the computer on which the Will was drafted by non-party Keith D. Perla, Esq. [hereafter,

Perla] be forensically examined for ESI [electronically stored information] with respect to the Will drafting. They proposed that D4, LLC [hereafter, D4], a firm based in Rochester, New York, conduct that examination. The estate opposed production but, by decision dated August 9, 2016, I granted the Morse objectants' request and then set the matter down for a pretrial conference to establish a Protocol to be followed in the examination process.

At the pretrial conference, the estate and the Morse objectants submitted separate Protocol proposals, some of which were ultimately agreed upon, with the balance left for this Court's determination. Attached hereto and made part hereof is the Protocol to be followed for the forensic examination of Perla's computer. The Protocol constitutes the order of this Court with respect to all the matters contained herein.

This Court, in establishing the Protocol to be followed by D4 in conducting the forensic examination of Perla's computer, has been guided by the unresolved proposed protocols submitted by petitioner and by the Morse objectants. This Court has also been guided by the September 15, 2015 affidavit of D4 Vice-President John Clingerman [hereafter, Clingerman], who principally will be conducting the forensic examination, as well as by Clingerman's April 20, 2016 testimony about the prospective examination issues.

The parties and D4 should understand clearly that the strict non-disclosure provisions in the Protocol are designed to ensure that no possibly

confidential information on Perla's computer is disclosed without the written authorization of this Court. The parameters I set out in my August 9, 2016 Memorandum and Order are also designed with that concern and consideration in mind.

With respect to the costs of this forensic examination, that shall be borne entirely by the Morse objectants seeking such examination, and shall be paid as required by D4's normal billing. However, at the conclusion of the within probate proceeding, the Morse objectants may make an application for possible allocation of such costs, on notice to all interested parties.

Finally, I direct that, upon receipt of this decision, counsel for the Morse objectants seeking the forensic examination of Perla's computer shall send a copy of (1) this decision, with attached Protocol, and (2) this Court's August 9, 2016 Memorandum and Order, to D4. Counsel shall also send a copy of its cover letter to D4, but without the enclosures, to this Court, to opposing counsel, to non-party Keith D. Perla, Esq., and to Deborah A. Benedict.

This decision shall constitute the Order of this Court and no other or further order shall be required.

DATED: BUFFALO, NEW YORK
September 20, 2016

HON. BARBARA HOWE
Surrogate Judge

APPENDIX A

PROTOCOL FOR EXAMINATION OF A COMPUTER OF NON-PARTY KEITH D. PERLA, ESQ., WITH RESPECT TO LAST WILL AND TESTAMENT OF WILLIAM R NUNZ, SR., DATED AUGUST 17, 2012

This Protocol is intended to set forth the procedure for the examination of the computer of non-party Keith D. Perla, Esq. [hereafter, Perla] for the purpose of retrieving any drafts of a Will for William R. Nunz, Sr. The examination is to be conducted by D4, LLC [hereafter, D4], a company hired by Michael O. Morse, Esq., who is attorney for the objectants seeking this examination. A copy of the Will of William R. Nunz, Sr. dated 8/17/12 which has been offered for probate is attached hereto.

1. The computer owned by Perla and used by him in the preparation of the 2012 Last Will and Testament of the within decedent shall be picked up by D4 from Perla at Perla's offices - - 7350 Quaker Road, Orchard Park, New York, 14127 [1-716-870-5683] [keithperla@verizon.net] - - at a date and time to be arranged by D4 directly with Perla, but on or before October 3, 2016.
2. D4 shall, upon receipt of Perla's computer, clone the hard drive within two business days of receiving it, and shall, within two business days thereafter, return the computer to Perla with the original hard drive intact and the computer unaltered.

3. D4 shall use a write-blocking device to ensure that the data on Perla's original hard drive is not altered in any way in the imaging process.

4. Following D4's receipt of Perla's computer, D4 shall not communicate about this forensic examination in any manner whatsoever with any of the parties to this proceeding, or with their attorneys [John Richard Streb, Esq., Michael O. Morse, Esq., or Justin S. White, Esq.], or with Perla, or with anyone else other than this Court, except that D4 may communicate with Perla for the purpose of returning his computer to him.

5. The D4 employees involved with this forensic examination project may communicate with each other, but D4 shall ensure that any and all communications about its findings and what, if anything, it has retrieved from the cloned hard drive shall be made directly and only to this Court by confidential correspondence only.

6. Any D4 employee involved in this project is hereby precluded, as well as being precluded by this Court's Memorandum and Order dated August 9, 2016, from disclosing any of D4's analysis, findings, or conclusions to any person or entity except to this Court or exept as may otherwise be authorized in writing by this Court.

7. D4 shall not examine any files on the cloned hard drive which would not likely lead to the discovery of evidence related to the Will in question. In

the event D4 inadvertently begins to examine any such unrelated information, D4 shall immediately cease examination of that file.

8. Any examination of the cloned hard drive shall be conducted on a closed system, that is, a system not connected to the internet.

9. D4 shall search the cloned hard drive for the following terms:

    (1) Nunz

    (2) Danheiser

    (3) Benedict

    (4) Tambra

    (5) Fecher

    (6) stepdaughter

    (7) Burke

    (8) stepson

    (9) Schatzel

10. Upon conclusion of its analysis, which shall be completed on or before November 1, 2016, and which will be delivered in confidential written report form directly and only to this Court, D4 shall also deliver to this Court, for safekeeping, the cloned hard drive after D4's review of same, and D4 shall certify to this Court that no other copies have been made of the hard drive or any of its contents. D4's report to this Court shall be marked "**CONFIDENTIAL TO ERIE COUNTY SURROGATE**

JUDGE BARBARA HOWE ONLY - - TO BE SEALED BY THE COURT", at the head of the report, and the outside of the envelope transmitting the report to the Court shall also be so marked.

11. Upon this Court's receipt of the report and findings of D4, this Court will print those documents and mail them directly and **only** to Perla. Perla shall then have 14 days to object to disclosure of any such ESI by notifying this Court that he is objecting, and his reasons for objecting. Any such objections should identify the document at issue and set forth the privilege or other legally cognizable reason for the objection. The objections should be submitted to the Court with copies of the objections provided to counsel for the parties and to Deborah Benedict (who is proceeding *pro se*).

    Thereafter, counsel for the parties and Deborah Benedict shall have fourteen (14) days to respond to the objections. This Court then shall rule on any objections made by Perla and deliver or otherwise make available to counsel those documents which are discoverable.

12. D4 shall produce any ESI it finds in a Portable Document Format [PDF] [that is, a standard image format capable of being viewed and printed on standard computer systems], and screenshots of metadata.

13. D4 shall, in its report, specify the format it used to image data -- such as, for example, E01 format -- and the software used to analyze any data, and

any other tools used in the cloning and examination of Perla's computer hard drive.

14. Any report by D4 shall document with sufficient detail the steps undertaken by D4 with respect to its examination and findings so that an independent third-party could replicate the same process. Any forensic images relied upon by D4 shall be specified and available for copying by a third-party.

15. D4 shall maintain a complete and documented chain of custody for all data it collects.

BY DAVID PAUL HOROWITZ

DAVID PAUL HOROWITZ (david@newyorkpractice.org) is a member of Geringer, McNamara & Horowitz in New York City. He has represented parties in personal injury, professional negligence, and commercial cases for over 26 years. In addition to his litigation practice, he acts as a private arbitrator, mediator and discovery referee, and is now affiliated with JAMS. He is the author of *Bender's New York Evidence* and *New York Civil Disclosure* (LexisNexis), as well as the most recent supplement to *Fisch on New York Evidence* (Lond Publications). Mr. Horowitz teaches New York Practice at Columbia Law School and lectured on that topic, on behalf of the New York State Board of Bar Examiners, to candidates for the July 2016 bar exam. He serves as an expert witness and is a frequent lecturer and writer on civil practice, evidence, ethics, and alternative dispute resolution issues. He serves on the Office of Court Administration's Civil Practice Advisory Committee, is active in a number of bar associations, and served as Reporter to the New York Pattern Jury Instruction (P.J.I.) Committee.

"I [Gotta] Guy [for That]"

Introduction

By now we are all acquainted with the concept of retrieving deleted material from a computer or other storage device, and understand that very often deleted material can be recovered, in whole or in part. At the same time, electronic disclosure issues continue to bedevil lawyers, and constantly test the limits of our admittedly limited technical knowledge. As a result, both the bench and bar rely more and more on the advice, and guidance, of "experts" (yes, as I am typing this I am making the air quotes[1] gesture).

We are also familiar with the term "forensic," when used in conjunction with examining, cloning, and recovering files and other data from a computer or other electronic storage device. So, for example, where a court directs that one party deliver to another a "clone" (copy) of a hard drive, a forensic computer expert will duplicate that hard drive so that the clone is an exact copy, and so that nothing is altered on the original drive. The same type of expert can examine a hard drive and determine if, and when, alterations were made to the data stored on the device and, in the case of deleted files, make efforts to recover the deleted data.

When the computer being examined belongs, for example, to the attorney draftsman of a will, additional considerations come into play, most significantly the protection of privileged and confidential information on the computer. It also matters that the attorney is a non-party to the proceeding. A recent decision by Surrogate Barbara Howe, Erie County, in *In re Nunz*,[2] (*Nunz* II) addressed the issues that arise in just this scenario, and built upon a prior decision in the same proceeding (*Nunz* I).

Nunz II

In *Nunz* II, a will was offered for probate by the nominated executrix, objections were filed by children of the decedent, and the objectants to the will sought, *inter alia*, forensic analysis of the computer of the attorney who prepared the will offered for probate.

The attorney draftsman (and witness) to the will furnished an affidavit to the court wherein he stated:

> that he had "prepared the will using a Microsoft Word for Mac word processing program on an Apple IMAC computer," that he had "*deleted the digital file* [he] had created in preparing the will *immediately after* printing *a copy of the will*," and that "*any computer files or other materials* relating to the preparation of this will which were *created and/or stored in electronic or digital format have been destroyed or no longer exist*" (emphasis added by court).[3]

In response to the affidavit, the objectants sought

> production of the computer used by [the attorney] in preparing decedent's Will, and [] electronically stored information [ESI] from the computer about the draft of the Will by means of forensic analysis. The estate has opposed production and forensic analysis of the computer, and has requested, *inter alia*, that this Court grant a protective order.[4]

The court ordered that the attorney "shall ensure that the computer on which he drafted decedent's 2012 Will at issue here is preserved and is not removed, replaced or destroyed pending the further Order of this Court."[5]

Thereafter, the attorney draftsman testified at a hearing about his use of the computer used to prepare the will at issue:

> Q. With regard to the computer at issue, has that been the computer you have done your legal work on since the day you did –
>
> A. Yes.
>
> Q. – this will?
>
> A. Yes.
>
> Q. Did you use any other computer?
>
> A. I might have. I mean, I might have used other computers, sure.

Q. All right. Could you characterize – and I understand it would only be a percentage estimate –
A. Well, 95 percent of my stuff is on that computer.
Q. Okay. For the time period –
A. Of the hundreds of clients I have, yes.
Q. Okay. From –
A. And all my personal information and personal photos, yes.

* * *

A. No, no, the computer, I haven't used the computer since the order when they said not to use it and the machine has not been functioning well. It's in the closet and I'm using another computer 'cause it's just very old and it doesn't operate correctly. And then I got nervous I couldn't fix it. If I had gone and fixed it, you know – I didn't fix it, but it's still sitting at my home.
Q. Where is the physical location of the computer, in your home?
A. It's in my office in my home.
Q. Okay. And that's the address you gave –
A. Yep.
Q. – on Quaker Street? Thank you. And is the computer functioning at the present time?
A. I – the last time I operated it, it had a question mark on it and I didn't know what that meant and I made some calls and they said, you have to bring it in, and then the order came down. I said, I'm not touching this computer.
Q. Okay. So the time the computer stopped functioning was in and around the time the order came out?
A. A month – month either way, yeah.

Nunz I

Surrogate Howe's 2015 decision in *Nunz I*[6] detailed the initial proposal by objectants' counsel (Morse) for a forensic examination of the draftsman's (Perla) computer.

On May 19, 2015, Morse served an additional subpoena duces tecum upon Perla, seeking production of the Apple iMac computer he used in preparing the decedent's will. In his cover letter to Perla, Morse wrote:

> All I am looking for in this subpoena is the Apple iMac computer you told me about in connection with preparing Bill Nunz' will. *While you informed me that you deleted the file, I have a guy who thinks he can restore the hard drive and retrieve almost all of it.*
> *I imagine that you have concerns over confidentiality for your other clients as their work is likely to be on that computer as well. I proposed that my computer tech guy can operate under a non-disclosure order. When he restores the hard drive, we can simply do a search for all files containing the word Nunz.* You should be able to identify any that deal exclusively with Mary Jane. The remaining files would then be relevant and ultimately, *we may be able to locate the digital file used to create the will.* We can do all of this at the courthouse or any other agreed upon location (emphasis added).[7]

Not surprisingly, the court expressed hesitancy about ordering a forensic analysis of the attorney's computer by the "guy:"

> Given the complexity of e-discovery issues, something more is required from the Morse objectants than their attorney's assertions that a forensic examination of Perla's computer "*should be able* to generate an exact unsigned paper copy of the purported will" (emphasis added), and that such an examination will reveal "metadata describing the document's creation, modification and last access date" (footnote omitted).
> More to the point, given the potential for harm in the forensic examination process, I am not prepared to allow any e-discovery request predicated on the assertion that counsel "*ha[s] a guy who thinks* he can restore the hard drive and retrieve almost all of it" (emphasis added). Similarly, I am not prepared to allow indiscriminate access to an attorney's computer where there *may* be attorney-client privilege issues involved, or unrelated confidential information on it, based on the mere assertion by Morse that "*[his] computer tech guy* can operate under a non-disclosure order" (emphasis added). These are sensitive issues, and they need to be carefully explored and resolved *first* before any forensic examination of the computer is permitted.[8]

Electronic disclosure issues continue to bedevil lawyers.

The court directed that Morse furnish the following information about the "guy:"

> (1) the expert's name, address, qualifications and credentials;
> (2) the expert's opinion regarding the ability to retrieve the relevant ESI from Perla's computer, including, if being sought, what type of metadata is at issue (using the definitions set out in the *Irwin* decision, *supra*);
> (3) how long the process ESI discovery and examination of Perla's computer would take to complete, whether it can be done at Perla's office, or whether some other approach or place is either necessary *or desirable*;
> (4) what exactly the expert would need to accomplish the data retrieval; and
> (5) how the expert proposes to identify and protect ESI on Perla's computer which may be subject to the attorney-client privilege or to other confidentiality considerations;
> (6) what the expert proposes with respect to the considerations set

out in the *Commercial Division, Nassau County Guidelines for Discovery of Electronically Stored Information (ESI)*, section C, items 3, 5, 6, 8, 9, 11, 13, and 15 (available online at www.nycourts.gov/courts/comdiv/PDFs/Nassau-E-Filing-Guidelines.pdf).[9]

Finally, the court, while holding in abeyance a determination in the objectants' request for relief pending the exchange of information concerning the proposed forensic expert, directed that Perla "ensure that the computer on which he drafted decedent's 2012 Will at issue here is preserved and is not removed, replaced or destroyed, pending the further Order of this Court."[10]

Conclusion

Following the exchange of the requested information, Surrogate Howe, in her 2016 decision, reviewed the "guy['s]" qualifications, together with the detailed proposal for conducting the forensic examination, all of which will be revealed in the January 2017 column.

Until then, have a Happy Thanksgiving, Holiday Season, and New Year! ■

1. A gesture with raised pairs of fingers, when making a statement, to simulate quotation marks. It indicates that what is being said is ironic or otherwise not to be taken verbatim, see https://www.italki.com/question/87547.
2. 2016 N.Y. Slip Op. 51185(U), 52 Misc. 3d 1216(A) (Sur. Ct., Erie Co.).
3. *Id.*
4. *Id.*
5. *Id.*
6. 2015 N.Y. Slip Op. 05462, 36 N.Y.S.3d 346 (Sur. Ct., Erie Co.).
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*

BY DAVID PAUL HOROWITZ

DAVID PAUL HOROWITZ (david@newyorkpractice.org) is a member of Geringer, McNamara & Horowitz in New York City. He has represented parties in personal injury, professional negligence, and commercial cases for over 26 years. In addition to his litigation practice, he acts as a private arbitrator, mediator and discovery referee, and is now affiliated with JAMS. He is the author of *Bender's New York Evidence* and *New York Civil Disclosure* (LexisNexis), as well as the most recent supplement to *Fisch on New York Evidence* (Lond Publications). Mr. Horowitz teaches New York Practice at Columbia Law School and lectured on that topic, on behalf of the New York State Board of Bar Examiners, to candidates for the July 2016 bar exam. He serves as an expert witness and is a frequent lecturer and writer on civil practice, evidence, ethics, and alternative dispute resolution issues. He serves on the Office of Court Administration's Civil Practice Advisory Committee, is active in a number of bar associations, and served as Reporter to the New York Pattern Jury Instruction (P.J.I.) Committee.

"What's the Guy Gonna Do?"

Introduction

This month's column returns, as promised, to the subject of forensic computer examinations, with a follow-up column to November/December 2016's "I Gotta Guy For That." That column discussed two decisions in *In re Nunz*, a will contest where the objectants to a will sought a forensic examination of the hard drive of the drafting attorney's computer in response to the drafter's affidavit testimony that he

> "[P]repared the will using a Microsoft Word for Mac word processing program on an Apple IMAC computer," that he had *"deleted the digital file* [he] had created in preparing the will *immediately after printing a copy of the will,"* and that *"any computer files or other materials* relating to the preparation of this will which were *created and/or stored in electronic or digital format have been destroyed or no longer exist"* (emphasis added).

In her first decision,[1] Surrogate Howe held in abeyance a determination on the objectants' request for relief pending the exchange of information concerning the proposed forensic expert's examination of the subject computer.[2] Following the exchange of the relevant information, an evidentiary hearing was conducted, on consent, before the Chief Attorney of the Court, on a "hear and report" basis.[3]

Portions of the transcript of the hearing follow, and provide a useful roadmap for attorneys questioning witnesses on this subject.

Testimony of the Objectants' Computer Forensic Expert

Following the testimony of the attorney draftsman, John Clingerman, the objectants' forensic computer expert, testified at the evidentiary hearing. Based upon his preliminary testimony, Surrogate Howe determined that Clingerman qualified as an expert on the subject matter at issue. Thereafter, Clingerman described how the computer hard drive would be cloned:

> **Q.** Could you explain step by step what's involved in a computer forensics examination of an Apple iMac computer approximately ten years old?
>
> **A.** Typically what is involved would be, for any forensic analysis, is to *remove the hard drive from the computer. That original hard drive that's in the computer is then write protected so it is connected to a hardware device to prevent the forensic person from making any changes whatsoever to that original hard drive. And then from there the data is* pulled out of that hard drive – or I should say *copied over to another destination piece of media. That destination piece of media is always sterilized ahead of time* so it is full of zeros and it has absolutely no data on it whatever. So *at the end of the process, what we get as the end result on that destination media is an exact replica of the original piece of media.*
>
> **Q.** When you make that copy, what danger is there to the originating computer? Is there any danger of damage?
>
> **A.** No. Everything that we do is forensically sound and it's fully defensible (emphasis added).
>
> * * *
>
> **Q.** The actual storage of a hard drive, the cloned hard drive, where would you put it?
>
> **A.** We have a secure evidence room. While it's under examination, it's in our secure forensic laboratory in Rochester. Very limited access to that room.

Clingerman next testified about the search of the cloned hard drive:

> **Q.** And you have observed the will, the purported will in this case?
>
> **A.** I have.
>
> **Q.** And you understand it's a three-page will and that there's a difference with the first page as opposed to the other two, correct?
>
> **A.** That's what I was told, yes.
>
> **Q.** Okay. But you did see the will, is that correct?
>
> **A.** Yes.
>
> **Q.** All right. *Now, how do you propose to conduct an investigation that would help us to determine what happened to that will and whether it was actually created on the date Mr. Perla said, whether there are other versions of the will or any other useful information* based upon both your experience with D4 and your law enforcement background?
>
> **A.** Quite specifically, *we would make a forensic image of the hard drive of that computer. We would then* take that forensic image, *load it into a software forensic tool and*

we would conduct examination by doing a couple of very specific things. So it's my understanding that this will was originally in a Microsoft Word document. *So I would look in the unallocated space of the computer and I would look for Microsoft Word type of documents. I would also run or execute very specific search terms against that area of the hard drive as well to see if we can find fragments of a deleted file* (emphasis added).

Clingerman was questioned about the limitations of utilizing very specific search terms:

Q. When Mr. Morse asked you what search terms you would use, *you suggested that perhaps ten search terms might be appropriate for this particular project.* Do you know – and the only specific you gave us was the word Nunz, N-u-n-z. Is it your understanding that the only file with the name Nunz in it on Mr. Perla's computer is the file regarding William R. Nunz, Sr.?

A. I have no idea.

Q. *Did Mr. Morse ever inform you, either by his own communication or by documents, that Mr. Perla has indicated that on his computer he also has files of many other Nunz family members, including William R. Nunz, Jr., Mary Jane Nunz, Michael Nunz and William R. Nunz, Sr.* – Jr.s' son. Has he ever told you that?

A. *I don't recall that being any of our conversations.*

Q. I'm so sorry, sir. The affidavit of Keith Perla's that you do recall receiving at one point, is that Exhibit 3 or Exhibit 4?

MR. SHIFFLETT: It's the earlier exhibit, Mr. Streb. It's the earlier.

MR. STREB: Thank you. *Would you agree then, sir, assuming hypothetically that there are many other files regarding other Nunz family members on Mr. Perla's computer, would you agree that using the search term Nunz will bring up those files as well if they can still be recovered on the hard drive?*

MR. MORSE: Objection. Nobody testified to those facts before the Court.

MR. SHIFFLETT: It's a hypothetical to an expert. Overruled.

A. *Certainly.*

Q. Okay. And *would you agree then that that* – we're going to get into the confidentiality issues in a moment, but would you agree then that that is going to pose an issue in terms of confidentiality, that *if you do recover some document fragments, you may be recovering document fragments for, say, a will for another Nunz family member or a DWI case for another family member or other sensitive matter, would you agree?*

A. *Yes.*

Q. *And would you agree that if you use the word will, w-i-1-1, that could also pose different possibilities*? For example, would you agree that if you find the word will, that we've now seen the ASCII binary code equivalent of, that that could reference a text that says the Last Will and Testament. Would you agree that's one possibility?

A. *Yes.*

Q. *Would you agree that it could also call up a person's name Will?*

A. *Yes.*

Q. For example, there's a William R. Nunz, Sr. and a Jr. Would you agree?

A. It would certainly find Will.

Q. *Would it also potentially call up phrases that say, "I will say" or "They will call you"?*

A. *Yes.*

Q. *So again, there's a potential here, a very serious potential, that you could be, when you try to do this analysis, looking at completely unrelated confidential files, correct?*

A. *Yes* (emphasis added).

Clingerman was questioned about who would be involved in the examination of the cloned drive:

A. Initially I would be doing the examination, but when it comes to digital forensics, we pride ourselves, industry standard, to do a peer review of our activities to ensure that we're doing everything correctly, we haven't missed something, in essence leaving no stone unturned.

Q. How many other people would be involved?

A. I would say probably one other person.

Q. So when you use the word team, you're just referring to one other person?

A. I have another person that works in the office next to me. My manager is in Chicago and I would discuss my findings with him, as I do all the time and the person who works in my office is a junior member of my team who I will frequently share results or investigative processes with him.

Q. So we've got at least three people that would be having access to Mr. Perla's computer, you, a junior member and your manager?

A. We could do it that way (emphasis added).

Clingerman next testified about how his findings would be reported:

MR. SHIFFLETT: All right. Mr. Morse, before I turn to you for redirect, Mr. Clingerman, what ultimately happens to the cloned hard drive?

THE WITNESS: Anything that the client wants to have happen to it. So when a case is resolved, we give the clients a choice and there are actually several choices. We can maintain possession of the cloned hard drives in our evidence vault until whenever they want to have something else occur to it. We can ship that to the client. We can ship it to a third party at their direction. We can have it physically destroyed if they want or we can wipe the hard drive, which means fill it full of zeros and purpose it for another day. So those are the choices.

MR. SHIFFLETT: And the client in this case would be Mr. Morse, as you understand where you are at this point in these proceedings?

THE WITNESS: Yes, he is my client, but *in a situation like this, we can be directed by the Court*, we can – you know, opposings could have an agreement. *You know, we can do whatever we're instructed to do.*

MR. SHIFFLETT: I understand. I just wanted to know what your normal procedure is. *What happens if, in your search of the cloned hard drive, you find no relevant document, as relevancy is defined for you?*

THE WITNESS: *Whatever we find or don't find gets reported.* You know, we're an unbiased third party. *We do our search and we provide the findings.*

MR. SHIFFLETT: *And you write a report, is that how it's done?*

THE WITNESS: It's always done differently. *It all depends on what protocol is agreed to between the parties, such as, you know, protocol would consist of search terms and the processes post examination. I mean, the protocol could address how, where, when we're going to do a forensic image, what we're gonna do with it afterwards and how the examination would be conducted, how we report our findings and who we report our findings to and then, you know, in what format and then ultimately what happens to the clone. So it can all be spelled out* (emphasis added).

Finally, Clingerman elaborated on the concept of, and need for, a well-defined protocol before proceeding:

A. Confidential protocol is the process that we're going to undertake and we have – it's basically rules of engagement and it's determined by the attorneys that are on each side of the matter, so together they devise a plan that we're going to work under and we follow that protocol.

Q. The confidential protocols in – so you're expecting a confidential protocol to be developed for this particular case?

A. Well, are we talking about protocol or are we talking about, say, the process of nondisclosure? Because which – I'm thinking that's maybe what I'm hearing. So when it comes to the protocol of nondisclosure, again, when we are engaged with clients, sometimes they request of us a very specific nondisclosure agreement, that either they can use our documentation or we can use theirs so – and the protocol may say who we can disclose things to and who we cannot (emphasis added).

Decision of the Court

Following the hearing, there were a number of issues for the court to decide.

First, the court determined that there was a proper basis to order production of the computer.[4] Second, the court determined that a forensic analysis could be performed properly by Clingerman's "team."

More problematic was selecting the protocol to be followed during the forensic examination:

> Some aspects of the protocol are easier to determine than others, but what is clear is (a) that the parties have never attempted to resolve these issues, and (b) that, left on their own, the parties seem unlikely to come to accord on the protocol. However, without a clear protocol in place, the process will be pointless.

To preserve confidentiality, the court ordered:

> (1) Perla's computer shall be delivered to D4 *either by* Perla himself or by the estate attorney, as they shall determine, at a date, time and place to be agreed upon directly with Clingerman, and neither the Morse objectants nor their attorney shall have any part in that turnover process, except that such objectants' attorney shall be notified by the estate attorney immediately after the turnover has taken place;
>
> (2) Once Perla's hard drive has been cloned, D4 shall ensure the immediate return of the computer itself to whomever D4 had received it from;
>
> (3) After it has received Perla's computer, D4 shall not communicate in any manner whatsoever either with the Morse objectants, or with their attorney, or with Perla or with the attorney for this estate (except to return the computer), or with anyone else except the three D4 employees involved with the project, and D4 shall direct any and all communications, including any reports about its findings, *directly and only* to this Court, by confidential correspondence only;
>
> (4) Any D4 employee who is involved in this project shall give written assurance that he or she shall abide by the directions herein, and by any further protocol established for this project hereafter, and shall not disclose any of D4's analysis, findings or conclusions except as may otherwise be authorized in writing by this Court;
>
> (5) Once D4's report and findings have been transmitted in confidential form to this Court, I will issue whatever further Order is appropriate and necessary regarding disclosure (or not) of all or any part of the contents thereof.

Notwithstanding the court's observation about the lack of cooperation among the parties, the court ordered that the remaining protocol issues be worked out by counsel for the parties:

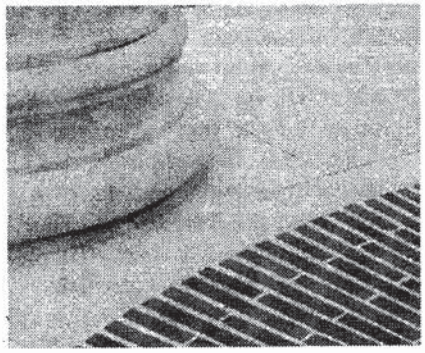
> I direct that counsel shall confer with each other and shall thereafter appear for a "protocol conference" with the Chief Attorney of this Court on *Wednesday, September 14, 2016, at 11:00 a.m.* At that conference, counsel should have with them proposed written protocols which can either by incorporated into a further Order to be issued by the undersigned on consent, or which can be tendered to the undersigned for review, consideration and determination. Counsel should reflect on the guidelines referred to in *Tener v. Cremer* (citation omitted), and should refer particularly to the Guidelines for Discovery of Electronically Stored Information [ESI] of the Nassau County Supreme Court Commercial Division. Counsel may also wish to consult with Clingerman prior to the protocol conference about any and all outstanding protocol issues that will be important to include in whatever Order I subsequently issue.

Conclusion

It is often difficult to locate sample transcripts to serve as a guide when questioning witnesses on an unfamiliar or novel subject, and this decision offers,

CONTINUED ON PAGE 51

BY LUKAS M. HOROWITZ



LUKAS M. HOROWITZ, Albany Law School Class of 2019, graduated from Hobart William Smith in 2014 with a B.A. in history and a minor in political science and Russian area studies. Following graduation, he worked for two years as a legal assistant at Gibson, McAskill & Crosby, LLP, in Buffalo, New York, and with the New York Academy of Trial Lawyers hosting CLE programs. Lukas can be reached at Lukas.horowitz@gmail.com.

Alphabet Soup

Alas, he still has a pulse! My first law school semester is officially in the record books. The three week-long finals period of the semester was interesting, to say the least, in much the same way that having dinner with Hannibal Lecter can be called interesting. Very trying at times but, overall, worthwhile and beneficial.

I didn't realize until I sat down to review the first semester's work just how much information had been covered, and how much knowledge I had acquired. The written material was a critical component, but not the only source of information. As I studied, I began to appreciate and understand how my professors had synthesized the entirety of the material we covered, and I realized I had been afforded the opportunity to acquire a deep and meaningful understanding of that material.

It felt as though at the beginning of the semester I was given various paints and pigments, brushes, and a canvas, and no instructions. As the semester progressed, what began with simple stick figures and finger painting gradually took form on the canvas, so that by the end of the semester I could produce a recognizable landscape. While my final grades made it clear the landscape was not a masterpiece, I know my parents will hang it up on their refrigerator.

I heard a lot about "thinking like a lawyer," and spent the better part of the semester certain I was definitely not thinking like a lawyer. However, by the end of the semester I was shocked to discover that I was able to carry on a legal conversation with my peers, thinking like a lawyer, and without ending every sentence with, "I think."

I left school after the first semester in good spirits, and hopeful. I embarked on a 12-day trip to Israel, an experience that not only met, but vastly exceeded, my expectations. From the Golan Heights in northern Israel to the Old City of Jerusalem, there was never a dull moment, a sentiment no doubt shared by "Big Bertha," the camel I rode while visiting a Bedouin camp.

With the holiday vibes dimming and my jetlag dissipating, I realigned my focus as the second semester of law school began. With torts and federal civil procedure behind me, I am taking on two new subjects: constitutional law and criminal law. Three weeks into the second semester and the wheels in my brain are beginning to spin again. Since I have been back at school, I have noticed a broadening of the areas of law that aroused my interest. Prior to law school, I had always told myself that criminal law was something I would avoid. I had always worked on the civil side of law in the past. To be honest, I had just never considered criminal law as an area I would be intrigued by. However, the cases that we have read thus far, though few in number, have held my attention more than any other type of case covered in my first semester. Proof that you really can't judge a book (or an area of law, for that matter) by its cover. I look forward to plunging further into criminal law as the semester progresses. Constitutional law has also caught my attention. Prior to class, the interpretation of the Constitution appeared to be straightforward. This is what the Constitution says, apply it literally, and you're done. Oh, how wrong I was! Looking at the Constitution through the lens my professor has provided in classroom lectures has changed my understanding of the word "interpretation." I am excited to view this historic document through a new pair of eyes. I know I will be surprised, and challenged, by what I learn this semester.

So, what you really want to know is how I did my first semester. As a child, there was nothing I loved more than alphabet soup. Enough said. ■

BURDEN OF PROOF
CONTINUED FROM PAGE 20

at the very least, a jumping off point for crafting a deposition or trial outline.

February provides many distractions, what with Valentine's Day, Washington's Birthday, Lincoln's Birthday, and my personal favorite, Groundhog Day. Nonetheless, for those of you involved in ESI issues, try and carve out a little time on one of these holidays and study *Nunz* and the guidelines referenced in the decision. And if you do so on Groundhog Day, review the material at least two times. ■

1. 53 Misc. 3d 483, 36 N.Y.S.3d 346 (Sur. Ct., Erie Co. 2015).

2. The same Order directed "that the computer on which he drafted decedent's 2012 will at issue here is preserved and is not removed, replaced or destroyed, pending the further Order of this Court."

3. The parties waived the filing of a written referee report and consented that the court could decide the issues on the record before it, pursuant to SCPA 506(6)(c).

4. The court noted "[a]lthough Clingerman was not in a position to state with *certainty* that anything relevant could be recovered due to various unknown factors, he pointedly observed: 'All things considered, I still – I don't know whether or not it's possible. I mean, it's always poss – *we have to look. Until we look, we don't know*'" (emphasis added).

Plenary Session
Recognizing the Legal Implications of Cultural Differences

Presented By:
Danielle Pelfrey Duryea
Veronica Escobar, Esq.
Pauline Yeung-Ha

The Latino Elderly In New York, An Introduction for Elder Law Attorneys: What you should know about the fastest growing group in the United States

by Veronica Escobar

This submission, written by a first-generation Latina attorney, gives an overview of the cultural and immigrant issues among Latinos which affect the delivery of services by elder law attorneys. [1]

LATINO DEMOGRAPHICS

What is a Latino? The term "Latino" refers to a person who was either born in or can claim descendance from Latin America: it is defined by geography. A Latino can be of any race, ancestry, ethnicity or religion, and can also speak a language other than Spanish (i.e Brazilians speak Portuguese and Haitians speak Creole). The term "Hispanic" refers to a person who was either born in or can claim descendance from a Spanish speaking country: it is defined by language.

For the purposes of this article we will use the term "Latino" to refer to a Spanish speaking person of Latin American descent.

Latinos, including the aging, are a growing population in the United States. According to the most recently available statistics released in 2014 by the Administration on Aging (an agency within the U.S. Department of Health and Human Services), the over the age of 65 Hispanic/Latino population numbered

[1]This article is to be published in the Summer 2018 edition of the Section's "The Elder Law and Special Needs Law Journal"

approximately 3.6 million in 2014 [2] and is projected to grow to approximately 21.5 million (to 22%) by 2060.[3]

Latinos comprised approximately 8% of the older population in the country in 2014.[4] In 2013, approximately 70% of the nation's older Latino population lived in four states; New York ranked fourth with 290,030 residents.[5]

This same year, 2013, approximately 66.4% of the total *general* New York Latino population resided in the five boroughs of New York City[6] while 13.1% resided on Long Island (Nassau and Suffolk Counties)[7]. Close to 81%, or 2,830,813 of the Latino population of the state resided in the five boroughs and Long Island. The remaining 19% of the Latino population resided in the upstate counties. [8]

[2] Administration for Community Living: A Statistical Profile of Older Hispanic Americans (2014)
https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/Statistical-Profile-Older-Hispanic-Ameri.pdf
(age 65 and over) These statistics originated from the U.S. Census Bureau and were made available the same year.
[3] Id.
[4] Id.
[5] Id.
[6]Bronx County *available at* http://www.pewhispanic.org/states/county/36005/
Richmond County at http://www.pewhispanic.org/states/county/36085/
(Richmond)
Queens County *available at* http://www.pewhispanic.org/states/county/36081/
Kings County *available at* http://www.pewhispanic.org/states/county/36047/
New York County *available at* http://www.pewhispanic.org/states/county/36061/
[7] Nassau County *available at* http://www.pewhispanic.org/states/county/36059/
(Nassau County)
Suffolk County *available at* http://www.pewhispanic.org/states/county/36103/
(Suffolk County)
[8] The below is not an exhaustive list of all of the state's counties:
Westchester County *available at*
http://www.pewhispanic.org/states/county/36119/
214, 087 or 22% of county population

Unfortunately, there are no available statistics offering further details about the numbers of Latino elderly living in the boroughs of New York City. But information released in New York City's 2010 census revealed that approximately 38.2% of New York State's *general* sixty and over population resided in New York City [9] and represented 17.2% of the city's population. [10]

In 2014 statistics, 21%of New York State's Latino population spoke only English at home[11]; while 79% spoke a language other than English.[12] Thirty nine percent of

Orange County *available at* http://www.pewhispanic.org/states/county/36071/
69,166 18% of county population
Monroe County *available at* http://www.pewhispanic.org/states/county/36055/
55,805 or 7% of county population
Rockland County *available at* http://www.pewhispanic.org/states/county/36087/
50, 686 or 16% of county population
Erie County *available at* http://www.pewhispanic.org/states/county/36029/
43,364 or 5% of county population
Dutchess County *available at* http://www.pewhispanic.org/states/county/36027/
32,136 or 11% of county population
Ulster County *available at* http://www.pewhispanic.org/states/county/36111/
16,372 or 9% of the county population

[9] Census 2010: Changes in the Elderly Population of New York City: 2000 to 2010 http://www.nyc.gov/html/dfta/downloads/pdf/demographic/elderly_population_070912.pdf

[10] Census 2010: Changes in the Elderly Population of New York City: 2000 to 2010 http://www.nyc.gov/html/dfta/downloads/pdf/demographic/elderly_population_070912.pdf *See also* United States Census Bureau for state wide older population for New York http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

[11] Demographic Profiles of Hispanics in New York, 2014 http://www.pewhispanic.org/states/state/ny/ (717,OOO people)

[12] Id. at Demographic Profiles of Hispanics in New York, 2014 http://www.pewhispanic.org/states/state/ny/ (2,646,000 people)

the New York Latino population was foreign born and their median age forty two, [13] compared to the 61% U.S. born with a median age of 22. [14]

Seventy four percent, the majority of Latinos in the United States, are citizens. [15] The New York statistics closely mirror those seen nationally as to citizenship. [16]

In terms of the undocumented population, although precise numbers can't be calculated, March 2010 statistics place that number at approximately 3.7% of the total Latino *and* Non-Latino United States population and 28% of the total foreign-born population.[17] In the year 2012, of the top fifteen states with the largest undocumented population, New York State ranked fourth. [18]New York's share of the

[13] Id. Demograpic Profiles of Hispanics in New York, 2014http://www.pewhispanic.org/states/state/ny/

[14] Id. at Demographic Profiles of Hispanics in New York, 2014 http://www.pewhispanic.org/states/state/ny/

[15] American Bar Association, Commission on Hispanic Rights and Responsibilities: *Latinos in the United States Overcoming Legal Obstacles, Engaging in Civic Life* at 9 http://www.americanbar.org/content/dam/aba/images/commission_on_hispanic_legal_rights_responsibilities/hispanicreportnew.pdf

[16] American Bar Association, Commission on Hispanic Rights and Responsibilities: *Latinos in the United States Overcoming Legal Obstacles, Engaging in Civic Life* at 9 http://www.americanbar.org/content/dam/aba/images/commission_on_hispanic_legal_rights_responsibilities/hispanicreportnew.pdf 62.9% U.S. Born; 37.1% Foreign Born. Of the foreign born population, approximately 26.2% are non citizens.

[17] American Bar Association, Commission on Hispanic Rights and Responsibilities: *Latinos in the United States Overcoming Legal Obstacles, Engaging in Civic Life* at 10 http://www.americanbar.org/content/dam/aba/images/commission_on_hispanic_legal_rights_responsibilities/hispanicreportnew.pdf

[18] See Pew Research Center, Unauthorized Immigrant Totals Rise in 7 States, Fall in 14, Ch. 1: State Unauthorized Immigrant Populations

undocumented population in 2012 was approximately 750,000 (or 8.2% of the total in those top fifteen states) . [19] In 2012, approximately 79% of the national unauthorized immigrant population was Latino. [20]

LATINO ATTORNEY DEMOGRAPHICS

When looking inward at our profession, statistics reflect that it is not racially or ethnically diverse. In fact, it is the least diverse profession in the United States. [21] Approximately 85% of the legal profession is white non-Latino. [22] Latinos comprise five percent of the legal profession nationwide. [23] In 2017, the total lawyer

http://www.pewhispanic.org/2014/11/18/chapter-1-state-unauthorized-immigrant-populations/ at Table 11. (Nov. 18, 2014)

[19] See Pew Research Center, Unauthorized Immigrant Totals Rise in 7 States, Fall in 14, Ch. 1: State Unauthorized Immigrant Populations http://www.pewhispanic.org/2014/11/18/chapter-1-state-unauthorized-immigrant-populations/ at Table 11. (Nov. 18, 2014)

[20] American Bar Association, Commission on Hispanic Rights and Responsibilities: *Latinos in the United States Overcoming Legal Obstacles, Engaging in Civic Life* at 10 http://www.americanbar.org/content/dam/aba/images/commission_on_hispanic_legal_rights_responsibilities/hispanicreportnew.pdf *See also* See Pew Research Center, Unauthorized Immigrant Totals Rise in 7 States, Fall in 14, Ch. 2: Birthplaces of U.S. Unauthorized Immigrants http://www.pewhispanic.org/2014/11/18/chapter-2-birthplaces-of-u-s-unauthorized-immigrants/
See also Unauthorized Immigrants: Length of Residency, Patterns of Parenthood http://www.pewhispanic.org/files/2011/12/Unauthorized-Characteristics.pdf

[21] The Washington Post, Law is the Least Diverse Profession in the Nation. And lawyers aren't doing enough to change that. (May 27, 2015) https://www.washingtonpost.com/posteverything/wp/2015/05/27/law-is-the-least-diverse-profession-in-the-nation-and-lawyers-arent-doing-enough-to-change-that/

[22] The Washington Post, Law is the Least Diverse Profession in the Nation. And lawyers aren't doing enough to change that. (May 27, 2015) https://www.washingtonpost.com/posteverything/wp/2015/05/27/law-is-the-least-diverse-profession-in-the-nation-and-lawyers-arent-doing-enough-to-change-that/ See generally ABA National Lawyer Population Survey

population in New York was 177,035. [24] For comparison, the 2016 figure was 175, 195.[25] The last publicly available statistic, from the year 2000, put the number of Latino attorneys in New York State at 3100; of that 2378 were located in New York City. [26] In a more recent NALP survey of New York City based law firms, approximately 5.14% or _626 Latinos (both male and female) were associates (out of a total associate pool of 12,172).[27] Latinas comprised approximately a little under half of that 5.14% (2.46%) of New York City based associates. [28] In that same year there were only 162 (2.48%) Latino partners (0.67% of that 2.48% were Latinas), out of a total of 586 (8.97%) minority partners, which was out of a total of

10-Year Trend in Lawyer Demographics (2017)
https://www.americanbar.org/content/dam/aba/administrative/market_research/national-lawyer-population-10-year-demographics-revised.authcheckdam.pdf

[23] See generally ABA National Lawyer Population Survey
10-Year Trend in Lawyer Demographics
https://www.americanbar.org/content/dam/aba/administrative/market_research/national-lawyer-population-10-year-demographics-revised.authcheckdam.pdf

[24] See ABA National Lawyer Population Survey
Lawyer Population by State, 2017
https://www.americanbar.org/content/dam/aba/administrative/market_research/National%20Lawyer%20Population%20by%20State%202017.authcheckdam.pdf

[25] Id.
[26] Report of the New York State Bar Association Committee on Minorities in the Profession: Miles to Go in New York: Measuring Racial and Ethnic Diversity Among New York Lawyers" at p. 6 Table 3.
[27] National Association of Law Placement, Inc. (NALP), 2017 Report on Diversity in U.S. Law Firms
https://www.nalp.org/uploads/2017NALPReportonDiversityinUSLawFirms.pdf
[28] Id. at Table 6. Associate Demographics at Law Firms — 2017

6534 partners city wide.[29] New York City Law firm attorneys amounted to approximately 12. 27% of attorneys statewide in 2017. [30]

This is the backdrop for the provision of legal services to a predominantly Spanish speaking Latino population in New York.

BEST PRACTICE STUDIES

Studies in related professions can offer us insight into best practices. A 2014 financial study entitled "The Hispanic American Experience," offers valuable feedback about the Latino community and their interaction with service providers who, like us, work on sensitive issues.[31] One thousand and twenty- three households participated[32], and it reported on the financial planning and readiness of Latinos.

Participants indicated that the primary barriers to accessing services were lack of trust of service providers and lack of understanding of the financial products and services.[33] Based on this study, Latinos are half as likely than the general

[29] Id. at Table 5. Partner Demographics at Law Firms — 2017
[30] ABA National Lawyer Survey 10-Year Trend in Lawyer Population by State https://www.americanbar.org/content/dam/aba/administrative/market_research/National%20Lawyer%20Population%20by%20State%202007-2017.authcheckdam.pdf

[31] The Hispanic American Financial Experience (2014) *available at* http://www.prudential.com/media/managed/hispanic_en/prudential_hafe_researchstudy_2014_en.pdf?src=Newsroom&pg=HAFEen_PDF at 1
[32] Id. at 1

[33] Id. at 2; see also page 15

population to have a financial advisor and are "significantly" less likely to have been contacted by a financial advisor- regardless of their income level. [34]

In the author's opinion the failure to be contacted is significant. Even more telling was that these same respondents stated they were likely to work with an advisor -if *contacted* (emphasis added).[35] The study also showed that the Latinos surveyed largely receive information or advice about finances from informal networks like family, friends, their local bank and the media (television, radio and social media).[36] This same study found that the language spoken at home strongly influenced preferred professional providers. [37] Among those who spoke Spanish only or predominantly at home, half preferred a bilingual financial advisor [38] and 49% percent also indicated that having information written materials in their native language was important. [39] The latter is indicative of the need for more multilingual professionals and for accessible information in the areas of law as well.

EFFECTS OF DEMOGRAPHICS ON QUALITY OF LONG-TERM CARE

There are other studies specifically focusing on issues of aging, Latino elderly, and their long-term care. These reflect similar results as the financial study- with

[34] Id.
[35] Id. at 3
[36] Id. at 15, see Figure 12
[37] Id. at 16
[38] Id. at 16

[39] Id.

language, cultural competency as well as access to resources as the most important factors.

How many Latinos live in nursing homes in New York State? According to statistics from the Kaiser Family Foundation for 2014 (the latest year available), Latinos comprised 8.6%, or approximately 9313, of nursing home residents in the state.[40] The total number of nursing residents in the state at the time was approximately 108, 291. [41]

According to a Center for Disease Control Study on long term care released in 2016 and looking at the years 2013-2014, it found Latinos were represented in adult day care programs at 20.3% nationally, while they only accounted for 7.7%, 5% and 5.5% of home health agency clients, nursing home and hospice residents, respectively. [42] They accounted for a mere 2.2% of assisted living residents. [43] Why is this important? There is existing literature that discusses the lesser quality of care Latinos receive in nursing homes.

[40] Distribution of Nursing Home Residents by Race/Ethnicity (2015). https://www.kff.org/other/state-indicator/distribution-of-nursing-facility-residents-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[41] Id.

[42] Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers, 2013-2014, http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf

[43] Id. See also Figure 24.

A 2010 study, which looked at the years 2000 to 2005, found that while Latinos use long term care services less frequently, they have a greater rate of disability than non-Latinos. [44] It also correctly stated that differences exist among the different Latino groups with regard to immigration patterns, education and income levels and these could account for disparities in long term care usage. [45] The results painted a picture of a group that is not homogeneous, but overall is receiving lower quality care in nursing homes compared to those where the majority of residents are white non-Latino. The study looked at disparities in nursing home performance, by assessing nursing home deficiencies, staffing levels, and financial viability. [46] There were three nursing home categories: 1) those with no Latino residents, 2) those with a maximum of 15% Latino residents; and 3) those with 15% or more Latino residents.[47] The study found that the percentage of white non-Latino residents declined, while the percentage of Latinos increased, from 5% in 2000 to 6.4% in 2005.[48] The study found that the percentage of Medicaid supported residents in nursing homes with more than 15% Latino residents was 30% higher than in those

[44] Elderly Hispanics More Likely To Reside in Poor Quality Nursing Homes- Heal Aff 2010 (29(1) pg. 2
[45] Id. at 2

[46] Id. at 2 (of note, financial viability looks at percentage of private pay residents; occupancy rate and percentage of Medicaid residents. The higher percentage of private pay means the facility is more financially viable).

[47] Id. at 5

[48] Id. at 4 (for white non Latinos, 82.7% in 2000 to 79.4% in 2005).

with fewer Latinos and more than 60% higher in all white homes. [49] Perhaps not coincidentally, elderly Latinos are more likely to reside in poor performing nursing homes than white non-Latino elderly.[50]

The authors of this study acknowledged that they could not account for differences in patterns among the different Latino groups. [51] There were also geographic differences, and this made it difficult to determine whether ethnicity or geography influenced the patterns. [52] Another factor is the varying migration patterns among the Latino groups; the time it occurred in history or their age at time of migration;[53] i.e. older Cuban Americans are more likely to be long-term US residents compared to their Mexican counterparts. This may be advantageous to the former in accessing higher quality nursing homes. [54]

The authors further noted that they did not address the confounding variable of nursing home care quality with access to resources. [55] However, they did find that the more Medicaid dependent a nursing home is, the less likely it is to have access to

[49] Id. at 6

[50] Id. at 7 (and this is across the three categories: inspection deficiencies, staffing and financial viability).

[51] Id.

[52] Id.

[53] Id.

[54] Id.

[55] Id.

resources to improve quality of care. [56] Under-resourced facilities care for a disproportionate number of patients both poor and from minority groups. [57]

A similar study, published a year later in 2011, found that changing demographics across the country appeared to drive the racial and ethnic makeup of nursing home residents.[58] It also remarked that changes in long-term care may also be responsible for the shifts and that as a result minority older people may face hurdles in accessing home and community-based care. [59] Hence the need for more legal services and providers in their dominant language, if that is Spanish, and in their geographic area.

In terms of the ethnic/ racial minority elder nursing home population, the study found that between 1999 and 2008 it outpaced the same population as a whole in metropolitan areas with a high concentration of these populations. [60] Ultimately, the nursing home population should mirror the country's elder population.[61] Will nursing homes be able to provide culturally competent and sensitive care?[62] A closer analysis showed that the percentage of racial/ethnic minorities in nursing

[56] Id.

[57] Id.

[58] Zhanlian Feng, et al. *Growth of Racial and Ethnic Minorities in US Nursing Homes Driven by Demographics and Possible Disparities in Options*, HEAL. AFF. 20(7) (2011) 1362

[59] Id. at 1362

[60] Id.

[61] Id.

[62] Id.

homes correlated to the overall percentage of elderly in the same minority group but that no such correlation existed for white non-Latinos.[63] The authors suggested that this meant the white non-Latino elderly had more options and more of an ability to pay for assisted living facilities. [64] In contrast, minority elders were more likely to have limited alternatives to nursing homes. [65] When they reside in nursing homes, the homes are usually of lower quality, with fewer resources, more reliance on Medicaid and less care than those in affluent communities. [66]

According to the National Hospice and Palliative Care Organization (NHPCO), less than 10% of eligible Latinos use hospice care nationally. [67] Some of the reasons for this are lack of knowledge and religious or spiritual beliefs.. [68] It was also found that Latinos are less likely to complete advance directives and some of the factors are poor communication with their physicians, religious or spiritual beliefs and language barriers. [69]

[63] Id. at 1363

[64] Id.

[65] Id.

[66] Id.

[67] Gerardo Fernandez, *Hispanics Overcoming Barriers to End of Life Care (Part 2) Gerardo Fernandez* (October 29, 2013) *available at* http://newamericamedia.org/2013/10/hispanics-overcoming-barriers-to-elders-end-of-life-care.php

[68] Id.

[69] Id.

The study highlighted that each ethnic group within the Latino ethnicity is different, and even more differences exist in each subculture within that group. [70] Families aalso have their own cultures. [71] Therefore, the authors recommended that properly trained bilingual staff is essential in order to make the information available and understood and[72] that workshops, seminars and courses should be provided to educate the community about the available options. [73]

In our profession, a good first step would be to have fully bilingual support staff. Proficiency in a language is insufficient, especially when it comes to important decision making. A further step would be to have this staff attend legal trainings to gain a better understanding of the law, the work you do and the clientele you serve. They should attend CLEs, not every single one that you do, but those that will serve to enhance their work and your practice. An even better step is to go out into the community and educate the public.

Not surprisingly, the authors found that more assimilated and higher socioeconomic status Latinos were more likely to use hospice.[74]

As attorneys, we can take away a few lessons from this. You must meet the client where they are and ensure that you have people working with you who are sensitive

[70] Gerardo Fernandez, *Why are Latinos Not Using Palliative Care and Hospice?* (Oct. 2, 2013) *available at* http://newamericamedia.org/2013/10/why-are-latinos-not-using-palliative-and-hospice-care.php

[71] Id.

[72] Id.

[73] Id.

[74] Id.

to and knowledgeable about the communities they intend to serve. I am fully bilingual; however when I assist clients *who are Spanish speaking only* in executing their advance directives, wills or other documents I ensure there is an official interpreter in the room.

While I read the English version of the document, the interpreter translates my words into Spanish. Even though I could read the document to them in Spanish, I personally feel I am better able to focus on my role as attorney by doing this. Obviously, if they have a question I counsel them in Spanish as I am an Attorney and *Counselor* at Law. This is the role I am best suited for.

Another study examined older Latinos' attitudes toward End of Life Planning[75]; and although the sampling was small,[76] the methodology used to assess the best way to provide guidance was insightful - and unsurprising. The subjects were divided among three groups: The control group received standard information; i.e. the New York State Health Proxy Form and instructional booklet in English and Spanish. The second group - "Conversación A" (Conversation A) received a one hour protocol in their homes, and there was a dialogue in Spanish that addressed Advance Directives, role of the agent, the importance of advance planning; medical, legal and value issues; and how to begin a conversation with loved ones and the standard information in the control group. The third group - "Conversación B" (Conversation B) was the "intensive" in that, in addition to being conducted in Spanish and

[75] Jenna C. Heyman & Irene A. Gutheil, *Older Latinos' Atittude toward Comfort with End-of-Life Planning*, National Assn of Social Workers 2010 at 17

[76] Id.

offering the same dialogue as in Conversation A, it also covered other themes developed in a focus group: burden of decision making, control (for decision making), communication, family relationships, religion and spirituality. [77] Of note is that the authors chose to work with majority Spanish speaking individuals who, on average, had only completed up to a sixth-grade education. [78] The authors admitted that findings could be different among Latinos with more education. [79]

Their study concluded that Conversation A made a significant difference in both attitudes toward and comfort with end-of-life planning, while Conversation B only made a significant difference in attitude.[80] The authors surmised that Conversation B was too much for a person to think about in one session; considering end-of-life is a difficult subject, the authors felt the topic was a powerful one that it deserved additional time – in a separate meeting. [81]

Additionally, the authors underscored the impact of a single session in the participants' native language as significant.[82] The study showed that, with respect to the control group that printed materials in Spanish were insufficient, especially if dealing with individuals with limited educations. [83]

[77] Id. at 19

[78] Id. at 21

[79] Id. at 23

[80] Id. at 24

[81] Id.

[82] Id at. 19

[83] Id. at 24

From this author's experience working within the Latino community, it is often the adult children, sometimes U.S. born, of Latino elderly clients who make the first contact with attorneys and other professionals. Typically, when I speak to the parent(s), they are often unprepared for aging and sometimes resistant to doing any kind of planning. This can be the result of factors such as lack of language sophistication, education, socio economic status, overall fear of the process and, sometimes fear of family discord.

Many of the older Latinos who consult with me know what a Last Will and Testatment ("A will") is, however there are times when they have failed to know and/ or recognize the value of Advance Directives. In other words, they are more familiar with the concept of death and the role a will plays upon death than they are with incapacity and why legal protection is necessary should they have a stroke, for example. Simply, they do not understand the breadth of the law available to protect them.

My experience has also shown me that Spanish speaking clients whose adult children are more knowledgeable with respect to planning seem to be better prepared when they meet with me. The issues I mentioned are not foreign to elder law attorneys generally, but when language and culture are factors the attorney may not be equipped to address them.

Another interesting study was caregiving from the perspective of paid and family (unpaid) caregivers.[84] There were two essential criteria for the study: 1) that the caregiver identify as Latino/a and 2) for the ill individual to have a terminal illness. [85] The sample was twenty caregivers and all were interviewed in their homes. [86] Half of them were caring for a person utilizing hospice services; while the other half was caring for a person not utilizing those services.[87] Thirteen caregivers were family and unpaid; while the remaining seven were paid caregivers.[88] Four of the unpaid family caregivers had no help; another four received help from other family members, while the remaining received help from a combination of family, friends and community.[89]

Twelve of the family caregivers preferred speaking Spanish.[90] The study related individual caregivers' stories in their own words and found that, in addition to the ill family member, many Latino caregivers have to deal with intergenerational issues, limited financial resources, and families fragmented due to geographic distance and

[84] Iraida V. Carrion & Frances R. Nedjat-Haiem, *Caregiving for Older Latinos at End of Life: Perspective From Paid and Family (Unpaid)Caregivers*. AMER. JOURNAL OF HOSPICE & PALLIATIVE MED. 30 (2) 2012.

[85] Heyman & Guthiel, supra at 184

[86] Id. at 185

[87] Id.

[88] Id.

[89] Id. at 186

[90] Id.

immigration laws. [91] The authors stressed that the provision of respite and additional support for the caregiver are critical. [92]

Based on this author's own knowledge, the likely reason for caregiver respite is obvious: when you are dealing with stressors, on top of caregiving for a loved one, there is not only strain on the caregiver and patient relationship, but negative impact on the caregiver themselves. A caregiver must provide self-care before they can care for another. Self-care is obligatory for any caregiver, irrespective of race or ethnicity.

Lastly, but not less important, the study also emphasized how essential Spanish language written materials and bilingual medical and health and other professionals were, especially those trained to provide services understanding cultural idiosyncrasies. [93]The statistics and anecdotes underscore the importance of meaningful and personal outreach, education and cultural sensitivity, which may also include language competency, and knowing that one size does not fit all—especially with such a heterogeneous group like Latinos. If these things were put into place, we would likely find a population more proactive in preparing for their old age and securing not only their financial futures but also that of their families. The public is there…you just need to know where and how to meet them.

[91] Id. at 189

[92] Id.

[93] Id.

CULTURAL DIFFERENCES IN THE PRACTICE OF ELDER LAW

By Pauline Yeung-Ha

The practice of elder law is practically non-existent in the New York City Chinese community. A Chinese consumer can easily come to this conclusion by leafing through the Chinese newspapers. Lawyer advertisements in these newspapers are predominantly on real estate, immigration, personal injury, commercial litigation, criminal, business incorporations, and contract law. I know about a dozen of Chinese attorneys practicing in wills and estates, but only a handful in elder law.

The lack of Chinese lawyers in the wills and estates or disability-related fields is not surprising to me. It is a "taboo" to speak about death and life-threatening illnesses in the Chinese culture. Logically, lawyers in the Chinese community assume that practicing in a field revolving around death and disability issues would be setting themselves up for failure. Even many Chinese attorneys have asked me why I have chosen to practice in the elder law field and how it would be possible for me to expand the practice in the Chinese community when the chances of success would be slim?

In the early 2000s, Judith D. Grimaldi, Esq. first offered me the opportunity to speak before a Chinese audience at a senior center. I was excited, yet hesitant. To present the sensitive topics of death and disability before fifty seniors was a daunting task. I knew I must tread lightly and broach the topics in a very round about fashion. Any words or expressions that would resemble death or disability would be considered offensive.

Another difficulty associated with this presentation was the translation of legal terms into Chinese. Terms used in the English dictionary such as elder law, health care proxy, living will, pre-paid funeral plans, Medicaid, Medicare, supplemental insurance, administrator/administration proceeding, revocable/irrevocable trust, supplemental needs trust are not provided in "English to Chinese" dictionaries, but would need to be translated into the best possible meaning. My preparation included hours of reviewing Chinese newspapers, researching on the internet, and consulting my parents to help me translate the English materials to Chinese.

To my surprise, the presentation was incredibly successful. The topics covered sparked tremendous interest from the seniors. Judie and I were amazed by the attentiveness and enthusiasm of the audience. There was a constant stream of questions throughout, and the two hours allotted for the presentation was not enough to cover all the material. This experience made me realized that the Chinese community is more receptive to the field of elder law than what I had originally anticipated and that the wealth of information that was provided to the Chinese elderly population was not rejected but widely accepted and valued.

Cultural Education to Facilitate the Elder Law Practice

As an American-born Chinese (or more commonly known as an "ABC"), my exposure and understanding to both the Chinese and American cultures were instrumental to the practice of elder law. I learned that the differences between the Chinese and American cultures are so significant that they are sometimes very difficult to reconcile. To provide culturally competent services to the Chinese elders, it is important for the elder law attorney to be aware of cross-cultural and diversity issues. This article is written from my personal experience as an elder law

attorney practicing in a Chinese setting and will focus on the important concepts of the Chinese culture that will be useful for those who have Chinese clients. I would caution the elder law attorneys to avoid developing stereotypes or biases based on the material but rather to be sensitive to the cultural differences.

Confucianism – Family as Source of Support

The teachings of Confucianism, which was established over 2000 years ago, are deeply rooted in the Chinese society. As a child, I was taught in Chinese school that each person has a special role in the hierarchy of social relationships. They are sovereign and subject, father and son, husband and wife, elder and younger brother, and friend and friend. The elder is considered a person of honor. They are deemed wise and educated and so the young must defer to the elder. The husband is the head of the family and thus, the wife must defer to the husband.

Confucius emphasized the need to achieve social harmony. He believed that in every relationship there exists a "collective responsibility" that includes duty, loyalty, honor, filial piety, respect for age and seniority, and sincerity. Individual rights or "I" is a foreign concept to the Chinese. The family is the "center" and comes before the individual, "I".

"Filial piety" is the core to family harmony. The Chinese elders are placed at the highest social level in the family and are well-respected. The family, especially the oldest son, is expected to dedicate their lives to support the elder's care and well-being. Due to the "collective" nature embedded in their culture, Chinese families are reluctant to seek outside assistance and prefer to remain private about family problems. Often times, if the elder becomes ill, the family will by all means work together to provide care themselves and would

quit their jobs rather than hire a home attendant or place the elder in an institution for long-term care. It is not until there is no way for the family to provide care for the elder that outside assistance would finally be sought.

Today, the very traditional Chinese families continue to strictly adhere to "filial piety" concept where the son is highly valued. This is because the son can carry on the family name (or surname). The daughter on the other hand is considered an "outsider" after marriage. During the estate planning phase, these clients have expressed that their entire estate be devised to the sons and nothing for the daughters, despite the care was provided by the daughters. It might seem odd to the Western eyes that sons have special treatment over daughters, but these are old Chinese traditions that have been practiced for many centuries. The newer generations, those who are educated and assimilated into the Western culture, are not as traditional and tend to treat the daughter on a closer level, if not equal, with the son.

Face (Mianzi)

I was raised in a community where all my relationships revolved around "face". Face is an abstract concept that cannot be easily defined in simple terms. It may take years for a non-Chinese to understand the true meaning of face. It is important to keep in mind that the Chinese takes face very seriously and are extremely sensitive to this issue. Personal or business relationships can break apart because of face and may never be reconciled even after many years.

Generally, face is a measure of one's public dignity and reputation. Education, wealth, knowledge, and success play a significant role in determining face. As can be expected, doctors

and lawyers will have more face than a secretary or a physical laborer. Having attained higher levels of education and receiving higher salaries, doctors and lawyers are considered successful people, who automatically earn higher social standing and more respect. As a result, Chinese clients will generally defer to the attorney's advice without questioning his or her intelligence. This show of respect is also known as preserving humbleness.

The intangible part of face can include any actions that cause insult or humility. For example, if another person openly disagrees with your statements, you will lose face (or "be embarrassed") as a result. You can also lose face if you create an outburst in public or commit a morally wrong action. Very often in my consultations, the elderly client will prefer to maintain his or her composure and keep silent rather than to outright dispute on issues. These actions do not necessarily signal their understanding but rather were committed to give face. Face can also be given as well by complimenting someone, preserving humbleness and enhancing another's reputation.

In dealing with the Chinese clients, criticisms must be crafted carefully. Even a subtle comment of disapproval that may not be considered offensive by Western standards can cause unnecessary awkwardness. Fortunately, attorneys in the elder law field develop expertise in dealing with all types of delicate issues and have an advantage in handling sensitive issues.

Because of face, Chinese clients may sometimes refuse to accept Medicaid planning. We have come across clients who would choose to private pay the nursing home for years rather than accept government benefits. When funds were finally exhausted, they would seek other means (i.e. children's funds, credit cards, home equity loans or mortgages) to pay the nursing home. It is not until the debts amounted to the point where the clients are in desperate financial

need, the family would finally agree to outside help, having no choice but to seek an elder law attorney. All their life-long savings were depleted because they did not want to lose face. The Chinese elders perceive the receipt of government benefits as an embarrassment and the last thing that they would want is for their families or friends to know about it.

Disability planning is difficult within the Chinese community as well. Families may not acknowledge that a family member has either physical or mental disability as he or she brings shame upon the family. The family would prefer to remain silent, keep things private, and carry out their daily lives as if the disability did not exist. Children with special needs, such as autism or mental retardation, are an extremely underserved population. Many parents are reluctant to address their children's condition and believe that the condition is temporary and will eventually resolve itself in the future.

The situations mentioned above are frequent in the Chinese community. My hope is to continue to educate and build a solid relationship ("guanxi") in the community so that these unfortunate circumstances can be prevented. The use of the intermediary "guanxi" is discussed below.

Connection (Guanxi)

The specialized nature of the elder law practice makes referral sources extremely valuable. Generally, my practice relies on former clients as primary referrals, while accountants, hospitals, social workers, and community organizations are secondary to them.

In the Chinese community, there is more to a referral than its Western version. If you promise legal service to the elderly client and deliver exceptional results, the elderly client will

likely become your “guanxi”. “Guanxi” means the client will become your referral source and will personally vouch for you. When this source refers you to his or her peers, it is customary for him or her to stand wholeheartedly behind you and praise your work. Referring back to the concept of Confucian loyalty in relationships, he or she has, in effect, become your advertising agent. You will not need to market yourself to your source’s peers because the source will already have established your credentials and given you his or her seal of approval. When you build up your “guanxi”, you will extend connections into the community with a reputation that is worthy of trust, respect and competence.

Since potential Chinese clients often like to rely on word of mouth when choosing a lawyer, it is important for you to build your “guanxi”. It is equally important to keep a permanent relationship with your Chinese clients to maintain your “guanxi”. They often invite you to dim sum and introduce you to their families and friends.

The Office Practice

Initial Telephone Call – “OK”

When making the telephone call to the law office to initiate contact, elderly clients generally prefer the warmth of a human voice to the impersonal nature of an automated message. This applies even more so for Chinese clientele. The personal feeling provided by a receptionist gives assurance to the Chinese elderly client that the service will be friendly. Many times, if the initial call was transferred directly to voicemail, the call would likely be dropped. In the more traditional Chinese families, many elders’ homes do not have answering

machines as the idea of leaving a message on a machine is foreign to them. The elderly client would rather attempt several calls until they reach a person.

Our office's receptionist was instructed not to put calls to voicemail unless it was absolutely necessary. However, during the earlier stages of expanding the Chinese clientele, we often encountered one dilemma, the language barrier. Around 2012, our office consisted of eight non-Chinese speaking staff and one part-time Chinese law intern. When a Chinese client heard a voice speaking English on the phone, he or she would become intimidated and drop the call. In order to mitigate this situation, our staff was trained to use the word "OK" or "Deng Deng" (meaning "wait" in Chinese) before transferring the call to my intern or me. Fortunately, the word "OK" was an universal adopted word which most elderly Chinese understood and "Deng Deng" was not a difficult word for my receptionist to say. When the elderly Chinese heard the word "OK" or "Deng Deng", he or she received the reassurance that the person on the other end could assist him/her. The client is then placed on hold with music playing in the background. This method had worked very well with our elderly Chinese clientele. Voicemail was only used as a last resort.

As my practice grew, there were instances when I was not available to answer phone calls. Therefore, during the initial consultation, it was important for me to stress and encourage my clients to use voicemail to facilitate future communications. Our office voicemail system is set up in both English and Chinese languages. The use of voicemail has proven to be a very effective method to maintain subsequent contacts during busy periods. Communication with the younger Chinese generation is entirely different. Our office rarely experienced

communication barriers because the younger generation speaks proficient English and almost all have email access.

Concept of "Service" versus "Product"

In general, legal fees in the elder law practice are a huge concern for our clients. A major factor as to whether the client decides to retain the services of an elder law attorney is often dictated by the fees. Unequivocally, legal fees are one of the first issues to be discussed at the outset prior to meeting with the Chinese client. While the non-Chinese client usually accepts the firm's established fees, Chinese clients will try to negotiate the amount. Bargaining for the lowest fee is common in the Chinese community. For example, many of my clients will attempt to lower the fee with statements such as:

"My friend had a trust done for $ x amount at another law firm, why I am being charged a lot more?"

"You don't need to collect so much from me. I will refer my friends to you so you'll get their future business."

"We are from the same home town, can't you lower the fee for a fellow Chinese?"

The need to educate the Chinese client on fees is important. Since most Chinese clients has never heard of or worked with an elder law attorney before, they are basing and applying their knowledge to the services of other attorneys, such as real estate and immigration. In these instances, it is crucial to explain to the clients and their family members that the fees paid for the knowledge and experience of an elder law firm will likely always exceed the fees for the service of a general practice firm. A simple analogy I frequently use was: if you have a heart problem, you go to a heart doctor; if you have an eye issue, you go to an eye doctor. If you

need surgery, would you have a general practice doctor to operate on your heart or eye? Furthermore, the client should be reminded that each case has its set of unique facts, and the fees charged for one case cannot be compared with that for another case.

In my interactions with the Chinese clients, I have learned that legal fees should be charged based on a package of services rather than individually for each item. For example, instead of establishing a fee of $ x for drafting a trust, $ y for drafting a will, and $ z for preparing advanced directives, the fee should be for the all three services combined without the need to itemize each service. Chinese clients prefer to know the bottom line quote.

When supplying quotes, I do not use the term "initial consultation fee" but rather the term "estate planning session fee" and request that the clients complete our firm's questionnaire and compile all the required documents in order to have a productive meeting. "Initial consultation fee" is a hard concept for the Chinese clients to grasp because they do not believe in paying for "talk". They consider consultations to be part of the sales pitch. Despite the fact that I was providing valuable legal advice, the advice was not a concrete product. Many of my clients believe in being charged for only the delivery of paperwork, such as a will or trust.

Further, follow-up telephone calls should not be attempted immediately with the potential Chinese clients after the initial meeting until two months later because they do not respond well to a pressured sales pitch. When the elderly client or the client's family members are in fact ready to retain my services, they will certainly call to schedule the appointment and return the retainer.

Before the elderly client is ready to commit to any services, he or she typically calls several times with additional questions. Thus, the typical timeframe from the initial call to the scheduling of an appointment is three to six weeks. In essence, the time and effort spent with the client and his or her families in these initial phone calls forge a relationship of trust that can culminate with the scheduling of an initial consultation.

The Meeting – Enhancing the Trust Relationship

The meeting is a collaborative effort of the family. The children voluntarily attend and contribute to the planning process. Although the children may offer their opinions, it is the elderly client who will ultimately make the decision.

The meeting often begins with a handshake with the elderly client. After he or she is seated, it is wise to offer the elderly client tea or water. Since the Chinese elders are not comfortable with physical affection, it is not advised to make physical contact with the elderly Chinese client.

It is important to have the elderly client feel as comfortable as possible. After all, I am a stranger whom the elderly client is about to reveal all his or her personal information to. The conversation will generally begin by sharing each other's background information and finding commonalities between us. Typical questions asked by my Chinese clients include:

"Where are you and your family from and how long have they been in the United States?"

"Where do you live now?"

"Do you have any brothers and sisters?"

"Are you married?"

Undoubtedly, these questions are personal in nature and the elder law attorney may not know whether it is appropriate to discuss his or her personal life with the client. However, the conversations build the "guanxi". The elder law attorney should not appear visibly surprised by these questions; otherwise it may cause unnecessary embarrassment to the elderly client, which may in turn, cause the loss of "face", dissolving the trust relationship.

The Chinese appreciate reciprocity and enjoy being asked questions in return. Ice breakers help the attorney and client gain familiarity with each other and allow the two parties to develop a closer bond. We as elder law attorneys are experienced in asking personal questions to our clients. Typical questions include:

"How many children do you have and what do they do?"

"Do you have any grandchildren and how old are they?"

"What did you do before you retired?"

"When did you get married?"

The entire planning process with the elderly client and their family typically requires 1½ to 2 hours to complete. The bulk of the time is spent explaining how to achieve their planning goals and making sure that they understand the new concepts. I am fluent in both the Cantonese and Mandarin Chinese dialects. Many ABCs speak simple Chinese and have trouble communicating difficult or technical terms in Chinese with their parents. I conduct my meetings in Chinese with the parents and translate in English for the children.

Given that the Chinese clients are very careful people and do not like risk, they tend to ask many questions about the details of the planning. The attorney should not be surprised if they conjure up endless "what if" scenarios for discussion. Chinese clients do not feel comfortable executing the planning unless they feel that they fully comprehend the material and are able to verify the benefits of the planning. Once the elderly client entrusts me with the work, he or she will consider me as almost part of the family and retain full confidence in my work.

Printed Materials in Chinese

The Chinese community in New York City is very diverse. Many Chinese have immigrated from Taiwan, Hong Kong (formerly a British colony which became part of China in 1997), and various parts of China. Although the Chinese follow the basic customs and traditions of Confucianism, their spoken language is not simple. The Chinese language has many dialects, each of which can be quite different. Understanding one dialect does not guarantee understanding another. For example, often Cantonese speakers can understand Mandarin, but not vice versa. Mandarin is the official dialect of the Chinese language. Today, the predominant dialects in New York City are Cantonese, Mandarin, and Fujianese.

Fortunately, the universal form of communication for the Chinese is the written language and the Chinese characters are the same regardless of dialect. When I conduct seminars in the community, I distribute written materials to reinforce some of the issues presented and more importantly to allow the Chinese elders who do not understand my Cantonese dialect to read the information discussed. Sometimes, for issues that are of sensitive nature (such as the living will), I would prefer to distribute written material instead of

presenting them in detail. Chinese clients like to review written material, which gives them time to absorb the issues and formulate questions. Once the elders are familiar with these issues, they will openly discuss them with me.

Often I am invited to speak in the Chinese community. However, one organization invited me to speak at a time which coincided with the celebration of the Chinese New Year. The organization's coordinator was not aware that during Chinese New Year only good health, wealth, and fortune can be discussed. She was unfamiliar with the Chinese culture and requested that I speak on topics relating to wills, trusts, and advanced directives. With good intent, she believed that it was an ideal opportunity to give this talk because all their Chinese seniors would be attending the New Year celebration activities. Unfortunately, the timing was absolutely inappropriate and such a talk would have offended many seniors. The Chinese elders believe that bringing up topics of bad luck at this time would actually cause the events of bad luck to happen to them. Facing this challenge, I changed my presentation to avoid all issues relating to disabilities, long-term care, illnesses, and death. The presentation had to be tactfully delivered with the focus on protecting and control of oneself to minimize long-term care and disability issues. I could only briefly mention that the power of attorney and health care proxy serve to preserve future control, and that a living will serves as a backup document for the health care proxy. As such, the written documents that day proved extremely useful. I avoided the taboo topics. After the presentation, I had a discussion with the coordinator to be mindful when planning their next event.

The written materials I distributed were very valuable to the Chinese community as they were unique and difficult to find. The elders rarely throw them out and tend to keep them

handy in the homes. We had one case where the Chinese elder and his family who had inquired with our firm kept these written materials and finally responded after five years.

As the Chinese clientele expanded, business cards were also printed in two languages, one side in English and the other side in Chinese. Since elder law practice is such a specialized area of law that many Chinese families are not familiar with, I also listed the types of services that our firm provided such as elder law, long-term care, Medicaid, disability issues, advanced directives, and wills and trusts.

Conclusion

As you can see, recognizing cultural differences may certainly enhance a law firm's practice. All throughout these years, our firm has thrived on having a diverse clientele which has become a pertinent aspect of our practice. We believe that cultural competency and awareness can be attained through education and communication between lawyer and staff as well as lawyer/staff and client. We further believe that the ability of the law firm to provide a comfortable environment and understand the needs of the diverse client will eventually bring everlasting and trusting relationships between the diverse client and the elder law firm.

Plenary Session
Ethical Considerations and Duties in Cyber Security: The Risks You Must Know, the Strategies You Cannot Avoid

Presented By:
Devika Kewalramani, Esq.

MOSES & SINGER

Ethical Obligations in Cyber Security: The Risks You Must Know, The Responsibilities You Cannot Avoid

July 14, 2018

***Presented By*:**

Devika Kewalramani, Esq.

Partner, Moses & Singer LLP

MOSES & SINGER LLP

Ethical Obligations in Cyber Security: The Risks You Must Know, The Responsibilities You Cannot Avoid

July 14, 2018

Presented By: Devika Kewalramani, Esq.

TABLE OF CONTENTS

N.Y. City Bar Opinion 2015-3 (2015) – Lawyers who fall victim to internet scams.

The State Bar of California Formal Opinion No. 2010-179 (2010) – http://ethics.calbar.ca.gov/LinkClick.aspx?fileticket=wmqECiHp7h4$3d&tabid=836 [See link - not included]

American Bar Association Formal Opinion 477 (2017) – Securing Communication of Protected Client Information. https://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/aba_formal_opinion_477.authcheckdam.pdf [See link - not included]

4. Cases of Interest:

Robert Millard and Bethany Millard v. Patricia L. Doran, Esq., Index No: 153262/2016, Supreme Court, New York County (April 18, 2016) [not included]

Jason Shore and Coinabul, LLC v. Johnson & Bell, Ltd. SDNY, 16 cv 4363 (April 15, 2016) [not included]

5. Speaker "bio"

* * *

RULE 1.1:
COMPETENCE

(a) A lawyer should provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

(b) A lawyer shall not handle a legal matter that the lawyer knows or should know that the lawyer is not competent to handle, without associating with a lawyer who is competent to handle it.

(c) A lawyer shall not intentionally:

(1) fail to seek the objectives of the client through reasonably available means permitted by law and these Rules; or

(2) prejudice or damage the client during the course of the representation except as permitted or required by these Rules.

Comment

Retaining or Contracting with Lawyers Outside the Firm

[8] To maintain the requisite knowledge and skill, a lawyer should (i) keep abreast of changes in substantive and procedural law relevant to the lawyer's practice, (ii) keep abreast of the benefits and risks associated with technology the lawyer uses to provide services to clients or to store or transmit confidential information, and (iii) engage in continuing study and education and comply with all applicable continuing legal education requirements under 22 N.Y.C.R.R. Part 1500.

RULE 1.4:
COMMUNICATION

(a) A lawyer shall:

(1) promptly inform the client of:

(i) any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(j), is required by these Rules;

(ii) any information required by court rule or other law to be communicated to a client; and

(iii) material developments in the matter including settlement or plea offers.

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with a client's reasonable requests for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by these Rules or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

RULE 1.6:
CONFIDENTIALITY OF INFORMATION

(a) A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:

(1) the client gives informed consent, as defined in Rule 1.0(j);

(2) the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or

(3) the disclosure is permitted by paragraph (b).

"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.

(b) A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;

(2) to prevent the client from committing a crime;

(3) to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;

(4) to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer's firm or the law firm;

(5) (i) to defend the lawyer or the lawyer's employees and associates against an accusation of wrongful conduct; or

(ii) to establish or collect a fee; or

(6) when permitted or required under these Rules or to comply with other law or court order.

(c) A lawyer shall exercise reasonable care to prevent the lawyer's employees, associates, and others whose services are utilized by the lawyer from disclosing or using confidential information of a client, except that a lawyer may reveal the information permitted to be disclosed by paragraph (b) through an employee.

Comment

Duty to Preserve Confidentiality

[17] When transmitting a communication that includes information relating to the representation of a client, the lawyer must take reasonable precautions to prevent the information from coming into the hands of unintended recipients. This duty does not require that the lawyer use special security measures if the method of communication affords a reasonable expectation of privacy. Special circumstances, however, may warrant special precautions. Factors to be considered in determining the reasonableness of the lawyer's expectation of confidentiality include the sensitivity of the information and the extent to which the privacy of the communication is protected by law or by a confidentiality agreement. A client may require the lawyer to use a means of communication or security measures not required by this Rule, or may give informed consent (as in an engagement letter or similar document) to the use of means or measures that would otherwise be prohibited by this Rule.

RULE 5.1:
RESPONSIBILITIES OF LAW FIRMS, PARTNERS, MANAGERS AND SUPERVISORY LAWYERS

(a) A law firm shall make reasonable efforts to ensure that all lawyers in the firm conform to these Rules.

(b) (1) A lawyer with management responsibility in a law firm shall make reasonable efforts to ensure that other lawyers in the law firm conform to these Rules.

(2) A lawyer with direct supervisory authority over another lawyer shall make reasonable efforts to ensure that the supervised lawyer conforms to these Rules.

(c) A law firm shall ensure that the work of partners and associates is adequately supervised, as appropriate. A lawyer with direct supervisory authority over another lawyer shall adequately supervise the work of the other lawyer, as appropriate. In either case, the degree of supervision required is that which is reasonable under the circumstances, taking into account factors such as the experience of the person whose work is being supervised, the amount of work involved in a particular matter, and the likelihood that ethical problems might arise in the course of working on the matter.

(d) A lawyer shall be responsible for a violation of these Rules by another lawyer if:

(1) the lawyer orders or directs the specific conduct or, with knowledge of the specific conduct, ratifies it; or

(2) the lawyer is a partner in a law firm or is a lawyer who individually or together with other lawyers possesses comparable managerial responsibility in a law firm in which the other lawyer practices or is a lawyer who has supervisory authority over the other lawyer; and

(i) knows of such conduct at a time when it could be prevented or its consequences avoided or mitigated but fails to take reasonable remedial action; or

(ii) in the exercise of reasonable management or supervisory authority should have known of the conduct so that reasonable remedial action could have been taken at a time when the consequences of the conduct could have been avoided or mitigated.

RULE 5.3:
LAWYER'S RESPONSIBILITY FOR CONDUCT OF NONLAWYERS

(a) A law firm shall ensure that the work of nonlawyers who work for the firm is adequately supervised, as appropriate. A lawyer with direct supervisory authority over a nonlawyer shall adequately supervise the work of the nonlawyer, as appropriate. In either case, the degree of supervision required is that which is reasonable under the circumstances, taking into account factors such as the experience of the person whose work is being supervised, the amount of work involved in a particular matter and the likelihood that ethical problems might arise in the course of working on the matter.

(b) A lawyer shall be responsible for conduct of a nonlawyer employed or retained by or associated with the lawyer that would be a violation of these Rules if engaged in by a lawyer, if:

(1) the lawyer orders or directs the specific conduct or, with knowledge of the specific conduct, ratifies it; or

(2) the lawyer is a partner in a law firm or is a lawyer who individually or together with other lawyers possesses comparable managerial responsibility in a law firm in which the nonlawyer is employed or is a lawyer who has supervisory authority over the nonlawyer; and

(i) knows of such conduct at a time when it could be prevented or its consequences avoided or mitigated but fails to take reasonable remedial action; or

(ii) in the exercise of reasonable management or supervisory authority should have known of the conduct so that reasonable remedial action could have been taken at a time when the consequences of the conduct could have been avoided or mitigated.

Comment

[2] With regard to nonlawyers, who are not themselves subject to these Rules, the purpose of the supervision is to give reasonable assurance that the conduct of all nonlawyers employed by or retained by or associated with the law firm, including nonlawyers outside the firm working on firm matters, is compatible with the professional obligations of the lawyers and firm. Lawyers typically employ nonlawyer assistants in their practice, including secretaries, investigators, law student interns and paraprofessionals. Such nonlawyer assistants, whether they are employees or independent contractors, act for the lawyer in rendition of the lawyer's professional services. Likewise, lawyers may employ nonlawyers outside the firm to assist in

[3] A lawyer may use nonlawyers outside the firm to assist the lawyer in rendering legal services to the client. Examples include (i) retaining or contracting with an investigative or paraprofessional service, (ii) hiring a document management company to create and maintain a database for complex litigation, (iii) sending client documents to a third party for printing or scanning, and (iv) using an Internet-based service to store client information. When using such services outside the firm, a lawyer or law firm must make reasonable efforts to ensure that the services are provided in a manner that is compatible with the professional obligations of the lawyer and law firm. The extent of the reasonable efforts required under this Rule will depend

upon the circumstances, including: (a) the education, experience and reputation of the nonlawyer; (b) the nature of the services involved; (c) the terms of any arrangements concerning the protection of client information; (d) the legal and ethical environments of the jurisdictions in which the services will be performed, particularly with regard to confidentiality; (e) the sensitivity of the particular kind of confidential information at issue; (f) whether the client will be supervising all or part of the nonlawyer's work. *See also* Rules 1.1 (competence), 1.2 (allocation of authority), 1.4 (communication with client), 1.6 (confidentiality), 5.4 (professional independence of the lawyer) and 5.5 (unauthorized practice of law). When retaining or directing a nonlawyer outside the firm, a lawyer should communicate directions appropriate under the circumstances to give reasonable assurance that the nonlawyer's conduct is compatible with the professional obligations of the lawyer.

NEW YORK STATE BAR ASSOCIATION
Serving the legal profession and the community since 1876

ETHICS OPINION 842

COMMITTEE ON PROFESSIONAL ETHICS

Opinion 842 (9/10/10)

Topic: Using an outside online storage provider to store client confidential information.

Digest: A lawyer may use an online data storage system to store and back up client confidential information provided that the lawyer takes reasonable care to ensure that confidentiality will be maintained in a manner consistent with the lawyer's obligations under Rule 1.6. In addition, the lawyer should stay abreast of technological advances to ensure that the storage system remains sufficiently advanced to protect the client's information, and should monitor the changing law of privilege to ensure that storing the information online will not cause loss or waiver of any privilege.

Rules: 1.4, 1.6(a), 1.6(c)

QUESTION

1. MAY A LAWYER USE AN ONLINE SYSTEM TO STORE A CLIENT'S CONFIDENTIAL INFORMATION WITHOUT VIOLATING THE DUTY OF CONFIDENTIALITY OR ANY OTHER DUTY? IF SO, WHAT STEPS SHOULD THE LAWYER TAKE TO ENSURE THAT THE INFORMATION IS SUFFICIENTLY SECURE?

OPINION

2. VARIOUS COMPANIES OFFER ONLINE COMPUTER DATA STORAGE SYSTEMS THAT ARE MAINTAINED ON AN ARRAY OF INTERNET SERVERS LOCATED AROUND THE WORLD. (THE ARRAY OF INTERNET SERVERS THAT STORE THE DATA IS OFTEN CALLED THE "CLOUD.") A SOLO PRACTITIONER WOULD LIKE TO USE ONE OF THESE ONLINE "CLOUD" COMPUTER DATA STORAGE SYSTEMS TO STORE CLIENT CONFIDENTIAL INFORMATION. THE LAWYER'S AIM IS TO ENSURE THAT HIS CLIENTS' INFORMATION WILL NOT BE LOST IF SOMETHING HAPPENS TO THE LAWYER'S OWN COMPUTERS. THE ONLINE DATA STORAGE SYSTEM IS PASSWORD-PROTECTED AND THE DATA STORED IN THE ONLINE SYSTEM IS ENCRYPTED.

3. A DISCUSSION OF CONFIDENTIAL INFORMATION IMPLICATES RULE 1.6 OF THE NEW YORK RULES OF PROFESSIONAL CONDUCT (THE "RULES"), THE GENERAL RULE GOVERNING CONFIDENTIALITY. RULE 1.6(A) PROVIDES AS FOLLOWS:

A LAWYER SHALL NOT KNOWINGLY REVEAL CONFIDENTIAL INFORMATION . . . OR USE SUCH INFORMATION TO THE DISADVANTAGE OF A CLIENT OR FOR THE ADVANTAGE OF A LAWYER OR A THIRD PERSON, UNLESS:

> (1) THE CLIENT GIVES INFORMED CONSENT, AS DEFINED IN RULE 1.0(J);
>
> (2) THE DISCLOSURE IS IMPLIEDLY AUTHORIZED TO ADVANCE THE BEST INTERESTS OF THE CLIENT AND IS EITHER REASONABLE UNDER THE CIRCUMSTANCES OR CUSTOMARY IN THE PROFESSIONAL COMMUNITY; OR
>
> (3) THE DISCLOSURE IS PERMITTED BY PARAGRAPH (B).

4. THE OBLIGATION TO PRESERVE CLIENT CONFIDENTIAL INFORMATION EXTENDS BEYOND MERELY PROHIBITING AN ATTORNEY FROM REVEALING CONFIDENTIAL INFORMATION WITHOUT CLIENT CONSENT. A LAWYER MUST ALSO TAKE REASONABLE CARE TO AFFIRMATIVELY PROTECT A CLIENT'S CONFIDENTIAL INFORMATION. *SEE* N.Y. COUNTY 733 (2004) (AN ATTORNEY "MUST DILIGENTLY PRESERVE THE CLIENT'S CONFIDENCES, WHETHER REDUCED TO DIGITAL FORMAT, PAPER, OR OTHERWISE"). AS A NEW JERSEY ETHICS COMMITTEE OBSERVED, EVEN WHEN A LAWYER WANTS A CLOSED CLIENT FILE TO BE DESTROYED, "[S]IMPLY PLACING THE FILES IN THE TRASH WOULD NOT SUFFICE. APPROPRIATE STEPS MUST BE TAKEN TO ENSURE THAT

CONFIDENTIAL AND PRIVILEGED INFORMATION REMAINS PROTECTED AND NOT AVAILABLE TO THIRD PARTIES." NEW JERSEY OPINION (2006), *QUOTING* NEW JERSEY OPINION 692 (2002).

5. IN ADDITION, RULE 1.6(C) PROVIDES THAT AN ATTORNEY MUST "EXERCISE REASONABLE CARE TO PREVENT . . . OTHERS WHOSE SERVICES ARE UTILIZED BY THE LAWYER FROM DISCLOSING OR USING CONFIDENTIAL INFORMATION OF A CLIENT" EXCEPT TO THE EXTENT DISCLOSURE IS PERMITTED BY RULE 1.6(B). ACCORDINGLY, A LAWYER MUST TAKE REASONABLE AFFIRMATIVE STEPS TO GUARD AGAINST THE RISK OF INADVERTENT DISCLOSURE BY OTHERS WHO ARE WORKING UNDER THE ATTORNEY'S SUPERVISION OR WHO HAVE BEEN RETAINED BY THE ATTORNEY TO ASSIST IN PROVIDING SERVICES TO THE CLIENT. WE NOTE, HOWEVER, THAT EXERCISING "REASONABLE CARE" UNDER RULE 1.6 DOES NOT MEAN THAT THE LAWYER GUARANTEES THAT THE INFORMATION IS SECURE FROM *ANY* UNAUTHORIZED ACCESS.

6. TO DATE, NO NEW YORK ETHICS OPINION HAS ADDRESSED THE ETHICS OF *STORING* CONFIDENTIAL INFORMATION ONLINE. HOWEVER, IN N.Y. STATE 709 (1998) THIS COMMITTEE ADDRESSED THE DUTY TO PRESERVE A CLIENT'S CONFIDENTIAL INFORMATION WHEN *TRANSMITTING* SUCH INFORMATION ELECTRONICALLY. OPINION 709 CONCLUDED THAT LAWYERS MAY TRANSMIT CONFIDENTIAL INFORMATION BY E-MAIL, BUT CAUTIONED THAT "LAWYERS MUST ALWAYS ACT REASONABLY IN CHOOSING TO USE E-MAIL FOR CONFIDENTIAL COMMUNICATIONS." THE COMMITTEE ALSO WARNED THAT THE EXERCISE OF REASONABLE CARE MAY DIFFER FROM ONE CASE TO THE NEXT. ACCORDINGLY, WHEN A LAWYER IS ON NOTICE THAT THE CONFIDENTIAL INFORMATION BEING TRANSMITTED IS "OF SUCH AN EXTRAORDINARILY SENSITIVE NATURE THAT IT IS REASONABLE TO USE ONLY A MEANS OF COMMUNICATION THAT IS COMPLETELY UNDER THE LAWYER'S CONTROL, THE LAWYER MUST SELECT A MORE SECURE MEANS OF COMMUNICATION THAN UNENCRYPTED INTERNET E-MAIL." *SEE ALSO* RULE 1.6, CMT. 17 (A LAWYER "MUST TAKE REASONABLE PRECAUTIONS" TO PREVENT INFORMATION COMING INTO THE HANDS OF UNINTENDED RECIPIENTS WHEN TRANSMITTING INFORMATION RELATING TO THE REPRESENTATION, BUT IS NOT REQUIRED TO USE SPECIAL SECURITY MEASURES IF THE MEANS OF COMMUNICATING PROVIDES A REASONABLE EXPECTATION OF PRIVACY).

7. ETHICS ADVISORY OPINIONS IN SEVERAL OTHER STATES HAVE APPROVED THE USE OF ELECTRONIC STORAGE OF CLIENT FILES PROVIDED THAT SUFFICIENT PRECAUTIONS ARE IN PLACE. *SEE, E.G.*, NEW JERSEY OPINION 701 (2006) (LAWYER MAY USE ELECTRONIC FILING SYSTEM WHEREBY ALL DOCUMENTS ARE SCANNED INTO A DIGITIZED FORMAT AND ENTRUSTED TO SOMEONE OUTSIDE THE FIRM PROVIDED THAT THE LAWYER EXERCISES "REASONABLE CARE," WHICH INCLUDES ENTRUSTING DOCUMENTS TO A THIRD PARTY WITH AN ENFORCEABLE OBLIGATION TO PRESERVE CONFIDENTIALITY AND SECURITY, AND EMPLOYING AVAILABLE TECHNOLOGY TO GUARD AGAINST REASONABLY FORESEEABLE ATTEMPTS TO INFILTRATE DATA);

ARIZONA OPINION 05-04 (2005) (ELECTRONIC STORAGE OF CLIENT FILES IS PERMISSIBLE PROVIDED LAWYERS AND LAW FIRMS "TAKE COMPETENT AND REASONABLE STEPS TO ASSURE THAT THE CLIENT'S CONFIDENCES ARE NOT DISCLOSED TO THIRD PARTIES THROUGH THEFT OR INADVERTENCE"); *SEE ALSO* ARIZONA OPINION 09-04 (2009) (LAWYER MAY PROVIDE CLIENTS WITH AN ONLINE FILE STORAGE AND RETRIEVAL SYSTEM THAT CLIENTS MAY ACCESS, PROVIDED LAWYER TAKES REASONABLE PRECAUTIONS TO PROTECT SECURITY AND CONFIDENTIALITY AND LAWYER PERIODICALLY REVIEWS SECURITY MEASURES AS TECHNOLOGY ADVANCES OVER TIME TO ENSURE THAT THE CONFIDENTIALITY OF CLIENT INFORMATION REMAINS REASONABLY PROTECTED).

8. BECAUSE THE INQUIRING LAWYER WILL USE THE ONLINE DATA STORAGE SYSTEM FOR THE PURPOSE OF PRESERVING CLIENT INFORMATION - A PURPOSE BOTH RELATED TO THE RETENTION AND NECESSARY TO PROVIDING LEGAL SERVICES TO THE CLIENT - USING THE ONLINE SYSTEM IS CONSISTENT WITH CONDUCT THAT THIS COMMITTEE HAS DEEMED ETHICALLY PERMISSIBLE. *SEE* N.Y. STATE 473 (1977) (ABSENT CLIENT'S OBJECTION, LAWYER MAY PROVIDE CONFIDENTIAL INFORMATION TO OUTSIDE SERVICE AGENCY FOR LEGITIMATE PURPOSES RELATING TO THE REPRESENTATION PROVIDED THAT THE LAWYER EXERCISES CARE IN THE SELECTION OF THE AGENCY AND CAUTIONS THE AGENCY TO KEEP THE INFORMATION CONFIDENTIAL); *CF.* NY CPLR 4548 (PRIVILEGED COMMUNICATION DOES NOT LOSE ITS PRIVILEGED CHARACTER SOLELY BECAUSE IT IS COMMUNICATED BY ELECTRONIC MEANS OR BECAUSE "PERSONS NECESSARY FOR THE DELIVERY OR FACILITATION OF SUCH ELECTRONIC COMMUNICATION MAY HAVE ACCESS TO" ITS CONTENTS).

9. WE CONCLUDE THAT A LAWYER MAY USE AN ONLINE "CLOUD" COMPUTER DATA BACKUP SYSTEM TO STORE CLIENT FILES PROVIDED THAT THE LAWYER TAKES REASONABLE CARE TO ENSURE THAT THE SYSTEM IS SECURE AND THAT CLIENT CONFIDENTIALITY WILL BE MAINTAINED. "REASONABLE CARE" TO PROTECT A CLIENT'S CONFIDENTIAL INFORMATION AGAINST UNAUTHORIZED DISCLOSURE MAY INCLUDE CONSIDERATION OF THE FOLLOWING STEPS:

(1) ENSURING THAT THE ONLINE DATA STORAGE PROVIDER HAS AN ENFORCEABLE OBLIGATION TO PRESERVE CONFIDENTIALITY AND SECURITY, AND THAT THE PROVIDER WILL NOTIFY THE LAWYER IF SERVED WITH PROCESS REQUIRING THE PRODUCTION OF CLIENT INFORMATION;

(2) INVESTIGATING THE ONLINE DATA STORAGE PROVIDER'S SECURITY MEASURES, POLICIES, RECOVERABILITY METHODS, AND OTHER PROCEDURES TO DETERMINE IF THEY ARE ADEQUATE UNDER THE CIRCUMSTANCES;

(3) EMPLOYING AVAILABLE TECHNOLOGY TO GUARD AGAINST REASONABLY FORESEEABLE ATTEMPTS TO INFILTRATE THE DATA THAT IS STORED; AND/OR

(4) INVESTIGATING THE STORAGE PROVIDER'S ABILITY TO PURGE AND WIPE ANY COPIES OF THE DATA, AND TO MOVE THE DATA TO A DIFFERENT HOST, IF THE LAWYER BECOMES DISSATISFIED WITH THE STORAGE PROVIDER OR FOR OTHER REASONS CHANGES STORAGE PROVIDERS.

10. TECHNOLOGY AND THE SECURITY OF STORED DATA ARE CHANGING RAPIDLY. EVEN AFTER TAKING SOME OR ALL OF THESE STEPS (OR SIMILAR STEPS), THEREFORE, THE LAWYER SHOULD PERIODICALLY RECONFIRM THAT THE PROVIDER'S SECURITY MEASURES REMAIN EFFECTIVE IN LIGHT OF ADVANCES IN TECHNOLOGY. IF THE LAWYER LEARNS INFORMATION SUGGESTING THAT THE SECURITY MEASURES USED BY THE ONLINE DATA STORAGE PROVIDER ARE INSUFFICIENT TO ADEQUATELY PROTECT THE CONFIDENTIALITY OF CLIENT INFORMATION, OR IF THE LAWYER LEARNS OF ANY BREACH OF CONFIDENTIALITY BY THE ONLINE STORAGE PROVIDER, THEN THE LAWYER MUST INVESTIGATE WHETHER THERE HAS BEEN ANY BREACH OF HIS OR HER OWN CLIENTS' CONFIDENTIAL INFORMATION, NOTIFY ANY AFFECTED CLIENTS, AND DISCONTINUE USE OF THE SERVICE UNLESS THE LAWYER RECEIVES ASSURANCES THAT ANY SECURITY ISSUES HAVE BEEN SUFFICIENTLY REMEDIATED. *SEE* RULE 1.4 (MANDATING COMMUNICATION WITH CLIENTS); *SEE ALSO* N.Y. STATE 820 (2008) (ADDRESSING WEB-BASED EMAIL SERVICES).

11. NOT ONLY TECHNOLOGY ITSELF BUT ALSO THE LAW RELATING TO TECHNOLOGY AND THE PROTECTION OF CONFIDENTIAL COMMUNICATIONS IS CHANGING RAPIDLY. LAWYERS USING ONLINE STORAGE SYSTEMS (AND ELECTRONIC MEANS OF COMMUNICATION GENERALLY) SHOULD MONITOR THESE LEGAL DEVELOPMENTS, ESPECIALLY REGARDING INSTANCES WHEN USING TECHNOLOGY MAY WAIVE AN OTHERWISE APPLICABLE PRIVILEGE. *SEE, E.G., CITY OF ONTARIO, CALIF. V. QUON*, 130 S. CT. 2619, 177 LED.2D 216 (2010) (HOLDING THAT CITY DID NOT VIOLATE FOURTH AMENDMENT WHEN IT REVIEWED TRANSCRIPTS OF MESSAGES SENT AND RECEIVED BY POLICE OFFICERS ON POLICE DEPARTMENT PAGERS); *SCOTT V. BETH ISRAEL MEDICAL CENTER*, 17 MISC. 3D 934, 847 N.Y.S.2D 436 (N.Y. SUP. 2007) (E-MAILS

BETWEEN HOSPITAL EMPLOYEE AND HIS PERSONAL ATTORNEYS WERE NOT PRIVILEGED BECAUSE EMPLOYER'S POLICY REGARDING COMPUTER USE AND E-MAIL MONITORING STATED THAT EMPLOYEES HAD NO REASONABLE EXPECTATION OF PRIVACY IN E-MAILS SENT OVER THE EMPLOYER'S E-MAIL SERVER). *BUT SEE STENGART V. LOVING CARE AGENCY, INC.*, 201 N.J. 300, 990 A.2D 650 (2010) (DESPITE EMPLOYER'S E-MAIL POLICY STATING THAT COMPANY HAD RIGHT TO REVIEW AND DISCLOSE ALL INFORMATION ON "THE COMPANY'S MEDIA SYSTEMS AND SERVICES" AND THAT E-MAILS WERE "NOT TO BE CONSIDERED PRIVATE OR PERSONAL" TO ANY EMPLOYEES, COMPANY VIOLATED EMPLOYEE'S ATTORNEY-CLIENT PRIVILEGE BY REVIEWING E-MAILS SENT TO EMPLOYEE'S PERSONAL ATTORNEY ON EMPLOYER'S LAPTOP THROUGH EMPLOYEE'S PERSONAL, PASSWORD-PROTECTED E-MAIL ACCOUNT).

12. THIS COMMITTEE'S PRIOR OPINIONS HAVE ADDRESSED THE DISCLOSURE OF CONFIDENTIAL INFORMATION IN METADATA AND THE PERILS OF PRACTICING LAW OVER THE INTERNET. WE HAVE NOTED IN THOSE OPINIONS THAT THE DUTY TO "EXERCISE REASONABLE CARE" TO PREVENT DISCLOSURE OF CONFIDENTIAL INFORMATION "MAY, IN SOME CIRCUMSTANCES, CALL FOR THE LAWYER TO STAY ABREAST OF TECHNOLOGICAL ADVANCES AND THE POTENTIAL RISKS" IN TRANSMITTING INFORMATION ELECTRONICALLY. N.Y. STATE 782 (2004), *CITING* N.Y. STATE 709 (1998) (WHEN CONDUCTING TRADEMARK PRACTICE OVER THE INTERNET, LAWYER HAD DUTY TO "STAY ABREAST OF THIS EVOLVING TECHNOLOGY TO ASSESS ANY CHANGES IN THE LIKELIHOOD OF INTERCEPTION AS WELL AS THE AVAILABILITY OF IMPROVED TECHNOLOGIES THAT MAY REDUCE SUCH RISKS AT REASONABLE COST"); *SEE ALSO* N.Y. STATE 820 (2008) (SAME IN CONTEXT OF USING E-MAIL SERVICE PROVIDER THAT SCANS E-MAILS TO GENERATE COMPUTER ADVERTISING). THE SAME DUTY TO STAY CURRENT WITH THE TECHNOLOGICAL ADVANCES APPLIES TO A LAWYER'S CONTEMPLATED USE OF AN ONLINE DATA STORAGE SYSTEM.

CONCLUSION

13. A LAWYER MAY USE AN ONLINE DATA STORAGE SYSTEM TO STORE AND BACK UP CLIENT CONFIDENTIAL INFORMATION PROVIDED THAT THE LAWYER TAKES REASONABLE CARE TO ENSURE THAT CONFIDENTIALITY IS MAINTAINED IN A MANNER CONSISTENT WITH THE LAWYER'S OBLIGATIONS UNDER RULE 1.6. A LAWYER USING AN ONLINE STORAGE PROVIDER SHOULD TAKE REASONABLE CARE TO PROTECT CONFIDENTIAL INFORMATION, AND SHOULD EXERCISE REASONABLE CARE TO PREVENT OTHERS WHOSE SERVICES ARE UTILIZED BY THE LAWYER FROM DISCLOSING OR USING CONFIDENTIAL INFORMATION OF A CLIENT. IN ADDITION, THE LAWYER SHOULD STAY ABREAST OF TECHNOLOGICAL ADVANCES TO ENSURE THAT THE STORAGE SYSTEM REMAINS SUFFICIENTLY ADVANCED TO PROTECT THE CLIENT'S INFORMATION,

AND THE LAWYER SHOULD MONITOR THE CHANGING LAW OF PRIVILEGE TO ENSURE THAT STORING INFORMATION IN THE "CLOUD" WILL NOT WAIVE OR JEOPARDIZE ANY PRIVILEGE PROTECTING THE INFORMATION.

(75-09)

One Elk Street, Albany , NY 12207
Phone: 518-463-3200 Secure Fax: 518.463.5993

NEW YORK STATE BAR ASSOCIATION
Serving the legal profession and the community since 1876

ETHICS OPINION 1019

New York State Bar Association
Committee on Professional Ethics

Opinion 1019 (8/6/2014)

Topic: Confidentiality; Remote Access to Firm's Electronic Files

Digest: A law firm may give its lawyers remote access to client files, so that lawyers may work from home, as long as the firm determines that the particular technology used provides reasonable protection to client confidential information, or, in the absence of such reasonable protection, if the law firm obtains informed consent from the client, after informing the client of the risks.

Rules: 1.0(j), 1.5(a), 1.6, 1.6(a), 1.6(b), 1.6(c), 1.15(d).

QUESTION

1. May a law firm provide its lawyers with remote access to its electronic files, so that they may work from home?

OPINION

2. Our committee has often been asked about the application of New York's ethical rules -- now the Rules of Professional Conduct -- to the use of modern technology. While some of our technology opinions involve the application of the advertising rules to advertising using electronic means, many involve other ethical issues. See, *e.g.*:

N.Y. State 680 (1996). Retaining records by electronic imaging during the period required by DR 9-102 (D) [now Rule 1.15(d)].

N.Y. State 709 (1998). Operating a trademark law practice over the internet and using e-mail.

N.Y. State 782 (2004). Use of electronic documents that may contain "metadata".

N.Y. State 820 (2008). Use of an e-mail service provider that conducts computer scans of emails to generate computer advertising.

N.Y. State 833 (2009). Whether a lawyer must respond to unsolicited emails requesting representation.

N.Y. State 842 (2010). Use of a "cloud" data storage system to store and back up client confidential information.

N.Y. State 940 (2012). Storage of confidential information on off-site backup tapes.

N.Y. State 950 (2012). Storage of emails in electronic rather than paper form.

3. Much of our advice in these opinions turns on whether the use of technology would violate the lawyer's duty to preserve the confidential information of the client. Rule 1.6(a) sets forth a simple prohibition against disclosure of such information, i.e. "A lawyer shall not knowingly reveal confidential information, as defined in this Rule . . . unless . . . the client gives informed consent, as defined in Rule 1.0(j)." In addition, Rule 1.6(c) provides that a lawyer must "exercise reasonable care to prevent . . . others whose services are utilized by the lawyer from disclosing or using confidential information of a client" except as provided in Rule 1.6(b).

4. Comment 17 to Rule 1.6 provides some additional guidance that reflects the advent of the information age:

> [17] When transmitting a communication that includes information relating to the representation of a client, the lawyer must take reasonable precautions to prevent the information from coming into the hands of unintended recipients. The duty does not require that the lawyer use special security measures if the method of communication affords a reasonable expectation of privacy. Special circumstances, however, may warrant special precautions. Factors to be considered to determining the reasonableness of the lawyer's expectation of confidentiality include the sensitivity of the information and the extent to which the privacy of the communication is protected by law or by a confidentiality agreement. A client may require the lawyer to use a means of communication or security measures not required by this Rule, or may give informed consent (as in an engagement letter or similar document) to the use of means or measures that would otherwise be prohibited by this Rule.

5. As is clear from Comment 17, the key to whether a lawyer may use any particular technology is whether the lawyer has determined that the technology affords reasonable protection against disclosure and that the lawyer has taken reasonable precautions in the use of the technology.

6. In some of our early opinions, despite language indicating that the inquiring lawyer must make the reasonableness determination, this Committee had reached general conclusions. In N.Y. State 709, we concluded that there is a reasonable expectation that e-mails will be as private as other forms of telecommunication, such as telephone or fax machine, and that a lawyer ordinarily may utilize unencrypted e-mail to transmit confidential information, unless there is a heightened risk of interception. We also noted, however, that "when the confidential information is of such an extraordinarily sensitive nature that it is reasonable to use only a means of communication that is completely under the lawyer's control, the lawyer must select a more secure means of communication than unencrypted internet e-mail." Moreover, we said the lawyer was obligated to stay abreast of evolving technology to assess changes in the likelihood of interception, as well as the availability of improved technologies that might reduce the risks at a reasonable cost.

7. In N.Y. State 820, we approved the use of an internet service provider that scanned e-mails to assist in providing user-targeted advertising, in part based on the published privacy policies of the provider.

8. Our more recent opinions, however, put the determination of reasonableness squarely on the inquiring lawyer. See, e.g. N.Y. State 842, 940, 950. For example, in N.Y. State 842, involving the use of "cloud" data storage, we were told that the storage system was password protected and that data

stored in the system was encrypted. We concluded that the lawyer could use such a system, but only if the lawyer took reasonable care to ensure that the system was secure and that client confidentiality would be maintained. We said that "reasonable care" to protect a client's confidential information against unauthorized disclosure may include consideration of the following steps:

(1) Ensuring that the online data storage provider has an enforceable obligation to preserve confidentiality and security, and that the provider will notify the lawyer if served with process requiring the production of client information;

(2) Investigating the online data storage provider's security measures, policies, recoverability methods, and other procedures to determine if they are adequate under the circumstances;

(3) Employing available technology to guard against reasonably foreseeable attempts to infiltrate the data that is stored; and/or

(4) Investigating the storage provider's ability to purge and wipe any copies of the data, and to move the data to a different host, if the lawyer becomes dissatisfied with the storage provider or for other reasons changes storage providers.

Moreover, in view of rapid changes in technology and the security of stored data, we suggested that the lawyer should periodically reconfirm that the provider's security measures remained effective in light of advances in technology. We also warned that, if the lawyer learned information suggesting that the security measures used by the online data storage provider were insufficient to adequately protect the confidentiality of client information, or if the lawyer learned of any breaches of confidentiality by the provider, then the lawyer must discontinue use of the service unless the lawyer received assurances that security issues had been sufficiently remediated.

9. Cyber-security issues have continued to be a major concern for lawyers, as cyber-criminals have begun to target lawyers to access client information, including trade secrets, business plans and personal data. Lawyers can no longer assume that their document systems are of no interest to cyber-crooks. That is particularly true where there is outside access to the internal system by third parties, including law firm employees working at other firm offices, at home or when traveling, or clients who have been given access to the firm's document system. See, e.g. Matthew Goldstein, "Law Firms Are Pressed on Security For Data," N.Y. Times (Mar. 22, 2014) at B1 (corporate clients are demanding that their law firms take more steps to guard against online intrusions that could compromise sensitive information as global concerns about hacker threats mount; companies are asking law firms to stop putting files on portable thumb drives, emailing them to non-secure iPads or working on computers linked to a shared network in countries like China or Russia where hacking is prevalent); Joe Dysart, "Moving Targets: New Hacker Technology Threatens Lawyers' Mobile Devices," ABA Journal 25 (September 2012); Rachel M. Zahorsky, "Being Insecure: Firms are at Risk Inside and Out," ABA Journal 32 (June 2013); Sharon D. Nelson, John W. Simek & David G. Ries, Locked Down: Information Security for Lawyers (ABA Section of Law Practice Management, 2012).

10. In light of these developments, it is even more important for a law firm to determine that the technology it will use to provide remote access (as well as the devices that firm lawyers will use to effect remote access), provides reasonable assurance that confidential client information will be protected. Because of the fact-specific and evolving nature of both technology and cyber risks, we cannot recommend particular steps that would constitute reasonable precautions to prevent confidential

information from coming into the hands of unintended recipients, including the degree of password protection to ensure that persons who access the system are authorized, the degree of security of the devices that firm lawyers use to gain access, whether encryption is required, and the security measures the firm must use to determine whether there has been any unauthorized access to client confidential information. However, assuming that the law firm determines that its precautions are reasonable, we believe it may provide such remote access. When the law firm is able to make a determination of reasonableness, we do not believe that client consent is necessary.

11. Where a law firm cannot conclude that its precautions would provide reasonable protection to client confidential information, Rule 1.6(a) allows the law firm to request the client's informed consent. See also Comment 17 to Rule 1.6, which provides that a client may give informed consent (as in an engagement letter or similar document) to the use of means that would otherwise be prohibited by the rule. In N.Y. State 842, however, we stated that the obligation to preserve client confidential information extends beyond merely prohibiting an attorney from revealing confidential information without client consent. A lawyer must take reasonable care to affirmatively protect a client's confidential information. Consequently, we believe that before requesting client consent to a technology system used by the law firm, the firm must disclose the risks that the system does not provide reasonable assurance of confidentiality, so that the consent is "informed" within the meaning of Rule 1.0(j), i.e. that the client has information adequate to make an informed decision.

CONCLUSION

12. A law firm may use a system that allows its lawyers to access the firm's document system remotely, as long as it takes reasonable steps to ensure that confidentiality of information is maintained. Because of the fact-specific and evolving nature of both technology and cyber risks, this Committee cannot recommend particular steps that constitute reasonable precautions to prevent confidential information from coming into the hands of unintended recipients. If the firm cannot conclude that its security precautions are reasonable, then it may request the informed consent of the client to its security precautions, as long as the firm discloses the risks that the system does not provide reasonable assurance of confidentiality, so that the consent is "informed" within the meaning of Rule 1.0 (j).

7-14

One Elk Street, Albany , NY 12207
Phone: 518-463-3200 Secure Fax: 518.463.5993

NEW YORK STATE BAR ASSOCIATION
Serving the legal profession and the community since 1876

ETHICS OPINION 1020

New York State Bar Association
Committee on Professional Ethics

Opinion 1020 (9/12/2014)

Topic: Confidentiality; use of cloud storage for purposes of a transaction

Digest: Whether a lawyer to a party in a transaction may post and share documents using a "cloud" data storage tool depends on whether the particular technology employed provides reasonable protection to confidential client information and, if not, whether the lawyer obtains informed consent from the client after advising the client of the relevant risks.

Rules: 1.1, 1.6

FACTS

1. The inquirer is engaged in a real estate practice and is looking into the viability of using an electronic project management tool to help with closings. The technology would allow sellers' attorneys, buyers' attorneys, real estate brokers and mortgage brokers to post and view documents, such as drafts, signed contracts and building financials, all in one central place.

QUESTION

2. May a lawyer representing a party to a transaction use a cloud-based technology so as to post documents and share them with others involved in the transaction?

OPINION

3. The materials that the inquirer seeks to post, such as drafts, contracts and building financials, may well include confidential information of the inquirer's clients, and for purposes of this opinion we assume that they do.[1] Thus the answer to this inquiry hinges on whether use of the contemplated technology would violate the inquirer's ethical duty to preserve a client's confidential information.

4. Rule 1.6(a) contains a straightforward prohibition against the knowing disclosure of confidential information, subject to certain exceptions including a client's informed consent, and Rule 1.6(c) contains the accompanying general requirement that a lawyer "exercise reasonable care to prevent ... [persons] whose services are utilized by the lawyer from disclosing or using confidential information of a client."

5. Comment [17] to Rule 1.6 addresses issues raised by a lawyer's use of technology:

> When transmitting a communication that includes information relating to the representation of a client, the lawyer must take reasonable precautions to prevent the information from coming into the hands of unintended recipients. The duty does not require that the lawyer use special security measures if the method of communication affords a reasonable expectation of privacy. Special circumstances, however, may warrant special precautions. Factors to be considered in determining the reasonableness of the lawyer's expectation of confidentiality include the sensitivity of the information and the extent to which the privacy of the communication is protected by law or by a confidentiality agreement. A client may require the lawyer to use a means of communication or security measures not required by this Rule, or may give informed consent (as in an engagement letter or similar document) to the use of means or measures that would otherwise be prohibited by this Rule.

6. In the recent past, our Committee has repeatedly been asked to provide guidance on the interplay of technology and confidentiality. N.Y. State 1019 (2014) catalogues the Committee's opinions on technology. In that opinion, we considered whether a law firm could provide its lawyers with remote access to its electronic files. We concluded that a law firm could use remote access "as long as it takes reasonable steps to ensure that confidential information is maintained." *Id.* ¶12

7. Similarly, in N.Y. State 842 (2010), which considered the use of cloud data storage, we concluded that a lawyer could use this technology to store client records provided that the lawyer takes reasonable care to protect the client's confidential information. We also reached a similar conclusion in N.Y. State 939 (2012) as to the issue of lawyers from different firms sharing a computer system.

8. The concerns presented by the current inquiry were also present in N.Y. State 1019, N.Y. State 939 and N.Y. State 842, and those opinions govern the outcome here. That is, the inquirer may use the proposed technology provided that the lawyer takes reasonable steps to ensure that confidential information is not breached.[2] The inquirer must, for example, try to ensure that only authorized parties have access to the system on which the information is shared. Because of the fact-specific and evolving nature of technology, we do not purport to specify in detail the steps that will constitute reasonable care in any given set of circumstances. *See* N.Y. State 1019. ¶10. We note, however, that use of electronically stored information may not only require reasonable care to protect that information under Rule 1.6, but may also, under Rule 1.1, require the competence to determine and follow a set of steps that will constitute such reasonable care.[3]

9. Finally, we note that Rule 1.6 provides an exception to confidentiality rules based on a client's informed consent. Thus, as quoted in paragraph 5 above, a client may agree to the use of a technology that would otherwise be prohibited by the Rule. But as we have previously pointed out, "before requesting client consent to a technology system used by the law firm, the firm must disclose the risks that the system does not provide reasonable assurance of confidentiality, so that the consent is 'informed' within the meaning of Rule 1.0(j), i.e. that the client has information adequate to make an informed decision." N.Y. State 1019 ¶11.

CONCLUSION

10. Whether a lawyer for a party in a transaction may post and share documents using a "cloud" data storage tool depends on whether the particular technology employed provides reasonable protection to confidential client information and, if not, whether the lawyer obtains informed consent from the client after advising the client of the relevant risks.

(17-14)

[1]Rule 1.6(a) defines "confidential information" generally to include "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."

[2]This result is consistent with results in other jurisdictions that have considered lawyers' use of off-site, third-party cloud services for storing and sharing documents. *See, e.g.*, ABA 95-398; Arizona Opinion 05-04; California Opinion 2010-179; Connecticut Inf. Opinion 2013-07; Florida Opinion 12-3 (2013); Illinois Opinion 10-01 (2009); Iowa Opinion 11-01; Maine Opinion 207 (2013); Massachusetts Opinion 12-03; Massachusetts Opinion 05-04; Missouri Inf. Opinion 2006-0092; Nebraska Opinion 06-05; New Hampshire Opinion 2012-13/4 (2013); New Jersey Opinion 701 (2006); North Carolina Opinion 2011-6 (2012); North Dakota Opinion 99-03 (1999); Ohio Opinion 2013-03; Oregon Opinion 2011-188; Pennsylvania Opinion 2011-200; Pennsylvania Opinion 2010-060; Vermont Opinion 2010-6 (2012); Washington Inf. Opinion 2215 (2012).

[3]It has been said for example that the duty of competence may require litigators, depending on circumstances, to possess a basic or even a more refined understanding of electronically stored information. *See, e.g.*, Zachary Wang, "Ethics and Electronic Discovery: New Medium, Same Problems," 75 Defense Counsel Journal 328, at 7 (October 2008) ("disclosure of privileged information as a result of a lack of knowledge of a client's IT system would subject an attorney to discipline under Rules 1.1 and 1.6"). The California State Bar Standing Committee on Professional Responsibility and Conduct has tentatively approved an interim opinion interpreting California ethical rules as follows:

> Attorney competence related to litigation generally requires, at a minimum, a basic understanding of, and facility with, issues relating to e-discovery, i.e., the discovery of electronically stored information ("ESI"). On a case-by-case basis, the duty of competence may require a higher level of technical knowledge and ability, depending on the e-discovery issues involved in a given matter and the nature of the ESI involved. ... An attorney lacking the required competence for the e-discovery issues in the case at issue has three options: (1) acquire sufficient learning and skill before performance is required; (2) associate with or consult technical consultants or competent counsel; or (3) decline the client representation.

COPRAC Proposed Formal Opinion 11-0004 (2014).

One Elk Street, Albany , NY 12207
Phone: 518-463-3200 Secure Fax: 518.463.5993

THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK
COMMITTEE ON PROFESSIONAL ETHICS

Formal Opinion 2015-3: LAWYERS WHO FALL VICTIM TO INTERNET SCAMS

TOPIC: Internet-based scams targeting law firms

DIGEST: An attorney who discovers that he is the target of an Internet-based trust account scam does not have a duty of confidentiality towards the individual attempting to defraud him, and is free to report the individual to law enforcement authorities, because that person does not qualify as a prospective or actual client of the attorney. However, before concluding that an individual is attempting to defraud the attorney and is not owed the duties normally owed to a prospective or actual client, the attorney must exercise reasonable diligence to investigate whether the person is engaged in fraud. In addition, because Internet-based trust account scams may harm other firm clients, a lawyer who receives a request for representation via the Internet has a duty to conduct a reasonable investigation to ascertain whether the person is a legitimate prospective client before accepting the representation. A lawyer who discovers he has been defrauded in a manner that results in harm to other clients of the law firm, such as the loss of client funds due to an escrow account scam, must promptly notify the harmed clients.

RULES: 1.1, 1.4, 1.6, 1.15, and 1.18

QUESTION: What are the ethical duties of a lawyer upon suspecting or discovering that he is the target of an Internet-based trust account scam?

OPINION:

I. INTRODUCTION

Internet-based scams targeting lawyers are not new and appear to be on the rise.[1] Since 2009, email scams have swindled lawyers out of an estimated $70 million.[2] These scams are often highly sophisticated, involving parties that appear to be representing legitimate international corporations and using high-quality counterfeit checks that can take a bank weeks

---

[1] *See, e.g.*, Jennifer Smith, *In Email, Scammers Take Aim At Lawyers*, Wall St. J., Aug. 5. 2012, http://www.wsj.com/articles/SB10000872396390443517104577571453933076304; James McCauley, *Increasingly Sophisticated Internet Scams Continue to Target Lawyers*, Va. State Bar, Dec. 2, 2013, http://www.vsb.org/site/news/item/increasingly-sophisticated-internet-scams-continue-to-target-lawyers; Todd C. Scott, *Scammed! Sophisticated Check Fraud Scheme Targets Lawyers*, Am. Bar Ass'n Law Trends & News, Fall 2010, Vol. 7, No.1., *available at* http://www.americanbar.org/content/newsletter/publications/law_trends_news_practice_area_e_newsletter_home/10_fall_pm_feat1.html.

[2] Smith, *supra* note 1.

to discover. One experienced ring obtained $29 million over a two-year period from seventy lawyers in the United States and Canada.[3] Once an attorney falls victim to a scam, his problems have just begun. Banks have sued attorneys for lost funds caused by counterfeit checks, and some malpractice insurers have refused to indemnify affected lawyers. *See e.g., Lombardi, Walsh, Wakeman, Harrison, Amodeo & Davenport, P.C. v. American Guarantee and Liab. Ins. Co.*, 924 N.Y.S.2d 201 (3d Dep't 2011) (coverage litigation between insurer and attorney, arising from settlement of bank's lawsuit against attorney as a result of an overdraft caused by a counterfeit check); *O'Brien & Wolf, L.L.P. v. Liberty Ins. Underwriters Inc.*, No. 11-cv-3748, 2012 WL 3156802 (D. Minn. Aug. 3, 2012) (holding that insurance company was required to cover losses from attorney trust account due to counterfeit check scheme); *Attorneys Liab. Protection Soc., Inc. v. Whittington Law Assocs., PLLC*, 961 F.Supp.2d 367 (D. N.H. 2013) (denying insurance coverage for losses due to "Nigerian check scam").[4] On top of that, a law firm that suspects or knows that it is a victim of an Internet scam faces serious questions about its ethical obligations. This opinion addresses some of those ethical issues and offers guidance to attorneys who believe they are (or have been) the target of an Internet scam.

II. A TYPICAL SCAM[5]

A common example of the internet-based scam begins with an email from an individual requesting assistance with an urgent transactional or litigation matter (the "email sender"). This email sender is generally located abroad, whereas the counterparty or adversary is usually located in the attorney's jurisdiction. The email sender often proposes a contingency fee arrangement whereby the attorney would receive a percentage of the transaction total or litigation settlement. If the attorney sends a draft engagement letter, the email sender swiftly executes it. Soon thereafter, the email sender notifies the attorney that transaction has been consummated or the litigation has settled. As a result, the attorney performs little or no work before the engagement ends.

---

[3] McCauley, *supra* note 1.

[4] A determining factor in lawyer-insurer litigation surrounding scams is often whether or not the activity was related to the firm's "professional" services. *See, e.g., Bradford & Bradford, P.A. v. Attorneys Liab. Prot. Soc'y, Inc.*, No. 0:09-CV-02981-CMC 2010 WL 4225907 (D.S.C. Oct. 20, 2010) (no duty to defend law firm against lawsuit by bank to recover funds lost due to trust account fraud). In New York, however, at least one appellate court has held that handling a client's funds is part of the legal services provided, even when the client is an imposter. *Lombardi*, 924 N.Y.S.2d 201 (insurance company required to defend law firm against lawsuit by bank for lost funds). We highlight these cases merely to alert attorneys to the insurance coverage issues; whether or not losses caused by Internet-based scams are covered by legal malpractice insurance is outside the Committee's jurisdiction, which is limited to interpreting the New York Rules of Professional Conduct.

[5] This description of the typical scam and the "red flags" identified in Sections II and III are derived from case law, articles, and ethics opinions cited throughout this opinion.

The attorney receives the closing or settlement check quickly. The attorney then deposits the check in the law firm's trust account and, once the check has "cleared," the attorney transfers his contingent fee into his operating account and wires the remainder of the funds to a foreign bank account designated by the email sender. Unfortunately, the attorney might not realize that a bank can "clear" a check and make the funds available before the bank actually *collects* the funds. The bank may take weeks or even months to discover that the check is fraudulent. When that happens, the bank will notify the attorney that the check was fraudulent.

If the trust account contains the funds of other clients, then those clients may be harmed because the bank may use those funds to cover all or part of the wire transfer. If the trust account contains no other client funds (or if the client funds are insufficient to cover the full amount of the wire transfer), then the bank will notify the attorney that his trust account is overdrawn, and will look to the attorney or the law firm to make up the deficiency.

III. RED FLAGS WHICH MAY ALERT AN ATTORNEY TO AN INTERNET SCAM

Before we discuss an attorney's ethical options and obligations upon receiving a scam communication, we will identify some of the elements that may alert an attorney to the scam. A lawyer's suspicion should be aroused by any one or more of these common "red flags" indicating a scam:

- The email sender is based abroad.
- The email sender does not provide a referral source. (If the email sender is asked how he found the firm, he may respond that it was through an online search. If prospective clients rarely approach the recipient attorney based on an Internet search, this should be an immediate red flag.)
- The initial email does not identify the law firm or recipient attorney by name, instead using a salutation such as "Dear barrister/solicitor/counselor."
- The email uses awkward phrasing or poor grammar, suggesting that is was written by someone with poor English or was converted into English via a translation tool.
- The email is sent to "undisclosed recipients," suggesting that it is directed to multiple recipients. (Alternatively, the attorney recipient may be blind copied on the email.)
- The email requests assistance on a legal matter in an area of law the recipient attorney does not practice.
- The email is vague in other respects, such as stating that the sender has a matter in the attorney's "jurisdiction," rather than specifying the jurisdiction itself.
- The email sender suggests that for this particular matter the attorney accept a contingency fee arrangement, even though that might not be customary for the attorney's practice.
- The email sender is quick to sign a retainer agreement, without negotiating over the attorney's fee (since the fee is illusory anyway).
- The email sender assures the attorney that the matter will resolve quickly.
- The counterparty, if there is one, will also likely respond quickly, settling the dispute or closing the deal with little or no negotiation.

- The email sender insists that his funds must be wired to a foreign bank account as soon as the check has cleared. (The sender often claims that there is an emergency requiring the immediate release of the funds.)
- The email sender or counterparty sends a supposed closing payment or settlement check within a few days. The check is typically a certified check or a cashier's check, often from a bank located outside of the attorney's jurisdiction.

IV. DUTIES OF A LAWYER WHO SUSPECTS OR LEARNS THAT HE IS THE TARGET OF AN INTERNET SCAM

When an attorney receives an email from what appears to be a prospective client, it may not be immediately obvious whether it is a legitimate inquiry or an Internet scam. The email sender may provide contracts or other legal documents that look completely genuine; the companies involved in the transaction or litigation may have realistic websites; and the closing or settlement check that the attorney receives may be so authentic looking that even a bank has difficulty detecting that it is fraudulent.

Consequently, if an email or the course of dealing with the client contains one or more of the red flags described above, the safest course may be to delete it. As the California State Bar Association Committee on Professional Responsibility and Conduct ("COPRAC") has noted: "The best approach is to ignore such solicitations altogether." COPRAC Ethics Alert: *Internet Scams Targeting Lawyers* (Jan. 2011). An attorney has no ethical obligation to respond to an unsolicited email inquiry from a prospective client. *See* NYSBA Ethics Op. 833 (2009) ("An attorney is not ethically required to respond to unsolicited letters from incarcerated individuals requesting legal representation."). If the attorney responds to the email, however, he should be mindful of certain ethical obligations that arise once he engages in those communications.

A. Ethical Duties Owed to the Email Sender

Even before an attorney-client relationship has formed, an attorney owes certain duties to prospective clients, including the duty to preserve confidential information. *See* Rule 1.18(b). Those duties do not apply, however, to someone who is merely posing as a "prospective client" but whose purpose is to defraud the attorney. The Committee on Professional Ethics of the New York State Bar Association ("NYSBA") has noted:

> [A] person who communicates with a lawyer seemingly for the purpose of forming a relationship to obtain legal services is presumptively a "prospective client" entitled to protections of confidentiality under the Rules. However, **if the purported prospective client is actually seeking to defraud the lawyer rather than to obtain legal services, then the person is neither an actual nor a prospective client and is not entitled to those confidentiality protections.**

NYSBA Ethics Op. 923 (May 18, 2012) (emphasis added). In light of these principles, an attorney must exercise diligence in investigating prospective clients before concluding that they

are not genuine and thus not owed any ethical obligations. "The presumption of confidentiality gives way only if and when the lawyer reasonably concludes that the purported client was not actually seeking legal services." *Id.*

While an attorney is investigating the validity of a potential new matter, he is still bound by his duties to a legitimate prospective client. In particular, Rule 1.18(b) prohibits the disclosure of any information learned in the consultation with the prospective client. If the attorney has not yet determined that the prospective client is trying to defraud the attorney, then the attorney is prohibited from disclosing confidential information about the client, including to banking and law enforcement authorities. If the attorney concludes after investigating the matter that the email sender is attempting to defraud him, then the attorney "may report the scheme to affected banks or law enforcement authorities, and may supply information and documents to those investigating the scheme, without violating any duty of confidentiality that would be owed to persons genuinely seeking legal services." *Id.*

B. Ethical Duties Owed to Other Clients of the Firm

When an attorney falls victim to the type of Internet scam described above, it could place other clients of the firm at risk. For example, if an attorney's trust account holds funds from multiple clients, then any funds that are transferred from the trust account to the email sender most likely belong to other clients of the firm. This would place the firm in violation of Rule 1.15(a), which imposes a fiduciary duty upon the attorney to preserve client funds. The loss of those client funds triggers other ethical obligations, including a duty to immediately notify all affected clients. *See* Rule 1.4(a)(1)(iii) (lawyer must "promptly inform the client of . . . material developments in the matter").

In addition to suffering the reputational damage and financial losses that may come with falling victim to a scam, a lawyer may have violated the duty of competence. Rule 1.1 requires a lawyer to provide competent legal representation to a client and not to "intentionally . . . prejudice or damage the client during the course of the representation except as permitted or required by these Rules." Rule 1.1(a), 1.1(c)(2). In our view, the duty of competence includes a duty to exercise reasonable diligence in identifying and avoiding common Internet-based scams, particularly where those scams can harm other existing clients. Since depositing a counterfeit check into a firm's trust account can negatively impact an attorney's other current clients whose funds are in the same account, an attorney who fails to exercise reasonable diligence to identify and avoid an Internet scam may violate Rule 1.1. *See Iowa Sup. Ct. Att'y Disciplinary Bd. v. Wright*, 840 N.W.2d 295 (Iowa 2013) (attorney violated duty of competence by failing to conduct a cursory Internet search, which would have revealed the existence of a commonplace internet scam that resulted in financial loss to attorney's other clients).

Thus, an attorney who receives an email solicitation from an unknown individual should conduct a reasonable investigation to ascertain that the email sender is a legitimate prospective client. The due diligence may include verifying the accuracy of the information provided by the email sender, such as names, addresses, telephone numbers, website addresses, and referral sources. The attorney should resist the temptation to depart from his customary intake procedures, such as performing conflict checks, verifying the prospective client's business and

financial status, executing a retainer agreement, and obtaining an advance retainer. The attorney should also take reasonable steps to ensure that all funds deposited into the trust account are held until the bank confirms that the funds have been honored or collected, not merely that a check has "cleared." As noted above, pressure from the email sender to wire the funds immediately on the basis of an emergency or urgent need is a red flag that should be scrutinized more closely.

V. CONCLUSION

An attorney who discovers that he is the target of an Internet-based trust account scam does not have a duty of confidentiality towards the individual attempting to defraud him, and is free to report the individual to law enforcement authorities, because that person does not qualify as a prospective or actual client of the attorney. However, before concluding that an individual is attempting to defraud the attorney and is not owed the duties normally owed to a prospective or actual client, the attorney must exercise reasonable diligence to investigate whether the person is engaged in fraud. In addition, because Internet-based trust account scams may harm other firm clients, a lawyer who receives a request for representation via the Internet has a duty to conduct a reasonable investigation to ascertain whether the person is a legitimate prospective client before accepting the representation. A lawyer who discovers he has been defrauded in a manner that results in harm to other clients of the law firm, such as the loss of client funds due to an escrow account scam, must promptly notify the harmed clients.

MOSES & SINGER LLP

Devika Kewalramani

Partner

dkewalramani@mosessinger.com
T (212) 554-7832
F (917) 206-4332

Devika Kewalramani is a partner and co-chair of Moses & Singer's Legal Ethics & Law Firm Practice which advises law firms, lawyers and legal departments on ethical and legal aspects of law practice. She also currently serves as the firm's general counsel. Devika represents law firms and attorneys in legal ethics, professional discipline, law firm risk management, lawyer licensing and admissions matters, including escrow issues, conflicts of interest, structuring arrangements with non-lawyers, multijurisdictional practice, disqualification, lateral transition, law firm mergers and break-ups, partner disputes, ethics in alternate dispute resolution, reporting/disclosure issues, attorney advertising, law firm cyber security issues, social media use, legal fee disputes, and other professional responsibility issues. She conducts ethics and risk management audits for clients.

A frequent lecturer, panelist and author on legal ethics, Devika speaks to law firms, corporate legal departments, bar associations and professional groups on a variety of legal ethics matters. The editor of *New York State Bar Association's Journal* magazine recognized Devika as author of one of the best articles of 2010: "Up Close and Professional With New York's Engagement Letter Rules" (September 2010). Her articles, "Trading Client Trust: A Glimpse Into Insider Trading Within the Legal Profession" and "Demystifying ESQrow Ethics" were featured on the front page of the *New York State Bar Association Journal's* May 2018 and May 2013 editions. Devika is a faculty member of the *Practising Law Institute* and of *Lawline.com*.

Devika is co-chair of the Council on the Profession of the New York City Bar Association.

She is the immediate past Chair of the Committee on Professional Discipline of the New York City Bar Association.

She was appointed a member of the New York Commission on Statewide Attorney Discipline in 2015 and served as a co-chair of its Subcommittee on Transparency and Access.

In 2014, 2015, 2016 and 2017, Devika achieved Super Lawyer status in the Metro Edition of *New York Super Lawyers®*.

PRACTICE AREAS

- Privacy
- Legal Ethics & Law Firm Practice

EDUCATION

- City University of New York School of Law (J.D.)
- St. Xavier's College (B.A.) Kolkata, India

BAR/COURT ADMISSIONS

- U.S. District Court, Southern District of New York
- New York
- Connecticut

FOREIGN LANGUAGES

- Bengali
- Hindi

PROFESSIONAL AFFILIATIONS

- Co-Chair, Council on the Profession, New York City Bar Association
- Past Chair, Committee on Professional Discipline, New York City Bar Association (2013-2017)
- Co-Chair, Subcommittee on Legal Ethics, Corporate Counsel Committee, American Bar Association Section of Litigation
- Member, New York Commission on Statewide Attorney Discipline, Co-Chair, Subcommittee on Transparency and Access (2015)
- Member, Committee on Continuing Legal Education, New York State Bar Association
- Member, Advisory Board of the Ethics Institute, New York County Lawyer's Association
- Member, Editorial Board of The Practical Lawyer, published by ALI CLE
- Member, Foundation Board of The City University of New York School of Law
- Member, International Board of Advisors, Jindal Global Law School, Sonipat, Haryana, India
- Past Chair, Subcommittee on Engagement Letters, Professional Responsibility Committee, New York City Bar Association
- Past Member, Committee on Professional Ethics, New York State Bar Association

PUBLICATIONS

- *Lexis® Practice Advisor for Corporate Counsel: Ethics For In-House Counsel*, Author (2012-current).
- "*The New York Rules of Professional Conduct*," Oxford University Press/New York County Lawyers' Association, Rules Co-Editor and Contributor of Three Chapters: "Rule 1.7 – Conflicts of Interest: Current Clients;" "Rule 1.8 – Current Clients: Specific Conflicts of Interest Rules;" and "Rule 1.9 – Duties to Former Clients" (2010-2012).

MOSES & SINGER LLP

Ethical Obligations in Cyber Security: The Risks You Must Know, The Responsibilities You Cannot Avoid

Presented By: Devika Kewalramani

July 14, 2018

MOSES & SINGER LLP

2

Overview

- Ethical duties relating to cyber security
- Guidance by bar associations
- Emerging law firm cyber security breach cases

MOSES & SINGER LLP

3

Ethical Duties Relating to Cyber Security

- Duty of competence (Rule 1.1); Comment [8]
- Duty to communicate (Rule 1.4)
- Duty of confidentiality (Rule 1.6); Comment [17]
- Duty to make reasonable efforts to ensure ethical compliance (Rule 5.1)
- Duty to adequately supervise non-lawyers (Rule 5.3); Comments [2] & [3]

MOSES & SINGER LLP

4

Ethical Duties Relating to Cyber Security

- Competence: Keep abreast of benefits/risks associated with use of technology in legal services
- Communication: Reasonably consult with client about means to accomplish client's objectives
- Confidentiality: Reasonable care to prevent unauthorized access or inadvertent disclosure
- Reasonable efforts to ensure ethical compliance
- Ensure non-lawyer conduct is compatible with professional obligations of lawyer

MOSES & SINGER LLP

5

Guidance By Bar Associations

- N.Y. State Bar Opinion 842 (2010)
- N.Y. State Bar Opinion 1020 (2014)
- N.Y. State Bar Opinion 1019 (2014)
- CA State Bar Opinion 2010-179 (2010)
- ABA Opinion 477 (2017)
- N.Y. City Bar Opinion 2015-3 (2015)

MOSES & SINGER LLP

6

Guidance By Bar Associations

Using outside online storage provider to store confidential client data (State Bar Opinion 842)

- "Reasonable care" standard to protect client against unauthorized disclosure
- Duty to keep up with advances in technology
- Monitor changing law of privilege to avoid loss of privilege
- Steps to take if there is a data breach

MOSES & SINGER LLP

7

Guidance By Bar Associations

Posting/sharing documents using cloud data storage tool in a transaction (State Bar Opinion 1020)

- Take reasonable measures to ensure client confidential data is not breached
- Duty of confidentiality ties in with duty of competence

MOSES & SINGER LLP

8

Guidance By Bar Associations

Remote access to firm's electronic files (State Bar Opinion 1019)

- Does particular technology provide reasonable protection to client data or has client consented after being informed of cyber risks?
- Recognizes cyber security threats to law firms but does not specify what reasonable precautions to take to prevent unintended disclosure

MOSES & SINGER LLP

9

Guidance By Bar Associations

Using laptop in local coffee shop for legal research via public wireless Internet (CA Opinion 2010-179)

- Steps to evaluate if duties of confidentiality and competence violated when using particular technology:
  - Level of security attendant to use of that technology
  - Legal ramifications to third party interceptor
  - Degree of sensitivity of data
  - Possible impact on client of inadvertent disclosure
  - Urgency of situation
  - Client's instructions and circumstances

10

Guidance By Bar Associations

Securing Communication of Protected Client Information (ABA Opinion 477)

- Updated Guidance in light of increasing cybersecurity threats and technology advances
- Case-by-case analysis of electronic communications about client matters
  - Is data sensitive?
  - How is data accessed and managed?
  - What security measures provide reasonable protection?
  - Discuss level of security with client
  - Label as "privileged and confidential"
  - Security training for legal/nonlegal personnel
  - Conduct due diligence on third-party vendors

MOSES & SINGER LLP

11

Guidance By Bar Associations

Internet scams targeting law firms (City Bar Opinion 2015-3)

- Exercise reasonable diligence to investigate
- Owe duty of confidentiality?
- Reporting to law enforcement
- Notice to clients who may be harmed

12

Emerging Law Firm Cyber Security Breach Cases

- *Millard v. Doran*, filed in N.Y. State Supreme Court, April 2016
- *Jason Shore and Coinabul, LLC v. Johnson & Bell, Ltd.*, filed in Northern District, Illinois, April 2016

13

Questions?

Contact:

Devika Kewalramani, Esq.
Partner
Moses & Singer LLP
405 Lexington Avenue
New York, NY 10174-1299
Telephone: 212-554-7832
E-mail: dkewalramani@mosessinger.com

TRACK 9
Basics of Managed Long Term Care (MLTC) Advocacy: More Than Just Filling in the Application

Presented By:
Britt Burner, Esq.
Richard A. Marchese, Esq.

Basics of Managed Long Term Care MLTC) Advocacy:
More Than Just Filling in the Application
By Richard A. Marchese, Esq. & Britt Burner, Esq.

1. What is Medicaid Managed Long Term Care (MLTC)?
    a. Helps people who are chronically ill or have disabilities and who need health and long term care services to help them stay in their homes communities as long as possible.
    b. Two basic models Programs for All-Inclusive Care for the Elderly (PACE) and the MLTC.
        i. PACE- both Medicare and Medicaid pay a capitated rate to a PACE Plan for services.
        ii. PACE members are required to use PACE physicians and work with the PACE interdisciplinary team to develop a care plan for on-going care management.
        iii. PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services.
        iv. MLTC provides long term care services and ancillary services in exchange for receiving a capitated rate paid by Medicaid.
        v. MLTC members may retain their primary care physician and they retain their Medicare card for Medicare reimbursable services.
2. Eligibility Requirements
    a. Have a chronic illness or disability that would make you eligible for nursing home care.
    b. Able to stay safely at home at the time you join the plan.
    c. Expected to need 120 days or more of long term care services in the community.
    d. Meet the age requirement (age 21 or older).
    e. Are "dual eligible", i.e., eligible for both Medicare and Medicaid.
        i. See attached notice re mandatory enrollment in Medicare as a condition of Medicaid eligibility for certain individuals.
    f. Live in the area served by the Plan.
3. Long Term Care Services which require enrollment in a MLTC:
    a. Personal Care Services
    b. Consumer Directed Personal Assistance Program
    c. Adult Day Care
    d. Private duty Nursing
    e. Certified Home Health Agency long-term services
    f. Nursing Home residential care
4. **Practice Tip:- DO NOT OVER PROMISE HOURS!**
5. UPSTATE VS. DOWNSTATE DIFFERENCES
    a. Turn-around time
    b. Shortage of aides in Upstate counties

6. Community-Based Medicaid
    a. Remember, no five year look-back, and no penalty for transfers.
    b. Must complete Supplement A and provide current asset/income documentation.
    c. If seeking retroactive coverage, supply documentation for past three months, and copies of medical bills (paid and un-paid) for this period.
    d. **Practice Tip**: Indicate on top of application and in cover letter- "seeking MLTC".
    e. Single vs. married:
        Income level (for one): $842.00
        Resource level (for one): $15,150.00
    f. Post- eligibility spousal impoverishment rules apply!
    g. **Practice Tip**: If applying for a married individual, assuming there are excess resources, always submit a spousal refusal for the non-applying spouse. Again, Upstate vs. Downstate differences.
7. Becoming Eligible: The Plan
    a. Is your client eligible as of the first of the month?
    b. There are no transfer rules, but you want to think ahead in case your client may need a nursing home in the future.
    c. **Practice Tip**: You may want to wait an additional month after making transfers, if possible, so the bank statements do not show the transfers. While the client is eligible either way, the application review time may be less if there are not large transfers to review.
    d. Transfers to a spouse
8. Advise your clients regarding spousal contribution. (should they apply or wait?)
    a. Usually makes sense to apply, unless the spouse has so much income that the contribution would be more than they are currently paying for care.
        i. Suffolk/Nassau: not currently seeking contribution from spouses.
        ii. Contributions sought in Upstate counties- some are very aggressive in their pursuit of spouses.
            1. Any negotiations are directly with the County Law Department, or counsel for DSS. Aggressiveness varies County to County.
        iii. NYC: actively seeking contribution
            1. Letter usually comes 6-12 months after spouse is approved for Medicaid.
            2. Negotiate claim with investigator – can get a reduction in amount owed. Does not cover future claims.
        iv. Income: 25% of excess over MMMNA ($3,090)

v. Assets: for each month over CSRA ($123,600), Spouse is asked to pay Medicaid rate
    1. Opportunities for spouse to transfer assets to an irrevocable trust.

b. Other options for transfers to gain eligibility:
    i. Medicaid Qualifying Trust.
    ii. Family member.
    iii. Pooled asset trust
    iv. **Practice Tip**: Again, be cautious and advise your client, in writing, with copy for your file, that any transfers will have an impact if the client needs skilled nursing care within the next five years and seeks to have Medicaid coverage for such care.

9. Forms:
    a. Access NY Health Care (DOH-4220)
    b. Access NY Supplemental A (DOH-4495A) application
    c. HIPAA form
        i. Realize that you will need this each time you call for an update; they will often ask you to fax it over before any case examiner speaks to you.
10. Application Cover letter:
    a. Outlining what the assets are, if there are any transactions over $2,000, and the income calculation.
        i. All gross income added up, subtract health insurance premiums, subtract $842 + $20 disregard, then list resulting excess.
        ii. Indicate that the client intends to spend down through the use of a pooled income trust.
        iii. **Practice Tip**: If the applicant is not in receipt of SSD or SSI and you want to utilize a pooled trust for the spend-down, you must complete and submit the disability application documents with your Medicaid application.
        iv. Subtract housing disregard if Medicaid paid in NH and being discharged to community.
            1. NYC: $1,171 / Long Island $1,285 / Northern Metro $892
11. If the client is the beneficiary of a trust, irrevocable or revocable:
    a. Include trust document, list of assets in trust with supporting documentation (i.e. bank statements, deed to house, etc.), and list the income generated by trust (and add this to income calculation).
12. Application processing time:
    a. 45 days
    b. 90 days if:

i. Awaiting a disability determination, i.e. has not previously been deemed disabled by the Social Security Administration
    1. This applies to most of our clients looking to utilize a supplemental needs trust, including a pooled income trust. 18 NYCRR 360-2.4

c. What can you do if you do not receive a timely determination?
    i. Can you find out who the caseworker is?
    ii. Suffolk will always send a deferral.
    iii. NYC only sends a deferral if they really need something.
    iv. Upstate-find out who the caseworker is, make sure the caseworker has all the documentation needed, try to explain the circumstances, sympathize with their caseload, and ask them to please expedite.

13. Immediate Need Application
    a. Put immediate need on cover letter; pursuant to 16 ADM-02 – Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services.
    b. Additional documentation:
        i. Immediate Need Transmittal to the Home Care Services Program (HCSP-3052 (E)); Medical Request for Home Care (HCSP- M11Q); Attestation of Immediate Need (OHIP-0103);
    c. NYC can submit application via Email:
        i. HCRequests@hra.nyc.gov
    d. M11-Q –
        i. Must be completed within 30 days of medical examination and filed with local district within 30 days
        ii. State regulation 505.14(b)(3)
14. Financial Approval with a spend down:
    a. What to submit for pooled trust approval?
        i. Joinder agreement
        ii. Welcome letter
        iii. Verification of Deposit statement
        iv. Disability Questionnaire (LDSS-1151)
        v. Medical Report for Determination of Disability (LDSS-486T)
        vi. HIPAA form (OCA No. 960)
        vii. Authorization to Release Medical Information form (MAP-751e(E))
    b. Can apply for Medicare Savings Program (MSP) once the pooled trust is accepted and the case is re-budgeted with a $0 spend-down.
        i. Pays Medicare premium; keep in mind this will increase the client's surplus income amount.

c. **Practice Tip**: make sure power of attorney is sufficient to allow agent to join and fund a pooled income trust (Nt.- this has yet to become an issue Upstate).
    i. Pre-approval of power of attorney
    ii. See MARC Alert attached.

15. Conflict Free Assessment through MAXIMUS
    a. MLTC Policy 14.06: implementation of the conflict free evaluation and enrollment center (CFEEC)- https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care
        i. Do you qualify for more than 120 days of long term care?
    b. When?
        i. Only valid for 75 days
            1. See NYS MLTC Policy 16.08
        ii. **Practice Tip**: You can have your client schedule the Conflict Free Evaluation before the approval comes in.
            1. Ex. After 30-45 days have passed after application is submitted
    c. When making appointment:
        i. Need: full name, address, DOB, SSN, Medicaid number, phone number
    d. At appointment:
        i. Insurance cards available
        ii. Medications available
        iii. Name and number for primary care physician
        iv. Bathing, grooming, dressing, meal preparation, reheating, chores, assistance with ambulation (use of a cane or walker, indoor and outdoor), transfers (getting up/down from a seated position, getting up/down from a laying position), toileting (use of diapers or liners any incontinence of bowel or urine)
        v. Cueing and reminding for tasks
    e. Conflict free assessment must be conducted within 7 days of request.
    f. After approval- mandatory enrollment packet sent by NY Medicaid Choice to recipient, who has 75 days to pick a plan or recipient will be auto-assigned to a plan.
    g. Note – the conflict free assessment does not determine hours- that is done by the Plan.

16. MLTC Assessment
    a. Must enroll in MLTC Plan, exceptions:
        i. Hospice
        ii. NHTDI/TBI/OPWDD/
        iii. ALP
        iv. Those who only need housekeeping – personal care level 1 services; see 18 NYCRR 505.14 – no ADL help

b. **Practice Tip**: Always tell clients you cannot promise hours and document the conversation.
c. How many appointments to schedule?
    i. Shop around
    ii. Plans can see when others have come in but CANNOT see the services offered
d. Who should attend the assessment?
e. Make a decision with the client regarding who should appear at the assessment.
f. **Practice Tip**: some firms employ a non-attorney to appear at assessments. Others have an attorney attend the assessment or refer the client to a geriatric care manager.
g. Prepping client/caregivers
    i. Doctor's letter
    ii. List from current caregiver of daily tasks
    iii. Give the narrative of the worst day
    iv. Why there are no informal supports, i.e. caretaker's limitations
h. Uniform Assessment tool

17. How do you pick a MLTC Plan?
    a. Providers
        i. If your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network
    b. Knowing the market – what plans are giving clients the hours they need and providing good customer service.
    c. Enrollment in plan by 19th day of month to allow coverage for the 1st day of the following month.
18. Immediate Need Assessment
    a. 8 days
    b. Auto enrolled into agency or FI
    c. CDPAP –issue
    d. Pooled trust not approved – agency may want spend down
    e. After 120 days of immediate need services client will get a letter requiring enrollment in MLTC. Will be auto-enrolled in 60 days.
19. Spousal Impoverishment Protections for Married MLTC members
    a. Choice- budget as household of one with a spend down (and use pooled trust) - or utilize post-eligibility spousal impoverishment budgeting. Compare budgeting, and use whichever one is most advantageous. GIS 14 MA/25

b. GIS 13 MA/018: " Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance, a family member allowance, if applicable, and a personal needs allowance ($391.00 for 2018)."
c. 12 MA/013 sets forth how to do the budgeting comparison:
    i. Use with spousal refusal
d. -Submit request for spousal impoverishment budgeting after enrollment in Plan.

20. Miscellaneous:
    a. Reimbursement
        i. After pooled trust approval
        ii. Can only be reimbursed up to the number of hours that are approved by MLTC after assessment
        iii. Must get a retroactive eligibility determination and then seek reimbursement for paid services (but only at the Medicaid rate).
            1. Make sure you ask for retroactive coverage on the application (Section G.)
    b. What happens when your MLTC leaves market?
        i. What to tell your client
            1. Appeal rights?
            2. See sample letter.

Other Resources

- MARC – join to get results
    - http://a069-marc.nyc.gov/marc/home.aspx
- Western New York Law Center; NY Health Access – updated by NYLAG
    - http://www.wnylc.com/health/
- Medicaid Reference Guide
    - https://www.health.ny.gov/health_care/medicaid/reference/mrg/
- Fair Hearings Database
    - https://otda.ny.gov/hearings/search/
- State Complaint Number for MLTC Problems- 1-866-712-7197
    - E-mail mltctac@health.ny.gov- put "COMPLAINT" in subject line
- **For enrollment complaints - call NY Medicaid Choice -**
    - **1-855-886-0570** (Advocates line)
    - **1-888-401-6582** (Consumers line)

Human Resources Administration
Department of Social Services

MEDICAID ALERT

Medicare Enrollment

December 13, 2017

The purpose of this Alert is to provide organizations assisting Medicaid consumers with information regarding the requirement for certain Medicaid applicants/recipients (A/Rs) to apply for Medicare as a condition of Medicaid eligibility.

Medicaid applicants/recipients who appear to be eligible for Medicare benefits are required to apply for Medicare as a condition of Medicaid eligibility. This requirement applies to individuals who are eligible for payment of their premiums either through the Medicare Savings Program or as a fully eligible Medicaid recipient (without deducting the premium payment from income). These Medicaid A/Rs are required to apply for Medicare as these benefits will reduce the costs incurred by the Medicaid program. This includes recipients receiving Medicaid on a Temporary Assistance case.

I. Medicare Eligibility

Some individuals get Medicare automatically and others must sign up for it. In most cases, it depends on whether the individual is receiving Social Security benefits. Individuals receiving Social Security or Railroad Retirement Benefits will automatically be enrolled in Medicare Parts A and B when they turn 65.

Individuals age 65 or over, who are not receiving Social Security retirement benefits or Railroad Retirement benefits, must enroll in Medicare by contacting the Social Security Administration. When an individual turns 65, the individual becomes eligible for Medicare if he or she:

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* **Karen Lane,** *Executive Deputy Commissioner* **Maria Ortiz-Quezada**, *Director of EIS*

- Receives or qualifies for Social Security retirement benefits or Railroad Retirement benefits; or
- Currently resides in the United States and is either a United States citizen or a lawful permanent resident who has lived in the US continuously for five years prior to applying.

An individual is eligible for Medicare Part A, at no cost, at age 65 if:

- The individual receives or qualifies for Social Security benefits or Railroad Retirement benefits; or
- The individual's spouse (living or deceased, including divorced spouses) receives or is eligible to receive Social Security or Railroad Retirement benefits; or
- The individual or individual's spouse worked long enough in a government job through which Medicare taxes were paid for at least 10 years.

Individuals who do not meet any of these requirements, may be able to get Medicare Part A by paying a monthly premium.

Before age 65, an individual is eligible for Medicare Part A at no cost if the individual:

- Has been entitled to Social Security disability benefits for 24 months; or
- Receives Social Security disability benefits for ALS; or
- Has End Stage Renal Disease (ESRD) and is:
    - Eligible for or receives monthly benefits under Social Security or the Railroad Retirement system; or
    - Worked long enough in a Medicare-covered government job; or
    - Is the child or spouse (including a divorced spouse) of A worker (living or deceased) who worked long enough under Social Security or in a Medicare-covered government job.

Anyone who is eligible for free Medicare Part A can enroll in Medicare Part B by paying a monthly premium. Anyone not eligible for free Part A, can buy Part B, without having to buy Part A, provided they are a U.S. citizen or a lawful permanent resident who has lived in the U.S. continuously for five years.

Most people who meet the eligibility criteria for Medicare apply for the benefits once eligible. Some individuals may decline Medicare Part B because of the premium cost and may not know that Medicaid can pay the premiums for fully eligible recipients and for individuals who qualify under the Medicare Savings Program. Each year, from January 1 through March 31, there is a Medicare General Enrollment Period (GEP) for Part B. The GEP is for individuals who did not sign up during their initial enrollment period Individuals who fail to enroll during their initial enrollment period, or refuse automatic enrollment, may only enroll during the GEP. Individuals whose Part B has ended because of non-payment of premiums or voluntary withdrawal, may reenroll only during the GEP. Medicaid recipients and individuals eligible for the Medicare

Savings Program do not have to wait for the GEP to enroll in Medicare. They are eligible to enroll in Medicare at anytime. Fully Medicaid recipients and individuals eligible for the Medicare Savings Program may be enrolled into the Medicare Savings Program at any time during the year if the individual has established Medicare entitlement with the SSA.

I. Medicaid Program Implications

A Individuals Who Must Apply for Medicare

Fully eligible Medicaid A/Rs (with income at or below the applicable income level) and A/Rs with income at or below 120% of the Federal Poverty Level (FPL) and who are age 64 and 9 months or older must apply for Medicare as a condition of eligibility for Medicaid. This requirement applies to Medicaid only applicant/recipients as well as cash assistance/Medicaid applicant/recipients.

B. Individuals Excluded from the Medicare Requirement

Individuals who are presumptively eligible for Medicaid, individuals who are not fully eligible for Medicaid and individuals who have income above 120% of the FPL are excluded from the requirement to apply for Medicare. Most immigrants and non-citizens are excluded from this requirement. Only lawful permanent residents who have lived continuously in the U.S. for five years must apply for Medicare as a condition of Medicaid eligibility.

C. Documentation Requirements

Medicaid A/Rs can apply for Medicare by calling the SSA at 1-800-772-1213 to apply by phone or to make an appointment at the local SSA office. Individuals may also apply on-line at https://www.ssa.gov/medicare/. Individuals who apply on-line may be re-directed to apply either by phone or in person if it is determined that the person does not have 40 work quarters. Once an application is completed, the SSA will issue an award or denial letter by mail within two weeks. The Medicare card is mailed separately and is usually issued after the award letter is mailed.

If applying on-line, the applicant will receive an on-line confirmation stating that "You have applied for Medicare with the Social Security Administration." This confirmation may be printed and used a proof of application. The award or denial letter, a copy of the Medicare card, or the printed on-line confirmation, are all acceptable forms of documentation.

Consumers Applying for Medicaid

Consumers aged 64 and 9 months or older who are applying for Medicaid will be required to apply for Medicare unless otherwise excluded. The OHIP-0112 has been added to our application kits to explain this requirement to applicants until the DOH 4220 can be revised. If an applicant fails to apply for Medicare and applied for Medicaid coverage for the three month

retroactive period, the individual will be ineligible for Medicaid prospectively and for any month in the three-month retroactive period where the condition of eligibility applies (i.e. the consumer was aged 64 and 9 months or older). The individual can qualify for assistance for the months in which the individual had not yet reached age 64 and 9 months. If an applicant provides proof of applying for Medicare following a denial or discontinuance of Medicaid but within 30 days of the effective date of the denial/discontinuance, the receipt of the documentation will be treated as a reapplication. Medicaid eligibility will be redetermined if all other documentation requirements were met. A new three month retroactive period may apply based on the date the documentation is received (reapplication month). The documentation received satisfies the requirement for the three-month retroactive period.

The Medicare requirement will also be applied when an individual aged 64 and 9 months or older is requested to be added to a case, or when an individual applies for a separate determination after losing cash assistance benefits.

E. Consumers Renewing their Medicaid

HRA's renewals for disabled, aged, and blind consumers, including those turning 65 include a notice regarding the Medicare requirement. If renewals are received for consumers aged 64 and 9 months or greater who appear to meet the income standard for the Medicare requirement but are not in receipt of Medicare, the client will receive a deferral for proof of Medicare application. If consumers fail to submit the required proof of application, their coverage will be discontinued. Consumers can request more time to provide the proof of Medicare application if needed by calling the Medicaid Helpline (888 692-6116).

F. Consumers already in Receipt of Medicaid

While the requirement to enroll in Medicare is not new, recent audits have found that it has not been consistently enforced across the state. Therefore, the New York State Department of Health (SDOH) has developed a project to identify consumers turning 65 or aged 65 and above who appear to meet the requirements of Medicare but who have not yet enrolled. This project will target consumers who have not enrolled in Medicare at all (not those enrolled only in Part A or only in Part B). These consumers (if not currently in the renewal cycle (see consumers renewing above)) will receive a notice requiring the individuals to submit proof of application for Medicare. Consumers eligible for Medicaid with a surplus, consumers in a nursing home, and consumers in the 5 year ban will be excluded from this selection. Surplus consumers with incomes at or below 120% of FPL and Nursing Home consumers will be subject to the requirement at renewal unless otherwise excluded. If an individual does not provide the required proof by the designated due date (approximately 30 days

from the notice date), the consumer will be sent a Notice of Intent to close their Medicaid coverage and the case will close 14 days from the Notice date. Prior to selection for closing,

however, system records will be checked to determine if the Welfare Management System now shows Medicare coverage for the individual. If the consumer has provided proof of application or denial or if the Welfare Management System now shows Medicare enrollment, the client's coverage will not be terminated.

In New York City, this notice process for current Medicaid only recipients will be divided into three separate mailings. The first mailing is expected to go out in early- mid December with the second and third mailings expected to occur in three to four month intervals.

Medicaid only consumers in this group who request more time to comply will be issued a new deferral and will receive a notice with a new due date. This process will allow us to properly track these consumers.

G. Consumers Needing More Time

If an A/R or the A/Rs legal representative requires additional time to meet the documentation requirement, additional time will be allowed. For Medicaid only clients, client representatives should submit MAP 3062(c) to the Undercare Processing Division to request more time for their clients. Alternatively, consumers or their representatives can call the HRA Medicaid Helpline (888-692-6116) to request additional time.

For additional information please see 17 OHIP/ADM-01 Medicare Enrollment at Age 65.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

REQUEST FOR A TIME EXTENSION:
MEDICARE APPLICATION

NYC Human Resources Administration
Department of Social Services

MAP-3062c 12/13/2017

Date: _____

Case Name: _____

Case Number: _____

CIN: _____

I am unable to provide the documentation that HRA requested at this time. I am requesting additional time past the deferral due date that HRA provided. I understand that this extra time will delay the final processing of my case which could result in an eligibility determination taking longer than the normal case processing timeframe of 30 days for a case containing a child, 45 days for a case containing adults only, or 90 cases for a case based on a disability.

INITIAL EXTENSION REQUEST (place a checkmark in the appropriate box or boxes)

My due date to provide documents is_____.

☐ I am requesting the following:

Up to_____additional calendar days to give you my documents

Reason for Extension: _____

_____

_____

_____

FOLLOW-UP EXTENSION REQUEST (place a check in the box below if this is **not** your first extension request)

I am requesting up to_____additional calendar days to give you my documents

Reason for Extension: _____

_____

_____

_____

Please tell us what you have done to get the documents. Include the name and contact information of the third party contacted (e.g. Bank, Life Insurance Company, Pension Company, IRS, SSA, etc.) the dates contacted and the response received. Attach any relevant correspondence.

I understand that if I do not provide the documents requested by the date it is due, or send HRA a request for an additional extension explaining why I need more time, HRA will make an eligibility determination based upon the documents and information on file and:

My application may be:

- Denied for Medicaid. HRA will not authorize Nursing Home coverage or any other type of Medicaid coverage
- Determined eligible for Medicaid Community Coverage **with** Community Based Long Term Care; **only**
- Determined eligible for Medicaid Community Coverage **without** Long-Term Care, **only**

Name of Consumer/Representative (Print)	Name of Consumer/Representative (Sign	Date

Do you have a medical or mental health condition or disability? Does this condition make it *hard for you to understand this notice or to do what this notice is asking? Does this condition* make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law

July 26, 2017

Power of Attorney Form *and* Statutory Gifts Rider

This Alert is to inform Providers, Client Representatives, Community Based Organizations and all organizations assisting clients with their Medicaid applications that a Power of Attorney signed in New York State after September 1, 2009, must comply with the detailed requirements of Title 15 of General Obligations Law to be valid. In particular**, to be valid**, the agreement must fully comply with all requirements of General Obligations Law § 5-1501B.

Furthermore, the New York Statutory Short Form Power of Attorney (NYSPOA) may only be used to establish a trust, if section (h) of the NYSPOA is initialed **and** if a Statutory Gifts Rider (SGR) is also signed and witnessed by two persons, who are not named in the SGR as permissible recipients of gifts, at the same time as the referencing NYSPOA. The SGR must meet the requirements of General Obligations Law § 5-1514.

All trusts signed by an agent with authority under an NYSPOA must also be accompanied by a properly executed SGR to be considered valid for Medicaid eligibility purposes.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

July 26, 2017

Power of Attorney Form *and* Statutory Gifts Rider

This Alert is to inform Providers, Client Representatives, Community Based Organizations and all organizations assisting clients with their Medicaid applications that a Power of Attorney signed in New York State after September 1, 2009, must comply with the detailed requirements of Title 15 of General Obligations Law to be valid. In particular**, to be valid**, the agreement must fully comply with all requirements of General Obligations Law § 5-1501B.

Furthermore, the New York Statutory Short Form Power of Attorney (NYSPOA) may only be used to establish a trust, if section (h) of the NYSPOA is initialed **and** if a Statutory Gifts Rider (SGR) is also signed and witnessed by two persons, who are not named in the SGR as permissible recipients of gifts, at the same time as the referencing NYSPOA. The SGR must meet the requirements of General Obligations Law § 5-1514.

All trusts signed by an agent with authority under an NYSPOA must also be accompanied by a properly executed SGR to be considered valid for Medicaid eligibility purposes.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care

ATTACHMENT: LDSS-3183, "Provider or Managed Long Term Care Plan/Recipient Letter"

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 advise local departments of social services (LDSS) of the expansion of spousal impoverishment budgeting for persons enrolled in managed long term care (MLTC) plans. There are three types of MLTC plans: Partially Capitated Plans, Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus. This GIS also informs LDSS staff of the requirement to apply institutional eligibility rules, including transfer of assets provisions, when an enrollee is in receipt of long term nursing facility services or is an institutionalized spouse.

Pursuant to federal approval under the State's 1115 waiver, all individuals enrolled in MLTC with a spouse residing in the community who is not participating in a home and community-based services (HCBS) waiver or enrolled in MLTC ("community spouse"), must have Medicaid eligibility determined under the spousal impoverishment rules that apply to HCBS waiver participants. Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance (up to a maximum of $2898 for 2013), a family member allowance (up to $647 for 2013), if applicable, and a personal needs allowance (PNA), ($375 in 2013). If it is more advantageous to budget only the MLTC enrollee's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one, this option is available. This budgeting methodology also applies to couples with a spouse participating in PACE. See GIS 12 MA/013, "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program," for a further explanation of the rules to be used when spousal impoverishment post-eligibility rules are not favorable for a couple. Under both options, spousal impoverishment rules are to be applied to the couple's resources.

Effective April 1, 2013, certain Long Term Home Health Care Program (LTHHCP) waiver participants began transitioning into MLTC. For couples with a "community spouse," spousal impoverishment rules will continue to apply as they transition to MLTC. Therefore, the transition to MLTC should not result in a change in eligibility.

NOTE: When the MLTC enrollee is subject to eligibility under spousal impoverishment rules, the special income standard described in Administrative Directive, 12 OHIP/ADM-5, "Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program" does not apply.

If an individual with a "community spouse" was enrolled in MLTC prior to April 1, 2013, eligibility must be re-determined using spousal impoverishment budgeting at next client contact, case maintenance or at renewal, whichever occurs first.

Monthly Spenddown

Medicaid recipients with a monthly spenddown are eligible for participation in MLTC. Once the LDSS receives verification that an individual is eligible for participation in a MLTC plan, 06 (provisional coverage) or 19 (community coverage with community based long term care) coverage, as applicable, should be authorized. Currently, Coverage Code 06 will not convert to the Prepaid Capitation Plan (PCP) Coverage Code 30 (PCP full coverage) in order to allow payment to the MLTC plan. However, a system change is pending that will convert the 06 to 30, when there is a prospective MLTC enrollment line in the PCP subsystem. Until districts are notified of the effective date of this change, 01 (full coverage) must be authorized.

The MLTC plan is responsible to collect the amount of the spenddown from the enrollee. The LDSS must inform both the Medicaid eligible applicant/recipient and the plan of the amount of the spenddown. A copy of the eligibility notice with just the enrollee's information displayed may be used for this purpose. Additionally, WMS will pass the spenddown amount to the MLTC plan on a monthly roster. A list of providers that participate in MLTC can be found on the website of the Division of Long Term Care.

Since certain out-of-pocket medical expenses (e.g. co-insurance charges) and expenses for necessary medical and remedial services that are recognized under State law but are not covered by Medicaid, which are the responsibility of the enrollee, must be used first to meet a spenddown liability, the amount owed to a MLTC plan must be reduced by these costs. Receipts, bills or other evidence of incurred expenses must be submitted to the LDSS by the enrollee. The district will need to advise both the MLTC enrollee and the plan when such expenses have been applied toward the monthly spenddown. The LDSS-3183, "Provider/Recipient Letter (Financial Obligation of Recipient Toward Medical Expenses)" has been revised for use in providing this notification. The revised letter is attached to this GIS.

Nursing Facility Admissions, Institutional Eligibility Rules, NAMI

The local district will be notified by the MTLC plan when an enrollee is in receipt of long term nursing facility services (more than 29 days of short-term rehabilitation) or the person is an institutionalized spouse. When an enrollee is to receive more than 29 days of short-term rehabilitation or the person is an institutionalized spouse, the LDSS must conduct a 60 month resource "look back" to determine whether a prohibited transfer of assets was made that may affect eligibility. If the individual is also determined to be permanently institutionalized or the person is an institutionalized spouse, chronic care budgeting rules are applied to determine the institutionalized individual's net available monthly income (NAMI). Since the responsibility for collection of the NAMI from the enrollee is pursuant to a contract between the nursing home and the MLTC plan, the local district must send a

copy of the eligibility notices to the nursing facility and the MLTC plan. The LDSS does not make a principal provider subsystem entry on WMS.

> **NOTE:** For a permanently institutionalized spouse whose eligibility was determined under spousal impoverishment rules while in the community, the nursing home budget needs to be changed to include a $50 PNA instead of a PNA of $375.

If the LDSS determines that the enrollee has transferred assets within the 60 month look-back period and as a result, is not eligible for Medicaid coverage of nursing facility services, the district must notify the plan that the enrollee is ineligible for payment of nursing facility services. The enrollee must be involuntarily disenrolled by the district. Upon disenrollment, the coverage must be changed to the appropriate coverage code based on the specific case circumstances (see 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes").

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program

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 advise local departments of social services of a change in policy concerning the use of spousal impoverishment budgeting with post-eligibility rules for married individuals who receive home and community-based waiver services under a waiver authorized under Section 1915(c) of the Social Security Act.

Pursuant to federal approval under the State's 1115 waiver program, individuals with a "community spouse," as defined in Section 366-c of the Social Services Law, who are receiving waiver services in the Nursing Home Transition and Diversion (NHTD) waiver, Traumatic Brain Injury (TBI) waiver or Long Term Home Health Care Program (LTHHCP) must have eligibility determined under spousal impoverishment budgeting with post-eligibility rules, unless it is more advantageous to budget only the waiver participant's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one.

Spousal impoverishment with post-eligibility treatment of income includes a deduction for a community spouse monthly income allowance (CSMIA), family member allowance (FMA), if applicable, and a personal needs allowance (PNA) for the waiver participant. These deductions are not available when the total net income of only the waiver participant is budgeted and compared to the Medicaid income level for one.

In order to determine whether spousal impoverishment budgeting with post-eligibility rules is more advantageous, a comparison must be made of the deductions allowed under each of the two methodologies. If the sum of the waiver recipient's PNA, CSMIA and FMA, if applicable, is less than or equal to the sum of the Medicaid income level for a household of one and the $20 unearned income disregard, spousal impoverishment budgeting with post-eligibility rules is not more advantageous.

For example: The waiver recipient has a CSMIA of $400. The 2012 PNA for the waiver recipient (the difference between the two-person and one-person income levels) is $367 ($1,159 minus $792). Since the sum of the CSMIA and the PNA ($400 + $367 = $767) is less than the Medicaid income level for one plus $20 ($792 + $20 = $812), it is more advantageous to budget only the waiver participant's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one.

In 2012, it will only be advantageous to the waiver recipient to apply the post-eligibility rules if the CSMIA, plus FMA, if applicable, exceeds $445.

NOTE: In both situations, spousal impoverishment rules for treatment of resources, including a community spouse resource allowance (CSRA), apply.

The CSMIA and FMA, if applicable, can be determined offline, using the LDSS-4346, "Budget Worksheet – Medical Assistance Institutionalized Spouse Budget Worksheet," or by using the appropriate MBL budget – Chronic Care Budget Type 08, 09 or 10. If the CSMIA plus the FMA, if applicable, is greater than $445 (for 2012), the income continues to be budgeted under the appropriate Budget Type 08, 09 or 10. If the CSMIA, plus the FMA, if applicable, is equal to or less than $445, only the waiver spouse's income is budgeted using Budget Type 04, case count of one. Income of the community spouse is not considered available and is not included in the income calculation. Only resources attributed to the waiver spouse, after providing for any CSRA, is entered on the 04 budget.

Please direct any questions to your local district support liaison.

MEDICAID MANAGED LONG TERM CARE

WOODS OVIATT GILMAN
ATTORNEYS
The art of representing people

BURNER LAW GROUP, P.C.

RATED BY Super Lawyers

NEW YORK STATE'S VISION OF MEDICAID MANAGED LONG TERM CARE

THE SOMETIME REALITY OF THE MMLTC TODAY!

"I JUST CAN'T BELIEVE THIS CAN GO ON THIS LONG WITH PEOPLE'S LIVES ON THE OTHER END.. CAN I DO ANYTHING TO MOVE THIS FORWARD?"

WHAT IS MEDICAID MANAGED LONG TERM CARE (MLTC) ?

a. Helps people who are chronically ill or have disabilities and who need health and long term care services to help them stay in their homes communities as long as possible.
b. Two basic models:
   i. Programs for All-Inclusive Care for the Elderly (PACE)
   ii. the MLTC.

PACE

PACE- both Medicare and Medicaid pay a capitated rate to a PACE Plan for services.

PACE members are required to use PACE physicians and work with the PACE interdisciplinary team to develop a care plan for on-going care management.

PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services.

MLTC

MLTC provides long term care services and ancillary services in exchange for receiving a capitated rate paid by Medicaid.

MLTC members may retain their primary care physician and they retain their Medicare card for Medicare reimbursable services.

MLTC ELIGIBILITY REQUIREMENTS

a. Have a chronic illness or disability that would make you eligible for nursing home care.
b. Are able to stay safely at home at the time you join the plan.
c. Are expected to need 120 days or more of long term care services in the community.
d. Meet the age requirement (age 21 or older).
e. Are "dual eligible", i.e., eligible for both Medicare and Medicaid.
f. Live in the area served by the Plan.

LONG TERM CARE SERVICES WHICH REQUIRE ENROLLMENT IN A MLTC

- Personal care services
- Consumer Directed Personal Assistance Program
- Adult day care
- Private duty nursing
- Certified Home Health Agency long-term services
- Nursing home residential care

PRACTICE TIP – DO NOT OVER PROMISE!

UPSTATE VS. DOWNSTATE DIFFERENCES

- Turn-around time.
- Shortage of aides in Upstate counties.

FIRST STEP: APPLY FOR COMMUNITY BASED MEDICAID

a. Remember, no five year look-back, and no penalty for transfers.
b. Must complete Supplement A and provide current asset/income documentation.
c. If seeking retroactive coverage, supply documentation for past three months, and copies of medical bills (paid and un-paid) for this period.
d. Indicate on top of application and in cover letter-"seeking MLTC."

SINGLE VS. MARRIED

- Income level (for one): $842.00 + $20.00 disregard
- Resource level (for one): $15,150.00
- Post- eligibility spousal impoverishment rules apply!
- If applying for a married individual, assuming there are excess resources, always submit a spousal refusal for the non-applying spouse. Again, Upstate vs. Downstate differences.

BECOMING ELIGIBLE: THE PLAN

Is your client eligible as of the first of the month?

- There are no transfer rules, but you want to think ahead in case your client may need a nursing home in the future.
- Practice tip: You may want to wait an additional month after making transfers, if possible, so the bank statements do not show the transfers. While the client is eligible either way, the application review time may be less if there are not large transfers to review.

SPOUSAL TRANSFERS

- Advise your clients regarding spousal contribution. (Should they apply or wait)?
  - Usually makes sense to apply, unless the spouse has so much income that the contribution would be more than they are currently paying for care.
  - Suffolk/Nassau: not currently seeking contribution from spouses.
  - Contributions sought in Upstate counties- some are very aggressive in their pursuit of spouses.
  - NYC: actively seeking contribution
    - Letter usually comes 6-12 months after spouse is approved for Medicaid.

SPOUSAL SUPPORT

- Income: 25% of excess over MMMNA ($3,090).
- Assets: for each month over CSRA ($123,600). Spouse is asked to pay Medicaid rate.
  - Opportunities for spouse to transfer assets to an irrevocable trust.

SPOUSAL SUPPORT

- Negotiate claim with investigator – can get a reduction in amount owed. Does not cover future claims.
- Upstate: Any negotiations are directly with the County Law Department, or counsel for DSS. Aggressiveness varies County to County.

PLANNING OPPORTUNITIES

Other options for transfers to gain eligibility:

- Medicaid Qualifying Trust.
- Family member.
- Pooled asset trust.
- Again, be cautious and advise your client, in writing, with copy for your file, that any transfers will have an impact if the client needs skilled nursing care within the next five years and seeks to have Medicaid coverage for such care.

APPLICATION PROCESS (FORMS):

- Access NY Health Care (DOH-4220).
- Access NY Supplemental A (DOH-4495A) application.
- HIPAA form (OCA 960).
  - Realize that you will need this each time you call for an update; they will often ask you to fax it over before any case examiner speaks to you.

COVER LETTER WITH APPLICATION

- Outlining what the assets are, if there are any transactions over $2,000, and the income calculation.
- All gross income added up, subtract health insurance premiums, subtract $842 + $20 disregard, then list resulting excess.

COVER LETTER WITH APPLICATION

- Indicate that the client intends to spend down through the use of a pooled income trust.
- Practice Tip: If the applicant is not in receipt of SSD or SSI and you want to utilize a pooled trust for the spend-down, you must complete and submit the disability application documents with your Medicaid application.
- Subtract housing disregard if Medicaid paid in NH and being discharged to community.
  - NYC: $1,171 / Long Island $1,285 / Northern Metro $892

DOCUMENTATION

If the client is the beneficiary of a trust, irrevocable or revocable:

- Include trust document, list of assets in trust with supporting documentation (i.e. bank statements, deed to house, etc.), and list the income generated by trust (and add this to income calculation).

APPLICATION PROCESSING TIME:

- 45 days
- 90 days if:
  - Awaiting a disability determination, i.e. has not previously been deemed disabled by the Social Security Administration.
  - This applies to most of our clients looking to utilize a supplemental needs trust, including a pooled income trust.
  - 18 NYCRR 360-2.4.

AWAITING A DETERMINATION

What can you do if you do not receive a timely determination?

- Can you find out who the caseworker is?
- Suffolk will always send a deferral.
- NYC only sends a deferral if they really need something.
- Upstate-find out who the caseworker is, make sure the caseworker has all the documentation needed, try to explain the circumstances, sympathize with their caseload, and ask them to please expedite.

IMMEDIATE NEED APPLICATION

- New York City
  - Put immediate need on cover letter; pursuant to 16 ADM-02 – Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services.
  - Additional documentation:
    - Immediate Need Transmittal to the Home Care Services Program (HCSP-3052 (E)); Medical Request for Home Care (HCSP- M11Q); Attestation of Immediate Need (OHIP-0103).

IMMEDIATE NEED APPLICATION

- VIA Email: **HCRequests@hra.nyc.gov**
- M11-Q –
  - Must be completed within 30 days of medical examination and filed with local district within 30 days
  - State regulation 505.14(b)(3)
  - Upstate vs. Downstate- Upstate counties may have different requirements for a physician's statement of need.

FINANCIAL APPROVAL

- With spend down- utilize a pooled trust.
- What to submit for pooled trust approval?
  - Joinder agreement.
  - Welcome letter.
  - Verification of Deposit statement.
  - Disability Questionnaire (LDSS-1151).
  - Medical Report for Determination of Disability (LDSS-486T).
  - HIPAA form (OCA No. 960).
  - Authorization to Release Medical Information form (MAP-751e(E)).

FINANCIAL APPROVAL

- Can apply for Medicare Savings Program (MSP) once the pooled trust is accepted and the case is re-budgeted with a $0 spend-down.

  - Pays Medicare premium; keep in mind this will increase the client's surplus income amount.
- Practice Tip: make sure power of attorney is sufficient to allow agent to join and fund a pooled income trust (Nt.- this has yet to become an issue Upstate).
- Pre-approval of power of attorney.
- This has not yet been an issue in Upstate counties.
- See MARC Alert attached.

CONFLICT FREE ASSESSMENT THROUGH MAXIMUS

- MLTC Policy 14.06: implementation of the conflict free evaluation and enrollment center (CFEEC)- https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care.
- Do you qualify for more than 120 days of long term care?
- When?
  - Only valid for 75 days.
    - See NYS MLTC Policy 16.08.
  - Can schedule it before approval comes in.
    - After 30 days have passed.

APPOINTMENT FOR ASSESSMENT

- When making appointment:
  - Need: full name, address, DOB, SSN, Medicaid number, phone number.
- At appointment:
  - Insurance cards available.
  - Medications available.
  - Name and number for primary care physician.

ACTIVITIES OF DAILY LIVING

- Bathing, grooming, dressing, meal preparation, reheating, chores, assistance with ambulation (use of a cane or walker, indoor and outdoor), transfers (getting up/down from a seated position, getting up/down from a laying position), toileting (use of diapers or liners any incontinence of bowel or urine).
- Cueing and reminding for tasks.

APPROVAL THROUGH CONFLICT FREE ASSESSMENT

- Conflict free assessment must be conducted within 7 days of request.
- After approval- mandatory enrollment packet sent by NY Medicaid Choice to recipient, who has 75 days to pick a plan or recipient will be auto-assigned to a plan.
- Nt.- the conflict free assessment does not determine hours- that is done by the Plan.

MLTC ASSESSMENT

- Must enroll in MLTC Plan, exceptions:
  - Hospice.
  - NHTDI/TBI/OPWDD.
  - ALP.
  - Those who only need housekeeping – personal care level 1 services; see 18 NYCRR 505.14 – no ADL help.

MLTC ASSESSMENTS

- Practice Tip: Always tell clients you cannot promise hours and document the conversation.
- How many appointments to schedule?
  - Shop around.
  - Plans can see when others have come in but CANNOT see the services offered.
- How do you pick a MLTC Plan?

MLTC ASSESSMENTS

- Providers
  - if your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network.
- Knowing the market – what plans are giving clients the hours they need and providing good customer service.

MLTC ASSESSMENTS

- Prepping client/caregivers
  - Doctor's letter.
  - List from current caregiver of daily tasks.
  - Give the narrative of the worst day.
  - Why there are no informal supports, i.e. caretaker's limitations.

MLTC ASSESSMENTS

- Who should attend the assessment?
  - Make a decision with the client regarding who should appear at the assessment.
  - Practice Tip: some firms employ a non-attorney to appear at assessments. Others have an attorney attend the assessment or refer the client to a geriatric care manager.
- Uniform Assessment tool.
- Enrollment in plan by 19th day of month to allow coverage for the 1st day of the following month.

IMMEDIATE NEED ASSESSMENTS

- 8 Days
- Auto enrolled into agency for FI
- CDPAP – Issue
- Pooled trust not approved – agency may want to spend down
- After 120 days of immediate need services client will get a letter requiring enrollment into MLTC . Will be auto – enrolled in 60 days

SPOUSAL IMPOVERISHMENT PROTECTIONS FOR MARRIED MLTC MEMBERS

- Choice- budget as household of one with a spend down (and use pooled trust) - or utilize post-eligibility spousal impoverishment budgeting. Compare budgeting, and use whichever one is most advantageous. GIS 14 MA/25.

SPOUSAL IMPOVERISHMENT PROTECTIONS FOR MARRIED MLTC MEMBERS

- GIS 13 MA/018: " Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance, a family member allowance, if applicable, and a personal needs allowance ($391.00 for 2018)."
- 12 MA/013 sets forth how to do the budgeting comparison:
  - Use with spousal refusal.
  - Submit request for spousal impoverishment budgeting after enrollment in Plan.

REIMBURSEMENT

- After pooled trust approval.
- Must get a retroactive eligibility determination and then seek reimbursement for paid services (but only at the Medicaid rate).
- Make sure you ask for retroactive coverage on the application (Section G.)

AFTER MLTC APPROVAL

- Second Step planning?
- Spousal refusal issues.
- What happens when your MLTC leaves market?

OTHER RESOURCES

- MARC – join to get results
  - http://a069-marc.nyc.gov/marc/home.aspx
- Western New York Law Center; NY Health Access – updated by NYLAG
  - http://www.wnylc.com/health/
- Medicaid Reference Guide
  - https://www.health.ny.gov/health_care/medicaid/reference/mrg/

OTHER RESOURCES

- Fair Hearings Database
  - https://otda.ny.gov/hearings/search/
- State Complaint Number for MLTC Problems
  - 1-866-712-7197
- E-mail mltctac@health.ny.gov- put "COMPLAINT" in subject line
- For enrollment complaints - call NY Medicaid Choice
  - 1-855-886-0570 (Advocates line)
  - 1-888-401-6582 (Consumers line)

THANK YOU!

CONTACT US

Richard A. Marchese, Jr., Esq.
rmarchese@woodsoviatt.com

Firm Phone: 585-987-2800
Firm Fax: 585-454-3968
woodsoviatt.com

Britt Burner, Esq.
bburner@burnerlaw.com

Firm Phone: 212-867-5612
Firm Fax: 631-941-3443
burnerlaw.com

TRACK 10
Advanced Special Needs Planning: New Strategies

Presented By:
Robert P. Mascali, Esq.
Joan Lensky Robert, Esq.

KASSOFF, ROBERT & LERNER, LLP
ATTORNEYS AT LAW
100 Merrick Road
West Building · Suite 508
Rockville Centre, New York 11570
(516) 766-7700
Fax (516) 766-0738

Joan Lensky Robert

NEW YORK STATE BAR ASSOCIATION ELDER LAW SPECIAL NEEDS SECTION

SUMMER JULY 2018

TRACK 10:

ADVANCED SPECIAL NEEDS PLANNING: NEW STRATEGIES. PLANNING OPPORTUNITIES TO REDUCE ESTATE RECOVERY FOR THE CLIENT WITH A DISABILITY

I. INTRODUCTION

Many plaintiffs who are injured become disabled and thus have received government entitlements. Although Special Needs Trusts remain a viable and essential planning tool, some clients look to avoid the estate recovery associated with an SNT. The following scenarios discuss planning options using the Medical Indemnity Fund, MAGI Medicaid and the ABLE Act in order to reduce Medicaid's recovery from the assets of a person with a disability after any lien has been satisfied. The materials also include drafting tips for trusts to promote flexibility in the plan.

You will meet with PAUL, Plaintiff's attorney, and his clients. The clients are interested in planning options that will eliminate or reduce estate recovery in the future but also keep their benefits.

II. MEET MAUDE AND THE MEDICAL INDEMNITY FUND

A. MAUDE is a 6 year old child who was injured at birth. She is totally dependent upon her mother for support. She is unable to perform any activities of daily living unassisted. She does not walk, talk, toilet or feed herself. She attends school where she has a 1:1 aide. She has a home attendant paid for by the Medicaid program from 3pm – 11pm. Her mother is unable to work outside the home because of MAUDE's needs. Whenever she tried to work, her frequent absences due to MAUDE's health crises resulted in her being fired. Her mother is a high school graduate who had worked at Macy's prior to MAUDE's birth. MAUDE's father has not been involved with MAUDE in any way.

Up until now, MAUDE has been receiving SSI based on her disability and MOM's low assets and income, and Medicaid. They live with Grandma. The apartment is crowded and the atmosphere is tense, because Grandma always thinks she knows what's best for MOM and MAUDE.

The case has settled for $4,000,000.00 in money from the Defendants. A portion will be allocated to the Medical Indemnity Fund. You are going to explain the Fund, its effect on MAUDE's government benefits, and what options are available to manage her money and also reduce Medicaid's recovery from her estate when MAUDE passes away.

MOM's goals are to be able to buy a home and continue her daughter's home attendant. PAUL wants to make sure that Medicaid recoups as little as possible from MAUDE's assets when she passes away.

B. The Medical Indemnity Fund:

A great deal of medical malpractice claims are paid for infants injured during birth who are born with neurological impairments. These large recoveries are often comprised

of money intended to provide for pain and suffering, past care, future damages and losses of the infant, but also include money needed for the future health care costs of the infants during their lifetimes. However, with the advent of SNTs, their care has often been paid for by the Medicaid program.

In an effort to stem the costs of medical malpractice insurance premiums and keep down Medicaid costs, the New York State legislature enacted the New York Medical Indemnity Fund. N.Y. Pub. Health L. § 2999-g. Proposed by the Medicaid Redesign Team, "[t]he purpose of the fund is to provide a funding source for future health care costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage." Id. The Fund will pay the medical costs of those enrolled, id. at h(3), and will be primary to Medicare and Medicaid. Id. at § 2999-j(3). There are no financial criteria in order for a qualified plaintiff to be enrolled in the Fund and no reimbursement to the State upon the death of the qualified infant plaintiff for the expenditures made from the Fund on his/her behalf. Id. at h(4).

It is a comprehensive Fund to provide all medical care for qualified infant plaintiffs. "Those expenses that will or can be covered as qualifying health care costs are defined as broadly as defined by the statute." Preamble, 10 N.Y.C.R.R. 69-10. The benefits are portable, and will be paid for even if the infant is no longer in New York.

When a settlement has been reached, the parties allocate a portion of the recovery for past losses and for future nonmedical needs such as loss of services and pain and suffering. The portion allocated to the Fund is then paid for by tax revenue. In a case that has settled for $4,000,000.00, for example, in which 50% is allocated to nonfund damages, the Defendant will pay $2,000,000 to the plaintiff for the portion representing the past medical expenses and the future nonmedical needs. The Plaintiff will pay legal fees on

his/her $2,000,000.00 to the attorney. The Defendant will pay the legal fees on the $2,000,000.00 allocated to future medical care, but the $2,000,000 being allocated to the Fund will be paid NOT by the Defendant, but by tax revenue.

For those enrolled in the Fund, Medicaid is no longer needed to enable an infant plaintiff to receive necessary medical care and services for his/her lifetime, whether in New York or elsewhere. The parents' assets and income are not a factor in the child's enrollment. The Fund pays providers at an insurance rate of reimbursement rather than at a Medicaid rate of reimbursement. Because Medicaid will no longer be needed for any medical services during the child's lifetime, the settlement of a lawsuit stops the Medicaid payback when the plaintiff passes away, whether prior to age 55 or after age 55, as there will be no Medicaid provided after age 55.

C. MAUDE and the Fund

Because MAUDE suffered a neurological injury at birth, she will be enrolled in the Medical Indemnity Fund. The parties have allocated 80% of the recovery to the fund and 20% to the nonfund damages. Legal fees on the 20% allocated to the fund will be paid by the Defendant, while MAUDE will pay the legal fees on her portion. However, the Defendant will not be contributing to the cost of the fund portion. This is funded by a special revenue on hospitals, and the Defendant essentially is paying $4,000,000.00, which includes legal fees on the 20% allocated to the fund. The net amount after payment of legal fees and liens will be $2,700,000.00. PAUL said that the court is willing to allocate $200,000.00 to MOM for her loss of services.

D. The Medicaid Lien

PAUL, the personal injury attorney, has negotiated the Medicaid lien against the lawsuit in accordance with Arkansas Dept. of Health & Human Services v. Ahlborn, 547

U.S. 268, 126 S. Ct. 1752 (2006). Although the case settled for $4,000,000, he demonstrated that due to the injuries sustained by MAUDE, the true value of the case would have been $12,000,000.00 based upon her damages. Because MAUDE received only 1/3 of the value of the case, the Department of Social Services accepted only 1/3 of its $1,000,000 lien filed against the lawsuit, or $333,333,333.33.

E. SSI

The Supplemental Security Income (SSI) program, 42 U.S.C. 1381 et seq., is a needs based program. The federal program provides a monthly cash stipend to the aged, blind and disabled whose available resources and income do not exceed the maximum income and resources standards of the program. A person with a disability is someone whose inability to perform substantial gainful employment is expected to last for 12 months. 20 C.F.R. § 416.905. New York State provides an Optional State Supplement of $87/month to the federal benefit amount, which is $750 for 2018.

An SSI recipient may have no more than $2,000 in countable assets. In general, the uncompensated transfer of resources will result in a period of ineligibility for SSI. The waiting period caused by the gifting of assets is calculated by dividing the amount of resources transferred by the monthly SSI benefit. There is a 36 month look-back, and the ineligibility period is capped at 36 months, no matter how great the transfer. 42 U.S.C. § 1382b(c)(1)(A). No ineligibility period will be assessed to transfers into a trust by someone under the age of 65 which provides a payback to the State for the lifetime of Medicaid provided pursuant to 42 U.S.C. § 1396p(d)(4)(A) (a "payback" trust) or, for a person with a disability under the age of 65, to a pooled trust pursuant to 42 U.S.C. § 1396p(d)(4)(C). There is no payback for SSI benefits when the trust terminates. 42 U.S.C.

§ 1382b(e)(5). Assets in the pooled trust remain with the organization for other persons with a disability.

Until a child reaches 18, the financial eligibility of a child for SSI depends upon the economic situation of the parents. The parents' assets and income are deemed available to the child when computing eligibility for SSI for the child with a disability through the month of his/her 18th birthday. If a parent has more than $2,000 in resources, the child will not be eligible for SSI. A parent's unearned income, as from annuities, reduces the SSI benefits of a child with a disability almost dollar for dollar, after a credit is given for the federal benefit level of an adult, currently $750.00/month. Earned income reduces the SSI benefit only by approximately one half, after a credit is given for the federal benefit level of an adult, currently $750/month.

F. Planning for Asset Preservation and Asset Management

Because a child is under a legal disability due to age, meaning that he or she is unable to own and manage assets, a child's lawsuit recovery will be under the jurisdiction of a court until the child reaches 18. As with any lawsuit, access to the "nonfund" portion of the personal injury lawsuit for an infant will be subject either to CPLR Article 12, SCPA 17, SCPA 17-A, or Article 81. CPLR Article 12 authorizes payment to a parent and natural guardian, jointly with an officer of a bank, blocking the account from use absent further Order of the Court. Any use of funds must be made by application to the Court.

When there is no parent and natural guardian, a legal Guardian may be appointed for an infant, pursuant to SCPA 17. This appointment is made regardless of his/her intellectual abilities, without any finding of disability other than age. This appointment lasts until the infant reaches the age of 18. The use of the infant's funds will be subject to the jurisdiction of the Surrogate's Court. After the infant reaches the age of 18, the assets

will be paid to him/her unless the child is incapacitated at that age. In that case, the court order will direct that the parents apply to a court of competent jurisdicition for the appointment of a guardian when the child is 18.

Pursuant to SCPA 17-A a legal Guardian may be appointed for a person or infant with intellectual or developmental delays. Use of funds of the ward will be subject to the jurisdiction of the Surrogate's Court. This Guardian may be appointed for an infant or adult and lasts for life, unless a court determines that the ward no longer is intellectually or developmentally delayed.

A Guardian appointed pursuant to Article 81 of the Mental Hygiene Law to manage the funds of an Incapacitated Person will be subject to the jurisdiction of the Supreme Court. That court will oversee the use of the funds.

Because MAUDE will be enrolled in the Fund, she will not need Medicaid during her lifetime. For her to continue to receive SSI, however, she may maintain the assets in blocked bank accounts until she is 18, meaning that they may not be available for her use and benefit. In the alternative, she may fund a SNT, have access to the funds as authorized by the court, and not lose SSI.

As discussed above, the Medicaid lien has been compromised for $666,666.64 less than the actual amount paid out. That amount not reimbursed upon lawsuit settlement will be subject to reimbursement upon her death if she establishes a Special Needs Trust. 42 U.S.C. 1396p(d)(4)(A); N.Y. Soc. Serv. L. 3662(b)(2)(iii)(A). Moreover, the use of the trust will be subject to reporting requirements set by the government.

If she retains her lawsuit proceeds in a blocked account in order to continue SSI, she will not be able to use the funds. If she maintains the funds in bank accounts but obtains withdrawal orders, without an SNT, she will lose SSI but will be able to continue

to receive her health care through the Medical Indemnity Fund. Obtaining withdrawal orders is cumbersome and time consuming, and there is no investment discretion afforded the parent. What to do?

G. An SNT: To Do or Not to Do

1. Supplemental Needs Trusts have Extensive Payback to Medicaid

The payback provision of a Supplemental Needs Trust requires reimbursement from remaining trust assets for all Medicaid provided to the beneficiary. Id. The State is not limited to reimbursement for Medicaid paid after the effective date of the trust. The trust assets must be used to repay the State for all Medicaid provided to the beneficiary, even when a lien has been satisfied for less than the full amount of Medicaid provided at the time of the lawsuit.

The payback to the State upon the death of the trust beneficiary can be much greater when there is an SNT than when there is no SNT. When an individual who received Medicaid for reasons unrelated to a lawsuit brought on his/her behalf establishes an SNT, there will be a payback to the State upon death from remaining trust assets for an amount inclusive of all Medicaid provided to him/her during lifetime. A prior condition will not insulate noncausally related Medicaid from recovery. If a lien against a personal injury lawsuit has been compromised, the unreimbursed Medicaid will remain subject to payback upon the termination of the SNT. The payback will occur even if the beneficiary is survived by a spouse or child with a disability, cf. N.Y. Soc. Serv. L. 369, and may extend to a home owned by the SNT in which a caregiver child or sibling with an equity interest or disabled or minor child resides.

2. Factors to Consider When Deciding Whether to Establish an SNT

The decision to establish an SNT for an infant enrolled in the Fund will be made by weighing the benefits of the SSI program with the payback provisions of an SNT and the continuing involvement of government agencies in monitoring the use of the SNT. Although the Fund eliminates the need for Medicaid for the qualified plaintiff, the funds held by or for the infant will preclude his/her eligibility for SSI. There is no payback to the State for SSI benefits provided to the beneficiary of an SNT upon his/her death. However, if a Medicaid lien imposed against a lawsuit has been greatly compromised, the unpaid portion of the lien will be subject to payback to the State upon the plaintiff's death if s/he has established a Supplemental Needs Trust.

If there is no SNT, and the plaintiff foregoes SSI, upon his/her death there will be no reimbursement to the State from the nonfund portion of the assets if there has been no further Medicaid provided. See N.Y. Soc. Serv. L. 369, limiting estate recovery to Medicaid provided after the age of 55 from the Medicaid recipient's probate estate. Homes purchased for an infant plaintiff will not be subject to estate recovery so long as purchased outside of an SNT. The unpaid amount of Medicaid and the nature and amount of assets owned by the qualified plaintiff will be factors to consider when comparing the benefits of SSI with a payback upon death to the State for all Medicaid ever provided from remaining trust assets if a trust is established.

H. Establishing a Settlement Trust in an Infant Compromise Order: CPLR Article 12

Is there any way to hold the funds so that they may be available to be used and yet not subject them to a payback for all Medicaid provided upon the death of the plaintiff? The CPLR, Article 12, lists individuals to whom an infant's lawsuit proceeds may be paid.

CPLR §1206 directs that an infant's lawsuit proceeds be paid to a Guardian of the Property, a Conservator or Committee to be held for the use of the infant.

CPLR §1206(c) further directs the manner in which an infant's funds may be invested. These authorized investments are limited to insured banks or trust companies or savings banks or state or federal credit unions or specified accounts in insured savings and loan associations, insured savings certificates or an insured money market account, or insured or guaranteed U.S. treasury or municipal bills, notes or bonds. In addition, a court may order that a structured settlement agreement be executed. CPLR does Not allow investments pursuant to the Prudent Investor Act.

Notably absent from the CPLR is any authority for the Infant Compromise Order to direct that funds be paid to a trustee of any type of trust. Consistent with CPLR, then, some courts require that if there is to be an SNT or investment discretion, this may be given only when there is a legal Guardian of the Property appointed either pursuant to SCPA 17, SCPA 17 A or Article 81 of the Mental Hygiene Law.

Other courts, however, routinely authorize both SNTs and "settlement trusts" to be funded with the proceeds of an infant's lawsuit. They will appoint an independent trustee and either a Referee or Court Examiner to review annual accountings.

QUERY: IS IT TIME FOR THE STATUTE TO CATCH UP TO THE PRACTICE SO THAT TRUSTS MAY BE ESTABLISHED WITHOUT A LEGAL GUARDIAN FOR AN INFANT SO LONG AS THE TRIAL COURT WILL PROVIDE COURT OVERSIGHT?

ISSUE: When the infant will be incapacitated after age 18, may/should the Supreme Court Infant Compromise Order establish a trust that will last past the 18th birthday of an infant without a finding by a guardianship court of incapacity? What if the

child will always have a physical disability and thus need Medicaid (no "Fund" case) but is not mentally incapacitated? Should such a trust be revisited upon the infant's turning 18, giving him/her the choice of continuing the trust or dissolving he trust?

I. Plan for MAUDE

If MOM receives $200,000, MAUDE will lose eligibility for SSI. In addition, if MAUDE retains her assets and is able to access them, she will also lose SSI unless she has an SNT. As a goal is to purchase a home in which MOM and MAUDE will reside, if an SNT is established, solely to keep the SSI, upon MAUDE's death the home owned by the SNT would be subject to estate recovery.

SO HERE IS THE PLAN:

1. MAUDE will forego SSI.

2. PAUL will request that the court establish a Settlement Trust to hold the assets. This trust will be revocable and authorize a court to allow it to become an SNT if, in the future, the SSI becomes more important;

3. PAUL will ask the court to give TO MOM each month $750.00 to replace the lost SSI PLUS an additional $1000/month for MAUDE's living expenses.

4. The court will appoint an independent trustee to serve as Trustee, with broad discretion to use money for the benefit of MAUDE, and to account annually each year to a Referee appointed by the Court.

5. MOM will be directed to apply for legal guardianship of MAUDE when MAUDE reaches 18.

6. The Trust will provide that it will be subject to the jurisdiction of either the trial court or a court having jurisdiction over the legal guardian of MAUDE.

7. If MAUDE passes away with assets in the Settlement Trust, including the home, there is no payback to Medicaid, because assets would not pass by probate or intestacy and because she will not have received Medicaid after the age of 55. As MAUDE will have the Fund pay for her medical care, no Medicaid would be expended after age 6. Hence, the Ahlborn allocation will permit MAUDE to have $666,666.64 to use during her lifetime and not have a payback upon her demise.

III: MEET MARK AND MAGI MEDICAID

A. MARK'S Situation

MARK is on SSI and Medicaid as a person with a disability receiving SSI, meaning he can have no more than $2,000.00 in countable assets. He was injured in a motor vehicle accident when he was 27. At that time he was working part time, off the books, as a waiter, and going to school part time. He is now 30 and paralyzed from the waist down. He has a home attendant paid for by the Medicaid program. He has been living back home with his parents and can't wait to get his own place and get on with his life. He hopes to marry some day and maybe go back to school or even work. He isn't sure. But he definitely wants his independence AND to keep his Medicaid, of course.

PAUL has settled his case for $3,000,000. He will pay back Medicaid $150,000.00 of the $600,000 they have expended to date. The net to PAUL will be approximately $1,850,000.00.

B. MAGI Medicaid

As part of the Affordable Care Act, New York State expanded Medicaid eligibility to those whose income is less than $138% of the federal poverty level. See N.Y. Soc. Serv. L. 366(1)(a).

At this time, 138% of the Federal Poverty Level for a household of one is $1,397.00 per month. If one's income exceeds that amount, he or she will not be eligible for Medicaid at all. Excess income may not be spent down on medical needs the way it can be with traditional non-MAGI Medicaid called "Benchmark Medicaid" because it establishes the services that will be provided for Medicaid, regardless of the manner in which eligibility is computed. N.Y. Soc. Serv. L. 366(1)(a)(1). Those with a disability who are under 65 and are not eligible for Medicare may be eligible for either Medicaid Program. See id. at (1)(b)(1)(i)-(iv). Home health aides are available with either MAGI or traditional non-MAGI (benchmark) Medicaid.

Modified Adjusted Gross Income is calculated as per Section 36B(d)(2)(B) of the Internal Revenue Code. Id. at (1)(a)(7). Modified Adjusted Gross Income (MAGI) includes income from all sources, other than Veteran's benefits, Workers Compensation and child support. Interest on tax free investments is also included in MAGI. The receipt of an inheritance or insurance proceeds or lawsuit proceeds is not considered income for purposes of MAGI Medicaid, as these are tax free payments. In addition, structured settlements, which provide periodic tax free payments to a Plaintiff, are not counted as income for Modified Adjusted Gross Income.

Once eligible financially for MAGI Medicaid, one is also eligible to receive home care provided by home attendants and paid for by Medicaid, if the individual's medical needs require such care.

C. Structured Settlements

1. Statutory Authority for Structured Settlements

The Internal Revenue Code exempts amounts received as compensation for physical injuries or physical sickness from federal income tax, regardless of whether such amounts

are received in a lump sum at settlement or paid over time in a structured settlement. IRC 104(a)(2). They are also exempt from New York State and local income tax. N.Y. Tax Law 612.

2. Basic Process

A structured settlement agreement must be entered into PRIOR to the plaintiff's or plaintiff's attorney's receiving the funds. Typically, an annuity is purchased and owned by an insurance company that will then assign to a subsidiary the obligation to make periodic payments as agreed upon by the plaintiff.

3. Your Role in Choosing the Structure

A structured settlement broker will meet and present various scenarios as to how money that is structured will be paid out. When should the payments begin? Should there be a Cost of Living Adjustment? What is the guaranteed period? Should the payments be made for life? What is the rated age (i.e, in the case of MARK, does he have a shortened life expectancy due to his paralysis?) Although 30, he may be rated as medically already being 40 years old. The higher the rated age, the shorter the life expectancy and therefore the larger the return on a structured settlement that is guaranteed to make payments for the life of the Plaintiff.

You will also advise how much money should NOT be structured. If there is money to be set aside for a home and car, that money should be paid in up front moneys. Although back-ending the payments may produce a better financial return, because the annuity company is retaining the funds and not paying them out for a longer period of time, very often the needs of a Plaintiff are immediate.

4. Structured Settlements and SNTS

What happens when a plaintiff with a structured settlement dies and guaranteed future payments remain? If the settlement agreement provides that guaranteed payments shall be made to the estate of the plaintiff, these future payments will not be trust assets upon the death of the beneficiary available to satisfy a Medicaid claim. Paid to the estate of the beneficiary, they will escape reimbursement to the State if the beneficiary is under the age of 55 at the time of his/her demise. N.Y. Soc. Serv. L. § 369. Paid to a named beneficiary, they will also escape estate recovery.

In Sanango v. NYCHHC, 6 A.D.3d 519, 775 N.Y.S.2d 343 (2d Dep't 2004), the Appellate Division held that the use of the structured settlement with guaranteed payments to the estate rather than to the SNT altered the terms of the settlement and should not provide a means to thwart a payback to Medicaid upon the death of the plaintiff whose periodic payments were sheltered in the SNT during his lifetime. Absent conflicting appellate division authority, then, the Structured Settlement Agreement paid into an SNT must reflect that guaranteed payments shall be made to the SNT rather than to the estate of the beneficiary of an SNT upon the death of the plaintiff.

D. Plan for MARK with MAGI Medicaid:

MARK will be able to convert his benchmark Medicaid to MAGI Medicaid without creating an SNT, by applying for that change on line. His income must not exceed the MAGI income limit of $1,397 per month, or $16,764.00/year.

If he creates an SNT, he will continue to receive both SSI and Medicaid. However, because controlling his money is very important to him, he will be able to continue to receive Medicaid based on his Modified Adjusted Gross Income so long as the interest or

dividends earned on his funds and periodic payments that accumulate will not exceed the MAGI income limits. The periodic payments will not count as income.

SO in this case:

1. He will discontinue his SSI.

2. He will keep $750,000.00 in cash in the bank. 2% interest = $15,000/year or $1,250/month.

3. He will choose a structure that will pay monthly $3,800.00/month, guaranteed for his life and 30 years.

4. He will currently name his parents as the remainder beneficiaries of the structure, but can change that to a spouse or someone else in the future.

5. He will control his funds.

6. If he passes away with assets solely in his name, there will be recovery for long term care services (i.e. home care or nursing home care) paid out for him after the age of 55 but not while he is survived by a spouse or minor children or a child with a disability and not if he avoids probate, under current law. N.Y. Soc. Serv. L. 369.

7. If he ever feels that SSI will be important to him, OR if this expansion of Medicaid is ended and not grandfathered in, he can create an SNT and change the payee on the structure to his trust. He would not have to place a home that he might have purchased while on MAGI Medicaid into the SNT, as it is an exempt asset so long as he is living there.

IV: MEET ANNNIE AND THE ABLE ACT

A. ANNIE'S Situation

ANNIE is a 10 year old who was born with many congenital conditions, including hydrocephalus, intellectual disabilities and spinal malformations that make it impossible for her to walk. She is totally dependent upon her mother. PAUL has retained medical experts who advised that there was no malpractice when she was born. She has a very shortened life expectancy due to her condition.

ANNIE was scalded in the bath, due to a faulty water heater in her apartment. PAUL brought suit against the landlord and settled the case for $250,000. Medicaid has already expended more than $1,000,000.00 on her care. She receives home attendants from 3 pm – 11pm and from 11 pm -7 a.m. She then attends school. She receives SSI and Medicaid. MOM has not been able to work outside the home, due to ANNIE's medical needs and because she has 2 other minor children. Medicaid waived the lien, because the medical treatment was small on this case. The net recovery will be $180,000.00.

It is important to MOM that ANNIE continue to receive her benefits. She has heard about a Special Needs Trust and has been told that this is the best way to proceed. PAUL very much would like to protect ANNIE's assets for MOM if ANNIE should pass away. He knows that if ANNIE's funds are placed in an SNT, that Medicaid will be reimbursed whenever she passes away from all remaining money in her trust. He wants to know if you have any other ideas that would let ANNIE keep her SSI and Medicaid but limit Medicaid's estate recovery.

B. ABLE Act

The ABLE Act of 2013 is a federal statute that amended 26 U.S.C. 529 by adding Section 529-A to create tax-free savings accounts for individuals with disabilities.

Discussed for years as a tool to allow families of people with disabilities to set aside funds for his/her use in a way similar to funds set aside for college expenses, the federal statute, in its final version, vastly limited the initial purpose of the statute. Pursuant to the federal law, each state shall establish funds to be administered by independent fiduciaries for persons whose disabilities began prior to the age of 26. Contributions to the fund of each individual may not exceed the gift tax exclusion, $15,000/year in 2018, AGGREGATE FROM ALL SOURCES. The assets accumulating in the fund up to $100,000.00 will not count as an asset for SSI and up to a certain amount fixed by each State will not affect Medicaid. Assets may be used for designated disability expenditures. However, upon the death of the account beneficiary, there will be a payback to the State for Medicaid provided to the individual from remaining account assets for Medicaid provided after the account was funded. See N.Y. Mental Hyg. L. 84.05 for New York State's implementing legislation.

ABLE accounts may be used for qualified disability expenses of the account holder, i.e., the person with a disability. These include housing, educational expenses, living expenses, transportation, personal assistance services, assistive technology and health care not covered by insurance, Medicaid or Medicare. The intent is that these accounts will supplement rather than supplant government entitlements and serve as an easier way to provide for the qualified disability expenditures of a person with special needs than a Special Needs Trust. It allows the person with a disability or his/her parent if the person with a disability is a minor, or agent with a Power of Attorney or Guardian to control the funds in this account. See CMS September 7, 2017 CMS letter confirming that moneys placed into the ABLE account are not countable assets and that Trustees may fund these accounts. However, for SSI purposes, money received by the SSI recipient and then

paid into the ABLE account remains countable income for SSI in the month received. There is no transfer penalty for SSI or Medicaid when funds are placed into the ABLE Account. See SI 01130740, www.ssa.gov, detailing the qualified disability expenses and www.mynyable.org for enrollment forms and investment options in New York State.

The great advantage in using an ABLE account comes from a Social Security interpretation that if funds are paid from an ABLE account to pay for food and shelter of an SSI recipient, these expenditures will NOT result in a 1/3 reduction of the SSI. So, in-kind income from an ABLE account used to pay for food and shelter will NOT affect SSI, while making the same payments from an SNT or by a third party will reduce the SSI by 1/3.

Upon the death of the designated beneficiary, there will be a payback to the State for all Medicaid provided after the establishment of the account from remaining account assets. This is much less onerous than the payback for a first party SNT, which is for an amount up to the total Medicaid expended. N.Y. Soc. Serv. L. 366(2)(b)(2)(iii)(A). However, if a supplemental needs trust contains only someone else's funds, there would be no payback had a third party SNT been used. See E.P.T.L. 7-1.12.

C. The Plan for ANNIE:

ANNIE's funds will be structured, providing $15,000 once a year during the next 4 years, with MOM directed to fund an ABLE account with the annual payment. The rest of the funds will be paid out annually, $15,000/year once a year, to MOM as Guardian of ANNIE beginning on ANNIE's 18th birthday, and guaranteed for 12 years. The Infant Compromise Order directs that the payments be made to MOM as parent of ANNIE while ANNIE is under the age of 18, but directs MOM to become ANNIE's legal guardian after age 18. At that time, the funds subject to the Infant Compromise Order will be subject to

the jurisdiction of the Guardianship Part. The Infant Compromise Order authorizes MOM to use the ABLE account for Qualified Disability Expenses of ANNIE, and to account to the Court showing how the funds have been used until ANNIE's 18th birthday.

By having the ABLE account funded annually, but with the payments made to MOM as parent and natural guardian of ANNIE, the annual payments will affect ANNIE's SSI once a month each year. However, that amount is arguably less than the cost of maintaining an SNT with an independent Trustee and commissions. Moreover, if ANNIE passes away, only remaining assets in the ABLE account would be subject to the payback. Remaining guaranteed payments will be paid to her estate, NOT to an SNT with a payback for the lifetime of Medicaid. This alleviates Paul's concern that ANNIE might not survive even until age 18, and that if all assets are placed in an SNT, that the payback would preclude any inheritance for MOM.

V. DRAFTING TIPS:

A. SETTLEMENT TRUSTS

1. Settlement trusts in which the infant will be enrolled in the Medical Indemnity Fund must indicate that the funds may be used ONLY for items that the Fund will not provide – like the customary language in an SNT that the trust should be used to supplement and not supplant government entitlements.

2. Settlement trusts should be revocable, at the discretion of the trial court OR guardianship part so that they may become first party SNTS if there is a need in the future.

3. Indicating proposed types of expenditures (recreation, transportation, clothing, tutoring) , for an independent trustee to make will limit applications to the court for expenditures after the case has ended.

4. The Infant Compromise Order should direct that the parents bring a Guardianship application for an infant upon his/her reaching 18 if there is any question as to whether or not the infant will have capacity at that time.

5. The Settlement trust should provide for annual accountings and a mechanism to review those accountings while the beneficiary is a minor.

6. The Settlement Trust should direct that if a Guardian is appointed for the plaintiff, that the Guardianship Part will have ongoing jurisdiction over the trust.

7. The Trustee should be given the authority to fund an ABLE account if in the best interest of the beneficiary.

Sample Provisions Annexed hereto.

B. SNTS: FIRST PARTY OR THIRD PARTY

1. Provide that the Trustee may fund an ABLE account;

2. If established within an Infant Compromise Order, should provide what court oversight, if any, will be needed after the beneficiary reaches the age of 18.

VI CONCLUSION

The federal law authorizing individuals with disabilities to fund their own trusts is now 25 years old. Revolutionary at the time, we now have other planning options that may better meet the goals of some clients with personal injuries who wish to keep Medicaid but also want control of their assets and/or want to pass their assets to their heirs.

SETTLEMENT TRUST PROVISIONS

1.1 - CREATION AND EFFECT; SETTLOR AND TRUSTEE(S)

This Agreement made the _____ day of _____, 2016, between MOM, as Parent and Natural Guardian of MAUDE, as Settlor, and BANK as Trustee, is established pursuant to Order of the COURT. The Grantor and the Beneficiary reside at --. Trustee BANK maintains offices at ---.

1.2 - REVOCABILITY

This Trust may be amended or revoked at any time upon Order of the Supreme Court, , which shall retain jurisdiction over this Trust. .

1.3 - PURPOSE AND INTENT OF SETTLOR

It is the intent of the Settlor that this Trust shall constitute a plan to provide asset management and to authorize expenditures in categories as set forth in the Infant's Compromise Order settling ---. Expenditures shall include …. No expenditures shall supplant the Medical Indemnity Fund. If a Guardian has been appointed for the beneficiary, use of trust assets shall be as required by the court having jurisdiction over the Guardian of the beneficiary.

1.4 - USE OF INCOME AND PRINCIPAL

The Trustees shall hold, invest and reinvest the trust estate, receive monthly income to the Trust and pay, distribute or apply the principal and income for the benefit of MAUDE as set forth in the Infant's Compromise Order. Any purchase or sale of real property to be owned by

this Trust shall be made pursuant to RPAPL 17, If a Guardian has been appointed for the beneficiary, use of trust assets shall be as required by the court having jurisdiction over the Guardian of the beneficiary.

1.5- TERMINATION OF TRUST

This Trust shall terminate upon the first to occur of the death of the beneficiary or of an application to the Supreme Court, ounty, to terminate the trust, upon the beneficiary's reaching the age of 18.

1.6- REMAINDERMEN

Upon the termination of this Trust, the Trustee shall distribute all remaining Trust corpus and accumulated income to MAUDE or to the legal representative of her estate appointed by the Surrogate's Court if she should not survive the term of the Trust.

1.7 - Powers of Trustees

In addition to any powers which may be conferred upon the Trustee under the law of the State of New York in effect during the life of this Trust, the Settlor hereby confers upon the Trustee all those discretionary powers mentioned in §11 of the E.P.T.L. or similar statute or statutes governing the discretion of Trustees so as to confer upon the Trustees the broadest possible powers available for the management of the trust assets.

1.8- COMMISSIONS OF TRUSTEE

The Corporate Trustee shall be entitled to such Commissions as set forth in its published rates in effect from time to time, including any minimum annual fee.

1.9 - Resignation of Trustee

Any Trustee may resign by delivering notice of such resignation to the Settlor, to the Beneficiary and to the Supreme Court, which shall have ongoing jurisdiction over this Trust. The Supreme Court, shall appoint a Successor Trustee until the beneficiary has reached the age of 18. After the beneficiary has reached the age of 18, the court having jurisdiction over the Guardian of the beneficiary shall appoint a successor Trustee. If no Guardian has been appointed for the beneficiary, then the beneficiary may appoint a Successor Trustee.

1.10 - ANNUAL ACCOUNTINGS

Until the beneficiary has reached the age of 18, the Trustee shall file with the Supreme Court, SUFFOLK County, annual accountings in the form of SCPA 1719 in the month of May for the preceding year. _____, maintaining offices at _____, telephone _____ be and hereby is appointed Referee until the beneficiary has reached the age of 18 to examine such Annual Accountings and to file a written report concerning these accountings with the Court. The fee for any such Court appointed Referee shall be paid, upon Court Order, by the Trustee, from the Trust income or accumulated principal. Upon the beneficiary's reaching the age of 18, the Trustee shall deliver annual accountings to the beneficiary if no guardian has been appointed for MAUDE or shall comply with the directives in the Order and Judgment Appointing Guardian if a Guardian has been appointed for the beneficiary. .

SCHEDULE A

Proceeds of lawsuit settling MAUDE LAWSUIT

ELDER LAW AND SPECIAL NEEDS SECTION:

SUMMER MEETING: JULY, 2018

ADVANCED SPECIAL NEEDS PLANNING: NEW STRATEGIES

TRACK 10

MSA FACT PATTERNS

I. MEET ALEX

Alex is 50. He has been receiving SSDI due to advanced and debilitating diabetes. He receives $1500/month. He has been covered by Medicare for 4 years and also by Medicaid. He has a home attendant. He owns his own home, and has an IRA of $150,000.00 from which he is taking distributions of $500/month. He has been spending down this excess income each month.

Alex underwent a below the knee amputation and is the plaintiff in a medical malpractice action. The action was for failure to timely diagnose and treat his infection in his leg. He will net $900,000.00.

His physicians say that he will have to be monitored for life, and that he may need additional surgeries in the future.

How does Alex consider Medicare's future interest in this case?

Alex knew about a Special Needs Trust and asked his girlfriend, a CPA, to be his trustee.

How does one establish an MSA within the Special Needs Trust?

Who will be managing the MSA portion of the Trust?

What are the obligations and tasks of the MSA administrator?

How does the MSA administrator get paid?

Can Girlfriend administer the MSA?

II MEET UMA

Uma is 67 years of age. She has been in a nursing home, in a semi-conscious state since her injury during "routine" surgery 4 years ago. Her long time companion is her legal guardian. He has consented to a settlement of a lawsuit that will net her $1,500,000.00. She receives Social Security retirement of $800/month that is paid to the nursing home to offset the cost of Medicaid. Medicaid pays for her care at the facility where she is sometimes on a ventilator. The actual cost of her care varies between $14,000.00 - $26,000.00 depending upon the number of ventilator days/month.

Uma will be a private paying patient for 5 years. After that time, she will be on Medicaid. She will be using a structured settlement providing periodic payments for 5 years that will cover the cost of her care.

An analyst determined that UMA's future medical care that would have been paid for by Medicare were it not for this lawsuit is $90,000. It is being paid in up front moneys of $20,000 and then annual payments of $8000/year for 8 years guaranteed.

1. Is an MSA a free-standing trust or part of a Pooled Trust or simply a separate account in UMA"S name?

2. What documents does UMA'S Guardian have to sign to implement the plan?

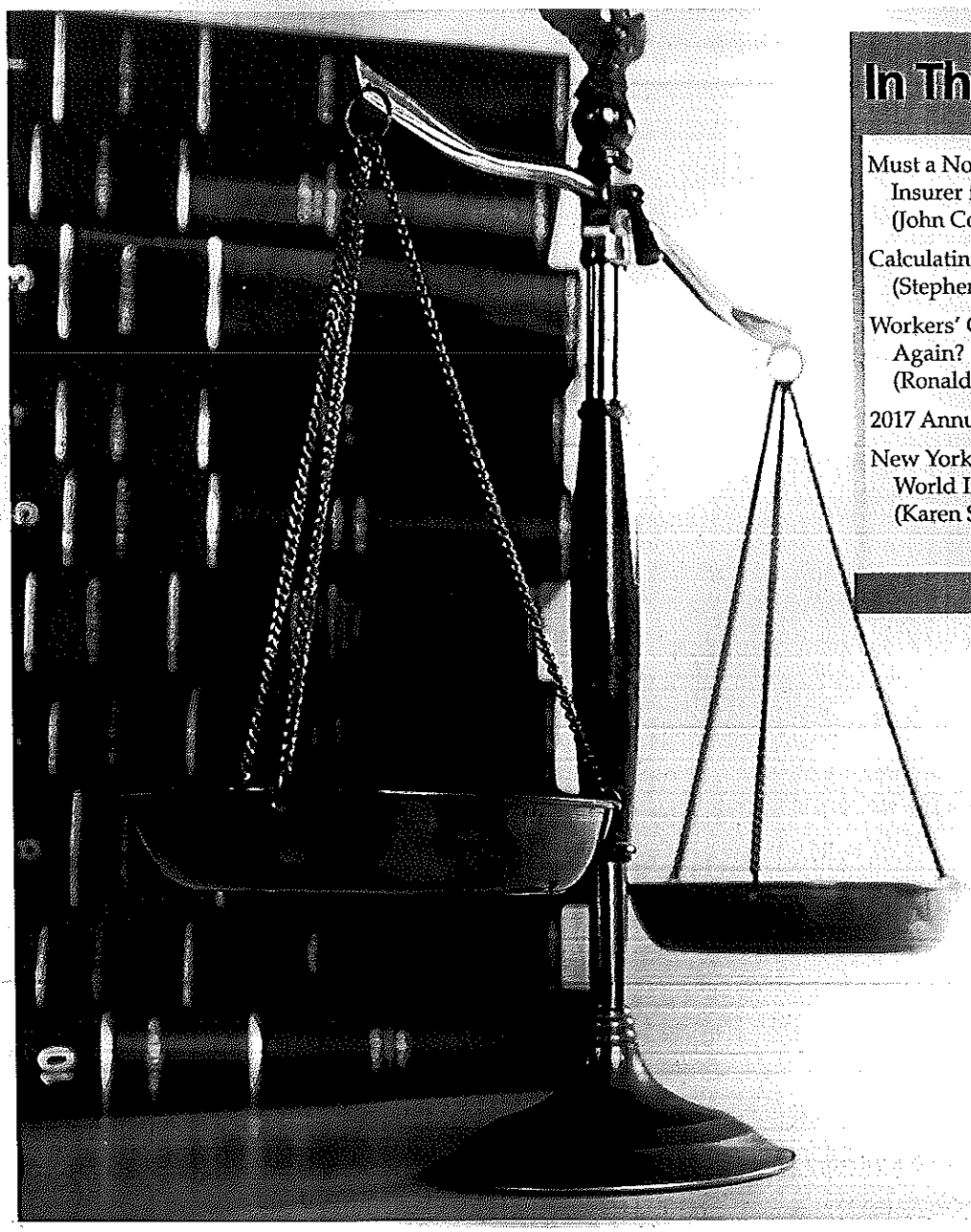
3. What approval must her guardian obtain from the Court in order to implement the plan?

4. To whom will the structured settlement payments be paid?

NYSBA FALL 2017 | VOL. 46 | NO

Torts, Insurance & Compensation Law Section Journal

A publication of the Torts, Insurance & Compensation Law Section
of the New York State Bar Association



In This Issue:

www.nysba.org/TICL

Must I Set Aside? Part One

By Robert P. Mascali

Like Alice starts her journey through Wonderland, many attorneys involved in third-party liability litigation feel they are descending the rabbit hole into chaos and confusion when confronted by the question of whether a Medicare Set Aside Account/Arrangement (MSA) is required for future medical expenses as part of a potential settlement. And for the most part their wariness is justified because of the lack of firm guidance on this issue from the Centers for Medicare and Medicaid Services (CMS). The basic premise underlying the MSA is that once a claimant has received settlement funds from a third-party carrier that covers in part the costs of future medical treatment, the Medicare program wants to make sure that those funds are used to pay for those expenses before Medicare starts paying for them.

"However, CMS has promulgated several memos on the issue of the need for a MSA in worker's compensation cases and while not binding, they are clearly instructive in the third-party liability realm."

Some historical context is enlightening. Prior to the adoption of the Medicare Secondary Payer (MSP) Act,[1] Medicare was in fact the primary payer of all services covered by Medicare except where there was worker's compensation. Then in 1980 this new law made Medicare a secondary payer to certain insurance plans and programs for beneficiaries, including auto and other third party liability insurance plans. Enforcement did not begin until 2001 following the issuance of the Patel Memorandum[2] which set forth that compliance with MSP was required *in workers' compensation* cases. Thereafter in 2007, legislation was enacted[3] that required insurance companies and other payers to provide information to CMS in any settlement payment situation in which Medicare was, or could become, the secondary payer. This legislation got everyone's attention because if reporting was required, then CMS would have the mechanism in place to track who received settlement funds and whether Medicare's interest as a secondary payer was being protected.

In any third-party liability-based personal injury settlement where the claimant is on Medicare for whatever reason, some of the available settlement funds are used to reimburse Medicare for injury-related "conditional payments" that were made for *past* medical expenses. It then follows that if part of the settlement funds are to cover *future* medical expenses for which Medicare would, or may be, responsible, that there be a system in place to ensure that the funds are used for that purpose so that Medicare is not in effect paying for something for which the claimant already was compensated. Enter the MSA.

Recent years have seen many fits and starts from CMS as it grapples with how to implement and enforce this mandate, and many in the field now feel that the well-known financial pressures on the Medicare system and the obvious need to generate revenue to shore up the system suggests a strong possibility that CMS will look to third-party litigants for some monetary relief. In fact, CMS recently signaled that it will start taking a closer look at enforcing the MSP Statute on liability cases similar to what it does in workers' compensation claims. A CMS directive issued on February 6, 2017, effective October 1, 2017, provided that Medicare contractors will be able to deny payment for items and/or services that should instead be paid from some form of an MSA. Essentially Medicare has now made known its intention to amend its internal processes so that it can receive and track data related to liability cases. Simply stated, CMS is finally starting to build some teeth behind enforcement of the statute on liability cases, just like it has on workers' compensation claims. Therefore, for the personal injury bar the "do nothing" strategy is certainly no longer a viable option.

What are attorneys to do in the face of no formal guidance from CMS on these situations when confronted with the successful claimant who may have future medical expenses for which compensation has been received and who may incur medical expenses in the reasonably foreseeable future that will be submitted for payment to Medicare because of the age or status of the claimant?

This article will attempt to dispel some of the chaos and confusion and provide a ready source of information for the personal injury bar when determining whether a MSA is advisable, even if not currently required.

CMS Guidance in Workers' Compensation Matters

As stated above, there are no rules or regulations under the Medicare Secondary Payer Act for either third-party liability or workers' compensation cases. However, CMS has promulgated several memos on the issue of the need for a MSA in workers' compensation cases and while not binding, they are clearly instructive in the third-party liability realm. Specifically, in a workers' compensation case there is no MSA required where it is clear the award is only for past medical expenses, the treating doctor can certify that to a reasonable degree of certainty there will be no need for Medicare-covered expenses in the future, and that there is no attempt by the claimant to maximize other portions of the settlement to the damage of Medicare's

interests. On the other hand, CMS has established certain review thresholds which are only workload guides and do not mean a MSA is not required even if the threshold is not met in a particular situation. Those thresholds for review are as follows:

A. The gross settlement amount exceeds $25,000 and the claimant is currently eligible for Medicare; or

B. The gross settlement is for more than $250,000 and the claimant can reasonably be expected to become eligible for Medicare within thirty (30) months.

In these situations, it is the total amount of the settlement that is determinative and not merely the portion attributed to future medical expenses. In those cases where there is a structured settlement it is the stated value of the settlement, and not the actual cost of the structure, that is determinative. Finally, it is important to note that a claimant may not attempt to waive a right to future Medicare coverage to avoid the requirement to establish a MSA—at least in workers' compensation cases.

"The wise personal injury attorney should take this into consideration when discussing a prospective settlement and should advise the client of the pros and cons of establishing a MSA where there is reasonable likelihood that there will be future medical care that would be covered by Medicare."

Since 2002 there have been various policy pronouncements from federal officials in a series of conference calls with the insurance industry, handouts and policy memoranda, in which CMS has stated its position on the issue of how Medicare's interest are to be considered and protected in liability cases, while conceding that there is no formal guidance in place at the current time. In addition, there have been several reported decisions that have addressed the question of whether a MSA or some other arrangement is required in liability cases—with differing conclusions.

Cases of Interest

The 2015 case of *Aranki v. Burwell*[4] from the U.S. District Court in Arizona caused a considerable amount of discussion and possibly some unwarranted encouragement for those who continue to assert that MSAs are not necessary and that they are used by overly cautious attorneys for no reason. The court held in response to a petition from a plaintiff's counsel who could not get a response from CMS that the question of whether a MSA is necessary in a medical malpractice case not ripe for review as MSAs are not *required* for future medical expenses in third party liability cases. According to the Court:

> To comply with the provisions outlined in the MSP [Medicare Secondary Payer statute, in worker's compensation case CMS Mandates the creation of a 'Medicare Set Aside' account (41C.F. R.Sec.411). The purpose of a MSA is to allocate a portion of a worker's compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay. However, no federal law or CMS regulation requires the creation of a MSA in personal injury settlements to cover potential future medical expenses...There may be a day when CMS requires the creation of an MSA in personal injury cases, but that day has not arrived.

But is that really the "final answer"? Not really and here's why

It is beyond dispute that there is a clear federal mandate that parties to a personal injury settlement must consider the interests of Medicare [42 U.S.C. 1395y(b)(2)]. Furthermore, and possibly most importantly, there are potential penalties and the looming malpractice suit for an attorney who fails to set up a MSA when one is found to have been required and the client's future medical expenses are rejected by Medicare and there are now no funds available to pay them. While arguably penalties would not be assessed against an attorney, nor would a claimant prevail in malpractice where no firm guidance is in place on the issue, certainly no attorney wants to be that "test case."

In addition to *Aranki, infra*, other cases from state and federal district courts in recent years do offer some guidance for the personal injury bar. Specifically, the following issues have been considered and ruled upon:

1. If medical providers can attest there will be no future medical expenses related to the injury for which compensation is paid and Medicare acknowledges it has been reimbursed for all conditional payments related to the injury, no MSA is necessary (*Berry v. Toyota Motor Sales, U.S.A., Inc.*).[5]
2. If past and future injury-related expenses have been, and reasonably will be, paid by private insurance and considering the lack of CMS policy or guidance on the issue, no MSA is required (*Tye v. Upper Valley Medical Center*).[6]
3. Since currently Medicare does not require or approve MSAs they are not *required* as part of a personal injury settlement (*Warren Frank v. Gateway Ins. Co.*).[7]

4. While a court has held MSAs for future medical expenses are not required in a personal injury settlement, a court can also determine that a MSA is still appropriate for future medical expenses (*Big R Towing, Inc.v.Trans Am Trucking, Inc.*).[8]

5. A court has not only opined on the necessity for a MSA in a liability but went so far as to apply a percentage formula to determine a specific part of the settlement that should be set aside for future medical expenses (*Benoit v. Neustrom*).[9]

Conclusion

Given the inherent difference between workers' compensation cases which are based on a rigid formula for damage calculation and traditional third-party litigation which is much more flexible in allocation of damages, adherence to the experience in the workers' compensation field can go only so far. However, that is all we have at this time, and at some point it seems likely that the federal government will start to enforce compliance with the MSP in liability cases. The wise personal injury attorney should take this into consideration when discussing a prospective settlement and should advise the client of the pros and cons of establishing a MSA where there is reasonable likelihood that there will be future medical care that would be covered by Medicare.

The second part of this article will deal with the evaluation of the funding amount, the aspects of the administration of a MSA and other practical advice.

The opinions and statements in this article are those of the author only and do not necessarily reflect the views of his employer, The Center for Special Needs Trust Administration, Inc.

Endnotes

1. 42 U.S.C. § 1395y(b)(2); 42 CFR 46(d)(b).
2. *Medicare Set Aside Arrangements Transmittal* (Patel Memo) July 23, 2001.
3. 42 U.S.C. § 1305 (*Medicare, Medicaid and SCHIP Extension Act of 2007*).
4. 151 F. Supp. 3d 1038 (D. Ariz. 2015).
5. 2015 WL 158889.
6. 2014 WL 2957037 (Ohio S.C. 2014).
7. 2012 WL 868872.
8. 2011 WL 43219.
9. 2013 WL 1702120.

THE CENTERS

Special Needs Trust Services • Lien Resolution
MSA Services • Structured Settlements

4912 Creekside Drive • Clearwater, FL 33760
(877) 766-5331 • www.centersweb.com

Administrating The Medicare Set Aside

Administration of the Medicare Set Aside Arrangement

Medicare Set Aside allocations may be administered by the claimant. Several stringent guidelines however, must be followed if this option is utilized. In fact, beneficiaries are essentially held to the same standards to which a professional custodian is held with regard to what may and may not be paid from the set-aside account. In addition, the same reporting requirements must be met. MSA funds can only be used to pay for the claimant's future injury-related medical expenses that would otherwise be covered by Medicare. This will require that the individual handling the MSA administration have some expertise in medical claims administration. Sufficient experience and knowledge to be able to make reasonable determinations about whether individual medical expense claims are injury related and about which expense claims would be covered under Medicare is crucial.

Medicare Set Aside Administered by Professional

Medicare Set Aside allocations may also be administered by a professional or a custodian. Indeed, if the amount of the set-aside is significant, it is often advisable to utilize a custodian for the administration of the fund. Medical providers covered by a Medicare set-aside may send bills for their services directly to the custodian. The custodian pays the medical bills in accordance with either the applicable state fee schedule or the Medicare fee schedule, depending upon which fee schedule the settlement agreement indicates or the allocation was based on. The custodian is limited, however, in what may be paid from the set-aside account with regard to medical expenses. First, the custodian may only pay for treatment that Medicare would cover. In addition, the fund must only be used to pay for medical expenses connected with the accident-related injury.

At least on an annual basis, the custodian must send reports to the appropriate Medicare regional office. This report must indicate all of the expenditures from and deposits made into the fund for that period of time. When the fund is exhausted, the custodian must then forward a report to the appropriate Medicare regional office detailing all expenses paid from the fund and all deposits for the life of the fund. Upon approval of the report, the custodian's duties end. Should the beneficiary die before the custodial fund is exhausted, the money will usually revert to his/her estate. In such a case, the custodian must ensure that the appropriate transfers are made before being released from obligations in connection with the Medicare set-aside.

THE CENTER

For Medicare Set-Aside Administration

MSA Administration Case Information

Name:_____
Last First M.I. Gender

Address:_____
Street Address City State Zip Code

Phone: _____ Date of Birth:_____ Social Security Number:_____

Medicare: ☐Yes ☐No If yes, Medicare Number:_____
If no, eligible within 30 months of the settlement: ☐Yes ☐No

Accident/Injury Information

Type of Case: ☐Workers Comp. ☐Liability Description of Accident:_____

Case Jurisdiction (State):_____ Date of Accident:_____

Description of Injury:_____

Pre-existing Conditions:_____

Date of Settlement:_____ Gross Settlement Amount: $_____

MSA Approved by CMS: ☐Yes ☐No ☐Expected

Medicare Set-Aside Account Funding

Amount Administered: $_____

Public Benefit Information

Is the claimant expected to receive, or currently receiving any of the following benefits?

Social Security Retirement (SSR) or Disability (SSDI)	☐Yes	☐No	☐Expected
Supplemental Security Income (SSI)	☐Yes	☐No	☐Expected
Medicaid	☐Yes	☐No	☐Expected

Referring Party or Law Firm

Name:_____ Phone:_____ Email:_____

Firm Name:_____

Address:_____

Firm Contact:_____ Email:_____

Residual Beneficiary Information (Please use additional sheets if needed)

Name:_____
Last First M.I. Gender

Address:_____
Street Address City State Zip Code

Relationship: _____ Social Security Number:_____ Date of Birth:_____
(If a minor)

Warranty

The above information is being provided to The Center for Medicare Set-Aside Administration, LLC (The Center) for the purpose of creating a Medicare Set-Aside Account which will be professionally administered by The Center. I hereby affirm and warrant by my signature that all of the information herein is accurate and complete to the best of my understanding. I further affirm and agree that I shall hold The Center harmless and indemnify it from any detrimental result that may occur from its reliance on any information provided by me that may later prove to be inaccurate or incorrect.

Signature:_____ Date:_____

Prior to administering please provide us with a copy of the allocation and CMS approval letter, if applicable. Please provide us with a list of treating physicians (name and address) as well as medications related to the injury.

Fee Schedule
$2,000 One-time account set-up fee
$1,000 Yearly administration fee

Internal Use Only:

4912 Creekside Drive Clearwater, Florida 33760 Phone (877) 433 8853 or (727) 497-4330 Fax (727) 471-1853
Date: 10/11/11

ADMINISTERING YOUR MEDICARE SET-ASIDE ARRANGEMENT (MSA)

Medicare regulations are found in Title 42 of the Code of Federal Regulations §411.46, state that Medicare will not pay for Medicare-covered medical expenses related to your liability injury until the MSA funds have been exhausted. Your MSA funds must be used to pay for all Medicare-covered medical services and supplies related to the liability injury. Once the lead contractor has confirmed that the MSA funds have been exhausted appropriately, Medicare will begin paying for Medicare-covered services related to the liability-related injury, illness, or disease.

Instructions for establishing and administrating a MSA account are listed below. If you have any questions regarding these requirements, please contact the CMS lead Medicare contractor at the following address:

BCRC-Liability MSA

PO Box 138899

Oklahoma City, OK 73113

Establishing and Using your Medicare Set-Aside Account

- MSA funds must be placed in an interest-bearing account, separate from any personal savings or checking account.
- Any funds and interest not used in a given year must remain in the account.
- MSA funds may only be used to pay for medical services related to your liability-related injury that would normally be paid by Medicare.
- Examples of some items that Medicare **does not** pay for are: Acupuncture, routine dental care, eyeglasses or hearing aids and therefore, these items cannot be paid from the MSA account. You may obtain a copy of the booklet “Medicare & You” from your local Social Security Office for a more extensive list of services not covered by Medicare.

Establishing and Using your Medicare Set-Aside Account (continued)

- If you have a question regarding Medicare's coverage of a specific item or service to determine if you pay for it from the MSA account call 1-800-MEDICARE (1-800-633-4227) or search the following CMS Websites:

www.medicare.gov

www.cms.hhs.gov/medicare.asp

Please note: If payments from the MSA account are used to pay for services other than Medicare allowable medical expenses related to the medically necessary services or supplies, Medicare will not pay injury related claims until these funds are restored to the MSA account and then properly exhausted.

(The balance of this page intentionally left blank)

Record Keeping

- As the administrator of the account, you will be responsible for keeping accurate records of payments made from the account. These records may be requested by CMS' lead Medicare contractor as proof of appropriate payments from the MSA account.

- You may use the MSA account to pay for the following costs that are directly related to the account:

  - Document copying charges
  - Mailing fees/postage
  - Any banking fees related to the account
  - Income tax on interest income from the set-aside account

- When you have exhausted your set-aside, send a notice to:

  NGHP

  PO Box 138832

  Oklahoma City, OK 73113

- Include your name and Medicare health insurance claim (HIC) number

When To Take Medicare's Interests Into Account

Based upon CMS regulations, the following guidelines are recommended when taking Medicare's interest into account when contemplating settlement with a primary source of the future medical care resulting from an accident or injury that Medicare would otherwise cover.

Medicare Payments Made While Claim is Open

Medicare insists, without question or doubt, that any payments it makes for medical services in an open claim are to be reimbursed as part of the settlement of the claim. There is no controversy about this issue. If the parties are settling a claim, they must ensure any Medicare payments for medical services related to the injury are reimbursed as part of the settlement. If you fail to do this, Medicare will pursue reimbursement, including the attorneys.

Current Medicare Beneficiaries

If the claimant is a current Medicare beneficiary at the time of settlement, Medicare requests that the settlement and allocation be submitted for approval only if the settlement is for more than $25,000. While Medicare recognizes that there is no statutory basis for the mandatory request, the stated benefit to the Medicare beneficiary is that once an allocation is approved, future Medicare coverage is assured after the approved allocation has been exhausted.

Medicare Eligible Within 30 Months of Settlement

If the claimant is not yet a Medicare beneficiary, but can reasonably be expected to become Medicare-eligible within 30 months of the settlement and the settlement is above $250,000, Medicare expects that its interests will be taken into account by making a reasonable allowance for the future projected costs. If such an allowance is not made in the form of an allocation or set-aside arrangement for future medicals, Medicare may claim the entire settlement amount as an allowance for medicals. And, Medicare will pay no benefits to the claimant for any medical services that may be linked to the injury until the entire settlement amount is exhausted.

No Expectation of Becoming Medicare Eligible

If the Claimant is not a current Medicare beneficiary, is not expected to become a Medicare beneficiary within 30 months following the settlement, and the total settlement amount is less than $250,000, Medicare's position is that they waive any interest in the settlement. However, Medicare officials have warned that this waiver is always subject to the Office of General Counsel review and change.

THE CENTER

For Medicare Set-Aside Administration

MSA Allocation Case Information

Name:_____
Last First M.I. Gender

Address:_____
Street Address City State Zip Code

Phone: _____ Date of Birth:_____ Social Security Number:_____

Medicare: ☐Yes ☐No If yes, Medicare Number:_____
If no, eligible within 30 months of the settlement: ☐Yes ☐No

Accident/Injury Information

Type of Case: ☐Workers Comp. ☐Liability Description of Accident:_____

Case Jurisdiction (State):_____ Date of Accident:_____

Description of Injury:_____

Pre-existing Conditions:_____

Has the case settled: ☐Yes ☐No Date of Settlement:_____ Gross Settlement Amount:_____

Public Benefit Information

Is the claimant expected to receive, or currently receiving any of the following benefits?

Social Security Retirement (SSR) or Disability (SSDI)	☐Yes	☐No	☐Expected
Supplemental Security Income (SSI)	☐Yes	☐No	☐Expected
Medicaid	☐Yes	☐No	☐Expected

Referring Party or Law Firm

Name:_____ Phone:_____ Email:_____

Firm Name:_____

Address:_____

Firm Contact:_____ Email:_____

Warranty

The above information is being provided to The Center for Medicare Set-Aside Administration, LLC (The Center) for the purpose of creating a Medicare Set-Aside Allocation. I hereby affirm and warrant by my signature that all of the information herein is accurate and complete to the best of my understanding. I further affirm and agree that I shall hold The Center harmless and indemnify it from any detrimental result that may occur from its reliance on any information provided by me that may later prove to be inaccurate or incorrect. I further give permission to my attorney to retain the services of The Center to prepare an allocation of future medical expenses and agree to pay a fee of $3,000 out of my settlement as a cost to the case.

Signature:_____ Date:_____

Prior to beginning work on your MSA allocation please provide the last 2 years of medical records related to the injury. If a workers' compensation case please also provide the last 2 years of claims payment history.

4912 Creekside Drive Clearwater, Florida 33760 Phone (877) 433 8853 or (727) 497-4330 Fax (727) 471-1853

Date: 10/11/11

CMS Consent to Release Form

I, _____, authorize The Center for Medicare and Medicaid Services (CMS), its agents and/or contractors to release any and all records to the person or entity below.

The Center for Medicare Set-Aside Administration, LLC
4912 Creekside Drive
Clearwater, FL 33760
727-471-1850

By completing and signing this consent form, I recognize and acknowledge that this consent: a) is for release of information purposes only and will have no effect on any benefits to which I may be entitled under the Medicare and/or Medicaid Program; b) allows the release of Medicare and Medicaid claims and other information related to my injury and/or illness; and, c) authorizes the release of information to the person(s) named above upon their request and that any such released information may be re-disclosed by them and may no longer be protected by law.

I further understand that I have the right to revoke my consent and authorization at any time in writing, except to the extent that CMS has already taken action in reliance thereof. If not previously revoked by me, this consent will terminate automatically when all claims, if any, have been resolved and all Medicare Secondary Payer files have been closed.

_____ _____
Claimant/Legal Representative Signature Date

_____ _____
Date of Injury/Accident Medicare Number

If signed by your legal representative, a copy of the documents authorizing your representative to act for you must be attached to this consent. Examples of such documents would include a Durable Power of Attorney, Letters of Guardianship/Conservatorship, or any other document that establishes your representative's authority.

PRIVACY STATEMENT

The information to be collected in regard to this consent will be used in furtherance of, and to comply with, Section 1862(b) of the Social Security Act (42 U.S.C. 1395y). This information will be used to determine whether any medical services received are covered by Medicare or Medicaid, or whether a no-fault, automobile, liability insurer, or any other person(s) may be responsible for such payment.

A photocopy or facsimile of this Consent to Release form shall be valid and given the same force and effect as the original.

HIPAA COMPLIANT AUTHORIZATION

Authorization for the Use and Disclosure of Protected Health Information

1. Personal Information:

   Name: _____ Birth Date: _____

   ID Number: _____ OR Social Security Number:_____

2. I give permission to_____(hereafter "Entity") and its contract representatives to share the health information listed below with the following:

   The Center for Medicare Set-Aside Administration, LLC
   4912 Creekside Drive
   Clearwater, FL 33760
   727-497-4330

3. Indicate the purpose for which the disclosure is to be made:

   __X__To substantiate a claim relating to a lawsuit or claim
   __X__Other

4. Indicate the information that you want to be disclosed, related to the following:

   __X__ Any and all records requested.

5. Enter the specific date that you want this authorization to expire: (i.e., one year from date of release)_____ (If you do not enter a date, this authorization will expire in five years.)

   I understand that the information described above may be re-disclosed by the person or group that I hereby give Entity, its employees, and its agents permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Entity, its employees, and its agents from all liability arising from the disclosure of my health information pursuant to this authorization. I understand that I may inspect or request copies of any information disclosed by this authorization if Entity, its employees, or its agents required the submission of this HIPAA Authorization in order to release information. I understand that I may revoke this authorization by notifying Entity through its employees and/or agents, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

6. Print Name_____Date_____

   Signature_____

   Or (please provide a copy of your letters of guardianship or conservatorship, durable power of attorney, etc., if applicable)

   Name of Legal Representative (Print)_____

   Relationship_____

   Signature of Legal Representative_____Date_____

Medicare Set Aside Allocations and Approvals

The Amount Placed in Medicare Set Aside Arrangements

The amount of money placed in a Medicare Set Aside is not negotiable. Instead, allocation experts are consulted to determine such amount. These experts begin the allocation process by performing in-depth evaluations of the injured party's medical records. Inquiries are then made to medical providers to determine the future medical treatment anticipated for the claimant. Next, a review is conducted of Medicare regulations to determine what part of that treatment Medicare would normally cover, as that is the only treatment for which money must be set aside. A projection is then made of the likely expenses for the covered treatment based upon the applicable medical reimbursement fee schedule. This is the amount that should be placed in the Medicare set-aside.

Getting Center for Medicare and Medicaid Services Approval

Involving CMMS in the determination of the amount that will be allocated toward future medical expenses is the only way to insure Medicare eligibility after the funds are exhausted. Since a settlement figure can be rejected by Medicare because it may seemingly attempt to shift claims payment responsibility to Medicare, the only way to truly ensure ongoing and future coverage is to secure CMMS approval of the set aside amount. Otherwise, an unrecognized settlement can affect claimant's eligibility for Medicare services and all other parties' responsibilities regarding same.

In order to approve a Medicare Set Aside, CMMS must be provided with all of the relevant facts concerning the claimant's injury and his or her medical treatment, including the basis for Medicare entitlement, the type of injury or illness, the age of the beneficiary, including an evaluation of whether the beneficiary's condition would shorten his or her life span, prior and future medical needs of the beneficiary due to the injury or illness, prior and future medical needs of the beneficiary due to pre-existing conditions, the living arrangement of the beneficiary and the level of continued care required, as well as copies of relevant documentation, including a copy of the settlement agreement and recent medical records, and the proposed Medicare Set Aside allocation taking Medicare's interests into account, including information as to whether the MSA will be self-administered or administered by a professional.

If the personal injury plaintiff is receiving Supplemental Security Income, Medicaid, or other needs based governmental benefits that require a first party special needs trust compliant with the requirements of 42 U.S.C. §1396p(d)(4)(A), the MSA must be imbedded within a (d)(4)(A) trust.

The (d)(4)(A) might provide for a separate account as follows:

I. OPTION ONE

Medicare Set Aside Account Pursuant to 42 U.S.C. § 1395Y(b)(2)(A):

A. Notwithstanding any other dispositive provision of this trust applicable during the lifetime of [Beneficiary], the [Beneficiary] Irrevocable Trust shall contain a Medicare Set Aside account (MSA) which shall be segregated from other trust assets. As soon as practicable after the receipt of the trust assets described in Schedule A to this agreement, the Trustee shall segregate from the remainder of the trust assets those funds and structured settlement annuities listed on Schedule A that are intended to fund the MSA.

B. Distributions During the Lifetime of [Beneficiary].

1. During the lifetime of [Beneficiary], both the corpus and income of the MSA, including any payments that may be received in the future from any structure settlement annuity that is purchased to fund the MSA, shall remain segregated as a part of the trust estate and separately administered as a Medicare Set Aside arrangement. Payments may be made from MSA for the sole benefit of [Beneficiary] subject, however, to the limitations set forth in Subparagraph 2 below.

2. Payment of Certain Medical Expenses If and As Required for Medicare Benefits. During the lifetime of [Beneficiary] both the corpus and the income from the MSA may be paid for medical services and supplies that would otherwise be reimbursable under Medicare but only if (1) such payments are necessary to entitle [Beneficiary] to Medicare coverage under the Medicare Secondary Payer Statute and (2) such payments shall be prudent in the discretion of the Trustee after considering all other benefits to which [Beneficiary] shall be entitled. Such medical expenses and supplies are hereinafter referred to as "eligible injury related medical expenses".

3. Engagement of Experts and Consultants. The Trustee shall engage the services of experts, including but not limited to [Name of Medicare Advisor], a Medicare claims and payment administrator, to advise and counsel the Trustee with respect to eligible injury related medical expenses. The Trustee may rely upon the written instruction and advice of such experts regarding disposition

of the trust as to eligible injury related medical expenses, and payments and distributions from the MSA, made in accord with such instructions and advice of such experts, shall be conclusively deemed authorized and proper. The Trustee is specifically authorized to appoint, direct and/or remove [Name of Medicare Advisor], as an agent for the administration of the MSA and to authorize [Name of Medicare Advisor], to hold the MSA, or any portion thereof, as a part of the trust. For administrative convenience, the Trustee is authorized to revocably assign to [Name of Medicare Advisor] any payments intended to fund the MSA.

4. Administrative Fees, Costs and Expenses Related to Medicare Set Aside Account. Administrative fees, costs and expenses related to the MSA shall not be paid from the MSA or its income. Any such fees, costs and expenses associated with the maintenance, management, and administration of the MSA, including but not limited to the fees of the Trustee and of [Name of Medicare Advisor] or any other Medicare claims and payments administrator or advisor, shall be paid from trust assets not contained in the MSA. The fees, costs, and expenses of experts and consultants retained in connection with the administration of the MSA shall not reduce or be paid from or as part of the compensation due the Trustee.

5. Distributions After the Death of [Beneficiary]. After the death of [Beneficiary], the remainder of the trust estate shall be distributed in accordance with the provisions of [Paragraph providing for the disposition of the remainder of the d4A trust after the death of the beneficiary] below.

II. OPTION TWO

Article II
SETTLOR'S INTENT

2.3 Additional Purpose. Because some portion of the Trust estate may represent funds received by the Beneficiary as the result of injuries for which future medical services might reasonably be necessary that would otherwise be covered by Medicare, it is the further intent of the Settlor and purpose of the Trust that such portion of the Trust estate qualify and be administered as a Medicare Set-Aside Arrangement ("MSA") pursuant to the provisions of 42 U.S.C. § 1395y and 42 C.F.R. §411.20 and all related Memoranda issued by the Centers for Medicare and Medicaid Services (herein after referred to collectively as the "Secondary Payor Act"), as provided more specifically herein, and to the extent the Beneficiary becomes and remains eligible to receive Medicare.

ARTICLE III

DEFINITIONS

3.1 "MSA Sub-account" means that portion of the Trust estate, if any, that is designated as a MSA because it represents funds received by the Beneficiary due to injuries for which future medical services can reasonably be expected to be needed that would otherwise be paid by Medicare but for the receipt of such funds. Just as with the entire Trust estate, no portion of the MSA Sub-account is available to the Beneficiary and shall not be considered or construed as being available for purposes of public benefits eligibility or otherwise.

ARTICLE VI
TAX PROVISIONS

6.6. Tax Attributable to MSA Sub-account. As provided by the CMS July 11, 2005 Policy Memorandum, the Trustee may pay any taxes owed on the MSA Sub-account from the MSA Sub-account as a, "cost that is directly related to the account."

ARTICLE VII
DISTRIBUTIONS DURING THE BENEFICIARY'S LIFETIME

7.11 Distributions for Medicare Related Expenses. Throughout the administration of the Trust and lifetime of the Beneficiary, the Trustee shall use the income and corpus of the MSA Sub-account to pay directly for medical services, supplies, prescriptions, and durable medical equipment, if any, that would otherwise be paid or reimbursed by Medicare, provided however, that any such direct payments are also: a) related to the injuries suffered by the Beneficiary for which damages for future medical services were paid to the Trust; and, b) made pursuant to an allocation or other pre-prepared plan identifying the Beneficiary's injuries and future medical costs otherwise payable by Medicare but for the receipt of such damages for future medicals (hereinafter "Qualified Expenses").

7.12 Engagement of Experts or Consultants. In addition to the Trustee's general authority to engage professionals, the Trustee is specifically empowered to engage the services of experts, including but not limited to, any entity engaged in the professional administration of MSAs. The Trustee shall be entitled to rely upon the advice and written instructions of such experts, including but not limited to an allocation or other pre-prepared plan identifying the Beneficiary's Qualified Expenses, and any distributions made from the Trust for the payment of such Qualified Expenses shall be conclusively deemed as proper, necessary, and authorized

ARTICLE IX
ADMINISTRATIVE PROVISIONS

9.3 MSA Sub-account Reports. The Trustee shall provide annual reports or accountings of the MSA Sub-account to the Centers for Medicare and Medicaid Services ("CMS") within thirty (30) days of the annual accounting period for the MSA Sub-account. The annual accounting period shall be the anniversary date of the funding of the MSA Sub-account unless otherwise provided in the allocation or other pre-prepared plan identifying the Beneficiary's Qualified Expenses. The Trustee shall also provide reports or accountings to CMS upon the exhaustion of the MSA Sub-account, whether such exhaustion of funds is temporary or permanent.

9.4 MSA Sub-account Reporting Fees and Other Costs. Any fees or costs that may be associated with filing annual reports of the MSA Sub-account with CMS shall be paid from that portion of the Trust estate not constituting the MSA Sub-account. Likewise, the Trustee shall not pay any administrative fees, including Trustee compensation, costs, or other expenses related to the MSA Sub-account from the MSA Sub-account but shall instead pay all such fees, costs or expenses from that portion of the Trust estate not constituting the MSA Sub-account.

OPTION THREE-SUPPLIED COURTESY OF ELDER COUNSEL, LLC AND NOT TO BE USED EXCEPT WITH WRITTEN CONSENT OF ELDER COUNSEL, LLC

Establishing the XXXX Special Needs Trust

The effective date of this Irrevocable Trust Agreement ("this agreement") is _____, 20___.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the Trustee agrees to hold the trust income and principal ("Trust Estate" or "Trust Funds"), IN TRUST, for the following uses and purposes and subject to the terms and conditions hereinafter set forth.

YYYY ("Trustmaker"), XXXX mother, hereby creates this Irrevocable Trust for XXXX benefit as the beneficiary hereunder ("Beneficiary"). Beneficiary is under the age of 65 years and is a disabled person as defined in Section 1382c(a)(3)(A) of Title 42 of the United States Code. This Irrevocable Trust includes a Medicare Set-Aside Subtrust. The trust, including the Medicare Set-Aside Subtrust, is to enable Beneficiary to qualify for (i) the Supplemental Security Income ("SSI") Program; (ii) medical assistance under the Medicaid program as provided for by Section 1396p(d)(4)(A) of Title 42 of the United States Code as enacted by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"); or (iii) any other governmental program.

This Irrevocable Trust is established with Beneficiary's assets and Beneficiary is the sole beneficiary of the trust.

Pursuant to federal law, Medicare's interests must be considered in a personal injury award because Beneficiary is entitled to Medicare. In reasonable consideration of Medicare's interests and to meet the criteria under Medicaid laws regarding the exemption of self-settled trusts from countable resources, Trustmaker intends to create an Irrevocable Special Needs Trust with an Irrevocable Medicare Set-Aside Subtrust. For that purpose, monies payable pursuant to the personal injury award for the benefit of Beneficiary will be paid to the Trustee to be held in accordance with the terms of this agreement.

Trustmaker enters into this Irrevocable Trust Agreement with YYYY (the "Trustee").

Section 1.01 Identifying the Trust

The trust is called the "XXXX Special Needs Trust." The following format should be used for taking title to assets: "YYYY, Trustee of the XXXX Special Needs Trust, dated _____, 20___."

However, for assets held in the Medicare Set-Aside Subtrust, the following format should be used for taking title: "YYYY, Trustee of the Medicare Set-Aside Subtrust under the XXXX Special Needs Trust, dated _____, 20___."

Section 1.02 An Irrevocable Trust

This trust is irrevocable, and Beneficiary may not alter, amend, revoke, or terminate it in any way. No other party, except as otherwise provided herein, may alter, amend, revoke, or terminate it in any way.

Notwithstanding the above, the TP may amend this trust so as to—

(i) qualify and maintain Beneficiary's eligibility for benefits under governmental programs, including but not limited to the Medicaid program and the Supplemental Security Income ("SSI") program;

(ii) meet the requirements under OBRA 1993 and the Oregon implementing statutes and regulations promulgated pursuant thereto; or

(iii) comply with the regulations and policy memoranda applicable to and interpreting Medicare set-aside allocations, being Section 411.20 and following of Title 42 of the United States Code of Federal Regulations and memoranda issued by the Centers for Medicare and Medicaid Services (CMS).

Section 1.03 Transfers to XXXX Special Needs Trust

Beneficiary transfers to the Trustee the property listed on Schedules A and B. Beneficiary retains no right, title, or interest in the income or principal of this trust, or any other incident of ownership in any trust property. Beneficiary, his guardian, his agent, or any duly authorized person on Beneficiary's behalf, may add from time to time to the Trust Estate any property by deed, Will, court order, or otherwise.

The property listed on Schedule B is property of the Medicare Set-Aside Subtrust. The Medicare Set-Aside Subtrust is being funded with a cash deposit in the amount of $500,000.00. The set-aside amount is listed on Schedule B (set-aside amount).

By execution of this agreement, the Trustee accepts and agrees to hold the trust property described on Schedules A and B. All property transferred to the trust after the date of this agreement must be acceptable to the Trustee. The Trustee may refuse to accept any property. The Trustee will hold, administer and dispose of all trust property accepted by the Trustee for Beneficiary's benefit in accordance with the terms of this agreement.

Section 1.04 Statement of Trustmaker's Intent

Trustmaker is creating this trust as a means by which trust assets may be held for the sole benefit of Trustmaker's son, XXXX , on the terms and conditions set forth in this instrument.

It is Trustmaker's intent to create a Special Needs Trust that conforms to ZZZZ law.

This trust is created expressly for Beneficiary's benefit, to supplement, not supplant, impair, or diminish, any benefits Beneficiary otherwise receives or may receive from or be funded by any local, state, or federal government, or from any private agency, any of which provides or funds services or benefits to developmentally disabled, incapacitated, or disabled persons, or from any private insurance carriers covering Beneficiary.

It is Trustmaker's intent that the funding and administration of this trust will not subject Beneficiary to a period of ineligibility under Medicaid law pursuant to 42 U.S.C. section 1396p(d)(4)(A) and ZZZZ law.

The purpose of the Medicare Set-Aside Subtrust is to pay for Beneficiary's injury-related medical expenses that would have been paid by Medicare had Beneficiary not received a personal injury award, and to avoid disqualifying Beneficiary from receiving benefits from any means-tested public benefit program, including, but not limited to, Medicaid and Supplemental Security Income (SSI). All provisions of this trust must be construed accordingly.

The set-aside amount is intended to reasonably consider Medicare's interest in Beneficiary's personal injury award. Medicare's interest is an amount that Medicare would have paid over Beneficiary's lifetime for medical expenses related to the personal injury claim.

The Medicare Set-Aside Subtrust must be administered according to the provisions of Section 1395y of Title 42 of the United States Code, entitled "Exclusions From Coverage and Medicare as Secondary Payer," (codification of Section 1862 of the Social Security Act, as amended by the Medicare Prescription Drug, Modernization, and Improvement Act of 2003) and the regulations and policy memoranda applicable to and interpreting the same, being Section 411.20 and following of Title 42 of the United States Code of Federal Regulations and memoranda issued by the Centers for Medicare and Medicaid Services (CMS), which provisions, regulations, and policies are herein referred to collectively as the Medicare Secondary Payor Law.

However, neither the segregation of assets into the Medicare Set-Aside Subtrust, nor payment of medical expenses therefrom, shall limit or impair the Trustee's discretion, nor cause the trust to be held other than for Beneficiary's sole benefit, nor cause any portion of the Medicare Set-Aside Subtrust to be considered available to Beneficiary, nor subject to his control.

The Medicare set-aside amount must be held in the Medicare Set-Aside Subtrust for Beneficiary's benefit and distributed pursuant to the provisions of this agreement as set forth in 0.

It is also intended that this trust will be treated as a grantor type trust for federal and state income tax purposes and that the funding of the trust will not be subject to federal and state gift taxation.

The Trustee must interpret all provisions of this trust to best effectuate these purposes and intentions.

Distributions During Beneficiary's Lifetime

The Trustee will hold, manage, invest and reinvest the Trust Estate, and will pay or apply the income and principal of the Trust Estate in the following manner:

Distributions of Income and Principal

During Beneficiary's lifetime, the Trustee will make distributions of income and principal according the provisions of this Section.

(a) Other Than From the Medicare Set-Aside Subtrust

Other than from the Medicare Set-Aside Subtrust, the Trustee will pay from time to time such amounts from the Trust Funds for the satisfaction and benefit of Beneficiary's Special Needs (as hereinafter defined), as the Trustee determines in the Trustee's discretion, as hereinafter provided. Under no circumstances may the Trustee distribute Trust Funds directly to Beneficiary. Any income of the trust not distributed will be added annually to the principal of the trust.

Notwithstanding the above paragraph, in no event may assets other than from the Medicare Set-Aside Subtrust be deemed available for payment of Beneficiary's Medicare reimbursable medical expenses.

(b) From the Medicare Set-Aside Subtrust

In making distributions of principal and income from the Medicare Set-Aside Subtrust, the Trustee is limited to making distributions to pay for Beneficiary's injury-related medical expenses, provided such medical expenses are ordinarily paid or reimbursed by Medicare. Distributions may be made from the income and principal as determined in the Trustee's discretion. The Trustee must make every effort to first ascertain those medical needs that would ordinarily be reimbursable or paid for by Medicare, and to pay for those medical expenses; however, the Trustee is not liable for making a distribution or payment for medical needs that are later determined to be a type that is not reimbursable by Medicare.

The Trustee has the power to make distributions from the Medicare Set-Aside Subtrust only for the purposes set out in this Article provided Beneficiary is currently entitled to Medicare benefits. The Trustee may not release the set-aside amount if Beneficiary loses his Medicare eligibility. However, the Trustee may

expend the set-aside amount for medical expenses for Beneficiary's benefit until Medicare entitlement is reestablished or the set-aside amount is exhausted. Any income of the Medicare Set-Aside Subtrust not distributed will be added annually to the principal thereof.

If the set-aside allocation is not sufficient to pay for Beneficiary's Medicare reimbursable medical expenses in any one year, the Trustee is authorized to submit such medical charges directly to Medicare for payment. In no event may assets other than from the Medicare Set-Aside Subtrust be deemed available for payment of Beneficiary's Medicare reimbursable medical expenses.

Administrative Expenses

The Trustee may use Trust Funds other than from the Medicare Set-Aside Subtrust to pay for any and all expenses necessary for the proper administration of the trust. Administrative fees, costs, and expenses related to the Medicare Set-Aside Subtrust may not be paid from the Medicare Set-Aside Subtrust or its income. Any such fees, costs, and expenses associated with the maintenance, management, and administration of the Medicare Set-Aside Subtrust, including, but not limited to, charges for fiduciary services of the Trustee or other ordinary and necessary trust administration expenses, including, but not limited to, the compensation of a Medicare Claims Administrator, must be paid or reimbursed, if at all, exclusively from Trust Funds other than from the Medicare Set-Aside Subtrust.

Medicare Claims Administrator

The Trustee has the authority to consult with and hire third-party administrators experienced in Medicare set-aside arrangements to comply with the investment, expenditure, reporting requirements, and any other requirements under Medicare laws. This Agreement shall be read to include the administrator's services in the event an administrator is retained. The fee for administrator services is a proper charge of the trust and may be paid in addition to the Trustee's fee. Notwithstanding any other provision of this Agreement to the contrary, in no event may fees for third-party administrators—and other fees and expenses of this trust, including Trustee fees—be paid from the Medicare Set-Aside Subtrust.

The Trustee is not liable for actions of an agent or administrator to whom a function is delegated under this Article if the Trustee exercises reasonable care in selecting the agent or administrator consistent with the purpose of this Agreement.

The Trustee may require that all requests for payment of medical benefits be submitted to the Trustee on a form approved by the Trustee. A request for payment of benefits may be submitted by Beneficiary or Beneficiary may authorize a provider of medical services or products to submit a request for payment directly to the Trustee.

Notwithstanding any other provision of this Agreement, the Trustee must invest the Medicare Set-Aside Subtrust assets in types of investments permitted under the Medicare laws and regulations

related to Medicare set-aside arrangements, such as FDIC-insured interest-bearing checking accounts, money market funds investing primarily in U.S. Treasury securities and repurchase agreements in respect thereof, and U.S. Treasury mutual funds, consistent with the investment objective of preservation of capital and maintenance of liquidity.

NYSBA ELSN SECTION
SUMMER MEETING
July 14 2018
ROBERT P. MASCALI, J.D.

MSA's and Medicaid, Administrative Issues

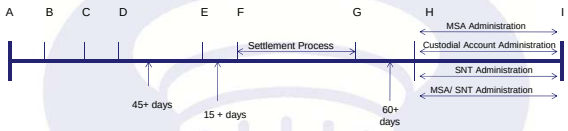
Public Benefits Generally

- SSDI / Medicare
  - Entitlement programs which individuals qualify for by a combination of age and/or the amount of calendar quarters worked.
- SSI / Medicaid
  - Needs based Federal and State programs that impose both income and asset limits.

Taking Medicare's Interest into Account

- Initial Reporting:
  - Carrier Responsibility
- Pre-Settlement:
  - Lien Status Verification, Conditional Payments, Dispute Unrelated Charges
  - Medicare Set-Aside Allocation Process begins
- Settlement:
  - Final Demand Letter and payment within 60 days
  - SNT / MSA Approval
- Post-Settlement:
  - MSA Administration
  - SNT Administration

Timeline of PI Case



A - Date of Accident
B - Mandatory Insurer Reporting
C - Investigation and Acceptance of Case
D - Notify CMS/ Medicaid/ Possible 3rd Party Lien
E - Get Conditional Payment Amount/ Identify what will need to be done with funds; MSA/Custodial Account/SNT/ Annuity

F - Begin to dispute false charges/ Mediation/ Begin MSA Allocation
G - Settlement/ Acquire Final Demand from CMS/ MSA Approval for CMS; Establish Trust/ MSA Custodial Account/ Fund Annuity or Other
H - Fund all vehicles and begin Administration of funds
I - Death and wrapping up of Affairs

Initial Reporting = Carrier Responsibility

The Medicare Secondary Payor Mandatory Reporting Provisions makes the Carrier responsible for reporting all payments over *$1,000.00** to the CMS Coordinator for Benefits Contractor.

Initial Reporting = Carrier / Attorney

Because of the Mandatory Insurer Reporting Requirements many Plaintiff firms are now receiving the ***FINAL DEMAND*** from MSPRC without ever requesting it.

When this happens the bill must be paid or interest could accrue.

Responsibilities of Attorneys

Upon taking a case where the beneficiary is a Medicare or Medicaid recipient the attorney is required to place the appropriate agency on notice.

Please note these agencies have no responsibility to contact the attorney or client.

Pre-Settlement
MSA / SNT or BOTH

- If a beneficiary is currently receiving Medicare and the gross settlement is over $25,000, or the total amount is over $250,000 and the beneficiary could be Medicare eligible within 30 months, or has end stage renal disease
- If a beneficiary is currently receiving Medicaid and chooses to preserve these benefits, a Special Needs Trust will preserve these benefits

Settlement = Attorney Responsibility

- MSA Allocation Submission* and Approval
  - Submit MSA Allocation to CMS with Final Settlement Agreement and a statement as to how the MSA will be Funded and Administered
- Establishment of a Special Needs Trust
  - Take into consideration age of beneficiary
  - Consider options for Trust Administration

Post Settlement = Attorney and Beneficiary

Self Administered MSA

- The Self Administered MSA requires the beneficiary to possess sound money management abilities, excellent judgment, keen organizational skills, and expertise in medical billing and fee schedules.

Self Administered SNT or Pooled SNT

- A Self Administered SNT is simply not an option. The beneficiary may never act as trustee of their own SNT. In addition it is not a wise decision to engage a family member for these fiduciary responsibilities.

Post Settlement = Attorney and Beneficiary

Professionally Administered MSA

- Safety, security and knowledge are all elements that a professional Medicare Set-Aside Administrator should possess, but be careful when choosing your MSA Administrator to ensure they have specific experience in MSA Administration.

Professionally Administered SNT or Pooled SNT

- Since Medicaid programs differ from state to state, the Trustee of a Special Needs Trust should have comprehensive knowledge of specific rules regarding program eligibility, otherwise the beneficiary could risk disqualification from these vital programs.

(d)(4)(A) Special Needs Trusts

Special Needs Trusts (SNT) must meet the following requirements:

- The beneficiary must be disabled as defined by law and under age 65;
- The beneficiary* or their parent, grandparent, legal guardian, or court may establish the SNT. **Special Needs Fairness Act 12/13/16*
- The SNT must be irrevocable, funded with the beneficiary's assets, be established and administered for the sole benefit of the beneficiary; and,
- Any funds that remain in the SNT at the beneficiary's death must be used to reimburse the State for all Medicaid benefits provided during the beneficiary's lifetime.
  - *The requirement to reimburse the State is commonly referred to as a payback provision.*

(d)(4)(C) Pooled Trusts

Pooled Trusts (PT) must meet the following requirements:

- The beneficiary must be disabled as defined by law
- Age >65 state by state. NY allowed for community Medicaid but issue for nursing home
- The PT account can be established by the beneficiary, the beneficiary's parent, grandparent, legal guardian, or a court.
- The PT account must be irrevocable, funded with the beneficiary's assets, be established and administered for the sole benefit of the beneficiary.
- PTs must be created and managed by a non-profit association.
- A separate account must be maintained for each PT beneficiary, but the trustee may "pool" the accounts for investment and management purposes.
- Any funds that remain in the SNT at the beneficiary's death ***must either be retained in the trust*** or used to reimburse the State for all medical benefits provided during the beneficiary's lifetime.

Post Settlement= Attorney and Beneficiary / Proper Administration

- In the event the beneficiary is a recipient of Medicare, Medicaid and or SSI those funds held in the MSA account can and will be counted as assets and will take the individual over their particular established asset limits. In this case, the MSA account must be held within a Special Needs Trust for the sole benefit of the beneficiary.

  Example:

  Claimant is currently receiving Medicare, Medicaid, and or SSI benefits and has received a settlement and needs to have a MSA established. If the funds were simply put into a MSA, the individual would be over asset limits. In this unique case, the MSA must be maintained within a SNT.

Email: Robert.Mascali@centersmail.com
877.766.5331 (office)
727.412.5760 (mobile)

Plenary Session
Advocating in the New Managed Long Term (MLTC) Environment
The Future of Medicaid under the Trump Administration

Presented By:
Valerie J. Bogart, Esq.

"Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing – Starts May 1, 2018

Valerie Bogart, Director, Evelyn Frank Legal Resources Program

New York Legal Assistance Group

Article submitted for publication by NYSBA Elder and Special Needs Law Section.

INTRODUCTION

Beginning May 1, 2018, members of Medicaid managed care plans in New York State, which include Managed Long Term Care (MLTC) plans, who wish to appeal an adverse determination by the plan, must first request an internal "plan appeal" within their plan, and wait until the plan issues a decision on that appeal, before they may request a Fair Hearing. This is called the "exhaustion" requirement, because the member must first "exhaust" the internal appeal available within the plan before requesting a State administrative fair hearing. 42 C.F.R. §438.402(c). This article explains the new requirement, and an exception, called "deemed exhaustion," which allows a request for a fair hearing before the plan decides an internal appeal.

WHO IS AFFECTED: This massive change in appeal rights affects 4.7 million Medicaid recipients in New York, 200,000 of whom are members of MLTC plans. When MLTC became mandatory in 2012 and rolled out statewide gradually over the next few years, exhaustion of internal appeals was required. In July 2015, the State lifted the exhaustion requirement entirely, allowing members to seek a fair hearing immediately to appeal an adverse plan determination.[1]

The vast majority of Medicaid managed care members in New York -- 4.5 million people -- are members of "Mainstream" Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARP), or HIV Special Needs Plans (HIV SNP). Enrollment in these MMC plans is mandatory for most Medicaid recipients who do not have Medicare or other primary insurance. While most people in these plans are under 65 and have Medicaid through the Affordable Care Act, some plan members are seniors or people with disabilities who either receive SSI or have no income at all, and who are not eligible for Medicare, usually because of immigration status. These seniors and people with disabilities obtain all medical care through the MMC plan, including personal care and other Long Term Services & Supports, They will also be required to request an internal plan appeal first to contest a proposed reduction or discontinuance of any long term care services.[2] Notably, "exhaustion" has never been required in the over twenty years that managed care has been mandatory for the non-Medicare population.

[1] See NYS Dept. of Health MLTC Policy 15.03: *End of Exhaustion Requirement for MLTC Partial Plan Enrollees,* dated July 2, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

[2] The law and regulations applying to "mainstream" managed care are at N.Y. Soc. Serv. Law . § 364-j; 18 NYCRR Subpart 360-10. All managed care plans, including MLTC plans, are also regulated as Managed Care Organizations (MCO) at NYS Public Health Law Article 44 and Article 49. Federal Medicaid requirements pre-empt those under

PRIMARY CONCERNS:

Educating Millions of Plan Members, their Families and Representatives. As New York implements this new requirement, there are concerns that 4.7 million people will not be adequately informed of this huge change. While plans' notices of adverse determinations have been modified to explain the new requirement, despite attempts to make the long, dense notices understandable to consumers in English and other languages, many will not read or understand the entire notice. Many will not show the complete notice to their family or representative – or will show the representative the notice in a foreign language that the representative does not understand.

Just educating the elder law bar, legal services advocates, and private geriatric care managers is a daunting task, let alone the huge network of social workers in hospitals, senior centers, and other community-based organizations. Lawyers and other professionals in the habit of requesting a fair hearing immediately must learn to request an internal plan appeal first instead of a fair hearing.

Barriers to Filing Appeals –Risk of Denial of Aid Continuing. The stakes are especially high when the plan proposes to reduce or discontinue personal care or other long term care services. The right to Aid Continuing has been a key element of due process since the seminal case of *Goldberg v. Kelly*. 397 U.S. 254 (1970). It has always been a challenge to file the appeal request within the short 10-day window between the date of the notice and the effective date of the reduction. Now, the appeal must be filed with a managed care or MLTC plan that may not have trained its call center staff to route these requests to ensure timely filing. Anyone who has tried to call the member services 800 number of an insurance plan knows a call may easily be mis-routed. To date, the NYS Office of Temporary Disability Assistance [OTDA] has not pledged to educate people who mistakenly request hearings adequately about the new requirements, or assist them in requesting a plan appeal. As a result, it is likely that home care will be reduced – with no Aid Continuing – for MLTC members, whose hearing requests will ultimately be dismissed, months after they requested them, for failure to "exhaust."

There are four additional barriers to filing the appeals, putting Aid Continuing at risk, all discussed at length below.

First, requests made orally must be confirmed in writing, unless an "expedited" appeal is requested. Fortunately, the regulations provide that the date of the oral request locks in Aid Continuing. 42 C.F.R. . § 438.402(c)(3)(ii).

Second, the consumer must either sign the appeal or hearing request or designate, in writing, a representative to request the appeal or hearing. 42 C.F.R. §438.402(c)(ii). This burdensome requirement is a departure from the NYS OTDA practice of allowing anyone to request a fair hearing on an individual's behalf, whether as a "representative," or as a mere "requester." See OTDA request form at http://otda.ny.gov/hearings/forms/request.pdf.

state Public Health Law, if the federal Medicaid requirements are more strict. For example, state law allows plans to have more than one level of internal appeal. The federal regulation allows only one internal appeal for Medicaid plans, and this controls. 42 C.F.R. § 408.402(b). .

Third, plans – and not OTDA -- are now the arbiter of whether Aid Continuing applies, at least at the initial level of the plan appeal. Will MLTC plans provide Aid Continuing where, for example, the plan's adverse notice is defective or was untimely – as OTDA has historically ruled in such cases? The federal regulations define at least one circumstances which warrant "deemed exhaustion," allowing a fair hearing request without exhausting the plan appeal. 42 C.F.R. § 438.408. That is where the plan failed to decide the internal plan appeal by the deadline. However, CMS permits states to deem exhaustion on a broader basis than does the final regulation, but the State has not done so to date. See n 5, *infra*, at p. 27510 and discussion in next section below.

Fourth, if the decision after the internal Plan Appeal decision is adverse, then the consumer must *again* appeal in the short time limit to get Aid Continuing. While the second appeal is a request for a fair hearing, which is familiar to the elder law bar, this is now a second hurdle for the consumer, requiring them to respond quickly to request appeals *two times.* Also, this request must comply with the new requirement that the consumer make or sign the hearing request or give written consent to a representative to sign it.

1. BACKGROUND – REVISION OF FEDERAL REGULATIONS in 2015-2016

This change in appeal rights is required by federal Medicaid regulations, as amended in 2016. In 2015, the Obama Administration initiated a formal rulemaking process to amend the Medicaid managed care regulations, which had last been amended in 2002.[3] After hundreds of comments were filed, by organizations including the National Health Law Program[4] and the New York Legal Assistance Group, the final regulations were adopted in 2016.[5] The regulations on grievances and appeals are at 42 C.F.R. Part 438. The regulations are effective on various dates in 2017. The effective date for the exhaustion requirement in New York's appeal system was extended to May 1, 2018.

The impetus for the revision was the expansion of Medicaid managed care from being a small demonstration program covering limited primary care services for families and children in the 1990's, to the principal model for delivering all Medicaid services for all populations, including Long Term Services and Supports (LTSS) for the elderly and disabled. Grievance and appeals systems are just one of many aspects of managed care affected by the amendments to the regulations. For summaries of the other changes, see the National Health Law Program series of seven issue briefs on the revisions.[6]

[3] Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015)

[4] NHELP comments filed in July 2015 are available at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>

[5] Notice of Final Rule, 81 Federal Register 88 at p. 27498 (May 6, 2016)

[6] National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs, available at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>

In its explanation of requiring "exhaustion" in the final regulation, CMS described its desire to align Medicaid appeals with those enrollees will experience in private health insurance as well as in Medicare Advantage.

> While we understand commenters' concerns and recommendations regarding direct access to a state fair hearing for vulnerable populations, we also have concerns regarding inconsistent and unstructured processes. We believe that a nationally consistent and uniform appeals process (particularly one consistent with how other health benefit coverage works) benefits enrollees and will better lead to an expedited resolution of their appeal.

81 Federal Register 88 at p. 27509 (May 6, 2016). The notion that Medicaid recipients flow back and forth from Medicaid to employer-based insurance to Qualified Health Plans through the ACA underlies many of the changes made, including the exhaustion requirement. Advocacy groups, including NYLAG, had opposed the exhaustion requirement, arguing that it would cause delay in accessing fair hearings, would put Aid Continuing rights at risk, and would confuse beneficiaries accustomed to requesting hearings directly on Medicaid eligibility issues. NYLAG comments pointed out that exhaustion had been confusing and harmful when it was required in New York briefly for MLTC until 2015.

CMS claimed that any delay in accessing fair hearings caused by the exhaustion requirement was mitigated by shorter deadlines for plans to decide appeals (30 calendar days, shortened from 45 days) and by "deemed exhaustion," which allows a consumer to request a fair hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 Federal Register 88 at 27510. CMS' preamble to the final regulations states, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." Id. As of February 12, 2018, the State has not responded to advocates' request to apply deemed exhaustion in other circumstances, such as when the plan fails to send any written notice, or a notice that is timely and adequate, complying with all requirements including language access and State DOH guidance specifying notice requirements in MLTC.[7]

2. New York State Rulemaking and Policy Guidance on New Exhaustion Requirement

State regulations on managed care appeals have not yet been amended to incorporate the federal changes, so should not be relied upon. 18 NYCRR Part 360-10. The New York State Department of Health [DOH] convened a Service Authorizations and Appeals Stakeholder Workgroup in 2017 to elicit stakeholder input on implementing the exhaustion requirement and other federal changes. Stakeholders included representatives of the MLTC and mainstream managed care plans and consumer advocates, including NYLAG. The Workgroup was led by administrators in two different divisions of DOH – one that oversees mainstream plans, and one that oversees MLTC plans.

The Workgroup focused on revising the adverse notice templates, which are now posted on a new webpage called "Service Authorizations and Appeals," available at

[7] See MLTC Policy 16.06, *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services (*available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. These templates must be used by both mainstream managed care and MLTC plans for Initial Adverse Determinations, which must be appealed to a plan appeal, and Final Adverse Determinations, which state the plan's decision after the plan appeal, which may be appealed to a Fair Hearing. New Appeal Request Form and Fair Hearing Request Forms for MLTC and other managed care appeals are included in the new model adverse notices. Since these forms will be pre-populated with information about the client's appeal, it is recommended that they be obtained from the client and used to file the appeal request.

Beside the notice templates, other policy guidance is apparently being issued separately by the two DOH divisions that oversee the two types of Medicaid managed care plans– one for MLTC plans and one for plans for Medicaid recipients who do not also have Medicare --Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP). As of February 20, 2018, only the division overseeing mainstream Medicaid managed care has conducted webinars and posted policy guidance and Frequently Asked Questions for plans. These are all available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

Policy guidance from the MLTC division is expected to be posted on the MRT 90 webpage at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/ - presumably under the link on that webpage for MLTC Policies. As of February 20, 2018, no guidance has been posted. However, the guidance posted for Mainstream MMC plans should be binding for MLTC plans since it is issued by the same State agency, which is the Single State Agency that administers the NY Medicaid program. 42 U.S.C. §1396a(a)(5).

Health care providers should stay tuned for a Medicaid Update article on the change, which will be posted at https://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

In March 2018, members of all managed care plans should receive by mail from their plans a letter with a revised Member Handbook. DOH must revise the standardized language for this handbook, which most plans post on their websites, and which is incorporated in the Contract by which plans contract with the NYS DOH.[8]

NYLAG's article on appeals in MLTC Plans will be updated to include links to any guidance issued by NYS DOH, available at http://www.wnylc.com/health/entry/184/.

3. **Definitions and Types of Notices; Appeal vs. Grievance**

[8] The Model MLTC contract is posted on the MRT 90 Webpage cited above. Click on Health Plans, Providers and Professionals at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm. Click on Model Contracts and select Partial Capitation Contract. Direct link is https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf (Contract 1/1/2015 - 12/31/16 is most current available). The Member Handbook is in Appendix K.

The exhaustion requirement specifically states, "An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld." 42 C.F.R. § 438.402(c). These terms are defined below. Appeals and grievances are also distinguished.

An **Appeal** is a request to review an **adverse benefit determination** made by a plan.[9] In New York, the notice of a plan's adverse benefit determination is called an **"Initial Adverse Determination" (IAD).** The plan must use the new notice templates issued by DOH.[10] *Adverse benefit determination* means, any of the following:

> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of a plan to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one plan, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
>
> (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities**.**

42 C.F.R. § 438.400(b). Thus an MLTC plan must issue a Notice of Initial Adverse Determination when it proposes to:

(1) Reduce or stop personal care, adult day care, or other services, or
(2) Deny a request for a new service, such as Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing
(3) Deny or partly deny a request to increase hours of personal care services or other services

If the plan decides the appeal in whole or in part adversely to the consumer, it must issue a notice of **"Final Adverse Determination" (FAD),** which explains the reason for the decision and explains the right to request a fair hearing. 42 C.F.R. § 438.408.

[9] 42 C.F.R. . § 438.400(b).

[10] Model notices posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. Though this webpage is directed to mainstream managed care plans, the same model notices are required for MLTC plans.

Grievance – which DOH is calling a "**complaint**" --means "an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by [the plan] to make an authorization decision." 42 C.F.R. §438.400(b). EXAMPLES of grievances that may be filed with MLTC plans as complaints include:

(1) The aide or transportation is late or does not show,
(2) The aide is poorly trained or otherwise does not provide quality care,
(3) Member cannot reach care manager by phone, or care manager does not respond or was rude.
(4) Member disagrees with plan's decision to extend time to decide a request for new or increased services.

Grievances/Complaints may not be appealed to a fair hearing, but may be appealed internally in a Complaint Appeal. DOH has posted a model template for a Complaint Appeal Resolution Notice and for a Complaint Resolution Notice. See https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

4. MORE ON INITIAL ADVERSE DETERMINATIONS – Reductions and Denials

Because Aid Continuing requires special notice content, timing and procedures, Initial Adverse Determinations (IAD) for plan REDUCTIONS or discontinuance of services will be discussed separately than for DENIALS of new or increased services.

A. FOCUS ON REDUCTIONS IN HOURS or SERVICES

After a plan sends an Initial Adverse Determination (IAD) to reduce or discontinue a service, Aid Continuing is only granted when the Plan appeal is requested before the effective date of the IAD. As has been true since *Goldberg v. Kelly*, *supra*, the plan need only mail the notice 10 days in advance of the effective date.[11] With mailing time and weekends, the consumer may well only receive the notice a day or two before the deadline to request the internal appeal. Clients should be advised to always keep the envelope in which notices are mailed. If the postmark is dated later than the mailing date, this can be a ground to obtain Aid Continuing based on untimely notice.[12] In the past, advocates successfully made that argument to OTDA. Now, the argument must be made to the plan itself – the same one that mailed the notice late.

[11] 42 C.F.R. § 438.404(c)(1) cross-references the long-standing regulations that establish timeliness of notices and other Medicaid fair hearing rights outside of managed care, 42 C.F.R. §§ 431.211 - 431.214.

[12] See, e.g. Fair Hearing No. 7182969J, dated Feb. 17, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-2/Redacted_7182969J.pdf (notice not mailed at least 10 days before effective date, citing 42 C.F.R. §§438.404, 431.211; 18 N.Y.C.R.R. §§ 358-2.23, 360-10.8).

i. Aid Continuing required even if the latest Authorization Period has expired

Managed care plans authorize services for specific authorization periods, which for MLTC plans may range up to six months. If a plan has authorized 24-hour x 7 day personal care services for a period that expires on December 31st, the prior federal regulations arguably allowed the plan to end or reduce that service authorization effective December 31st, precluding the consumer from receiving Aid Continuing because the authorization period expired. The amended regulations end this practice, entitling the consumer to Aid Continuing regardless of whether the authorization period for the contested service ends during the course of the appeal, as long as it had not expired at the time the appeal or hearing was requested. 42 C.F.R. §438.420(b)-(c). Additionally, to protect New York Medicaid recipients from the harshness of the former version of the federal regulations, the legislature amended the Social Services Law in 2015, to guarantee that Aid Continuing is required regardless of whether the authorization period expired. N. Y. Social Serv. L. 365-a, subd. 8.

ii. Practitioners Should Become Familiar with the new Initial Adverse Determination (IAD) notices

The DOH templates for the IAD notices, while adopting many recommendations made by NYLAG and other advocates, may still be confusing to consumers, their families and representatives.[13] The notices are in a form of a letter, rather than as a traditional notice. Here is the first paragraph of a hypothetical reduction notice dated May 1, 2018:

> This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by June 30, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by May 11, 2018. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

In this example, May 11th is the effective date of the proposed action and the deadline to request the appeal to secure Aid Continuing, yet appears in the notice only *after* the plan appeal deadline – 60 days from the date of the notice or June 30th. This may mislead consumers into thinking they have plenty of time to appeal, obscuring the 10-day time limit to secure Aid Continuing. Also, the language explaining the deadline to get Aid Continuing (May 11th) is subtle – "If you want to keep your services the same until your Plan Appeal is decided…" The language may not be clear to members.

The content of a notice to reduce services must comply with other precedent that requires a change in the consumer's medical condition or other circumstances that justify the reduction. A key authority is NYS DOH MLTC Policy 16.06, see note 7, supra. This is an important directive for practitioners opposing a proposed reduction. The directive clarifies the limited reasons why a plan may reduce personal care services, and requires very specific facts in the notice justifying the reduction. Permitted reasons

[13] See template posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf; see sample of completed reduction notice in hypothetical case posted at http://www.wnylc.com/health/download/644/.

include a change in the medical condition or social circumstances that result in needing fewer hours, not merely the fact that the plan conducted a new assessment that determined fewer hours are needed. The directive also clarifies that "mistake" may only rarely justify a reduction. The directive is rooted in a lawsuit brought against the New York City Medicaid program in the 1990's, challenging a pattern of arbitrary reductions in personal care hours. *Mayer v. Wing,* 922 F. Supp. 902 (S.D.N.Y. 1996). That decision was codified in state regulation, which applies to MLTC plans. 18 NYCRR § 505.14(b)(5)(c).

The lack of an adequate justification for reducing services, and lack of specificity of an alleged justification in the plan's notice, has been a frequent basis for reversal of proposed reductions in fair hearings.[14] Will a plan, reviewing its own proposed reduction and notice, critically review the content of the notices against the applicable standards? It seems doubtful, even though the plan employee conducting the plan appeal must have been "neither involved in any previous level of review or decision-making nor a subordinate of any such individual." 42 C.F.R. §438.406(b)(2). NYLAG and other advocates have asked the State DOH and OTDA to include an inadequate IAD as a ground for waiving exhaustion through the "deemed exhaustion" mechanism.

Plans also may fail to send any notice at all, giving only oral notice, or may send the notice less than 10 days in advance of the proposed effective date, making the notice untimely and defective. Practitioners should advise clients to keep all envelopes in which plan correspondence is mailed. The postmark may show that the notice was not mailed until days after the date of the notice. If the right to Aid Continuing is not recognized by the plan, this postmark should convince them that the notice was untimely. In such cases, if the plan will not authorize Aid Continuing, advocates should request a Fair Hearing and ask OTDA to apply "deemed exhaustion" and order Aid Continuing because the initial IAD notice was untimely. Also, complaints can be made in such cases to the NYS DOH MLTC Complaint Line: 1-866-712-7197 or e-mail mltctac@health.ny.gov. NYLAG is interested in hearing about these cases.

B. Initial Adverse Determinations - Denial of a New Service or of an Increase in A Service

If a plan member has requested a new service, or an increase in services, such as an increase in hours of personal care services, the federal regulations specify deadlines for the plan to issue determinations on these requests, which the consumer may then appeal in a "plan appeal.'

i. Background- how to request an increase or a new service – "Service Authorization Request"

A "Service Authorization Request" is a request by or on behalf of a member to increase an existing service or to authorize a new service. 18 N.Y.C.R.R. §360-10.3(o). The federal regulation for managed care service authorizations was also amended in 2016. 42 C.F.R. §438.210.

[14] See V. Bogart, R. Novick, A. Lowenstein, et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf) [hereafter "Medicaid Matters NY Report on MLTC Reductions"]

The deadline for the plan to issue a written Initial Adverse Determination notice on these requests depends on whether "expedited" review was requested. For standard requests, the plan decision must be issued within 14 calendar days from the date of the receipt of the request, but plan may extend that time for another 14 calendar days on the member's request or if the plan "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." § 438.210(d). The member, or her provider, may request that the plan expedite a decision.

> For cases in which a provider indicates, or the [plan] determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the [plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

42 C.F.R. § 438.210(d)(2). The plan may extend the time to decide an expedited decision by up to 14 calendar days, on the same basis as extending the time for a standard request.

ADVOCACY TIP – A request for an increase in hours or other services or for a new service should be made in writing, or if made orally, should be confirmed in writing. This would start the clock for the plan to make a decision following the deadlines above. Additionally, a statement from a physician or other medical professional is recommended to substantiate the increase or need for the service. The request can be made by calling Member Services or by FAX or certified mail. If the request is made in person with the care manager or at the in-home bi-annual nursing reassessment, ask the nurse or care manager to acknowledge receipt on the member's copy.

ii. Initial Adverse Determination of Service Authorization and Plan Appeal

The plan must use the State-required template for the IAD notice.[15] Under the new rules effective May 1, 2018, the member will have 60 calendar days to request a Plan Appeal (internal appeal) from the date of the notice. This is an increase from 45 days under the old rules before May 1, 2018.

If the plan fails to decide whether to grant a Service Authorizations, above, this constitutes a "denial," and the plan is required to send a notice "on the date that the timeframes expire." 42 C.F.R. § 438.404(c)(5). The member or her representative should check to see if the Plan extended the deadline by up to 14 days. If so, the Plan should have sent written notice of the extension. 42 C.F.R. § 438.408(c)(2). The regulation is unclear on the member's recourse if the plan sends no IAD notice and no extension notice. However, the regulation does state that failure to decide a service authorization within the timeframes "constitutes a denial and is thus an adverse benefit determination." Id. Therefore, presumably the member may request a plan appeal on or after the timeframes expired.

C. Nuts & Bolts of Filing PLAN APPEALS of an Initial Adverse Determination (IAD)

[15] Since it does not include the Aid Continuing provisions of a reduction notice, DOH devised a separate template, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

DOH is requiring plans to accept appeal requests by phone, fax, or mail. Plans have the option of also accepting appeal requests by e-mail or online. The phone and fax number mailing address, and at plan option, email address and online portal, should all be on the plan's IAD notice. The IAD Notice template includes a Plan Appeal Request Form, which is pre-populated with information about the member and the issue. This Appeal Request Form should be used if available. However, two new strict requirements for filing appeals must be heeded in order to ensure timely filing and, in cases of reductions, ensure Aid Continuing. First, an oral request must be confirmed in writing, unless it requests an expedited appeal. Second, the consumer must sign the written request, or authorize a representative in writing to request the appeal. Both of these new requirements are described below.

i. Oral appeal must be confirmed in writing unless it requests expedited appeal

"Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal." 42 C.F.R. § 438.402(c)(3). In other words, if a request is made by phone, unless the member, her provider or representative requests that the appeal be expedited or "fast tracked," (defined below) the phone request must be followed up by a written appeal request. Providing some relief, the regulation provides that "…oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." 42 C.F.R. § 438.402(c)(3). The phone call requesting the appeal, therefore, if made before the effective date of a reduction, locks in Aid Continuing.

An FAQ issued by State DOH regarding this regulation provides guidance as to the consequence of not confirming an oral appeal in writing:

> *FAQ 5. How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?*
>
> *Enrollees must follow verbal requests in writing unless the request is for an expedited Plan Appeal. Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return. The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the plan must make a determination even if a written Plan Appeal is not received.*

NYS DOH FAQ No. V. 5, dated Feb. 7, 2018.[16] Note that the sole FAQs posted on the NYS DOH website were specifically issued for Mainstream Medicaid Managed Care (MMC) by the division of State DOH that has oversight over those plans. A separate division has oversight over MLTC plans, which has, as of Feb. 18, 2018, not issued any policy guidance. Since the FAQ was issued by the same state agency

[16] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v) [hereafter referred to as "DOH 42 C.F.R. 438 FAQ"}

that oversees MLTC, and under general principles of administrative law requiring consistency of state policy, they should be binding on MLTC plans. 42 C.F.R. § 431.10.

The federal regulation does not require written confirmation of an oral appeal request if an expedited appeal is requested. An appeal is expedited (fast-tracked) if:

> …the [plan] determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function.

42 C.F.R. § 438.410(a). The language implies that a *provider's* request that the appeal be expedited is binding on the plan, while the plan must determine whether it agrees that a the appeal must be expedited when requested by the *member.*

ii. Client must Sign the Appeal Request Or Give Written Authorization for a Representative to File Request

The new federal regulations require the member to file the appeal request directly, and only allows a health care provider or an authorized representative to request an appeal , grievance, or a State fair hearing on the enrollee's behalf "with the written consent of the enrollee." §438.402(c)(1)(i) and (ii). Additionally, "providers cannot request continuation of benefits as specified in §438.420(b)(5)" – referencing Aid Continuing. Id. A legal practitioner, geriatric care manager, or even a family member must obtain the client's signature to show her consent for the representative to request the appeal or fair hearing, which will likely delay filing an appeal request. The model Appeal Request Form asks for the signature of both the enrolled and the "requester." As a result, the client could miss the deadline to request Aid Continuing and her home care hours could be reduced.

However, the DOH model Notice template states, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal."[17] The model Appeal Request Form has a checkbox to indicate "yes" or "no" to the question, "Have you authorized this person with [Plan Name] before?" If the practitioner or a family member had been authorized before, attach any written authorization or explain when and how the authorization was made on an attachment to the request.

NYLAG has created an Authorization form on which client can authorize her attorney, a family member, a neighborhood organization, the ICAN Ombudsprogram (www.icannys.org), or all of the above, to request plan appeals and fair hearings and, if applicable, represent her in such appeals. Form is available at http://www.wnylc.com/health/download/646/. The practitioner should have all clients sign the form before there is a crisis, and keep the signed copy on file, and give a copy to client and the family member. The form should be sent to the plan return receipt requested, or given to the care

[17] DOH Notice to Suspend, Reduce or Stop Services, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm, under heading "Who May Ask for a Plan Appeal."

manager, with the care manager asked to sign the client's copy to acknowledge receipt. Attach a copy of the signed authorization to the appeal request, and check YES to the question, "Have you authorized this person with [Plan Name] before?"

NYS DOH has issued two FAQ's regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. These FAQs do not expressly apply to MLTC plans, since they were issued by a separate division within DOH that oversees Mainstream Medicaid Managed Care (MMC) and not MLTC plans. However, as stated above, the policy should be binding on MLTC plans as well.

In the original FAQ issued by DOH to managed care plans, Question V. 8 provides:

> *FAQ V. 8. If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?*
>
> *Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment. The plan should have a process to recognize and include an enrollee´s representative when an enrollee has authorized the representative for services authorization and appeal activities prior the decision under dispute and such authorization has not expired.*[18]

This FAQ is important for several reasons. First, the plan must process the appeal request – and presumably comply with Aid Continuing – even if it has not received the member's written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, NYS DOH acknowledges the plans' duty to provide reasonable accommodations of such disabilities. These must include policies and procedures to recognize "previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment." Id. The model Appeal Request Form incorporates this policy by stating, "If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal."

A Supplemental FAQ, also issued by the DOH division that oversees "mainstream" Medicaid managed care plans, states that Aid Continuing will not be provided if the appeal is requested by a health care provider, unless the enrollee has authorized the provider as their representative.

> *FAQ IV. 2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?*
>
> *42 C.F.R. § 438.402(c)(1)(ii) requires the enrollee´s written consent for the provider or authorized representative to file a Plan Appeal on the enrollee´s behalf. Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their*

[18] DOH 42 C.F.R. 438 FAQ, *supra*, n. 15, Question V.8

representative for the Plan Appeal and the Aid Continuing request, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.[19]

The prohibition on a health care provider requesting Aid Continuing, unless specifically authorized by the plan member, reflects a suspicion that providers are acting in their own interests in receiving payment for services and not in the interests of the member.

iii. Appellant's Potential Liability to Repay Cost of Services Received as Aid Continuing – and Appeal Request Form Checkbox to indicate that Aid Continuing is not requested

It has always been true that a Medicaid recipient may be held liable to pay for services received as Aid Continuing, if the recipient is ultimately found, after a hearing, not eligible for those services. As before, the revised federal managed care regulations provide:

> (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the [plan's] adverse benefit determination, the [plan] may, consistent with the state's usual policy on recoveries under 431.230(b) of this chapter and as specified in the [plan's] contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

42 C.F.R. § 438.420(d). New York's model contract for MLTC plans has language in the Member Handbook advising the member that, "if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing."[20] Both the Initial and Final Adverse Determination Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 C.F.R. § 438.404(b)(6).

The federal regulations arguably allow states to limit Aid Continuing to those appellants who specifically request Aid Continuing when they file the appeal. New York continues to take a more liberal view, and presumes that the appellant is requesting Aid Continuing unless they indicate otherwise. Hence, the

[19] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; SUPPLEMENTAL FINAL RULE FAQ's -- *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), Question IV.2. revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#iv [hereafter "Supplemental NYS DOH FAQ"]

[20] See Model Contract for Partial Capitation Plans, *supra* n. 8, Appendix K (pp. 145 and 147 of PDF)

model Appeal Request Form has a checkbox to indicate, "I do not want my services to stay the same while my Plan Appeal is being decided."

Though clients should be advised about the potential liability to repay services provided with Aid Continuing if they ultimately lose the Fair Hearing, they should also be advised about the high probability that they will win their appeal of a reduction, at least for personal care or CDPAP services. In a study analyzing all fair hearing decisions posted on the OTDA online archive involving reductions of home care hours by MLTC plans in the last seven months of 2015, MLTC plans prevailed in only 1.2% (13 out of 1,027) of the hearings.[21] The report explains the law and policies governing plan reductions, including the plan's burden of proof that a reduction is justified by a change in the medical condition or other circumstances. Since that Report was issued, the client's ability to defeat a proposed reduction in hours has been strengthened by additional State policy directives.[22]

DOH has also clarified that if members lose the initial Plan Appeal, plans may not recoup the cost unless and until a member fails to request a fair hearing within the statute of limitations.[23]

D. When Must Plan Decide Standard Appeals and Expedited Appeals – and Member's Right to Request Fair Hearing if Plan Does Not Meet Deadlines (Deemed Exhaustion)

Where delay is harmful to the client, such as where the client is seeking an increase in home care hours or a new service, or does not have Aid Continuing on a reduction, the practitioner will need to monitor the plan's compliance with the regulatory deadlines for deciding the plan appeal, and oppose any extension of the deadline that does not comply with the regulations described below. Importantly, the plan's failure to comply with the deadlines set forth below constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i).

The Deadlines. A standard appeal must be decided by the plan within - within **30 calendar days** of receipt of the appeal request, subject to an extension of up to **14 calendar days** described below. 42 C.F.R. § 438.408(b). The member or her provider or representative have the right to request an expedited or "Fast Track" appeal, if "taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum

[21] See Medicaid Matters NY Report on MLTC Reductions, supra at n. 14.

[22] See NYS DOH MLTC Policy 16.06, *supra* , n 7, and MLTC Policy 16.07: *Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services,* both dated Nov. 17,2016 (both available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm *)*

[23] DOH 42 C.F.R. 438 FAQ*, supra,* n. 16, at Section VII, Question 3 FAQ (The FAQ says plan cannot recoup losses until member "fails to request a fair hearing within 10 days of the Final Adverse Determination, which appears to be an error and is presumably meant to say within 120 days of the FAD. NYLAG has requested a correction).

function." 42 C.F.R. § 438.410. An expedited appeal must be decided within **72 hours** after the plan receives the appeal, subject to the same 14-day extension as for standard appeals. 42 C.F.R. § 438.408(b).

Extension of the Deadline. The Plan may extend its time to decide a standard or expedited appeal by up to 14 calendar days if the enrollee requests the extension, or if the plan "shows (to the satisfaction of the State agency, upon request)that there is need for additional information and how the delay is in the enrollee's interest." 42 C.F.R § 438.408(c). The regulation does not explain by what procedure the extension would be approved to the State agency's (State DOH) satisfaction, but presumably the enrollee would utilize the existing DOH MLTC Complaint Line – 1-866-712-7197 or email mltctac@health.ny.gov**.**

If the "… plan extends the timeframes not at the request of the enrollee, it must complete all of the following:

> (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.
>
> (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
>
> (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

42 C.F.R §438.408(c)(2). NYS DOH has issued a model Notice of Extension for plans to use to fulfill the requirement above.[24]

If a member or her representative wishes to dispute an extension, from the regulations above, the member may file a grievance with the plan and/or file a complaint with the State DOH at 1-866-712-7197 or e-mail mltctac@health.ny.gov.

The plan's failure to comply with the deadlines set forth above constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i). The hearing request could be requested either 72 hours after a request for expedited review was filed, or 30 days after a standard appeal was filed, subject to the 14 day extension if warranted.

5. Member Rights in Plan Appeal

While practitioners may not have utilized the internal Plan Appeal process when it was optional, going instead directly to a fair hearing, now there is no choice but to use it. At best, the client will win the plan appeal and no fair hearing will be necessary. Even if not favorably decided, the plan appeal provides an opportunity to obtain the plan's case file, and provide additional documentation in support

[24] Extension notice available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf

of the claim to the plan, with no harm to the client if there is Aid Continuing. At worst, the plan appeal can cause great harm to the client, adding extra delay until a Fair Hearing is held and decided, which can be harmful when an increase is being requested or services are reduced without Aid Continuing.

i. Plan Must Provide Case File to Enrollee and Representative without Request

In the past, the plan only had to provide the case file upon request. Under the new regulation, the plan must:

> 5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by … (or at the direction of the [plan] in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §§438.408(b) and (c).

42 C.F.R. §438.406(b)(5). NYS DOH has issued several FAQ's to clarify the plan's duty to provide the case file while the plan appeal is pending. See *Supplemental NYS DOH FAQ*, supra, n. 19.

> *2. Is it the State´s expectation that Health Plans will send a case file upon every request for a Plan Appeal (standard and expedited) requests?*
>
> > *Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.*
>
> *3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?*
>
> > *42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.*
>
> *4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical fair hearing evidence packet?*
>
> > *The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal. Upon receiving a Plan Appeal, the plan must automatically send the enrollee´s case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally–generated documents but does not necessarily generally include all medical records that may be in the plan´s possession. The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the fair hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the fair hearing request from OAH.*

If you want the file to be provided directly to the representative, submit a signed HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA , available at http://www.nycourts.gov/forms/Hipaa_fillable.pdf.

ii. Right to present new evidence in person or in writing

Plan must consider new evidence submitted in support of the appeal "…without regard to whether such information was submitted or considered in the initial adverse benefit determination." 42 C.F.R. § 438.406(b)(2)(iii).

The plan must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 42 C.F.R. § 438.406(b)(4)

TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if the appellant or her representative wants to include additional documents with the appeal request, or to give information in person. The member or representative could also write on the form that they request time to submit additional written documentation.

iii. Reasonable Accommodations to help with appeal

The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 C.F.R. § 438.406(a).

iv. Appeal Must be Decided by Individuals who were Not Involved in Initial Decision

The plan appeal must be decided by individuals:

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
(A) An appeal of a denial that is based on lack of medical necessity.
(B) A grievance regarding denial of expedited resolution of an appeal.
(C) A grievance or appeal that involves clinical issues.

42 C.F.R. §§ 438.406(b)(2)(i) and (ii).

6. Plan's "Final Adverse Determination" (FAD) after the Plan Appeal and Request for Fair Hearing

State DOH has issued a model notice template for a Final Adverse Determination (FAD), which is a Plan's decision after the plan appeal that is wholly or partially adverse to the member. Practitioners should note that the word "Final" on the notice means that this is the decision after the Plan's plan, meaning that the member has met the exhaustion requirement and may request a Fair hearing.

Where the appeal involves a reduction in home care hours or other services, the FAD Notice is both a decision explaining the reason for denying the appeal AND a new Notice of Reduction, which again must be provided 10 days before the effective date of the proposed reduction. A Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action, in order to secure Aid Continuing. In the state's model FAD notice template,[25] note that the "effective date" is listed *after* the statute of limitations for requesting a fair hearing, which is now 120 calendar days. 42 C.F.R. §438.408(f)(2). This placement may cause members to delay seeking representation or requesting a fair hearing. Of course, it is crucial to request a fair hearing within 10 days of the notice date, and not wait for the 120 day statute of limitations.

Where the effective date has already lapsed by the time the member has consulted an attorney, one strategy is to obtain the postmarked envelope in which the notice was mailed. If it was not mailed 10 days in advance of the effective date, Aid Continuing should be awarded. See fn. 11, *supra*. Another strategy is to look for other defects in the notice content. See, e.g. the Medicaid Matters NY Report on MLTC Reductions, supra, n. 14 for more information.

The next step is to request a FAIR HEARING. While hearings may be requested by the same modes as in the past, see http://otda.ny.gov/hearings/request/, Just like for Plan Appeals, the new regulations require the member to SIGN the request, or authorize a representative to do so. See above recommendation to have all clients sign "authorization" to request appeal or hearing in advance to have on file, and to attach to hearing request.

It is recommended to use the new Fair Hearing Request Form that should be part of the FAD Notice from the plan, since it has pre-populated information that is useful to OTDA.

If plan does not send the FAD notice by the deadline (30 days for standard appeals / 72 hours for expedited appeals, both subject to 14 day extension) then the member may request the FAIR HEARING even though the plan has not made a decision on the Internal Appeal. This is called "Deemed Exhaustion." 42 C.F.R. § 438.402(c)(1)(A).

7. Optional External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an External Appeal, if the reason for the denial is because the plan determines the service is not medically necessary or is experimental or investigational. An external appeal, like Fair Hearings, requires exhaustion of the internal plan appeal and may only be requested after receipt of the FAD.

[25] Model FAD Notice of Reduction available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_reduce_services.htm.

One may request an External Appeal even if one also requests a Fair Hearing, but the decision from the Fair Hearing supersedes the External Appeal decision. NY Public Health Law § 4910.

If the issue involves a plan's proposal to reduce or stop a service, the member MUST request a Fair Hearing before the effective date of the FAD in order to receive Aid Continuing.

For more information about External Appeals see
http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

8. Additional information and Contacts

For updates on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/

Fax, phone and email contact info to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197 mltctac@health.ny.gov

NYS DOH Mainstream managed care complaints --1-800-206-8125

NYS DOH Managed care webpage on appeals
https://www.health.ny.gov/health_care/managed_care/plans/appeals/

ICAN – Independent Consumer Advocacy Network – Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org
ican@cssny.org

Jane Perkins, *Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems*, (National Health Law Program, May 12, 2016), available at
http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WoGveSXwa2w

The New Exhaustion Rules for Appeals in Medicaid Managed Care and MLTC
CLE - Implementation in NYS

Valerie Bogart, Director and Rebecca Wallach, Coordinating Attorney
Evelyn Frank Legal Resources Program, NYLAG

APPENDIX

Revised Federal Regulations

Form Notices and Appeal Request Forms -- Exhaustion of Internal Appeals

Advocacy Documents

NYS Policy / Public & Professional Education documents

1. MLTC Plan Letter to Members about changes -- April 2018 with: 36
   - DOH Fact Sheet on Exhaustion 37-38
   - DOH revised Member Handbook section on Appeals & Grievances (MLTC) 39- 49
2. NYS Webpage on Exhaustion - *Service Authorization and Appeals for Mainstream Medicaid Managed Care Plans, HARP, and HIV SNP, at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm - oriented to training mainstream plans. Includes FAQs, PowerPoints, policy, notice templates. .....
3. DOH MLTC Webpage MRT 90 – links to model contracts, MLTC policies, etc. https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/index.htm
   - https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm - Webinars, FAQs, notice templates on Exhaustion .....
4. DOH Medicaid Update – March 2018 Issue – for Providers 50

   https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc

Consumer Advocates Fact Sheets, Resources on Exhaustion

1. Consumer advocate suggested edits of NYS DOH Draft of Fact Sheet on Exhaustion 51
2. Graphic of steps in appeals and fair hearings – one for denials, one for reductions..... 53
3. Flow Chart with Suggested Script by OTDA Fair Hearing Request Intake Staff 54
4. Chart to log key dates to determine whether exhaustion may be "deemed" – Consumers suggested this as a tool for OTDA, but also useful for consumer advocates 55

Other Online Resources

1. *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf)
2. *Article on Managed Care Appeal Procedures* –http://www.wnylc.com/health/entry/184/
3. **Fax, phone and email contact info** to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

HOTLINES/ COMPLAINTS

1. **NYS DOH MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
2. **NYS DOH Mainstream managed care complaints --** 1-800-206-8125 managedcarecomplaint@health.ny.gov
3. **ICAN – Independent Consumer Advocacy Network –** Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org

SEE OUR http://nyhealthaccess.org Health Care Advocacy Webpage

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of June 23, 2017

Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart F

Title 42: Public Health
PART 438—MANAGED CARE

Subpart F—Grievance and Appeal System

Contents

SOURCE: 81 FR 27853, May 6, 2016, unless otherwise noted.

Back to Top

§438.400 Statutory basis, definitions, and applicability.

(a) *Statutory basis.* This subpart is based on the following statutory sections:

(1) Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) of the Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

State fair hearing means the process set forth in subpart E of part 431 of this chapter.

(c) *Applicability.* This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

Back to Top

§438.402 General requirements.

(a) *The grievance and appeal system.* Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F.

(b) *Level of appeals.* Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c) *Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.

(A) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(B) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(*1*) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(*2*) The review must be independent of both the State and MCO, PIHP, or PAHP.

(*3*) The review must be offered without any cost to the enrollee.

(*4*) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5).

(2) *Timing*—(i) *Grievance.* An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.

(ii) *Appeal.* Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) *Procedures*—(i) *Grievance.* The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.

(ii) *Appeal.* The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

Back to Top

§438.404 Timely and adequate notice of adverse benefit determination.

(a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.

(b) *Content of notice.* The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210 (d)(1).

(4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).

Back to Top

§438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).

(6) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

Back to Top

§438.408 Resolution and notification: Grievances and appeals.

(a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(d) *Format of notice*—(1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.

(2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(B) The review must be independent of both the State and MCO, PIHP, or PAHP.

(C) The review must be offered without any cost to the enrollee.

(D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(2) *State fair hearing.* The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

(3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Back to Top

§438.410 Expedited resolution of appeals.

(a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2).

(2) Follow the requirements in §438.408(c)(2).

Back to Top

§438.414 Information about the grievance and appeal system to providers and subcontractors.

The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

Back to Top

§438.416 Recordkeeping requirements.

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:

(1) A general description of the reason for the appeal or grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the appeal or grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

Back to Top

§438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.

(a) *Definition.* As used in this section—

Timely files means files for continuation of benefits on or before the later of the following:

(i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.

(ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.

(b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:

(1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii);

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The enrollee timely files for continuation of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal or request for state fair hearing.

(2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2).

(3) A State fair hearing office issues a hearing decision adverse to the enrollee.

(d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

Back to Top

§438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.

Back to Top

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of June 23, 2017

Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart D → §438.210

Title 42: Public Health
PART 438—MANAGED CARE
Subpart D—MCO, PIHP and PAHP Standards

---

§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.

(5) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for an enrollee to achieve age-appropriate growth and development.

(C) The ability for an enrollee to attain, maintain, or regain functional capacity.

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.

(e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

[81 FR 27853, May 6, 2016, as amended at 82 FR 39, Jan. 3, 2017]

ACME MLTC PLAN
100 Acme Lane – New York, NY 10000
1-800-MCO-PLAN

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

April 1, 2018

Jane Doe
111 Consumer Lane
New York, NY 11111

Enrollee Number: 5555
Coverage Type: Managed Long Term Care
Service: Personal Care services
Provider: Helping Hands Home Care
Plan Reference Number: 222222

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

Why am I getting this notice?

You are getting this notice because ACME MLTC Plan is reducing the service(s) you are getting now.

Before this decision, from April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 11, 2018 the plan approval **changes** to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week
From April 11, 2018 to October 11, 2018.

We will review your care again in six months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

Why did we decide to reduce your service?

ACME MLTC Plan is taking this action because the service is not medically necessary.

- Your personal care services will be reduced because:
  - Your social circumstances have changed since the previous authorization was made.
  - On January 1, 2018, your daughter, with whom you live, retired from her job.
- You no longer meet the criteria for your current level of service because:

- Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

If you want to keep your services the same

- **You must ask for a Plan Appeal within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Plan Appeal and keep your services the same is April 11, 2018,**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services you got while waiting for the decision.

You have a total of **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to ask for a Plan Appeal is **May 31, 2018.**

Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: 1-800-MCO-PLAN. TTY users call TTY.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at 1-800-MCO-PLAN.**

Step 1 – Gather your information.

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number

- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling 1-800-MCO-PLAN.

Step 2 – Send us your Plan Appeal.
Give us your information and materials by phone, fax, email, mail, online, or in person**:**

Phone……. 1-800-MCO-PLAN
Fax…….. 1-800-MCO-EFAX
Email…….. appeals@acme.com
Mail or In Person …..…….. ACME MLTC PLAN, 100 Acme Lane, New York, NY 10000 ATTENTION: APPEALS
On Line…….. [web portal]
If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, ACME MLTC Plan will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your appeal, you may request a Fair hearing and, in some cases, an External Appeal.

When will my Plan Appeal be decided?

Standard– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

Fast Track –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:
- Delay will seriously risk your health, life, or ability to function;

- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

For both Standard and Fast Track - If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision, **after** you ask for a Plan Appeal **and:**

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

OR

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing**. To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp.

Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan's network, or 4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may also be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call ACME MLTC Plan at1-800-MCO-PLAN; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

Other help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC complaints 1-866-712-7197.

You can call ACME MLTC PLAN at 1-800-MCO-PLAN if you have any questions about this notice.

Sincerely,

ACME MLTC Plan

Enclosure: Appeal Request Form

cc: Requesting Provider

At your request, a copy of this notice has been sent to:

John Doe –Authorized Representative
Chris Roe – Legal Guardian

ACME MLTC PLAN APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To:
ACME MLTC Plan
[Address]
[City, State Zip]

Fax to: 1-800-MCO-EFAX

Today's date: April 1, 2018

DEADLINE:

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is April 11, 2018**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is May 31, 2018. If you want a Plan Appeal, you must ask for it on time.**

Enrollee Information
Name: Jane Doe]
Enrollee ID: 5555
Address: 111 Consumer Lane, New York, NY 11111
Home Phone: 1-212-111-1111 Cell Phone: [Cell Phone]
Plan Reference Number: 222222
Service being reduced, suspended or stopped: Personal Care Services

I think the plan's decision is wrong because:

_____

_____

_____

Check all that apply:

- ☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with ACME MLTC Plan before? ☐ YES ☐ NO
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me):

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____

Requester Signature: _____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

NOTICE OF NON-DISCRIMINATION

ACME MLTC PLAN complies with Federal civil rights laws. **ACME MLTC PLAN** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ACME MLTC PLAN provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **ACME MLTC PLAN** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[ACME MLTC PLAN]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[ACME MLTC PLAN]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل بالرقم toll free number المبين على الصفحة التالية <TTY/TDD>	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD>.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-MCO-PLAN TTY: TTY	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں <toll free number> <TTY:>.	Urdu

FINAL

APPEAL

DETERMINATION

(FAD)

With Appeal Request Form

Reduction of Home Care Services

[Ultra-Health MLTC Plan]
[Address]
[Phone]

FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

May 1, 2018

Jane Doe
10000 W. 96th St.
New York, NY 10000

Enrollee Number: xxxx
Coverage type: Personal Care Services
Plan reference number: 5555555
Provider: Happy Home Care

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you have **four months** to ask for an External Appeal or you can ask for a Fair Hearing by **August 28, 2018, If you want to keep your services the same until your Fair Hearing is decided, you must ask for a Fair Hearing by May 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help 1-800-MCO-PLAN.

Why am I getting this notice?

You are getting this notice because on April 5, 2018 you or your provider asked for a Plan Appeal about our decision to reduce personal are services.

On April 30, 2018 Ultra-Health decided we are changing our decision and will partially approve your service.

From April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week

On May 1, 2018, we have partially denied your Plan Appeal and:
On May 11, 2018, we will reduce your personal care services to
10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week

We will review your care again in 6 months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

Why did we reduce your service?

We made this decision because the service is not medically necessary

- Your personal care services will be reduced because:
  - Your personal care services will be reduced because:
    - Your social circumstances have changed since the previous authorization was made.
    - On January 1, 2018, your daughter, with whom you live, retired from her job.
  - You no longer meet the criteria for your current level of service because:
    - Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8.

What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a <u>Fair Hearing</u>** – and an Administrative Law Judge will decide your case.

- If we said your service was not medically necessary, you can **ask the State for an <u>External Appeal</u>** – this may be the best way to show how this service is medically necessary for you. Your services may change while you are waiting for an External Appeal decision.

If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will be the final answer about your benefits.

<u>If you want to keep your services the same</u>

- **You <u>must</u> ask for a Fair Hearing within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Fair Hearing and keep your services the same is May 11, 2018**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services provided while waiting for the decision.

You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **August 28, 2018.**

How Can I Ask for a Fair Hearing?

To ask for a Fair Hearing, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)

- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp

- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

  MAIL FAIR HEARING REQUEST FORM TO:
  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Unit
  P.O. Box 22023
  Albany, New York 12201-2023

  FAX FAIR HEARING REQUEST FORM TO: 518-473-6735

OR

- **WALK IN – New York City Only:**
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  14 Boerum Place - 1st Floor
  Brooklyn, New York 11201

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

After the hearing, you will be sent a written decision about your case.

How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC [1-866-712-7197].

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

You can call [CONTACT PERSON NAME] at Ultra-Health MLTC Plan at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
External Appeal Standard Description and Application

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[DAUGHTER]]

[266] MLTC MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC

MAIL TO: *NYS Office of Temporary and Disability Assistance*
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

FAX TO: *518-473-6735*

DEADLINE:

- ***If you want to keep your services the same*** *until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.*
- ***The last day to ask to keep your services the same is May 11, 2018***
- *You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing.* ***The last day to ask for a Fair Hearing is August 28, 2018. If you want a Fair Hearing, you must ask for it on time.***

☐ ***I want a Fair Hearing. This decision is wrong because:***

Enrollee	*Name*	*Signature*	*Phone*
Representative (if any)	*Name*	*Signature*	
	Relationship	*Phone*	

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by May 11, 2018 If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you ***do not want*** *to keep your health care the same:*

☐ *I* ***DO NOT want*** *to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.*

FOR NYS OTDA ONLY *MANAGED CARE DECISION FAIR HEARING REQUEST FORM*		
Notice Date [DATE]	*Effective [DATE]*	*Service Type:[Service]*
Case Name (c/o, if present) and Address: *[ENROLLEE NAME* *ENROLLEE ADDRESS]* *CIN: [MEDICAID CIN]*		*[MCO/URA NAME* *MCO/URA ADDRESS]* *Reference No.: [MCO REFERENCE NUMBER]*

A Plan Appeal was filed on April 5, 2018. On May 1,2018, [Plan Name] decided we are changing our previous decision and will partially approve the service.

From April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week

On May 1, 2018, we have partially denied your Plan Appeal and:
On May 11, 2018, we will reduce your personal care services to
10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week

Authorization to Request Appeal or Hearing

AUTHORIZATION – Medicaid Managed Care Requests

I authorize the following individuals or organizations to represent me in making requests regarding my Medicaid managed care or Managed Long Term Care Services. They may, on my behalf make requests including but not limited to:

1. Request an Internal Appeal of an adverse determination by my plan;
2. Request a Fair Hearing of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review").
4. File a grievance with my plan.
5. File a complaint with the NYS Department of Health.

This authorization applies to my current plan, which is (NAME) _____ _____and also to any different plan I might enroll in at a later date.

Authorized Individuals or Organizations (fill in and check one or more):

- ☐ NAME _____ Relationship _____
  - Address _____
  - Cell phone _____ E-mail _____
  - ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.
- ☐ ORGANIZATION NAME _____
  - Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
  - Contact person: _____
  - Address _____
  - Phone _____ E-mail _____
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.
- ☐ **Independent Consumer Advocacy Network (ICAN)** - including all participating organizations in the network. Main tel 844-614-8800
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____

BLANKS for

1. Requesting Plan Appeal (Internal Appeal Request)
2. Requesting Fair Hearing after Final Adverse Determination (FAD)

These are generic versions of the requests that SHOULD be attached to the Plan's IAD and FAD notices, pre-filled with client's information. If client did not receive any notice, or not this part of notice, use these

These are oriented for reductions in hours. Can adapt for other types of issues.

MLTC APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To: **Date**: _____
Plan Name/UR AGENT] _____ **Fax:** _____

Address _____City, State Zip _____

DEADLINE:

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Notice Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [Notice DATE+60**]. **If you want a Plan Appeal, you must ask for it on time.**

Enrollee Information

First Name _____ Last Name_____

Enrollee ID: _____Plan Reference Number _____
Address: _____City, State, Zip _____
Home Phone: _____ Cell Phone: _____

Type of Service being reduced, suspended or stopped: _____

I think the plan's decision is wrong because:

_____

_____

_____

Check all that apply:

- ☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with this plan before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me):

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____

Requester Signature: _____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC

MAIL TO: NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

FAX TO: 518-473-6735

DEADLINE:

- **If you want to keep your services the same** until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.
- **The last day to ask to keep your services the same is [Notice Date+10].**
- You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120**]. **If you want a Fair Hearing, you must ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

Enrollee	Name	Signature	Phone
Representative (if any)	Name	Signature	
	Relationship	Phone	

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by [date+10]**.** If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you **do not want** to keep your health care the same:

☐ I **DO NOT want** to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.

MANAGED CARE DECISION FAIR HEARING REQUEST FORM

Notice Date	Effective date	Service Type:
Case Name (c/o, if present) and Address: ENROLLEE ADDRESS CIN:		MLTC/Managed Care Plan Name: Plan Reference No.:

A Plan Appeal was filed on DATE: _____ Plan decided appeal by Final Adverse Determination dated: : _____

Amount/type of service plan provided before:

On DATE OF Initial Adverse Determination Notice _____, Plan proposed to reduce services to (Amount) _____ starting on DATE _____.

After the Appeal, by Final Adverse Determination NOTICE dated _____ Plan decided to reduce services to _____ starting on

DATE _____

NEW YORK LEGAL ASSISTANCE GROUP

Consumer Concerns on Implementation of New Exhaustion Requirement April 1, 2018

February 7, 2018

I. Regarding OTDA implementation –

1. **Intake of fair hearing (FH) requests** – I'm pleased to hear that OTDA and DOH are working to add a question at intake about whether the caller requested an internal appeal. It is critical that intake call center staff be trained to ask this question and explain the internal appeal requirements.

   A. **Revising online, paper and fax forms for requesting hearings** to include questions about the status of the internal appeal request and decision, if any and to inform the requester of the internal appeal requirement.

      - The templates developed by DOH for requests for internal appeal and for fair hearing could be adapted as generic templates and posted on the OTDA website. However, the existing FH request forms also need to be revised because people are already familiar with them.
      - A list of all plans, with their appeals contact info (phone, fax, email, mail) should be printed on the back of these forms, as well as be posted on the OTDA and DOH websites.
      - The forms must elicit facts that show whether "deemed exhaustion" is warranted – date of the internal appeal request, date of the final adverse decision, etc.

   B. **Front-end screening of requests for "deemed exhaustion."** If I understand your email correctly, OTDA will make no inquiry or determination about whether "deemed exhaustion" applies until the hearing is held. Respectfully, in most cases this will be too late. Especially where the issue is a reduction or termination, the appellant is entitled to request the FH and receive Aid Continuing without exhausting the internal appeal, if certain circumstances apply. In order to determine whether to order Aid Continuing, OTDA will need to review the notice, or lack of notice, and determine, where an internal appeal was requested, whether the time limit for the plan to make a final decision has passed, warranting deemed exhaustion. While we realize that this imposes a demand on OTDA staff and legal resources, we just don't see how this change can be implemented without having a front-end process for screening for "deemed exhaustion."

- **OTDA should issue policy guidance defining when "deemed exhaustion" applies, so that plans, consumers, ALJs, all know the standards. At a minimum, deemed exhaustion should apply when:**

    a. No written notice of initial adverse determination (IAD) was provided by the plan, or

    b. The IAD does not include the requisite information regarding the right to Aid Continuing, how to request an appeal, how to obtain representation, how to submit evidence, and other information in the DOH notice templates and otherwise required by law and regulation.

    c. The IAD did not incorporate necessary translation or alternative formats, was not on the required template, or did not offer auxiliary aids and services, free of cost, during the appeal, thus impeding the enrollee's time to appeal or request Aid Continuing.

    d. The IAD does not comply with other applicable requirements, ie. MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services;*

    e. The Plan did not decide the internal appeal within 30 days from member's appeal request, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless extended pursuant to the regulations by up to 14 calendar days. 42 CFR § 438.408.

C. Special protections, at least for an initial transition period, for FH requests that involve a reduction or termination of a service - At least during a transition period while millions of people are being educated on the new procedures:

- **The filing of the fair hearing request should be deemed the filing date of the internal appeal, for purposes of triggering Aid Continuing.** OTDA would then either assist the appellant in requesting the internal appeal, as discussed below, or, when OTDA notifies the plan through its normal procedures that the fair hearing was requested, the plan would be required to commence processing the internal appeal, as if the appellant requested it. The date of the "request" for the internal appeal would be the date of OTDA's notification to the plan, for purposes of the plan's time limit to decide the appeal. For purposes of Aid Continuing, the date of the request would be the date of the fair hearing request.

- **Alternatively, the time limit to request internal appeal should be tolled, if the hearing was requested within the aid continuing deadline for an internal appeal request**. At least for a transition period, the statute of limitations for requesting the internal appeal should be tolled from the

date of the FH request until a reasonable time after OTDA has contacted the appellant to advise them of the internal appeal requirement.

- **OTDA staff should assist with internal appeal request in these cases where the Aid Continuing time limit is imminent**. If the FH request is made by phone, the OTDA staff should do a 3-way call with the plan and the appellant as a "warm transfer" of the request to the plan for the internal appeal. (see #4 below about improved communications lines between OTDA and plan appeal units).
    - If the FH request is made by other formats, and the Aid Continuing clock is ticking, OTDA should contact the appellant within 24 hours to advise of the internal appeal requirement and assist with filing of the appeal.
- All of these requests need to be screened for "deemed exhaustion."

D. Communications must be established between OTDA and all of the plans for OTDA to quickly ascertain whether an internal appeal was requested, when, and the status of that appeal. The consumer cannot be told simply to call their plan. Nor can OTDA be required to call the plan member services numbers, which can take time to be routed to the appeals unit. Nor can OTDA simply ask the member for the status of their internal appeal. Some members or their representatives will know if they requested an internal appeal. But others will not understand or know the answer.

2. Other Systems Actions That are Needed by OTDA –

A. Making changes to the OTDA fair hearing request web pages - Instructions posted on the site must explain the new requirements in clear language.

- A list of all plans, with their appeals contact info (phone, fax, email, mail) should be posted on this page. This is very difficult information to obtain. Even though I've now represented consumers in MLTC for 5 years, I still don't have a good working list of appeals contacts or fax numbers for each plan. This needs to be public information accessible on DOH and OTDA websites.

B. Revision of FH request "acknowledgement letters" and other form letters – If a fair hearing is requested against a managed care plan, this letter is a critical opportunity to inform the requester and appellant that their fair hearing request may be dismissed if they did not request an internal appeal from the plan. If the case involves a reduction or termination of benefits, then, as discussed above, more affirmative steps should be taken by OTDA staff to ensure Aid Continuing is provided.

C. Training ALJs on all of the above.

II. Regarding DOH Systems -

1. **Educating plans** - I'm pleased to see that webinars have been conducted for mainstream MMC plans and that materials, notice templates, FAQ's and more have been posted for MMC plans on the DOH website. I do not see anything yet for **MLTC plans** on the website and would like to know if comparable materials will be posted and webinars conducted. Also, while top-level plan managers may attend these webinars, what is to ensure that all pertinent plan staff are trained, from care managers and grievance and appeal staff to call center staff. See issues re plan surveillance and readiness review below.

2. **DOH Website updates** – The implementation timeline indicates these are being done Feb – March. Will this include DOH/MLTC websites as well as the MMC? We urge that the consumer-oriented webpages be updated along with the plan-oriented webpages, including but not limited to these –

   https://www.health.ny.gov/health_care/managed_care/complaints/index.htm ,

   https://www.health.ny.gov/health_care/managed_care/mltc/mltcomplaint.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/enrollee_information.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/

   - **Post Plan Appeals Contacts** – DOH Websites must include information on each MCO's appeal phone number, fax, email and online portal if available. In order to have access to the appeal procedures as set out in the new federal regulations, DOH must maintain and provide this appeal contact list for the public. This list should be maintained on the DOH and OTDA websites. We suggest that Maximus also include this information on NYMedicaidChoice.com. Appeals contacts could be added to their existing lists of plan contacts.

   - **Post consumer-friendly information on the new appeal procedures**, and include samples of the plan notices, the **internal appeal and fair hearing request forms**. (below we suggest a downloadable fact sheet for consumers) We are glad to see the webpage oriented to MMC plans includes copies of the **notice templates**, but consumers won't see those. Also, would be more helpful for consumers to post samples of the forms completed in a hypothetical case, rather than the templates with all of the alternate language, which can be confusing. We posted one sample that we created for a reduction notice.

3. **DOH Policy and Guidance --**

    a. **MLTC Policy Guidance** - We strongly urge DOH to prepare a new MLTC policy to be posted on the MRT 90 website detailing the MLTC plan obligations under the new appeal process. This guidance should include requirements for using the new notices properly, timely logging in and tracking internal appeals, and providing AID CONTINUING as required. This document should set clear standards for MLTC plans regarding compliance with the federal regulations. The FAQs posted for mainstream plans provides useful guidance on issues such as requirements for sending the enrollee's case file prior to an appeal or fair hearing. MLTC policy guidance is needed to provide clear guidance to plans on their responsibilities in the hearing process.

    b. **New MMC and MLTC model contract language** regarding the exhaustion requirement must be drafted and executed. Advocates would like to know DOH's timeframe for the revisions to the model contracts and would be interested in reviewing any model language.

    c. **DOH Policy needed on reasonable accommodations required to assist members in understanding notices and requesting appeals.**

4. **Plan Readiness Review and Compliance** -- As discussed at the workgroup meetings, we were pleased to hear that DOH's surveillance unit intends to monitor MCO implementation of the new appeals process. We would like to know more about the surveillance and monitoring plan.

    a. **Specifically, what testing of MCO systems is planned before April 1st** to ensure that appeal requests are timely logged in and processed? Consumers reported to the Workgroup difficulties in navigating plan call centers, and being routed to care managers or other departments, which can all delay or even prevent logging in an appeal request. Of course where the issue is a reduction or termination, the right to Aid Continuing is threatened with any barriers or delays to filing the request, whether by phone, fax, or otherwise.

    b. Do MCOs have sufficient staff in their appeal departments to meet this obligation?

    c. Have care managers and other plan staff been trained to forward any appeal request to the correct department within the MCO to process the appeal request, so that there is "no wrong door" for a member seeking to appeal?

    d. **Systems to ensure that AID CONTINUING is ordered and implemented are particularly critical.** Before this change, plans have only had to implement an Aid Continuing directive given by OTDA. Even during the short time that exhaustion was required for MLTC, the appellant had to request a FH simultaneously with the internal appeal in order to obtain Aid Continuing. For this reason, both MMC and MLTC plans have not had the need to develop systems to INTERNALLY make a determination of whether a member is entitled

to Aid Continuing, and then implement that directive. This requires that plans develop procedures, designate staff responsible for determining when Aid Continuing applies, developing systems to ensure that a reduction or termination is not automatically implemented, merely by the passage of time (10 days from the notice), without ensuring that an internal appeal request was not filed. DOH will need to ensure that these systems are set up and ready for implementation.

e. **Is DOH checking to see that plans have implemented their new systems to allow filing appeal requests by fax, email, mail, and in some cases online?** This will need to ensure that these requests are logged in and read on a timely basis, so that Aid Continuing is directed and implemented in the short time frame required, and that requests are otherwise processed on a timely basis.

f. **Systems for sending the enrollee's case file in advance of the appeal and hearing** - Since there are new requirements for this aspect of appeal procedures, DOH should ascertain the plan's readiness to timely comply. Does the plan have adequate procedures and designated personnel for this task?

g. **Plan website updates –** We assume that plans will be **posting the revised member handbooks online** as soon as they are completed. In addition, plans need to post accessible information for members on how to request internal appeals, with downloadable forms, and complete information on how to file – fax numbers, e-mail and mail addresses, phone numbers, and online portal, if available. .

5. **Provider education -- Medicaid Update** – We're pleased to see you are planning to publish a Medicaid Update article; the timeline shows March. We would appreciate reviewing a draft and an opportunity for comments. Are there other plans to ensure that providers are up-to-date with this change? The Implementation timeline shows a "Provider/CBO Education Tool," which we'd like to learn more about, and would welcome the opportunity to review a draft.

6. **Consumer and Public education –**

   a. **Member handbook –**The implementation timeline states that updates have been in process since December and will be until March. We would very much appreciate the opportunity to review and comment on the latest drafts. (Can you confirm that this is both the mainstream and MLTC member handbooks that are being revised?). Please advise us of the timeframe for mailing these to members.

   b. **Cover letter to be mailed with handbook –** Will DOH be issuing a standardized letter to be mailed to members with the revised member handbook? We would welcome the opportunity to review a draft and provide feedback. On the letters to MLTC members, and those MMC members receiving long term care services and supports, ICAN contact information should be listed.

c. **We also encourage DOH to develop a brief fact sheet for consumers to include in the plan's mailing to members, to post on the DOH website and to distribute via list-serv**. This document should explain the appeals process in simple terms, and also define new terms such as FAD and IAD for consumers. We urge DOH to solicit advocate input in reviewing these documents before they are finalized and to include **ICAN Ombudsman program** contact information where applicable.

d. **Public Webinar** – We see that this is planned for March, according to the Implementation Timeline. Will this be oriented to mainstream or MLTC or both?

e. **Member newsletters –we see this on the implementation timeline.** Which newsletters does this reference? Is DOH releasing an article that could be completed in newsletters of CBOs and other networks that educate consumers, their families and advocates?

February 7, 2018

Submitted by:

Valerie Bogart and Rebecca Wallach, NYLAG
Rebecca Antar Novick and Belkys Garcia, The Legal Aid Society
Susan Dooha, Center for Independence for the Disabled, New York
Shelly Nortz, Coalition for the Homeless
Adam Prizio, Empire Justice Center
Mel Tanzman, Westchester Disabled on the Move

CONTACT:
Valerie Bogart, Esq.
Director, Evelyn Frank Legal Resources Program
New York Legal Assistance Group
7 Hanover Square, 18th floor
New York, NY 10004
Direct Dial 212.613.5047
vbogart@nylag.org

MODEL MEMBER HANDBOOK COMPLAINT AND APPEAL LANGUAGE

The following language relating to the managed long term care demonstration complaint and appeal process must appear in the Contractor's Member Handbook.

UnitedHealthcare Personal Assist™ will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by (insert plan name) staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: 1-877-512-9354 TTY711 or write to:

UnitedHealthcare Personal Assist
Att: MLTC Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When UnitedHealthcare Personal Assist denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-877-512-9354 TTY711 or writing to:

UnitedHealthcare Personal Assist
Att: MLTC Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp

- Mail a Printable Request Form:

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit: http://otda.ny.gov/hearings/request/

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

3. SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request

b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

    a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

4. Enrollee or provider may appeal decision – see Appeal Procedures.

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

    a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

    a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
    b. the Contractor may mail notice not later than date of the Action for the following:

        i. the death of the Enrollee;
        ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where

the Enrollee understands that this must be the result of supplying the information);

iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;

iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or

vi. the Enrollee's physician prescribes a change in the level of medical care.

c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

a. the date the restriction will begin;
b. the effect and scope of the restriction;
c. the reason for the restriction;
d. the recipient's right to an appeal;

e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
f. the right of Contractor to designate a primary provider for recipient;
g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
k. the name and telephone number of the person to contact to arrange a conference;
l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
n. the right of the recipient to examine his/her case record; and
o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.

Medicaid Managed Care Enrollees Service Authorization and Appeals Procedure Changes

The State will implement several changes related to Medicaid managed care service authorization, appeals, fair hearings and grievances (complaints) as required by the Center for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance (CHIP) Programs Final Rule published May 6, 2016, amending federal rules at 42 CFR Part 438. These changes apply to mainstream Medicaid managed care, Health and Recovery Plans (HARPs), HIV Special Needs Plans, Managed Long-Term Care Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus. These managed care plans are certified under Public Health Law Article 44, and therefore must also continue to comply with the service authorization, appeals and grievance requirements in State statutes. The Department has issued guidance to the health plans for compliance with these changes (including the use of new model enrollee notices) at: https://www.health.ny.gov/health_care/managed_care/plans/index.htm and https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm.

Enrollees will receive notice of these changes on or before April 1, 2018. Health plans will begin handling service authorization requests, appeals and grievances (complaints) under these new rules on May 1, 2018, and thereafter. Starting May 1, 2018, plans will be required to complete review of service authorization requests under different time frames, issue revised enrollee notices, and, for adverse determinations made on May 1, 2018 and thereafter, follow revised appeal processes. Although there are several changes, two key provisions are:

- Starting with plan service determinations made on May 1, 2018 and thereafter, enrollees wishing to dispute a plan's adverse determination regarding their services must exhaust the plan's internal appeal process **before** requesting a State Fair Hearing. This means the enrollee must request a plan appeal, which may be expedited, and receive a Final Adverse Determination upholding the plan's decision prior to requesting a State Fair Hearing. Enrollees will have 120 days from the Final Adverse Determination to request a State Fair Hearing. If the plan does not respond to the Plan Appeal or the response is late, the appeal process will be deemed exhausted and the enrollee may request a State Fair Hearing.

- Upon review, health plans may determine to reduce, suspend or terminate authorized services. The enrollee will be able to have their aid continue from the plan upon filing a plan appeal within 10 days of the Initial Adverse Determination notice, or before the effective date of the decision, whichever is later. If the plan upholds its decision and issues a Final Adverse Determination, the enrollee may have their aid continue by requesting a State Fair Hearing within 10 days of the Final Adverse Determination notice, or before the effective date of the decision, whichever is later. If the enrollee loses their plan appeal or Fair Hearing, they may have to pay for the services they received while their appeal/fair hearing was being decided.

Complete information on these appeal processes will be posted on to the Department and health plan websites.

The federal rules changes do not impact the processes for providers to file plan appeals or complaints on their own behalf. However, providers often assist enrollees in filing appeals of plan service denials. Federal regulations now require the enrollee to sign an agreement that they wish the provider to represent them during the appeal and complaint processes prior to the provider filing an appeal or complaint with the health plan on the enrollee's behalf. Providers may still request a reconsideration of a medical necessity denial, otherwise known as "peer-to-peer," if such decision was made by the plan without prior consultation with the provider. The federal rules also limit enrollees to only one level of internal appeal for plan adverse benefit determinations. Otherwise, Independent External Appeal processes for disputing medical necessity decisions as provided by Public Health Law Article 49 remain unchanged.

Please contact 438reg@health.ny.gov if you have any questions regarding these regulation changes. Questions regarding a health plan's authorization, appeals or complaint procedures should be directed to the health plan.

****

available at https://www.health.ny.gov/health_care/medicaid/program/update/2018/

Important Change for Medicaid Managed Care and MLTC Enrollees Appeals and Fair Hearing Rights

What is changing on May 1, 2018?

New rules change how and when you can ask the State for a Fair Hearing to appeal a decision by your Medicaid managed care plan, HARP plan, or Managed Long Term Care (MLTC) plan. Starting May 1, 2018, if your plan denies, reduces or stops a service, and you think the decision is wrong, **you must first ask your plan to look at your case again. This is called a Plan Appeal**. You must then wait for the plan's decision **before** asking for a Fair Hearing.

This is a big change. Before May 1, 2018, you could request a Fair Hearing right away if you thought your plan's decision about your services was wrong. **Now you must first request a Plan Appeal before you can ask for a Fair Hearing.**

What happens if the plan decides to reduce or stop a service I am getting now?

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan says that it will reduce or stop any of your services. You have 60 days from the date of the plan's notice to ask for a Plan Appeal, **but if you want to keep your services the same while your case is appealed, you must ask for a Plan Appeal within 10 days** of the date of the plan's notice or by the date the notice says the change will take effect, whichever is later. If you request the Plan Appeal within 60 days but after the effective date of the reduction, you can ask the plan to "fast track" your Plan Appeal. If you lose your Plan Appeal, you may ask for a Fair Hearing. If you don't request a Fair Hearing, or if you don't win your Fair Hearing, and you received your services unchanged while waiting for the decision, you may have to pay for those services

What happens if the plan denies my request to approve a new service or to provide more services?

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a notice of its decision. If your health is at risk, you or your provider may request that approval be "fast tracked." This requires the plan to decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information, and why the delay needed to obtain this information is in your interest. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If the plan denies your request for approval, the decision is called an "Initial Adverse Determination." If you think your plan's decision is wrong, you can ask for a Plan Appeal. After May 1, 2018, **you must first ask for a Plan Appeal and wait for a plan appeal decision before you may ask for a Fair Hearing.** You have 60 days to ask for a Plan Appeal. If you disagree with the Plan Appeal decision, you may ask for a Fair Hearing.

How do I request a Plan Appeal?

You can request a Plan Appeal by completing and faxing or mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. Some plans allow you to e-mail the request. The plan's contact information for requesting the appeal should be printed on the Appeal Request Form. You can also call the plan to request the appeal, but you will then also need to mail or fax confirmation of a request made by phone, unless you ask your Plan Appeal to be "fast tracked."

Can someone ask for a Plan Appeal for me?

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must both sign and date the appeal request. Or you must give written permission to that person to request an appeal for you, unless you gave them permission in the past.

What happens in a Plan Appeal and How Long Does it Take?

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk and you or your provider request a "fast track" appeal, your plan must decide it within 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information to decide, and why the delay needed to obtain this information is in your interest. If the plan's appeal decision denies you all or some of the services you are seeking, the plan must send you a "Final Adverse Determination."

What if the Plan does not decide my Plan Appeal on time?

If you do not receive a "Final Adverse Determination" – a decision for your Plan Appeal -- by the time limits in the question above, you can ask for a Fair Hearing without waiting for the plan's decision.

What if I think the Plan Appeal decision is wrong?

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for a Fair Hearing, but if the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, **you must ask for a Fair Hearing within 10 calendar days** from the date of the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same as they were before, until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. Your services may be reduced while awaiting an External Appeal, unless you also requested a Fair Hearing in time to prevent a reduction.

You can ask for a Fair Hearing or an External Appeal or both. If you ask for both, the Fair Hearing decision will always be the final answer.

Where can I get more information?

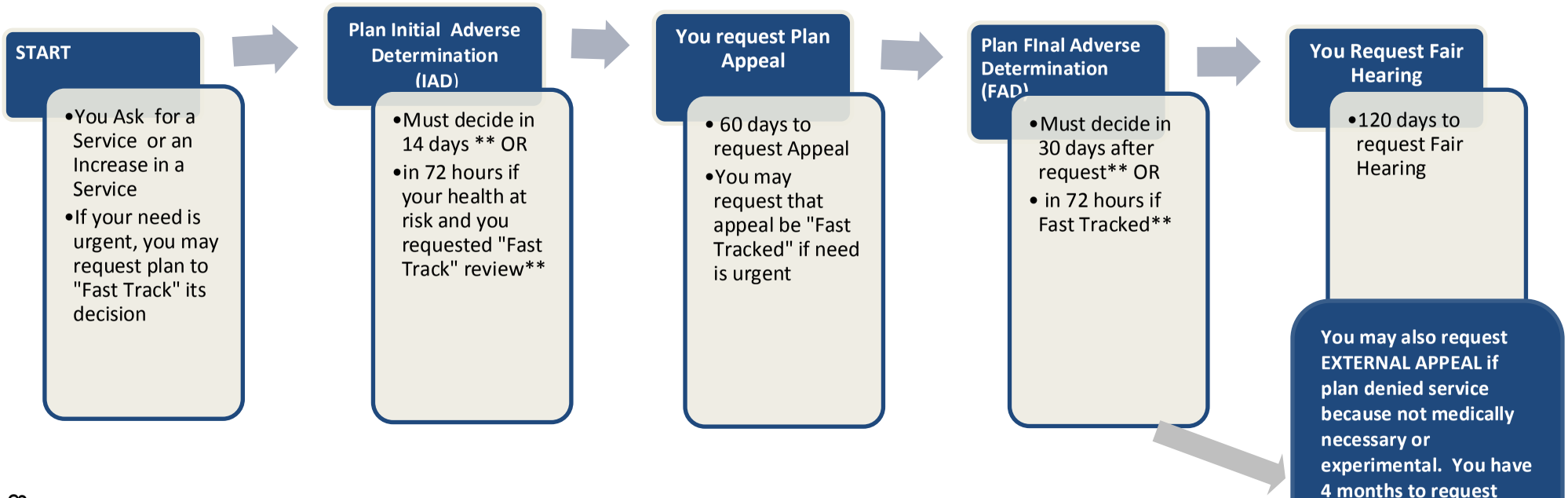
You can call your plan at the number on your plan ID card. See your plan's member handbook for full information about your appeal rights.

For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN –Independent Consumer Advocacy Network** Phone: **844-614-8800**

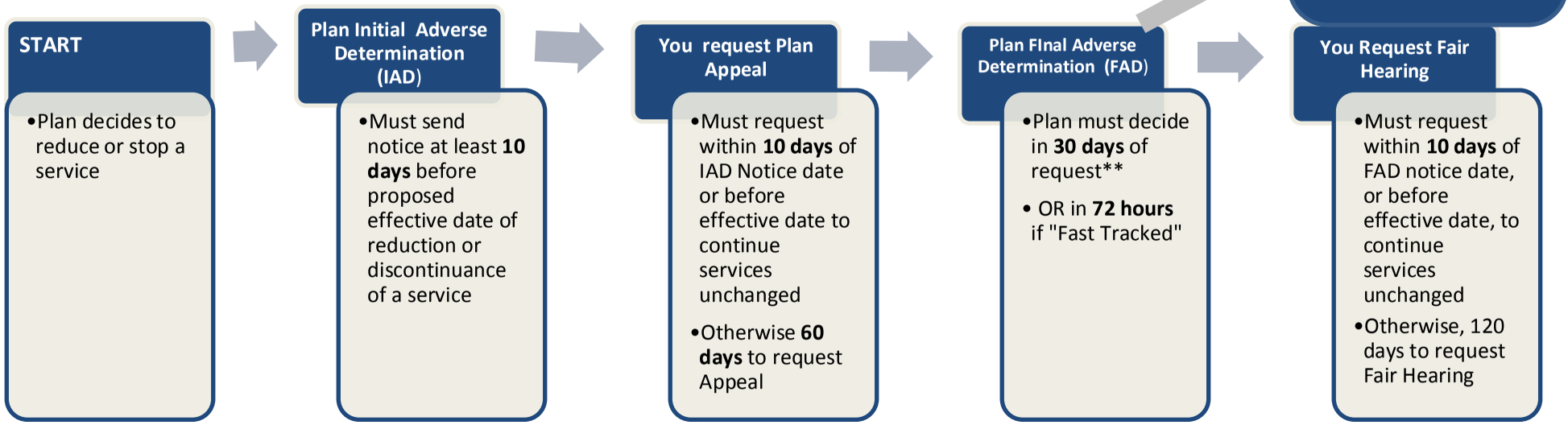
TTY Relay Service: 711 Website: icannys.org E-Mail: ican@cssny.org

By NYLAG – EFLRP contact eflrp@nylag.org April 2018

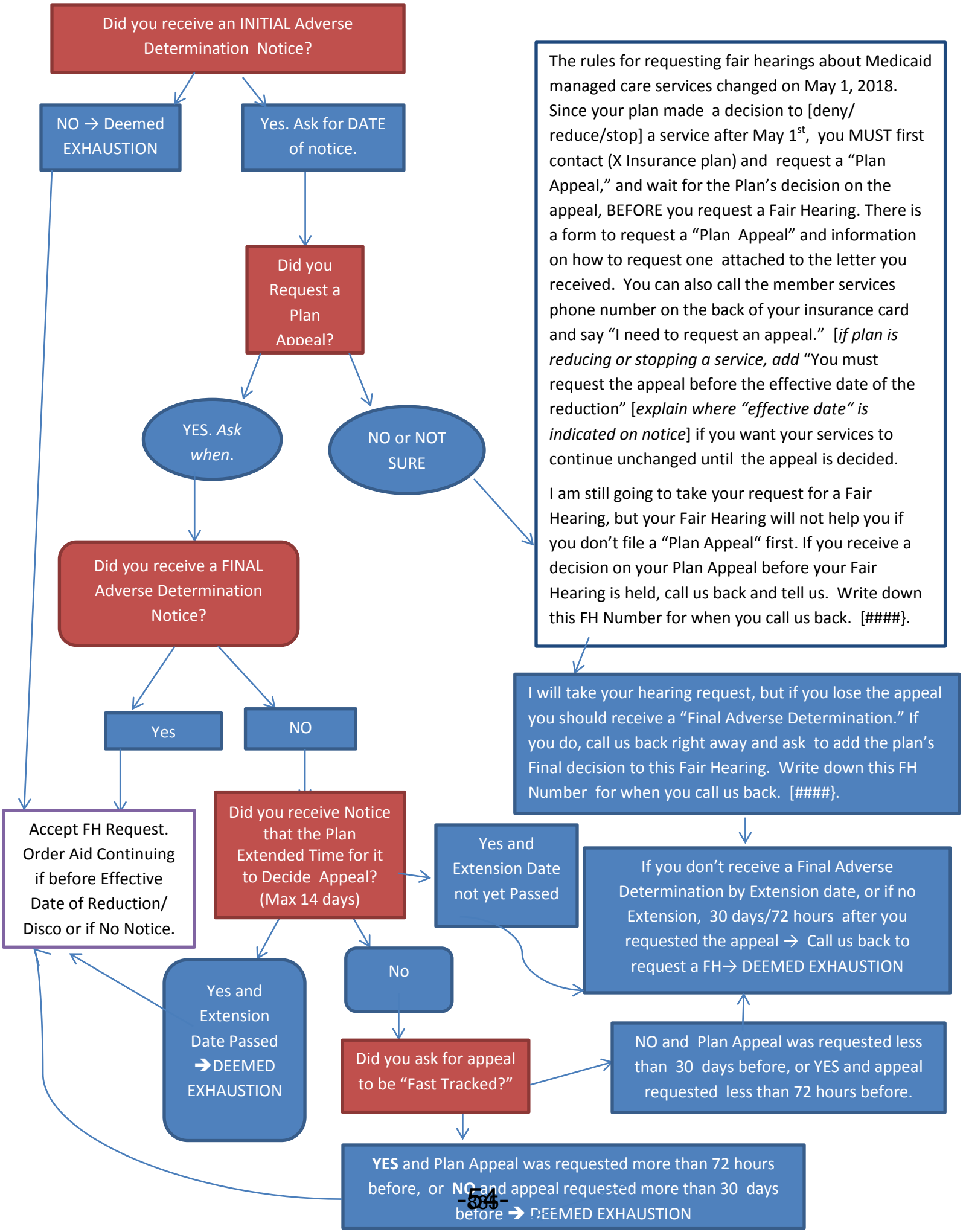
1. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN DENIES YOUR REQUEST FOR A SERVICE



2. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN REDUCES OR STOPS A SERVICE



** Plan may extend deadline up to 14 days if it needs more information, and if delay is in your interest. Plan must send you notice of why it needs more time.


Did you receive an INITIAL Adverse Determination Notice?
NO → Deemed EXHAUSTION
Yes. Ask for DATE of notice.
Did you Request a Plan Appeal?
YES. *Ask when.*
NO or NOT SURE
Did you receive a FINAL Adverse Determination Notice?
Yes
NO
Accept FH Request. Order Aid Continuing if before Effective Date of Reduction/ Disco or if No Notice.
Did you receive Notice that the Plan Extended Time for it to Decide Appeal? (Max 14 days)
Yes and Extension Date not yet Passed
Yes and Extension Date Passed ➔DEEMED EXHAUSTION
No
Did you ask for appeal to be "Fast Tracked?"
YES and Plan Appeal was requested more than 72 hours before, or **NO** and appeal requested more than 30 days before ➔ DEEMED EXHAUSTION
NO and Plan Appeal was requested less than 30 days before, or YES and appeal requested less than 72 hours before.
If you don't receive a Final Adverse Determination by Extension date, or if no Extension, 30 days/72 hours after you requested the appeal → Call us back to request a FH→ DEEMED EXHAUSTION
I will take your hearing request, but if you lose the appeal you should receive a "Final Adverse Determination." If you do, call us back right away and ask to add the plan's Final decision to this Fair Hearing. Write down this FH Number for when you call us back. [####}.
The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is reducing or stopping a service, add* "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.
I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

Information to be Obtained and Provided by OTDA in FH Requests

	DATE	Received? Or Requested?		NOTICE/EVENT
		YES	NO	
1				**Initial Adverse Determination Notice received?** If YES, enter date of notice If NO – oral notice only ➔ accept FH request. Deemed Exhaustion.
2		[redacted]		• Effective Date of Notice (if reduction)
3				Was Plan Appeal Requested? If YES, Enter date of request. If NO, give **Script A** below.
If Plan Appeal Requested ➔ Identify if Past Deadline for Plan to Decide Plan Appeal				
4				- Was Fast Track Requested? If YES, enter Fast Track Deadline (Line 3 + 72 hours). If YES, GO TO LINE 6. SKIP LINE 5.
5		[redacted]		- Standard (Line 3 + 30)
6				- Was Extension Notice Received from Plan? If YES, enter date to which review extended. (See "Review Extended" notice.)
7				**Final Adverse Determination (FAD) Notice received?** IF YES, enter Date of notice
8		[redacted]		• Effective Date of Notice (if reduction)
				-- If NO, and Latest of DATES in Lines 4, 5, or 6 have passed, Exhaustion is Deemed. Accept FH request. -- If NO, and Latest of DATES in Lines 4, 5, or 6 have not passed, accept FH request and give **Script B.**

SCRIPT A

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received from your plan. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is*

reducing or stopping a service, add "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.

I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

SCRIPT B

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Now, you must wait to receive the Plan's decision on your appeal before you request a Fair Hearing. I will take your Fair Hearing request, but if you lose the appeal you should receive a notice called a "Final Adverse Determination." If you receive this notice, call us back right away and ask to add the plan's Final Adverse Determination to this Fair Hearing. Write down this FH Number for when you call us back. [####}.

If you don't receive a Final Adverse Determination by [*Extension date – Line 6 in Chart or if no Extension, Line 4 or 5 in Chart*] → Call us back after that date and tell us you did not receive a final decision from your plan. Write down this FH Number [####] for when you call us back.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

MLTC Update: 2018-19 NYS Budget Changes/ National Forecast and New MLTC Appeals Rules

Valerie Bogart, NYLAG May 2018
eflrp@nylag.org 212-613-7310

2

Topics

1. Growth of MLTC – leading to 2018-19 NYS Budget Changes in Medicaid and Managed Long Term Care
2. National picture – Threat of budget cuts, block grants, ACA repeal
3. New Rules for Appealing an Adverse Action by an MLTC Plan or other Medicaid Managed Care Plan – the Requirement to "EXHAUST" Plan Appeals.

NYLAG

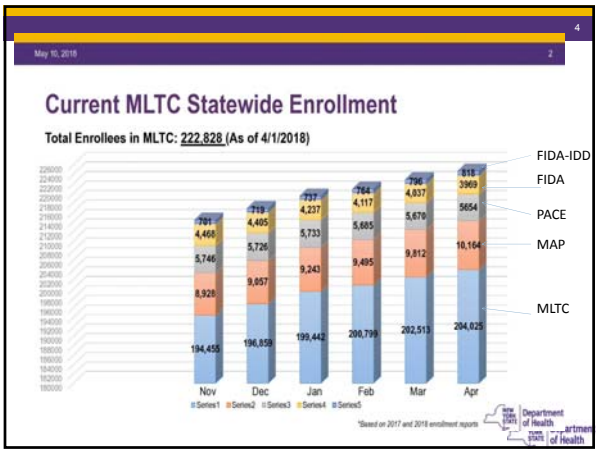
3

Gov's State Budget – Proposed Cuts:

Trying to Slow MLTC Enrollment Growth

- After several years of promotion of MLTC growth, the State is now trying to put on the brakes.
- **Next slides show growth in home care since MLTC started.** The growth is more than State expected. Not just from moving consumers from Fee for Service or from "baby boomers." Possible causes:
  - **Marketing – Plans, LHCSAs, CDPAP FI's,** and
  - **Expansion of CDPAP** – Consumer Directed Personal Assistance.- addresses shortage of aides upstate. Plus now parents may be aides for adult children and adult children for their parents. CDPAP agencies must be certified to meet standards under 2017-18 State Budget.

NYLAG



Growth in NYS Home Care population

	2007/08			5/2018
	NYC	ROS	**NYS**	
MLTC	18,000	1,514	19,500	204,025
MAP, PACE, FIDA	2,500	793	3,500	19,787
Personal Care/ CDPAP	48,000	12,000	60,000	6,000 (NYC =3000)
Lombardi	15,000	10,000	25,000	0
TBI/NHTDW			4,500	5,592
CHHA long-term?			20,000	0
TOTAL			**133,500**	**229,635**

Is growth solely due to aging of population?

FINAL 2018-19 NYS BUDGET -- CARVING OUT NURSING HOME FROM MLTC

NYLAG

7

Background:

NYS Mantra: "Managed Care for All"

- In 2015, the MLTC program was expanded to require all adult **nursing home residents** to enroll in an MLTC plan if they have Medicare, once they are approved for Institutional Medicaid after the "lookback."
- If they did not pick an MLTC plan, they were auto-assigned to an MLTC plan by NY Medicaid Choice.
- The MLTC plan became responsible for paying the Nursing Home and for collecting the NAMI from the resident.
- If the consumer was already in an MLTC plan when they entered the NH, they would remain in that plan – or could change plans. But had to be in a plan.
- By 2018, 23,000 NH residents in MLTC plans (> 10% of all MLTC members)

MLTC rates ↑ 2015 to include NH care

MLTC Capitation Rates (estimated average)	**$4000 - $5500/mo.**
Aide services (estimated $18/hour)	
• 5 days x 7 hours	$2,730/mo.
• 12 hours x 7 days	$6,670/mo.
• **Live-in x 7 days @ 13 hours/day**	**$7,117/mo.**
• **Split – shift 2x12**	**$13,340/mo.**
Average Medicaid Nursing Home (non-specialty – excl. AIDS, vent, pediatric)	
• **NYC**	**$8,604/mo.**
• Albany	$5,811/mo.
• Nassau	$7,898/mo.

Plus admin, care management costs, and other services – adult day care, dental, supplies, transportation, audiology, nursing, etc.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

Who Pays for the Nursing Home Care?
Competing Interests Push State to Change Policy

- **NHs** want to be paid same rate they received from State pre-managed care/MLTC ("benchmark rate"). Nursing homes won law requiring plans to pay this rate until end of 2020.
- **Plans** say they can't absorb high NH cost. Guildnet & other plans have closed or reduced service area, citing high NH costs. Want either:
  - Take NH benefit OUT of MLTC – back to Fee for Service or
  - State pay for NH care outside of the MLTC capitation premium through a separate **"NH rate cell."**
- State said would save $$ removing permanent NH care from MLTC. State explained duplicates care management by NH. Or because increased premiumacross the board?

Who Pays for the Nursing Home Care?
Competing Interests Push State to Change Policy

- **Consumers** fear that removing the cost of NH care from MLTC plans – whether through a NH rate cell or if NH care "carved out" of the MLTC package – but plans still responsible for 24-hour home care, incentivizes plans to put members in NHs rather than give them high hours of home care they need.
- Consumers want a **high need "rate cell" for community care** to give plans incentive to keep out of NH. Otherwise will never approve 24-hour care.
  - Would pay plans more for members who meet certain high-need criteria, i.e. paraplegia, stroke, MS, live-alone, etc.
  - Would have incentive for plan to provide care at home, not in NH.

2018 NYS Budget - Nursing Home residents excluded from MLTC after 3 months of "permanent placement"

In the budget enacted April 1, 2018**,** those "permanently placed in nursing homes for 3 consecutive months or more" will no longer be eligible for MLTC enrollment**.** This impacts 3 groups – each discussed further below.

1. **New Nursing Home residents who were not previously in an MLTC plan** -- will no longer be required to enroll in MLTC. No more auto-assignment to an MLTC plan.
2. **23,000 current NH residents are in MLTC plans**. Will they be disenrolled from MLTC even if they hope to return home?
3. **MLTC members in community** – what happens to them if placed in a NH, even temporarily? Are they more at risk of being placed in NH's if plans deny adequate hours?

Guidance on transition to come from DOH

"Side Letter" entered between NYS DOH and Assembly Health Chair Richard Gottfried as part of State Budget agreement:

- "The Department will provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, **the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports."**

DOH Guidance needed on implementation -- "Permanent Placement" definition

1. **Who decides if an individual is "permanently placed?"** Maximus? DSS? Plan? NH?
   - Does consumer have a say? A right to appeal this determination?
   - Important determination because starts clock to disenroll from MLTC plan after 3 months. Consumers want to slow down clock.
2. **What are the criteria for "permanent placement**"? Is it enough that applied for – or approved for -- Institutional Medicaid (5-year lookback)? Or that DOH-3559 Form filed by NH? (Also used for Medicaid app, community budgeting)
   - Anyone in a NH > 29 days must apply for Institutional Medicaid, even if just to pay Medicare SNF Coinsurance thru Day 100.
   - Does not mean Permanently Placed!

NYLAG

DOH Guidance needed on implementation -- more on Permanent Placement

3. **What notice and appeal rights does member have:**
   a. To appeal determination that "permanently placed?"
   b. To appeal disenrollment after permanently placed for 3 months?
   - DOH has said it may extend enrollment past 3 months if consumer intends to return to community. But what is procedure? Who determines this?
4. To address concern that it will be harder to return home from a NH if no longer in an MLTC plan, DOH has proposed policy that if consumer later wants to re-enroll to return home with home care, CFEEC will not be required if last CFEEC done < 6 months ago, or if disenrolled < 6 mos ago.

NYLAG

Questions about implementation Group 1 – NH residents not in an MLTC plan

1. Statute says individual "permanently placed" for more than 3 months is *excluded* from MLTC.
   - Is she barred from enrolling in an MLTC plan? If so, could violate the ADA by creating barrier to discharge home. Could only use "immediate need" which is not readily available statewide.
   - Will Maximus be required to conduct a CFEEC in the NH?
2. Assuming individual may enroll in the MLTC plan from the NH in order to return home -- it is even now difficult to arrange discharge for the 1st day of the month. If enrollment begins on the 1st, ideally the MLTC plan pays the NH rate for a few days until discharge is arranged. Will this still be possible? May plan refuse to pay NH care temporarily?
   - Can Capitation be pro-rated so enrollment can start any day of month? Assembly budget bill had proposed this.

NYLAG

Questions about implementation
Group 2 – 23,000 NH residents in MLTC plans

- DOH has said in post-budget discussions that those in NH as of April 1, 2018 will be disenrolled from MLTC plan after 3 months – effective July 1, 2018. On hold pending CMS approval.
  - What are member's rights to notice and to appeal determination that "permanently placed" for the 3 months?
  - DOH has said it may extend enrollment past 3 months if consumer intends to return to community. But no procedures as of yet.
- DOH has proposed policy that if these individuals are disenrolled and later want to re-enroll to return home with home care, CFEEC not required if last CFEEC done < 6 months ago, or if disenrolled < 6 mos ago.

17

Questions about Implementation
Groups 2 & 3 – How Get out of NH?

- If NH residents are no longer auto-assigned to an MLTC plan once their Institutional Medicaid is approved, and if MLTC members are disenrolled from the MLTC after permanently placed for 3 months – How will they get out of a NH?
- DOH says will waive CFEEC if recently disenrolled.
- But still delays in MLTC enrollment and meet resistance of plans "cherry picking" to avoid high hour cases.
- **Immediate Need** should be available, since Attestation Form has a check-off to show applying from a hospital or nursing home. but some counties not implementing. See next slide.

18

Questions about Implementation
How Get out of a NH? **Problems with "Immediate Need"**

- Some counties reportedly not processing Immediate Need applications at all.
- Some counties use wrong standard to determine need. 16-ADM-02 & Attestation form say "You have no informal caregivers available, able and willing to provide or continue to provide *needed* assistance," or Medicare not available to provide *needed* help. See http://www.wnylc.com/health/entry/203/. SSL 366-a(12)
- Nassau DSS denying immediate need if family or Medicare providing ANY care, even if not enough or can't continue.
- The Special Income Standard for Housing Expenses* which can reduce or eliminate the spend-down if leave NH after > 30 days and enroll in MLTC, not Immediate Need.

*NY Social Serv. Law 366.14; NYS DOH 12- ADM-05; MLTC Policy 13.02: MLTC Housing Disregard; http://www.wnylc.com/health/entry/212/.

Questions about implementation
Group 3 – MLTC plan members in community

- If a member requests an increase in hours, may plan decide that consumer needs to be "permanently placed in NH" and deny increase? What are consumer's appeal rights?
- If a member admitted to NH for short-term rehab, and then plan refuses to reinstate home care, claiming member needs to be "permanently placed in NH" – what are consumer's rights?
  - *Granato* case (GIS 96 MA/023) -- failure to reinstate home care in same amount received prior to a hospital stay is a "discontinuance" of home care, requiring Notice and Aid Continuing rights.
  - What are appeal rights for determination of "permanent placement?" Plan is really DENYING increase in home care which is appealable.
  - What notice and appeal rights are required to disenroll member from plan after permanently placed for the 3 months?

High-need rate cell in the future?

- To counter the financial incentive that carving out NH care gives plans to deny high-hour home care, and instead place members in NHs, consumers advocate for a **community-based High Need rate cell.** This was not enacted in the budget.
- The "Side Letter" entered between NYS DOH and Assembly Health Chair Richard Gottfried states this:
  - "The Department commits to exploring separate rate cells or risk adjustments for the nursing home, high cost / high need home and personal care, and Health and Recovery Plan (HARP) populations. The Department will re-engage CMS regarding this reimbursement methodology with the assistance of health care industry stakeholders impacted by these changes (e.g. advocates, providers and managed care organizations)."

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

FINAL 2018-19 NYS BUDGET – OTHER LTC CHANGES

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

UAS Scores

- **Disqualifying the lowest need individuals from MLTC**, under a UAS score of 9. They would access personal care or CDPAP from local DSS as pre-MLTC, like Housekeeping recipients. Concerns about DSS staffing capacity, resources, contracts with home care agencies to meet the demand.
- **REJECTED in FINAL BUDGET**

LIMIT on How Many LHCSAs (home care staffing agency) an MLTC may Contract With

- **Downstate** – MLTC plan may contract with only:
  - one LHCSA per 75 members, eff. Oct. 2018, and
  - one LHCSA per 100 members as of Oct. 2019.
- **Upstate** – MLTC Plan may contract with only:
  - One LHCSA per 45 enrollees as of Oct. 2018 and
  - One LHCSA per 60 members as of Oct. 2019.
- Requires plans to provide evidence annually of compliance and provides flexibility to DOH to allow exceptions where needed and to ensure continuity of care.
- New LHCSAs will go through stricter Certificate of Need approval process. Before, all were reportedly approved
- Crain's Health Pulse reported one small NYC plan (ICS) will have to cut from 150 to 65 agencies.

LIMIT on How Many LHCSAs an MLTC may Contract With (cont'd)

- In the "side letter" from the NYS DOH to Assembly Health Chair Gottfried, it says:
  - "The Department will issue guidance to assist both MLTC and LHCSAs in minimizing the disruption of care for Medicaid members and the impacted workforce when methodologies are enacted to limit the number of LHSCAs with MLTC Plans."
- Concern re continuity of care, members will lose long-time aides – can they change plans to follow aide? See next slide..

MLTC Lock-In

- **LOCK-IN – Eff 10/1/18 --** MLTC members may not change plans after 1st 90 days of enrollment, except annually, unless for good cause.
- Good cause "may include:
  - poor quality of care,
  - lack of access to covered services,
  - lack of access to providers experienced in dealing with the enrollee's care needs,
  - or as otherwise determined by the commissioner."
- COMMENT: With LHCSAs being dropped from MLTC plans, consumers will want to switch MLTC plans to keep their aide – but will be locked in.

NYLAG

26

Moratorium on new LHCSA's

- 2-year moratorium on approval of applications for licensure of Licensed Home Care Services Agencies (LHCSAs). Effective April 1, 2018 until March 31, 2020. Section 9-e of Part B of Chapter 57 Laws 2018.
- 1400 LHCSAs in NYS; 350 were in pipeline for approval
- **Exceptions**:

1. Seeking licensure of a LHCSA submitted with application for an **Assisted Living Program** (ALP) to serve the ALP's residents
2. Transfer/change ownership for an existing LHCSA that has been operating for minimum of 5 years to **consolidate 2 or more LHCSAs** and;
3. LHCSA applicant demonstrates, to the satisfaction of DOH, that the application **addresses a serious concern such as a lack of access to home care services in a geographic area or lack of appropriate care, language and cultural competence or special needs services**

See https://www.health.ny.gov/facilities/cons/

NYLAG

LIMIT on Marketing by CDPAP Agencies

- CDPAP Fiscal Intermediaries must submit any ads or marketing materials to DOH for approval.
- If publish 2+ ads that are "false or misleading "or not approved by DOH, license will be revoked.
  - QUERY: What is false or misleading advertising? CDPAANYS – the trade association of CDPAP agencies – gave an example of an ad saying "Take control of your home care. No more eating meals at awkward times." Is that false or misleading? S
  - ome FI's promising workers guaranteed high income – is that misleading?
- No other providers had marketing limitations enacted in the state budget – LHCSAs, MLTC plans, nursing homes.

NYLAG

FINAL 2018-19 NYS BUDGET MEDICAID OTHER THAN HOME CARE

Cap on Physical, Speech, & Occupational Therapy – GOOD NEWS

- Cap on PHYSICAL THERAPY visits per year increased from 20 to 40 visits.
- Speech and Occupational Therapy REMAIN capped at 20 visits/year each.
- No exceptions/override to caps, which also apply to Mainstream MMC and MLTC plans, though MLTC members also receive Medicare therapies.
- EXCEPTION: As before, caps do not apply to people with DD or TBI diagnoses, but note – recent case where mainstream plan only authorized PT 2 sessions at a time, requiring repeated requests for reauth by MD/PT clinic.

Spousal Refusal, Impoverishment – Good News

- Proposed Repeal of Spousal Refusal REJECTED.
- Proposed Reduction of Spousal Impoverishment Resource Allowance REJECTED.
  - Proposal would have reduced NYS to the MINIMUM allowed by federal law – $24,180 – rather than $74,820 allowed currently. NYS still far under the MAXIMUM allowed by federal law, which in 2018 is $123,600.

THE FUTURE?

Forecast 2019

NYLAG

32

FY 2019 Trump budget proposal

- Pays for cost of Tax Bill – slashed $1 Trillion revenue
- $490 bill. Medicare cuts over 10 years; curb appeal rights, slow shrinking Part D Donut hole, increase prior authorization for original Medicare services (home health?)
- $1.4 trillion Medicaid cuts over 10 years – transform from entitlement to Per Capita Cap or Block Grant.
  - Would force states to cut services, eligibility – long term care
- Would repeal the ACA. Though ACA expanded Medicaid eligibility for < 65 with no Medicare – repeal would also impact seniors and older adults (> 55).

NYLAG

33

Most Seniors' Medicaid is Not Thru ACA. But Repeal will Still Hurt!

Most low income 65+ or < 65 with disabilities have Medicaid through old pre-ACA rules – with lower income and resource limits. They did not directly benefit from the Medicaid expansion.

Why should older adults care if the ACA is repealed?

1. 4.5 million older adults age 50- 65 will lose Medicaid coverage.
2. ACA expands home care options in NYS and elsewhere.
3. ACA stabilizes private insurance premiums for adults age 55-65
4. NYS would lose $3 billion/yr. in federal funds – forcing state to cut Medicaid costs for everyone. Long term care is biggest part of State Medicaid budget.
5. ACA makes Medicare more affordable – 20% of Medicare ben'ies are also on Medicaid!

- Beyond ACA repeal, beware of block grants & caps!

34

ACA Repeal -

Loss of Federal $ ➔ May Cause LTC Cuts

- ACA repeal will remove **$3 billion** of federal funding from NYS - $30 billion over 10 years.
- How will NYS cope with that lost funding? Likely cuts in Medicaid eligibility and/or services and/or provider payments.
- Age 65 + and disabled are only 24% of all Medicaid recipients, but use 36% of all Medicaid dollars – so at risk of cuts.
- **Long Term Care** – Uses 69% of Medicaid dollars for seniors
  - Home-and-community-based services likely target for cuts, waiting lists. But -- needs increase as baby boomers age, elderly live longer and more seniors live in or near poverty.
  - Reverse progress in rebalancing Institutional vs. Community-Based LTSS?
- **Medicare Savings Program** subsidies of Medicare costs – states can limit to poorer beneficiaries.
- **States pressured to increase Medicaid copayments**, deductibles, charge premiums to defray state costs, cut other services.

35

Block Grants or Caps → Cuts in Services or Eligibility

CURRENT SYSTEM:

- Medicaid is an "**entitlement**." If applicant meets eligibility guidelines, State must approve Medicaid promptly, and provide services following minimal basic federal requirements.
  - Generally, **no waiting lists** allowed,
  - States must cover certain **populations** (poorest children, elderly), with option to cover more (e,g. higher income may "spend down" to Medicaid limits).
  - States must cover certain **services** (hospital inpatient, nursing home) for certain populations, with option to cover more (personal care, prescription drugs). NYS has expansive home care programs!
- **Federal match** – (FFP) Feds pays 50% of all Medicaid expenses in NYS (higher % in poorer states).
  - Population ↑ - In a recession, or as baby boomers age, or after a disaster and more apply for Medicaid, feds and state share increased costs & risk.
  - Services ↑ -Population ages and need more costly services – federal and state share increased costs.

36

Medicaid Block Grants

1. **WHAT ARE THEY?** States would receive a fixed amount of federal funds annually, instead of a percentage of **actual costs**.
   - Amount allocated among states based on spending in base year, with yearly increases based on trend factor (eg CPI), not actual spending.
     - What if % who are frail elderly in NYS grows in later years?
   - States may or may not be required to pay state share
2. **Proponents argue:** Give states **more flexibility** to set eligibility rules, define services & program features.
3. **Opponents argue :** With cap on federal share regardless of need, States cannot predict costs, forced to cut services, impose waiting lists or cost-sharing. Waivers, DSRIP, ACOs already give flexibility, integrated care.
4. **Proponents argue will cut costs**, but Medicaid cost per enrollee has grown more slowly than private insurance. (Urban Institute 2010). May undo savings achieved with DSRIP, ACOs, other delivery system reforms such as from reduced hospitalizations, institutionalization.

37

Per Capita Caps

- States would receive fixed amount of federal funds per Medicaid enrollee. May or may not set different cap amounts for seniors/disabled/children, etc.
- Based on spending in base year, with trend factor year to year.
- Offers states more protection from growth in enrollment, since receives per capita payment for each enrollee, but State still capped on COST of services per enrollee.
- Some proposals may include a **NATIONAL CAP**, which would limit increased payments for influx of enrollees, shifting risk of increased enrollment AND cost to State
- **State MATCH** typically required, federal funds match state expenditures up to a cap.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

THE NEW MLTC APPEAL RULES – "EXHAUSTION" OF PLAN APPEALS

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

39

New "exhaustion" requirement for MANAGED CARE APPEALS

- The Obama Administration revised the federal regulations that govern Medicaid "managed care" plans. 42 CFR Part 438 (App. p. 1). They had not been revised since 2002.
- Many changes in regs – appeals is just one. See NHELP summaries. http://www.healthlaw.org/issues/medicaid/managed-care
- **General new rule-- After May 1, 2018,** a managed care or MLTC member may not request a Fair Hearing against the plan until **AFTER BOTH OF THESE OCCUR:**
  1. Member has requested a **plan appeal** (internal appeal) of an adverse plan determination, and
  2. The plan has EITHER
     a. issued a final appeal **decision**. 42 CFR 438.402(c) OR
     b. has **failed to make an appeal decision in the required time** (**30 days** or **72 hours if "Fast Tracked**"), or failed to give required notice that it was extending its time to decide up to 14 days. (This is "Deemed Exhaustion)

40

Summary of Topics

1. **Basics on the new rule and why it changed** , general concerns
2. **WHO is affected and WHAT types of issues** and appeals require exhaustion?
3. **Two Types of appeals – Spotlight on New Notices**
   - DENIALS of services
   - REDUCTIONS of services
4. **Nuts and Bolts of Requesting Plan Appeals** –
   - How to Request Appeals, Who may request appeals
   - Requesting an Expedited Appeal
   - When must Plan Decide Appeal
6. **Plan's Final Adverse Determination Notice** after appeal and request for Fair Hearing or External Appeals
7. **"Deemed Exhaustion"**
8. **Member Rights in a Plan Appeal**
9. **Contacts**

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

41

Why Did CMS Require Exhaustion?

- To align Medicaid appeals with those enrollees experience in private health insurance with employers, Qualified Health Plans and Medicare Advantage.
- CMS thought this approach would be less confusing if similar process, but ignored fact that private insurance doesn't have **Aid Continuing** or **Fair Hearings**! And that Medicaid eligibility issues other than managed care services STILL have direct access to Fair Hearings
- CMS responded to concerns **about extra delay in waiting for a plan appeal** by:
  - shortening deadline for plan to decide plan appeal (30 calendar days, shortened from 45 days) and by
  - "**deemed exhaustion**," which allows a consumer to request a fair hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 FR 88 at 27510.

42

Concerns: 5 million members & their advocates don't know about the change!!!

Exhaustion is a Massive Change to the Appeals Process

- In 20 years of mandatory "mainstream" managed care – exhaustion never required. 4.5 million "mainstream" managed care members (those without Medicare < 65).
- When MLTC became mandatory in 2012-14, exhaustion was required, but July 1, 2015 the State lifted that requirement. Since then one may do an internal appeal, but must request a FH to get Aid Continuing. (MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Plan Enrollees).

NEW FOR PLANS TOO –

- call centers can be hard to navigate to request appeal;
- plan has to decide if consumer gets Aid Continuing.

43

NYS DOH Implementation of Exhaustion

- **New DOH webpages for plans**, with **Model NOTICEs, webinars, and FAQs**. Include **plan trainings & ALJ training**
  - *Mainstream Medicaid Managed Care, HARP, and HIV SNP plans* https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm
  - *MLTC plans* https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm
- "**Medicaid Update**" for providers – issued 3/2018 https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc Appendix p. 50
- **Plans sent letter with 2-page DOH Fact Sheet to consumers** April 2018 (App. pp 36-38), referring them to plan websites for insert to Member Handbook section on Appeals (App. pp. 39-49) (Consumer advocates version of fact sheet in Appendix p. 51-52)
- **OTDA Fair Hearing request website – NOT updated**

44

Exhaustion applies to ALL Medicaid Managed Care Plans

1. **Managed Long Term Care** (MLTC) - **206,000 members** mostly Dual Eligibles = have Medicaid and Medicare)
2. "**Mainstream" plans** - **4.39 million members**
   a. For people who have Medicaid but not Medicare and do not have a "spend-down" – income under Medicaid limit
      - Mostly < 65 and not on Medicare for disability, eligible for Medicaid through Affordable Care Act – kids, families, singles
      - Some > 65 and receive SSI and not Medicare (usually because of immigration status)

   b. Include specialized "mainstream" plans–
      HARP (Health & Recovery Plans) –if have Behavioral Health history **14,000 members**
      HIV Special Needs Plans **9,500 members**
3. **Medicaid Advantage Plus** – hybrid MLTC + Medicare Advantage – **9,500 members**
4. **Medicaid Advantage Plans – 7,070 members**

TOTAL **4,613,000**

45

Which PLAN actions now require Exhaustion?

APPEAL vs. COMPLAINT/ GRIEVANCE

Appeal = A request to review an **"Initial Adverse Determination" (IAD)** -- require EXHAUSTION. 2 types of **IAD**'s:

- **REDUCTIONS of any service**
- **DENIALS of a new service or increased service**

Complaint (formerly "grievance") - filed with plan about anything NOT an adverse benefit determination.

- quality of care, services or treatment,
- delays in services (aide/ transportation late) or
- poor communications with the plan (ie care manager)
- Dispute extension of time for plan to decide request for new or increased services (make authorization decision).
- **NO Fair Hearing rights with Complaints** but may request Complaint Appeal in 30 days. Plan must resolve in 30 business days - New NYS Complaint resolution notice templates at https://www.health.ny.gov/health_care/managed_care/plans/appeals/

46

Which Medicaid actions do not require exhaustion?

- Local DSS/ HRA/ NYSofHealth actions re financial eligibility for Medicaid.
- Recipient may request Fair Hearing without a Plan Appeal (i.e., no exhaustion required).
- Must request a Fair Hearing before the effective date of a reduction or termination fc services to remain the same ("Aid Continuing").

47

Warning: May not be how it appears!!

DSS/HRA Discontinuance of Medicaid Leading to MLTC Plan Disenrollment

If home care stops, it *might* be an action by the MLTC plan.

But often this chain reaction happens –

1. Medicaid is discontinued by LDSS/HRA because of a Medicaid renewal problem
2. Client is automatically DISENROLLED from the plan
3. Home care stops.

► **REQUEST Fair Hearing against LDSS/HRA for Medicaid discontinuance** (investigate if notice provided, etc). If merited (no notice, late notice, etc.)

► Request **Aid Continuing** with "relinking" or reinstatement of enrollment with MLTC plan. Must advocate with DSS/HRA for relinking.

► ALSO may request Plan Appeal and ask for "Aid Continuing," especially if plan assisted with the renewal.

48

NEW Appeals Process and Vocabulary

Red equals change from previous deadlines

1. *Plan* "**INITIAL Adverse Determination" notice (IAD)**
   - Deadline (if member requested new or increased service): 14 calendar days/ 72 hours fast track*
2. *Member* Requests **Plan Appeal**
   - Deadline: 10 days for Aid Continuing; 60 days other
3. *Plan* "**FINAL Adverse Determination" notice (FAD)**
   - Deadline: **30 calendar days (was 45)**/ 72 hours Fast Track*
4. *Member* Requests **Fair Hearing**
   - Deadline: 10 days for Aid Continuing; **120 days (was 60)** other
   - Optional: External Appeal request if medical necessity but no Aid Continuing

*** Plan may extend 14 days if need more info & in member's interest**

1. INITIAL ADVERSE DETERMINATION (IAD) - 2 TYPES

1. DENIAL of new service or increase in services
2. REDUCTION of services

50

Initial Adverse Determination (IAD)

- Plan makes an adverse determination to either:
  1. DENY a request for a new "service authorization" – a new service OR denies an increase in hours of home care or other services (sometimes called "concurrent review")
  2. REDUCE home care or other services.
- For both, plan must use new NOTICE TEMPLATES, posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm – scroll down to PLAN NOTICES
  - Initial Adverse Determination
    - Denial Notice (denial of new or increased service)
    - Notice to Reduce, Suspend or Stop Services

51

More about IADs for **Denial** of Request

- Plan sends Initial Adverse Determination notice (IAD) if **denies or partially denies** the service authorization request. Also send to provider if provider made request.
- **Plan must send IAD notice (**new template – previous slide**) 14 calendar days from receipt of request for a new or increased service authorization.**
- **Fast Track -** If the plan determines or the provider indicates that a delay would **seriously jeopardize** the enrollee's **life or health or ability to attain, maintain, or regain maximum function- must decide in 72 hours.** 42 CFR 438.210
- Either way plan may **extend up to 14 calendar days** if plan can justify that it needs additional info and the extension is in enrollee's interest. Plan should send Extension Notice

52

If Plan denies "Service Authorization" request --

More on IADs for DENIALs

1. **If plan fails to send IAD notice by the deadline** (14 calendar days/ 72 hours from receipt if expedited/ + extension up to 14 days) and did not give notice extending time by up to 14 days - **This is a "denial."** 42 C.F.R. 438.404(c)(5)
   - Member **may request a plan appeal** on or after the date plan SHOULD have sent written notice.
   - This is why it is important to request increase/new service in writing – to start clock for plan to decide. And keep proof that requested.
   - May you request Fair Hearing if no IAD notice? **NO**. Must request plan appeal.
2. After May 1st, Member has **60 calendar days** to request a Plan Appeal (internal appeal) from the date of the IAD notice (increase from 45 days under old rules).

FOCUS ON **REDUCTIONS** IN HOURS OR SERVICES

Initial Adverse Determination to reduce services

NYLAG

Aid Continuing (AC)

- **Aid continuing** - Plan must give written notice 10 days before proposes to **reduce or stop** a service. If hearing requested before effective date, services continue ***unchanged***.
  - SOURCE: ***Goldberg v. Kelly,*** 397 U.S. 254 (1970) – Right to Pre-Termination Hearing – Right to have a hearing held and decided BEFORE a proposed reduction or discontinuance can take effect, because Medicaid is an ENTITLEMENT based on financial need.
  - 10 days includes weekends and mailing time!
- **Now, member must meet that short AC deadline TWICE –**

1. File PLAN APPEAL before effective date in IAD, and then, if she loses plan appeal,
2. File HEARING REQUEST before effective date of Final Adverse Determination (FAD).

NYLAG

55

Aid Continuing & Authorization Periods

Consumers are entitled to Aid Continuing (AC) if plan reduces services, "without regard to expiration of the prior service authorization." SSL 365-a, subd. 8 (2014). EXAMPLE:

- Jan. 1st - through June 30, 2018 - Ann has 24-hour live-in care, authorized for a 6 month period.
- June 20th - Plans sends an IAD notice that new authorization is 10 hours daily, effective July 1st – Dec. 31, 2018.
- This is a **reduction** effective July 1st. Ann will get aid continuing if she requests a **Plan Appeal** before July 1st.

Federal reg requires AC if Auth'n period expires while FH is pending, but not if Auth'n Period expired before FH requested. But NYS law does require AC in both situations.

Federal reg says if plan reduces amount authorized for any long term care service, including Nursing Home, in the next authorization period, compared to current Auth period, must give Aid Continuing.

*42 C.F.R. §438.420(b)-(c).

56

Member Liability for Services Provided as Aid Continuing

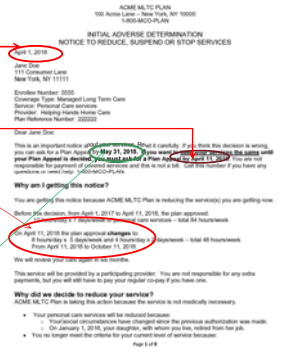
- Both the IAD and FAD Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 CFR 438.404(b)(6).
- State DOH FAQ** says plans may recoup cost of services during Aid Continuing period, but only:
  - after FAD is issued and member fails to request a hearing within the 10-day Aid Continuing period.
  - NYLAG asked to bar recoupment until after 120-day time limit to request FH. DOH says plan can start recovery if FH not requested in 10 days, but must stop if requests FH within 120 days.
- NOTE: Most Fair Hearings on reductions of services are in FAVOR OF THE MEMBER (> 90%). See Medicaid Matters NY report. Appendix TOC. The potential liability should not deter member from appealing.

**See DOH I FAQ # VII. 3, 1. 2/7/18
https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm

Initial Adverse Determination Notice - Appendix Page 10

Look for 3 KEY DATES in Reduction Notice

1. **Notice Date**
   - Date the plan printed the notice and, hopefully, mailed it to the member
2. **Effective Date**[1]
   - Aid Continuing Deadline!
   - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, this is a Defective Notice.
   - Get Postmarked envelope!
3. **Appeal deadline (60 days)**



(1) 42 CFR § §438.404(c)(1) & 431.211;
(2) 18 NYCRR §358-2.2(a)(2).

Warning

IAD Notice template language says --

> "This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN."

The notice mentions the APPEAL DEADLINE first (May 31st) before the EFFECTIVE DATE (April 11th) – the deadline for requesting appeal to get AID CONTINUING!

The real deadline is April 11th to get Aid Continuing.

59

Content of Notice – Reasons for reduction

DOH has stressed that plans must be specific about justification for reductions, as stated in MLTC Policy 16.06: *Guidance on Notices … to Reduce or Discontinue Personal Care or CDPAP.***

- Must specify a change in condition or circumstances, and "Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services." Can't just say their task assessment results in x hours.

- WARNING: Uses vague language for "If you want Aid Continuing" – instead says "if you want to keep your services the same…" .

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

NUTS & BOLTS OF PLAN APPEALS:
APPEALING AN INITIAL ADVERSE DETERMINATION (IAD)

- How to Request appeals?
- Who may request appeals?
- Requesting an Expedited Appeal
- When must Plan Decide Appeal?
- **Plan's Final Adverse Determination Notice (FAD)**

61

How to request Plan Appeal

Notice of Initial Adverse Determination should include a **Plan Appeal Request Form (Appendix p. 15)**.

Use this form if possible.

It includes a lot of pre-filled information (**Blank on App. 27**).

ACME MLTC PLAN APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

62

How to Request a Plan Appeal

1. ***FAX*** the request - fax number should be on the Notice. But Fax numbers not in revised "Member Handbook" posted on plan websites. NYLAG informal list fax numbers at http://www.wnylc.com/health/entry/179/
   - Use Appeal Request Form that should be part of the NOTICE from the plan.
   - Keep FAX CONFIRMATION.
2. ***Call*** plan member services and ask for **APPEALS UNIT**.
   - **Must confirm an ORAL request in WRITING unless you request it to be "expedited" (Fast Track)**. See more about Fast Track later.
   - Date of CALL locks in Aid Continuing and meets appeal deadline. 42 C.F.R. § 438.402(c)(3).
   - WARNING: You have no proof you called. You may get bounced to wrong unit and request won't be logged in. Confirm by fax or letter! Get name of person who took appeal request.
3. ***E-mail*** – if an e-mail address is on the NOTICE received from the plan (optional for plan). Attach the Appeal Request Form that should be part of the NOTICE.
4. ***Write*** to plan and send via certified mail. But don't do this if need AID CONTINUING! Takes too long. Use Appeal Request Form attached to notice.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

63

Confirming ORAL appeal in writing

- Must confirm an ORAL request in WRITING unless you request it to be "expedited." 42 C.F.R. § 438.402(c)(3).
- An FAQ asked DOH, "How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?"* DOH Response was:

  "... Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. **Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return.** The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the **plan must make a determination even if a written Plan Appeal is not received**."

*FAQ # V. 5, revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v)

64

Request Expedited or "Fast Track" Appeal

- Member or her provider have the right to request an **expedited or "Fast Track" appeal** – plan must decide **in 72 hours instead of 30 calendar days** "…if :
  - the [plan] determines (for a request from the enrollee) or
  - the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request)

  …that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function." 42 CFR 438.410(a).
- best if PROVIDER requests it or supports the enrollee's request
- Check-off box on **Appeal Request Form** for requesting a **Fast Track Appeal (**included in IAD notice). May attach provider letter in support.
- If request Expedited Appeal, do not have to confirm ORAL appeal request in writing.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

65

ALERT: WHO may request Plan Appeal?

- The member must **SIGN** the appeal request, or give **written consent for a health care** provider or an authorized representative to request an appeal or file a grievance, or to request a State fair hearing." 42 CFR § 438.402(c)(1)(ii).
- Getting client's signature could delay filing appeal request. The client could miss the deadline to request Aid Continuing and could have home care hours cut.
- Tip: The State Notice template says, "**If you told us *before* that someone may represent you, that person may ask for the Plan Appeal**;" and Appeal Request Form asks, "Have you authorized this person with [Plan Name] before?"
- No particular form should be required.

NEW YORK LEGAL ASSISTANCE GROUP

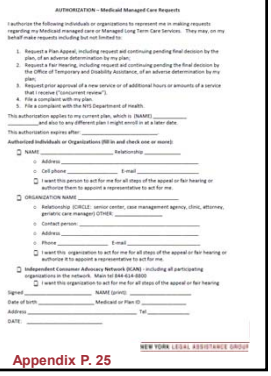
66

WHO may request Plan Appeal?

Get Signed Authorization!

- **NYLAG created an Authorization form** for client to authorize a legal or social service organization, law firm, ICAN, and/or specific family member(s) to request appeals and hearings. Can list many people! http://www.wnylc.com/health/download/646/. Form Is not a "retainer" – doesn't commit your org to representing.
- When you assist/counsel clients in enrolling in a plan, have them sign the form (or make an "x" if can't sign).
- Keep it on file & give a copy to family AND send to plan for client's file (or give to care manager and get her signature of receipt).
- Attach a copy of the signed authorization to the appeal request. Even if you will not REPRESENT in appeal, you can REQUEST it. Non-legal org's can contact ICAN for representation.

Prevent Problems!



AUTHORIZATION – Medicaid Managed Care Requests

I authorize the following individuals or organizations to represent me in making requests regarding my Medicaid managed care or Managed Long Term Care Services. They may, on my behalf make requests including but not limited to:

1. Request a Plan Appeal, including request aid continuing pending final decision by the plan, of an adverse determination by my plan;
2. Request a Fair Hearing, including request aid continuing pending the final decision by the Office of Temporary and Disability Assistance, of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review");
4. File a complaint with my plan;
5. File a complaint with the NYS Department of Health.

This authorization applies to my current plan, which is: [NAME] _____ _____and also to any different plan I might enroll in at a later date.

This authorization expires after: _____

Authorized Individuals or Organizations (fill in and check one or more):

☐ NAME _____ Relationship _____
- Address _____
- Cell phone _____ E-mail _____
- ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.

☐ ORGANIZATION NAME _____
- Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
- Contact person: _____
- Address _____
- Phone _____ E-mail _____
- ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.

☐ Independent Consumer Advocacy Network (ICAN) - including all participating organizations in the network. Main tel 844-614-8800
- ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____

NEW YORK LEGAL ASSISTANCE GROUP

Appendix P. 25

67

Who may request appeal?

***Provider* May Request Aid Continuing with Member's Authorization**

- The federal regulation says that a provider or authorized rep MAY request an appeal or hearing for the member with member's consent.
- **EXCEPT that a provider may not request Aid Continuing**. § 438.402(c)(1)(ii). But may if has written authorization by member.
- See DOH Supplemental FAQ-"*…Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their representative for the Plan Appeal and the Aid Continuing request…"*

**See DOH Supplemental FAQ # IV. 2. 2/7/18 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm

68

Who may request appeal?

What if client can't sign? Or doesn't submit a signed authorization?

- Per FAQ # IV.2, *"…Plans should have policies and procedures for… designation of a representative **where the enrollee cannot provide written authorization due to an impairment**."*
- In FAQ V. 8,* *If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?*
  - DOH response: "Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment.

    The plan should have a process to recognize and include an enrollee´s representative when an enrollee has authorized the representative for services authorization and appeal activities prior [to] the decision under dispute and such authorization has not expired."

*DOH FAQ # V.8, https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm

69

If Plan Extends its time to Decide Appeal

If the plan has extended the time to decide by up to 14 days -- it must

- make reasonable efforts to give enrollee prompt **oral** notice of the delay, and
- within 2 calendar days, give **written notice of the reason for the delay** and of the right to file a grievance about the delay. Plan should send extension notice at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf
- Plan must resolve appeal "as expeditiously as the enrollee's health condition requires and no later than date the extension expires." 42 CFR 438.408(c)(2).

PLAN MAKES "FINAL ADVERSE DETERMINATION" (FAD) -- IF DENIES PLAN APPEAL

30 Day Deadline, unless Fast Tracked or Extended

What to Look for in Notice

Next Step – Fair Hearing and/or External Appeal

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

71

Plan must decide appeal in 30 days -- "Final Adverse Determination" Notice

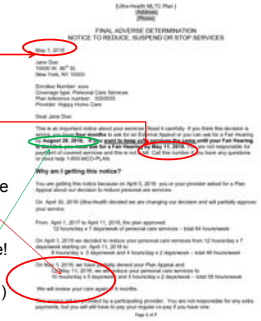
- **STANDARD** APPEAL - Plan has 30 days to decide
- **Fast Tracked** APPEAL – Must decide in 72 hours
- EITHER can be extended up to 14 days with Notice of Extension, if additional info is needed and the delay is in the enrollee's interest.
  - Plan must make a reasonable effort to give oral notice of extension first, then give written notice within 2 calendar days.
- Must use "Final Adverse Termination" template posted here https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. See 1st page on next slide.
- **REDUCTIONS** – Notice is both a *decision* on the plan appeal AND a Notice of Reduction –
  - Must be given 10 days in advance of the effective date of reduction.
  - **Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action**. See next slide.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

Final Adverse Determination Notice (FAD)

LOOK FOR TWO KEY DATES if REDUCTION

1. Notice Date
   - This is the date the plan printed the notice and, hopefully, mailed it to the member
2. Effective Date (May 11th) [1]
   - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, then this is a Defective Notice.
     - Get Postmarked envelope!
3. Appeal Time Limit (120 Days)(irrelevant if reduction!)


FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

Why am I getting this notice?

(1) 42 CFR § §438.404(c)(1) & 431.211;
(2) 18 NYCRR §358-2.2(a)(2).

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

73

Requesting a Fair Hearing

- **How to Request a Fair Hearing –** request still made to NYS OTDA– can do by phone, fax, online, or in writing. See http://otda.ny.gov/hearings/request/,
  - TIP: Use new Fair Hearing Request Form that should be part of the FAD Notice from the plan – has pre-filled info.
  - TIMING: If plan is REDUCING hours, make sure to call or fax OTDA before the EFFECTIVE DATE.
- **WHO may request FH** – Just like Plan Appeals (internal appeal), the new regulations require the member to SIGN the request, or give written authorization for a representative to do so. See slides 58-60 suggesting all clients sign "authorization" to request appeal or hearing in advance to have on file. Attach to hearing request.

74

If Plan Does Not Send FAD by Deadline – May Request Hearing! "Deemed Exhaustion"

Member may request FAIR HEARING if the plan has not made a decision on the Internal Appeal on time = "Deemed Exhaustion." 42 CFR 438.402(c)(1)(A).

1. If plan does not process appeal or at all or send FAD notice by deadline (30 days for standard/ 72 hours for fast-track/expedited), OR
2. If plan extends time to decide by up to 14 days without giving prompt ***oral notice of extension*** with **written notice** in 2 calendar days, OR
3. If plan denied request for expedited appeal without giving prompt oral notice and written notice in 2 calendar days ➔

CMS in preamble to regulations permits states to define Deemed Exhaustion more broadly. NYS has not yet done so.

75

A few scenarios re exhaustion

Next slides give advocacy strategies in these situations:

1. No written notice from plan (oral notice only)
2. If past Aid Continuing deadline – look for defects in notice or if not mailed 10 days before reduction
3. You or member mistakenly request a FAIR HEARING instead of a plan appeal

76

Strategy: **No** Written IAD Notice from Plan – or Late notice

- MLTC member reports plan rep or home care agency TOLD her that the hours are being cut, but with no written notice – or notice postmarked < 10 days before reduction (always save envelopes!).
- In the past, clients could request a Fair Hearing and Aid Continuing, based on lack of written notice or late notice.
- Now, client **must request Plan Appeal**, and ask Plan to give Aid Continuing, which means recognizing its own notice was defective.
- **If plan does not accept the appeal request or provide Aid Continuing --**
  1. **Immediately Request a Fair Hearing with Aid Continuing**. DOH said in meeting on 4/16/18 that MUST still request plan appeal but do not have to wait for appeal decision. Deemed exhausted.
  2. **Complain to DOH MLTC or mainstream Complaint lines** (last slide)
  3. **Call ICAN** (last slide)

77

Strategy: If Miss Aid Continuing Deadline for Plan Appeal or Hearing

- If notice postmarked LESS than 10 days before the EFFECTIVE DATE – Client should receive AID CONTINUING.
- If can't find postmark, or mailed 10 days in advance – look for DEFECTS in notice CONTENT. Violate MLTC Policy 16.06, didn't use new template or complete it properly; 18 NYCRR 358-2.2
- **Request Plan Appeal** - **If Plan does not give AID CONTINUING –**
  1. **Request a Fair Hearing**– with aid continuing if notice untimely or defective
  2. **CALL MLTC or Mainstream DOH Complaint lines** (last slide)
  3. **Call ICAN** (see last slide)

78

What if Member Requests Fair Hearing instead of Plan Appeal? OTDA role

- Undoubtedly, consumers & their families and rep's will, by habit, and unaware of change, request FHs when they receive an IAD.
- OTDA says it will accept FH request and order Aid Continuing – and plan must comply. OTDA will also advise caller to request a Plan Appeal.
- **WARNING** – **while FH pending**, **member must STILL request a Plan Appeal**! If they don't, may ultimately LOSE the FH for failure to exhaust, unless "deemed exhaustion" applies.
1. Final Adverse Determination received ➔
2. Call back OTDA to request NEW FH or amend original FH to appeal the FAD, If don't, may lose FH because FH requested BEFORE appeal decided, unless "deemed exhaustion" applies.
- OTDA FH webpage–---not yet updated to alert requesters to new rules. http://otda.ny.gov/hearings/request/

79

What if Member Requests Fair Hearing instead of Plan Appeal? Plan role

- DOH told plans that when they are notified by OTDA that a Fair Hearing was requested, if no Plan Appeal was requested,
  - "…**The plan may contact the enrollee, remind them of the need to ask for a Plan Appeal, and ask if they wish to file a Plan Appeal**. The plan may contact the enrollee and attempt to resolve their dispute prior to the fair hearing. **UNDER NO CIRCUMSTANCES MAY A PLAN INTERFERE WITH THE FAIR HEARING PROCESS OR SUGGEST/DIRECT AN ENROLLEE TO WITHDRAW THEIR FAIR HEARING REQUEST**." (Slide 19)*
- If the matter is "resolved" less than fully favorably with the plan, we think plan must still send notice with appeal rights.

https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-04-13_appeals.pdf

NYLAG

80

Optional – External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an **External Appeal**, if the reason for the denial is because they determine the service is **not medically necessary or is experimental or investigational.**

- You may request an External Appeal even if you also request a Fair Hearing. External Appeals are reviewed by a different State agency than Fair Hearings.
- BUT – if plan is REDUCING or STOPPING a service **you MUST request a Fair Hearing to get Aid Continuing.**
- If you request both an External Appeal and a Fair Hearing, the decision from your Fair Hearing will be the one that is followed by your plan. NY Public Health Law 4910
- For more info go to http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

NYLAG

MEMBER RIGHTS IN PLAN APPEAL

NYLAG

82

Plan must provide case file to enrollee and rep even without request

- **Plan must provide the enrollee *and his or her representative* the enrollee's case file**, including medical records, other documents, and any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal. This information must be provided free of charge. 42 CFR 438.406(b)(5).
- See DOH FAQs on producing file - https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm (V. #2-4)
  - Unless other requested, plan must send by regular mail
  - Differentiates "evidence packet" provided for fair hearing
- Must be provided "sufficiently in advance of resolution timeframe."
- Plan must provide file even if not requested.
- Unclear if HIPPA required for plan to send file directly to the representative - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA .

NYLAG

83

Right to present new evidence

- Plan must consider new evidence submitted in appeal. 42 CFR 438.406(b)(2)(iii)
- **Must provide enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony** and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 438.406(b)(4)
- **TIP: On the Appeal Request Form** that plans must attach to their IAD notice, there is a **checkbox** if you want to include additional documents with the appeal request, or if you want to give information in person. You could also write in that you would like time to submit additional documentation.

NYLAG

84

Reasonable Accommodations to help with appeal

- **IF YOU NEED HELP REQUESTING or taking other Procedural Steps Relating to the APPEAL -** The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 CFR 438.406(a).

NYLAG

85

Online info & Contacts

- NYLAG Article on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/
  - News updates on same http://www.wnylc.com/health/news/80/
- We hope to post **fax, phone and email contact info** to request appeals for all MLTC plans here - http://www.wnylc.com/health/entry/179/
- **NYS Dept. of Health MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
- **NYS DOH Mainstream managed care complaints** 1-800-206-8125 managedcarecomplaint@health.ny.gov
- NYS DOH Managed care webpage for plans on appeals

https://www.health.ny.gov/health_care/managed_care/plans/appeals/

Get Help From ICAN!

Call
844-614-8800
TTY Relay Service 711

Email
ican@cssny.org

Website:
http://icannys.org

87

Online info & Contacts

- NYLAG Article on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/
  - News updates on same http://www.wnylc.com/health/news/80/
- We hope to post **fax, phone and email contact info** to request appeals for all MLTC plans here - http://www.wnylc.com/health/entry/179/
- **NYS Dept. of Health MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
- **NYS DOH Mainstream managed care complaints** 1-800-206-8125 managedcarecomplaint@health.ny.gov
- NYS DOH Managed care webpage for plans on appeals

https://www.health.ny.gov/health_care/managed_care/plans/appeals/

Biographies

Burke & Casserly, P.C.
ATTORNEYS AT LAW

James R. Barnes, Esq., is a shareholder of Burke & Casserly, P.C., and joined the firm as an attorney in 2005. He focuses his practice in elder law, trusts and estates, guardianship, special needs planning, business formation and succession planning, and real estate. James is admitted to practice law in New York State and is also a member of the Bar of the United States Supreme Court.

James is an active member of the New York State Bar Association, where he serves on the Executive Committee of the Elder Law and Special Needs Section. In addition, he is currently the Chair of the Association's Committee on Continuing Legal Education. James is a Past-Chair of the Association's Young Lawyers Section. He has also served on the Association's Executive Committee, House of Delegates, in addition to several special committees and task forces.

James presently serves on the board of directors for The New York Bar Foundation, a not-for-profit organization dedicated to aiding charitable and educational projects to meet the law-related needs of the public and legal profession. As part of his work with the Bar Foundation, he currently serves as Vice-Chair of the Fellows. His other bar association affiliations are as a member of NYSBA's Trusts & Estates Section, as well as a member of the Albany County Bar Association, where he served as a Co-Chair of its Young Lawyers Committee for several years. He is also a member of the Estate Planning Council of Eastern New York.

James' commitment to his practice is reflected in his involvement with many community organizations and events. James currently serves as a Trustee of the Foundation for Ellis Medicine in Schenectady, as well as a member of the board of directors of the Visiting Nurse Service of Northeastern New York. He is a Past-President of the Visiting Nurse Service of Northeastern New York's Foundation Board, which is now a part of the Foundation for Ellis Medicine. He conducts regular speaking engagements in various community and professional forums, lecturing about current topics affecting seniors and their families. James is also a frequent speaker at continuing legal education programs for attorneys and other professionals involved with estate planning and elder law.

James received his Juris Doctorate from Wake Forest University School of Law in 2004, where he studied as an A.J. Fletcher Law Scholar. While at Wake Forest, he became an active member of the Phi Alpha Delta National Law School Fraternity, serving for two years as the chapter's Vice-President. James pursued his undergraduate education at the State University of New York at Binghamton. In 2001, he received his Bachelor of Arts, *summa cum laude*, double majoring in Philosophy, Politics and Law, and in Music. At Binghamton, he became a member of the Phi Beta Kappa, Golden Key and Phi Eta Sigma National Honor Societies.

James lives with his wife and two children in Latham.

James R. Barnes, Esq.
Burke & Casserly, P.C.
255 Washington Avenue Extension, Suite 104
Albany, NY 12205
Phone: (518) 452-1961
E-mail: jbarnes@burkecasserly.com
Website: www.burkecasserly.com

VALERIE J. BOGART
BIOGRAPHY

Valerie Bogart has been Director of the Evelyn Frank Legal Resources Program (EFLRP) since June 2002. Originally founded by Selfhelp Community Services, Inc., the Evelyn Frank program moved to the New York Legal Assistance Group in April 2013, a non-profit legal services organization. Valerie continues to serve as EFLRP's Director. EFLRP advocates for access to long-term care and other health care for low-income seniors and people with disabilities through direct legal representation, policy advocacy, legal education, and its website http://NYHealthAccess.org. Earlier, Valerie was an attorney for the Legal Aid Society Brooklyn Office for the Aging, Legal Services for the Elderly in Manhattan, and the Legal Aid Society in Minneapolis, where she was a Reginald Heber Smith Fellow. A graduate of the New York University School of Law, she lectures extensively for bar and social services organizations, has taught adjunct courses at CUNY and Fordham law schools, and has received numerous awards.

NEW YORK LEGAL ASSISTANCE GROUP
7 Hanover Square, 18th fl., NY NY 10004
212-613-5074
vbogart@nylag.org

MICHAEL A. BURGER

Michael Burger is a founding partner of Santiago Burger LLP, a litigation-based law firm in Rochester, NY, and he is a founding member of Neutral Mediation Group LLC. Prior to that, Mr. Burger was a partner in two Rochester, New York law firms. Before relocating to Rochester, New York, in 1999, Mr. Burger spent several years practicing law in a large non-profit New York City based public interest law firm where he handled a variety of constitutional law matters including impact litigation that successfully secured the right to a jury trial for housing court litigants city-wide.

Mike focuses his litigation practice on fiduciary relationships within New York State and Federal Trial and Appellate Courts. His representative clients run the range from businesses of various sizes and structures, trusts, estates, and individuals owed or under a fiduciary duty such as officers, directors, executors, trustees, agents under a power of attorney, and guardians. Mike also handles Election Law cases during the season for both petitioners and respondents. These practices are equally divided between representing plaintiffs and defendants, affording an alacrity with the issues and arguments attending all facets of litigated matters. The substantive areas he focuses on consists of complex commercial disputes, corporate, LLC, and partnership dissolutions and disagreements, challenges to agency authority, congested article 81 guardianship, labor and employment matters (including class and collective action experience as lead counsel), election law, campaign finance, ballot access proceedings, and civil rights impact litigation challenging laws that work a constitutional deprivation on a segment of the citizenry. Michael commonly employs mediation as a tool across disciplines as an alternative to litigation.

Mr. Burger is also a founding member of the Neutral Mediation Group, LLC which provides mediation services to parties and industries needing to mediate disputes both pre-suit and during litigation. Michael brings over 20 years of experience as a litigator to the process, as coursework, lecturing, and writing in the field of mediation dating back to law school coursework. Mr. Burger is a member of the New York State Bar Association Dispute Resolution Section and serves on the Monroe County Bar Association's Fee Arbitration Committee where he acts alternatively as mediator or arbitrator. A passionate proponent for the mediation process, Mr. Burger stresses the importance of the parties being heard and empowered to chart their own resolutions.

Mr. Burger has written and lectured before the state and local bar associations on a variety of topics within his practice concentrations, including mediation and mediation clauses. His ready rapport and ability to build bridges of trust make him a consummate friend of the honest deal.

Veronica Escobar
Principal and Founder
The Law Offices of Veronica Escobar

Veronica Escobar has been practicing law in her home state for fourteen years. For the past eight years, she has been the Principal and Founder of The Law Offices of Veronica Escobar, a practice focusing in the areas of Elder Law, Special Needs Planning, and Trusts and Estates. She has two offices, one in her home borough of Queens and the other on the island of Manhattan.

Veronica is admitted to practice in the state of New York. She is also admitted to practice before the U.S. District Courts for the Eastern and Southern Districts of New York. She graduated summa cum laude from Fordham College at Rose Hill, Fordham University, where she was also elected to Phi Beta Kappa, with a degree in American Studies and a minor in Latin American/Latino Studies. Veronica also received her law degree from Fordham, where she was a Notes and Articles Editor of the *Fordham International Law Journal*. She is a member of NYSBA, and Chair of this section's Diversity Committee.

She is also the Chair for both the Solo and Small Firm Affinity Group and the Alumni Attorneys of Color (AAC) Solo and Small Firm Committee at her alma mater, Fordham Law.

On a personal note, she is happy to be at this year's Summer Meeting and to be presenting on a topic that is near and dear to her.

She can be reached at vescobar@veronicaescobarlaw.com

Linda Grear, Esq., Associate

Linda brings over two decades of experience in elder law, estate planning, trusts, guardianship law and probate estates.

Her deep experience in elder law has built her expertise, as well as her understanding of the importance of compassion in dealing with clients who are enduring emotionally difficult times.

A frequent speaker on issues related to elder law and estate planning, she has been honored in Buffalo Spree Magazine and in Who's Who in Law in Business First of Buffalo.

Grear is a graduate of the University of Akron School of Law (1994) and holds a B.S in Criminal Justice from the State College of New York at Buffalo (1991). She is a resident of Pendleton.

Joseph A. Greenman
Of Counsel
jgreenman@bsk.com

Syracuse, NY
(315) 218-8178
(315) 218-8100 fax

Practice
Trust and Estate

Education
Syracuse University College of Law (*cum laude*, 1974)
Colby College (B.A., 1971)

Bar/Court Admissions
New York
U.S. Supreme Court
U.S. Court of Appeals for the Second Circuit
U.S. District Court for the Northern District of New York
U.S. District Court for the Western District of New York

Joseph A. Greenman

Joseph counsels individual clients and business owners in estate and financial planning, estate administration, asset preservation and elder law matters. He has lectured extensively on probate and administration of estates, elder law and estate planning.

Honors and Affiliations

- Listed in:
  - *The Best Lawyers in America*® 2016, Litigation - Trusts and Estates; Trusts and Estates
  - *Martindale-Hubbell*®, AV Preeminent Rated
  - *New York Super Lawyers 2015*®, Estate & Probate
- New York State Bar Association, Elder Law Section, Committee on Estates, Trusts and Medicaid; Co-Vice Chairman, Special Needs Subcommittee Elder Law Section; Trust and Estate Section; Past Chair, Estates & Surrogate's Court Committee
  - 2014 Co-Chair, Elder Law and Special Needs Section Summer Meeting, 8/7-9/14

Other Activities

- President & Director, Jewish Home of CNY, Inc.
- Village Justice, Village of Manlius
- Director, Menorah Park Foundation
- Advisory Board, FM A Better Chance
- Past Director, CNY Estate Planning Council

MOSES & SINGER LLP

Devika Kewalramani

Partner

dkewalramani@mosessinger.com
T (212) 554-7832
F (917) 206-4332

Devika Kewalramani is a partner and co-chair of Moses & Singer's Legal Ethics & Law Firm Practice which advises law firms, lawyers and legal departments on ethical and legal aspects of law practice. She also currently serves as the firm's general counsel. Devika represents law firms and attorneys in legal ethics, professional discipline, law firm risk management, lawyer licensing and admissions matters, including escrow issues, conflicts of interest, structuring arrangements with non-lawyers, multijurisdictional practice, disqualification, lateral transition, law firm mergers and break-ups, partner disputes, ethics in alternate dispute resolution, reporting/disclosure issues, attorney advertising, law firm cyber security issues, social media use, legal fee disputes, and other professional responsibility issues. She conducts ethics and risk management audits for clients.

A frequent lecturer, panelist and author on legal ethics, Devika speaks to law firms, corporate legal departments, bar associations and professional groups on a variety of legal ethics matters. The editor of *New York State Bar Association's Journal* magazine recognized Devika as author of one of the best articles of 2010: "Up Close and Professional With New York's Engagement Letter Rules" (September 2010). Her articles, "Trading Client Trust: A Glimpse Into Insider Trading Within the Legal Profession" and "Demystifying ESQrow Ethics" were featured on the front page of the *New York State Bar Association Journal's* May 2018 and May 2013 editions. Devika is a faculty member of the *Practising Law Institute* and of *Lawline.com*.

Devika is co-chair of the Council on the Profession of the New York City Bar Association.

She is the immediate past Chair of the Committee on Professional Discipline of the New York City Bar Association.

She was appointed a member of the New York Commission on Statewide Attorney Discipline in 2015 and served as a co-chair of its Subcommittee on Transparency and Access.

In 2014, 2015, 2016 and 2017, Devika achieved Super Lawyer status in the Metro Edition of *New York Super Lawyers®*.

PRACTICE AREAS

- Privacy
- Legal Ethics & Law Firm Practice

EDUCATION

- City University of New York School of Law (J.D.)
- St. Xavier's College (B.A.) Kolkata, India

BAR/COURT ADMISSIONS

- U.S. District Court, Southern District of New York
- New York
- Connecticut

FOREIGN LANGUAGES

- Bengali
- Hindi

PROFESSIONAL AFFILIATIONS

- Co-Chair, Council on the Profession, New York City Bar Association
- Past Chair, Committee on Professional Discipline, New York City Bar Association (2013-2017)
- Co-Chair, Subcommittee on Legal Ethics, Corporate Counsel Committee, American Bar Association Section of Litigation
- Member, New York Commission on Statewide Attorney Discipline, Co-Chair, Subcommittee on Transparency and Access (2015)
- Member, Committee on Continuing Legal Education, New York State Bar Association
- Member, Advisory Board of the Ethics Institute, New York County Lawyer's Association
- Member, Editorial Board of The Practical Lawyer, published by ALI CLE
- Member, Foundation Board of The City University of New York School of Law
- Member, International Board of Advisors, Jindal Global Law School, Sonipat, Haryana, India
- Past Chair, Subcommittee on Engagement Letters, Professional Responsibility Committee, New York City Bar Association
- Past Member, Committee on Professional Ethics, New York State Bar Association

PUBLICATIONS

- *Lexis® Practice Advisor for Corporate Counsel: Ethics For In-House Counsel*, Author (2012-current).
- "*The New York Rules of Professional Conduct*," Oxford University Press/New York County Lawyers' Association, Rules Co-Editor and Contributor of Three Chapters: "Rule 1.7 – Conflicts of Interest: Current Clients;" "Rule 1.8 – Current Clients: Specific Conflicts of Interest Rules;" and "Rule 1.9 – Duties to Former Clients" (2010-2012).

KATHLEEN D. KRAUZA, ESQ., has served as a New York State Chief Clerk IV in Erie County Surrogate's Court from August, 2016 to present. She previously held the positions of Chief Clerk of Supreme and County Court and Commissioner of Jurors in Chautauqua County, and Deputy Chief Clerk of Chautauqua County Surrogate's Court. Ms. Krauza has assisted with various state wide court initiatives including the implementation of New York State's first summary jury trial program. Ms. Krauza graduated from St. Michael's College in 1981 and was a 1985 graduate of The University of Dayton School of Law. She is a member of the New York State Surrogate Courts Association of Chief Clerks and the Erie County Bar Association. She was the recipient of the N.Y.S. Unified Court System's first Quality Service Leadership Award for her professionalism and dedication to promoting quality service in the courts. Prior to her career in the Unified Court System, she was engaged in the private practice of law in Fredonia, New York.

Richard A. Marchese is a partner at Woods Oviatt Gilman LLP in Rochester, NY in the firm's Elder Law and Health Care Practice Group. He is 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.

Robert Mascali is an attorney with over forty years' experience in the nonprofit, government and private sectors. He is currently a senior consultant with the Center for Special Needs Trust Administration, Inc. which is a national nonprofit organization that administers special needs trusts throughout the United States. In addition, Mr. Mascali is admitted to practice before the courts in the Commonwealth of Massachusetts and the State of New York and is currently "of counsel" with Bourget Law Group in Falmouth, Massachusetts and with Pierro, Connor and Associates, LLP in Latham, New York. He concentrates in the areas of Special Needs Planning for persons with disabilities and their families and care givers, Long-Term Care Planning, and Elder Law and Estate Planning. He previously served as the Associate General Counsel at NYSARC, INC. and served as Counsel to NYSARC Trust Services, one of the largest pooled trust organizations in the United States. Prior to that position, Mr. Mascali served as Deputy Counsel and Managing Attorney for the New York State Office of Mental Retardation and Developmental Disabilities (now the Office for People with Developmental Disabilities). Mr. Mascali is a member of the New York State Bar Association and the Elder Law and Special Needs Section and the Trusts and Estates Section. He serves on the Executive Committee and is the Section's liaison to the National Academy of Elder Law Attorneys (NAELA). He is also a member of Massachusetts NAELA and is the Past President of the New York Chapter of NAELA. Mr. Mascali is a member of the Academy of Special Needs Planners and is a frequent presenter and author on topics dealing with elder and special needs law and planning.
Mr. Mascali is a member of the Town of Falmouth Commission on Disabilities and is president elect of the Rotary Club of Falmouth as well as a member of the Board of Directors of the National Association for the Blind at Albany Foundation.

Kerry McGrath is a senior attorney at the Cuddy Law Firm. Her practice is focused on special education advocacy and litigation. Kerry is a graduate of Syracuse University (B.A., *magna cum laude*, Maxwell School of Public Citizenship), City College of New York (M.S., Ed.) and New York Law School (J.D.).

Prior to beginning a career in special education law, Kerry was a New York City public school teacher. She taught English as a Second Language (ESL) at Intermediate School 52. As an NYLS law student, she was a member of the Justice Action Center, participated in the civil rights clinic and participated in the New York Law School Street Law Program.

Sara Meyers, Esq.
Enea, Scanlan & Sirignano, LLP
245 Main Street
White Plains, NY 10601
(914) 948-1500
s.meyers@esslawfirm.com

Ms. Meyers is a Member of the firm of Enea, Scanlan & Sirignano, LLP, and concentrates her practice on Elder Law, Estate Planning, Special Needs Planning, Guardianships, and long term care planning strategies, with a focus on Medicaid home care and nursing home. She has been named to the 2013, 2014, 2015, 2016 & 2017 New York Metro Super Lawyers list in Elder Law.

Prior to Enea, Scanlan & Sirignano, Ms. Meyers was a staff attorney at the Sadin Institute on Law of the Brookdale Center for Healthy Aging and Longevity and the New York Legal Assistance Group. At Sadin, Sara concentrated on Medicaid, home care, and the Medicare Part D prescription drug program. She created materials and conducted training seminars for social service providers, attorneys, and social workers on topics including Elder Law, Medicaid, Medicare, home care, and Administrative Appeals.

Ms. Meyers has authored "Using SCPA Article 17-A and MHL Article 81 Guardianships for Disabled Children," New York State Bar Association, Senior Lawyer Section, The Senior Lawyer, Spring 2015; "Medicaid Managed Long Term Care is Coming to Westchester. Are You and Your Clients Ready?," Westchester County Bar Newsletter, January 2013; "Guardianships and Supplemental Needs Trusts (SNT) as planning tools for Parents of Adult Disabled Children," New York State Bar Association Elder Law and Special Needs Journal, Winter 2012; "An Overview of Medicaid Home Care Options for Seniors," New York State Bar Association Elder Law Attorney, Winter 2010; "Utilizing Medicaid Home Care as a Solution in a Post-DRA World," New York State Bar Association Elder Law Attorney, Summer 2007 and Westchester County Bar Newsletter, June 2007. Ms. Meyers coauthored with Anthony J. Enea "The Doors Open Further for the Nursing Home without Walls Program," Westchester County Bar Newsletter, November 2007.

Ms. Meyers is a frequent lecturer for Elder Law Programs sponsored by the New York State and Westchester County Bar Associations. She is a member of the New York State Bar Association, the Elder Law and Special Needs Section (Executive Committee, vice-chair Guardianship Committee and 9th District Delegate; Editor, Elder Law and Special Needs Journal) and Trust and Estates Section, and a member of the Westchester County Bar Association (Co-Chair Guardianship Committee, past Co-Chair of the Elder Law Committee) and is an editor of the Westchester County Bar Journal. She is also Co-Chair of Westchester County Senior Law Day.

Ms. Meyers has a B.A. in History, cum laude, from Brandeis University and a J.D. from the Cardozo School of Law. She is also a volunteer attorney for Legal Services of the Hudson Valley. She is a Trustee of the Board of Directors of the Westchester Day School in Mamaroneck, New York.

TARA ANNE PLEAT, ESQ.

"AV" rated by Martindale-Hubbell---the highest rating for expertise and ethics given by the independent rating service of the legal profession.

TARA ANNE PLEAT, Esq., co-owns the law firm Wilcenski & Pleat PLLC. She practices in the areas of special needs estate planning and administration, traditional estate planning and administration, long-term care planning, and elder law. Tara graduated *cum laude* from Albany Law School with honors in the Estate Planning concentration and earned her undergraduate degree from the State University of New York at Albany.

Tara is the Vice-Chair of the Elder Law and Special Needs Section of the New York State Bar Association. Tara is the co-editor in chief of the publications committee of the Elder Law Section of the New York State Bar Association which publishes the Elder and Special Needs Law Journal on a quarterly basis. She is also an active member of the Trusts and Estates Law Section, where she serves as District Delegate for the Fourth Judicial District. She is honored to be a member of the Special Needs Alliance, an invitation-only, national network of leading attorneys dedicated to the practice of disability and public benefits law. She is also a Member of the Academy of Special Needs Planners and the National Academy of Elder Law Attorneys.

In March of 2016, Tara was elected as a Fellow of the American College of Trust and Estate Counsel (ACTEC). ACTEC Fellows are selected on the basis of experience, professional reputation and ability in the fields of trusts and estates and on the basis of having made substantial contributions to these fields through lecturing, writing, teaching and bar activities.

Tara is a Past President of the Board of Directors of the Estate Planning Council of Eastern New York. In addition, Tara is a graduate of the 2006 class of Leadership Saratoga, sponsored by the Saratoga Springs Chamber of Commerce, and currently is a member of the Leadership Saratoga Advisory Board. Tara is a Member of the Board of Directors of AIM Services, Inc., a disability service organization based in Saratoga Springs, New York. She is a Member of the Board of Directors of the Wesley Community, a continuing care community for seniors in Saratoga Springs, New York as well serves on the Board of the Wesley Foundation. Tara also chairs the Planned Giving Committee of the Wildwood Foundation, an organization that supports Wildwood Programs, a school for individuals with disabilities in Albany, New York.

In the fall of 2012, Tara was appointed as an adjunct professor of law at Albany Law School, where she teaches a course in the spring semester on estate and financial planning for the elderly and individuals with special needs.

KASSOFF, ROBERT & LERNER, LLP
ATTORNEYS AT LAW
100 Merrick Road
West Building · Suite 508
516 766 7700 Fax (516) 766-0738

JOAN LENSKY ROBERT is a member of KASSOFF, ROBERT & LERNER LLP, a law firm in Rockville Centre, New York practicing exclusively in the areas of elder law, special needs planning and disability law. Ms. Robert is a graduate of Skidmore College, where she was a member of Periclean, the University of Pennsylvania, where she studied pursuant to a Ford Foundation Fellowship, and Touro College School of Law, summa cum laude, where she was valedictorian of the part time division. Prior to entering the practice of law, Ms. Robert taught French with the Valley Stream Central High School District.

Ms. Robert served as Chair of the New York State Bar Association Elder Law & Special Needs Section from 2003-2004 and serves as Co-Chair of its Special Needs Planning Committee. She founded and served as Chair of its Mentorship Committee. She received a Lifetime Achievement Award from the New York State Elder Law and Special Needs Section in January, 2014. She is a Fellow of the New York State Bar Association. She co-wrote the chapter on Special Needs Planning in the book Guardianship Practice in New York State and wrote the chapters on Medicaid liens and planning in Personal Injury Actions in New York published by the New York State Bar Association. She is an attorney member of the Guardianship Advisory Committee formed by the Office of Court Administration.

Ms. Robert has been named a Super Lawyer since 2013 and was chosen as a Top Lawyer in North America. Ms. Robert has been Board Certified as a Certified Elder Law Attorney (CELA) by the National Elder Law Foundation, as accredited by the ABA. In March, 2016, she was honored as one of the 50 Outstanding Women in the Law on Long Island.

Ms. Robert served as a member of the Board of Directors of the Nassau County Bar Association for 6 years, and is a past chair of its Elder Law/Social Services/Health Advocacy Committee. Ms. Robert served as Dean of the Nassau Academy of Law, and now is co- chair of the Senior Lawyers committee.

Ms. Robert is a member of the Board of Directors of NAELA. She is a member of the steering committee for the 2018 Annual Meeting and Summit. She received the NAELA award as outstanding member of the New York Chapter in 2012 and also received the Theresa Foundation Award for outstanding service and advocacy to persons with special needs. She is a member of the Council of Advanced Practitioners.

Ms. Robert has been honored for outstanding service by the Long Island Alzheimer's Foundation, Project Real , the New York State Trial Lawyers Association, and the National Multiple Sclerosis Society.. She served on the Board of Editors of the Bill of Particulars, the publication of the New York State

Trial Lawyers Association. She is a past Editor in Chief of the New York Elder Law and Guardianship Newsletter.

Joan and Charles Robert are the proud parents of Heather Robert Coffman, who practices employment law in San Francisco, and of Jay Robert, an attorney with Kassoff, Robert & Lerner. They are the doting grandparents of Naomi and Leo Coffman and Edie and Ike Robert.

VINCENT J. RUSSO, J.D., LL.M., CELA, CAP, is the Managing Shareholder of Russo Law Group, P.C., Long Island's Signature Elder Law, Special Needs and Estate Planning Law Firm with offices on Long Island and New York City.

He has championed the rights of seniors and people with special needs since 1985.

Vincent is a Founding Member, Fellow and Fifth President of the National Academy of Elder Law Attorneys (NAELA) and is a Founding Member and First President of the New York Chapter of NAELA. Additionally, he is the only NAELA member to receive the prestigious President's Award twice and is also a member of the invitation only, NAELA Council of Advanced Practitioners (CAP).

He is a Trustee and was the Founding Chair of the NAELA Foundation. Vincent is a certified elder law attorney by the National Elder Law Foundation. He is a Founding Member and Past Chair of the Elder Law Section and Co-Chair of the Special Needs Section of the New York State Bar Association (NYSBA).

Vincent is a Co-Founder of the Academy of Special Needs Planners and Past Board Member and President of the Guardianship Corporation of Cerebral Palsy of Nassau County. He is also Co-Founder and Chairman of the Board of ElderCounsel, LLC.

Vincent is a Co-Founder of the Theresa Alessandra Russo Foundation and the Theresa Academy of Performing Arts for Children with Special Needs, which were established in memory of his daughter, Theresa. He also created and co-hosts Family Comes First, a television on cable TV, which has won Three Telly Awards.

He is admitted to the New York, Massachusetts and Florida State bars and is the co-author of *New York Elder Law and Special Needs Practice* (Thomson Reuters).

Mr. Russo is a nationally recognized speaker and noted authority on Elder Law, Special Needs and Estate Planning. His distinction in Elder Law, Special Needs and Estate Planning has made him one of the most prominent attorneys in his field.

JOSEPH A. SHIFFLETT, ESQ.

Joseph A. Shifflett is Chief Court Attorney of Erie County Surrogate's Court. Prior to assuming that position in November 2004, he had been Surrogate Judge Barbara Howe's Principal Law Clerk in Surrogate's Court and previously from 1993 when Judge Howe was a New York State Supreme Court Justice. Shifflett served, before that, as Principal Law Clerk for two Erie County Court Judges. Prior to joining the court system, Shifflett was an attorney at the Buffalo Legal Aid Bureau.

A graduate of the University of Toronto and the State University of New York at Buffalo Law School, Shifflett is a member of the Bar Association of Erie County, and a past chair of the Criminal Law Committee of the BAEC. He was a long time member of the Erie County Bar Association's Aid to Indigent Prisoners Society, Inc. board of directors. Shifflett also served on an OCA committee set up to implement e-filing in Surrogate's Courts in New York State.

BOND SCHOENECK & KING ATTORNEYS

Richard L. Weber

Member
rweber@bsk.com
One Lincoln Center
110 West Fayette Street
Syracuse, NY 13202-1355
(315) 218-8375
(315) 218-8100fax

Profile

Rick resolves toxic situations, whether they be interpersonal or environmental. Trust and estate conflicts, rocky transitions in family businesses, injuries from exposure to toxic chemicals, breaches of contractual relationships, creditor's rights and construction law are all interpersonal situations that Rick guides clients through on a regular basis.

As a co-chair of the firm's toxic tort and environmental litigation practice, Rick represents clients facing potential liability for discharges or releases of toxic substances, such as discharges of petroleum products and exposure to industrial chemicals, and for the failure to abate or remediate such substances. By guiding his clients expediently through their options to determine how they can resolve an issue before trial, Rick reduces stress and facilitates timely resolution reduces costs.

A trial attorney, Rick regularly addresses toxic relationships in areas such as commercial disputes, will contests, estate accountings, libel law and premises liability (including defense of lead paint exposure and Labor Law § 240 “Scaffold Law” claims.) Rick has extensive experience in securing pre- and post-judgment remedies for clients, including temporary restraining orders, specific enforcement of contract remedies (including non-compete and non-solicitation clauses) and disclosure of judgment debtor assets.

Representative Matters

- represented residential landlords in multiple lead-paint exposure cases, including securing dismissal of claims by motion for summary judgment
- secured a temporary restraining order and other relief related to the dissolution of a business partnership
- secured a guardian for an incapacitated elderly woman pursuant to Article 81 of the Mental Hygiene Law
- represented office supply wholesaler in action against software developer for defective software development and installation
- settled multiple actions related to trust and estate accountings
- defended a manufacturer of commercial kitchen equipment in a product liability lawsuit

Education

- College of William and Mary School of Law (J.D., 1999)
- State University of New York at Buffalo (B.A., *magna cum laude*, 1994)

Bar/Court Admissions

- New York
- U.S. District Court for the Eastern District of New York
- U.S. District Court for the Northern District of New York
- U.S. District Court for the Southern District of New York
- U.S. District Court for the Western District of New York

Practices

- Higher Education
- Toxic Tort and Environmental Litigation
- Litigation
- Environmental and Energy
- Business Restructuring, Creditors' Rights and Bankruptcy

- foreclosed on a commercial shopping center, with appointment of a receiver to manage the property during pendency of the action
- enforced a restrictive covenant with preliminary injunction, to bar competition by a disloyal former employee
- defended a scaffold law claim related to the collapse of an incomplete building addition

Honors & Affiliations

- Listed in:
  - *New York Super Lawyers 2017*®, Environmental Litigation
- New York State Bar Association, Torts, Insurance and Compensation Law Section, Chair, Toxic Tort Committee
- Onondaga County Bar Association
- Onondaga County Bar Foundation, Past President
- Mediator, ADR Mandatory Mediation Program, Northern District of New York
- Articles Editor, 1998-1999, *William and Mary Law Review*

Representative Presentations

- Going Beyond Lead: Lessons Learned from Lead Litigation and Trending Substances, HB Litigation Conferences, 2015 National Lead Litigation Conference 2015, November 6, 2015
- Libel: Say it Safely, New York Press Association Convention, 2012, 2013
- Advanced Insurance Coverage: Exclusions in Personal Lines Insurance,' New York State Bar Association Continuing Legal Education Program, 2012
- Estate Litigation, New York State Bar Association Continuing Legal Education Program, 2011
- Basic Tort and Insurance Law Practice: Automobile Insurance Sources of Coverage, New York State Bar Association Continuing Legal Education Program, 2008, 2010
- Defamation, Disparagement and Language: Avoiding Libel Issues', New York Press Association Convention, 2010
- Collections and the Enforcement of Money Judgments: The Negotiated Settlement, New York State Bar Association Continuing Legal Education Program, 2005, 2007

Representative Publications

- Richard L. Weber and Thomas R. Smith, “Regulatory Corner,” *NYS Chemistry Council Newsletter*, March 2017
- "No Greater Rights: The Limits of Pro Se Litigation in New York Courts," *NYSBA Journal*, July/August 2007, at 10
- "Stipulators Beware: The Perils of CPLR 2104," *NYSBA Perspective*, Fall/Winter 2006, at 14
- "State v. Speonk Fuel: The Untold Story Behind the Court of Appeals Decision," *The New York Environmental Lawyer*, Spring/Summer 2005, Vol. 25 No. 2, pgs.

16-20

- "Playground Personal Injury Law - A Primer," *NYSBA Perspective*, Spring/Summer 2004, at 12
- "Riding on a Diamond in the Sky: The DBS Set Aside Provisions of the 1992 Cable Act," 40 *Wm & Mary L. Rev.* 1795, 1999

Other Activities

- Former member, Board of Directors, Skaneateles Ski Hill, 2012-2016

Richard A Weinblatt
Attorney at Law

Richard A. Weinblatt is a partner in the law firm of Haley Weinblatt & Calcagni, LLP located in Islandia, New York. He practices primarily in the areas of Elder Law and Trusts and Estates. Richard graduated *magna cum laude* from St. John's University School of Law in 1988. He is a member of the New York State Bar Association, National Academy of Elder Law Attorneys and a former Director of the Suffolk County Bar Association. He is a Past Chair of the New York State Bar Association's Elder Law and Special Needs Section. Richard is a past Associate Dean of the Suffolk County Bar Association's Academy of Law, past President of the Estate Planning Council of Long Island, Suffolk Chapter and is a former Co-Chair of the Suffolk County Bar Association's Elder Law Committee, Surrogate's Court Committee and Tax Committee. Richard is also an adjunct professor at Touro College Jacob D. Fuchsberg Law Center.

GRIMALDI & YEUNG LLP

ELDER LAW
SPECIAL NEEDS PLANNING
ESTATE PLANNING

Judith D. Grimaldi*
Pauline Yeung-Ha*
Joanne Seminara*

*Also admitted in New Jersey

9201 Fourth Avenue, 6th Fl.
Brooklyn, NY 11209

546 Fifth Avenue, 6th Fl.
New York, NY 10036

Phone: (718) 238-6960
Fax: (718) 238-3091
www.gylawny.com

PAULINE YEUNG-HA, ESQ.

pyeung@gylawny.com

Pauline Yeung-Ha is a Partner in the law firm of Grimaldi & Yeung LLP.

Ms. Yeung-Ha concentrates in the practice areas of Trusts, Wills and Estates, Elder Law as well as Special Needs Planning. She received her undergraduate degree from Vassar College and her law degree from St. John's University School of Law. She is admitted to practice in both New York and New Jersey.

In addition to her practice, Ms. Yeung-Ha holds the following professional positions:

- Vice-Chair of the Diversity Committee of the Elder Law Section of the New York State Bar Association (NYSBA)
- Vice-Chair of the Membership Committee of the Elder Law Section of NYSBA
- Member of the Estate Planning Committee of the Trusts & Estates Law Section of NYSBA
- Co-Chair of the Pro Bono Clinic of the Asian American Bar Association of New York (AABANY) – named Committee of the Year for 2016 and Program of the Year for 2017
- Trustee on the Board of Directors of the Brooklyn Bar Association
- Secretary on the Board of Directors of CaringKind (formerly Alzheimer's Association, NYC Chapter)
- Member of the Board of Directors of the New York Chapter, National Academy of Elder Law Attorneys (NAELA)

Recognitions:

- *Honoree, St. John's University School of Law Chapter of the Asian-Pacific American Law Student's Association (APALSA), 2018*
- *"Super Lawyer" 2015 to 2018*
- *"Best Lawyer" 2012 to 2018*
- *Brooklyn's Women of Distinction, 2017*
- *Honoree, General Human Outreach in the Community, Inc., 2017*
- *Honoree, Chinese-American Planning Council, Inc., Brooklyn Branch for service and dedication to the Brooklyn Chinese community, 2015*
- *New York's Women Leaders in the Law, 2012*
- *Super Lawyer's "Rising Star" 2011 to 2014*
- *NAPABA's "Best Lawyer Under 40", 2011*
- *Citation awarded by former Assemblywoman (now Congresswoman) Grace Meng, 2010*

Ms. Yeung-Ha is active in serving the community as well. Aside from conducting presentations in English, she also gives seminars in Cantonese and Mandarin Chinese. Ms. Yeung-Ha was key speaker for Assemblywoman Grace Meng's Senior Law & Financial Planning Workshop.