

A publication of the **Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale**  
in collaboration with the **Westchester Public Private Partnership for Aging Services** and the **Pace Women's Justice Center**

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# Elder Law

## Q&A:

### An Introduction to Aging Issues and Planning for the Future

18th Edition

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FOR AGING SERVICES



The Harry and Jeanette Weinberg Center  
for Elder Abuse Prevention

at the Hebrew Home at Riverdale



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## Dear Friends,

Growing older is, as the phrase implies, a fruitful process enabling increased familial connection, community engagement and leisure time. This manual, in its 18th printing, is an excellent guide to ensuring legal health during this period, a critical prerequisite for a positive aging experience.

Advance planning is one of the most important ways to protect yourself and your assets. This publication provides useful information about making short and long term healthcare decisions. It also provides valuable information about financial planning and asset preservation, including powers of attorney, health care proxies, living wills, wills, trusts, taxes, insurance and Medicaid planning. This manual is meant to be a guide, not a substitute for good, sound advice and individualized attention from an experienced lawyer.

While older adulthood has tremendous positive potential, societal forces like ageism can exacerbate physical and financial vulnerabilities, with negative consequences to almost every aspect of an older person's life, including increased susceptibility to abuse and mistreatment. Recently, the concept of elder justice has emerged as a national response to the societal, governmental and communal forces that can converge to marginalize older people. Fundamentally, this movement is about creating the societal framework that allows individuals to live with safety and dignity as full citizens and community members throughout their lifespans. This guide is also meant to serve as a critical resource for allies and activists in the elder justice movement, including older adults and their caring family members, friends and neighbors.

The Westchester County community is fortunate to have a robust array of professionals, organizations and caring individuals with a variety of backgrounds and abilities who are dedicated to the cause of elder justice. For the last decade, The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale (a program of RiverSpring Health) has been honored to count itself among this group, providing emergency shelter for victims of elder abuse. We have provided over 100,000 days of shelter since 2005. The Weinberg Center, a national model, operates a comprehensive shelter program, including holistic medical, social, therapeutic and case management services, as well as direct legal services. The Weinberg Center also provides extensive outreach and training each year to thousands of professionals and others who work with older adults, and is proud to be a founding member and coordinator of Westchester County's Multidisciplinary Team (MDT) which coordinates victim-centered responses to complex cases of elder abuse among diverse professionals throughout the county. If you are a Westchester County professional interested in learning more about the MDT, please email the team's coordinator at [malya.levin@hebrewhome.org](mailto:malya.levin@hebrewhome.org).

We are deeply indebted to the extremely caring professionals at the Hebrew Home for their excellent care of older victims of abuse who have found refuge at the Weinberg Center and to our friends at the Pace Women's Justice Center, a critical partner in the creation of the Weinberg Center. The Women's Justice Center, a non-profit training resource, legal service provider, and legal education and information service continues to be a center of excellence for women, young and old, in our community.

We are also extremely grateful to Steven A. Schurkman, Esq. of Keane & Beane, P.C. for his expertise in the elder law field, and for writing and annually editing the Elder Law Q & A. He is a wonderful friend to the Hebrew Home at Riverdale by RiverSpring Health, the Weinberg Center, and the Pace Women's Justice Center.

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This publication is also available online:

Westchester County Government website Money and Legal page  
<http://seniorcitizens.westchestergov.com/money-and-legal>

Senior Law Day Website <http://www.seniorlawday.info/elderlaw/>

Pace Law School website <http://www.law.pace.edu/resources>

The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale <http://www.weinberg-center.org/publications/>

To find out more about the Weinberg Center, please email me at [joy.solomon@hebrewhome.org](mailto:joy.solomon@hebrewhome.org)



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## ELDER LAW AND ELDER LAWYERS – THE BASICS

### What is elder law?

The phrase elder law encompasses a wide range of legal topics and is used generally to refer to all legal matters that affect the senior citizen and elderly population. Of course, many of the legal issues that are faced by the elder population are also confronted by others in the general population, including, in particular, people with disabilities.

### What is an elder law attorney?

An elder law attorney is a lawyer who concentrates his or her practice in legal matters of the elderly. Elder law attorneys are skilled in addressing a wide range of needs of the elderly. They can assist with estate planning, locating programs to address the needs of the elderly and their families, and helping their clients obtain the care and help they need now and in the future. Among the issues an elder law attorney might be called upon to address are:

- Financial and health care planning for seniors
- Estate and tax planning
- Transfer of assets and asset preservation and protection
- Medicare and Medicaid planning
- Issues affecting older workers
- Hospital discharge and nursing homes admission issues
- Housing alternatives for seniors
- Surrogate decision making, including guardianships

## I would like some advice on estate and financial planning. How do I find an elder law attorney?

As is often the case with hiring professionals, obtaining recommendations from friends, relatives, business associates, and others who are likely to have had regular contact with lawyers is a good place to start. The National Academy of Elder Law Attorneys, based in Vienna, Virginia, is a national organization of elder law attorneys which can make referrals of attorneys with elder law expertise located in your geographic area. On a local level, the Westchester County Department of Senior Programs and Services (formerly the Westchester County Office for the Aging), the Pace Women's Justice Center, the Westchester County Bar Association, other local bar associations and legal not-for-profit groups may be able to assist in providing information concerning elder law issues and/or offer lawyer referral services, which are useful resources for locating experienced counsel. The Westchester County Library System may also be a useful resource to obtain information concerning the selection of an elder law attorney. Often, such services will provide several names from a panel of attorneys known to have expertise in elder law.

It is best to interview more than one lawyer before making a choice. During the initial interview, you should request that the prospective lawyer address the issues that you believe are most important. Make sure that your lawyer is experienced in the area of elder law. To determine the lawyer's expertise, it is acceptable and proper to ask the attorney how many elder law matters the attorney handles annually, and/or what percentage of his or her practice is devoted to elder law. Inquiring as to the attorney's involvement in civic or professional groups that focus on elder law issues may also be useful in determining the attorney's expertise and level of commitment to elder law practice.

## HEALTH CARE PLANNING

### Health Care Proxies and Living Wills

**I am healthy now, but want to make sure that if I ever become severely incapacitated, no artificial life-sustaining treatments will be imposed. How can I ensure that my wishes will be carried out?**

There are three (3) documents which you should consider signing to make sure your health care wishes are followed.

- 1) A **health care proxy** is a legal document that can be used to protect your health care wishes in the event of your incapacity. A health care proxy allows you (the principal) to appoint someone else (the health care agent) to make health care decisions for you if you become incompetent. A successor health care agent, to act if the primary agent cannot act, may also be appointed. Routine decisions and decisions regarding life-sustaining treatment may be made using a health care proxy, but your health care agent will not be able to withhold artificial nutrition or hydration unless your intention to do so has been clearly expressed in the health care proxy itself, or in more detail in a separate living will or medical order for life-sustaining treatment. In addition, pursuant to legislation passed on October 4, 2000, you can now also state your wishes concerning organ donorship in your health care proxy. **A copy of the health care proxy form is included as Appendix A in this booklet.**
- 2) A **living will** is a document that sets forth your intentions concerning health care, particularly with respect to artificial life-sustaining procedures. In a living will, you can set forth your intention to forgo certain life-sustaining measures, such as artificial nutrition or hydration (which may be imposed if you are unable to eat or drink on your own) or mechanical respiration (which may be imposed if you cannot breathe on your own). Other types of treatments that you may decide to forgo include, but are not limited to, cardiopulmonary resuscitation (if your heart stops beating), antibiotic treatment, saline injections (to prevent dehydration), and pain relief (beyond a stated maximum amount). The living will sets forth your intentions concerning these important issues in the event that you, at some future point, become unable to make these decisions for yourself. **A copy of a living will form is included as Appendix B in this booklet.**



3) **A Medical Order for Life-Sustaining Treatment (“MOLST”)** is an alternative form to a living will in that it allows individuals, working together with their physicians, to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. The MOLST document is a physician order form (DOH-5003) on bright pink paper approved by the New York State Department of Health to be used statewide by health care providers and facilities. The MOLST form can be used to issue any orders for life-sustaining treatment for general hospital inpatients and nursing home residents. In the community, the form can be used to issue a non-hospital Do Not Resuscitate (DNR) or Do Not Intubate (DNI) order, and in certain circumstances, orders concerning other life-sustaining treatment. **A copy of a MOLST form with supporting checklists is included as Appendix C in this booklet.**

### **When should I create a health care proxy?**

Every person eighteen (18) years and older should have a health care proxy.

### **When should I create a Living Will?**

A Living Will should be created if you do not want to be kept alive artificially by medical devices if you were to be in a persistent vegetative state.

### **When should I ask my doctor for a MOLST?**

Consider completing a MOLST with your physician if you reside in a long term care facility, reside in the community and need long term care services such as home health aides, have a serious illness, have a limited life expectancy, or if you want to avoid or receive all or some life sustaining treatment.

## What do the medical terms on the MOLST form mean?

- CPR is cardiopulmonary resuscitation, a combination of techniques, including chest compressions and rescue breathing designed to pump the heart to get blood circulating and deliver oxygen to the brain until definitive treatment can stimulate the heart to start working again.
- Cardiac arrest is a condition when the heart stops beating.
- Intubation is the insertion of a tube into the windpipe to breath for you when you cannot.
- Mechanical ventilation is a machine that delivers oxygen and eliminates carbon dioxide from the body.
- Feeding tubes are inserted into the body through the nose or in the abdomen.
- Antibiotics are for the treatment of bacterial infections.

## At what point does a health care proxy, living will or MOLST form become effective?

A health care proxy becomes effective when your attending physician determines, to a reasonable degree of medical certainty, that you, as the principal, lack capacity to make your own health care decisions. If a decision to withhold life-sustaining treatment is involved, the attending physician must consult with a second physician to confirm that you lack capacity.

If you are using a living will to decide in advance that certain life-sustaining treatments should not be used, you should also decide when and how a determination should be made that you are in a condition in which artificial life-sustaining methods should be withheld. For example, your living will might provide that artificial life-sustaining methods should be withheld if your attending physician determines that you have suffered a substantial and irreversible loss of mental or physical capacity, and that there is no reasonable expectation of recovery. Other standards can be specified as well.

If using a MOLST document instead of a living will, its effectiveness will be immediate in that a MOLST document has the strength and benefit of having your end-of-life preferences being contained in an enforceable physician's order.

## **Who can I appoint as my health care agent?**

You can appoint almost any adult to serve as your health care agent. Often, health care agents are the spouse, children, brothers, sisters, or other relatives or close friends of the principal. It is important to choose someone you trust, someone who understands your health care concerns, and someone you believe will actively and effectively carry out your health care wishes.

State law does impose some limitations on individuals serving as health care agents. For example, if you live in a residential health care facility or hospital, the operator, administrator, or employee of that facility or hospital cannot serve as your health care agent (unless that operator, administrator or employee is related to you by blood, marriage or adoption). Also, absent a relationship to you by blood, marriage or adoption, any doctor affiliated with your residential health care facility or hospital cannot serve as your health care agent. In addition, an individual who is already serving as a health care agent for ten or more principals cannot be your health care agent unless such person is your spouse, child, parent, brother, sister, or grandparent.

## **Can I ask my doctor to serve as my health care agent?**

As long as your doctor is not associated with a health care facility or hospital in which you reside, she or he can serve as your health care agent. However, the doctor you designate as your health care agent cannot also be the doctor responsible for determining when you lack capacity to make your own health care decisions. Such determination must be made by a second independent physician.

## **How can I be certain that my wishes, whether contained in a health care proxy, living will, or MOLST form will be respected?**

Both a health care proxy and a living will serve as substantial evidence in a court of law of your intentions concerning health care decision making. However, general instructions about refusing treatment, even if written, may not be effective. Therefore, although it is often difficult to anticipate future medical needs, it is best to be as specific as possible about the kinds of treatment you do not want and the medical conditions under which you would refuse those treatments.

If you do not wish to be kept alive by artificial means, it is important to state your intention in both your health care proxy and your living will documents.

The law states that unless your agent is aware of your wishes about artificial nutrition or hydration, she or he will not be allowed to refuse or consent to these matters for you. Therefore, if you are sure that you do not want to be artificially fed or hydrated, you should put specific language concerning the withholding of these interventions in your health care proxy. The following language might be used to express such an intention:

*My agent knows my wishes concerning artificial hydration and nutrition and is authorized to make such decisions.*

Your living will is the document in which you can set forth in further detail under what circumstances life support can be withheld or withdrawn (specifically as relates to artificial nutrition or hydration), as well as to discuss other types of health care treatment, including:

- Artificial respiration,
- Cardiopulmonary resuscitation (CPR),
- Administration of antipsychotic medication,
- Palliative care,
- Electric shock therapy,
- Antibiotic treatments,
- Psychosurgery,
- Dialysis,
- Organ transplants,
- Blood transfusions,
- Abortion, and
- Sterilization.

To assist in making sure your wishes concerning health care are enforced, you should sign multiple originals of the health care proxy and living will forms. You should then furnish duplicate originals of both your living will and health care proxy to the primary and successor agents you designated in the proxy, as well as to your primary care physician for immediate placement in your medical file. Your attorney should also retain a copy of your health care proxy and living will. You may also want a member of your clergy to hold original copies of these documents for you.

Finally, in 2008, Governor Paterson signed legislation allowing the use of Medical Orders for Life-Sustaining Treatment (MOLST) primarily intended for persons facing end-of-life decisions. The MOLST form gives specific instructions to medical personnel regarding treatment. A MOLST form is enforceable as it is a medical order, signed by a physician.

### **Can anyone make health care decisions for me if I do not have a Health Care Proxy or Living Will?**

New York passed the Family Health Care Decision Act, which became effective June 1, 2010. The law allows the appointment of a spouse or domestic partner, adult child, parent, adult sibling or close friend to be designated as a surrogate with authority to make medical decisions for an individual not able to make their own decisions concerning their health care. This includes the right to withhold or withdraw life-sustaining treatment, including artificial nutrition and hydration. The law is effective only if the patient is in a hospital, nursing home or hospice setting. The law fills in some gaps if an individual does not have a health care proxy; however, because of the delays inherent in deciding who is an appropriate surrogate under the Family Health Care Decision Act, it is preferable for all individuals to have a health care proxy.

### **What is palliative care?**

Palliative care is the specialized health care treatment including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life including hospice. Palliative care is appropriate at any stage of a serious illness, whether that illness is potentially curable, chronic or life-threatening.

This type of care is focused on providing patients with relief from the symptoms, including the pain and stress of a serious illness, assisting with medical decisions and establishing goals of care – **whatever the diagnosis and regardless of the prognosis. The goal of palliative care is to improve quality of life for the patient, and family and caregivers.** Palliative care is provided by doctors, nurse practitioners, nurses, social workers and other practitioners who work with a patient's health professionals to provide an extra layer of support. Palliative care is appropriate at any age and at any stage of a serious illness, and can be provided together with curative treatment. Palliative care is covered by Medicare, Medicaid and most commercial insurance.

### **Has any legislation been passed in New York State concerning palliative care?**

The Palliative Care Information Act was executed and became effective in February 2011 and is a critically important patient's rights law and a model for the nation. Seriously and terminally ill patients now have a clearly defined right to receive information and counseling about their palliative care and end-of-life options, including hospice, enabling them to make informed treatment decisions.

### **What information should attending health care practitioners offer as a result of the new Palliative Care Information Act legislation?**

The new law requires them to provide information and counseling regarding palliative care and end-of-life options appropriate to the patient, including:

- Prognosis
- Range of options appropriate to the patient
- Risks and benefits of various options
- Patient's "legal rights in comprehensive pain and symptom management of the end of life"

Appropriate means it must be consistent with the patient's psychosocial circumstances and cultural and religious beliefs. Information needs, patient preferences and options may need to be revisited as the disease progresses. The delivery of palliative care and

end-of-life counseling need not, and should not, be the same for every patient. The practitioner should be sensitive to the patient's emotional cues, preferences and ability to absorb information.

### **What is hospice care?**

Hospice care is a formal system of care, specific to end of life for individuals who have a life-limiting illness that is no longer responsive to curative treatment. The patient must be certified by a physician to have approximately 6 months or less to live. Hospice care is provided by certified hospice agencies.

Hospice care is comfort care and is not provided together with curative treatment, but can be provided with palliative care. Hospice care is covered by Medicare, Medicaid and most commercial insurance. The Medicare Hospice Benefit covers nursing care, durable medical equipment, some home health aide services, social work visits, pastoral care and other supportive services for the patient and their family. Hospice care is provided in a patient's home, but can also be provided in nursing homes, assisted living facilities, hospice residences and hospitals. Under the hospice program, your own doctor can continue to participate in your care plan. The Medicare Hospice Benefit also provides bereavement support for 18 months after the passing of the patient.

### **Can I be admitted to hospice if I lack capacity?**

Yes. A health care agent appointed under a health care proxy can consent to hospice enrollment when the patient lacks capacity. The patient must also be certified by a physician that death is likely to occur within six (6) months if the disease runs its natural course to be eligible under the Medicare Hospice Benefit.

## **FUTURE CARE PLANNING – MANAGING FINANCES AND ASSETS**

### **Powers of Attorney**

**My children would like me to execute a Power of Attorney. Do I need one and who should I appoint?**

Everyone should consider signing a power of attorney. A **power of attorney** is a legal document that allows you (the principal) to appoint another individual (your agent) to act in your place for the purposes stated in the document. Powers of attorney can be used to assist you in managing your day-to-day financial affairs. For example, a power of attorney can grant your appointed agent the authority to write checks on your behalf or to sell or purchase property for you. A power of attorney may also be used to permit someone to act on your behalf in the event of a sudden emergency or to manage your affairs if you should become incapacitated.

A power of attorney is a very powerful document as the person you appoint has control over your assets. Thus, only a person you absolutely trust (e.g., spouse, child, other close family relation, lifelong friend or clergy) should be appointed as an agent in the power of attorney.

**A copy of the most current New York State Statutory Power of Attorney Form is included as Appendix D in this booklet.**

**Can a Power of Attorney be used for health care decision making?**

No. Only a health care proxy, discussed in the preceding section, can be used to appoint someone to make health care decisions for you. A power of attorney is used primarily for financial decision making.

**Can I limit my Agent's authority to act under a Power of Attorney?**

Yes. A power of attorney can be tailored to meet your individual needs. At one extreme, a power of attorney can be general and give your agent unlimited and unbridled discretion to make all decisions for you (except decisions concerning your health care). A power of attorney can also be limited to provide that your agent can



act on your behalf only with respect to a particular activity or activities (e.g., act at a real estate closing or manage a particular account).

## **What is a Durable Power of Attorney? Do I need one?**

A durable power of attorney is a power of attorney that continues to be effective even after you are no longer competent to make decisions for yourself. If a power of attorney is not “durable,” it cannot be used after the principal (i.e., the person signing the power of attorney) becomes incapacitated. The durability of the power insures that you have someone to take care of your affairs should you ever become incapacitated. If you do not have a durable power of attorney and you become incapacitated, there will be no individual who can act on your behalf or access your individual assets to pay any of the expenses arising from your incapacity. (This includes assets such as an IRA, 401(k) or other retirement accounts, which accounts, although they designate a beneficiary, such beneficiary can only act after your death and not at the time of your incapacity). If you become incapacitated without a durable power of attorney, then only a court appointed guardian may access your assets. The legal proceeding to appoint a guardian is often expensive, time consuming, unpleasant and may result in the appointment of someone you would never want to act on your behalf. Using a durable power of attorney avoids the necessity of a guardianship.

## **How do I know if the Power of Attorney I have is durable?**

In New York State, a power of attorney containing language which states that “**this power of attorney shall not be affected by the subsequent disability or incompetence of the principal,**” or similar language, confirms that the power of attorney is durable. You should check any of your existing powers of attorney to make sure they have durability language. Failure to include such language means that the power of attorney you have signed will no longer be valid if you become incapacitated.

## **Does New York State have a standardized Power of Attorney Form?**

Yes. Effective September 1, 2009, New York State adopted legislation authorizing the use of a new statutory power of attorney document which is required to be recognized

by all financial institutions authorized to do business in New York State. This power of attorney is durable unless the principal states otherwise in the document. The New York State legislature adopted technical corrections to the Power of Attorney form which became effective September 13, 2010. **A copy of this Statutory Power of Attorney Form is included as Appendix D in this booklet.**

### **Are Powers of Attorney properly signed prior to September 13, 2010 still valid?**

Yes, if they were signed in compliance with the law prevailing at the time of signing.

### **Can you make changes to the new Statutory Power of Attorney?**

Yes, but only if such changes are incorporated in a special “Modifications” section of the power of attorney set forth in subsection (g) of the document. No changes are permitted to be made to the new statutory power of attorney unless expressly set forth in this Modifications section.

### **Does the new Power of Attorney revoke prior Powers of Attorney executed by the Principal?**

No, not unless the power of attorney specifically states so. It is sometimes suggested that the power of attorney state that only prior general powers of attorney be revoked and that powers of attorney used for a specific purpose (i.e., powers of attorney designated for use at a particular financial institution or limited to a specific purpose) not be revoked.

### **Can the Principal appoint someone to oversee the actions of the Agent under the Power of Attorney?**

Yes. Under the new power of attorney legislation, the principal may appoint a “Monitor” to oversee the activities of the agent. The monitor may demand that the agent furnish the monitor with a record of all transactions which the agent has completed on behalf of the principal and the agent must comply with such demand.

## **Can the Agent be compensated for the work it performs on behalf of the Principal?**

Yes. The agent is entitled to reimbursement for all reasonable expenses incurred on behalf of the principal. The agent may also be reasonably compensated for services rendered on behalf of the principal pursuant to compensation terms further specified in the Modifications sections of the power of attorney.

## **Can the Agent still make gifts of the Principal's assets in the Statutory Power of Attorney?**

Yes, but only in the amount of \$500 per year unless subsection (h) of the power of attorney is initialed by the principal directing that gifts be made pursuant to the terms of a Statutory Gifts Rider ("SGR") which is annexed to the power of attorney **and is also annexed as part of Appendix D in this booklet.**

## **What sort of gifts is the Agent authorized to make on behalf of the Principal in the SGR?**

If subsection (a) of the SGR is initialed by the principal, the agent may only make gifts to the principal's spouse, children and more remote descendants and parents not to exceed the annual gift exclusion amount (which is currently \$14,000 per person per year).

## **May the Agent make gifts of the Principal's assets to individuals other than immediate family and in amounts exceeding the annual gift exclusion amount?**

Yes, but only if the principal initials subsection (b) of the SGR entitled "Modifications" and then identifies those individuals or charities to whom the agent may gift and specifies the nature and amount of the gifts permitted.

## **May the Agent make gifts of the Principal's assets to him or herself?**

Yes, but only if the principal initials Section (c) of the SGR expressly authorizing the agent to make gifts to him or herself.

## **Should I consider authorizing my Agent in the Power of Attorney to make gifts of my assets to him or herself or others?**

Maybe. New York State law states that unless the power of attorney expressly authorizes the agent to make gifts of the principal's assets, the agent does not have such authority. If your estate is of a size in which you had been or would be making gifts to reduce your estate tax liability or if you had been or would be making gifts of your assets in order to qualify for Medicaid in the event you suffered a long term custodial care health care crisis, then you should consider including in your power of attorney and SGR express language giving your agent the authority to gift your assets to those individuals or charities whom you would wish to benefit.

## **Should there be a monetary limit on the value of the Principal's assets which the Agent is authorized to gift in the Power of Attorney?**

Provided that you have full faith and trust in your agent, the principal may want to authorize the agent in the power of attorney and SGR to make gifts in unlimited amounts to a specific group of individuals and/or charities designated by the principal to be the beneficiary of his or her assets. Such expansion of the gift giving power may allow the principal to achieve estate tax reduction and/or Medicaid qualification. The agent should always be advised to consult with an elder law attorney and/or tax advisor prior to actually making such gifts.

## **When does a Power of Attorney become effective, and how long does it remain effective?**

Unless the power of attorney is a "springing power" which expressly states that it will become effective at a specified moment in the future, a power of attorney becomes effective immediately upon its execution. All powers of attorney executed beginning on September 1, 2009 must be executed by both the principal and all primary agents

named thereunder. In addition, such signatures must be notarized and, if gift giving is to be authorized, the signature of the Principal on the SGR must be both notarized and witnessed by two (2) witnesses. Thereafter, once an individual signs and delivers a power of attorney to his or her agent, the agent can have immediate access to the principal's assets. A power of attorney is an enormously powerful document, and the agent you select must be someone you trust implicitly. If you prefer that your agent not be given powers immediately, New York State recognizes a springing power of attorney, which becomes effective only on a certain date or upon the occurrence of a certain event. A springing power of attorney might only be activated, for example, upon a physician determining that you are incapacitated. Since both principal and agent need to sign, one way to have a power of attorney become effective at a later date is to have the principal sign it but withhold delivery to the agent(s) until the occurrence of a specific event.

### **Do I need to have a Power of Attorney if all of my assets are owned jointly with another person?**

While the ownership of a joint account with another allows such joint owner of the account, like the agent in a power of attorney, to manage such account during your lifetime, establishment of a joint account with another person may also result in the surviving owner of the account having a right of inheritance in the account at the time of your death. (This is particularly true on accounts which state "JTWROS" meaning that the owners of the account own such account "joint with rights of survivorship" such that each party will inherit such account at the time of death of the other.)

Joint ownership of an account can prove to be problematic in situations in which it was your intention that individuals, other than or in addition to the joint owner, were to receive the assets in the account at your death. Even if your Will states that all of your assets are to be divided equally among multiple individuals, the fact that you own certain assets jointly with another results in those particular assets being distributed automatically, by operation of law, to the surviving joint owner at your death irrespective of the fact that the terms of your Will state otherwise.

Joint ownership of an account may also prove problematic from an estate tax perspective since if one of the joint parties (other than a spouse) were to die, the entire value of the joint account becomes part of the taxable estate of such predeceased joint owner. This is true even if the predeceased joint owner did not contribute any funds to the joint account. The burden to overcome the presumption that the predeceased joint owner did not own 100% of the account is on the executors of the decedent's estate to demonstrate (by furnishing records and otherwise) that the deceased party did not contribute all of the assets to the account and therefore the entire account should not form part of his or her taxable estate.

A Will only controls assets in your individual name and does not control joint accounts or other contract assets, like life insurance or retirement assets, which have designated beneficiaries. A power of attorney ceases to be effective at the time of your death resulting in the assets owned in your individual name during your lifetime being distributed in accordance with the terms of your Will at death. If you intend that multiple beneficiaries share in your estate at death, use of a power of attorney, rather than joint ownership of assets, becomes particularly important.

### **What about my passwords and other digital assets?**

The New York Estates Powers and Trust Law was amended Sept. 29, 2016 to deal with the administration of digital assets upon the death or incapacity of their owner and to give individuals the power to control their digital footprint. A provision discussing how digital assets should be handled can be incorporated into a New York State Durable Power of Attorney. Such a provision grants specific permission to allow the agent to have the power and authorization to access, take control of, conduct, continue, or terminate accounts on digital devices or digital assets, as defined by Article 13-A of the New York Estates Powers and Trusts Law. Such a provision can also detail whether or not you wish to grant your agent the power to obtain log-on credentials, including usernames and passwords for all types of online accounts including but not limited to banking, email and social media.

## Living or Inter Vivos Trusts

### What is a Living or Inter Vivos Trust?

Like a power of attorney, a **living trust** (also known as an inter vivos trust) is a legal tool that you can use to plan for the possibility of your future incapacity. To create the trust, you (the **grantor**) transfer all of your assets into the name of the legal entity known as the trust (e.g., the Jane Doe Trust) and appoint a **trustee** to manage the trust's assets. The trustee makes all decisions concerning the trust. Generally, income generated by the trust is paid to the grantor on a regular basis. Payments from the principal of the trust are made, within the trustee's discretion, for the support, maintenance, and care of the grantor. Similar to a Will, the trust also details how the trust's assets are to be distributed after the death of the grantor. The most common form of living trust is a Revocable Living Trust which the grantor may revoke at any time.

Trusts can be complicated documents with significant tax ramifications. If you are considering transferring your assets to a trust, it is strongly recommended that you consult with an attorney first.

### **I am healthy and competent and not comfortable with the idea of having someone else manage my assets right now. Can I serve as the Trustee of my own Living Trust?**

Yes. You can name yourself as the trustee of your own living trust and provide for a successor trustee to take over in the event of your incapacity or upon your death. You can also name yourself and an independent third party trustee as co-trustees, and provide that you and the independent trustee will act together to manage the trust until you become incapacitated or die, at which time the independent trustee will take over. Finally, you can appoint a third party trustee to manage the trust assets without your acting as co-trustee, but still maintain control over the trust by reserving the power to terminate the trust at any time.

## **Can a Revocable Living Trust be used to distribute my assets at death instead of a Will?**

Yes. In certain states the revocable living trust, rather than the Will, has become the instrument of choice for distributing assets at death. This is because in certain states the cost of probate (i.e., a legal proceeding to have the court approve a Will at death) is expensive, as it can be equal to as much as 5% or more of your estate. In contrast, a revocable living trust is a private document which permits distribution of assets after death without court approval.

The majority of the states in the United States (including New York) are probate friendly, meaning that the statutory fees to submit the Will to the court for probate approval are reasonable. In New York, the court costs related to a probate filing do not exceed \$1,250. In probate friendly states, it may not be appropriate to establish a revocable living trust, since in order for a revocable living trust to save a modest amount of probate fees, an individual must totally overhaul the manner in which his or her assets are owned by currently transferring all assets into the title of the Living Trust. For example, real estate owned in the name of John Smith has to be transferred to the Trust of John Smith, and a bank account in the name of Mary Jones must be transferred to the Trust of Mary Jones. Such costly and time consuming asset transfers, combined with legal fees to establish the trust may outweigh the savings of minimal probate fees.

## **Are there circumstances where it still makes sense to use a Revocable Living Trust even if you reside in a probate friendly State such as New York?**

Absolutely. A revocable living trust may be the preferred estate planning instrument to a Will and more appropriate in the following circumstances:

- 1) If you own real property in multiple states, the law requires that you probate the Will in each state in which the decedent owned real estate. To avoid probates in multiple states under such circumstances, which could prove to be costly, complicated and time consuming, it may make more sense to establish a single living trust which can own all the real property and more efficiently distribute such property out at death without the need to follow the probate requirements of multiple states.



- 2) If you do not intend to leave your assets to your heirs at law (also referred to as distributees) and/or the whereabouts of such heirs at law are unknown, the use of a living trust may be preferred so that your estate is not burdened, both financially and otherwise, with the probate notification laws which require having to locate estranged family members to advise them of their rights in your estate even though you have not provided for them in your Will.
- 3) Where privacy/confidentiality is a concern, use of a living trust may be preferred since unlike a Will, a trust document is not required to be filed with the court and thereby made a public record at death.
- 4) To provide a more detailed and streamlined asset management tool during life (i.e., more than just a power of attorney which only gives someone general authority to act). A revocable living trust is easy to administer (as it does not even require the filing of separate income tax returns) and will avoid the necessity of guardianship proceedings in the case of future incapacity.

### **Will the use of a Revocable Living Trust save income or estate taxes?**

No. Since the trust is revocable (meaning the trust can be terminated and its assets can be taken back by the grantor at any time), the Internal Revenue Service taxes all income generated by the assets in the same manner as if they were owned in the individual name of the grantor. The Internal Revenue Service has also stated that all assets in a revocable trust form part of the grantor's taxable estate (since the grantor could take the assets back into his or her individual name until the time of the grantor's death) and are subject to estate taxes to the extent the grantor's estate exceeds taxable limits (see Section on "Taxes" discussed later in this publication).

### **Will the use of a Revocable Living Trust protect the trust assets and allow the Grantor to qualify for Medicaid?**

No. Since the grantor can terminate the trust at any time and take the assets back for him or herself, the Department of Social Services considers the assets in the trust to represent part of the overall resources owned by the grantor and will disqualify the grantor from receiving Medicaid assistance to the extent the grantor's resources exceed the Medicaid resource allowance.

## **What type of Trust will offer tax and asset protection advantages?**

An irrevocable trust. An irrevocable trust is a trust in which the grantor has irrevocably transferred his or her assets into the trust and no longer has access to the principal assets placed in such a trust. Similarly, a properly drawn irrevocable trust will protect the principal assets contained in the trust and allow the grantor to qualify for Medicaid after the transfer penalty period has lapsed (discussed later in this publication in the Section entitled “Preservation of Assets/Medicaid Planning”). It is possible for the grantor of the irrevocable trust to retain a right to receive the income generated by the assets owned by the trust (i.e., interest and dividends) and still protect the principal assets in the trust from spenddown in order to qualify for Medicaid in the event of a long term custodial care crisis.

## **Do I still need a Will if I have a Trust (Revocable or Irrevocable)?**

Yes. A Will is always important to have in case there are certain assets which cannot be transferred into trust title (e.g., a co-op which the Board of Directors refuses to transfer) or if assets are discovered which were inadvertently left out of the trust. The Will can direct that such miscellaneous assets be paid to and thereafter distributed in accordance with the terms of the trust at the time of the grantor’s death. This type of Will is called a “Pour Over Will” and is important for purposes of controlling those miscellaneous assets still remaining in the grantor’s individual name at the time of his or her death. Without a Will, such assets would be distributed in accordance with the intestacy laws of the State of New York, which laws dictate how assets not controlled by a Will or Trust are to be distributed at the time of a person’s death (discussed in the following Section on “Wills” in this publication).

## Wills

### **I am married, have no children, and do not have much property. Do I need a Will?**

If you do not have a Will (or a funded trust) to dispose of your assets upon your death, your assets will be distributed according to the New York State intestacy law, irrespective of what you otherwise would have intended. The New York intestacy laws prioritize the distribution of assets, as follows:

- (a) If survived only by spouse (no children or parents) – everything to spouse,
- (b) If survived by spouse and parent or parents (no children or grandchildren, great-grandchildren, etc.) – entire estate to spouse,
- (c) If survived by spouse and any children (or grandchildren of deceased children) – \$50,000 plus ½ of estate to spouse and ½ of estate to children or grandchildren,
- (d) If no spouse, children or parents, then to grandchildren and further descendants, if any,
- (e) If no descendants as in (d), then to brothers or sisters or their issue, and
- (f) More remote family relationships extending out to first cousins once removed (sometimes referred to as “laughing heirs” as they would inherit assets not having ever known the decedent).

**NOTE:** Adopted children and illegitimate children of decedent have same rights as biological and legitimate children (except illegitimate children only have inheritance rights from deceased father if they prove paternity).

Even if your estate is small, a Will can ensure that certain items of personal property are given to specific individuals upon your death. A Will is also useful to provide instructions regarding the disposition of your remains (i.e., your burial, cremation), and whether you want to be an organ donor. If you intend to donate your organs, however, it is best to set forth this intent in a separate document (e.g., the appropriate portion of your New York State driver’s license or in your health care proxy as previously discussed), since your Will may not be accessible in a timely manner upon

your death and organ donorship requires quick action. Likewise, your funeral arrangements should be set forth in an accessible letter of instructions, since your Will may not be readily available.

**If my assets will be distributed by the laws of intestacy to the same people who would inherit my assets if I had used a Will, do I still need a Will?**

It is best still to have a Will. If you do not have a Will, a bond will need to be posted at additional cost to the estate before anyone can be appointed to administer your estate. Also, the individual appointed to administer your estate may not be someone who you would want to manage your affairs.

**My Will provides for all of my assets to pass to my spouse. I have a joint bank account with my daughter. Who will get the funds in that account when I die?**

A Will only controls assets in your individual name. The funds contained in the joint account are not controlled by your Will and will pass to your daughter (unless the account was set up without a survivorship feature). The same is true for other jointly owned real or personal property. In addition, proceeds from life insurance policies or other accounts that have specific designated beneficiaries (e.g., IRA, 401(k) or other retirement accounts, or “in trust for” or “payable upon death” bank accounts) are not controlled by your Will. These assets will pass outside of your probate estate to the designated beneficiaries. These assets are, however, still included in your estate for estate tax purposes.

## TAXES

### I am married and plan to leave my estate to my spouse. How much of that estate will go to taxes?

The law provides for an **unlimited marital deduction**, meaning a surviving spouse pays no federal or New York State estate taxes if the entire estate is left to a surviving spouse and/or charity. However, when the surviving spouse dies, then the estate may be subject to both state and federal estate taxes.

In those instances where the assets are left to someone other than a surviving spouse and/or charity, federal and/or New York State estate taxes may be due to the extent they exceed the then prevailing federal and/or New York State estate tax exemption amounts.

### What are the laws concerning the Federal Estate Tax?

Since the American Taxpayer Relief Act of 2012 (the “Tax Act”) went into effect on January 2, 2013, the imposition of federal estate taxes have continued with some modifications. While the current administration has proposed further modifications, no new laws have been passed as of this writing, and New York State estate taxes will continue unless separately modified.

The Tax Act initially increased the amount which may be exempted from federal estate tax to \$5.25 million dollars per person (or \$10.5 million dollars for a married couple) which amount is subject to further annual adjustment based on inflation. The 2017 amount as adjusted for inflation is \$5.49 million dollars per person (or \$10.98 million dollars for a married couple).

The Tax Act also increased the federal estate tax rate on the amount over that exemption to 40%. The Tax Act further continues the law of portability which allows the surviving spouse to use or “port over” any unused portion of the estate tax exemption amount of the predeceased spouse as part of the surviving spouse’s exemption when such survivor dies.

In addition, the Tax Act continues to unify the gift and estate tax exemptions. Thus, the lifetime gift tax exemption is also \$5.49 million dollars and is indexed for inflation.

Notably, unlimited gifts may be made to a spouse or charity without any gift tax consequence just as there is no estate tax assessed on assets passing from a decedent to a spouse or charity. As a result each person may now make up to \$5.49 million dollars of gifts (in addition to the \$14,000 per person annual gift exclusion amount) before being subject to tax and may make unlimited gifts to a spouse or charity. It is important to understand, however, that any gift made (other than the tax exempt gifts made to a spouse or charity) which are over \$14,000 per person per annum will reduce the estate tax exemption on a dollar for dollar basis. Therefore, if one was to make gifts totaling \$2 million dollars during their lifetime (in excess of the \$14,000 per person annual exclusion amount) and the estate tax exemption was still at the time of such person's death equal to \$5.49 million dollars, then such person will only have a \$3.49 million dollar exemption at death.

However, the advantage of making such a gift is that any appreciation in the value of the gifted asset will occur outside the taxable estate and thus the loss of \$2 million dollars of estate exemption may be insignificant if the asset grew to be valued at \$5 million dollars at the time of the donor's death as such appreciated value of \$3 million dollars is not subject to estate tax. Thus, the ability to make larger gifts without paying up front gift tax combined with the ability to continue to do minority and other discount planning in a low interest rate environment may result in the ability to transfer large sums of wealth to succeeding generations without being subject to gift or estate tax.

## **What are the laws concerning the New York State Estate Tax?**

In addition to the federal estate tax referenced above, estates of individuals who are residents of the State of New York at the time of their death may be subject to a separate state estate tax if the Decedent's assets are passing to someone other than a spouse or to a charitable entity.

Effective April 1, 2014 New York State adopted sweeping changes to its state estate tax law which previously had taxed estates passing more than \$1 million dollars to non-spousal and non-charitable beneficiaries. Under the new law, the New York State estate tax exemption amount (referred to as the "exclusion amount" under New York law and so referred to in this publication) incrementally increases over time from

April 1, 2014 through December 31, 2018 such that individuals dying between the following dates have the following state estate tax exclusions:

\$2,062,500 exclusion for individuals dying on or after April 1, 2014 and through and including March 31, 2015

\$3,125,000 exclusion for individuals dying on or after April 1, 2015 and through and including March 31, 2016

\$4,187,500 exclusion for individuals dying on or after April 1, 2016 and through and including March 31, 2017

\$5,250,000 exclusion for individuals dying on or after April 1, 2017 and through and including December 31, 2018

Starting on January 1, 2019, the New York State exclusion amount will be indexed for inflation from 2010 which should result in linking the state estate tax exemption amount to the federal estate tax exemption amount in effect in 2019 and thereafter.

As a consequence of the new legislation, those estates valued at more than the New York State estate tax exclusion amount referenced above will continue to pay a separate New York State estate tax. Significantly, however, for those estates which are valued at more than 5% of the then prevailing New York State exclusion amount, there will be a New York State estate tax calculated based on the full value of the estate rather than just on the amount exceeding the exclusion amount as had been past practice.

Such calculation has a cliff effect and can be confiscatory in nature. For example, assume an individual dies on June 1, 2017, when the New York exclusion amount will be \$5.25 million dollars. If that individual's New York taxable estate was \$5,512,500 (which exceeds the then prevailing \$5.25 million dollar exclusion amount by \$262,500 or 5%), that estate would pay \$452,300 in New York estate tax. If that individual had instead died with an estate valued at \$5.25 million dollars, however, the estate would have owed no New York estate tax. Thus, there would be New York estate tax of \$452,300 (at a marginal New York estate tax rate of over 172%) on the additional New York taxable estate of \$262,500 in excess of the basic exclusion amount of \$5.25 million dollars.

Based on the above, it is of critical importance that a careful analysis of estate tax value be conducted so steps can be taken through gifting, disclaimer or other strategies to reduce the New York State estate tax liability.

### **Are gifts I give while I am alive also taxed?**

You can give unlimited separate gifts of \$14,000 per year (\$28,000 per year for married couples) to as many friends or family members as you would like without any tax consequences. These gifts are referred to as the annual exclusion amount and are not income to the recipient. However, any income (i.e., interest and dividends) generated by the gifts after transfer are taxed to the recipient.

The Tax Act and subsequent inflation adjustments increased the lifetime gifting amount to a maximum amount of \$5.49 million dollars per person. The Tax Act and subsequent inflation adjustments imposes a separate federal gift tax on the amount over the \$5.49 million dollar gift tax exemption amount at a rate not to exceed 40%. New York State does not impose a separate gift tax but instead adds back certain federally taxable gifts made during a decedent's lifetime which may cause additional estate tax to become payable.

Once you give any individual or entity (other than a spouse or charity), in any one year, more than \$14,000 (or \$28,000 for a married couple), you are obligated to file a federal gift tax return as such gifts constitute taxable gifts. In addition, there is an interplay between the gift and estate tax laws such that the amount gifted over \$14,000 (or \$28,000 for married couples) reduces the lifetime estate tax exemption amount of the maker of the gift. For example, if you gave any one individual, in any one year, \$19,000 instead of the \$14,000 annual exclusion amount, your \$5.49 million dollar lifetime federal estate tax exemption and \$5.25 million dollar New York State estate tax exclusion which exists in 2017 would be reduced by the \$5,000 excess over \$14,000 or down to \$5,485,000 or \$5,245,000, respectively.

If the excess gifts ever totaled more than the \$5.49 million dollar lifetime federal gift tax exemption amount, an upfront federal gift tax would have to be paid at a rate of 40% on such excess. In addition, an estate tax would be paid on the decedent's estate to the extent the value of the decedent's estate exceeds the estate tax exemption



amount (in the year of the decedent's death) as reduced by the amount of gifts made over the annual exclusion amount during the decedent's lifetime.

Although New York State had abolished its separate gift tax in 2000, the new New York legislation has resulted in New York State adding to the taxable estates of its decedents dying beginning on April 1, 2014 through December 31, 2018 the value of all taxable gifts made during the three (3) year period preceding death. This "add back" provision appears to apply to both real estate and tangible personal property located in New York State.

## **What can I do to reduce taxes due on my estate?**

### **As an individual**

If your estate exceeds the then prevailing Federal or New York State estate tax exemption, you can act during your lifetime to reduce the value of the estate by making tax free gifts of \$14,000 per year (\$28,000 for a married couple) to as many friends or family members as you would like. Larger gifts may be contemplated, particularly of assets likely to appreciate, so such appreciation occurs outside of the donor's taxable estate. In addition, an individual may want to consider gifting larger amounts (not to exceed the \$5.49 million dollar lifetime federal gift tax exemption as a gift of that magnitude would cause an immediate federal gift tax to be due). The gifting of such amounts will not result in the imposition of gift tax and may lower the overall estate tax liability at death (although special consideration must be given to those gifts made prior to 2019 by New York residents within three (3) years of their death as previously discussed). There are also other estate tax reduction strategies (e.g., life insurance trust, split interest trusts and discount planning) which may be applicable but are beyond the scope of this publication and should be explored with a skilled estate planning attorney or tax advisor.

### **As a married couple**

In 2017, a married couple is able to take advantage of the \$5.49 million dollar per person federal exemption amount and exempt up to \$10.98 million dollars over their joint lifetimes by implementing proper estate planning.

One strategy that may continue to be implemented since the Tax Act is “portability” of the unused portion of the federal estate tax exemption. Please note that portability is only permitted under federal law and is not permitted for New York resident decedents.

Portability is a concept which allows for the executor of the deceased spouse’s estate to transfer any unused portion of the current \$5.49 million dollar federal estate tax exemption belonging to such spouse’s estate to the surviving spouse. Thus, if the first spouse to die had an estate of \$3.49 million dollars which was bequeathed to the couple’s children, then the unused portion of such predeceased spouse’s \$5.49 million dollar estate tax exemption (i.e., \$2 million dollars) could be “ported over” to the surviving spouse. This would allow the surviving spouse to have a \$7.49 million dollar estate tax exemption at the time of his or her subsequent death consisting of the surviving spouse’s \$5.49 million dollar exemption plus the \$2 million dollar unused portion of the predeceased spouse’s estate tax exemption. Thus, \$10.98 million dollars passes to the next generation estate tax free as a result of the fact that \$3.49 million dollars of the estate tax exemption was used up by the estate of the first spouse to die and the remaining \$7.49 million dollars was used up by the surviving spouse’s estate.

For portability to be effective, the executor of the estate of the first spouse to die must make an affirmative election on the estate tax return of the predeceased spouse (which must be filed within 9 months of such spouse’s death) stating that the surviving spouse wishes to transfer to him or herself the unused portion of the predeceased spouse’s estate tax exemption. Filing of these portability elections will become very important in spousal cases as even if the first spouse to die has very modest net worth, the surviving spouse is going to want to make sure that the unused portion of such predeceased spouse’s exemption is transferred to him or her so that if at the time of the surviving spouse’s death their estate has increased to \$10.98 million dollars (through successful investment, winning the lottery or otherwise), the full \$10.98 million dollars will be exempt from estate tax.

However, to maximize the use of the New York State estate tax exemption (since portability is only recognized for federal and not New York State estate tax purposes) and to plan for any future federal tax changes that may eliminate large exemptions and portability, married individuals may elect to incorporate a Credit Shelter Trust in their Wills so that they can exempt two times the estate tax exemption amount

(currently \$10.98 million dollars for federal estate tax purposes or \$10.5 million dollars for New York State estate tax purposes in 2017) from estate taxation.

Without portability being available, leaving assets directly to one's spouse outright will result in there being no estate tax at the time of the death of the first spouse, but all of the assets left to the surviving spouse will become part of such survivor's estate, and will be subject to applicable estate taxes upon that spouse's death. If a credit shelter trust is established, the estate of the first spouse to die may still be exempt from the payment of federal estate taxes at the time of that spouse's death. In addition, even in instances where portability is still applicable, credit shelter trusts may still be employed to avoid having the assets go directly to the surviving spouse and have such assets be subject to the claims of such survivor's creditors or the uncertainties of remarriage.

The use of the Credit Shelter Trust in a Will effectively allows a husband and wife to collectively shelter up to \$10.98 million dollars of their assets from federal estate taxes and \$10.50 million dollars from New York State estate taxes (i.e., 2 x the \$5,459,000 federal exemption or 2 x the \$5,250,000 New York State exemption amount which exists in 2017). This sheltering occurs since:

- 1) At the time of the death of the first spouse, the surviving spouse can decide not to accept up to the first \$5.25 million of the assets of the deceased spouse for New York State estate tax purposes or \$5.49 million dollars for federal estate tax purposes in 2017 and instead have such assets fall into a credit shelter trust exempt from tax both in the estates of the deceased spouse and the surviving spouse and thereafter; and
- 2) The surviving spouse's own personal exemption removes the second sum of \$5.25 or \$5.49 million dollars from his or her taxable estate.

A Credit Shelter Trust may provide for all income from the trust's assets to be paid to a surviving spouse during his or her lifetime. The trust principal may be made available for direct withdrawal by the surviving spouse (in annual amounts not to exceed 5% of the trust principal), if the surviving spouse so elects, or if larger amounts are needed by the surviving spouse, such additional amounts may be withdrawn by the surviving spouse for their health, education, maintenance or support as they so determine or may be distributed to such spouse for other purposes as determined

within the sole discretion of an independent (but friendly) trustee. Upon the death of the surviving spouse, the trust's principal (i.e., the exemption amount of assets contained in the trust and all appreciated value of such assets) pass to the trust's beneficiaries (children or other individuals) estate tax free.

To maximize flexibility and allow for consideration of future income tax or other considerations, a Will can also provide for a type of Credit Shelter Trust which only becomes funded at the option of the surviving spouse. Such a credit shelter trust is referred to as a renunciation or disclaimer credit shelter trust.

## MEDICARE

### What is Medicare?

Medicare is a federal non means-tested health care program for qualified persons over 65 and recipients of Social Security Disability (SSD) benefits. Generally, a qualifying work history for you or your spouse is required and you must either be over 65 years of age or in receipt of Social Security Disability benefits for more than two years to enroll in Medicare. Medicare has no income or resource limits; however, it does require co-payments and has deductibles for most services.

Medicare Part A is free and can cover hospitals, home health care, and time-limited nursing home costs. Medicare Part B requires a premium, but covers many more services, including doctors, ambulance and outpatient services. The amount of the premium required is now based on income.

In 2005, Medicare Part D was introduced, which provides prescription drug coverage for Medicare recipients through private insurance companies. Premiums are required and coverage varies from provider to provider.

### What does Medicare cover?

In general, **Part A** covers:

- Hospital care;
- Skilled nursing facility care, for up to 20 days without co-pays, and up to an additional 80 days with co-pays;
- Hospice; and
- Home health services; however only skilled and rehabilitative services are covered, not custodial care. The care must be part-time and intermittent.

**Part B** covers:

Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice are covered.

Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best, are covered and being expanded.

Part B also covers items such as:

- X-rays;
- Ambulance services;
- Durable medical equipment (DME);
- Mental health treatment;
- Lab costs;
- Getting a second opinion before surgery; and
- Limited outpatient prescription drugs.

## Part C

Also known as Medicare Advantage, Part C is a comprehensive plan which combines Parts A, B, and D in one private insurance plan.

## Part D (Prescription Drug Plans)

Each Medicare Prescription Drug Plan has its own list of covered drugs (called a formulary). Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost.

A drug in a lower tier will generally cost less than a drug in a higher tier. In some cases, if a drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you or your prescriber can ask your plan for an exception to get a lower co-payment.

## How do I enroll in Medicare?

People under age 65 receiving Social Security Disability payments will automatically be enrolled in Medicare Parts A and B after two years. People receiving Social Security retirement benefits are automatically enrolled in Medicare Parts A and B. If you are not receiving Social Security payments, you can enroll in Medicare by contacting the Social Security Administration when you reach age 65.

## When is Medicare Open Enrollment?

Medicare's Open Enrollment period is October 15 - December 7. During this period is when ALL people with Medicare can change their Medicare health plan and prescription drug coverage. Information on available plans will be available beginning in October. People with Medicare can call 1-800-MEDICARE or visit [www.medicare.gov](http://www.medicare.gov) for plan information. If a person is satisfied that their current plan will meet their needs for next year, they do not need to do anything.

## What if I don't have enough income to pay Medicare Part B or Part D premiums?

A program called the Medicare Savings Program is available to those who meet the income and asset guidelines of the program and is available from a Medicaid office. This program will pay for Part B premiums. Similarly, a program called Extra Help is available to low-income individuals to pay Part D premiums.

## Do I need a supplemental (Medigap) policy?

A Medicare supplement (Medigap) insurance, sold by private companies, can help pay some of the health care costs that Medicare doesn't cover, like co-payments, co-insurance, and deductibles.

Some Medigap policies also offer coverage for services that Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

### **Is my Medicare being changed by the Affordable Care Act?**

Yes, the Affordable Care Act is closing the gap in prescription drug plans when the Part D coverage limit is exceeded (the “doughnut hole”), and increasing preventive care coverage. You do not have to enroll in a new insurance program to get this coverage. In fact, it is illegal for a representative of a Health Insurance Marketplace to sell Qualified Health Plan coverage to a person receiving Medicare.

### **Will Medicare pay for long term care?**

No, Medicare will not pay for extended periods of home care, custodial care, or a long term skilled nursing facility.



## **LONG TERM CARE INSURANCE**

### **Do Medicare and Medigap insurance cover all types of medical care?**

Medicare and Medigap insurance cover skilled medical care services but not prolonged custodial care services.

### **What is custodial care?**

Custodial care is care required to assist an individual with his or her activities of daily living (e.g., care during recovery from a stroke or while suffering from Alzheimer's disease or other dementia). Activities of daily living include eating, bathing, dressing, transferring or mobility (e.g., moving from a bed to a chair) and toileting.

### **Do Medicare and Medigap insurance cover any custodial care costs?**

Such insurance may cover custodial care in a skilled nursing facility for a maximum of 100 days following a hospitalization of at least 3 days duration, provided the doctor's plan of care contains a rehabilitative component and it can be shown that the patient is being benefited by such rehabilitation. The first 20 days of such care will be fully paid for by Medicare. The remaining 80 days of such care are subject to a daily co-insurance payment (in year 2013 of \$161 per day). Many (but not all) Medigap insurance policies will cover this daily co-insurance payment. Other part-time or intermittent custodial care coverage at home may be available but is usually very limited in scope.

### **How will I pay for custodial care services?**

There are 3 principal ways to pay for custodial care:

- 1) Private payment (average annual nursing home costs in the greater New York area are currently around \$12,000 per month or \$144,000 per year),
- 2) Long Term Care Insurance, and
- 3) Medicaid.

## What is Long Term Care Insurance?

Long Term Care Insurance is a special kind of insurance designed to cover custodial care costs. It can be purchased to cover custodial care costs at home and/or in a nursing home.

## What considerations should be taken into account when purchasing Long Term Care Insurance?

When purchasing a Long Term Care Insurance policy you should consider the following:

- 1) Cost – Premiums should remain steady; examine deductibility and waiting period features; inflation rider,
- 2) Length and amount of coverage – 3 years, 5 years or lifetime,
- 3) Type of coverage may be actual costs coverage or indemnity coverage in which a fixed sum is paid regardless of costs once coverage is triggered,
- 4) Cover both at-home and nursing home care (probably want significant home care benefit, if possible as indemnity coverage),
- 5) Require as few activities of daily living as possible in order to trigger coverage,
- 6) No prior hospitalization should be required,
- 7) Days spent in hospital awaiting placement should be covered,
- 8) Guaranteed renewability of policy, and limitations on premium increases,
- 9) Waiver of premiums during period of claim,
- 10) Respite care coverage,
- 11) Flexibility in applying benefits so that insured may choose among a nursing home, assisted living, adult day care center, or care at home,
- 12) Stability of Insurance Company, i.e., that it has been in the long term care industry for a long time with a good claims payment history (rated A+ by Best insurance rating service or others), and
- 13) May want to work with an insurance agent who can issue insurance for several different companies.

## **How do Hybrid/Combination Long Term Care and life insurance policies work?**

Hybrid long term care and life insurance policies pay for services such as home care, assisted living room and board, and nursing home care services that are not covered by private health insurance or Medicare. These are policies that allow the owner to tap into their long term care insurance benefit if needed and/or provide a death benefit to their beneficiary if they do not eventually need long term care. Some combination policies provide a small death benefit no matter what, while others apply the portion of the benefit that has not been fully used to pay for long term care services as a benefit to your beneficiary upon your death.

## **Can I cancel a Hybrid/Combination Long Term Care and life insurance policy?**

There's a money-back guarantee with some combination policies. The insurance company will return your premium if you decide you don't want the policy after a certain period of time. Before then, you can get a percentage of the premium back. Please discuss your individual policy with your insurance professional.

## **What is partnership insurance also known as Robert Wood Johnson Long Term Care Insurance?**

New York State and several private insurance companies have entered into a joint venture to create a long term health care insurance product, which if purchased, would allow individuals with such insurance coverage to retain assets and still qualify for Medicaid after expiration of insurance coverage. This insurance is known as Robert Wood Johnson insurance or "Partnership Product" insurance.

## **Are there different kinds of Partnership Product Long Term Care Insurance?**

Yes. There is coverage referred to as “Total Asset Protection” coverage or coverage referred to as “Dollar for Dollar Asset Protection” coverage. Total Asset Protection coverage offers unlimited asset protection when the policyholder exhausts the policy benefits and applies for Medicaid. Dollar for Dollar Asset protection coverage allows policyholders to establish asset protection based on the amount of benefits paid from the policy at the time the policy benefits are exhausted and the application for Medicaid is made.

## **Is it preferable to purchase Partnership Product Long Term Care Insurance rather than regular private Long Term Care Insurance?**

It depends. Partnership Product insurance is not entirely portable in that it requires that you return to New York State in order to receive Medicaid coverage once the long term care insurance component has been exhausted. It also requires that your income be used toward the payment of the costs of your care (although your principal assets would remain protected). Ordinary private long term care insurance has no restrictions concerning geography, nor does it require that your income be used to pay for the custodial care after the insurance coverage period has lapsed, although Medicaid rules generally require it.

Determining which type of long term care insurance to purchase may be a function of age, as the older you get the more costly Partnership Product insurance tends to be due to the various requirements imposed by the State relative to regulation of this product. The decision may also be guided by whether or not the insured has significant retirement or other fixed income since this income would have to be paid to the long term care provider once the Medicaid component of the coverage becomes effective. However, Partnership Product insurance can be significantly less expensive for younger individuals and may, in certain circumstances, be the appropriate product of choice. Since Partnership Product coverage must be exhausted before Medicaid benefits may be obtained, it is important to consider whether the coverage provided will be sufficient to enable you to pay actual nursing home costs in your region.

## **PRESERVATION OF ASSETS/MEDICAID PLANNING**

### **What is Medicaid?**

Medicaid is a “needs based” government program established during President Johnson’s administration to pay for the medical costs of the indigent population. As health care costs (particularly long term care custodial costs), have outpaced the rate of inflation, the middle class and upper middle class have also looked to the Medicaid program to pay for skyrocketing long term care expenses.

On February 8, 2006, President Bush signed into law legislation, entitled the Deficit Reduction Act of 2005 (the “DRA”), which made significant modifications to the then existing Medicaid laws. In addition, in April 2006, New York State passed legislation adopting the DRA and making other modifications to the laws implementing Medicaid in New York for applications filed beginning in August 2006.

Where relevant, the changes to the Medicaid laws as a result of the federal DRA legislation and the recent New York State laws, as well as the possible effect of such changes on strategies for Medicaid qualification, are discussed in this section.

**Asset protection and Medicaid planning are very complicated areas of law, particularly as a result of the DRA and legislation in New York State. It is highly recommended that you see an elder law attorney and/or other qualified professional before developing an appropriate estate plan.**

## Can you retain assets and income and still qualify for Medicaid?

Yes, subject to very stringent statutory limitations. The asset and income criteria for qualification for nursing home and home care Medicaid differ as do the Medicaid qualification requirements for a married couple as compared to a single person. Such qualification criteria are adjusted for inflation annually and are set forth below. (Please note figures set forth below are for the year 2017 only).

### Medicaid in a Nursing Home

If **married**, the institutionalized spouse will qualify for Medicaid provided he or she has no more than \$14,850 in resources and \$50 per month of income, and provided that the Community Spouse (well spouse) does not have resources or income in addition to the following exemptions:

- 1) The family residence (no matter what the value) and provided the community spouse, or a minor or disabled child, resides there,
- 2) Between \$74,820 and \$120,900 of non-homestead assets,
- 3) \$3,022.50 of monthly income which may consist of the community spouse's income and income from institutionalized spouse if the community spouse's income is insufficient,
- 4) Automobile of any value,
- 5) Life insurance not exceeding \$1,500 in cash value, if designated as a burial fund,
- 6) Retirement assets except for required minimum distribution ("RMD"), which must be paid out in monthly installments, and
- 7) A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract plus additional \$1,500 to be deposited in a burial fund account.

**If single, a Medicaid applicant may only retain:**

- 1) A limited homestead exemption (potentially subject to a lien) if the institutionalized individual has subjective intent to remain home and provided equity value of residence does not exceed \$840,000,
- 2) \$14,850 of resources,
- 3) \$50 monthly income,
- 4) No automobile,
- 5) Life insurance not exceeding \$1,500 in cash value, if designated as a burial fund,
- 6) Retirement assets except for RMD which must be paid out in monthly installments, and
- 7) A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract, a deed to a grave or family plot, plus additional \$1,500 to be deposited in a burial fund account.

**Medicaid at Home**

**If married**, the spouse applying for Medicaid will qualify for Medicaid provided the married couple has no more than \$21,750 of joint resources and \$1,209 of monthly income although the Medicaid applicant spouse may have more income and still qualify for Medicaid subject to certain limitations (see below) and provided that the spouse not applying for Medicaid does not have resources or income in addition to the following:

- 1) Family residence of any value,
- 2) \$21,750 of joint resources,
- 3) \$1,209 per month of income, with an additional \$20 per month of unearned income,
- 4) Automobile,
- 5) Life insurance not exceeding \$1,500 cash value, if designated as a burial fund,
- 6) Retirement assets except for RMD, which must be paid out in monthly installments, and
- 7) A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract plus an additional \$1,500 to be deposited in a burial fund account.

If a married person is applying for **Managed Long Term Care services**, which is now required for most individuals in need of home care (see below), the Medicaid applicant spouse may retain \$384 in monthly income and the Community Spouse (well spouse) can retain \$3,022.50 in monthly income which may consist of the Community Spouse's income and income from spouse receiving Medicaid services if the Community Spouse's income is insufficient. In addition, the couple can retain the following resources:

- 1) The family residence (no matter what the value) and provided the Community Spouse, or a minor or disabled child resides there,
- 2) \$14,850 in resources for the applying spouse and between \$74,820 and \$120,900 of non-homestead assets for the community spouse,
- 3) Automobile of any value,
- 4) Life insurance not exceeding \$1,500 in cash value, if designated as a burial fund,
- 5) Retirement assets except for required minimum distribution ("RMD") which must be paid out in monthly installments and counted as income, and
- 6) A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract, a deed to a grave or family plot, plus an additional \$1,500 to be deposited in a burial fund account.

**If single, a Medicaid applicant may retain:**

- 1) Family residence of any value provided equity value of residence does not exceed \$840,000,
- 2) \$14,850 of resources,
- 3) \$825 per month of income, with an additional \$20 per month of unearned income,
- 4) Automobile,
- 5) Life insurance not exceeding \$1,500 cash value,
- 6) Retirement assets except for RMD, which must be paid out in monthly installments, and
- 7) A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract plus additional \$1,500 to be deposited in a burial fund account.



The New York State expansion of Medicaid in response to the Affordable Care Act includes coverage under Modified Adjusted Gross Income (MAGI) rules for persons under age 65. Coverage may be obtained for individuals with monthly income from 100% of federal poverty level, or \$996 in 2017, up to 223% of federal poverty level, or \$2,242, with no resource test. However, MAGI individuals cannot have surplus income.

### **Can an individual qualify for Medicaid even if his or her income exceeds Medicaid limits?**

Yes. Although individuals applying for community Medicaid (Home Care Services) must pay their income in excess of the Medicaid allowance towards their cost of care, they can, as an alternative, join a community pooled trust and then place their surplus income into their own trust sub-account. Since the trust assets are an exempt resource, the funds are then sheltered from a Medicaid “spend down”. Community pooled trusts are, by law, established and operated by a not-for-profit organization, and can only be used by disabled individuals; however, once the account is established, the funds can be used to pay for household bills in the name of the Medicaid applicant who is the trust beneficiary. In this way, Medicaid applicants may continue to use their income for their own benefit and still qualify for community Medicaid without a monthly spend down. Most trusts require a small monthly administrative fee and require that the funds be used for supplemental needs which include almost anything other than medical care, which is assumed to be covered by Medicaid. These trusts cannot be utilized by someone receiving nursing home Medicaid, and any funds remaining in a trust account after the beneficiary’s death are retained by the not-for-profit organization.

**Please see Appendix E for a more detailed illustration of the use of community pooled trusts.**

### **What is Managed Long Term Care?**

On Sept. 4, 2012, the federal Center for Medicare and Medicaid Services (CMS) approved a “1115 waiver” that allows New York State to require all dually eligible (for Medicare and Medicaid) adults now applying for or receiving long term care in the community to enroll in a Managed Long Term Care (MLTC) plan.

The MLTC provider will now control access to, approve, and pay for all Medicaid home care services and other long term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

Those already receiving Medicaid home care services will not have their level of care affected for 60 days after enrollment. After that, services may change, based on needs.

### **Who must enroll?**

People must enroll if applying for the following services:

Personal Care/Home Attendant, Consumer Directed Personal Assistance, Adult Day Care, Certified Home Health Aides, Private Duty Nursing. Nursing Home applicants will have to enroll in a managed care program in phases as that program is implemented.

### **Who is exempt?**

People applying for the following services are presently exempt, but may be required to enroll in the future:

Traumatic Brain Injury, Home and Community-Based Services, Nursing Home Transition and Diversion Waiver, Assisted Living Program, Intermediate Care Facilities for the Developmentally Disabled, and Hospice. Children under age 18 are exempt.

### **How do I enroll in a plan to receive home care services?**

In Westchester, new applicants for Medicaid home care must enroll in an MLTC program, which will perform the assessment to determine the level of services received. Once an applicant receives approval for Medicaid, he or she must first contact the New York Medicaid Choice Conflict-Free Evaluation and Enrollment Center (CFEEC) at 1-855-222-8350 to schedule an independent assessment to determine whether he or she is eligible for long term services. This evaluation will only determine whether the person is appropriate for any care. It does not establish the hours or levels of care.

Once the initial assessment is completed the person must enroll in a MLTC program. A list of programs serving New York State is included in Appendix F. The MLTC provider will perform a second assessment, which will determine what type of care the person can receive and how many hours of home care are medically necessary.

Persons already receiving services are being phased in over a period of time. Everyone is given the opportunity to choose an MLTC provider; however, if no choice is made, they will be auto-enrolled with a plan chosen by the coordinator.

### **Will Medicaid pay for Assisted Living?**

Assisted Living combines residential and home care services. Most facilities are designed as an alternative to nursing home placement for people who do not require daily supervision by skilled nurses. Assisted living residences provide services that may include housing, meals, housekeeping, supervision, personal care, case management and home health services. There are many different varieties of Assisted Living which range from places offering basic room and board to residences that are designed for people with special needs.

Certain residences are licensed by New York State as Assisted Living Program (ALP) residences. ALP's accept Medicaid as full payment for residency. Your Social Security and other income must be remitted to the ALP on a monthly basis up to the level set by New York State, and residents are entitled to keep a personal needs allowance. In addition, a community pooled trust may be used for surplus income in excess of the New York State level.\*

A number of Assisted Living residences are also licensed to provide enhanced care. Though Medicaid may not be available to pay for room and board, it may pay for home care and other community-based covered services in a non-Medicaid assisted living residence. Since there are many different types of residences which could call themselves "Assisted Living", you should always check with the admissions staff at the residence prior to signing any admission agreements.

\*A directory of Medicaid Assisted Living Program residences can be found at [www.health.ny.gov/facilities/assisted\\_living/licensed\\_programs.htm](http://www.health.ny.gov/facilities/assisted_living/licensed_programs.htm)

## **How many months of financial records must be submitted to the Department of Social Services for review with a Medicaid application?**

The DRA legislation states that up to sixty (60) months of financial records can be reviewed for nursing home Medicaid. This review period is referred to as a “lookback period”. If during the look back period, the Department of Social Services (“DSS”) discovers that an uncompensated transfer of assets (i.e., a gift) was made to a third party, DSS will apply a formula to determine how long an individual must wait before becoming eligible for nursing home Medicaid. Such waiting period is referred to as a “penalty period”.

## **May an individual transfer assets and still qualify for Medicaid and, if so, how is the “penalty period” calculated?**

### **For Home Care Medicaid**

Yes. Under the current law in New York State, gifts made during the lookback period for purposes of qualifying for home care (also referred to as community based) Medicaid are not subject to a penalty period, but rather an individual may qualify for home care Medicaid on the first day of the month after the gift is made provided that at the time of the filing of the Medicaid application the individual seeking home care Medicaid does not have more than \$14,850 (\$21,750 if the Medicaid Applicant is married) of resources nor more than \$825 of monthly income in his or her single name. To the extent the individual has income exceeding the \$825 monthly income limit, such excess must either be used to pay the home health care agency providing services or be paid to a pooled income charitable trust which trust can use such income to pay the ongoing household and other expenses of the homecare Medicaid applicant or to pay the premiums of a private health insurance plan.

### **For Nursing Home Medicaid**

Yes. There is, however, a penalty period resulting from a gift made when the donor of the gift will be applying for nursing home Medicaid. If applying for nursing home Medicaid during the applicable lookback period, most transfers of assets will result in a penalty period (i.e., delay in qualification for Medicaid) equal to one month for every \$12,198 transferred. Said amount of \$12,198 is fixed by New York State as the average monthly nursing home cost in Westchester County during the year 2017 and is revised annually. (The 2017 rate amount in New York City is \$12,157.)

Such penalty period is computed by taking the amount transferred during the lookback period and dividing such transferred sum by the regional rate New York State mandates as the average monthly nursing home cost in the area in which the donor of the gift resides (i.e., \$12,198 in Westchester or \$12,157 in New York City). The quotient of such formula is the penalty period in that it determines how many months an individual applying for nursing home Medicaid must wait until eligible.

By way of example, in Westchester County, New York State has fixed \$12,198 as the average monthly nursing home cost in 2017. Thus, if the donor gifted the sum of \$121,980 during the lookback period, such a transfer would result in a penalty period of ten months ( $\$121,980 \div \$12,198 = 10$  months). The determination of the commencement date of the penalty period is further discussed below.

### **When does the penalty period begin?**

The penalty period to receive nursing home Medicaid commences on the later of such date or “the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional care services based on a Medicaid application for such care but for the application of the penalty period”.

The legislation indicates that in order to start the penalty period running, all of the following must occur:

- 1) The Medicaid applicant must have less than \$14,850 in non-exempt resources; and
- 2) The Medicaid applicant must be in a nursing home or receiving home care benefits; and
- 3) The Medicaid applicant must have formally applied for Medicaid benefits.

Applying the current law to our example would have the following result. If the Medicaid applicant transferred the sum of \$121,980 in June 2013, and was admitted to a nursing home and also submitted a Medicaid application in June 2017, the lookback period (which extends back 60 months prior to the date of the application) would capture the transfer made 48 months before the date of the application and the resulting penalty period would cause the Medicaid applicant not to be eligible for Medicaid until May 2018. May 2018 becomes the Medicaid eligibility or

“pick- up” date because the commencement of the 10 month penalty period would start to run in July 2017 as that is the first month after the transfer in which the Medicaid applicant had: 1) no more than \$14,850 in his or her name, 2) entered the nursing home and 3) submitted the Medicaid application.

During the period from the date of filing the Medicaid application and entering the nursing home in June 2017 and until the expiration of the penalty period in May 2018, the Medicaid applicant would have to pay privately for his or her stay at the nursing home, using funds that he or she had previously gifted to others in June 2013.

Thus, in order to avoid the spenddown of previously transferred funds during the penalty period, it may be necessary for a Medicaid applicant to wait 5 years from the date of transfer until applying and becoming eligible for Medicaid.

Transfers of assets must be carefully calculated to assure that elderly individuals are not deprived of the funds they need to provide for their care during any resulting penalty period or Medicaid disqualification. No individual should transfer funds for Medicaid planning purposes without consulting with an experienced elder care attorney.

### **Can one spouse qualify for Medicaid even if the resources and/or income of the other spouse exceeds Medicaid limits?**

Yes, by the practice of “Spousal Refusal.” Current New York State law provides that Medicaid may not be denied to an ill spouse (the applicant spouse) even if the other spouse (the well spouse) has excess resources and/or income if the well spouse refuses to contribute such excess resources to the cost of the care of the ill spouse. In such a case, the refusing spouse must disclose the amount of assets in his or her possession and the applicant spouse must assign his or her obligation of support from the refusing spouse to the State of New York. Spousal Refusal may result in the State of New York or local Department of Social Services suing the refusing spouse for the support the State has expended on behalf of the applicant spouse. (However, the State can only sue the refusing spouse for services provided at the Medicaid rate which is often considerably less than the private pay rate which the refusing spouse would otherwise be paying).

## **Are there assets which can be transferred which will not cause a transfer penalty period delaying Medicaid qualification?**

Yes. The transfer of an asset is not subject to the Medicaid penalty period if:

- 1) The asset is transferred to the Community Spouse (however, a subsequent transfer by the Community Spouse may result in additional transfer penalties),
- 2) The asset is transferred to a blind or disabled child,
- 3) The asset was transferred to a trust established solely for the benefit of any disabled individual,
- 4) The asset is the Medicaid applicant's residence and the residence is transferred to a sibling of the Medicaid applicant with an equity interest in the house,
- 5) The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who is blind, disabled or less than 21 years of age, or
- 6) The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who has resided with and cared for the Medicaid applicant for two years prior to institutionalization, which care allowed the Medicaid applicant to remain at home ("Caretaker Child" exception).

## **Will ownership of retirement assets by the Medicaid applicant disqualify such individual from Medicaid eligibility?**

The answer is "NO" irrespective of the value of the retirement account provided that the retirement account (e.g., IRA, 401(k), 403b or other retirement plan) is in periodic payment status.

Thus, if the Medicaid applicant is taking his minimum distribution amount from his IRA or other retirement account on a monthly basis (as opposed to an annual basis), such retirement account will not be counted for Medicaid purposes and the Medicaid applicant can still qualify for Medicaid. However, although the principal portion of the retirement account is unavailable, the minimum distribution amount,

which is deemed to be an income stream, must still be paid to the nursing home or home health care agency or pooled income charitable trust while the Medicaid applicant is receiving Medicaid benefits.

In addition, the retirement account of the community spouse, no matter its value, is also an unavailable resource because it forms part of the community spouse resource allowance. The community spouse's retirement account need not be in periodic payment status and is still a fully unavailable resource even if the amount of the account exceeds the community spouse resource allowance.

### **Can a Medicaid applicant's home be protected upon entry into a nursing home?**

It is possible for the Medicaid applicant to sign a statement of intent to return home and the execution of such a statement will cause the residence to become an unavailable resource. However, if the Medicaid applicant enters a nursing home and becomes permanently absent from the premises, New York State, by its local County Department of Social Services, can place a lien on the premises, which lien could be satisfied out of the proceeds from the eventual sale of the residence. The payback of the lien is at the Medicaid rate rather than the private pay rate.

A Medicaid applicant's ownership of a residence with an equity interest in excess of \$840,000 will make that residence an available resource that cannot be sheltered by the execution of a statement of intent to return home. However, any residence, no matter its value, could still be protected if occupied by a spouse or minor or disabled child or if transferred to such individuals or to a caretaker child, or to a sibling with an equity interest as described above, or by encumbering the residence with a mortgage or other debt to reduce its equity interest below \$840,000.

### **What are the methods for transfers of assets?**

- 1) Outright gifts,
- 2) Life Estate Deed,
- 3) Transfers in Trust, and
- 4) Annuities, mortgages, promissory notes, personal service contracts.



## **What are the consequences of making an outright gift for Medicaid qualification purposes?**

You lose control of the asset by giving full control of the asset to another. In addition, depending upon the value of the asset, there may be gift tax considerations which must be evaluated. Finally, if you are transferring appreciated property (e.g., a residence or securities), the recipient of the property receives your original low cost tax basis, meaning that upon a subsequent sale of the property by the recipient, there may be a significant capital gains tax to pay.

## **What are the consequences of using a life estate deed for Medicaid qualification purposes?**

A transfer of real property subject to the transferor's retention of a "life interest" in the property may be an effective way of sheltering an asset for Medicaid qualification. If properly drawn, it avoids the applicability of the federal gift tax law. In addition, use of a life estate deed allows the transferor to shorten the transfer penalty period, since the value of the asset transferred does not include the actuarial value of the transferor's life interest in the property.

For example, a 75 year old Westchester resident transferring a \$300,000 property in July 2017 is only deemed to have transferred \$237,954 for Medicaid transfer purposes and thus would qualify for Medicaid in 19.5 months ( $\$237,954 \div \$12,198 = 19.5$  months) rather than the 24.6 month period that would have applied if an outright transfer had been made ( $\$300,000 \div \$12,198 = 24.59$  months).

In addition, if the property is not sold until after the death of the transferor, the remaindermen (i.e., the individuals referenced in the deed as receiving the property at the life tenant's death) will inherit the property at its fair market value as of the date of death. The appreciated property will have a higher cost basis (not the original purchase price cost basis) and should be able to be sold shortly after the transferor's death with negligible, if any, capital gains.

Selling the property during a transferor's lifetime may create unintended tax consequences and may trigger undesirable additional Medicaid eligibility problems.

If the property is sold during the transferor's lifetime there will be a capital gains tax due on any portion of the gain which relates to the remainder interest in the property as only the life interest is eligible for the \$250,000 per person lifetime capital gains exemption. In addition, if the sale occurs during the transferor's life, such a sale may cause significant asset exposure in that the portion of the sales proceeds allocable to the life estate interest must be returned to the life tenant and again becomes an exposed resource which would be subject to new lookback and penalty periods and then have to be retransferred in order to be protected, which further protection would only occur if such new lookback and penalty periods had expired before the need for Medicaid.

Thus, if using a life estate deed, there should be a commitment that the property not be sold during the life estate owner's lifetime.

The advantages of using a life estate to shorten the transfer penalty period is less important now that New York State has formally implemented the DRA legislation. The advantages are largely lost because the commencement of the Medicaid penalty period for all asset transfers which occur within the 60 month lookback period, including life estate transfers, commence when the Medicaid applicant first goes into a nursing home, applies for Medicaid and is otherwise eligible for benefits. Thus, a full five years has to elapse from the date of the transfer before a life estate transfer, like any other transfer, is not considered as a countable resource for Medicaid eligibility purposes.

However, it is still possible to do planning by having an individual purchase for value a life estate interest in the residence of another. If the purchaser of the life estate resides in such residence for at least a one year period following the date of purchase, then the funds used to purchase the life estate are an exempt resource and not countable when such individual applies for Medicaid. Thus, if a Medicaid Applicant is "over resourced" (i.e., has assets exceeding Medicaid eligibility limits) but uses such assets to purchase an interest in the residence of another and then resides in such residence for at least one year thereafter, they will obtain Medicaid eligibility in just one year's time which is far more quickly than if they had made a direct transfer of the excess assets to such individual which would then be subject to the five (5) year look back and penalty period computations previously mentioned.

## **What are the consequences of transferring assets to an Irrevocable Trust for purposes of Medicaid qualification?**

A properly drafted irrevocable trust will minimize gift and capital gains tax problems, whether the property is sold while the grantor is alive, or after the grantor's death, and allows the proceeds from the sale of property to remain in the trust and be protected. Generally, the income tax treatment of an irrevocable trust is the same as if the grantor of the trust had continued to own the asset in his or her individual name. An irrevocable trust also has the advantage of allowing the grantor to place a variety of assets, in addition to the real estate, into the ownership of the trust.

The irrevocable trust further allows the grantor to retain certain control of the assets contributed because the grantor can continue to receive the income generated by the trust assets and still protect the principal asset (i.e., corpus of the trust) and still qualify for Medicaid. (Of course, the principal assets contributed to the irrevocable trust cannot be directly returned to the grantor). In addition, by having the trust document retain for the grantor a "power of appointment", the grantor will be able to change the identity of the beneficiaries of the trust.

## **Will the S.T.A.R., Veteran's and/or Senior's Exemption still apply to real property transferred to an Irrevocable Trust?**

Yes, to the extent the grantor still retains a lifetime use and occupancy of the real property.

## **Can assets still be protected even after an individual has been admitted to a nursing home?**

Yes, under current law, it is possible to protect assets even after an individual has been admitted to a nursing home. The percentage of the assets that may be protected, however, will not be as significant as if advance planning had been done. Gifts made by the Medicaid applicant in exchange for an annuity, loans extended in return for a promissory note, or the establishment of a personal services contract where the Medicaid application enters into a formal contract with others (including family members) to have personal or financial care services performed are possible asset savings strategies which can be utilized even after entry to the nursing home. These strategies are further discussed herein.

## **Can the purchase of an annuity by the Medicaid applicant result in Medicaid qualification?**

Sums used to purchase an irrevocable and actuarially sound annuity may, in certain limited circumstances, serve to shelter assets for Medicaid qualification. However, under the DRA legislation, the State of New York must be named as a beneficiary of the annuity to reimburse the State for care it funded through Medicaid. Moreover, the income paid out by the annuity must be paid towards the cost of care or sheltered in a charitable pooled income trust. New York State does not need to be named a primary beneficiary if the Medicaid applicant has a spouse or minor or disabled child.

## **Can the making of a loan by a Medicaid applicant result in Medicaid eligibility?**

Loans, mortgages and promissory notes may be used in a similar manner to the use of an annuity and New York State does not have to be named as a beneficiary of the remainder. However, the loan, mortgage or note must be actuarially sound, non-negotiable and non-assignable, made in equal monthly installments over the term of the loan and cannot be cancelled because of the death of the lender meaning that the Medicaid applicant's estate may be responsible to pay back the State of New York for health services rendered to the Medicaid applicant.

## **An example of the use of an annuity or promissory note loan to protect assets for Medicaid eligibility is as follows:**

An 80 year old parent owns \$585,504 in assets. The parent gifts one-half of that amount (i.e., \$292,752) to the child causing a penalty period delaying eligibility for the parent to receive Medicaid for 24 months (i.e.,  $\$292,752 \div \$12,198$  regional rate = 24 months). The penalty period does not begin to run until the parent enters a nursing home, makes a Medicaid application and is otherwise eligible for Medicaid but for the gift which was made.

The parent uses the other \$292,752 to purchase an annuity or makes a loan for a term which cannot exceed her life expectancy (an 80 year old woman has life expectancy of 9.64 years or 115.68 months). Based on a loan or annuity term of 2 years

(i.e., equal to the 24 month penalty period) and an interest rate of 3.0%, payments of \$12,582.84 would have to be made on the annuity or loan to the parent which, in turn, would have to be paid to the nursing home for her care during said 24 month penalty period.

If the nursing home costs \$15,000 per month privately and parent has Social Security and pension of \$2,000 per month and the annuity or promissory note is producing \$12,582.84 per month, then the parent has monthly income of \$14,582.84 to pay toward the \$15,000 per month nursing home cost leaving a shortfall of \$417.16 per month which could be paid from the \$292,752 gifted to the child which over the 24 month penalty period would reduce said gift of \$292,752 by \$10,011.84 ( $\$417.16 \times 24$  months).

Once the 24 month penalty period has expired, the parent is on Medicaid and no further payments from the child of the gifted funds are required. Thus, parent has safely transferred to child \$273,504.10 (i.e.,  $\$585,504 - \$301,988.06$  promissory note payments including interest -  $\$10,011.84 = \$273,504.10$ ) in order to qualify for Medicaid.

In addition, if the parent dies prior to expiration of an annuity, the balance of the annuity first must be used to pay back Medicaid expended by New York State as primary beneficiary, at the Medicaid rate, but the balance, if any could be paid to the child as secondary beneficiary. Similarly, if the parent dies prior to expiration of promissory note, the estate of the parent, as owner of the note, must first pay back Medicaid before distributing further to the surviving family. However, with a promissory note, generally, no Medicaid will have been paid because of the penalty period.

An asset preservation instrument called the Grantor Retained Annuity Trust (GRAT) has been used in New York with mixed results. A GRAT is similar to a private annuity and provides for the Trustee to make periodic payments back to the Grantor, similar to the promissory note and annuities described above. It has been used with some success in several parts of the state; however, there was a 2007 case where the entire trust was determined to be available to pay for nursing home care. In 2008, the State Department of Health determined that, since a GRAT was a trust, it could be invaded to the extent that any or all of it could be used for health care costs. Use of a GRAT in connection with Medicaid planning should only be undertaken under the supervision of an elder law attorney thoroughly familiar with the current treatment of GRATs in the Medicaid applicant's county.

## **Can a personal services contract be used to obtain Medicaid benefits?**

Existing law has held that payment for personal or financial services pursuant to a written personal services contract is not a transfer of assets. To be recognized, such care agreements must be in writing, must be prospective in nature and the compensation must be reasonable. Such contracts can pay a lump sum to the service provider for anticipated services to be provided over the actuarial life of the Medicaid applicant. Family members can certainly be the providers of such services. Good recordkeeping, with payments being made “on the books” as income taxable to the recipient with appropriate deductions for worker’s compensation, etc. should be kept.

### **An example of the use of a personal services contract for Medicaid eligibility is as follows:**

Daughter/Caregiver works full time and assists her 80 year old mother who has an actuarial life expectancy of 9.64 years. Daughter provides to her mother five (5) hours per week of financial and health care management at the rate of \$30 per hour, and ten (10) hours per week of personal care at the rate of \$25. In this example, the caregiver earns \$150 per week or \$7,800 annually for financial and health care management services and \$250 per week or \$13,000 per year for personal care services. For the 9.64 years of the estimated life of the contract, \$75,192 represents the value of the contract’s managerial component and \$125,320 represents the value of the contract’s personal service component. The entire contract is valued at \$200,512.

NYSDOH has indicated that a personal services contract will be considered a transfer of assets unless it provides for a return of prepaid funds if the caregiver is unable to continue services or if the Medicaid recipient dies before his or her calculated life expectancy.

Also, the same directive, issued in 2007, states that no credit will be given for services that are provided as part of the Nursing Home rate. This makes it very difficult to use a personal services contract for a nursing home resident.

However, a personal services contract can properly be used while a person is residing at home and can provide for compensation to family members who are acting as caregivers. Caregivers should also be aware that amounts received from a personal services contract are subject to income tax.

## Can Medicaid take my assets after I die?

If you received Medicaid during your lifetime, a claim may be made against your estate for the amount of benefits you received after age 55. If your estate is greater than the total of benefits received, Medicaid's total recovery is limited to the amount of benefits provided; on the other hand, if your estate is less than the total of benefits received, the claim is limited to the funds in your estate. Funeral expenses, taxes, administrative expenses of the estate, including legal fees, and commissions earned by the estate fiduciary could all be paid first, and will reduce the amount available to pay this claim.

In addition, recovery is deferred, but not exempted, if there is a surviving spouse, a blind or disabled child of any age, or child under age twenty-one. If the sole asset of the estate is a homestead, Medicaid recovery is also deferred if the home is occupied by a "caretaker" child who resided in the home for two years prior to the institutionalization of the decedent or a sibling of the decedent who resided in the home for at least one year prior to the institutionalization of the decedent.

Estate claims are limited to probate assets, and do not include jointly-held bank and investment accounts, retained life estates created in property, and/or jointly-held real estate.

In the case of a spouse who has refused to provide support (as discussed), a claim may be made against that spouse's estate to the extent that the refusing spouse had assets over the Medicaid allowance when benefits were being provided.

**Information and documentation concerning the Medicaid applicant and his or her spouse must be gathered together and accompany the submission of a Medicaid Application. A checklist detailing the information required to complete the Medicaid application and a sample Medicaid application is set forth as Appendix G and Appendix H, respectively, in this booklet.**

## ELDER ABUSE

This chapter was written for *Elder Law Q & A: An Introduction to Aging Issues and Planning for the Future* by the Harry and Jeanette Elder Abuse Prevention at the Hebrew Home at Riverdale.

### What is elder abuse?

According to a 2016 report issued by the Centers for Disease Control<sup>†</sup>, elder abuse is an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.

<sup>†</sup>Hall, JE, Karch, DL, Crosby, AE. *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements For Use In Elder Abuse Surveillance, Version 1.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016.

### What are some common forms of elder abuse?

Physical abuse, psychological and emotional abuse, sexual abuse and economic or financial exploitation are all forms of elder abuse. Abuse may be subtle; even inaction can sometimes be abusive. Abuse is generally a pattern repeated over time, and is rarely a one-time occurrence. It is important for older adults to know their legal rights to prevent or stop abuse.

It is estimated that one out of ten Americans over sixty living in the community has experienced some form of elder abuse. In New York State, only one in twenty four cases of elder abuse is reported to social services or law enforcement professionals.

### Who is the typical abuser?

Among reported cases, a family member, including adult children and spouses, was often the abuser.

While any family member could be abusive or neglectful, adult children are the most common perpetrators. Abusers often live with the parent they are mistreating and frequently depend on that parent financially and emotionally. Other abusive family members may be spouses, adult grandchildren or other relatives, such as nieces, nephews, cousins, stepchildren or step-grandchildren or siblings. While there is no “typical” abuser profile, many abusers often have drug addictions, substance abuse problems, serious and untreated mental health issues and a past history of violence.



Abusers can also be trusted professionals. In a 2011 study by the MetLife Mature Market Institute\*, they found that a large percentage of elder financial abuse cases involved close associates of the victim – families, friends, caregivers and neighbors – as the perpetrator of the abuse, accounting collectively for 34% of the reported cases. Exploitation within the business sector, coupled with Medicare and Medicaid fraud, accounted for a combined 16% of reported cases. The MetLife study estimated that \$2.9 billion was taken from seniors, while a more recent Senior Vulnerability Survey\*\* estimated a much higher figure – over \$30 billion.

\*The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation and Predation against America’s Elders, June 2011

\*\*The True Link Report on Elder Financial Abuse 2015

## What are some instances of Elder Abuse and neglect?

Every elder abuse situation has its own unique and distinct set of circumstances.  
Some examples of abuse are:

A son, in order to punish his 76 year old father, takes his dentures to limit what he can eat.

- **Physical Abuse** is the intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object or weapon), hitting, beating, scratching, biting, choking, suffocation, pushing, shoving, shaking, slapping, kicking, stomping, pinching, and burning. In addition, inappropriate use of medications and physical restraints, pinning in place, arm twisting, hair pulling, force-feeding, and physical punishment of any kind also are examples of physical abuse.

A daughter intentionally isolates her 67 year old mother from friends and family by keeping her from having any visitors or leaving the home.

- **Psychological and Emotional Abuse** is verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress, that is perpetrated by a caregiver or other person who stands in a trust relationship to the elder. May include any of the following: humiliation/disrespect, threats, harassment and isolation/coercive control.

A nephew makes demeaning remarks about his 85 year old aunt's intimate body parts.

- **Sexual abuse** is forced and/or unwanted sexual interaction of any kind with an older adult. This includes non-contact acts of a sexual nature such as forcing a victim to view pornographic materials, photographing an elder for sexual gratification, voyeurism and verbal or behavioral sexual harassment.

A granddaughter uses the power of attorney she has gotten for her 90 year old grandfather to take \$1,000 from his checking account to buy herself a new diamond ring without her grandfather's permission or knowledge.

- **Financial Abuse or Exploitation** is the illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual. This includes, but is not limited to, depriving an older individual of rightful access to, information about, or use of personal benefits, resources, belongings, or assets.

A sister, knowing that her 75 year old brother is unable to care for himself and angry at the burden placed on her, often is too busy and fails to give her brother his medicine.

- **Neglect** is failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety.

### What should I do if I suspect elder abuse?

- If an emergency, call 911
- Talk to someone you trust
- Get help from a social service agency
- Call an Elder Law attorney
- Go to Court

## **If an emergency, call 911**

In an emergency situation, call 911 and get immediate help. In a non-emergency, contact your local police department or another community resource listed below. Many police departments now have community police officers and domestic violence officers specially trained in dealing with abusive situations who can arrange for regular wellness checks and connect the older adult to other community resources.

## **Talk to someone you trust**

If the mistreatment is kept a secret and nothing is done, chances are the abuse or neglect will worsen. No matter what happened in the past, it is never acceptable for someone to hurt or mistreat an older person. Speaking up about the abuse increases the likelihood of finding someone who can help provide workable and desirable alternatives. A safety plan should be developed to fit the particular circumstances of each victim.

## **Whom do I contact to report elder abuse in Westchester County?**

- Adult Protective Services – (914) 995-2259
- Westchester Department of Senior Programs and Services – (914) 813-6436
- Victims Assistance Services – (914) 345-9111 or (914) 345-3113
- Westchester District Attorney’s Office (Elder Abuse Unit) – (914) 995-3414
- Pace Women’s Justice Center – (914) 287-0739
- Westchester County Office for Women Helpline – (914) 995-5972

## **For Professionals Only**

- The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale (800) 56-SENIOR (567-3646)

## National Resources

### **United States Department of Justice Elder Justice Initiative.**

[elderjustice.gov](http://elderjustice.gov)

The mission of the Elder Justice Initiative is to support and coordinate the Department's enforcement and programmatic efforts to combat elder abuse, neglect and financial fraud and scams that target our nation's seniors. The website is a comprehensive resource for both professionals and community members about national initiatives and local resources.

### **National Committee for the Prevention of Elder Abuse.**

Phone: (202) 682-4140; [www.preventelderabuse.org](http://www.preventelderabuse.org)

A comprehensive website for information about elder abuse, including how to report abuse, what services are available to stop abuse, and how to find those services in your community.

### **National Center on Elder Abuse.**

Phone: (855) 500-3537; <https://ncea.acl.gov>

This site provides guidance on responding to elder abuse – who to call if abuse is suspected, what to expect, prevention methods, and what can be done to stop elder abuse. Website includes a listing of statewide toll free telephone numbers to call to report elder abuse.

## Call an Elder Law Attorney

An elder law attorney can help with obtaining a guardianship for the personal needs and property management of an older person, provide advice on the older person's legal rights and available remedies, or even help set up a financial plan or financial instruments to preserve/protect the older person's assets. One way to contact an elder law attorney is through references from friends, family or trusted acquaintances.

Online resources may also aid in the search for an elder law attorney:  
<http://lawyers.findlaw.com/lawyer/practicestate/Elder-Law/New-York>

<http://www.seniorlaw.com/elder-law-attorneys-on-the-web/>

## Legal Interventions

Older adults can take action to stop the abuse by obtaining a Family Court Civil Order of Protection against an abuser. In New York State, Family Court has jurisdiction where the parties are or have been married to, have a child in common, are or were in an intimate (can be non-sexual) relationship or are related to by blood or marriage. A civil lawyer can help discuss this option.

**If abuse is financial**, there are additional avenues of assistance to pursue.

Some examples of financial exploitation are where an older person is being pressured to: sign a document that he or she doesn't understand, distribute his or her money or belongings to someone he or she did not choose, add an unwanted name to his or her deed, give up control of his or her personal business or health care decisions, change his or her will, or add an unwanted beneficiary to his or her Will or pension accounts. It is important to be aware of the risks of joint bank accounts and credit card accounts, co-signing a loan or designating someone as power of attorney. Some organizations and resources that can provide counseling or assistance for cases of financial exploitation include:

- Westchester County Department of Consumer Protection (Consumer Assistance)  
(914) 995-2155; [westchestergov.com/consumer](http://westchestergov.com/consumer)
- Community Capital New York  
(914) 747-8020; <https://communitycapitalny.org>
- New York State Office of the Attorney General  
(914) 422-8755; [ag.ny.gov](http://ag.ny.gov)
- Go Direct (for direct deposit of Social Security checks)  
(800) 333-1795; [www.GoDirect.org](http://www.GoDirect.org)
- Women's Institute for a Secure Retirement  
[wiserwomen.org](http://wiserwomen.org)

## **The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale (a program of RiverSpring Health)**

Established in 2005, the Weinberg Center is the nation's first shelter for elder abuse victims, serving eligible individuals 60 years and older. The Weinberg Center provides short-term housing, comprehensive healthcare, legal advocacy and therapeutic services.

### **Intervention**

Professional referrals provide prompt access to the Weinberg Center team for consultation and assessment to determine shelter eligibility. Once admitted, each client receives individualized and comprehensive coordinated care provided by the Hebrew Home's medical and professional staff.

The Weinberg Center's multidisciplinary team develops a holistic and trauma informed action plan based on each client's particular circumstances and goals. Civil legal services are a cornerstone of our work, and can include obtaining Orders of Protection, representing clients in Housing Court or advocating in a guardianship proceeding.

### **Outreach and Training**

The Weinberg Center offers a wide range of training and community outreach programs to increase professional and public awareness about the signs and symptoms of elder abuse and neglect. If you are interested in setting up a training or community outreach program, please call (718) 581-1472.

### **National Model**

The Weinberg Center continues to foster replications of the shelter model around the country. The SPRiNG Alliance (Shelter Partners: Regional, National, Global.) is a network of elder abuse shelters with close working relationships, shared expertise, common standards of excellence and a vibrant community of support. Learn more at [spring-alliance.org](http://spring-alliance.org).

## Assessment

The Weinberg Center has developed an elder abuse assessment tool to screen for at-risk and abused older adults. The screen is available to all long-term care facilities, community-based social workers, health care agencies and other programs serving older adults. If you are interested in learning more about our screen, please call (718) 581-1472.

## Community Partnerships

The Weinberg Center coordinates Westchester County's Multidisciplinary Team on Elder Abuse, a group of professionals who meet monthly to strategize, develop action plans and coordinate services around complex cases of elder abuse. Since its inception in 2012, the team has addressed over a hundred complex cases of elder abuse. For more information, or to make a professional referral to the team, contact the team coordinator at [malya.levin@gmail.com](mailto:malya.levin@gmail.com).

## **COLLABORATIVE PARTNERS**

The Center works closely with other agencies concerned with the welfare of older adults

Brookdale Center for Healthy Aging and  
Longevity David Berg Center for Law and Aging

HELP Clinic  
(Helping Elders through Litigation and Policy)

Jewish Association for Services for the Aged (JASA)

New York City Adult Protective Services

New York City Council

New York City Elder Abuse Center

New York City Department for the Aging

New York City Mayor’s Office to Combat  
Domestic Violence

New York-Presbyterian Hospital/  
Weill Cornell Medical Center,  
Division of Geriatrics and Gerontology

New York State Attorney General’s Office

New York State Consumer Protection Board

New York University, College of Nursing

Office of the District Attorney, Bronx, Kings,  
New York, Queens & Westchester Counties

Pace Women’s Justice Center

Westchester County Department of Senior  
Programs and Services

Westchester County Protective Services for Adults

Westchester Public/Private Partnership for  
Aging Services

## **WITH THE GENEROUS SUPPORT OF:**

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Starr Foundation



## SERVICES FOR OLDER ADULTS

As we age, we face transitions and challenges. Most of the time, we weather what comes our way without any difficulty. Sometimes, we can benefit from support and counseling. At these times, we are often unsure where to go. We hope this section will provide you, or those you care about, with information and guidance.

Individuals may find that they can get anxious, have feelings of sadness and face losses, and can be stressed about daily events and changes. When older adults face difficulties that interfere with day to day activities, it is best to reach out for help. If you are an older adult or a person that is caring for an older adult, you should be aware that changes in your physical and/or emotional health could trigger symptoms related to anxiety, depression, or other mental disorders.

### Difficulties we may face

**Depression** is one of the most common mental illnesses that affects older adults. Although depression is not a part of normal aging, in older adults it causes distress, suffering and leads to impairments in physical, mental, and social functioning. Depression affects approximately 15 out of every 100 adults over age 65 in the United States. Depression is characterized by persistent feelings of sadness, hopelessness, worthlessness, and loss of interest in activities lasting two weeks or longer. A change in mood can be accompanied by changes in sleep, appetite, energy, memory problems, confusion, withdrawal from social situations, and irritability. Depression often interferes with the person's ability to complete everyday tasks over a prolonged period of time.

The recognition of depression in the elderly can be challenging because many older adults have physical illnesses that trigger or co-exist with depression. Some of these conditions include heart disease, stroke, chronic lung disease, arthritis, Alzheimer's disease, cancer, and Parkinson's disease. Life events such as the loss of a loved one, retirement, and/or a lack of a supportive social network can trigger depression. Often individuals miss the opportunity to seek help because they assume the symptoms are "expected". However, in reality these symptoms should not be expected and compromise your quality of life. Untreated depression does not go away and leads to increased doctor visits, hospitalizations, isolation, and mortality.

## **What are some signs that I may be depressed?**

If you are experiencing feelings of exhaustion, helplessness, hopelessness, and changes in mood or interest in things you usually enjoy, you may be depressed. It is important for you to seek guidance from someone who can help decide what you need. It is difficult to take any action to help yourself when depressed. Negative thinking and low mood are part of the depression and can keep individuals from seeking help. As you begin treatment, these feelings will go away.

## **What if I am uncomfortable talking to my doctor?**

If you are uncomfortable talking with your doctor, there are other health care professionals to talk with. Time pressures resulting from insurance guidelines make it difficult for your doctor to adequately assess and diagnose your emotional and mental health needs. Other health professionals such as a social worker/case manager, counselor, psychologist, advanced practice nurse, geriatric psychiatrist, or a mental health counselor who specializes in this area are available to help you identify the appropriate care.

## **Is there any treatment for depression or other mental health disorders?**

There are several options available to help individuals reduce their pain and suffering caused by the symptoms of depression and other mental health disorders. These treatments include medications and psychotherapy (talk therapy). Your doctor may start your treatment with medication to address the depression on a biological level. It may take some trial and error to find the right dosage that works for you. Do not be discouraged during this period. In addition to medication, your doctor or mental health provider may recommend that you participate in psychotherapy. In a safe environment, psychotherapy will often help you to cope with your feelings and help change some of the patterns in your life that may contribute to the illness.

## What are some of the barriers to seeking treatment?

People who are experiencing symptoms of depression or anxiety worry about how they will be perceived if other family members or friends find out they have this diagnosis. Feelings of shame and self-doubt can result in the person isolating themselves from others. Often the fear of being treated differently causes individuals to delay seeking treatment, or even talking to others. Another common misconception is that insurance will not cover the cost of treatment. In fact, most insurance companies will adequately cover the cost of both medication and a variety of treatment modalities. In addition, lack of accessibility to the mental health treatment facility is another barrier to treatment.

**If you are experiencing symptoms of depression or anxiety, remember to contact your doctor or a mental health professional. Options for help from professionals who specialize in working with older adults are listed below.**

### **Weill Cornell Institute of Geriatric Psychiatry/New York Presbyterian Hospital** *(across from The Westchester Mall)*

Since 1994 the Weill Cornell Institute of Geriatric Psychiatry in White Plains has been the center for state of the art care for older adults with depression. We provide psychotherapy and medication services through participation in research programs. All of our studies seek to produce and share knowledge and programs that reduce the burden of depression and disability in older adults, many of whom have limited access to good care. Eligible individuals who participate in our studies receive free transportation and free treatment with talk therapy or FDA-approved medication. All studies provide treatment and we seek to promote excellence in care for older adults with depression. In addition, we can provide psychotherapy services to older adults.

For a free screening for depression or more information, please contact the Weill Cornell Institute of Geriatric Psychiatry at (914) 997-4331.

<http://psychiatry.weill.cornell.edu/weill-cornell-institute-geriatric-psychiatry>

## Family Services of Westchester, Inc. (FSW)

FSW is a private, non-profit, mental health and social service organization serving Westchester County since 1954. FSW has more than 55 years' experience providing licensed mental health services to older adults. In addition to geriatric mental health services, FSW offers a comprehensive range of both community-based and residential Elder Services to help Westchester's older residents maintain their highest possible level of independence in the community. A broad variety of services are provided to meet the needs of older adults and enhance their quality of life at whatever level they are functioning.

To schedule an appointment or consultation, please call the main number at 914-937-2320.

For information regarding Geriatric Mental Health Services:

<http://www.fsw.org/our-programs/older-adults/geriatric-mental-health>

## Westchester Jewish Community Services (WJCS)

The Geriatric Mental Health Service at WJCS provides specialized counseling services to older adults, fifty five and over, and their families utilizing a variety of modalities, including individual, family and group treatments, psychiatric assessment and medication monitoring. Evidenced based practices, including cognitive behavioral therapy and problem solving treatment, address issues of aging, loss, disability, and changes in the family that can trigger anxiety and depression. Older adults recovering after discharge from psychiatric hospitalization also receive continuing treatment in an outpatient setting through our Service.

For more information or to apply for our services, contact Ellie Einzig, LCSWR, Coordinator, (914) 949-7699, ext. 329.

## **Phelps Memorial Hospital Center**

Phelps Memorial Hospital Center has 238-beds and is a not-for-profit, acute care community hospital in Westchester County. Through their Senior Health and Internal Medicine Practice, The Phelps Memorial Hospital Center offers adult and geriatric primary care, including memory loss and depression screenings. The hospital also has an outpatient service called the Phelps Counseling Service that provides assessments, treatment, and support groups run by board certified psychiatrists, nurse practitioners and Licensed Clinical Social Workers.

To schedule an evaluation, please call (914) 366-3677.

<https://phelpshospital.org/clinical-services/senior-health-internal-medicine/>

## **St. Vincent's Hospital Westchester**

St. Vincent's Hospital in Westchester is one of the largest providers of mental health counseling in the Westchester area. The Geriatric Inpatient Program at St. Vincent's Hospital offers a therapeutic environment for older adults aimed at promoting safety, mental health and physical well-being for adults suffering from psychiatric disorders.

To schedule an evaluation or refer a client, please call the Evaluation and Referral Service at (914) 925-5320.

<http://www.stvincentswestchester.org/outpatient-programs/geriatric-services>

## Human Development Services of Westchester

Human Development Services of Westchester, Inc. (HDSW) serves adults throughout Westchester County recovering from behavioral health and complex medical conditions, through a combination of inter-related programs. The Care Management Program assists clients to maintain their stability in the community, to access and coordinate treatment and recovery services, enrich their support system, prevent crises, and meet emergency service needs. The Residential Program includes transitional congregate residences and treatment apartments, and supportive housing in permanent, independent apartments throughout Westchester chosen by our clients. Recovery Services: HOPE House, located in Port Chester, a day program with many opportunities to pursue employment, education, social engagement, peer support, and community participation. Also, The Living Room: A Day Respite Service, HDSW's newest recovery service, an alternative to hospital emergency departments for individuals in emotional or situational crisis and who have a prior history of using behavioral health services.

Please call Andrea Kocsis, LCSW, Chief Executive Officer,  
at (914) 835-8906, ext. 1012.

[www.hdsw.org](http://www.hdsw.org)

## What other organizations provide support?

Dorot is a private not for profit, culturally Jewish non-sectarian organization. We are considered an intergenerational agency dedicated to enhancing the lives of homebound and socially isolated elderly population. With the help of our free Friendly Visiting program, volunteers in the community visit with the senior for one hour a week for socialization. DOROT enables older people to maintain their independence and live in dignity in their own homes for as long as possible.

Please call Patricia Cipora Harte at (914) 573-8906 for more information on our other programs and services.

*Prepared with the assistance of the Westchester Geriatric Mental Health Collaborative, an alliance of independent professionals joined to promote awareness of mental health issues and to provide advocacy for greater access to services for seniors.*



The Westchester Public/Private Partnership for Aging Services (the “Partnership”) is a not for profit organization founded in 1991 and, as its name implies, is a joint venture between Westchester County, the public partner, and the Westchester business community, voluntary service agencies and consumers, the private partners. The private partners work with the Westchester Department of Senior Programs and Services to develop resources and provide substantial services to advance and protect the rights of seniors. The Partnership’s mission is to help seniors age with independence and dignity in their home communities.

The Partnership recruits corporations to contribute unrestricted funds, underwrite specific programs or donate in-kind services that expand needed services to the elderly. To this end, the Partnership has raised more than 3 million dollars to date to enrich the quality of life for older adults and their families.

Throughout the years, the Partnership has committed its resources to supporting many issues, including improving community-based long term care options; preventing elder abuse, and intervening when it is found; and offering caregivers information and respite. As part of its mandate for educating the public on legal issues affecting the elderly, the Partnership was and continues to be one of the organizations that has underwritten the cost for the publication and printing of this Q & A.

Some of the other recent accomplishments of the Partnership include:

- 1) Establishing the Telehealth Intervention Program for Seniors (“TIPS”) which delivers remote patient monitoring targeting low income older adults with high health risks.
- 2) Advancing the Livable Communities initiative by funding comprehensive analysis of the institutions, public facilities, land use, transportation options and environmental factors in all 43 municipalities in Westchester County to enable seniors to grow old in their homes and remain vital members of their neighborhoods.

- 3) Developing an Ambassadors For Successful Aging Navigation Program to connect Seniors to services to enhance their independence in the community
- 4) Promoting the Westchester Alliance which is a coalition which works with local colleges and universities to educate college aged residents about the issues affecting the elderly and to find ways to incorporate this information into academic course offerings.
- 5) Sponsoring Senior Law Day programs throughout Westchester County, chaired by attorneys, accountants, financial planners and geriatric social workers to educate seniors and caregivers about legal, financial and healthcare issues affecting the elderly and their families.
- 6) Creating the Caregiver Coaching Program, having garnered special recognition from the AARP, trains volunteers to provide one-on-one support to assist caregivers in making more informed decisions.
- 7) Initiating the SMART program which is a model intergenerational literacy program that recruits and trains older adult volunteers from the community to read with and mentor children in public schools throughout Westchester County.
- 8) Developing MAP: My Aging Plan which is a step-by-step guide on how to age successfully starting in your 20's and following through to your 80's and beyond.
- 9) Continuing the New York Southern Area Aging Network or "NY-SANN" initiative, which is a consortium of government and senior service providers representing 2.2 million older adults residing in southern New York State comprising New York City, Long Island and the Hudson Valley. These geographic areas represent 69% of the State's older adult population. The NY-SANN Consortium will examine strategies to alleviate the serious workforce shortage for senior services in this region.
- 10) Providing funding for safe centers for "at-risk" seniors who have been neglected, threatened or physically or sexually abused. These safe centers have provided assistance and information to thousands of seniors and caregivers.



- 11) Initiating the long term care insurance education and outreach program dedicated to informing and educating the general public about long term care insurance. This program has furnished information to 4,200 businesses as well as sponsored presentations which have reached over 3,000 individual seniors.
- 12) Supporting programs for Health and Wellness, educating grandparents raising grandchildren, funding transportation of seniors to volunteer assignments, and promoting intergenerational literacy programs.

Notwithstanding the impressive private membership of its Board – currently chaired by Judy Fink, Director of Geriatric Services at Westchester Jewish Community Services – the Partnership could never have completed its many accomplishments without the support of its public partner, the Westchester County Department of Senior Programs and Services. This agency is led by its extraordinary Commissioner, Mae Carpenter, the founder of the Partnership in 1990. Commissioner Carpenter has taken a leadership position, on a national scale, to develop an agenda to address issues affecting the senior community in Westchester County and across the Country.

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Appendix A  
Health Care Proxy

# Health Care Proxy

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## *Appointing Your Health Care Agent in New York State*

*The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent’s decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.*

# About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

# Frequently Asked Questions

## **Why should I choose a health care agent?**

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

## **Who can be a health care agent?**

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

## **How do I appoint a health care agent?**

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

## **When would my health care agent begin to make health care decisions for me?**

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

## **What decisions can my health care agent make?**

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

## **Why do I need to appoint a health care agent if I'm young and healthy?**

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

## **How will my health care agent make decisions?**

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

## **How will my health care agent know my wishes?**

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care

## Frequently Asked Questions, *continued*

agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

### **Can my health care agent overrule my wishes or prior treatment instructions?**

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

### **Who will pay attention to my agent?**

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

### **What if my health care agent is not available when decisions must be made?**

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

### **What if I change my mind?**

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

### **Can my health care agent be legally liable for decisions made on my behalf?**

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

### **Is a Health Care Proxy the same as a living will?**

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

### **Where should I keep my Health Care Proxy form after it is signed?**

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe

## Frequently Asked Questions, *continued*

deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

### **May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?**

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

**Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

### **Can my health care agent make decisions for me about organ and/or tissue donation?**

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

### **Who can consent to a donation if I choose not to state my wishes at this time?**

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; or a guardian appointed by a court prior to the donor's death.

# Health Care Proxy Form Instructions

## Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

## Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

## Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

## Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

*If I become terminally ill, I do/don't want to receive the following types of treatments....*

*If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....*

*If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....*

*I have discussed with my agent my wishes about \_\_\_\_\_ and I want my agent to make all decisions about these measures.*

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

## Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

## Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

## Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.



# Health Care Proxy

**(1) I,** \_\_\_\_\_  
hereby appoint \_\_\_\_\_  
*(name, home address and telephone number)*

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*as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.*

**(2) Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint \_\_\_\_\_  
*(name, home address and telephone number)*

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*as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.*

**(3)** Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):* \_\_\_\_\_

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**(4) Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):* \_\_\_\_\_

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In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

**(5) Your Identification** *(please print)*

Your Name \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Your Address \_\_\_\_\_

**(6) Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of:  
(check any that apply)

- Any needed organs and/or tissues
- The following organs and/or tissues \_\_\_\_\_

Limitations \_\_\_\_\_

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**(7) Statement by Witnesses** *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date \_\_\_\_\_ Date \_\_\_\_\_

Name of Witness 1 *(print)* \_\_\_\_\_ Name of Witness 2 *(print)* \_\_\_\_\_

Signature \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

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Appendix B  
New York Living Will

APPENDIX B

**NEW YORK LIVING WILL**

I, \_\_\_\_\_, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician and other medical personnel to withhold or withdraw treatment that serves only to prolong the process of dying if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am: a) in a terminal condition; b) permanently unconscious; or c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. While I understand that I am not legally required to be specific about future treatments; if I am in the condition(s) described above, I feel especially strong about the following forms of treatment.

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want tube feeding.
- I do not want antibiotics.
- I do want maximum pain relief.

Other instructions (insert personal instructions):

These directions express my legal right to refuse treatment under the laws of the State of New York. Unless I have revoked this instrument or otherwise clearly and explicitly indicated that I have changed my mind, it is my unequivocal intent that my instructions as set forth in this document be faithfully carried out.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

**Statement By Witnesses (Must be 18 or Older)**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

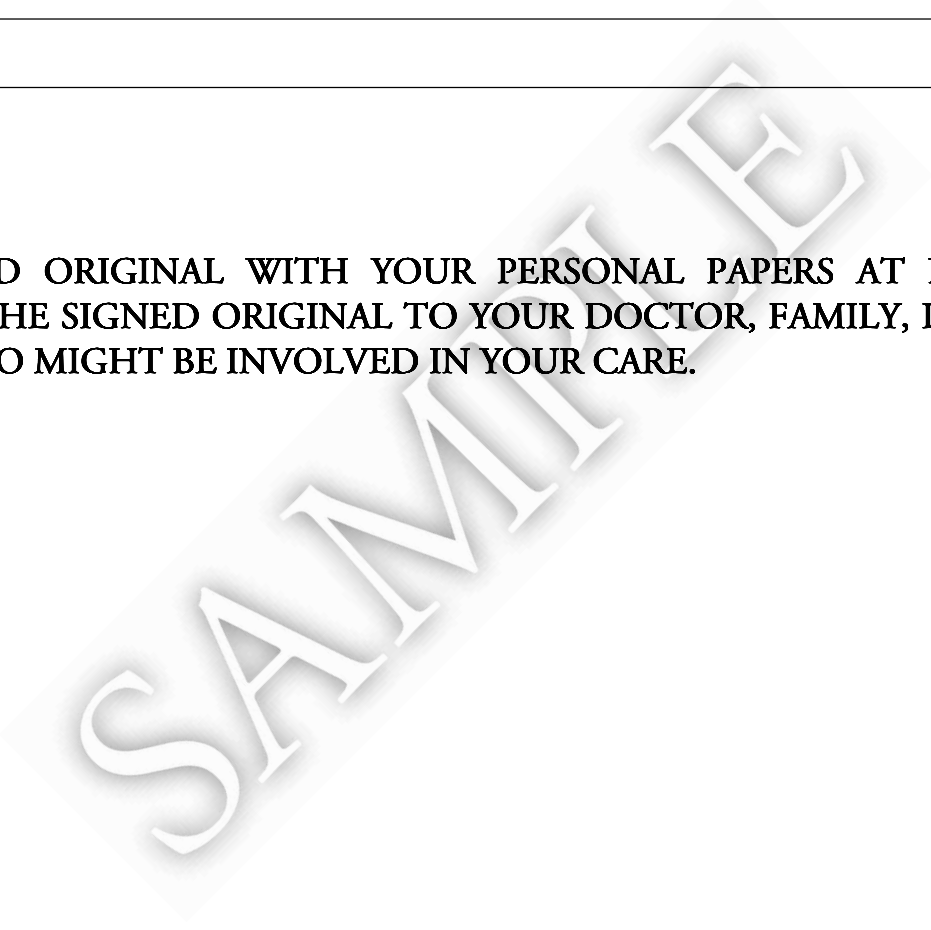
Witness: \_\_\_\_\_

Address: \_\_\_\_\_

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

**KEEP SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS AT HOME. GIVE COPIES OF THE SIGNED ORIGINAL TO YOUR DOCTOR, FAMILY, LAWYER AND OTHERS WHO MIGHT BE INVOLVED IN YOUR CARE.**



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**Appendix C**  
**MOLST**  
Medical Orders for Life-Sustaining Treatment

**THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.**

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY)

Male  Female

eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

**Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)**

This is a medical order form that tells others the patient’s wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient’s current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

**MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:**

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

**If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.**

**SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing**

Check *one*:

**CPR Order: Attempt Cardio-Pulmonary Resuscitation**

CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

**DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**

This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

**SECTION B Consent for Resuscitation Instructions (Section A)**

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

\_\_\_\_\_  
SIGNATURE  Check if verbal consent (Leave signature line blank) \_\_\_\_\_  
DATE/TIME

\_\_\_\_\_  
PRINT NAME OF DECISION-MAKER

\_\_\_\_\_  
PRINT FIRST WITNESS NAME

\_\_\_\_\_  
PRINT SECOND WITNESS NAME

**Who made the decision?**  Patient  Health Care Agent  Public Health Law Surrogate  Minor’s Parent/Guardian  §1750-b Surrogate

**SECTION C Physician Signature for Sections A and B**

\_\_\_\_\_  
PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

\_\_\_\_\_  
PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

**SECTION D Advance Directives**

Check all advance directives known to have been completed:

- Health Care Proxy  Living Will  Organ Donation  Documentation of Oral Advance Directive

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT \_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_

**SECTION E**

**Orders For Other Life-Sustaining Treatment and Future Hospitalization  
When the Patient has a Pulse and the Patient is Breathing**

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

**Treatment Guidelines** No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

- Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- No limitations on medical interventions** The patient will receive all needed treatments.

**Instructions for Intubation and Mechanical Ventilation** *Check one:*

- Do not intubate (DNI)** Do not place a tube down the patient’s throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should **not** be checked if full CPR is checked in Section A.)
- A trial period** *Check one or both:*
  - Intubation and mechanical ventilation**
  - Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**
- Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient’s throat and connect to a breathing machine as long as it is medically needed.

**Future Hospitalization/Transfer** *Check one:*

- Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- Send to the hospital, if necessary, based on MOLST orders.**

**Artificially Administered Fluids and Nutrition** When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. *Check one each for feeding tube and IV fluids:*

- No feeding tube**
- A trial period of feeding tube**
- Long-term feeding tube, if needed**
- No IV fluids**
- A trial period of IV fluids**

**Antibiotics** *Check one:*

- Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- Determine use or limitation of antibiotics when infection occurs.**
- Use antibiotics** to treat infections, if medically indicated.

**Other Instructions** about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, etc.).

**Consent for Life-Sustaining Treatment Orders (Section E)** (Same as Section B, which is the consent for Section A)

\_\_\_\_\_  
SIGNATURE  Check if verbal consent (Leave signature line blank) \_\_\_\_\_ DATE/TIME

PRINT NAME OF DECISION-MAKER \_\_\_\_\_

PRINT FIRST WITNESS NAME \_\_\_\_\_

PRINT SECOND WITNESS NAME \_\_\_\_\_

**Who made the decision?**  Patient  Health Care Agent  Based on clear and convincing evidence of patient’s wishes  
 Public Health Law Surrogate  Minor’s Parent/Guardian  §1750-b Surrogate

**Physician Signature for Section E**

\_\_\_\_\_  
PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME



LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT \_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_

**SECTION F** Review and Renewal of MOLST Orders on This MOLST Form

The physician must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
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			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT \_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_

**SECTION F**

**Review and Renewal of MOLST Orders on This MOLST Form** *Continued from Page 3*

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form

## General Instructions for the Legal Requirements Checklists for Adult Patients and Glossary

The MOLST form is a medical order form that tells others the patient's medical orders for life-sustaining treatment. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders, and changes them.

MOLST is generally for patients with serious health conditions. Physicians should consider consulting with the patient about completing a MOLST form if the patient:

- Wants to avoid or receive life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

**These instructions and checklists are intended to assist health care professionals in completing the MOLST form with adult patients and/or the patients' authorized health care decision-makers. They are NOT intended for use with minor patients, or patients with developmental disabilities who lack medical decision-making capacity, or patients with mental illness in a mental hygiene facility.**

### General Instructions

The MOLST form must be completed based on the patient's current medical condition, values, wishes, and these MOLST instructions. Completion of the MOLST begins with a conversation or a series of conversations between the patient, the health care agent or the surrogate, and a qualified, trained health care professional that defines the patient's goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed medical decision-making. The conversation should be documented in the medical record. The patient or other medical decision-maker must consent to the MOLST orders, with the exception of patients covered by Checklist #4 (for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law surrogate).

Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician must always, at a minimum: (i) confer with the patient and/or the patient's health care agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

Completion of both the first and second pages of the MOLST form is strongly encouraged. However, the patient or decision-maker (i.e., a health care agent or surrogate) may not be physically or emotionally prepared to reach a decision concerning every treatment option on the form in a single meeting. Completion of only page 1 of the MOLST form (concerning CPR/DNR) is permissible, and page 2 (Section E) may be completed at a later time. If a patient or decision-maker can reach a decision on one or more treatment options, but not others, on page 2, the physician may cross out the portion of the form with the treatment option(s) for which there is no decision and write "Decision Deferred" next to those treatment option(s). If the patient or decision-maker reaches a decision concerning that treatment option(s) at a later time, a new form must be completed and signed by a physician, indicating all of the patient's or decision-maker's decisions.

Verbal orders are acceptable with a follow-up signature by a NYS licensed physician or a border state physician in accordance with facility/community policy. Verbal orders must be authenticated within 48 hours under Medicare and Medicaid hospital conditions of participation.

Printing the form on bright "pulsar" pink, heavy stock paper is strongly encouraged. When EMS personnel respond to an emergency call in the community, they are trained to check whether the patient has a pink MOLST form before initiating life-sustaining treatment. They might not notice a MOLST form on plain white paper. However, white MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**MOLST orders completed in accordance with New York law remain valid when the patient transitions from one health care setting to another. Non-hospital DNR orders must be reviewed by a physician at least every 90 days. In addition, all MOLST orders must be reviewed consistent with facility policy and when the patient transitions between care settings, when there is a major change in health status, and when the patient or other health care decision-maker changes his/her mind about treatment.**

Decision-making standards, procedures and statutory witness requirements for decisions to withhold or withdraw life-sustaining treatment, including DNR, vary depending on who makes the decision and where the decision is made. Accordingly, there are different checklists for different types of decision-makers and settings.

**Please note: There are 5 different checklists for adult patients:**

**Checklist #1** - Adult patients with medical decision-making capacity (any setting)

**Checklist #2** - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

**Checklist #3** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

**Checklist #4** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the list is available

**Checklist #5** - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community

Choose the correct checklist. Then, complete the clinical steps and legal requirements based on who makes the decision and the setting.

The checklists can be found on the Department of Health's website at:  
[http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/).

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## Review and Renewal of MOLST Orders

The physician must review the MOLST form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

If the patient lacks capacity to make health care decisions, the Health Care Agent or Surrogate may request a change in the MOLST and must be consulted about any changes recommended by the patient's health care provider when any of the above circumstances arise.

**DNR/Allow Natural Death orders:** Public Health Law requires the physician to review non-hospital DNR orders and record the review at least **every 90 Days**. In hospitals and nursing homes, MOLST orders must be reviewed regularly in accordance with facility policies.

**Life-Sustaining Treatment orders:** The patient's medical condition, prognosis, values, wishes and goals for his/her care may change over time. The physician should review these orders at the same time as DNR/Allow Natural Death orders are reviewed and the review is recorded.

Review all medical orders in Sections A through E of the MOLST form.

Document the outcome of the review in Section F

- If there is no change in the patient's health status, medical decision-making capacity or preferences, sign, date and check the "No Change" box.
- If there is a substantial change in patient's health status, medical decision-making capacity, goals for care or preferences that results in a change in MOLST orders, write "VOID" in large letters on pages 1 and 2, and complete a new form, in accordance with NYS Public Health Law decision-making standards and procedures. Check box marked "FORM VOIDED, new form completed". (RETAIN voided MOLST form in chart, medical record, or electronic registry as required by law.)

- If this form is voided and no new form is completed, full treatment and resuscitation will be provided, unless a different decision is made by the patient, surrogate or health care agent. Write “VOID” in large letters on pages 1 and 2 and check box marked “FORM VOIDED, no new form.” (RETAIN voided MOLST form in chart, medical record, or electronic registry as required by law.)

For more information about the MOLST Program, view the Department of Health’s website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/) and the Compassion and Support website, Professionals section and the MOLST Training Center at [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org).

## Glossary

“Adult” means any person 18 or older or any person who has married.

“Clear and convincing evidence” is evidence that the patient held a firm and settled commitment to the withholding of life-sustaining treatment in the event of circumstances like the patient’s current medical condition. The evidence may be in a written living will, and/or previous oral statements indicating the patient’s wishes, considering the circumstances under which such statements were made and to whom. In order to decide whether the evidence of the patient’s wishes is clear and convincing, consideration should be given to:

- whether the statements were general or specific;
- whether the statements were about specific circumstances (for example, terminal illness, persistent vegetative state) that are similar to the patient’s current medical condition;
- the intensity, frequency, consistency, and seriousness of such statements;
- whether the statements tended to show that the patient held a firm and settled commitment to certain treatment decisions under circumstances like those presented;
- whether the strength and durability of the patient's religious and moral beliefs make a more recent change of heart unlikely; and
- whether the statements were made to one person only or to more than one person close to the patient.

“Close friend” is any person 18 or older who is a friend or relative of the patient. This person must have maintained regular contact with the patient; be familiar with the patient’s activities, health, and religious or moral beliefs; and present a signed statement to that effect to the attending doctor.

“Community” means not in a hospital or nursing home.

“Domestic partner” means a person who:

- has entered into a formal domestic partnership recognized by a local, state or national government; or
- has registered as a domestic partner with a registry maintained by the government or an employer; or
- is covered as a domestic partner under the same employment benefits or health insurance; or
- shares a mutual intent to be a domestic partner with the patient, considering all the facts and circumstances, such as:
  - They live together.
  - They depend on each other for support.
  - They share ownership (or a lease) of their home or other property.
  - They share income or expenses.
  - They are raising children together.
  - They plan on getting married or becoming formal domestic partners.
  - They have been together for a long time.

The following may not be a “domestic partner:”

- A parent, grandparent, child, grandchild, brother, sister, uncle, aunt, nephew or niece of the patient or the patient’s spouse.
- A person who is younger than 18.

“Health or social service practitioner” means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the Education Law and acting within his or her scope of practice. A health or social service practitioner who determines that a patient lacks medical decision-making capacity must be competent to do so, based on his/her experience and training.

“Hospital” means a general hospital as defined in subdivision ten of section twenty-eight hundred one of the Public Health Law, excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the New York State Office of Mental Health; or a hospice as defined in Public Health Law Article 40, without regard to where the hospice care is provided.

“Life-sustaining treatment” means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty. Cardiopulmonary resuscitation (CPR) is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

“Mental hygiene facility” means, for purposes of these checklists, a facility operated or licensed by the Office of Mental Health (OMH) or the Office for People With Developmental Disabilities (OPWDD) as defined in subdivision six of section 1.03 of the Mental Hygiene Law; i.e., any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution or

building, except that in the case of a hospital as defined in article 28 of the Public Health Law it shall mean only a ward, wing, unit, or part thereof which is operated for the purpose of providing services for the mentally disabled. A mental hygiene facility also includes a community residence operated by or subject to licensure by OMH or OPWDD (MHL § 1.03 (28)).

“Nursing home” means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of the Public Health Law.

“Physician” means a licensed physician.

“Qualified psychiatrist” means a physician licensed to practice medicine in New York State, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

“Reasonably available” means that a person to be contacted, can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital or nursing home.



**MOLST LEGAL REQUIREMENTS CHECKLIST FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**

\_\_\_\_\_  
LAST NAME/FIRST NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
ADDRESS

**Note:** Actual orders should be placed on the MOLST form with this completed checklist attached. Use of this checklist is required for individuals with developmental disabilities (DD) who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life sustaining treatment (LST) for individuals with DD who lack capacity and do not have a health care proxy must comply with the process set forth in the Health Care Decisions Act for persons with MR (HCDA) [SCPA § 1750-b (4)]. Effective June 1, 2010, this includes the issuance of DNR orders.

**Step 1** – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

- \_\_\_\_\_ a. 17-A guardian \_\_\_\_\_
- \_\_\_\_\_ b. actively involved spouse \_\_\_\_\_
- \_\_\_\_\_ c. actively involved parent \_\_\_\_\_
- \_\_\_\_\_ d. actively involved adult child \_\_\_\_\_
- \_\_\_\_\_ e. actively involved adult sibling \_\_\_\_\_
- \_\_\_\_\_ f. actively involved family member \_\_\_\_\_
- \_\_\_\_\_ g. Willowbrook CAB (full representation)
- \_\_\_\_\_ h. Surrogate Decision Making Committee (MHL Article 80)

**Step 2** – 1750-b surrogate has a conversation or a series of conversations with the treating physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withhold or withdraw LST, either orally or in writing.

**Specify the LST that is requested to be withdrawn or withheld:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Decision made orally

\_\_\_\_\_  
Witness – Attending Physician

\_\_\_\_\_  
Second Witness

\_\_\_\_\_ Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician).

\_\_\_\_\_  
LAST NAME/FIRST NAME

\_\_\_\_\_  
DATE OF BIRTH

**Step 3** – Confirm individual’s lack of capacity to make health care decisions. Either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a DDSO; or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.

\_\_\_\_\_  
Attending Physician

\_\_\_\_\_  
Concurring Physician or Licensed Psychologist

**Step 4**– Determination of Necessary Medical Criteria.

We have determined to a reasonable degree of medical certainty that **both** of the following conditions are met:

(1) the individual has one of the following medical conditions:

- \_\_\_\_\_ a. a terminal condition; (briefly describe \_\_\_\_\_  
\_\_\_\_\_) ); or
- \_\_\_\_\_ b. permanent unconsciousness; or
- \_\_\_\_\_ c. a medical condition other than DD which requires LST, is irreversible and which will continue indefinitely (briefly describe \_\_\_\_\_  
\_\_\_\_\_)

**AND**

(2) the LST would impose an extraordinary burden on the individual in light of:

- \_\_\_\_\_ a. the person’s medical condition other than DD (briefly explain \_\_\_\_\_  
\_\_\_\_\_ ) and
- \_\_\_\_\_ b. the expected outcome of the LST, notwithstanding the person’s DD (briefly explain \_\_\_\_\_  
\_\_\_\_\_ )

If the 1750-b surrogate has requested that artificially provided nutrition or hydration be withdrawn or withheld, one of the following additional factors must also be met:

- \_\_\_\_\_ a. there is no reasonable hope of maintaining life (explain \_\_\_\_\_  
\_\_\_\_\_ ); or
- \_\_\_\_\_ b. the artificially provided nutrition or hydration poses an extraordinary burden (explain \_\_\_\_\_  
\_\_\_\_\_ ).

\_\_\_\_\_  
Attending Physician

\_\_\_\_\_  
Concurring Physician

\_\_\_\_\_  
LAST NAME/FIRST NAME

\_\_\_\_\_  
DATE OF BIRTH

**Step 5 – Notifications.** At least 48 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time prior to a decision to withhold LST, the attending physician must notify the following parties:

\_\_\_\_\_ the person with DD, unless therapeutic exception applies  
notified on \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ if the person is in or was transferred from an OPWDD residential facility

\_\_\_\_\_ Facility Director notified on \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ MHLS notified on \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ if the person is not in and was not transferred from an OPWDD residential facility

\_\_\_\_\_ the director of the local DDSO notified on \_\_\_/\_\_\_/\_\_\_

**Step 6 -** I certify that the 1750-b process has been complied with, the appropriate parties have been notified and no objection to the surrogate’s decision remains unresolved.

\_\_\_\_\_  
Attending Physician

\_\_\_\_\_  
Date

**Note: The MOLST form may ONLY be completed with the 1750-b surrogate after all 6 steps on this checklist have been completed.**

## Checklist #1 Adult Patients with Medical Decision-Making Capacity (Any Setting)

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. \_\_\_

Step 2: Check all advance directives known to have been completed.

\_\_\_ Health Care Proxy \_\_\_ Living Will \_\_\_ Organ Donation \_\_\_ Documentation of Oral Advance Directive

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.

*Any patient should be counseled to complete a health care proxy, if he/she has not already completed one.*

Document the result of patient counseling, if applicable. ***Check one.***

\_\_\_ Patient retains the capacity to choose a health care agent and completes a health care proxy.

\_\_\_ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.

Step 4: Determine the patient's medical decision-making capacity. ***Check one.***

\_\_\_ Patient has the ability to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

(If the patient lacks medical decision-making capacity, go to Step 7 and select the appropriate checklist)

Step 5: Identify the decision-maker.

\_\_\_ Patient is the decision-maker

Step 6: Document where the MOLST form is being completed. ***Check one.***

\_\_\_ Hospital (see Glossary for definition)

\_\_\_ Nursing Home (see Glossary for definition)

\_\_\_ Community (see Glossary for definition)

Step 7: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. ***Check one:***

This is Checklist # 1 (for patients who have medical decision-making capacity). If this is the appropriate checklist, proceed to Step 8 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/).

\_\_\_ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

\_\_\_ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

- \_\_\_ Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)
- \_\_\_ Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available
- \_\_\_ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

**Step 8: Discuss goals for care with the patient.** \_\_\_

**Step 9: Patient has given informed consent.**

- \_\_\_ Patient has been fully informed about his or her medical condition and the risks, benefits and burdens of, and alternatives to, possible life-sustaining treatment. Patient has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.

**Step 10: Witness requirements are met. Check one:**

Two witnesses are always recommended. The physician who signs the orders may be a witness. To document that the attending physician witnessed the consent, the attending physician just needs to sign the order and print his/her name as a witness. Witness signatures are not required -- printing the witnesses' names is sufficient.

- \_\_\_ Patient consented in writing.
- \_\_\_ Patient is in a hospital or nursing home, the patient consented verbally, and two witnesses 18 years of age or older (at least one of whom is a health or social services practitioner affiliated with the hospital or nursing home) witnessed the consent.
- \_\_\_ Patient is in the community, patient consented verbally, and the attending physician witnessed the consent.

**Step 11: Physician signature**

- \_\_\_ The attending physician signed the MOLST form.

**Step 12: Notify director of correctional facility.**

- \_\_\_ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician has notified the director of the correctional facility of the determination that the inmate has medical decision-making capacity and that the inmate has MOLST orders.

## **Checklist #2 Adult Patients Without Medical Decision-Making Capacity who Have a Health Care Proxy (Any Setting)**

A health care agent may make medical decisions on behalf of a patient, after two physicians concur that the patient lacks medical decision-making capacity. Health care agents are generally authorized to make decisions as if they were the patient. However, sometimes the patient's health care proxy limits the authority of the health care agent.

Health care agents are required to make decisions according to the patient's wishes, including the patient's religious and moral beliefs. If the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, the health care agent may make decisions according to the patient's best interests, except a decision to withhold or withdraw artificial nutrition or hydration. Health care agents are authorized to make a decision to withhold or withdraw artificial nutrition or hydration only if they know the patient's wishes regarding the administration of artificial nutrition and hydration.

**Complete each step and check the appropriate lines as indicated.**

**Step 1: Assess health status and prognosis.** \_\_\_

**Step 2: Check all advance directives known to have been completed.**

\_\_\_ Health Care Proxy \_\_\_ Living Will \_\_\_ Organ Donation \_\_\_ Documentation of Oral Advance Directive

**Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.**

*A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.*

Document the result of patient counseling, if applicable. ***Check one:***

- \_\_\_ Patient retains the capacity to choose a health care agent and completes a health care proxy.
- \_\_\_ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
- \_\_\_ Patient lacks capacity to choose a health care agent.

If there is no health care proxy, and patient chooses not to complete one or lacks capacity to do so, go to Step 8 and select the appropriate checklist. If there is a health care proxy, proceed to Step 4.

**Step 4: Determine the patient's medical decision-making capacity. *Check appropriate line(s) under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for adults with medical decision-making capacity.):***

**(A) Attending Physician Determination *Check both:***

- \_\_\_ The attending physician has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.
- \_\_\_ The determination contains the attending physician's opinion regarding the cause and nature of the patient's incapacity as well as its extent and probable duration. The determination is documented in the patient's medical record.

**(B) Assessment for Mental Illness or Developmental Disability and Concurring Physician Determination *Check (i), (ii) or (iii) and all line(s) underneath:***

- \_\_\_ (i) The attending physician has determined that the patient's lack of medical decision-making capacity is *not due* to mental illness or a developmental disability; and
  - \_\_\_ A concurring physician confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.
- \_\_\_ (ii) The attending physician has determined that the lack of medical decision-making capacity is *due* to mental illness (this does not include dementia); and ***Check both:***
  - \_\_\_ A concurring physician confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.
  - \_\_\_ One of the two physicians who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.
- \_\_\_ (iii) The attending physician has determined that the lack of medical decision-making capacity is *due* to a developmental disability; and ***Check both:***
  - \_\_\_ A concurring physician or clinical psychologist confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.
  - \_\_\_ The concurring physician or clinical psychologist is employed by a Developmental Disabilities Services Office (DDSO), or has been employed for a minimum of two years to render care and service in a facility operated or licensed by the Office for People With Developmental Disabilities, or has specialized training and two years' experience treating persons with developmental disabilities or has three years' experience treating persons with developmental disabilities. The determination by the concurring physician or clinical psychologist is documented in the medical record.

**Step 5: Notify the patient *Check one:***

- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient, orally and in writing (the patient may be able to comprehend such notice).
- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend such notice.

**Step 6: Identify the decision-maker:**

- \_\_\_ The health care agent is the decision-maker.

**Step 7: Document where the MOLST form is being completed. *Check one:***

- \_\_\_ Hospital (see Glossary for definition)
- \_\_\_ Nursing Home (see Glossary for definition)
- \_\_\_ Community (see Glossary for definition)

**Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:***

This is Checklist # 2 (for adults without medical decision-making capacity who have a health care proxy). If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/)

- \_\_\_ **Checklist #1** - Adult patients with medical decision-making capacity (any setting)

- \_\_\_ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- \_\_\_ Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)
- \_\_\_ Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available
- \_\_\_ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

**Step 9: Discuss goals for care with the health care agent.** \_\_\_

**Step 10: Health care agent has given informed consent.**

- \_\_\_ ○ Health care agent has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.
- \_\_\_ ○ Health care agent has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.
- \_\_\_ ○ If health care agent is consenting to withholding or withdrawing artificial nutrition or hydration, health care agent knows the patient's wishes regarding the administration of artificial nutrition and hydration (this may be presumed if the health care proxy states that the health care agent knows the patient's wishes regarding the administration of artificial nutrition and hydration).

**Step 11: Witness requirements are met. Check one:**

Two witnesses are always recommended. The physician who signs the orders may be a witness. To document that the attending physician has witnessed the consent, the attending physician just needs to sign the order and print his/her name as a witness. Witness signatures are not required -- printing the witnesses' names is sufficient.

- \_\_\_ Health care agent has consented in writing.
- \_\_\_ Patient is in a hospital or nursing home, the health care agent consented verbally, and two witnesses 18 years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital or nursing home, have witnessed the consent.
- \_\_\_ Patient is in the community, health care agent has consented verbally and the attending physician has witnessed the consent.

**Step 12: Physician signature**

- \_\_\_ The attending physician has signed the MOLST form.

**Step 13: Notify director of correctional facility.**

- \_\_\_ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and that the inmate has MOLST orders.



### **Checklist #3: Adult Hospital or Nursing Home Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and Decision-Maker is Public Health Law Surrogate (Surrogate selected from the surrogate list)**

Under the Family Health Care Decisions Act, a surrogate selected from the surrogate list can make any kind of medical decision in a hospital or nursing home, after the attending physician and another health or social services practitioner at the facility concur that the patient lacks capacity. For decisions to withhold or withdraw life-sustaining treatment, specific clinical criteria must be satisfied. Sometimes, the facility's ethics review committee must agree.

**Complete each step and check the appropriate lines as indicated.**

**Step 1: Assess health status and prognosis.** \_\_\_

**Step 2: Check all advance directives known to have been completed.**

\_\_\_ Health Care Proxy \_\_\_ Living Will \_\_\_ Organ Donation \_\_\_ Documentation of Oral Advance Directive  
(If there is a health care proxy, and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy.)

**Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.**

*A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.*

Document the result of patient counseling. **Check one**

- \_\_\_ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy).
- \_\_\_ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
- \_\_\_ Patient lacks capacity to choose a health care agent.

**Step 4: Determine the patient's medical decision-making capacity. Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity):**

**(A) Attending Physician Determination Check both:**

- \_\_\_ The attending physician has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.
- \_\_\_ The determination contains the attending physician's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

**(B) Assessment for Mental Illness and Concurring Determination Check (i) or (ii) and all line(s) underneath:**

- \_\_\_ (i) The attending physician has determined that the patient's lack of medical decision-making capacity is **not due** to mental illness; and
  - \_\_\_ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the

likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

\_\_\_ (ii) The attending physician has determined that the lack of medical decision-making capacity *is due* to mental illness (this does not include dementia); and ***Check both:***

\_\_\_ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

\_\_\_ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

### **Step 5: Notify the patient. *Check one:***

\_\_\_ Notice of the determination that the patient lacks medical decision-making capacity and that a surrogate will make medical decisions on his/her behalf has been given to the patient (the patient may be able to comprehend such notice).

\_\_\_ Notice of the determination that the patient lacks medical decision-making capacity and that a surrogate will make decisions on his/her behalf has not been given to the patient because there is no indication of the patient's ability to comprehend the information.

### **Step 6: Identify and notify the appropriate Public Health Law surrogate. *Check both:***

\_\_\_ The attending physician has identified a person **from the class highest in priority** who is reasonably available, willing, and competent to serve as a surrogate decision-maker. Such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects. ***Check one:***

\_\_\_ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81

\_\_\_ b. Patient's spouse, if not legally separated from the patient, or the domestic partner

\_\_\_ c. Patient's son or daughter, age 18 or older

\_\_\_ d. Patient's parent

\_\_\_ e. Patient's brother or sister, age 18 or older

\_\_\_ f. Patient's actively involved close friend, age 18 or older

\_\_\_ The attending physician has notified at least one person on the surrogate list who is highest in order of priority, and who is reasonably available, that he/she will make medical decisions because the patient has been determined to lack medical decision-making capacity.

### **Step 7: Document where the MOLST form is being completed. *Check one:***

\_\_\_ Hospital (see Glossary for definition)

\_\_\_ Nursing Home (see Glossary for definition)

### **Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:***

This is Checklist # 3 (for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and whose decision-maker is a Public Health Law surrogate). If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, find and complete the correct checklist. All checklists can be found on the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/)

- \_\_\_ Checklist #1 - Adult patients with medical decision-making capacity (any setting)
- \_\_\_ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- \_\_\_ Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)
- \_\_\_ Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available
- \_\_\_ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

**Step 9: Discuss goals for care with the Public Health Law surrogate.** \_\_\_

**Step 10: Surrogate has given informed consent. Check all:**

- \_\_\_ Surrogate has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.
- \_\_\_ Surrogate has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.
- \_\_\_ Surrogate's decision is *patient-centered*, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The surrogate's assessment is based on the patient's wishes and best interests, not the surrogate's, and includes consideration of:
  - the dignity and uniqueness of every person;
  - the possibility and extent of preserving the patient's life;
  - the preservation, improvement or restoration of the patient's health or functioning;
  - the relief of the patient's suffering; and
  - any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

**Step 11: If the decision is to withhold or withdraw life sustaining treatment, the surrogate's decision complies with the following clinical standards, as determined by the physician, with independent physician concurrence and, where applicable, by an ethics review committee. Check (i) and/or (ii) and (iii) and any applicable lines underneath:**

- \_\_\_ (i) Treatment would be an extraordinary burden to the patient, **and** an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,
  - the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
  - the patient is permanently unconscious.
- \_\_\_ (ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances; **and** the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accordance with accepted medical standards.

- **Special requirements for declining artificial nutrition and hydration in a hospital over the attending physician’s objection, and for certain life sustaining treatments in a nursing home, based on “irreversible or incurable condition” (clinical standard (ii) above)** *Note – These requirements do not apply to a decision for a patient in hospice or to a decision to withhold or withdraw life-sustaining treatment under clinical standard (i) above (death is expected within 6 months with or without treatment, or patient is permanently unconscious):*
  - In a hospital (other than a hospice), when the medical order involves the withdrawal or withholding of nutrition or hydration provided by means of medical treatment, and the attending physician objects to the order, the ethics review committee (including a physician who is not directly responsible for the patient’s care) or an appropriate court has determined that the medical order meets the patient-centered and clinical standards.
  - In a nursing home, for MOLST orders other than a DNR order, the ethics review committee, (including at least one physician who is not directly responsible for the patient's care) or an appropriate court has determined that the orders meet the patient-centered and clinical standards described above.
- (iii) The concurring physician’s determination is documented in the medical record.

**Step 12: Witness requirements are met. Check one:**

Two witnesses are always recommended. The physician who signs the orders may be a witness. To document that the attending physician witnessed the consent, the attending physician signs the order and prints his/her name as a witness. Witness signatures are not required -- printing the witnesses' names is sufficient.

- The surrogate consented in writing.
- The surrogate consented verbally, and the attending physician witnessed the consent.

**Step 13: If the surrogate is a close friend, verify the age and relationship with the patient.**

- The surrogate is 18 or older and has signed a statement that he or she is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs. A copy of the signed statement is in the medical record.

**Step 14: Physician signature**

- The attending physician signed the MOLST form.

**Step 15: Notify director of mental hygiene facility and Mental Hygiene Legal Services (MHLS).**

- For patients who are residents in, or are transferred from, a mental hygiene facility, the attending physician has notified the director of the facility and MHLS of the determination that the resident lacks medical decision-making capacity and that the resident has MOLST orders.

**Step 16: Notify director of correctional facility.**

- For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and that the inmate has MOLST orders.

## **Checklist #4 Adult Hospital or Nursing Home Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy and for Whom No Surrogate From the Surrogate List is Available**

Under the Family Health Care Decisions Act, life-sustaining treatment may be withheld from a patient in a hospital or nursing home who does not have a health care proxy or a surrogate, only if a court makes the decision or two physicians authorized by the facility concur that the patient would die imminently, even if the patient received the treatment, and that provision of the treatment would violate accepted medical standards.

**Complete each step and check the appropriate lines as indicated.**

**Step 1: Assess health status and prognosis. \_\_\_\_**

**Step 2: Check all advance directives known to have been completed.**

Health Care Proxy    Living Will    Organ Donation    Documentation of Oral Advance Directive  
(If there is a health care proxy and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy.)

**Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.**

*A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.*

Document the result of patient counseling, if applicable. ***Check one.***

- \_\_\_\_ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy).
- \_\_\_\_ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
- \_\_\_\_ Patient lacks capacity to choose a health care agent.

**Step 4: Determine the patient's medical decision-making capacity. *Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity.):***

**(A) Attending Physician Determination (check both)**

- \_\_\_\_ The attending physician has determined in writing to a reasonable degree of medical certainty that the patient lacks the ability to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including benefits and burdens of and alternatives to such orders, and to reach an informed decision regarding the orders.
- \_\_\_\_ The determination contains the attending physician's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

**(B) Assessment for Mental Illness and Concurring Determination *Check (i) or (ii) and all line(s) underneath:***

- \_\_\_\_ (i) The attending physician has determined that the patient's lack of medical decision-making capacity is ***not due*** to mental illness; and

- \_\_\_ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.
- \_\_\_ (ii) The attending physician has determined that the lack of medical decision-making capacity *is due* to mental illness (this does not include dementia); and ***Check both:***
  - \_\_\_ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.
  - \_\_\_ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

**Step 5: Notify the Patient. Check one:**

- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient (the patient may be able to comprehend such notice).
- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend the information

**Step 6: Determine that there is no Public Health Law Surrogate. Check both:**

- \_\_\_ The attending physician, or someone acting on behalf of the attending physician or the hospital or nursing home, made diligent efforts to contact a surrogate from the list below:
  - a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
  - b. Patient's spouse, if not legally separated from the patient, or the domestic partner
  - c. Patient's son or daughter, age 18 or older
  - d. Patient's parent
  - e. Patient's brother or sister, age 18 or older
  - f. Patient's close friend, age 18 or older
- \_\_\_ No surrogate was reasonably available, willing and competent to make medical decisions for the patient.

**Step 7: Document where the MOLST form is being completed. Check one:**

- \_\_\_ Hospital (see Glossary for definition)
- \_\_\_ Nursing Home (see Glossary for definition)

**Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:***

This is Checklist #4 for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/).

- \_\_\_ Checklist #1 - Adult patients with medical decision-making capacity (any setting)
- \_\_\_ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- \_\_\_ Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)
- \_\_\_ Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available
- \_\_\_ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

**Step 9: Identify patient goals for care based on patient's wishes, if known, or patient's best interests\_\_\_\_\_**

**Step 10: If the decision is to withhold or withdraw life sustaining treatment, the following standards and procedures are implemented to ensure that patient-centered goals of care are met. *Check A or B:***

- \_\_\_ (A) A court of competent jurisdiction is the decision-maker: The court has determined that the medical orders meet the patient-centered and clinical standards set forth in the Family Health Care Decisions Act.
- \_\_\_ (B) The attending physician is the decision-maker: ***Check all***
  - \_\_\_ The facility has identified, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending medical decisions and has recorded such findings in the medical record.
  - \_\_\_ The decision is patient-centered and is not based on the financial interests of the facility or any other health care provider. The decision is in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The assessment of the patient's best interests included consideration of:
    - the dignity and uniqueness of every person;
    - the possibility and extent of preserving the patient's life;

- the preservation, improvement or restoration of the patient's health or functioning;
  - the relief of the patient's suffering; and
  - any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.
- \_\_\_ The attending physician has determined to a reasonable degree of medical certainty that:
- the life-sustaining treatment being withheld offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; **and**
  - the provision of the life-sustaining treatment would violate accepted medical standards.
- \_\_\_ A second physician designated by the facility has concurred in this determination, and the concurrence is documented in the medical record.

**Step II: Physician signature**

- \_\_\_ The attending physician has signed the MOLST form.

**Step I2: Notify director of mental hygiene facility and Mental Hygiene Legal Services (MHLS).**

- \_\_\_ For patients who are residents in, or are transferred from, a mental hygiene facility, the attending physician has notified the director of the facility and MHLS of the determination that the resident lacks medical decision-making capacity and, that there is no surrogate or health care proxy and that the resident has MOLST orders.

**Step I3: Notify director of correctional facility.**

- \_\_\_ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity, that there is no surrogate or health care proxy and that the inmate has MOLST orders.



## **Checklist #5: Adult Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and MOLST Form is Being Completed in the Community**

In the community, Public Health Law surrogates (surrogates selected from the surrogate list) can consent to a nonhospital DNR order or a nonhospital DNI order, on behalf of patients who lack medical decision-making capacity. If MOLST is being completed in the community for a patient who does not have a health care proxy, the physician may issue medical orders to withhold life-sustaining treatment – other than DNR and DNI – only if there is clear and convincing evidence of the patient’s wishes to refuse the treatment (see Glossary for definition of “clear and convincing evidence”).

**Complete each step and check the appropriate lines as indicated.**

**Step 1: Assess health status and prognosis.** \_\_\_\_

**Step 2: Check all advance directives known to have been completed.**

Health Care Proxy    Living Will    Organ Donation    Documentation of Oral Advance Directive  
(If there is a health care proxy and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy).

**Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.**

*A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.*

Document the result of patient counseling. ***Check one:***

- \_\_\_\_ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy.)
- \_\_\_\_ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
- \_\_\_\_ Patient lacks capacity to choose a health care agent.

**Step 4: Determine the patient’s medical decision-making capacity. Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity.):**

**(A) Attending Physician Determination Check both:**

- \_\_\_\_ The attending physician has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment orders*, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.
- \_\_\_\_ The determination contains the attending physician's assessment the cause and extent of the patient’s incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

**(B) Assessment for Mental Illness and Concurring Determination Check (i) or (ii) and all line(s) underneath:**

- \_\_\_\_ (i) The attending physician has determined that the patient’s lack of medical decision-making capacity is ***not due*** to mental illness; and
  - \_\_\_\_ A health or social services practitioner has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the

cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

- \_\_\_ (ii) The attending physician has determined that the lack of medical decision-making capacity *is due* to mental illness (this does not include dementia); and *Check both:*
  - \_\_\_ A health or social services practitioner has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.
  - \_\_\_ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

**Step 5: Notify the patient. Check one:**

- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has been given to the patient (the patient may be able to comprehend such notice).
- \_\_\_ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has not been given to the patient, because there is no indication of the patient's ability to comprehend the information.

**Step 6: Identify and notify the appropriate Public Health Law surrogate for DNR/DNI order. Check both:**

- \_\_\_ The attending physician has identified a person **from the class highest in priority** who is reasonably available, willing, and competent to serve as a surrogate decision-maker. Such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects. *Check one:*
  - \_\_\_ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
  - \_\_\_ b. Patient's spouse, if not legally separated from the patient, or the domestic partner
  - \_\_\_ c. Patient's son or daughter, age 18 or older
  - \_\_\_ d. Patient's parent
  - \_\_\_ e. Patient's brother or sister, age 18 or older
  - \_\_\_ f. Patient's actively involved close friend, age 18 or older
- \_\_\_ The attending physician has notified at least one person on the surrogate list **highest in order of priority** who is reasonably available that he/she will make health care decisions related to DNR and/or DNI orders because the patient has been determined to lack medical decision-making capacity.

**Step 7: Document where the MOLST form is being completed. Check one:**

- \_\_\_ Community (see Glossary for definition)

**Step 8: Be sure you have selected the appropriate legal requirements Checklist, based on who makes the decision and the setting. Check one:**

This is checklist #5 for adults without medical decision-making capacity in the community, who do not have a health care proxy. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, find and complete the correct checklist. All checklists can be found on the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/).

- \_\_\_ Checklist #1 - Adult patients with medical decision-making capacity (any setting)
- \_\_\_ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- \_\_\_ Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)
- \_\_\_ Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available
- \_\_\_ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

**Step 9: Discuss goals for care with the Public Health Law surrogate. \_\_\_**

**Step 10: For DNR and/or DNI orders, surrogate has given informed consent Check all:**

- \_\_\_ Surrogate has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.
- \_\_\_ Surrogate has consented to the DNR and/or DNI orders.
- \_\_\_ Surrogate's decision is *patient-centered*, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The surrogate's assessment is based on the patient's wishes and best interests, not the surrogate's, and includes consideration of:
  - the dignity and uniqueness of every person;
  - the possibility and extent of preserving the patient's life;
  - the preservation, improvement or restoration of the patient's health or functioning;
  - the relief of the patient's suffering; and
  - any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

**Step 11: Surrogate's DNR and/or DNI decision complies with clinical standards, as determined by the physician with independent physician concurrence Check (i) and/or (ii) and (iii):**

- \_\_\_ (i) CPR and/or intubation would be an extraordinary burden to the patient **and** an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
  - the patient is permanently unconscious.
- \_\_\_ (ii) The provision of CPR and/or intubation would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances, **and** the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.
- \_\_\_ (iii) The concurring physician's determination is documented in the medical record.

**Step I2: For medical orders other than DNR and DNI, secure and document “clear and convincing evidence” of the patient’s wishes. (If only DNR and/or DNI orders are entered on the form, go to Step I3.) *Check all:***

- \_\_\_ There is clear and convincing evidence (see Glossary for definition) of the patient’s wishes, the evidence has been documented, and the documentation is in the medical record.
- \_\_\_ The Public Health Law surrogate has been notified and has been given an opportunity to present any additional evidence.
- \_\_\_ Check the “Based on clear and convincing evidence of patient’s wishes” box in addition to the “Public Health Law Surrogate” box, if a medical order other than DNR and DNI is being issued based on clear and convincing evidence of the patient’s wishes.

**Step I3: Witness requirements are met. *Check one:***

Two witnesses are always recommended. The physician who signs the orders may be a witness. To document that the attending physician witnessed the consent, the attending physician just needs to sign the order and print his/her name as a witness. Witness signatures are not required -- printing the witnesses' names is sufficient.

- \_\_\_ The surrogate consented in writing.
- \_\_\_ The surrogate consented verbally, and the attending physician witnessed the consent.

**Step I4: If the surrogate is a close friend, verify the age and relationship with the patient.**

- \_\_\_ The surrogate is 18 or older and has signed a statement that he or she is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs. A copy of the signed statement is in the medical record.

**Step I5: Physician Signature**

- \_\_\_ The attending physician has signed the MOLST form.

**Step I6: Notify director of correctional facility.**

- \_\_\_ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and the inmate has MOLST orders.

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Appendix D

Power of Attorney

New York Statutory Short Form



**POWER OF ATTORNEY  
NEW YORK STATUTORY SHORT FORM**

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

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

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

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

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

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

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

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

**(b) DESIGNATION OF AGENT(S):**

I, \_\_\_\_\_  
*(name of principal)*

\_\_\_\_\_  
*(address of principal)*

**hereby appoint:**

\_\_\_\_\_  
*(name of agent)*

\_\_\_\_\_  
*(address of agent)*

\_\_\_\_\_  
*(name of second agent)*

\_\_\_\_\_  
*(address of second agent)*

**as my agent(s).**

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

**(\_\_\_) My agents may act SEPARATELY.**



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

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

\_\_\_\_\_  
*(name of successor agent)*

\_\_\_\_\_  
*(address of successor agent)*

\_\_\_\_\_  
*(name of second successor agent),*

\_\_\_\_\_  
*(address of second successor agent)*

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

My successor agents may act SEPARATELY.

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

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

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

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

**(f) GRANT OF AUTHORITY:**

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

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

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

- (A) real estate transactions;
- (B) chattel and goods transactions;
- (C) bond, share, and commodity transactions;
- (D) banking transactions;
- (E) business operating transactions;
- (F) insurance transactions;
- (G) estate transactions;
- (H) claims and litigation;
- (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable



organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;

- (J) benefits from governmental programs or civil or military service;
- (K) health care billing and payment matters; records, reports, and statements;
- (L) retirement benefit transactions;
- (M) tax matters;
- (N) all other matters;
- (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;
- (P) EACH of the matters identified by the following letters: \_\_\_\_\_.

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

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

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

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

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

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

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

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

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

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

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

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





**(k) ACCEPTANCE BY THIRD PARTIES:**

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

**(l) TERMINATION:**

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

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

**(m) SIGNATURE AND ACKNOWLEDGMENT:**

In Witness Whereof I have hereunto signed my name on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

PRINCIPAL signs here: ==> \_\_\_\_\_

STATE OF NEW YORK )

ss:

COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public

**(n) IMPORTANT INFORMATION FOR THE AGENT:**

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

- (1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;
- (2) avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;
- (4) keep a record or all receipts, payments, and transactions conducted for the principal; and
- (5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).



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

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

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

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

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

I/we, \_\_\_\_\_, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here:                   ⇒ \_\_\_\_\_

  ⇒ \_\_\_\_\_

STATE OF NEW YORK    )

)

ss:

COUNTY OF \_\_\_\_\_ )

)

On the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public

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

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



I/we, \_\_\_\_\_, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

Successor Agent(s) sign(s) here:                   ⇒ \_\_\_\_\_

⇒ \_\_\_\_\_

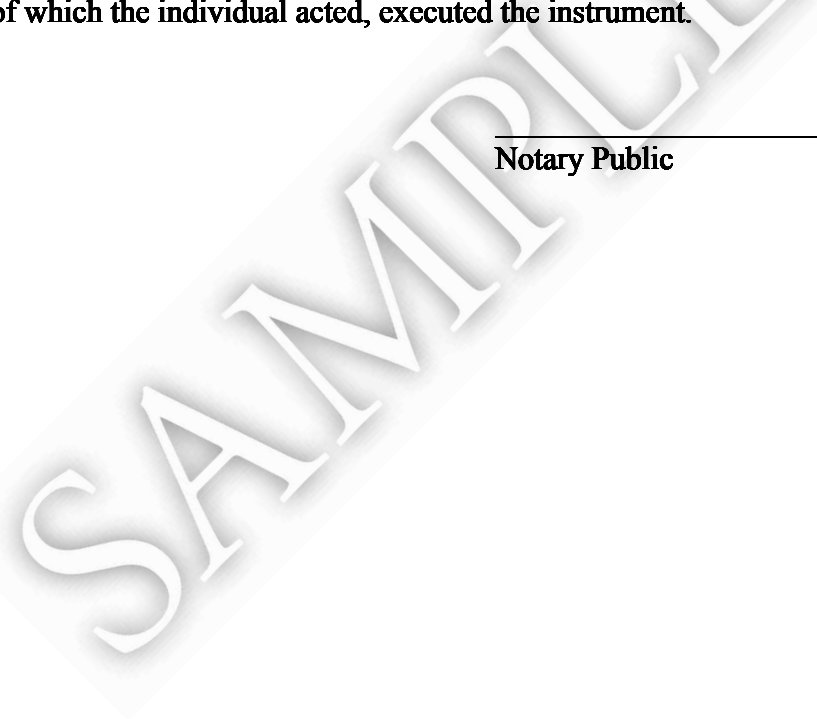
STATE OF NEW YORK    )

)           ss:

COUNTY OF \_\_\_\_\_)

On the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public





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

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

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

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

**(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS**

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

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

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

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

**(b) MODIFICATIONS:**

Use this section if you wish to authorize gifts in amounts smaller than the gift tax exclusion amount, in amounts in excess of the gift tax exclusion amount, gifts to other beneficiaries, or other gift transactions. Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. If you wish to authorize your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

(\_\_\_\_\_) I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:



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

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

(\_\_\_\_\_) I grant specific authority for the following agent(s) to make the following gifts to himself or herself:

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

**(d) ACCEPTANCE BY THIRD PARTIES:**

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

**(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:**

In Witness Whereof I have hereunto signed my name on \_\_\_\_\_, 20\_\_.

PRINCIPAL signs here: ==> \_\_\_\_\_

STATE OF NEW YORK )

) ss:

COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in her/his capacity, and that by her/his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public



**(f) SIGNATURES OF WITNESSES:**

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

\_\_\_\_\_  
Signature of witness 1

\_\_\_\_\_  
Signature of witness 2

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
City, State, Zip code

**(g) This document prepared by:**

SAMPLE

## Suggested Modifications to New York Statutory Gifts Rider

Please review these carefully to ensure these modifications are applicable to/desired by the Principal.

### Exclusionary Gifting Modifications

(b) to make gifts to my parents, spouse, children and other descendants, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. The maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

(c) my agent(s), \_\_\_\_\_ and \_\_\_\_\_, may make gifts to him, her or themselves, as the case may be, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. The maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

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### Full Gifting Modifications

#### (b) Modifications

1) to transfer, gift or convey any and all property that I may own as I may do under all circumstances for purposes of gift, estate or tax planning, Medicaid planning or for whatever purposes my agent(s) deems appropriate.

2) to make or change all beneficiary designations, withdrawals, rollovers, transfers, elections and waivers under law regarding all life insurance contracts, annuity contracts, qualified plans, employee benefit plans and individual retirement accounts, whether as plan participant, as beneficiary, IRA owner or as spouse of a participant, including, without limitation, the waiver of qualified joint and survivor annuity and qualified pre-retirement survivor annuity benefits as provided in I.R.C. § 417; to authorize any distribution, transfer or rollover from all qualified plans and IRAs.

3) to create trusts, whether revocable or irrevocable, on my behalf; to fund such trusts on my behalf or to make transfers and additions to any trusts already in existence; to withdraw income or principal on my behalf from any trust; to exercise whatever trust powers or elections which I may exercise; to open, modify or terminate deposit accounts and any other joint accounts, in my name and the name of other joint tenants, bank accounts in trust form and transfer on death accounts, and to designate or change the beneficiary(ies) of such accounts.

(c) My agent(s), \_\_\_\_\_ and \_\_\_\_\_, may:

1) Transfer, gift or convey any and all property that I may own as I may do under all circumstances for purposes of gift, estate or tax planning, Medicaid planning or for whatever purposes my agent(s) deems appropriate. This grant of authority shall include the ability of my agent(s) to transfer, gift or convey any and all property to himself, herself, or themselves, as the case may be.

2) Make or change all beneficiary designations, withdrawals, rollovers, transfers, elections and waivers under law regarding all life insurance contracts, annuity contracts, qualified plans, employee benefit plans and individual retirement accounts, whether as plan participant, as beneficiary, IRA owner or as spouse of a participant, including, without limitation, the waiver of qualified joint and survivor annuity and qualified pre-retirement survivor annuity benefits as provided in I.R.C § 417; authorize any distribution, transfer or rollover from all qualified plans and IRAs. This grant of authority shall include the ability of my agent(s) to make or change said beneficiary designations, withdrawals, rollovers, transfers, elections and waivers to name himself, herself, or themselves, as the case may be, as the beneficiary(ies) thereof.

3) Create trusts, whether revocable or irrevocable, on my behalf; fund such trusts on my behalf or make transfers and additions to any trusts already in existence; withdraw income or principal on my behalf from any trust; exercise whatever trust powers or elections which I may exercise; open, modify or terminate deposit accounts and any other joint accounts, in my name and the name of other joint tenants, bank accounts in trust form and transfer on death accounts, and designate or change the beneficiary(ies) of such accounts. This grant of authority shall include the ability of my agent(s) to create trusts or accounts naming himself, herself, or themselves, as the case may be, as the beneficiary(ies) or joint tenant(s) of such trusts or accounts.

---

## **Other Possible Modifications**

(Please review these carefully to ensure these modifications are applicable to/desired by the Principal. Some of the modifications are mutually exclusive.) Modifications may be made under paragraph (b) and/or (c) as indicated below.

### **Paragraph (b)**

1. Any gift of my property may be transferred in cash or in kind, and may pass outright to the recipient or may be transferred to a custodian under the Uniform Transfer to Minors Act, which may be established by my agent.
2. Any gift made of my property may be transferred to a trust for the benefit of the recipient. Such trust may be an existing trust or a trust which can be created by my agent for the benefit of the recipient.
3. In making gifts of my property, my “best interest” shall include gifts which would be likely to cause a reduction in estate tax due or which would carry out a plan for the protection of my assets against the costs of nursing home care in the foreseeable future.
4. My agent shall be authorized to make gifts to charities or individuals so long as such gifts are consistent with a gifting pattern I have established previously. For example, charitable pledges, regular gifts to my church or other charities may be carried out or continued at the levels at which I have previously given.

### **Paragraph (b and c)**

5. My wife/husband shall be entitled to give herself/himself any amount of my property. She/he shall also be entitled to give any amount of my property to any descendant of mine without regard to equality or proportionality.



6. When a child of mine acts as agent hereunder, the agent/child shall be prohibited from making any gift to himself/herself that exceeds the least amount, which is gifted to a sibling of the agent or to the descendants, collectively, of any deceased sibling.

7. Any agent who is not my spouse or descendant shall not be eligible to receive any gift of my property hereunder.

SAMPLE

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Appendix E

# How to Get Medicaid Despite Having Excess Income

Thank you to the New York Legal Assistance Group (NYLAG) for  
supplying these useful examples and explanations.



New York Legal Assistance Group (NYLAG)  
Evelyn Frank Legal Resources Program  
212.613.7310  
eflrp@nylag.org  
Fax 212.967.0725

Revised September 4, 2014

### **How to Get Medicaid Despite Having “Excess Income”**

Using a Supplemental Needs Trust to Eliminate the Spend-down for Persons who are Elderly (65+), Blind or Disabled

**The Problem:** Medicaid requires elderly, blind, and disabled persons to “spend-down” their income to the Medicaid levels: \$809 for singles and \$1192 for couples (2014).<sup>1</sup> The amount that their income exceeds these levels, after they have paid for Medicare Part B and any other health insurance premiums, is called the “spend-down.” Every month, they must first incur medical bills in an amount that equals their “spend-down” to qualify for Medicaid. Some people may be able to meet their “spend-down” by using bills other than their current regular monthly medical bills.<sup>2</sup>

Since living costs are so high in New York, no one can live at the Medicaid levels. So the “spend-down” is a huge burden and makes it impossible for many people to get Medicaid.

**Why Do I Need Medicaid?** Medicaid provides access to home care, not paid for by Medicare. Also, any Medicaid beneficiary is deemed eligible for **Extra Help**, the Low Income Subsidy for the Medicare Part D drug program. This greatly reduces the cost of Part D – it pays the monthly premium, eliminates the annual deductible and “donut hole”, and reduces copayments.

**The Solution:** People who are disabled of any age may enroll in a pooled “Supplemental Needs Trust” sponsored by a non-profit organization. There are now many pooled trusts in New York State. This fact sheet uses one trust – the Center for Disability Rights (CDR) pooled trust as an

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<sup>1</sup> These numbers include a disregard of \$20/mo. per household of unearned income for disabled, aged and blind applicants.

<sup>2</sup> They can use to meet the spend-down:

- old *unpaid* and unreimbursed medical bills they still owe and *paid* bills for medical care received within the 3 months before they applied for Medicaid
- over-the-counter or other medical expenses Medicaid and Medicare do not pay for, if a doctor says in writing that they are medically necessary
- the amounts that EPIC or ADAP have paid for their prescription costs, beginning up to three months before they applied for Medicaid, in addition to the co-payments the client pays for these programs

See complete outline on spend-down posted at <http://wnylc.com/health/download/70/>.

example.<sup>3</sup> The Trust is open to any person who is “disabled” as defined by the Social Security laws. When the client joins this Trust, the client agrees to deposit with the Trust each month the amount of their “spend-down.” Once the Trust documents are signed, and the local Medicaid program approves the client’s enrollment in the Trust, Medicaid will change the budget so that the client has NO SPEND-DOWN. The client requests the Trust to pay certain bills, such as rent, mortgage, electric, etc. from the money the client sends in each month. This is explained more below.

**EXAMPLE:** Sally is age 67. Her gross Social Security is \$1875 Her Medicare Part B premium of \$104.90 is deducted from her check, so she receives \$1880.10. She also pays for an AARP Medigap policy of \$250.10/mo.

Sally’s spend-down calculation is:

<u>Total Income</u>	\$1875.00	Gross Income
	- 104.90 Medicare Part B premium	
	- 20.00 Disregard for aged, disabled (standard)	
	- <u>250.10</u>	<u>AARP - Medigap premium (Plan F)</u>
	- <u>375.00</u>	TOTAL DEDUCTIONS
	1400.00	Countable net income
	- <u>809.00</u>	Medicaid level for ONE (2014)
	<b>\$591.00</b>	<b>Spend-down or Excess Income</b>

Monthly Expenses

Rent	\$850
Con Ed	40 (average)
Phone	60 (average)
AARP Medigap	250.10 (was deducted in Medicaid budget)
Food	280
Transportation	80
Cable	70
Clothing, household, leisure, etc.	<u>240</u>
<u>TOTAL</u>	\$1870.10

Pages 3 – 8 of this fact sheet explain the steps of how to enroll in a pooled trust, how to figure out how much to deposit into the trust, and how to ask Medicaid to eliminate your spend-down.

Pages 9-11 explain what expenses the trust may pay for, how do you leave a pooled trust, and provide links to more information.

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<sup>3</sup> There are many non-profit organizations in New York State that offer pooled Supplemental Needs Trusts- see <http://wnylc.com/health/entry/4/> for an unofficial list. New ones have sprouted recently.

## STEPS FOR ENROLLING INTO A POOLED TRUST

### Step One - Apply for Medicaid with a Spend-Down

The first step is to apply for Medicaid with a spend-down. If you need to start getting Medicaid home care or other services quickly, it is best to first apply for Medicaid WITHOUT enrolling in the pooled trust, and then enroll in the pooled trust once your Medicaid application has been filed. Medicaid is approved more quickly if you are not yet enrolled in the pooled trust. By applying for Medicaid first, before enrolling in the trust, the person can start receiving home care services while the following steps are being worked on.

When you are approved for Medicaid with a spend-down, if you begin receiving home care from a Managed Long Term Care (MLTC) plan or certified home care agency or other home care agency, you are expected to pay your spend-down to the plan or agency every month. You will probably be unable to do this because you're sending the money to the SNT. You can explain to the plan or agency that your spend-down will eventually be retroactively reduced to zero and that they will then be able to back-bill Medicaid for the spend-down amount. Some plans will ask for proof that you have submitted your SNT enrollment to Medicaid for approval.

**WARNING – Request CODE 06:** Sometimes your local Medicaid office wrongly “denies” your Medicaid application if you have a spend-down, because you have not submitted medical bills in the amount of your monthly spend-down. This creates a catch-22, because no MLTC plan will enroll you unless the eligibility code in the computer shows you have active Medicaid. To address this problem, applicants for Medicaid who want to enroll in MLTC must request **Eligibility CODE 06**. See [Medicaid Alert dated July 12, 2012](#). (<http://wnylc.com/health/download/329/>) This gives them "Provisional Medicaid" eligibility so that an MLTC plan sees they have Medicaid and will enroll them. See also NYS DOH GIS 14/MA/10 at [http://www.health.ny.gov/health\\_care/medicaid/publications/docs/gis/14ma010.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/14ma010.pdf).

### Step Two - Enroll in the Pooled Supplemental Needs Trust

The second step is to **enroll in the pooled SNT**. Most pooled SNTs have a list of documents on their website, including FAQs and Procedures which you should read before enrolling. There are [many Pooled SNTs in New York](#), but the Center for Disability Rights (CDR) has the most favorable fee structure for monthly contributions of excess income. Using their SNT as an example, here is what you need to send CDR to enroll. All forms can be downloaded – link in CDR info at <http://www.wnyc.com/health/entry/4/>.

- Beneficiary Profile & Joinder Agreement - Filled out and signed before a notary public.
- Disbursement/Withdrawal Form- For every expense that you want CDR to pay for you, you need to submit one of these forms and attach proof that the amount is due (e.g. a copy of your lease, monthly utility bill, credit card statement). Carefully read the SNT’s rules to make sure they will pay the type of expense. Remember the expense has to be

yours and not anyone else's or a gift for anyone else, and the SNT will never pay you directly.

- ACH Request Form- If you want CDR to make automatic withdrawals from your bank account each month in the amount of your monthly SNT contribution. You can specify the day of the month that the withdrawal is made.
- FEE - Enrollment funds (check or money order)- Payable to CDR (minimum initial deposit is \$240 but see below for advice about how much to send for your full monthly contribution). Every trust has different fees. Here is link to NYSARC Fee Schedule - [http://www.nysarc.org/files/8813/1076/2571/Community\\_Trust\\_II\\_-\\_Fee\\_Schedule.pdf](http://www.nysarc.org/files/8813/1076/2571/Community_Trust_II_-_Fee_Schedule.pdf), See other trusts at <http://www.wnylc.com/health/entry/4/>.

CDR and the other trust organizations will take about 2 weeks to process your application, and if you are enrolled in their SNT, they will send you an Acceptance Letter. Keep that handy because you will need it in Step Three.

### **Step 2(A) How Much to Put into Pulled Trust**

Here are some tips for deciding how much to put into the trust each month. For help determining the appropriate amount to contribute each month to eliminate your spend-down, obtain the Medicare Savings Program, and ensure that all SNT fees and your bills are paid, you can use [this Excel worksheet](#) at <http://www.wnylc.com/health/download/316/>.

**The Bare Minimum – Actual Spend-down amount.** At a minimum, deposit your actual spenddown. For example, if Sally (example on page 2 above) deposits \$591 each month into the Trust, once Medicaid approves it, she will have NO spend-down. With this option, CDR keeps \$20 as a monthly fee, and \$571 is available to pay her bills.

**Strategy Tip #1 – Enough to pay full rent:** How much should she put in the Trust each month if she wants the Trust to pay her rent? If she puts her exact spend-down of \$591 into the Trust, so that \$571 is left to pay her bills, she could have the trust pay \$571 of the rent and she would pay the balance to the landlord. Alternately, she can put \$870 into the Trust which would include the \$20 fee and the \$850 rent. Some trusts, such as NYSARC charge a higher monthly fee if the deposit into the trust is higher. The convenience of having the trust pay the whole rent may be worth it.

**Strategy Tip #2: Extra benefit of the Trust- Medicare Savings Program (MSP) -** By reducing one's "countable" income, one also becomes eligible for one of the Medicare Savings Programs. These programs pay the Medicare Part B premium which is \$104.90 in 2014. That savings more than offsets the monthly fee. For the income limits and more info see the State website at <http://tinyurl.com/W393P> and the advocacy article at <http://wnylc.com/health/entry/99>. Once Medicaid starts paying her Part B premium through the MSP, her Social Security check will increase by \$104.90. As a result, her spend-down will also increase by \$104.90. If Sally wants to be in the MSP, and have no spend-down, she should increase her monthly trust deposit by \$104.90. For help determining the appropriate amount

to contribute each month to eliminate your spend-down, obtain the Medicare Savings Program, and ensure that all SNT fees and your bills are paid, you can use [this Excel worksheet \(http://www.wnylc.com/health/download/316/\)](http://www.wnylc.com/health/download/316/).

**\*\* MSP TIP:** If you were contributing the \$104.90 more to the SNT, you will be retroactively enrolled in the Medicare Savings Program, and you will receive a reimbursement for the Part B premiums you paid while contributing to the SNT. For this all to work, you must continue making your deposit in the SNT every month.

**\*\* APPLICATION TIP WITH MSP:** On the Medicaid application, write across the top of the first page that the client is applying for both Medicaid AND the Medicare Savings Program. The Medicaid office is required to screen the client for the MSP anyway, but it helps to remind them. See GIS 05/MA033, at <http://tinyurl.com/L7AUSK> .

**Strategy Tip #3: WARNING- Deposit only what you can routinely spend every month - Don't let the trust deposit accumulate!** If you don't spend the money deposited each month into the Trust, and it accumulates, then you may be denied Medicaid to pay for nursing home care if you need it in the next five years. This is because of the Deficit Reduction Act enacted Feb. 8, 2006. Transfers of assets made by someone age 65 or over after that date can cause a delay (transfer penalty) in qualifying for Medicaid to pay for nursing home care for five years. This delay for nursing home eligibility can also be triggered by transfers of income into a Trust by someone age 65+ if the income is not spent. Fortunately, the New York State Department of Health policy has said that placing income into a pooled Trust will not result in a transfer penalty for Medicaid coverage of nursing home care, as long as the balance of the pooled Trust account does not accumulate. If the individual needs Medicaid coverage of nursing home care in the future, the amount of money remaining in the trust account that has not been spent on rent and other expenses will be deemed a transfer of assets and a penalty imposed. For more information on these rules, see <http://wnylc.com/health/entry/38/> .

**Strategy Tip #4: Married couples** - If both spouses need Medicaid, it may be possible for only one to establish a Trust account, depending on their respective incomes. Their combined income remaining after taking all deductions, and after the deposit into the Trust, should be the Medicaid couple income limit (\$1192/mo. in 2014). Having only one spouse enroll in the Trust can save the couple administrative fees and administrative hassle.

**Married couple EXAMPLE:** Sally has the same income and insurance as in the example above, but is married to John whose gross income is \$900. He also has the same AARP Medigap policy. Their budget would be as follows:

\$1875.00	Gross Income - Sally
<u>900.00</u>	<u>Gross Income - John</u>
2775.00	TOTAL GROSS INCOME
- 209.80	Medicare Part B premium x 2
- 20.00	Disregard for aged, disabled (only \$20/couple)
<u>- 312.20</u>	<u>AARP Medigap premium (Plan A) (156.50 x 2)</u>
- 545.00	TOTAL DEDUCTIONS
2230.00	Countable net income
<u>-1192.00</u>	Medicaid level for TWO (2014)
1038.00	Spend-down as a couple
<u>+ 209.80</u>	Extra to deposit for Medicare Savings Program
<b>\$1247.90</b>	<b>Total to deposit if want MSP</b>

If they are applying as a couple, assuming they are both disabled, it makes more sense for Sally to establish a trust, since John’s income isn’t high enough to deposit \$1247.90, which is the full spend-down plus the extra \$209.80 if they want to enroll in an MSP and still have no spend-down. Since John only has \$900 in income, it may make more sense to keep his entire income, and have Sally enroll in the Trust, and deposit \$1247.90 into the Trust. Of course, if Sally was not disabled, then only John could enroll in the Trust.<sup>4</sup> In some cases, both spouses will need to join the Trust if both have higher incomes.

**Strategy Tip #5: If you don’t have Medicare, don’t reduce spend-down to ZERO- Keep a nominal spend-down - Even a few dollars.** Why? For people who do not have Medicare, it may be advantageous to retain a minimal spend-down to avoid being required to enroll in a Medicaid Managed Care Plan. Currently, having a spend-down means one is exempt from the requirement to enroll in a Managed Care Plan. See at <http://wnylc.com/health/entry/166/>. Caution: These programs are changing rapidly so check back for updates. (If the client has Medicare and needs long term care, having a spend-down will not exempt the client from the requirement to enroll in a Medicaid Managed Long Term Care plan.)

**Step Three - Notify Medicaid about the Supplemental Needs Trust and Request Medicaid to Re-Budget to Eliminate Spend-down**

The last step is to **notify Medicaid that you have a pooled trust (SNT) account**. There are two things you have to show to your local social services office (in NYC that is the NYC Human Resources Administration):

1. That you are enrolled in a SNT (and making monthly deposits), and
2. That you are disabled.

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<sup>4</sup> Let’s say John enrolled in the Trust because Sally was not disabled. But let’s say his income was much lower- only \$500, and hers was \$500 higher than in the example. One fair hearing decision held that he may deposit HER income into HIS Trust to reduce his or their spend-down. See In the Matter of J.T., Fair Hearing No. 4576742M (Nov. 16, 2006), available from Fair Hearing Database at <http://onlineresources.wnylc.net>



1. **Proof that you are enrolled in a SNT- You need to send**

- **Master Trust Agreement**- available as a printable PDF on the SNT's website
- **Beneficiary Profile Sheet and Joinder Agreement**, signed by both you and the trustee (CDR for example)- The version sent to you with your Acceptance Letter will have the trustee's signature
- **Acceptance Letter**
- **Verification of Deposits**- If you are sending this paperwork more than a month after you were accepted into the SNT, you need to send proof that you have been making monthly deposits. You can call the SNT to ask for a statement.

2. **Proof that you are Disabled-** DOWNLOAD forms listed below at <http://www.wnylc.com/health/entry/134/>

- If you have been approved for either SSDI or SSI benefits on the basis of a disability, then all you have to send to prove that you are disabled is a copy of your SSA Award Letter or SSA Disability Determination (that you got when you were first approved for benefits). Otherwise, you need to send the documents below and ask the DSS for a [disability determination](#).
- [DSS-486T - Medical Report for Determination of Disability \(Rev. 6/2012\)\)](#)  
This form needs to be filled out by your doctor(s). In January 2013, HRA published a [Medicaid Alert stating that 12 months of medical records must be included with every 486T form](#). So if your primary care physician filled out a 486T, you need to send 12 months of records from their office. If any of your specialists filled out 486Ts then you need to send 12 months of records from their offices as well. If you are able to get records from any hospitalizations or nursing home stays in the past 12 months, send those too. You want to ensure that the medical information you send gives Medicaid a clear picture of your medical and psychological conditions for them to base their disability determination on. So if your primary disability is treated by a specialist(s), be sure to get the 486T and medical records from that doctor(s).
  - **NOTE:** The 486T form revised in June 2012 shortens the form from a 25-page form to a one page form, which is less intimidating to doctors. The old form consisted of numerous attachments that elicited information about the different body systems, such as a musculoskeletal or cardiac impairments. Those attachments, while burdensome, were helpful to show the criteria for "meeting the listings" to be found disabled (Step Three in the [sequential evaluation process described in this article](#)). While no longer required, you might find some of these attachments helpful as a guide for your physician to provide information about particular conditions. Click here for the [old 486T](#).

- [DSS-1151 - Disability Questionnaire \(Rev. 6/2012 to replace Disability Interview Form\)](#)  
This form can be filled out by you, a social worker or family member.
- [LDSS-1151.1 \(6/2012\) Disability Questionnaire Continuation Sheet-](#) If you need more space than the lines on the DSS-1151 to list your medical providers or hospitalizations, you can use this form.
- [MAP-751D - Authorization for Disclosure of Individual Health Information](#)  
You should submit this form if you want someone else (e.g., social worker, family member or attorney) to be able to talk with Medicaid about your case.
- [OCA Official Form 960 - NY State HIPAA](#)  
You need to submit **three** original copies of this form, signed and dated by the applicant, with the provider information left blank. See this [Medicaid Alert](#) for more information.

### 3. Cover Letter

- Enclose a cover letter with this great packet of information, to explain what you are asking the DSS to do- rebudget your Medicaid case with no spend-down - and why- because you have a SNT and are disabled. You can use this [sample cover letter](#) (<http://www.wnylc.com/health/download/64/>) as a starting point. You should customize it to apply to your specific medical and psychological conditions and the information in the 486 and 1151 forms.
  - Use the [NYS Medicaid Disability Manual](#) ([http://www.health.ny.gov/health\\_care/medicaid/reference/mdm/](http://www.health.ny.gov/health_care/medicaid/reference/mdm/)) as a guide for your specific disability(ies), which explains the "sequential evaluation process" for determining disability, has the Listing of Impairments, and other information.
- You should also ask to be enrolled in the **Medicare Savings Program (MSP)**, to have your Medicare Part B premium paid by Medicaid. Just as using the SNT has brought your income under the limit for Medicaid, if you have been contributing \$104.90 more to the SNT than your Medicaid spend-down, it has also brought your income under the limit for MSP. [Click here for more information about this program.](#)

### STEP FOUR - Following-Up and Ensuring Medicaid Re-Budgeting Is Done Correctly

Once you have submitted the SNT and disability documentation to your DSS, they will typically take many months to process the information. You should eventually get a written notice stating that your Medicaid case has been rebudgeted with no spend-down (and telling you that are enrolled in MSP if you applied for it). Make sure that the **effective date** of this notice is correct - it should be the month that you first began making a contribution of your full spend down amount (+\$104.90 if you wanted MSP) in the SNT. If it is not correct, you may have to request a Fair Hearing to appeal the notice for the date to be corrected ([click here to request a hearing](#) - <http://otda.ny.gov/hearings/>).

As you can see, this is one of the most complicated things you can do involving Medicaid. Many people find that it is worth hiring a [private elder attorney \(www.naela.org\)](http://www.naela.org) or [geriatric care manager \(www.caremanager.org\)](http://www.caremanager.org) to help with this process. Some [free legal services \(http://www.lawhelpny.org/\)](http://www.lawhelpny.org/) may be available to help, also. For more in-depth information on SNTs, including how a SNT affects eligibility for other public benefits, see our [Training Outline for Advocates](#).

#### **WHAT HAPPENS IF THE SPEND-DOWN CHANGES ONCE THE CLIENT HAS JOINED THE TRUST?**

**Almost every year, the amount of Social Security increases for most retirees, increasing their spend-down. They** increase the amount placed into the trust each month. Also, some pooled trusts require a sort of “security deposit” – the equivalent of one month’s spend-down to be on deposit at all times. If Social Security or other income goes up, client may have to increase this deposit.

#### **WHAT BILLS MAY TRUST PAY?**

***WARNING: These rules are for people using a pooled trust solely for Medicaid only, not SSI.*** If you have SSI and want to use a trust for a lawsuit settlement or other lump sum, the rules are different.

The Trust may pay the client’s rent, mortgage, maintenance, utility bills, credit card bills, as long as it makes the payments directly to the landlord or other third party. The Trust *may not give the client money directly*. Such in-kind payments are not considered “income” for Medicaid purposes, regardless of what the payments are for.<sup>5</sup>

*Rent or mortgage payments* are the ideal expense for the trust to pay, since most trusts will set up an automatic monthly payment. Some trusts will not put the client on automatic payment of rent or mortgage until the client has been enrolled and paid in the client’s spend-down for 3 months. So during the first 3 months the client must make individual disbursement requests for the client’s rent or mortgage. After that, ask for automatic payment.

Though the trust may pay bills only for the benefit of the Trust beneficiary (the client), and NOT for the client’s family members or friends, payments that incidentally benefit a third party may be permissible, such as rent where the client’s spouse benefits from the payment. The client needs the trust’s permission to pay expenses that benefit a third party, such as paying the expenses for a travel companion of the beneficiary, or travel expenses for a close family member to visit the beneficiary.

Trusts vary on whether utility and other bills must be sent each month to the trust for payment, or whether bills on a budget plan with fixed monthly payments may be automatically paid by the trust, like rent.

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<sup>5</sup> 18 NYCRR § 360-4.3(e)

Some trusts permit a family member or other individual who paid for a client's expense, such as paying rent or buying clothing, to be reimbursed if receipts are submitted. However, they must contact the trust to get approval BEFORE making the expenditure to assure reimbursement.

*Credit cards-* Some trusts will pay credit card bills, provided that the bill is in the client's name, and that there are no past due charges being carried forward. The actual monthly bill must be submitted for the Trust to verify that no cash withdrawals were made. The Trust has the right to inquire whether the expenses were for the benefit of the beneficiary and not for anyone else.

Trusts may not honor disbursement requests for gifts, nor can charitable donations be made from the Trust.

*Funeral expenses-* Funds in a trust may pay for a *pre-paid* funeral agreement while the client is *alive*. Client may enter an installment plan for a funeral agreement with a funeral home and submit monthly installment bills to the trust to pay. **NO POOLED TRUST *may pay for funeral expenses after the client dies.***

## **HOW DOES THE CLIENT/BENEFICIARY LEAVE THE TRUST?**

*The client leaves the Trust when she dies.* Money left in the Trust when the client dies stays in the Trust for the benefit of other disabled persons. It may NOT be inherited by the client's family or heirs. Also, after the client's death, the Trust is very limited in what expenses it may pay for the client. The Trust may NOT pay funeral costs after the client's death. The Trust may NOT pay debts owed to third parties, such as paying off a mortgage, credit card debts, etc. The Trust also may NOT pay taxes due upon death, nor fees for administration of the estate. However, the Trust MAY pay the client's current expenses at the time of her death, such as the rent and current bills.

*The client leaves when she is admitted to a nursing home.* The type of Medicaid budget used in the nursing home does not allow the client to deposit income into a Trust to eliminate the spend-down. Once the client enters a nursing home, the client would stop making any further deposits. The client can still submit expenses requests to the trust to use up any remaining funds.

The client may leave any time by stopping making any further monthly deposits. But if the client does that, the client's spend-down will go up. The spend-down is reduced only as long as the client makes monthly deposits. At annual recertifications, Medicaid will request proof that these deposits are being made.

The trust must be notified in writing of any change in participation of the Trust in order to free up the remaining one month security deposit, if any.

**TROUBLESHOOTING** - Each local Medicaid office may have contact people to troubleshoot SNT problems.

**In NYC** - Here are suggested contacts within HRA. CAUTION: The time limit to request a fair hearing can run out, even if you are trying to informally advocate. Keep your eye on the deadlines!

- **HOME CARE CASES** – When a client has or is seeking MLTC, CHHA or CASA home care, the Medicaid application and SNT documents should be sent to- HRA HCSP Central Medicaid Unit, 785 Atlantic Avenue, 7th Floor, Brooklyn, NY 11238
  - Contact person- Yvette Poole-Brooks [poolebrooksy@hra.nyc.gov](mailto:poolebrooksy@hra.nyc.gov) Phone (929) 221-2493 Fax (718) 636-7848
- **NON-HOME CARE CASES** – The Medicaid application and SNT documents can be turned in at "regular" Medicaid offices where they will then be sent internally to the Spend-Down Unit
  - Contact Person- Eileen Fraser-Smith [fraser-smithe@hra.nyc.gov](mailto:fraser-smithe@hra.nyc.gov) Phone (929) 221-0868/69 Fax (718) 636-7847
  - Eligibility Information Services- Phone (929) 221-0865/66/67/68

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#### ONLINE LINKS

<http://wnylc.com/health/14/> - General info on supplemental needs trusts

<http://www.wnyc.com/health/download/9/> - training outline on SNTs posted (updated May 2014) explained how Supplemental Needs Trusts work (both individual and pooled). The Appendix includes information on how they affect eligibility for many different public benefits.

<http://www.wnyc.com/health/entry/134/> --Proof of Disability forms

<http://www.wnyc.com/health/entry/4/> - Contact List of pooled trusts in NYS

Watch this [taped seminar by David Silva, Asst. Director of the Evelyn Frank Legal Resources Program, explaining pooled trusts.](#) (July 16, 2013)

<https://www.youtube.com/watch?v=oRR7VM4HdJ4>

Visit NY Health Access at <http://nyhealthaccess.org>.

June 1, 2005, rev'd March 28, 2011, May 4, 2012, Oct. 24, 2012, July 29, 2013 and Sept. 4, 2014 by David Silva and Valerie Bogart.

Contact: [EFLRP@NYLAG.org](mailto:EFLRP@NYLAG.org)

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Appendix F

Managed Long-Term Care  
(MLTC)

Plans Serving New York State

## Managed Long-Term Care (MLTC) Plans Serving New York State

Name	Counties Served	Mailing Address/Phone
Aetna Better Health	Kings, New York (Manhattan), Queens, Nassau, Suffolk	55 West 125th St. Suite 1300 New York, NY 10027 (855) 456-9126
Aetna Better Health FIDA	Kings, New York (Manhattan), Queens, Nassau Approved in Suffolk but not yet live	55 West 125th St. Suite 1300 New York, NY 10027 (855) 494-9945
AgeWell New York	Bronx, Kings, New York, Queens, Nassau, Suffolk, Westchester	1991 Marcus Ave., Suite M201 Lake Success, NY 11042 (866) 586-8044
AgeWell New York FIDA	Bronx, Kings, New York, Queens, Nassau	1991 Marcus Ave., Suite M201 Lake Success, NY 11042 (866) 586-8044
AlphaCare of New York, Inc	Bronx, Kings, New York, Queens, Westchester	335 Adams St., Suite 2600 Brooklyn, NY 11201 (888) 770-7811
AlphaCare Signature FIDA	Bronx, Kings, New York, Queens	335 Adams St., Suite 2600 Brooklyn, NY 11201 (855) 632-5742
Empire BlueCross BlueShield HealthPlus MLTC	New York City (All boroughs)	9 Pine St., 14th Fl New York, NY 10005 (800) 950-7679
Empire BlueCross BlueShield HealthPlus MAP	New York City (All boroughs)	9 Pine St., 14th Fl New York, NY 10005 (866) 805 - 4589
ArchCare Community Life	Bronx, Kings, New York, Queens, Richmond, Putnam, Westchester	33 Irving Place, 11th Fl New York, NY 10003 (855) 467-9351
ArchCare Senior Life	Bronx, New York, Richmond	1432 Fifth Ave New York, NY 10035 (866) 263-9083
Catholic Health-LIFE	Erie	55 Melroy Ave Lackawanna, NY 14218 (855) 671-3341
CenterLight Healthcare Select MLTC	NYC (All boroughs) Nassau, Rockland, Suffolk Westchester	1250 Waters Place Tower 1, Suite 602 Bronx, NY 10461 (877) 226-8500
CenterLight Healthcare Select PACE	NYC (All boroughs), Nassau, Suffolk, Westchester	1250 Waters Place Tower 1, Suite 602 Bronx, NY 10461 (877) 226-8500

<b>Name</b>	<b>Counties Served</b>	<b>Mailing Address/Phone</b>
Centers for Healthy Living	NYC (All boroughs), Erie, Niagara, Rockland)	75 Vanderbilt Ave. 7th Floor Staten Island, NY 10304 (855) 270-1600
Centers Plan for FIDA Care Complete	NYC (All boroughs)	75 Vanderbilt Ave. 7th Floor Staten Island, NY 10304 (800) 466-2745
Complete Senior Care	Niagara	1302 Main St Niagara Falls, NY 14301 (888) 303-4333
Eddy Senior Care	Parts of Albany and Schenectady counties	504 State St Schenectady, NY 12305 (518) 382-3290
Elant Choice d.b.a. Evercare Choice	Dutchess, Orange, Rockland	31 Cerone Place Newburgh, NY 12550 (877) 255-3678
Elderplan, Inc. MAP	NYC (All boroughs), Monroe, Nassau, Westchester	6323 Seventh Ave Brooklyn, NY 11220 (866) 362-4265
HomeFirst, a product of Elderplan, Inc.	NYC (All boroughs) Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester)	6323 Seventh Ave Brooklyn, NY 11220 (866) 353-4681
Elderplan FIDA Total Care	NYC (All boroughs), Nassau, Approved in Suffolk & Westchester but not yet live	6323 Seventh Ave Brooklyn, NY 11220 (866) 353-4681
EmblemHealth Managed Long Term Care	NYC (All boroughs), Suffolk, Nassau, Westchester	55 Water St., 12th Fl New York, NY 10041 (888) 447-9161
EmblemHealth Managed Long Term Care Plus	NYC (All boroughs), Suffolk, Nassau, Westchester	55 Water St., 12th Fl New York, NY 10041 (888) 447-9161
Erie Niagara d/b/a. Kalos Health	Chautauqua, Erie, Genesee, Niagara, Orleans	2424 Niagara Falls Blvd. Ste 400 Niagara Falls, NY 14304 800-894-2464
Evercare Choice	Dutchess, Orange, Rockland	31 Cerone Place Newburgh, NY 12550 (877) 255-3678
Extended MLTC, LLC	NYC (All boroughs), Suffolk, Nassau	360 West 31st St., Suite 304 New York, NY 10001 (855) 299-6492



<b>Name</b>	<b>Counties Served</b>	<b>Mailing Address/Phone</b>
Fallon Health Weinberg, Inc.	Erie and Niagara	461 John James Audubon Parkway Amherst, NY 14228 (866) 882-8185
Fidelis Care at Home	NYC (All boroughs), all Upstate counties	95-25 Queens Blvd Rego Park, NY 11374 (800) 688-7422 (Partial)
Fidelis Medicaid Advantage Plus	NYC (All boroughs), Albany, Montgomery, Rensselaer, Schenectady	95-25 Queens Blvd Rego Park, NY 11374 (877) 533-2404 (MAP)
Guildnet	NYC (All boroughs), Nassau, Suffolk, Westchester	15 West 65th St. 4th Fl New York, NY 10023 (800) 932-4703
Guildnet Gold	Bronx, Kings, New York, Queens, Nassau, Suffolk	15 West 65th St. 4th Fl New York, NY 10023 (800) 815-0000
Guildnet Gold Plus FIDA	Bronx, Kings, New York, Queens, Richmond, Nassau Approved in Nassau and Suffolk but not yet live	15 West 65th St. 4th Fl New York, NY 10023 (800) 815-0000
Hamaspiik Choice, Inc.	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster	58 Rt. 59, Suite 1 Monsey, New York 10952 (855) 552-4642
Healthfirst CompleteCare	NYC (All boroughs), Nassau	100 Church St. 18th Fl New York, NY 10007 (888) 280-1010
Healthfirst AbsoluteCare FIDA	Kings, Queens, Bronx, New York, Richmond, Nassau Approved in Westchester but not yet live	100 Church St. 18th Fl New York, NY 10007 (855) 675-7630
iCircle Care	Broome, Cayuga, Chemung, Chenango, Cortland, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates	860 Hard Rd Webster, NY 14580 (844) 424-7253
Independence Care System	Bronx, Kings, New York, Queens	257 Park Ave. South 2nd Fl New York, NY 10010 (212) 584-2500

<b>Name</b>	<b>Counties Served</b>	<b>Mailing Address/Phone</b>
ICS Community Care Plus FIDA MMP	Bronx, Kings, New York, Queens	257 Park Ave. South 2nd Fl New York, NY 10010 (877) 427-2525 (FIDA)
Independent Living for Seniors d/b/a ElderONE	Monroe	2066 Hudson Ave Rochester, NY 14617 (585) 922-2800
Integra MLTC, Inc.	NYC (All boroughs), Nassau, Suffolk, Westchester	1981 Marcus Avenue, Suite 100 Lake Success, NY 11042 (855) 800-4683
MetroPlus MLTC	Bronx, Kings, New York, Queens	160 Water St New York, NY 10038 (855) 355-6582
MetroPlus FIDA	Bronx, Kings, New York, Queens	160 Water St New York, NY 10038 (855) 355-6582
Montefiore Diamond Care MLTC	Bronx and Westchester	200 Corporate Blvd. South Yonkers, New York 10701 (855) 556-6683
Niagara Advantage Health Plan LLC d/b/a Elderwood Health Plan	Niagara Advantage Health Plan LLC d/b/a Elderwood Health Plan	7 Limestone Drive Williamsville, NY 14221 (866) 843-7526
NorthShore-LIJ Health Plan, Inc.	Kings, Queens, New York, Richmond, Nassau, Suffolk	2200 Northern Blvd, Suite 104 East Hills, NY 11548 (855) 421-3066
NorthShore-LIJ FIDA LiveWell	Kings, Queens, New York, Richmond, Nassau	2200 Northern Blvd, Suite 104 East Hills, NY 11548 (844) 288-3432
PACE CNY	Onondaga	100 Malta Ln North Syracuse, NY 13212 (888) 728-7223
Prime Health Choice LLC	Albany, Dutchess, Orange, Putnam, Rockland, Warren, Washington	3125 Emmons Ave Brooklyn, NY 11235 (855) 777-4630
RiverSpring at Home, formerly ElderServe Health, Inc	NYC (All boroughs), Nassau, Suffolk, Westchester	94 West 225th St., 2nd Fl Bronx, NY 10463 (800) 370-3600
RiverSpring FIDA	NYC (All boroughs), Nassau Approved in Suffolk & Westchester but not yet live	94 West 225th St., 2nd Fl Bronx, NY 10463 (800) 950-9000
Senior Health Partners A Healthfirst Company	NYC (All boroughs), Nassau, Westchester	100 Church St., 18th Fl New York, NY 10007 (866) 585-9280

<b>Name</b>	<b>Counties Served</b>	<b>Mailing Address/Phone</b>
Senior Network Health, LLC	Herkimer & Oneida	1650 Champlin Ave. Utica, NY 13502 (315) 624-4545
Senior Whole Health of New York MLTC	Bronx, Kings, New York, Queens	111 Broadway, Suite 1505 New York, NY 10006 (877) 353-0185
Senior Whole Health of New York MAP	Bronx, Kings, New York, Queens	111 Broadway, Suite 1505 New York, NY 10006 (877) 353-0185
Senior Whole Health of New York FIDA	Bronx, Kings, New York, Queens	111 Broadway, Suite 1505 New York, NY 10006 (844) 861-3432
Total Senior Care, Inc.	Allegany, Cattaraugus, Chautauqua	519 North Union St Olean, NY 14760 (716) 379-8474
United Healthcare Personal Assist	NYC (All boroughs), Albany, Broome, Erie, Monroe, Oneida, Onondaga	77 Water St., 14th Fl New York, NY 10005 (877) 512-9354
VillageCareMAX	Bronx, Kings, New York, Queens	112 Charles St New York, NY 10014 (800) 469-6292
VillageCareMAX Full Advantage FIDA	Bronx, Kings, New York, Queens	112 Charles St New York, NY 10014 (800) 469-6292
VNA Homecare Options, LLC	All upstate counties	1050 W. Genesee St. Syracuse, NY 13204 (315) 477-9500
VNSNY CHOICE Managed Long Term Care	NYC (All boroughs), Albany, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Madison, Monroe, Montgomery, Nassau, Oneida, Onondaga, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester	1250 Broadway, 11th Fl New York, NY 10001 (866) 783-1444
VNSNY CHOICE Total	NYC (All boroughs), Nassau, Suffolk, Westchester	1250 Broadway, 11th Fl New York, NY 10001 (866) 783-1444
VNSNY CHOICE FIDA Complete	Kings, Queens, Bronx, New York, Richmond, Nassau Approved in Suffolk & Westchester but not yet live	1250 Broadway, 11th Fl New York, NY 10001 (866) 783-1444

<b>Name</b>	<b>Counties Served</b>	<b>Mailing Address/Phone</b>
Wellcare Advocate MLTC	NYC (All boroughs), Albany, Erie, Orange, Nassau, Rockland, Suffolk, Ulster, Westchester	One New York Plaza, 15th Floor, New York, NY 10004 (866) 661-1232
Wellcare Advocate Complete FIDA	Kings, Queens, Bronx, New York, Richmond, Nassau Approved in Suffolk & Westchester but not yet live	One New York Plaza, 15th Floor, New York, NY 10004 (855) 595-2063

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**Appendix G**  
Documents Required for  
**Medicaid Application**

# DOCUMENTS REQUIRED FOR MEDICAID APPLICATION

APPLICANT NAME: \_\_\_\_\_

## \_\_\_\_\_ A. Proof of Identity and Family Relationship – Required for Applicant and Spouse

- \_\_\_\_\_ Union Card
- \_\_\_\_\_ Social Security Card
- \_\_\_\_\_ Medicare Card
- \_\_\_\_\_ One of the following:
  - Birth Certificate or Census Records or Baptismal Certificate or Certificate of Naturalization or passport or visa or driver license or non-driver identification card
- \_\_\_\_\_ Military discharge papers
- \_\_\_\_\_ Marriage Certificate or divorce/separation papers
- \_\_\_\_\_ Death Certificate of spouse
- \_\_\_\_\_ Private health insurance card and monthly premium bill
- \_\_\_\_\_ Medicare C and/or D cards and monthly premium bills (if applicable)
- \_\_\_\_\_ Other

## \_\_\_\_\_ B. Residency and Living Arrangement – Required for Applicant and Spouse

- \_\_\_\_\_ Rent receipt and/or Lease
- \_\_\_\_\_ Most current utility or telephone bill
- \_\_\_\_\_ Deed to residence or co-op share certificates
- \_\_\_\_\_ Other

## \_\_\_\_\_ C. Income – Required for Applicant and Spouse

- \_\_\_\_\_ Pension or pay stubs
- \_\_\_\_\_ IRA monthly required minimum distribution payments
- \_\_\_\_\_ Support payments – divorce or separation papers
- \_\_\_\_\_ Award Letter for the following benefits:
  - ( ) Social Security (call 1-800-772-1213) for Income Beneficiaries
  - ( ) Military or Veterans Pension

- ( ) Pension
- ( ) Railroad Retirement
- ( ) Insurance endowment
- ( ) Annuity
- ( ) New York State Disability
- ( ) Worker's Compensation

- \_\_\_\_\_ Business records, if self-employed
- \_\_\_\_\_ Past five (5) years of income tax returns, with 1099 Forms (as available)  
(Only the most current return is needed for a home care application)
- \_\_\_\_\_ Other: \_\_\_\_\_

**D. Resources – Required for Accounts/Stocks/Bonds/Policies bearing name of Applicant and Spouse**

- \_\_\_\_\_ All bank account statements, IRA account statements, mutual fund statements and investment account statements for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts\*
- \_\_\_\_\_ All passbook bank accounts for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts
- \_\_\_\_\_ All checking account statement for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts with all checks (front and back) in the amount of \$2,000 and over\*.
- \_\_\_\_\_ Life insurance policies and current cash value
- \_\_\_\_\_ Stock and Bond Certificates
- \_\_\_\_\_ Real estate deeds or co-op shares
- \_\_\_\_\_ Closing papers on property sales
- \_\_\_\_\_ Information about any pending lawsuits
- \_\_\_\_\_ Other: \_\_\_\_\_

***\*All financial documentation must be accompanied by an explanation for deposits and withdrawals over \$2,000. For example, if an account is closed, you must provide the bank name and account number that the funds were transferred to, proof of receipt by that account, and a closed account letter on bank letterhead.***

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## Appendix H

Access New York Health Care

# Medicaid Application

(with NYC and non-NYC supplements)





**Health  
Insurance**  
APPLICATION

# access NY

**for Children,  
Adults and  
Families**

health care



[Return to Table of Contents](#)



# INSTRUCTIONS

**CONFIDENTIALITY STATEMENT** All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

**PURPOSE OF THIS APPLICATION** Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

**PLEASE READ** the entire application booklet before you begin to fill out the application. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only Sections A through G and Sections I and J. Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must also complete Supplement A. The supplement includes questions about your resources, such as money in the bank or property you own.

Whenever you see the words **SEND PROOF** on the application refer to the “Documentation Needed When You Apply for Health Insurance” section for a listing of acceptable supporting documents.

**HOW TO GET HELP** When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE. (1-877-898-5849 TTY line for the hearing impaired)**

## SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

## SECTION B Household Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person. Also include City, State and Country of birth. If a person was born outside of the United States, just write the country of birth. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, brother, sister, niece, nephew, etc.)

- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card or plan identification card for Child Health Plus.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.  
  
Effective July 1, 2010, citizen children who provide their Social Security Number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.  
  
Children who are New York State residents and do not have other health insurance are eligible, regardless of their immigration status.

## PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

**The State will not report any information on this application to the USCIS.**

- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

## SECTION C Household Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

## SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. This information may affect their eligibility for coverage; for some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective.

Some children who had employer-based health insurance within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will



depend on your household income and the reason your children lost employer-based coverage.

NOTE: State Health Benefits Plans provide health insurance coverage through the New York State Health Insurance Program (NYSHIP). Coverage is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer. If your child has access to State Health Insurance Benefits through NYSHIP, he/she will be ineligible for Child Health Plus coverage.

We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.



## SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

## SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

## SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with a Facilitated Enroller. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

## SECTION H Parent or Spouse Not Living in the Household or Deceased

- If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.
- Pregnant women do not have to answer these questions until 60 days after the birth of their child. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of “good cause” is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- If the parents are not willing to provide this information, the applying child may still be eligible for Medicaid or Child Health Plus.

## SECTION I Health Plan Selection

**What is a Health Plan?** Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

**Who Must Choose a Health Plan?** People who are eligible for Family Health Plus and Child Health Plus **MUST** choose a health plan to get medical care. **MOST** people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

### How Do I Know What Health Plan to Choose and If I Can Enroll?

For Medicaid and Family Health Plus, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678**, or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYSDOH website at [www.nyhealth.gov](http://www.nyhealth.gov). You can also enroll by phone, by calling **1-800-505-5678**.

**NOTE:** If you or a family member are found eligible for Medicaid, and are in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

### For Child Health Plus:

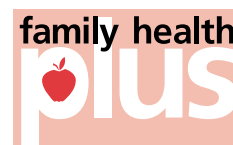
For information about Child Health Plus plans, call **1-800-698-4543**.

### Child Health Plus Premium

There are no premiums for Medicaid, or Family Health Plus. There may be a monthly premium for Child Health Plus. Use the enclosed chart to determine if you need to pay a premium based on your monthly income. You must include the first month's premium with the completed application or your child will not be enrolled.

## SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application.



# ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

## Section A Applicant's Information Please tell us who you are and how to contact you.

Legal First Name		Middle Initial	Legal Last Name	
Primary Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		Another Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		What Language Do You Speak? _____ Read? _____
<b>HOME ADDRESS</b> of the persons applying for health insurance <input type="checkbox"/> Check here if homeless		Street		Apt.#
		City		State
<b>MAILING ADDRESS</b> of the persons applying for health insurance if different from above.		Street		Apt.#
		City		State
<b>OPTIONAL:</b> If there is another person you would like to receive your Medicaid notices, please provide this person's contact information. I want this contact person to:  <input type="checkbox"/> Apply for and/or renew Medicaid for me <input type="checkbox"/> Discuss my Medicaid application or case, if needed <input type="checkbox"/> Get notices and correspondence		Name		State
		Street		Apt.#
		City		Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other

## Section B Household Information If you live in the household, start with yourself. If you do not, start with any adults who live in the household. List the full legal names of the persons applying for or already receiving Medicaid, Family Health Plus or Child Health Plus and list the ID Number from their Benefit Card or health plan ID card. You must provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21). Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.

#	Legal First, Middle, Last Name	Date of Birth <b>SEND PROOF</b>	Is this person applying for health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this person pregnant? <b>SEND PROOF</b> <input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	Is this person the parent of an applying child? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women <b>SEND PROOF</b>	*Race/Ethnic Group
01	_____ Full Maiden Name (person's birth name before they were married) _____ City of Birth                      State of Birth                      Country of Birth _____ This Person's Mother's Full Maiden Name	/ /  <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month   Day   Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
02	_____ Full Maiden Name (person's birth name before they were married) _____ City of Birth                      State of Birth                      Country of Birth _____ This Person's Mother's Full Maiden Name	/ /  <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month   Day   Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.  
**SEND PROOF** Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.  
 \*Race/Ethnic Group Codes (optional): A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

**Section B Household Information** (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth <b>SEND PROOF</b>	Is this person applying for health insurance?	Is this person pregnant? <b>SEND PROOF</b>	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women <b>SEND PROOF</b>	*Race/Ethnic Group
03	<input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female Full Maiden Name (person's birth name before they were married) City of Birth      State of Birth      Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
04	<input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female Full Maiden Name (person's birth name before they were married) City of Birth      State of Birth      Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
05	<input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female Full Maiden Name (person's birth name before they were married) City of Birth      State of Birth      Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
06	<input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female Full Maiden Name (person's birth name before they were married) City of Birth      State of Birth      Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
07	<input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female Full Maiden Name (person's birth name before they were married) City of Birth      State of Birth      Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	

Is anyone in your household a veteran?     Yes     No

If yes, name: \_\_\_\_\_

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

**SEND PROOF** Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.

\*Race/Ethnic Group Codes (optional): A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

## Section C Household Income Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

**Earnings from Work:** Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed check here:  Check here if no earnings from work:

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (weekly, monthly)

**Unearned Income:** Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. Check here if no unearned income:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

**Contributions:** Money from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). Check here if no contributions:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

**Other:** Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. Check here if none:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

1. Do you or any applying adult in Section B have no income?  No  Yes Who? \_\_\_\_\_

2. If there is no income listed above, please explain how you are living:  
(For example: living with friend or relative)

3. Have you or anyone who is applying changed jobs or stopped working in the last 3 months?  No  Yes

If yes: Your last job was: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Employer: \_\_\_\_\_

4. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program?  No  Yes

If yes:  Full Time  Part Time  Undergraduate  Graduate Student's Name: \_\_\_\_\_

5. Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school?  No  Yes

Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)

6. If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only?  No  Yes

## Section D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare?  No  Yes **If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary. SEND PROOF**  
Complete the rest of this application and complete Supplement A.

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance?  No  Yes **If yes, you must send a copy of the front and back of the insurance card with this application. SEND PROOF**

Name of Insured (primary) \_\_\_\_\_ Persons Covered \_\_\_\_\_ Cost of Policy \_\_\_\_\_ End date of coverage, if ending soon \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A.

3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions)  No  Yes  
If yes, does the public agency where that person works pay all or part of the cost of the health plan?  No  Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer?  No  Yes (If no, skip to question 5) If yes, what date did you lose coverage? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Your answer to this question will help us understand why people change their health insurance.

Why do the person(s) no longer have the health insurance? (Check only one)

- |  |   |
|--|---|
| <input type="checkbox"/> 1. The person who had the insurance no longer works for the employer that provided the insurance.   | <input type="checkbox"/> 4. The cost of health insurance went up and it was no longer affordable.   |
| <input type="checkbox"/> 2. The employer stopped offering health insurance.  | <input type="checkbox"/> 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.             |
| <input type="checkbox"/> 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent. | <input type="checkbox"/> 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have. |

5. Does your current job offer health insurance? **We may be able to help pay for it.**  No  Yes If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

## Section E Housing Expenses

1. Monthly housing payment such as rent or mortgage, including property taxes (just your share). \$ \_\_\_\_\_

2. If you pay for water separately how much do you pay? \$ \_\_\_\_\_ **SEND PROOF** How often do you pay?  every month  2 times a year  quarterly (4 times a year)  once a year

3. Do you receive free housing as part of your pay?  No  Yes

## Section F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home **STOP** please go to Section G.

1. Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution?  No  Yes  
If yes, finish completing this application **AND** complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill?  No  Yes If yes, finish completing this application **AND** complete Supplement A.  
Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.



## Section G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.

No  Yes If yes: Name: \_\_\_\_\_ In which month(s) of the previous three months do you have medical bills? \_\_\_\_\_

**SEND PROOF** of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months?  No  Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months?  No  Yes

If yes, who? \_\_\_\_\_ Which state? \_\_\_\_\_ Which county? \_\_\_\_\_

4. Does anyone who is applying have a pending lawsuit due to an injury?  No  Yes If yes, who: \_\_\_\_\_

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)?  No  Yes

If yes, who? \_\_\_\_\_

## Section H

**Parent or Spouse Not Living in the Household or Deceased** Families who are applying for their children and pregnant women are **NOT** required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause**. You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased?  No  Yes

If yes, name of applicant with deceased parent or spouse : \_\_\_\_\_ (If spouse or parent is deceased go to question 3.)

2. Does a parent of any applying child live outside the home? (If no, skip to question 3)  No  Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box

Child's Name:	Name of parent living outside the home _____ Date of Birth (if known): ____/____/____	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	Name of parent living outside the home _____ Date of Birth (if known): ____/____/____	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home?  No  Yes If yes, name of person applying who is still married: \_\_\_\_\_

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box

Legal name of spouse living outside of the home:	Date of Birth (if known):	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____
--	---------------------------	--

## Section I Health Plan Selection

If you are in receipt of Medicare, **STOP** skip this section.

**IMPORTANT:** People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan you want, use this section for your plan choice.

**NOTE:** If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

## Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of adult applicant or authorized representative for the applicant

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of adult applicant or authorized representative for the applicant

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus,

I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

### SOCIAL SECURITY NUMBER

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

### FOR MEDICAID APPLICANTS ONLY

#### • Release of Educational Records

I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

#### • Early Intervention Program

If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

- **Reimbursement of Medical Expenses**

I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

### FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership.

I understand that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in.

I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

- **Release of Medical Information**

I consent to the release of any medical information about me and any members of my family for whom I can give consent:

- By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, and Family Health Plus programs; and

- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

- **Reimbursement of Medical Expenses**

I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

## FOR OFFICE USE ONLY

### To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information:  X _____	Employed By: (check one)  <input type="checkbox"/> Community-Based Facilitated Enrollment Agency <input type="checkbox"/> Health Plan <input type="checkbox"/> Social Services District <input type="checkbox"/> Provider Agency <input type="checkbox"/> Qualified Entities  Employer Name: _____
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### To be completed by Facilitated Enrollers

Facilitated Enroller:	Lead Agency/Plan Name:	Lead Org/Plan ID:		
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

### To be used by the local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:	Date:
Center Office:	Application Date:	Unit ID:	Worker ID:
Case Name:	District:	Case Type:	Case #:
Effective Date:	MA Disposition Reason Code: <input type="checkbox"/> Denial Code <input type="checkbox"/> Withdrawal	Proxy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Registry #: Ver:

### To be used by Child Health Plus Plans

CHPlus Disposition: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):
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# Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

## This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.  
This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

### INSTRUCTIONS:

- Sections A through E must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections F through G.

## A. Applicant and Spouse Information

### 1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

### Is a person named above:

- Chronically ill?  Yes  No  
*(Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)*
- Certified Blind by the Commission for the Blind and Visually Handicapped?  Yes  No  
**(If yes, send proof.)**
- Interested in applying for the MBI-WPD program if disabled and working?  Yes  No  
*The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.*

## For New York State Residents outside of New York City

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code
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### 2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home?

Yes  No

If yes, provide the following information:

Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State Zip Code

Is the applicant's spouse deceased?  Yes  No

If yes, what is the date of death? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## For New York State Residents outside of New York City

### B. What Care and Services are you Applying for? (check the box that applies)

- You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.\*

- You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See “Documentation Requirements” below for a list of these resources.

This coverage includes the following services:\*

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

**Note: Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.**

- You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See “Documentation Requirements” below for a list of these resources.

\*You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

### DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care**, provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

**You do not need to send proof of any other resources at this time.** This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.



## For New York State Residents outside of New York City

### C. Resources/Assets

#### INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the “**NONE**” box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care, also list any accounts CLOSED in the past 60 months; include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of \$2,000 or more.**  
Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

#### 1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): NONE

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$

#### 2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): NONE

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /	\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /	\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /	\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /	\$

#### 3. Annuities, Stocks, Bonds, Mutual Funds: NONE

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				\$	/ /	\$
				\$	/ /	\$
				\$	/ /	\$
				\$	/ /	\$
				\$	/ /	\$
				\$	/ /	\$
				\$	/ /	\$

**For New York State Residents outside of New York City**

4. Life Insurance Policies: <span style="float: right;"><input type="checkbox"/> NONE</span>						
Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$

5. Burial Assets/Burial Contracts: (Include copies): <span style="float: right;"><input type="checkbox"/> NONE</span>		
a. Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Do you and/or your spouse have a burial space or plot for you or anyone else in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Do you and/or your spouse have money in a bank account set aside for a burial fund?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		\$
		\$
		\$

d. Do you have life insurance to be used as your burial fund?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>yes</b> , what is your policy number(s)? _____		
If <b>yes</b> , is the full cash value to be used for your burial expenses?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Does your spouse have life insurance to be used as a burial fund?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>yes</b> , what is the policy number(s)? _____		
If <b>yes</b> , is the full cash value to be used for burial expenses?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. <span style="float: right;"><input type="checkbox"/> NONE</span>					
Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			\$		\$
			\$		\$
			\$		\$
			\$		\$

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. <span style="float: right;"><input type="checkbox"/> NONE</span>					
Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

## For New York State Residents outside of New York City

8. List Any Other Resources:		
Resource Type	Name of Owner(s)	Value
		\$
		\$
		\$
		\$
		\$
		\$

### D. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate?  Yes  No
2. If you are in a medical facility and own your home, do you intend to return to your home?  Yes  No  
 If no, is anyone living in the home?  Yes  No  
 Who is living in the home? \_\_\_\_\_  
 How is this person related to you and/or your spouse? \_\_\_\_\_  
 If you and/or your spouse's child (of any age) is living in the home, is the child disabled?  Yes  No

**Note:** If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility. **Send proof of legal impediment.**

3. Equity Value in Home:  
 If you own your home, what is the equity value in your home? \$ \_\_\_\_\_  
**Note:** Equity value is the fair market value less any outstanding liens, mortgages, etc.

### E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply)  Yes  No

Rental Property   
  Vacation Property   
  Time Share   
  Vacant Land   
  Other Property Rights  
(In or outside of New York State)

If yes, provide the following information:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$

**STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.**

## For New York State Residents outside of New York City

### F. Asset Transfers

#### 1. Transfers

- a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property?  Yes  No
- 
- b. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust?  Yes  No

**If you answered yes to either of the questions above, explain the transfer(s) below.  
Attach additional sheets of paper, if needed.**

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			\$
			\$
			\$
			\$

- c. Are you in the process of selling property?  Yes  No
- 
- d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate?  Yes  No  
 If yes, when? \_\_\_\_\_
- 
- e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate?  Yes  No
- 
- f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note?  Yes  No  
 If yes, when? \_\_\_\_\_
- 
- g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity?  Yes  No  
 If yes, when? \_\_\_\_\_

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community?  Yes  No  
 If yes, send copy of agreement.

### G. Tax Returns

- Did you and/or your spouse file U.S. income tax returns in the last four years?  Yes  No
- If yes, send complete copies of these returns including all schedules and attachments.**

## For New York State Residents outside of New York City

### H. Important Information

#### ■ Liens on Real Property

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

#### ■ Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

#### ■ Annuities

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

### I. Certification and Authorization

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X \_\_\_\_\_  
SIGNATURE OF APPLICANT/REPRESENTATIVE

X \_\_\_\_\_  
DATE SIGNED

X \_\_\_\_\_  
SIGNATURE OF APPLICANT'S SPOUSE

X \_\_\_\_\_  
DATE SIGNED

## Access NY Supplement A

**This Supplement must be completed if anyone who is applying is:**

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.  
This includes care in a hospital that is equivalent to nursing home care

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

### INSTRUCTIONS:

- Sections A through F must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I.

### A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status

Note: The remaining questions are for the person(s) named above.

### B. Blind, Disabled or Chronically Ill

1. Are you chronically ill?  Yes  No  
*(Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)*

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped?  
**(If yes, send proof.)**  Yes  No

3. If you are disabled and working, are you interested in applying for the MBI-WPD program?  Yes  No  
*The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.*

C. Are you living in an adult home or assisted living facility?  Yes  No

## For New York City Residents

### D. Resources/Assets (check the box that applies):

- You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.\*
- You are applying for coverage of community-based long-term care services. You must submit documentation of the current amount of your resources.\* These services include:
- Adult day health care
  - Limited licensed home care
  - Private duty nursing
  - Hospice in the community
  - Hospice residence program
  - Assisted living program
  - Consumer directed personal assistance program
  - Certified Home Health Agency services
  - Residential treatment facility care
  - Personal emergency response services
  - Personal care services
  - Managed long-term care in the community
  - Waiver and other services provided through a home and community-based waiver program

**Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.**

- You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

\* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care**, also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of \$2,000 or more. **Note:** Medicaid retains the right to review all transactions made during the transfer look-back period.

#### 1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):

Bank Name and Account Number	Name of Owner(s)	Current Dollar Amount	Closed Account Balance/ Date Closed
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$

#### 2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

Account Number	Name of Owner(s)	Type/Institution	Current Dollar Amount	Pay Out
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

## For New York City Residents

3. Life Insurance Policies:				
Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$

4. Annuities, Stocks, Bonds, Mutual Funds:			
Name of Owner(s)	Company	Date Purchased	Value
			\$
			\$
			\$
			\$
			\$
			\$
			\$

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.					
Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			\$		\$
			\$		\$
			\$		\$

**6. Burial Assets/Burial Contracts: (Include copies)**

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family?  Yes  No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family?  Yes  No

Do you and/or your spouse have money in a bank account set aside for a burial fund?  Yes  No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		\$
		\$
		\$

Do you have life insurance to be used as your burial fund?  Yes  No  
 If **yes**, what is your policy number(s)? \_\_\_\_\_

If **yes**, is the full cash value to be used for your burial expenses?  Yes  No

Does your spouse have life insurance to be used as a burial fund?  Yes  No  
 If **yes**, what is the policy number(s)? \_\_\_\_\_

If **yes**, is the full cash value to be used for burial expenses?  Yes  No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.				
Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No



## For New York City Residents

### 8. Equity Value in Home:

If you own your home, what is the equity value in your home? \$ \_\_\_\_\_

**Note:** Equity value is the fair market value less any outstanding liens, mortgages, etc.

### 9. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		\$
		\$
		\$
		\$
		\$
		\$

### E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply)  Yes  No

<input type="checkbox"/> Rental Property	<input type="checkbox"/> Vacation Property	<input type="checkbox"/> Time Share	<input type="checkbox"/> Vacant Land	<input type="checkbox"/> Other Property Rights (In or outside of New York State)
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If **yes**, please answer the following questions:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$

### F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate?  Yes  No

2. If you are in a medical facility and own your home, do you intend to return to your home?  Yes  No

3. If **no**, is anyone living in the home?  Yes  No

Who is living in the home? \_\_\_\_\_

How is this person related to you and/or your spouse? \_\_\_\_\_

If you and/or your spouse's child (of any age) is living in the home, is the child disabled?  Yes  No

**Note:** If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

**STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, the last page of this document MUST be signed.**

## For New York City Residents

### G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

### H. Asset Transfers

#### 1. Transfers

- a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property?  Yes  No
- b. Are you in the process of selling property?  Yes  No
- c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate?  
If **yes**, when? \_\_\_\_\_  Yes  No
- d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate?  Yes  No
- e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note?  
If **yes**, when? \_\_\_\_\_  Yes  No
- f. Did you, your spouse, or someone on your behalf purchase or change an annuity?  
If **yes**, when? \_\_\_\_\_  Yes  No

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust?  Yes  No

**If you answered yes to any of the questions above, explain the transfer(s) below.  
Attach additional sheets of paper, if needed.**

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			\$
			\$
			\$
			\$

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.**  Yes  No

### I. Tax Returns

- Did you and/or your spouse file U.S. income tax returns in the last four years?  Yes  No  
**If yes, send copies of these returns.**

## For New York City Residents

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X \_\_\_\_\_  
SIGNATURE OF APPLICANT/REPRESENTATIVE

X \_\_\_\_\_  
DATE SIGNED

X \_\_\_\_\_  
SIGNATURE OF APPLICANT'S SPOUSE

X \_\_\_\_\_  
DATE SIGNED

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Senior Law Day  
Sponsorship Form



## Sponsorship Options

### Corporate Sponsorship: \$1,500

- Listing in all print and digital advertisements
- Logo/Name recognition at event and on event website
- Distribution of your organization's own printed advertising materials at the event

### Committee Member Sponsorship: \$1,000

- Listing in all print and digital advertisements
- Logo/Name recognition at event and on event website
- Distribution of organizations own advertising materials at the event

### Friends of Senior Law Day: \$350

- Individual Name Listing in the printed program under Friends of Senior Law Day

### Gifts to Senior Law Day

Private donations to help fund community programming

# Thank you.

Name of Sponsor

---

Contact Name (if different from above)

---

Business/Organization Name

---

Address

---

Phone / Fax

---

Email

---

Amount Authorized: \$ \_\_\_\_\_

Enclosed is a check made payable to: **Westchester Public/Private Partnership for Aging Services**

Please charge \$ \_\_\_\_\_ to my:

Visa  
 MasterCard

Card No.

---

Exp. Date

---

Print name as it appears on card

---

Signature

Please submit this registration form by mail, email, or fax.

Ms. Martha Marzano, c/o DSPS 10th Fl., 9 South First Avenue, Mount Vernon, New York 10550

Phone: (914) 813-6435

Fax: (914) 813-6296

Email: [mmm0@westchestergov.com](mailto:mmm0@westchestergov.com)

*Senior Law Day programming is under the 501(c)(3) status of Westchester Public/Private Membership Fund for Aging Services Inc. (Tax ID #:13-3631718).*

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