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Elder Law Attorney

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

Chair to Chair

Ellen G. Makofsky
Outgoing Chair

And so it is done. My term as Chair of the NYSBA Elder Law Section is complete. It was an extraordinarily busy year. The pace was quick and the challenges were many. At times I wanted to pull my hair out because there were so many "to do" items on my list and at other times I had the supreme satisfaction of knowing the Section accomplished so much. The Section's success was due to the efforts of its officers, **Ami S. Longstreet, Timothy E. Casserly, Stephen J. Silverberg, Michael J. Amoruso**, and **Daniel G. Fish** and the hard work of the Section's Executive Board. I have had the extreme pleasure of working with a very special board: **Joan L. Robert, Alfreida B. Kenny, Amy S. O'Connor, Deborah A. Slezak, Anne B. Ruffer, T. David Stapleton, Jr., Michel P. Haggerty, Howard F. Angione, Pauline**

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Ami S. Longstreet
Incoming Chair

It is with great excitement, and some trepidation, that I take on the role as Chair of the Elder Law Section. Each Chair that has preceded me has handled the job tremendously and gracefully and has garnered the utmost of respect from the Elder Law Section members, as well as the legal community as a whole. I hope to continue in that tradition and will work hard to earn your respect and to benefit the Section.

I am succeeding **Ellen Makofsky,** who has worked tirelessly to maintain and improve on the efforts of the Elder Law Section and who has successfully increased the Section's visibility within the New York State Bar Association as a whole as well as in the community at large. Ellen has also worked hard to increase the par-

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Yeung, Donald W. Mustico, Gayle L. Eagan, Richard A. Weinblatt, Batya S. Levin, Steven H. Stern, Rose Mary K. Bailly, Bruce L. Birnbaum, Marcia J. Boyd, Walter T. Burke, Edward V. Wilcenski, Hon. Joel Asarch, Gary E. Bashian, Valerie J. Bogart, Dean S. Bress, Ann Carrozza, Lawrence Eric Davidow, Anthony J. Enea, Ronald A. Fatoullah, Rita K. Gilbert, Cristine Cioffi, Ellice Fatoullah, Lisa K. Friedman, David Goldfarb, Judith D. Grimaldi, Lee A. Hoffman, Jr., Ellyn S. Kravitz, Howard S. Krooks, Kenneth F. Grabie, Sharon Kovacs Gruer, Hon. Edwin Kassoff, Bernard A. Krooks, Robert Kruger, Albert Kukol, Anthony J. Lamberti, Antonia J. Martinez, Robert J. Kurre, Tammy Rose Lawlor, Laurie L. Menzies, Frances Pantaleo, Louis W. Pierro, Margaret Z. Reed, Neil Rimsky, Joseph A. Rosenberg, Martin B. Petroff, Marie Elena Rosaria Puma, René H. Reixach, Jr., Ellen P. Rosenzweig, Vincent J. Russo, Ira Salzman, Robert M. Freedman, Robert Abrams, Muriel S. Kessler, Kathryn Grant Madigan, Michael E. O'Connor, Crystal Ann Doolity, Louis W. Pierro, Cora A. Alsante, Lisa K. Friedman and **Lawrence R. Bailey, Jr**. Two members of the NYSBA staff, **Lisa Bataille** and **Kathy Heider,** also contributed mightily to the success of the Section. I thank each of you for making me look so good and for the tremendous contributions you have made this year.

Much of the strength of the Elder Law Section has its roots in the generous manner its members share and disseminate information. Faced with a difficult year due to the changes wrought by the Deficit Reduction Act, the proposed New York State budget and other legislative proposals, the Section provided substantive, meaty interactive programming for its members, published the highly regarded *Elder Law Attorney*, disseminated a quarterly E-news electronic publication and provided up-to-the-minute updates on many important matters on the Section's listserve. These endeavors provide so much value to Section members that it is hard to understand how anyone could put out their shingle claiming to concentrate in Elder Law without membership in the NYSBA Elder Law Section. I thank all of you who have contributed your time and shared your knowledge with others in the Section.

This year the Section undertook an exciting new project, the Pro Bono Initiative. Our hardworking District Delegates each organized pro bono clinics for senior citizens around New York State in the fall of 2006 and again in the spring of 2007. Elder Law Section volunteers then met with the seniors and provided free legal advice to them. The program was exceedingly successful and the Section served hundreds of seniors all over the state. Again I thank all of you who contributed your time and efforts to this very worthwhile project.

This past year was also a time when the Elder Law Section became involved with numerous legislative proposals, which included the Compact for Long Term Care and a Living Will legislative proposal. As I write this column, Section members are currently expending much energy lobbying both of these propositions to the New York State Legislature. This year the Section has also created a broad outline for legislation designed to curb abusive sales of annuities to seniors and has tackled a problematic issue of redefining the elective share to include supplemental needs trusts for disabled spouses. These two proposals will require much additional effort before we can draft proposed legislation, but I know our members are up to the task. I thank all of those who have worked so hard to make the legislative landscape friendlier to the frail, elderly and disabled clients we serve.

The Section also updated and reissued the *Guidelines to Guardians* booklet, a Section publication distributed by numerous judges around the state following the appointment of a guardian. The Section went a step further and, understanding the problem for many non-English-speaking guardians, arranged and financed the translation of the booklet into Spanish to be sure that the Hispanic population also had the benefit of this very useful publication. Not only am I grateful for all of the effort that was put into this project but I am sure judges and guardians will also be expressing their thanks to those Section members who made the effort to see this happen.

Elder Law Section members are a collaborative group and as a result we have completed those tasks I have outlined above as well as numerous other projects. We have had a very productive year, and I thank you all.

As my term ends I know I am leaving the Section in the very capable hands of our new Chair, **Ami Longstreet,** and an exceptional group of Section Officers. I welcome the new Section Officers, **Sharon Kovacs Gruer** and **T. David Stapleton,** whose terms began on June 1, 2007. I know that Ami and the Section Officers have the vision, fortitude and energy to lead the Elder Law Section forward, and I wish them well.

Ellen G. Makofsky

ticipation of all of the Executive Committee members in the workings of the Elder Law Section.

As Chair, I plan to assist and promote the legislative efforts of the Section leaders, including lobbying for the Compact for Long-Term Care, which would provide our seniors with an alternative to the draconian rules of DRA 2005. The Compact, which is proposed legislation in the New York State Senate, would not be possible without the ongoing efforts of **Michael Amoruso, Howard Angione, Gail Holubinka, Howard Krooks, Marc Leavitt, Ellen Makofsky, Louis Pierro** and **Vincent Russo**.

I also plan to assist and promote lobbying for the proposed Living Will legislation which is already underway. This legislation was jointly drafted by the Elder Law Section and the Trusts and Estates Law Section, and approved by the House of Delegates of the New York State Bar Association, thanks to the diligent efforts of **Amy S. O'Connor**, and was lobbied for in Albany on April 17, 2007.

I also plan to assist in moving forward with the Concept Paper drafted by the Financial Planning and Investments Committee chaired by **Tim Casserly** regarding abusive sales practices of annuities to seniors. Additionally, I will assist with advancing the legislative proposals drafted by the Estate and Tax Planning Committee chaired by **Sharon Kovacs Gruer** and **Ellyn Kravitz**, which would allow a supplemental needs trust to satisfy the elective share when a spouse is disabled.

Additionally, it is my goal to maintain the outstanding programming that has been a consistent hallmark of our Section. The 2007 Summer Meeting will take place at scenic and activity-filled Stowe, Vermont. **Amy S. O'Connor** and **Fran Pantaleo** have done an outstanding job at putting together a stellar program including in-depth analysis of planning opportunities after DRA with an expert panel discussing all of the up-to-date planning methods available, as well as a lot of fun social activities including a lobster bake and hot-air balloon rides.

The 2007 Fall Meeting, co-chaired by **Sharon Kovacs Gruer** and **Joe Greenman,** will take place at the Turning Stone Resort and Casino, which is a beautiful resort with three championship golf courses and a brand new spa. The programming is also shaping up to be excellent, including in-depth analysis regarding supplemental needs trusts and other issues that arise with our clients with disabilities. The Fall Meeting will be immediately followed by the Elder Law Advanced Institute. Following in the footsteps of the 2006 Advanced Institute, this year's Institute will provide participants with up-to-the-minute information on current Elder Law issues and include interactive dialogues with panels of experts. The program co-chairs for the Advanced Institute are **Anthony Enea** and **Robert Kurre**.

The 2008 Annual Meeting will once again take place in New York City and will be chaired by **Judy Grimaldi**. Then, following the successful launch of the Spring 2007 new concept, the UnProgram, we will continue that for Spring of 2008 as well. For those that were unable to attend the UnProgram, it is unique as it is scheduled without formal speakers or formal agenda, but instead is driven by the questions, issues and topics raised by the attendees. Substantive as well as practice-related topics were discussed, and the UnProgram was very well received by all.

I also plan to continue the program started by **Ellen Makofsky** of holding Pro Bono Senior Clinics, which are run by each **District Delegate** for each of their respective districts. In doing so the District Delegate arranges to hold two to four clinics per year, in which older adults can receive a free 15 to 20 minute consultation with an attorney who is a member of the Elder Law Section on an Elder Law topic. This has been well received by seniors across the State and has helped forward the New York State Bar Association President's initiative to increase respect for attorneys and what we do as attorneys.

I also plan to continue the initiative of my predecessors in expanding opportunities for active participation by Section Members in this Section. Anyone who currently is not actively participating in this Section, please e-mail me with your interests and how you wish to participate in the Section and I will do everything I can to assist you in becoming an active member of our Section.

I wish to thank in advance all of the officers of this Section: **Timothy E. Casserly**, Chair-Elect; **Michael Amoruso**, Vice-Chair; **Sharon Kovacs Gruer**, Secretary; and **T. David Stapleton**, Treasurer, as I will need their able assistance in leading this Section. I also want to thank **Ellen Makofsky** for her wonderful leadership over the past year, and her mentoring to me to make my job much easier, and look forward to working with her again this year as immediate past chair.

I look forward to my term as Chair of the Elder Law Section, although a daunting task, but I know that the officers, the other members of the **Executive Committee** and the Section Members themselves will be there for active participation and support, and together we should have a productive and fun-filled year.

Ami S. Longstreet

Editor's Message

At about the same time that this edition of the *Elder Law Attorney* goes to print this summer, one year will have passed since the Deficit Reduction Act of 2005 (DRA) was implemented in New York.

I am certain that as Elder Law Practitioners we have all felt at one time or another the horrendous impact of the DRA upon the elderly and disabled requiring long-term care. This anniversary provides us with the opportunity to reflect upon what we have learned about the DRA, its impact upon our clients and the planning options available.

Former Section Chair Louis Pierro and his associates Jane-Marie Schaeffer and Ryan Coutlee have provided us with the first of a two-part article which provides a comprehensive and detailed review of the impact of the DRA entitled "The DRA One Year Later—Pitfalls and Opportunities Under the New Regime." The second part of the article to be published in the fall edition will focus on Spousal and Home Care issues post-DRA. We also have an excellent article by Ron Fatoullah and Stacey Meshnick focusing on "Innovative Planning with the Home Post-DRA." Sara Meyers has provided us with a detailed article entitled "Utilizing Medicaid Home Care as a Solution in a Post-DRA World." Finally, Kristin S. Jonsson has authored a wonderful short piece entitled "A Response to the Deficit Reduction Act of 2005: United States Savings Bonds as a Planning Tool." I believe all of these articles will provide the reader with greater insight into the status of long-term care planning post-DRA.

As a follow-up to our edition focusing on elder abuse, we have an interesting article by Gina Danetti addressing "Predatory Lending" and its impact upon seniors.

Additionally, in light of the tragedy at Virginia Tech, I have included a timely article by Lydia Hoffman Meunier and Carolyn Reinach Wolf entitled "Mental Health Issues on College Campuses." I felt that as Elder Law practitioners this is an issue we may encounter in our representation of the parents of children suffering from mental illnesses.

Finally, I wish to acknowledge the hard work and achievements of our Section Chair, Ellen Makofsky, during the past year, and wish our incoming Chair, Ami Longstreet, and all Section Officers the best of luck in their endeavors.

Anthony J. Enea
Editor-in-Chief

The DRA One Year Later—Pitfalls and Opportunities Under the New Regime

By Louis W. Pierro, Jane-Marie Schaeffer and Ryan Coutlee

On August 1, 2006, the Medicaid eligibility changes mandated by the Deficit Reduction Act of 2005[1] ("DRA") went into effect in New York State.[2] Since that time, elder law attorneys have been challenged to provide new solutions to clients that are in compliance with the amended law. Adding to the challenge is the fact that there are 58(!) agencies (57 County Departments of Social Services plus HRA in the five boroughs) charged with enforcing the new rules, apparently having wide latitude in enforcement. A number of strategies that existed pre-DRA have gained new significance, including caregiver agreements, exempt transfers and use of the irrevocable income only trust. Other strategies that have been developed to ameliorate the harsh results brought about by changes in the implementation date of the asset-transfer penalty, while conforming to the new rules, involve the use of annuities, promissory notes and grantor retained annuity trusts. Clearly, long-term care insurance must be considered for those clients who are medically qualified and can afford it, with the new federal partnership going into effect in other states, but New York's partnership remaining intact under the DRA.

This article will examine the old and new tools available to clients to navigate the rough seas of Medicaid eligibility.

Exempt Transfers

One thing the DRA did not change was the use of exceptions built into the law to allow exempt transfers. Specifically, the following transfers of the home are still considered exempt transfers: transfer of the home to the applicant's spouse; to a child under the age of 21 or a child who is certified blind or disabled; to a sibling with an equity interest in the home who resided there for one year prior to the date the applicant became institutionalized; and to a "caretaker child."[3] The following transfers of assets other than the home are still exempt: transfers to the spouse; to the individual's child who is certified blind or disabled, or to a trust for such a child; and to a trust established solely for the benefit of an individual under age 65 who is disabled.[4]

Making any of the above-listed transfers will *not* cause a penalty period for Medicaid purposes. For a client in long-term care crisis planning, it is critical to review the exceptions to transfer penalties and determine if any can be used to help the client spend down to the appropriate level. Spousal transfers may be followed by execution of a spousal refusal, although litigation against the spouse is increasing in a number of counties.

Caregiver Agreements

Caregiver agreements continue to be a viable Medicaid planning tool not impacted by the implementation of the DRA. The payments made to caregivers under these contracts are not considered uncompensated transfers that would result in a transfer penalty. However, it is important to formalize the agreement in writing and structure the terms of the agreement appropriately in order for the payments to the caregiver to be considered a transfer for value.

"A number of strategies that existed pre-DRA have gained new significance, including caregiver agreements, exempt transfers and use of the irrevocable income only trust."

A properly implemented caregiver agreement can avoid the new five-year look-back and penalty period commencement. A 2002 Fair Hearing decision confirmed the validity of the use of caregiver agreements and established necessary elements of such contracts.[5] The agreement needs to be written, specify the services being provided, establish an effective date, identify the parties involved, establish a reasonable rate of compensation that is reflective of the type and place of service and be executed by all parties identified in the agreement. The failure to include this information in a formalized writing jeopardizes the validity of the contract and related transactions upon review by Medicaid. In addition, it is important to remember that payments made to caregivers prior to the execution of an agreement are not allowed and will result in a transfer penalty if attempted.

There are tax implications involved with the use of caregiver agreements that should be considered and discussed with clients prior to entering into this arrangement. The provider of the services under the

caregiver agreement may be classified as an employee and the recipient (client) the employer.[6] However, if the service provider is arranged through an agency that establishes the compensation, the agency will likely be considered the employer.

As an employer, the recipient (client) will be responsible for collecting, reporting and maintaining information on the employee as well as withholding and paying Social Security, Medicare and unemployment taxes. Also, the compensation to the service provider must be compliant with minimum wage requirements. Clients can potentially utilize the payments under the contract as a deduction for health care expenses if it exceeds 7.5% of their adjusted gross income, they itemize their tax returns and the services were not provided by a family member unless the family member is a licensed professional in the health care industry. Often, the client will not be in a position to take advantage of the potential deduction. Finally, the employee will be responsible for claiming the compensation as earned income and usually end up paying tax at a higher bracket. Thus, if the agreement is utilized in a family situation for purposes of preserving income or resources, it may not completely achieve the intended result and requires the client to take on additional responsibilities.

The use of caregiver agreements should be considered on an individualized basis and must be weighed against the tax implications to the caregiver as well as treatment of the recipient of services as the employer of the caregiver. In addition, counties have recently challenged the use of such agreements for nursing home residents, arguing that the payment for services is a fully uncompensated transfer. Having an independent valuation of the services to be provided is key in establishing that the amount of consideration paid is correct, and that no transfer has occurred.

Irrevocable Income Only Trust

Planning five years in advance of the need for care is necessary regardless of the method of transfer, and the new law did not change the protection afforded by the irrevocable income only trust. Assets that have been placed into a properly drafted trust are considered unavailable assets for Medicaid purposes, and if they are transferred to the trust outside the five-year look-back period, there will be no penalty period imposed for the transfer. Of course this option is available only to generally healthy individuals who are able to part with control of the assets five years in advance of needing nursing home care or to pay privately until the time has run. Provisions can be drafted into the trust agreement to give the elderly individual some sense of control over the assets, such as the ability to change trustees and the ability to change the remainder beneficiaries of the trust by means of a special power of appointment. An irrevocable income only trust can be used as a planning tool for an individual who needs home care, as there are no transfer penalties associated with applying for Community Medicaid. In such case the individual may transfer the house to the trust, apply for and receive Community Medicaid, and if they are able to remain at home for the next five years, then the house is completely protected if they need to enter a nursing home. There exists the risk that nursing home care may be required within the five-year look-back period, and contingent plans must be made to cover the cost of institutional care if needed.

"The use of caregiver agreements should be considered on an individualized basis and must be weighed against the tax implications to the caregiver as well as treatment of the recipient of services as the employer of the caregiver."

Annuities

Perhaps one of the areas that changed the most under the DRA is the law surrounding annuities. For the purchase of an annuity to be treated as a transfer for value (and not cause the imposition of a transfer penalty) the annuity must meet the following requirements:[7]

- The annuity contract must be irrevocable
- The annuity contract must be actuarially sound (return of principal through payments must be made within the life expectancy of the individual)
- The payments must begin immediately (cannot have deferred payments or a balloon payment)
- The state must be named as the remainder beneficiary up to the amount of Medical Assistance provided (unless there is a spouse or minor or disabled child)

Therefore, the purchase of an annuity that meets the above-listed requirements is a planning tool that protects the assets used to purchase the annuity, although the annuity payments count as income and are budgeted toward the individual's NAMI (Net Amount of Monthly Income). This option works best for a married individual or an individual with a minor

or disabled child, since the spouse or child may be named the beneficiary of the annuity and will receive any funds remaining upon the individual's death. For a single individual without a minor or disabled child, this planning opportunity is not as attractive because the state must be named as the remainder beneficiary, and will receive the funds remaining in the annuity upon the individual's death, up to the amount of Medicaid provided.

However, an annuity used in conjunction with a reverse rule of halves transfer can offer a planning opportunity for many individuals. We have successfully used this technique with both a promissory note and a Grantor Retained Annuity Trust.

Promissory Notes

Generally, a promissory note can be utilized to convert resources of an individual into a stream of income to bring the individual below the applicable Medicaid resource levels without incurring a transfer penalty much in the same way as an annuity. The formation of a promissory note does not incur a transfer penalty. The monthly payments provide a means to pay for long-term care during a penalty period for any uncompensated transfers that were made during the applicable look-back period.

Unlike an annuity, a promissory note does not have to name the state as the remainder beneficiary. Yet, any unpaid amount under the note is payable to the individual's estate, which is subject to a Medicaid lien. One option yet to be tested is to make the promissory note owned by a Revocable Living Trust, which will receive the unpaid amount upon the individual's death and avoid the Medicaid lien.

The payments made under a promissory note must still start immediately and be in equal amounts. The promissory note must also be irrevocable and non-assignable and not provide for balloon payments or be self-cancelling at death. Caution must also be used when structuring the terms of repayment under the note to ensure the total monthly income of the individual will not exceed the Medicaid rate paid to the nursing facility or risk not being deemed "otherwise eligible" to commence the running of any transfer penalty.

Promissory notes, post-implementation of the DRA, appear to be receiving mixed treatment among New York counties. Some counties have denied applications if a promissory notes strategy is being employed. These counties have stated that the promissory note constitutes excess resources based upon the premise that the promissory note is an available resource for its value on the secondary market. However, the inclusion of language indicating the note is non-assignable is a viable argument against their holding. Other counties have approved the technique.

In Nassau County, a case was approved post-DRA successfully using the promissory note. The individual was in a nursing home and sold her home for approximately $140,000. (The house was in her name and had not been transferred before entering the nursing home). She immediately went off Medicaid upon receiving the sales proceeds. She then transferred approximately half of the assets to her children, incurring approximately an eight-month penalty period. She also immediately transferred the remaining half of the assets to her son in exchange for a promissory note that promised to pay her $8,700 per month for the next eight months (less than her life expectancy). The note payments, along with her other income, are just below the nursing home private pay rate. We then applied for Medicaid, and since she was otherwise eligible, she was approved and the penalty period began to run. When the penalty period runs out, in eight months, she will re-apply and become eligible for Medicaid.

We have had similar success in Oneida County. However we have been informed that Albany County has denied several applications that used a promissory note transfer. Fair hearings were conducted on the issue of counting the note as an asset (without a nonassignability clause) and on treating the loaned amount as a transfer. Ultimately, the effectiveness of promissory notes as tools for Medicaid planning remains county-specific at this point.

Grantor Retained Annuity Trust (GRAT)

One novel Medicaid planning technique involves an estate planning concept known as the Grantor Retained Annuity Trust ("GRAT"). Long used as an estate planning tool to transfer assets to one's heirs at a discounted value, these trusts can now be used for Medicaid planning. The technique used is similar to the promissory note transfer described above, but instead uses a GRAT that has a corporate trustee. This technique is useful for an individual who does not have any close family members to hold a note or for an individual who is not able to purchase a commercial short-term fixed annuity.

The reason the GRAT is a viable method is that the terms of the GRAT meet all the requirements for an annuity under the DRA rules. The GRAT is irrevocable, it is actuarially sound, payments begin immediately, and the state is named as the primary beneficiary, up to the

amount of Medicaid it has paid on the beneficiary's behalf. In setting the terms of the GRAT, we make sure the term is shorter than the life expectancy of the beneficiary and use a market rate of interest.

A case utilizing the GRAT technique, combined with an Irrevocable Trust, recently was approved in Rensselaer County. The individual had about $250,000 in assets. She transferred approximately half into an Irrevocable Income Only Trust, which resulted in an approximately 17-month penalty period. The remaining half of the assets were placed into a GRAT, with a local bank serving as the corporate trustee. The terms of the GRAT provided that the individual would receive payments over the next 17 months, which when combined with her other income, would cover her long-term care costs. The county issued a notice imposing a 17-month penalty period for the transfer of the assets to the Irrevocable Trust, after which she becomes otherwise eligible for Medicaid benefits. The county agreed that the funding of the GRAT was a conversion of resources into an income stream; therefore, the transfer of the assets to the GRAT was treated as a transfer for fair market value and no penalty period was imposed on that transfer.

Conclusion

Despite the harsh measures imposed by the DRA upon the frail and the elderly, there still remain several opportunities to help individuals plan to preserve assets, while providing for their long-term care cost needs.

Endnotes

1. Public Law 109-171 (2006).
2. New York State Department of Health Directive 06 OMM/ADM-5, effective August 1, 2006.
3. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(1-4).
4. Social Services Law § 366(5)(d)(3)(ii).
5. *In re the Appeal of Carolla*, FH3565848H (2002).
6. IRS Publication 926.
7. 06 OMM/ADM-5, pages 5-7.

Utilizing Medicaid Home Care as a Solution in a Post-DRA World

By Sara Meyers

It is safe to say that New York State has been committed to allowing persons to remain at home rather than to institutionalize them. Unfortunately, the delivery of home care services in New York is fragmented with many different reimbursement sources, kinds of services and kinds of providers involved. Irrespective of this fragmentation, Medicaid continues to be the primary funding source for most home care services.

The federal Deficit Reduction Act of 2005[1] (DRA), effective February 8, 2006, imposed harsh cuts on the Medicaid program and severely limited the ability to do crisis planning for Medicaid nursing home services. Medicaid-covered home care services remain an important solution for most Medicaid-eligible seniors because there are no transfer penalties for uncompensated transfers of assets for Medicaid-covered home care services in New York State. A client may transfer assets to a family member or friend, and apply for Medicaid home care services the following month. Medicaid-covered home care follows community Medicaid budgeting rules. Home care enables a senior to achieve the preferred goal of aging-in-place with the necessary support services.

The following is an overview of Medicaid-covered home care services. As a reminder, the application for home care services does not trigger the commencement of the transfer-of-assets penalty period. In order for the penalty period to start, the person must be residing in a nursing home and be "otherwise eligible for Medicaid."[2]

For Medicaid-funded personal care in general, the client's health and safety must be able to be maintained in the home. The client's medical condition must be *stable*,[3] defined as: not expected to suddenly deteriorate or improve; not requiring frequent medical or nursing judgment to determine changes in the plan of care; and be such that skilled professional care is not needed but assistance in the home is "to prevent a health or safety crisis from developing" as determined by the assessing nurse. In addition, the senior must be "self-directing."[4] He or she must be able to make choices about his or her activities of daily living, while understanding the impact of, and assuming responsibility for, the results of those choices. Non-self-directing clients who require continuous supervision and direction for making choices about activities of daily living are not eligible for personal care services unless a self-directing person or an outside agency or other formal organization provides supervision or direction of the worker on an interim or part-time basis as part of the plan of care.

New York State regulations divide personal care services into two levels of care: Level I and Level II.[5] There is no Medicaid transfer-of-assets penalty for Level I or II.

Level I services include housekeeping and chore services.[6] These services include the performance of "nutritional and environmental support functions," including:[7]

- making and changing beds;
- dusting and vacuuming;
- light cleaning of kitchen, bedrooms and bathrooms;
- dish washing;
- preparing a shopping list;
- shopping, if no other arrangements are possible;
- laundry, ironing and mending;
- payment of bills and other essential errands; and
- preparing meals, including simple modified diets.

Level I services can be authorized for a maximum of eight hours per week except that up to twelve hours per week can be authorized if the client needs meals prepared, including a simple modified diet, and informal caregivers are "unavailable, unable or unwilling" to provide assistance or are unacceptable to the client and community resources to provide meals are unavailable, inaccessible or inappropriate because of the client's dietary requirements.[8] In New York City, Level I services can be offered alone. Outside New York City, Level I services can only be offered in conjunction with Level II services.

Level II home care is better known at the Home Attendant (HA) Program in New York City or Personal Care Services (PCS) outside New York City.[9] PCS/HA services provide a custodial level of care which is not

covered by Medicare. For the purposes of Medicaid, PCS/HA are "prior approval" programs. The individual must submit an application for home care services (known in New York City as the M11-q, Medical Request for Home Care; or outside New York City, Form 1050, Medical Recommendation for Personal Care Services). Applications are made to the local department of social services or to a CASA office in New York City. The local agency then conducts a number of evaluations and assessments to determine how much care, if any, is needed and then authorizes the kind and amount of services.

The applicant for PCS/HA services must need assistance with a minimum of two Activities of Daily Living (ADLs). ADLS are defined as: feeding, toileting, grooming, bathing, ambulating, and transferring.

In addition to Level I tasks, the home attendant may perform "personal care" functions and assist with "activities of daily living," which include:[10]

- bathing the client in bed or in the tub or shower;
- dressing the client or helping the client to dress;
- grooming, including hair care, shaving and ordinary care of teeth and mouth;
- toileting, including helping the client get on and off, to use the toilet, commode or bedpan;
- helping the client to walk, inside or outside;
- helping the client to transfer from bed to chair or wheelchair;
- preparation of modified diets, such as low sugar, low fat, and low salt diets;
- feeding;
- administration of medication "*by the client*," including:
  - prompting the client as to time;
  - identifying the medication for the client;
  - bringing the medication along with any "necessary supplies" to the client;
  - opening the container;
  - providing the necessary liquid;
  - positioning the client;
  - disposing of used supplies;
  - storing the medication;
- routine skin care;
- use of medical supplies and equipment such as walkers and wheelchairs;
- changing of simple dressings;
- use of elastic support stockings;
- use of condom catheter;
- daily care of in-dwelling catheters;
- emptying of urinary drainage bags;
- use of hydraulic (Hoyer) lift;
- measuring intake and urinary output; and
- weighing client.

"Safety monitoring," the supervision of cognitively impaired home care recipients to prevent them from injuring themselves, is not a task that a home attendant is allowed to perform.[11] Home care recipients requiring the kind of care previously described as "safety monitoring" should, however, still be able to receive Medicaid-covered PCS/HA services if they phrase their requests for services as the need for assistance with specific activities of daily living. Clients who have dementia and exhibit such behaviors can obtain care if the needed assistance is not mischaracterized as a stand-alone task of safety monitoring, but rather is described as a form of verbal or physical assistance with a recognized activity of daily living such as ambulation.

Personal care service/home attendant hours can be authorized from four hours per day up to around the clock ("split shift") care. "Live-in" service means that the personal care worker spends the night at the client's home but is not required to assist the client more than once or twice during the night. "Split shift" (continuous care) service means that one worker is present during the day for twelve hours and another worker is present for twelve hours during the night who does not sleep and is available to care for the client all night. Continuous 24-hour care is provided to persons requiring *total assistance* with toileting and/or walking and/or transferring and/or feeding at *unscheduled* times during the day and night.[12] Total assistance is defined to mean that a specific function is performed and completed for the patient.[13] In many counties around the state, it is difficult to get 24-hour care because of cost and the lack of aides.

The Consumer Directed Personal Assistance Program (CDPAP) was previously known as the patient managed care program and is a part of the personal care/home attendant program. Since 1995, local districts have been mandated to ensure access to CDPAP "intended to permit chronically ill and/or physically

disabled individuals . . . greater flexibility and freedom of choice. . . ."[14] All eligible individuals receiving home care must be given notice of the availability of such programs and the opportunity to apply. Eligible individuals include recipients of personal care services, Certified Home Health Agency services and Lombardi services who have been assessed as able and willing to make informed choices as to the type and quality of services or who have designated an adult to make informed choices for them. The recipient need not be self-directing. Adult children or other family members can direct care of a patient.

The CDPAP agency acts as the fiscal agent for home attendants/personal care aides. Clients hire, train and supervise their home attendants/personal care aides, who are allowed to perform tasks which ordinarily would require the skills of a home health aide or even a licensed practical nurse.

In addition to the personal care/home attendant program, a senior can receive medical home health services through an agency certified to receive Medicaid reimbursement. In New York State, Certified Home Health Agencies and Long Term Home Health Care programs provide Medicaid home health services. Medicaid home health services must be provided pursuant to a physician's written plan of care and do not require prior approval.

Certified Home Health Agencies (CHHAs) are certified and regulated by the New York State Department of Health.[15] CHHAs must provide skilled services; in addition, they also provide personal care services to clients who need them in addition to the skilled services. There is no Medicaid transfer penalty for CHHA services.

A "home health aide" carries out health care tasks under the supervision of a registered nurse or licensed therapist and may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care at home. Some examples of health care tasks which home health aides may perform but personal care aides (home attendants) cannot are:

- preparation of meals in accordance with complex modified diets (but only nurses may add oral medications to food);
- assistance with tube feedings and total parenteral nutrition with such tasks as assembling, cleaning and storing equipment, disposing of used equipment and supplies, observing, recording and reporting and daily monitoring by taking temperature, weighing and testing urine for sugar (but only nurses may insert tubes, irrigate tubes, mix solutions, hook up solutions, etc.);
- placement of spray or spoon of medication in patient's mouth, but only if the patient is self-directing, apply topical medications for stable skin surfaces, assist patients with self-injection, administer nasal and ocular medications (not eye drops); give medicated baths;
- performance of skin and nail care, dressing changes on stable skin surfaces (but only nurses may perform dressing changes on unstable skin surfaces or cut nails);
- monitoring vital signs (pulse, temperature and blood pressure);
- performance of maintenance exercise program (passive and resistive range of motion, observe, record and report exercises, but only a licensed therapist may do active range of motion and adjust traction equipment); and
- care for mature and stable colostomies and tracheotomies.

The Long Term Home Health Care Program (LTHHCP), also known as Lombardi, is certified and regulated by DOH.[16] (This program is also known as "nursing home without walls.") The purpose of a Lombardi program is to provide the equivalent of nursing home care at home for chronically ill clients. A client must be medically eligible for nursing home services to qualify for the Lombardi program.

Lombardi programs must provide skilled services and "waivered" services.[17] Waivered services under the Lombardi program include: home maintenance tasks, housing improvements, transportation to social events, congregate or home-delivered meals, respite care, social day care, personal emergency response services, moving assistance, social work services, respiratory therapy, and nutrition counseling. Lombardi programs also provide personal care services to their clients when needed. In the Lombardi program, the cost of all services for each client may not be more than 75% of all the cost of nursing home care for that client. Some Lombardi programs provide services under a 100% cap through the "special needs" program.[18]

Lombardi budgeting follows nursing home budgeting rules for Medicaid purposes. The community spouse is entitled to spousal impoverishment budgeting and the Medicaid transfer rules do apply to the Lombardi program only when waivered services are included in the care plan. Individuals who have trans-

ferred assets during the look-back period are eligible for Medicaid coverage of Lombardi for non-waivered services.

Though the Lombardi program is similar to Medicaid-covered nursing home care for the purpose of the transfer-of-assets rules, an application for Lombardi does not trigger the commencement of the penalty period if transfers occurred. The only way for the penalty period to commence for individuals who have transferred assets and applied for LTHHCP would be if they entered a nursing home. Medicaid will not cover the cost of their nursing home care due to the transfer, but the penalty period will start.

Application procedures vary according to the kind of home health services required. Upon referral or request from a client, a CHHA or Lombardi program sends a nurse to visit the home and prepare a nursing assessment. A plan of care is prepared in consultation with the physician, the client, informal caregivers and any other agencies involved with the client's care.

"Practitioners should counsel their clients about Medicaid home care options and help them plan accordingly. Especially in light of the DRA, home care should be the long-term care option of choice for many seniors."

Practitioners must be mindful that while the home care program is a viable and practical option for many clients, the DRA does place limits on the home care recipient. The DRA imposes a $500,000 cap on the equity value of an exempt residence when the owner is residing in a nursing home or receiving community-based long-term care services.[19] New York State opted to increase the cap to $750,000.[20]

"Community-based long-term care services" for only purposes of the home equity cap include: inpatient hospital "alternate level of care," home and community-based waivered services (Lombardi with waivered services), home health care services (CHHA), and personal care services (home attendant in New York City).[21]

There are three exceptions to the home equity cap. If the Medicaid-eligible person's spouse, blind or disabled child of any age, or minor child resides in the person's home, there is no home equity cap.[22]

Medicaid-covered home care services have been an underutilized program in much of New York State. Practitioners should counsel their clients about Medicaid home care options and help them plan accordingly. Especially in light of the DRA, home care should be the long-term care option of choice for many seniors.

Endnotes

1. Deficit Reduction Act of 2005 (DRA), Public Law 109-171 (2006).
2. DRA § 6011(b)(2).
3. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(4)(i).
4. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(4)(ii).
5. Although detailed in State Regulations, Level III (N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(6)(iii)) home care services have never been implemented. Department of Health draft guidelines generated so much controversy about paraprofessionals performing health-related tasks that they have never been finalized.
6. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(6)(i).
7. 92 LCM-70 Personal Care Aide Scope of Practice (April 24, 1992).
8. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(6)(i)(b)(1).
9. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(6)(ii).
10. 92 LCM-70 Personal Care Aide Scope of Practice (April 24, 1992).
11. *Rodriguez v. Debuono*, 197 F.3d 611 (2d Cir. 1999), *cert den'd*, October 2, 2000; DOH GIA 03/MA 003 *Rodriguez v. Novello* (January 24, 2003).
12. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(3).
13. N.Y. Comp. Codes R. & Regs. title 18 § 505.14(a)(2)(ii).
14. N.Y. Soc. Serv. Law § 367-f.2.
15. N.Y. Comp. Codes R. & Regs. title 10 §§ 761 through 763.
16. N.Y. Comp. Codes R. & Regs. title 10 §§ 763.1 through 763.14; title 18, § 505.21.
17. These services are called "waivered" because they are authorized in federal Medicaid law under a waiver provision for home- and community-based services. 42 U.S.C. § 1396n(d); 42 C.F.R. §§ 440.181, 441.300 *et seq*.
18. N.Y. Soc. Serv. Law § 367-c2.
19. DRA § 6014(a).
20. DOH 06 OMM/ADM-5 Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes (July 20, 2006) § III.B.
21. DOH 06 OMM/ADM-5 § IV.A.14.
22. DOH 06 OMM/ADM-5 § III.B.

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Innovative Planning with the Home Post-DRA

By Ronald A. Fatoullah and Stacey Meshnick

In light of the Deficit Reduction Act of 2005 (DRA), the Elder Law attorney may need to seek creative options with regard to advising a client how to protect the residence. Planning using the homestead must be done because under the DRA, in order to be eligible, the Medicaid applicant may not have equity exceeding $750,000. New York State exercised its option under the DRA to raise the equity level from $500,000 to $750,000. The home equity limitation does not apply if the applicant's spouse or minor, blind or disabled child is living in the home. The following represent some of the options that have been discussed and are currently being tested by attorneys and their clients. Of course, these options are not necessary if there is not an individual to whom an exempt transfer could be made. Exempt transfers of the homestead may be made to (i) a spouse or minor or disabled child; (ii) a caregiver child who has been living in the home for two years prior to institutionalization; and (iii) a sibling who has an equity interest in the home and has been residing there for at least one year.

One option is to transfer the remainder interest in the home, with the applicant retaining a life estate, executing a note to repay a portion of the transfer. The transfer of the remainder interest would be characterized as part gift/part loan, with the recipient executing a promissory note to repay the applicant for the loan portion. The payments on the note would be used to pay during the penalty period those results from the gift. For example, if a 75-year-old New York City resident transferred the remainder interest in a $750,000 home, according to Medicaid tables the resulting transfer is $358,882.50 (.47851 remainder interest). The private cost of the nursing home in which she resides is $12,000 per month and her income is $2,000 per month. If the transferor takes back a note for $180,000, the gift is reduced to $178,882.50. The resulting penalty period for a transfer of $178,882.50 is 19.58 months. The income on the note of $180,000, paid back over the 19 months at an interest rate of 5.75%, is $9,954.16 monthly. That will be enough to cover the monthly cost of care, along with the individual's income. It is imperative that the promissory note complies with the terms of the DRA so that it is deemed to be a compensated transfer and so the note is not deemed to be asset for Medicaid purposes.

Another option is to transfer one-half of the home to a family member. The Medicaid applicant/transferor would subsequently sign a letter expressing the intent to return home so his or her one-half of the asset would not be considered an available resource. Once the Medicaid application is submitted and the penalty period starts to run, the home would be sold. The applicant would receive one-half of the proceeds, which would be used to pay for nursing home care during the penalty period. Note that in this scenario, the client would lose the $250,000 capital gains exemption on the half of the home transferred outright to a family member.

To illustrate using the above figures, the individual would transfer one-half of the home valued at $750,000, or $375,000. He or she would submit an application for Medicaid, as he would be "otherwise eligible" so long as a statement of intent to return home was submitted. There would be a period of ineligibility of approximately 41 months (40.53) for a New York City resident ($380,000/$9,375). When the property is sold the proceeds would be used to pay for the 41 months. The client may net $370,000, which may not be enough for the 41 months, so the figures may have to be tweaked just a bit, but the client could protect close to one-half of the asset.

There has been a lot of discussion about purchasing a life estate in a relative's home, in which the purchaser will live for one year subsequent to the purchase. An individual can purchase a life estate in a relative's property and the purchase will not result in a period of ineligibility so long as the purchaser resides in the home for one year subsequent to the purchase. Hence, if the same 75-year-old New York City resident purchases a life estate in her daughter's $750,000 home, it would be valued at $391,175 (.52149 of the value) and the transfer would not result in a period of ineligibility for Medicaid as long as the individual resided in her daughter's home for one year subsequent to the purchase. The seller may apply the capital gains tax exclusion to the sale of the remainder interest but must specifically elect to do so (I.R.C. § 1.121(d)(8)(A); Reg. § 1-121-4(e)(2)(ii)(A)). However, it appears that the seller cannot claim more than one exclusion on the sale of the same residence (Reg. § 1.121-2(a)(1)).

Another way to purchase a life estate is with the remainder interest in one's homestead. Using the prior example, if a 75-year-old transfers a remainder interest in her $750,000 home to her daughter, valued at $358,882.50, in exchange for a life estate in the daughter's $950,000 home, the transfer would be compensated as long as she lived in the daughter's home for a continuous period of one year after the transfer. The

life estate in the daughter's home would be valued at $495,415.50 (.52149). If the woman did not have any liquid assets to use toward the purchase, the purchase would be considered to be a partial gift from daughter to mother, using up some of the daughter's lifetime gift exemption. If the woman had liquid assets, up to $136,533 could also be protected in this example by using the assets toward the purchase.

Instead of purchasing only a life estate in a child's house, an individual can purchase the entire house. If the individual lives in the home for at least two years after the transfer, the home would then be transferred to the child who resides in the home as an exempt transfer to a caretaker child. So, for example, if Mom purchases daughter's home at the fair market value of $700,000 and lives in the home for two years after purchase, at which time Mom requires nursing home care, Mom can transfer the home to the daughter as caretaker child without incurring a penalty period.

It is important to utilize any available exempt transfers of the homestead. These have not been affected by the DRA. Further, exempt transfers can be used in conjunction with other methods such as the purchase of a life estate. For example, a caregiver child has been living with Mom, who is 76 years old, for several years. Mom has a home valued at $400,000 and $200,000 in liquid assets. Mom gifts her home to the caregiver child. This is an exempt transfer and will not create a penalty period. Subsequent to the gift, Mom uses her liquid assets of $200,000 to purchase a life estate on the home. Mom continues to reside in the home for one year and then is eligible for Medicaid nursing home care.

An individual can also purchase a joint interest in a property held by a family member with whom they will reside for a period after the purchase. The purchase is a compensated transfer because the client is receiving a one-half interest in real property. After an application is made with submission of the intent to return home, Medicaid can place a lien on the applicant's one-half. It has been proposed by some attorneys that on death the lien dissolves because the property passes to the joint owner. If Mom purchases a 50% joint interest in daughter's $950,000 home, valued at $475,000, it is a compensated transfer. Mom will then submit a statement of intent to return home. A lien will be placed on Mom's one-half interest. However, when Mom dies, the lien may dissolve.

Attorneys will be recommending more personal care contracts between seniors and their caretaker relatives. If an individual has an interest in a residence or any property for that matter, he or she could transfer as fair market compensation some or all of said interest in exchange for the family member's promise to provide personal and/or managerial services.

Another untested option for the younger Medicaid applicant is to transfer the home to a revocable trust. The revocable trust would, in turn, transfer the home in exchange for a promissory note. This option would benefit younger applicants who have longer life expectancies. Monthly payments would be made to the trust and upon death the payments would continue to be made to the beneficiaries pursuant to the terms of the trust. The transfer in exchange for the promissory note would not be considered a gift if the note meets the following requirements of the DRA: (i) it is actuarially sound; (ii) it provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments; and (iii) it prohibits the cancellation of the balance of the note upon the death of the applicant/recipient. Further, if the note is non-assignable, it will not be deemed an available asset.

Finally, many clients are overwhelmed and some have neither liquid assets nor access to liquid assets. They come in for a consultation and are willing to simply sell the home and spend down all of the proceeds. For those few clients who are unable or unwilling to effectuate a plan, at a minimum they can apply for Medicaid with the submission of a statement of intent to return home. Medicaid may put a lien on the home and when the home is sold, Medicaid will be repaid. However, Medicaid will be paid back at the Medicaid rate.

An individual who is doing Medicaid planning using the homestead should not retain a life estate if he or she or the family intends to sell the home during the individual's lifetime. Both the remainderman and life tenant would have income tax ramifications. While the life tenant would be able to utilize the I.R.C. § 121 exclusion, the remainderman would not (unless he or she occupied the property as a personal residence).

In the current climate, it is difficult to be certain what method will go unchallenged by Medicaid agencies. It will likely be necessary for attorneys to attend fair hearings to argue the validity of some of the plans proposed herein.

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A Response to the Deficit Reduction Act of 2005: United States Savings Bonds as a Planning Tool

By Kristin S. Jonsson

Introduction

The changes effected by the Deficit Reduction Act of 2005 (DRA)[1] made it much harder and more complicated to plan for long-term care under Medicaid. However, the DRA did not alter the pre-existing planning tools set forth in the NYS Department of Health's *Medicaid Reference Guide*, including the policy in the "Stocks, Bonds and Securities" section, which states that certain U.S. Savings Bonds are not available resources.

Owning and Purchasing United States Savings Bonds

Savings Bonds can be purchased in paper form or electronically.[2] In either case, there are three available registration forms for the bonds: sole ownership, co-ownership and beneficiary registration.

Regardless of the registration form, the Department of the Treasury dictates that each individual is permitted to purchase up to $30,000 of Series I and $30,000 of Series EE Savings Bonds per calendar year.[3] These bonds are neither transferable nor negotiable and are payable only to the owner(s) named on the bonds.[4] In addition, there is a mandatory initial holding period of twelve months, during which time the bonds cannot be redeemed.[5]

Savings Bonds Are Unavailable Resources

During the mandatory initial holding period, Series I and Series EE Savings Bonds are not considered an available resource in determining eligibility for Supplemental Security Income (SSI).[6] In turn, because Medicaid may not have a more restrictive methodology for determining resource eligibility than SSI,[7] Savings Bonds cannot be considered an available resource during the mandatory initial holding period in determining Medicaid eligibility.[8] As a result, $60,000 of available assets can be sheltered by simply investing them in Savings Bonds, rendering the assets unavailable.[9]

Furthermore, in using the beneficiary registration, the bonds are payable on death to the designated beneficiary and remain outside the reach of any claims by the Department of Social Services upon the death of the A/R.[10] Since they are not part of the probate estate, they are not subject to recovery.[11]

During the A/R's life, however, the bonds will be considered an available resource as of the first moment of the thirteenth month after they were purchased. It is, therefore, imperative that the bonds be redeemed and new bonds be purchased within that month.[12] Although the A/R may be considered ineligible for the month in which the bonds were redeemed (most likely requiring repayment to Medicaid for that month), the bulk of the assets will continue to be protected.

Also keep in mind that interest earned on Savings Bonds will be counted as an increase in the value of the resource (not as income) in the month received.[13] For both series, interest is only available, and therefore only considered for Medicaid purposes, at redemption.[14]

Hardship Waiver

The Commissioner of the Public Debt does have the authority to waive the initial holding period "in order to relieve any person or persons of unnecessary hardship."[15] As a result, some states have taken the position that United States Savings Bonds are an available resource, unless a hardship waiver request is granted.[16] New York State is reportedly working on a GIS to tackle how to deal with Savings Bonds in New York. It is possible that they will take a similar position, and require the A/R to request a hardship waiver from the Commissioner of the Public Debt. The waiver authority clearly is aimed at hardship for the bond owner, not a third party. If a general creditor's claims were deferred during the holding period, that should not justify a waiver and the policy should be no different for Medicaid. Further, since SSI does not require pursuit of hardship waivers, Medicaid should not be able to do so either.

Conclusion

There is no telling what the GIS will say or how long it will be before it is issued. Until then, purchasing United States Savings Bonds is a quick and inexpensive way for clients to protect some of their assets.

Endnotes

1. Public Law 109-171 (2006).
2. Paper bonds can be obtained at most banks and electronic bonds can be purchase through www.treasurydirect.gov.
3. 31 C.F.R. §§ 360.10 and 353.10(a).
4. 31 C.F.R. § 353.15.
5. 31 C.F.R. §§ 360.35(b) and 353.35(b).
6. POMS § SI 01140.240.
7. 42 U.S.C. § 1396a(a)(10)(C)(i)(III).
8. NYS Department of Health, *Medicaid Reference Guide*, p. 268. The *Medicaid Reference Guide* still refers to a six-month holding period, but that was changed to 12 months in 2003. Department of the Treasury, 68 Fed. Reg. 2666, 2667 (Jan. 17, 2003).
9. In a spousal situation, each spouse can purchase $60,000 of Savings Bonds.
10. The beneficiaries are subject to the same mandatory retention period as the A/R.
11. *See* N.Y. Social Services Law § 369.
12. This can be done at any time during the thirteenth month as the issue date of the bonds is the first day of the month in which payment for the bonds is received. 31 C.F.R. § 359.3.
13. *See* NYS Department of Health, *Medicaid Reference Guide*, p. 269. *See also,* POMS § SI 01140.240.
14. 31 C.F.R. §§ 353.30 and 359.17.
15. 31 C.F.R. § 353.90.
16. *See, e.g.*, Georgia Medicaid Policy § 2310-1.

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The Power of Florida's Qualifying Supplemental Needs Trust to Satisfy the Elective Share

By Howard S. Krooks and Scott M. Solkoff

Howard S. Krooks

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Florida's elective share is an amount equal to 30 percent of the elective estate. (F.S. § 732.2065.) The property that is included in the elective estate is augmented for elective share purposes in Florida since 1999 as set forth in F.S. § 732.2035. The augmented elective estate includes, among other things, assets in the decedent's probate estate, the decedent's ownership interest in "transfer on death," "payable on death" and "in trust for" accounts or accounts co-owned with rights of survivorship. The elective share is in addition to the homestead, exempt property and the family allowance.

In Florida, one can satisfy the elective share by creating in his or her Last Will and Testament a qualifying supplemental needs trust (SNT) for the benefit of the surviving spouse. As gifts made via non-SNT trusts could constitute a gift resulting in a penalty period for Medicaid eligibility purposes, it is best to provide for the SNT in the decedent's will as opposed to a revocable or irrevocable trust.

Under Florida law, the income and principal of the qualifying supplemental needs trust must be distributable to or for the benefit of the spouse for life in the discretion of one or more trustees less than half of whom are "ineligible" family trustees. Ineligible family trustees include the decedent's grandparents and any descendants of the decedent's grandparents who are not also descendants of the surviving spouse. Thus, this would include the decedent's parents and brothers and sisters, nieces and nephews, etc.

Florida law also requires court approval for the creation of such a qualifying supplemental needs trust in satisfaction of the elective share if the aggregate value of all property in the trust is $100,000 or more. While this will require some additional legal fees and probate fees that might have otherwise been avoided through the use of a non-SNT trust, the benefits far outweigh these additional costs.

A "reverse pour-over supplemental needs elective share trust" may sound like a mouthful of legalese—but this advanced Florida planning strategy provides the client with the benefits of a revocable trust along with the benefits of elective share preservation. The trust typically owns all of the couple's assets. The trust includes a provision for the calculation of the elective share amount and directs that the elective share amount shall pass to the decedent's estate. The decedent's Last Will and Testament provides for the creation of the supplemental needs elective share trust. Because the supplemental needs trust is created under the Will, the client avoids potential Medicaid transfer penalties. Because the couple's assets were owned by the trust, all of the other assets pass outside of the estate and are not subject to a Florida probate proceeding. The "reverse pour-over supplemental needs elective share trust" provides clients with the best of both worlds, avoiding the delay and expense of probate with respect to the bulk of estate assets while allowing for the elective share to be made available to the surviving spouse free of Medicaid penalties.

"In Florida, one can satisfy the elective share by creating in his or her Last Will and Testament a qualifying supplemental needs trust for the benefit of the surviving spouse."

Imagine a married couple whose estate is valued at $400,000. Whether utilizing the reverse pour-over concept or simply having all of the assets pass through probate, if the spouses execute wills creating a qualifying supplemental needs trust for each other's benefit when they die, then $120,000 would go into a supplemental needs trust upon the death of the first spouse for the benefit of the surviving spouse. Rather than being forced to spend down these funds on long-term care costs, these funds would remain available to supplement those costs to the extent not covered by a government program such as Medicaid. In New York, which does not presently allow the satisfaction of the elective share by creating an elective share trust, the surviving spouse would either have to spend down the elective share amount or could engage in Medicaid planning to protect a portion of that amount. However,

the surviving spouse's ability to engage in Medicaid planning is severely restricted due to the provisions of the Deficit Reduction Act of 2005.

"It is an approach that makes sense because it preserves the surviving spouse's right to the elective share amount while also permitting the spouses to engage in some type of planning designed to achieve asset protection in the face of exorbitant long-term care costs."

The Elder Law Section of the New York State Bar Association is currently spearheading an effort to pass legislation that would codify the approach available in Florida. It is an approach that makes sense because it preserves the surviving spouse's right to the elective share amount while also permitting the spouses to engage in some type of planning designed to achieve asset protection in the face of exorbitant long-term care costs.

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Recent New York Cases

By Judith B. Raskin

Supplemental Needs Trust

A property management guardian requested authority to purchase a house for the trust beneficiary with trust funds. She would live there with family members. The Dept. of Human Resources objected. Granted. *In re Cooper*, 2007 N.Y.; Misc. LEXIS 391; 237 N.Y.L.J. 27 (Sup. Ct., Queens County, February 2, 2007).

Miss Cooper, age 14, lived in poor, crowded conditions that lacked room for the equipment needed to make her safe and comfortable. Her guardian sought authority to purchase a three-bedroom house, and the trustee of Miss Cooper's supplemental needs trust agreed. The Dept. argued that the motion was not made by the trustee, Deutsche Bank, that the purchase would not primarily benefit Miss Cooper, that the trust income would be greatly reduced and that the other family members living in the house would not substantially contribute to its upkeep.

The court approved the purchase. Income from the trust would still be sufficient, the trustee supported the petition and the purchase was necessary to improve Miss Cooper's current deplorable living conditions. An indirect benefit to others is not reason to reject an expense that in this case would primarily benefit Miss Cooper.

In an Article 78 proceeding, petitioner appealed from a fair hearing decision upholding a determination that petitioner Medicaid recipient could not deposit her excess income into a supplemental needs trust for the benefit of her son. Reversed. *Hammond v. Commissioners NYSDSS and NCDSS*, Index No. 15833/06 (Sup. Ct., Nassau County, January 11, 2007).

Nassau County DSS denied petitioner the right to deposit her excess income into a supplemental needs trust for the benefit of her disabled son. A fair hearing upheld this determination. In this Article 78 proceeding the court held that the facts in this case could not be distinguished from the facts in *Kaiser v. Commissioner of NYS Dept. of Health*, 13 Misc. 3d 1211(A) (Sup. Ct., Nassau Co., 2006). The determination at the fair hearing was reversed based upon the reasoning in *Kaiser.*

Thank you to Beth Polner Abrahams for submitting this case for review. Beth was the attorney for the petitioner.

Legal Malpractice

Plaintiffs brought an action for legal malpractice for improper will drafting. The will was drafted 3.5 years prior to commencement of the action. Dismissed. *Iser v. Kerrigan et al.*, 2007 N.Y. Slip Op. 01522 (App. Div. 2d Dep't February 20, 2007).

Plaintiffs sought to recover damages for legal malpractice alleging that the will drafted by the defendants omitted provisions to protect the estate against significant estate tax. The will was executed on June 25, 2001 and the action for malpractice was commenced in January 2005.

The defendants moved to dismiss the complaint as time barred.

The Appellate Division agreed with the defendants and dismissed the complaint as time barred. A legal malpractice claim accrues when the facts are known and generally when the injury has occurred. Although the plaintiffs were not aware of the injury until they brought the action, the malpractice, if any, was committed when the will was executed. If representation of the client had continued beyond the date of execution of the will the three-year limitation might have been tolled.

Article 81

Petitioner appealed the dismissal of her petition to appoint a guardian for her father. Reversed. *In re Daniel TT*, 2007 N.Y. Slip Op. 1458, 2007 N.Y.; App. Div. LEXIS 1968 (App. Div. 3d Dep't February 22, 2007).

Petitioner daughter Donna sought appointment of a guardian for her father, Daniel TT. Mr. TT was living with his other daughter, Diane, who was granted power of attorney, appointment as health care agent and unequal benefits under an irrevocable trust. These documents were prepared in March 2006 by an attorney chosen by Diane and not the father's long-standing attorney. Donna alleged in her petition that her father was living in unsanitary conditions, that the documents were signed when her father did not understand what he was signing, that Diane exerted undue influence, that Diane was not acting in her father's best interests as attorney-in-fact and that Diane restricted access to Mr. TT. Counsel for Mr. TT and Diane opposed the appointment of a guardian.

The court evaluator reported that although Mr. TT was oriented and able to converse about his desire to live with Diane under her financial management, he

did not fully understand his estate planning documents. The court evaluator was concerned about Diane's overreaching because although Mr. TT had previously expressed his desire to leave his assets equally to his two daughters, the trust provisions favored Diane. Mr. TT's long-standing attorney stated by affidavit that Mr. TT had some form of dementia and that for many years he stated he wanted his assets distributed equally. The court evaluator and the petitioner requested discovery to determine capacity issues and other relevant matters.

The Supreme Court dismissed the petition based upon the estate planning documents already in place and the determination that the petitioner could not meet her burden of proof required to terminate them.

The Appellate Division reversed. The court below erred in determining the two factors to be considered. One was the need for the appointment of a guardian and the other was whether Mr. TT was incapacitated. Mr. TT's ability to execute his estate planning documents was in question and the petitioner produced evidence sufficient to raise a question of fact as to whether Mr. TT was incapacitated. The petitioner must have a hearing and the opportunity to present witnesses. The court evaluator's motion to inspect medical records should have been granted.

Trust Reformation

The grantor of an irrevocable trust sought reformation of the trust to reflect her intent to protect principal if she needed to apply for Medicaid. Granted. *In re Scheib*, 2007 N.Y. Slip Op. 50122U; 14 Misc. 3d 1222A; 2007 N.Y. Misc. LEXIS 162 (Sup. Ct., Nassau County, January 26, 2007).

Genevieve Scheib executed an irrevocable trust dated March 4, 1996. The attorney draftsman wrote to her prior to the execution that the trust was created to protect certain assets from claims by Medicaid. However, the trust contained provisions permitting the trustee to provide principal for the grantor for items including medical, hospital and nursing home expenses. When the grantor discovered this error she brought this proceeding to have the trust reformed to delete those provisions that were contrary to her stated objective. The trustee had not yet distributed any principal to or for the benefit of the grantor and agreed with the request for reformation.

The court granted the request to reform the trust to comply with the grantor's intent. While courts rarely reform trusts to correct mistakes, in this case clear proof was presented that the *inter vivos* trust did not reflect the grantor's intent and the mistake should be corrected.

Petitioner sought reformation of a testamentary trust to an Escher trust. Granted. *Estate of Hyman*, 2007 N.Y. Slip Op. 50265U; 2007 N.Y. Misc. LEXIS 402 (Surr. Ct. Nassau County, February 16, 2007).

A non-interested trustee was appointed as a co-trustee to distribute assets to the beneficiary because the other co-trustees were also remaindermen and so could not make such distributions. With the support of the non-interested trustee, his co-trustee, a daughter of the decedent, sought to amend the testamentary trust in her father's will.

The testamentary trust for the benefit of her disabled brother provided for income and principal distributions to the beneficiary for "health, support and maintenance." Petitioner argued that the decedent's intent was to provide funds for the comfort and maintenance of her brother and that it not be spent on medical care that would otherwise be provided by government entitlement programs.

The court ordered that language be substituted that would convert the trust to an Escher trust. In *In re Escher*, Mr. Escher similarly did not intend that his daughter's trust fund would be used to pay for expensive medical costs that would otherwise be paid through government entitlement programs. In this case, all interested parties consented to the reformation of the trust and the Dept. of Social Services did not appear.

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Predatory Lending: Targeting Seniors

By Gina T. Danetti

Seniors are one of the main target groups for predatory lending scams. Many seniors are vulnerable to unscrupulous lenders because they lack financial sophistication or have diminished mental capacity due to the onset of dementia-related diseases. This article is written to give you a basic understanding of predatory lending laws and issues.

On March 27, 2007, the United States Congress, Financial Services Subcommittee, heard testimony regarding subprime lending practices. Consumer groups advocated for the expansion of protections under current federal law, the Home Ownership and Equity Protection Act of 1994 ("HOEPA") (15 U.S.C. § 1639). HOEPA establishes disclosure requirements and prohibits certain practices in connection with high-cost mortgages. HOEPA is triggered if a loan meets specific rated-based and/or points and fee-based criteria, provided that the loan is secured by the customer's principal dwelling and is not a residential mortgage transaction (financing the purchase or initial construction of your home), a reverse mortgage transaction or an open-end credit plan.

Evaluating the annual percentage rate of a loan is one way to determine if a loan is subject to the high cost rules of HOEPA. Generally, a primary home equity loan falls under HOEPA if the loan's annual percentage exceeds the yield of a comparable treasury security by more than 8%. A secondary loan must exceed a comparable treasury security by more than 10%. The treasury security index that is selected should have a comparable maturity to the loan and should be selected as of the fifteenth day of the month preceding the month the application is submitted to the creditor.

If the loan is not subject to the annual percentage rate rules of HOEPA, it may still qualify under the points and fees test. This test is based on total finance charges and fees as a percentage of the loan amount. The loan falls under HOEPA if the total points and fees the consumer pays at or before loan closing exceed the greater of $547 (for 2007) or 8% of the total loan amount. There are special calculations for this trigger. The calculation should include usual finance charges, charges that are exempt but deemed unreasonable, compensation to institutions or affiliates, and credit life, accident or loss of income insurance.

If a loan falls under HOEPA, the lender is required to provide a required verbal disclosure statement three days before the closing and a written disclosure statement by the closing date. The lender must disclose the annual percentage rate of the loan, the amount of the regular monthly payment, a statement that the interest rate and monthly payment may increase, and the amount of the maximum monthly payment, based on the maximum interest rate allowed by law.

"Evaluating the annual percentage rate of a loan is one way to determine if a loan is subject to the high cost rules of HOEPA."

The lender is also required to provide the following specific written disclosure:

> NOTICE: You are not required to complete this agreement merely because you have received these disclosures or have signed the loan application.
>
> NOTICE: If you obtain this loan, the lender will have a mortgage on your home. You could lose your home, and any money you have put into it, if you do not meet your obligations under this loan. HOEPA, 15 U.S.C. § 1639(a)(1).

HOEPA is aimed at protecting seniors from the following abuses and practices:

Loan Flipping: The lender assures the client that they may refinance in the future if they are unable to pay the monthly cost. Then the lender encourages them to repeatedly refinance the loan and to borrow more money. Each time they refinance, they are charged additional fees and interest points.

Balloon Payments: The client pays low monthly payments upfront but the loan has a large balloon payment due in less than five years.

Direct Payment to a Contractor: The lender arranges for direct payment of a loan to a bogus contractor and charges exorbitant financing fees.

Insurance Packing: The lender adds overpriced single premium credit, life, disability and unemployment insurance to the loan. The full premium is paid upfront instead of monthly. The insurance may never be needed.

Bait and Switch: The lender pressures the client to accept higher charges at the closing. For example, they are told that the loan will have a 12.3% interest rate. At the closing they are told that they found a blemish on

their credit report and in order to get the loan, they have to charge 18% interest.

Equity Stripping: The lender sells a loan based on the equity in the home and does not consider whether the income is sufficient to pay the premiums. If the client cannot make the payments, they could end up losing their home.

Non-traditional Products: The monthly payments do not cover the principal and interest due, causing the loan balance, and eventually, the monthly payments, to increase.

Deceptive Loan Servicing: The lender does not provide the client with accurate or complete account statements and payoff figures. It is almost impossible to determine how much has been paid or how much is owed. The borrower may pay more than is owed.

Other deceptive practices include: pressuring the client to make false statements on the loan application; encouraging them to use an appraiser who will inflate the fair market value of the home; and pressuring them to sign an application with missing information, which the lender fills in with false information after signing.

Under New York Law, General Business Law Article 22-A § 349, the Attorney General may bring an action for equitable relief. An individual also has a private right of action. Under section 349-c, a person or entity that engages in deceptive acts and practices against an elderly person may be liable for an additional civil penalty not to exceed $10,000.

If your client signed papers for a loan and has second thoughts, they have three business days to send written notice of cancellation to the lender.

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Mental Health Issues on College Campuses

By Lydia Hoffman Meunier and Carolyn Reinach Wolf

Introduction

Several recent and much-publicized campus suicides have drawn attention to the issue of increasing numbers of students on campus with a diagnosed mental illness and highlight the challenges this issue poses to educational institutions. A less visible, but equally troubling challenge, is the increase in the number of students on campus experiencing all forms of psychiatric disorders. In a recent survey, over 90% of the directors of college counseling centers stated that the problems presented by students with significant psychological disorders are a growing concern on campus.[1] Claims data also indicate that in recent years demand for mental health services on campus has increased steadily and, in some cases, dramatically.[2]

This article examines the impact of the increased incidence of mental illness on campus, the inherent legal issues in managing mental illness in the campus setting, and discusses a much-anticipated decision in a Massachusetts case, *Shin v. Massachusetts Institute of Technology*. In the *Shin* case, the parents of a student who committed suicide in her dorm room sued the Massachusetts Institute of Technology. The school's motion for summary judgment was granted on several claims, but denied with respect to the claims of negligence against the counseling center's medical staff and school administrators. The *Shin* case illustrates that post-secondary institutions must now recognize, evaluate, and appropriately respond to the increasing numbers of students experiencing psychiatric problems on their campuses in a way that protects students as well as the institution.[3]

The Problem

Most students enter college at a developmentally pivotal time. Students are likely to be dropped at their freshman dorm by parents whom they have lived with their entire lives. Adjusting to the relative freedom and autonomy of campus life, increased academic demands, and an entirely new social milieu will be managed differently by every student. Traditionally, counseling centers have dealt with roommate disputes, relationship issues, substance abuse, academic anxieties and identity issues. More recently, campus counselors report that in addition to typical adjustment problems, counselors are increasingly seeing clients with severe psychological problems, and of those many have significant psychological disorders.[4] While mostly anecdotal, it appears that a perfect storm of factors is contributing to placing a greater number of vulnerable people on campus.[5]

Psychiatric diagnosis and treatment have progressed rapidly in recent years. Many conditions such as mood disorders, anxiety disorders and eating disorders were barely recognized a generation ago. With recognition came treatment, especially medication, that can dramatically diminish symptoms and permit those affected to function far closer to their potential than in years past. As a result, students who would otherwise have been precluded by their mental illnesses from completing high school are able to do so successfully, and to enroll in colleges and universities.

A positive societal adjustment is also at play as the stigma of mental illness is decreasing. Awareness of the prevalence, variety, and ability to treat mental illness has increased, and the acceptance of those in our midst who are affected with mental illness has likewise increased. It is not unusual for children to be medicated at an early age for conditions such as attention deficit disorder and hyperactivity disorder. The prospect of individuals with psychiatric disorders living and working among us is no longer a frightening anomaly.

Many psychiatric conditions develop or are discovered in early adulthood. Conditions such as depression and bipolar disorder often develop at this time. Anxiety disorders, including panic disorder and obsessive compulsive disorder, may be triggered by stressors, including those typical of campus life. Eating disorders, such as anorexia nervosa and bulimia nervosa, are most likely to develop during these years. Substance abuse may also become apparent in the campus environment. More severe psychiatric disorders, including schizophrenia and other conditions associated with psychosis often develop in late adolescence.

Students may be slow to recognize the symptoms of many of these disorders. Most symptoms, such as insomnia or increased sleep patterns, weight gain or loss, restlessness, fatigue, mood swings, increased anxiety, worry and tension, inconsistent eating habits, and the use of drugs and alcohol are probably an aspect of most students' experiences at college. Often, considerable time passes before the student recognizes these symptoms constitute a problem. Once a student has come to recognize he or she needs help and seeks assistance, it may be some time before a condition is stabilized. However, students who do seek help for a psychiatric disorder that develops while at college stand a very good chance of being effectively treated, and are often able to resume or maintain their presence at school.

The increased demands on college counseling centers is attributable in large part to these essential changes in the treatment and perception of mental illness. It is essential that schools recognize the issues attendant to a student population that includes those with psychiatric disorders, and develop strategies to manage

mental health issues in a way that protects both the institution and the students.[6]

The Parties

College campuses are typically micro-societies consisting of students, administration, and staff functioning as a self-contained unit within a larger community. In this context, the impact of even a single student experiencing symptoms of a psychiatric disorder is likely to affect most components of the campus community.

Counselors and Counseling Centers

The range of mental health services available on campus can vary widely, but on all campuses, college counseling centers are on the front line in evaluating and responding to the increasing incidence of mental illness on campus. A core mission of college counselors has been identified as "improving retention and graduation rates" through their work.[7] At a minimum, counseling centers must address the needs of students who come to the center seeking assistance by assessing the severity of the student's condition and providing medically appropriate treatment. In light of the *Shin* decision, this basic activity must be re-evaluated by the counseling center and the administration. Counseling centers must now be cognizant of the duty to assure the safety of these students and even others on campus under some circumstances.

Most campus counseling centers are also actively involved in education and outreach efforts to identify at-risk students and encourage them to seek treatment. As the number of students arriving on campus with a history of a psychiatric disorder increases, the counseling center may assume an oversight role in managing these students' illnesses and medications. As a component of the institution, campus counseling centers are also uniquely challenged to dodge potential conflicts of interest and confidentiality breaches. Campus counseling centers also may find challenges in continuity of care, as students leave campus and possibly experience stressful situations without the benefit of ongoing counseling.

Students

An inevitable feature of the prospective freshman's campus tour is a recitation of the resources available to meet student needs and security measures to assure student safety. Students do not typically arrive on campus concerned about their personal safety or believing that the school will fail to meet the student's health needs.

Students who are diagnosed with a psychiatric disorder or who have experienced symptoms of mental illness before attending college or university may or may not disclose this fact to the schools. Most schools do not directly ask students to disclose information pertaining to mental health history, but may ask about prescribed medication or general ongoing health concerns. Students may not feel comfortable disclosing this information before they even arrive on campus, as they are uncertain about with whom it will be shared and whether it will affect them socially or academically.

At most campuses students attend classes together, eat together, socialize together and live in close proximity to one another. It may be readily apparent to other students when a student is experiencing psychological problems. It is not unusual for students to assume a duty in caring for their peers who are experiencing symptoms of mental illness, particularly when the affected student is reluctant to seek counseling services. Students who share living space will inevitably be affected by the condition of their peers, and may find themselves in the demanding role of monitoring and counseling a peer. Schools may place a burden on students in a supervisory role, such as Resident Assistants, to refer students to counseling and report instances of concern, and outreach programs typically encourage students to be involved in getting others to treatment.

Parents

Most students entering college are, or soon will be, eighteen and are therefore adults for most purposes. But there is a distinct and growing expectation that parents will play a continuing role in their offsprings' lives. The phenomenon of parents hovering over their adult offspring has been identified as "helicopter parenting." This emerging trend is attributable to many factors, including smaller families, the increased cost and competition of education giving rise to a sense of entitlement, increased communication modes, such as instant messaging and cell phones, that allow parents to closely track activities, and intimate parental involvement in their children's academic, sports and leisure activities throughout childhood.[8] Helicopter parents expect to be well-informed by their children and by their children's schools. These parents expect their children's needs, as expressed by their children, to be promptly addressed and are not shy about intervening, with or without their children's knowledge. Colleges note that today's parents are not hesitant to make demands on college administration and services and expect institutions to be responsive to their concerns.

Administration

An incident involving a mentally ill student, particularly a student suicide, is devastating to the administrators and staff involved and impacts the entire campus community. The public reaction to such an event can be similarly difficult. Less dramatic, but more common and nonetheless disruptive, a student struggling with a psychiatric disorder may impact a roommate, a dormitory, a classroom or the entire campus. A student's mental illness may potentially affect the academic performance

of the ill student (and those around him or her), and ultimately could affect admission, retention, and graduation rates. Campus resources must be stretched to meet these existing needs. Finally, there are many potential legal liabilities for colleges and universities related to their treatment of the mentally ill student.

The administration's approach to this issue must balance protecting the individual student with the integrity of the institution. From a public relations standpoint, prospective students may be seeking evidence that the school provides extensive counseling services. An institution's ability to address student mental health needs is even becoming a factor in college application decisions.[9] Conversely, students may perceive incidents such as campus suicide as evidence that a college is unable to meet student needs.

Potential Pitfalls

Confidentiality and Disclosure

Campus counseling centers are uniquely challenged to meet their obligation to maintain patient confidentiality set out in professional ethical standards as well as in law and regulations.[10] Counseling centers report that parents, administration, and other departments of a college or university often feel entitled to confidential information. The college community setting also presents special challenges in preventing disclosure. In contrast, recent cases have indicated that schools *should* disclose under some circumstances, and could face liability if they fail to do so. Institutions should be prepared and willing to consult legal counsel with specialized expertise in mental health, psychology, risk management, or privacy law, either alone or as co-counsel to university counsel to review present policies and address specific disclosure questions. Advice and counsel regarding these and related matters should be available and accessible to ensure preventive measures are in place and to respond appropriately in a crisis.

Applicable Regulations

The treatment relationship has long been subject to confidentiality rules. In general, providers, including psychiatrists, psychologists, and social workers, are prohibited from disclosing treatment information for adult patients. Under state licensing laws, such disclosure would constitute professional misconduct. Federal regulations also prohibit disclosure of health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). HIPAA does not apply to education records covered by FERPA.[11] FERPA establishes a series of privacy protections and access requirements related to educational records. FERPA defines "educational records" as "those records, files, documents, and other materials" that (1) contain information directly related to a student; and (2) are maintained by an educational agency or institution or by a person acting for such agency or institution. Records maintained by campus counseling centers are generally subject to FERPA. It is conceivable that records created and maintained by a campus-based clinic that is not funded or run by the university would not be subject to FERPA, but this material would then be subject to HIPAA. In any event, the records remain subject to state privacy rules. While there is no private right of action for violation of either HIPAA or FERPA, there are substantial civil penalties for a violation of these rules, including termination of all government funding of a college or university.

Potential Disclosures

Counseling centers report that it is not uncommon for a student's parents to expect notification of any conditions affecting their children. Parents may be dismayed to learn that if their child is eighteen, federal and state law generally provide that their child's written consent is required for disclosure of education and health information. Students who are struggling at school may be very reluctant to authorize disclosure to parents. Schools must determine whether and when it is appropriate to break confidentiality rules and communicate a student's condition to family. It has been our experience in counseling a variety of health care facilities on this issue, that the facts may dictate a "pick your liability" dilemma, and the advice of counsel is essential in weighing the choices.

The close proximity of students and the frequent contact with staff inevitably result in a community of shared knowledge. Students and staff may contact the counseling center with their concerns about a particular individual, and may feel responsible for assuring that the troubled student is receiving treatment. The small size and limited resources of many campus counseling centers may also result in unintentional disclosures. Counseling centers have described situations where confidentiality is compromised by student employment at the centers, students encountering one another when seeking treatment, and one counselor even described a practice of conducting admission tours through the counseling center.[12]

Intra-facility Disclosures

In addition to the professional and legal conflict of interest rules applicable to all counseling professionals, the accreditation standards promulgated by the International Association of Counseling Services note that,

> it is critically important that the service be administratively neutral. If it is perceived as being linked with units that are involved in making admissions, disciplinary, curricular, or other administrative decisions it can severely restrict the utilization of the service. Such perceptions may prevent

students from seeking services for fear that information they disclose may negatively affect their college careers.

It is not uncommon for the administration to believe that, as an entity within an institution, the counseling center is subject to the greater interests of the institution. Typically, the Dean of Students, or similar administrative office, is charged with overseeing all issues related to students' well-being on campus. While it is natural and desirable for this office to work closely with counseling professionals, these interests may nonetheless diverge.

The administration or other departments on campus may feel entitled to confidential student information as a matter of course. Examples raised by counseling staff include requests for information for use in housing determinations, to be provided to resident advisors; for inclusion in records for special programs, such as study abroad or internships or as needed to prepare recommendations for programs, such as the Peace Corps or federal agencies; for use in preparing statistical information; and for use in readmission decisions. Counseling centers have also been requested to provide student health information in special situations. For example, counseling centers have been asked to provide information in the defense of a lawsuit brought by a former counseling client against the university in which the counseling center is not a party. Similarly, information was requested for use in investigating a sexual harassment claim by a student counseling client against a staff member. Some counselors report that deans have demanded to be provided with information on all clients who have expressed any suicidal ideation and some request forensic information on clients.

The administration may ask the counseling centers to evaluate whether a student should continue or be readmitted to school following an incident of concern to the administration. This is particularly troubling if a student had been in treatment with the evaluating counselor. A variation of this request is an administrative request for an evaluation of a student client's readiness for a particular academic program. Depending on a particular institution's policy toward students with mental illness, the counseling center may be asked to evaluate a student upon admission, if a history of mental illness is disclosed, in order to determine the reasonable accommodations the facility must or is able to provide to the student, should he or she be admitted.

In addition to penalties for violating state and federal privacy rules, the institution and/or counseling center staff could face liability and monetary penalties for damages resulting from such disclosures. If an institution violates confidentiality by improperly providing information to a potential employer or graduate school, and it can be shown this resulted in the student not obtaining employment or admission, the disclosing institution will certainly be vulnerable. Counseling staff have reported administration requests for client information for use in a client's application for admission to the bar (the state was not specified). An illegal disclosure in this circumstance would certainly create potential liability.

While it is difficult to imagine a student prevailing against a university for damages the student incurred as a result of a disclosure that prevented the student's suicide, it is not so difficult to imagine in some of the other disclosures discussed above. Campus counseling centers and the administration must be aware of when intra-facility disclosures are necessary and permitted, or even required, and when a disclosure would violate confidentiality rules.

Americans with Disabilities Act and the Rehabilitation Act

Students with mental illness are afforded protection under both the Americans with Disabilities Act and the Rehabilitation Act of 1973. Under these laws, "reasonable accommodation" must be made for those with disabilities and an individual may not be denied participation by reason of his or her disability. Most psychiatric disorders are a disability under both laws.

Section 504 of the Rehabilitation Act of 1973 (the "Rehab Act") and implementing regulations require that all post-secondary institutions receiving federal funding (virtually all colleges and universities) must make their programs accessible to students with psychiatric disabilities who are "otherwise qualified."[13] This rule is applicable to the admissions process, as institutions are prohibited from having eligibility requirements that screen out those with disabilities and applicants may not be asked if they have a disability, including a history of mental illness. The Rehab Act is applicable to the enrolled student, as the institution is required to make reasonable accommodation for the individual's disability, including psychiatric disabilities. Any criteria that are imposed by an institution must be based on actual risk and not on stereotypes or assumptions. The prohibition on excluding an individual from, or denying participation in, a post-secondary program by reason of his disability will also be implicated in an institution's decision to dismiss a mentally ill student.

The Americans with Disabilities Act (ADA) was enacted in 1990, several years after the Rehab Act. The ADA extended the protections of the Rehab Act to a much wider realm, and created other protections for those with disabilities. The ADA imposed administrative requirements, but had little practical effect on colleges and universities, as most institutions were required to implement the provisions of the Rehab Act years before. Institutions that are not subject to the Rehab Act are almost certainly subject to the ADA.

A disabled person who requests and does not receive accommodation under either the Rehab Act or ADA may make a complaint to the Office of Civil Rights of the U.S. Department of Education. Both the Rehab Act and the ADA provide a private right of action. A complainant may seek injunctive relief and may even win monetary damages if the discrimination is determined to be intentional.

In Loco Parentis

The doctrine of *in loco parentis*, wherein an institution stands in the place of parents, has been much discussed in the context of an institution's responsibility and liability for student safety. The doctrine has come to be applied to the concept of colleges' and universities' responsibility for the safety of a student's character and morals, as well as the student's physical well-being.[14] Although traditionally *in loco parentis* was applied as "a shield for colleges, not a sword for students" allowing institutions to impose authority on students,[15] New York courts have cited this doctrine (or more accurately the abandonment of this doctrine) in discussing the absence of a duty running from the institution to their students. Under this reading of *in loco parentis* by New York courts, universities and colleges have enjoyed a general aura of protection from negligence claims. Other theories negating institutional liability include charitable immunity, governmental immunity, proximate cause rules (cases have held that injuries were not proximately caused by universities, but by intervening, superceding events, such as an attacker or the illegal use of liquor), and contributory negligence theories.

Nationally, a trend away from a general protection from liability has been identified and attributed to the erosion of immunities in tort law, the demise of contributory negligence, increased awareness and disapproval of excessive use of alcohol, and the swinging of the societal pendulum back toward parental involvement and oversight in the lives of their children, even children over the age of eighteen.[16] FERPA is a signpost on this road. Passed in 1974 in the wake of student activism and the lowering of the voting age in 1972 as part of a movement to treat those over eighteen as autonomous adults, FERPA effectively codified the privacy rights of students over eighteen. However, in response to the increase in the drinking age from eighteen to twenty-one, FERPA was amended in 1998 to permit colleges to overrule students' wishes and inform parents of students under age twenty-one when a drug or alcohol law is broken. Recently, courts in several jurisdictions have been holding that, under certain circumstances, there can be a duty running from an educational institution to students, and institutions should no longer rely on the absence of *in loco parentis* responsibilities to insulate them from liability when students are injured on campus. The shift toward campus responsibility has occurred incrementally, with cases looking closely at the facts leading to injury, and particularly the foreseeability of an incident.

Recent cases have held that educational institutions had a duty to students in cases involving injuries resulting from an assault in a campus dorm,[17] fraternity hazing incidents,[18] alcohol excesses,[19] injuries to athletes,[20] and injuries related to a student's mental illness.[21] In each instance, the court held that the institution was, or should have been, aware of the likelihood of injury because of the pattern of behaviors or events leading up to the injury.

Although New York cases have generally not found a duty running from the institution to individual students, these cases have uniformly noted that in those cases the institution had no notice of the conditions that led to a student's harm.[22] In a factually appropriate case, it is quite possible that a New York institution could be held liable for injury inflicted by a student on him or herself or another. For example, a fact pattern in which a mentally ill student harms him or herself or another student on campus is very likely to involve the kind of behavior and contacts with administration and staff that would make such an injury foreseeable in the eyes of a court. This was precisely the case in *Shin v. Massachusetts Institute of Technology*. In this 2005 opinion, the plaintiff withstood a motion for summary judgment on a claim for wrongful death of a student who committed suicide in her dorm room following a substantial and well-documented deterioration of her mental condition. The case has significant implications for the way colleges and universities handle students suffering from a mental illness.

The *Shin* Case

Elizabeth Shin entered MIT in 1998.[23] The following February she was taken by ambulance to Massachusetts General Hospital when her boyfriend found Elizabeth was acting disoriented following an alleged overdose of Tylenol with codeine. According to her parents, Elizabeth denied this was a suicide attempt, and Elizabeth claimed that she took what she thought would be a sufficient dose of the prescribed medication to afford her a good night's sleep following a diagnosis of mononucleosis. During her week-long hospitalization, MIT court papers claimed that Elizabeth revealed that she had mental health problems while in high school (her parents claim not to have known this). Elizabeth's housemaster contacted Elizabeth's parents who met with Elizabeth's treating physicians and social workers.

Before her discharge, Elizabeth's father met with Dr. Kristine Girard, one of the full-time psychiatrists at the Mental Health Services department (counseling center) at MIT, and it was agreed that, upon discharge, Elizabeth would resume classes at MIT and she would see Dr. Girard every 2-3 weeks. Dr. Girard met with Elizabeth three times between February and May. She

diagnosed Elizabeth with "adjustment disorder" and later noted she was suffering from "situational issues." At the end of the term, Dr. Girard recommended more therapy upon her return to campus for her sophomore year.

Elizabeth spent an uneventful summer with her parents at home in New Jersey. She returned for the fall term at MIT and did not visit the counseling center until early October, following a break-up with her boyfriend. During this time, Elizabeth was engaged in cutting behavior, something she had done in high school. The psychiatrist who met with Elizabeth at the counseling center noted general symptoms of mood disorder, such as reduced sleep and erratic eating habits, but felt she was in no immediate danger. Elizabeth returned to the counseling center about a week later, and met again with Dr. Girard. She claimed she was feeling "significantly better," but the doctor noted an "underlying sadness."

In November, Elizabeth's friends, concerned about her cutting activity, urged her to meet with Dean Arnold Henderson, and she did so, showing the Dean the scratches on her arm, at the Dean's request. The Dean made an appointment at the counseling center, but it is unclear whether this meeting occurred. In December, Dean Henderson received an e-mail from Elizabeth that was forwarded by one of Elizabeth's professors indicating that Elizabeth said she had bought a bottle of sleeping pills with the intention of using them to overdose, but she had changed her mind. The Dean contacted Elizabeth, but she appeared to be doing well. The Dean reported the incident to Dr. Girard.

It was not until several months later that Elizabeth's behavior again began to worry those around her. Just before spring break, early in the morning on March 18, 2000, following another break-up with a boyfriend, a student notified the housemaster that Elizabeth was extremely upset and was cutting herself. She was taken immediately to the MIT campus infirmary, where the physician who examined Elizabeth contacted the on-call psychiatrist. The psychiatrist admitted Elizabeth to the infirmary, as it was determined it would not be safe to return Elizabeth to her dorm.

The following day, Elizabeth was discharged back to her dorm, where students reported she remained distraught. Shortly thereafter, her parents arrived to bring her home for spring break. Elizabeth's parents were informed that she had been admitted to the infirmary, but they contend they were not told why she had been admitted, and Elizabeth refused to discuss it. Her parents stated that she appeared to be fine while she was home for break, and they saw no reason to keep her home. Upon her return to school however, her housemaster received numerous reports from students and graduate resident tutors in her dorm that her condition was deteriorating. Friends were staying up with her at night to assure her safety.

On March 23, Elizabeth was seen by a new psychiatrist at the center, Dr. Linda Cunningham, who noted she was experiencing a "severe" depressive episode, and prescribed anti-depressant medication. On subsequent visits through the end of March, Dr. Cunningham noted that Elizabeth might require hospitalization. During the first week in April, Elizabeth contacted Dean Henderson's office about rescheduling exams and the Dean agreed, remaining in contact with her housemaster about her condition. Elizabeth also had several therapy sessions with Dr. Cunningham at the MIT Mental Health Department, and arrangements were made for Elizabeth to be evaluated for therapy at a clinic off campus. On April 5 and 6, two of Elizabeth's Spanish instructors expressed concern about cuts on Elizabeth's arms. After one instructor placed four calls to Dean Henderson, she was informed there was no need to be concerned because action was being taken to assure Elizabeth's safety.

On the evening of April 8, 2000, Elizabeth informed another student in her dorm that she intended to kill herself with a knife. The student called campus security, and Elizabeth was taken to the Mental Health Center. The staff physician contacted the on-call psychiatrist, Dr. Anthony Van Niel, who spoke with Elizabeth briefly on the phone, and determined that Elizabeth was not acutely suicidal. Elizabeth was returned to her dorm with no restrictions or follow-up planned.

On April 9, 2000, Elizabeth's parents visited her for the afternoon. They noted that Elizabeth looked a bit tired and harried, but nothing about her appearance or behavior led them to be concerned. She discussed plans for the week ahead and plans for the future. No one at MIT disclosed to Elizabeth's parents her frequent visits to the counseling center or their concerns about her recent behavior.

About 12:30 a.m. on April 10, 2000, two students notified the housemaster that Elizabeth requested that a student erase her computer files, as she planned to kill herself that day. The housemaster called the Mental Health Center and her call was returned by Dr. Van Niel. Dr. Van Niel told the housemaster to check on Elizabeth, but that it was not necessary to bring her to the Center as Elizabeth had assured Dr. Van Niel that she was fine and Elizabeth's friends had overreacted two days before. The housemaster checked on Elizabeth at 6:30 a.m., and decided not to wake her, as all was quiet. The housemaster conveyed these events to Dean Henderson, as a "deans and psychs" meeting was scheduled later that morning. A little later, around 9:45 a.m., Elizabeth called the housemaster and accused her of wanting to send her home, and stated words to the effect that the housemaster would not have to worry about her anymore. The housemaster again called Dean

Henderson, and he assured the housemaster that the conversation would be mentioned at the meeting.

Elizabeth's case was discussed at the "deans and psychs" meeting held at 11:00 a.m. on April 10, 2000. An appointment was made for Elizabeth at an off-campus facility, and a message was left with Elizabeth notifying her of the appointment.

Shortly before 9:00 p.m. that same day, the smoke alarm in Elizabeth's room went off. Campus police and the Cambridge Fire Department found Elizabeth engulfed in flames. She was transported to Massachusetts General Hospital, with third degree burns over 65% of her body. Four days later, her parents were told that she had suffered irreversible neurological brain damage and life support was terminated.

Two years later, in 2002, Elizabeth Shin's parents filed a lawsuit against MIT, as well as the clinicians at the MIT Mental Health Center, two Deans, and the housemaster, claiming breach of contract, gross negligence, negligent infliction of emotional distress, and a violation of the Massachusetts' consumer protection statute. The plaintiffs contended that defendants failed to inform them of their daughter's condition and the opportunity to oversee her care, and that the defendants failed to provide adequate coordinated care for her. The defendants moved for summary judgment dismissing the claims. The Court granted summary judgment on the breach of contract, consumer protection and negligent infliction of emotional distress claims, but denied summary judgment on the claim of gross negligence against the dean, the housemaster, and the psychiatrists. The defendants claimed that there was no duty running from the defendants to Elizabeth Shin. However, the Court held that the number and nature of contacts between defendant physicians, administrators and housemaster was sufficient to establish that defendants "could reasonably foresee that Elizabeth would hurt herself without proper supervision. Accordingly, there was a 'special relationship' between the MIT Administrators, Dean Henderson, [the housemaster], and Elizabeth imposing a duty [on the defendants] to exercise reasonable care to protect Elizabeth from harm."

The *Shin* court cited *Schieszler v. Ferrum College*, in which the Court also found a special relationship running from the institution to the student which was sufficient to meet the burden on summary judgment of the existence of a special relationship between the college and the student, giving rise to a duty of care. The Court denied defendant's summary judgment motion, holding that the student's several contacts with the campus police, the dean and the dormitory resident assistant indicating the student's intent to take his life, could lead a trier of fact to conclude that there was "an imminent probability" that the student would try to hurt himself, and the defendants had notice of this specific harm. The defendant's failure to contact the student's guardian with information about threats to harm himself supported the plaintiff's allegation that the college breached a duty of care to the student. This case was eventually settled.

The factual basis for the holding in these cases should give institutions of higher learning pause. It is clear that courts will look specifically at how a student's needs are handled by a particular administration and counseling center, and lofty concepts, such as *in loco parentis*, will not protect an institution where the facts indicate the institution knew of a threat and did not act to prevent harm. The summary judgment rulings in *Shin* and *Schieszler* did not address the difficult issue of whether defendants were actually responsible for preventing the troubled students' suicides as the Court did not reach the question of causation on summary judgment. However, the holding that the schools had a duty to the students is significant. Both *Shin* and *Schieszler* plaintiffs alleged that the schools' failure to notify the students' parent/guardian was a factor in causing each student's death. Both Courts agreed, holding that there was an obligation to notify the students' parents and guardian of an imminent potential threat of which the school is aware and which the parent or guardian may be able to prevent. The duty to notify is in direct contravention of confidentiality requirements, and schools must tread a careful path in the decision to disclose confidential patient information. While duty is just one element of a negligence claim, the acceptance of a duty running from the institution to a student is a substantial change in the law with significant consequences.

Responding to the Issue

Post-secondary institutions must recognize and respond to the increased number of students with psychiatric disorders on campus. The possibility of liability arising from a duty to respond to foreseeable injuries requires institutions of higher learning to examine what would constitute a breach of this duty and how to reduce this liability. Even as most institutions report stepped-up efforts to meet student mental health needs—such as increasing staff training, more counseling staff, adding counseling hours, and part-time counseling staff during peak demand periods—these efforts are not enough, as about 75% of counseling centers surveyed believed that their centers continue to require more hours based on client needs, stating that present psychiatric hours were "woefully inadequate."[24] In addition, institutions have begun to intensify outreach programs, including providing information on mental health services at orientation; training for faculty, staff, and residence personnel; regular education programs, education materials sent to students and parents; and mental health screening days in an effort to identify and serve those on campus with psychiatric issues.[25] Despite these efforts, it appears that many institutions have not

reconciled their policies with the reality of a responsibility to protect students from foreseeable harm.

In an on-line forum discussing the *Shin* case, some participants strongly expressed the feeling that institutions should bear no responsibility for the mental health of their students, that students at risk of harm should be removed from campus housing, and possibly from the institution entirely. Some noted that the case would have a chilling effect on the admission of students with certain disorders, or worse yet, would prevent students from getting the help they need.[26] Some institutions have taken a tack of essentially weeding out students as soon as their symptoms become manifest by imposing a choice between an involuntary medical leave or a voluntary leave of shorter duration.[27] Students experiencing psychiatric disorders may also engage in behavior that violates the rules of student conduct, and colleges may offer a "choice" between voluntary medical leave or disciplinary action. This course of action could constitute "intentional" discrimination under the Rehab Act and ADA and legal counsel should certainly be consulted if an institution elects to remove risky students in this manner.

A far more effective and practical solution is to address the issue directly so that the institution is in a position to demonstrate that even if there is a duty to an injured student, the institution will not be in breach of that duty. The administration must demonstrate a recognition that mental health services are a critical component of caring for today's student and must assure that every member of the campus community recognizes the signs and symptoms of a mental illness and knows when and how to respond. In accomplishing this, the institution must evaluate its particular needs and implement an effective risk management program in consultation with clinicians and attorneys experienced in mental health law, college campus liability, risk management, and related areas of practice. Existing policies and procedures should be carefully reviewed by the administration and expert legal counsel. The administration and counsel should identify, compose, and implement any new procedures necessary to assure that confidentiality and accommodation rules are preserved at the same time mechanisms are in place to protect the students and campus from harm. The administration should conduct regular reviews of these procedures and actively assure that the procedures are implemented, and that the mechanism for implementing these is sufficient. The following are considerations in constructing a strategy for protecting an institution from liability:

- Clear directives and procedures must be established for assuring that any concerns raised about a student's mental health are addressed promptly and appropriately.
- The administration must recognize the counseling center's role in fulfilling the mission of the university to retain students and help the students meet their academic goals.
- The counseling center and the administration must understand the limits of the counseling center's abilities, establish clear policies to protect students whose needs exceed the resources of the campus counselors, and establish protocols for promptly meeting the students' and the community's needs in any way necessary. This must include clear policies for disclosure including contacting parents, warning those at risk, or making arrangements for hospitalization or other care, if indicated.
- The university must identify off-campus resources for addressing those in crises, including law enforcement, treatment providers, and hospitals, and must identify the circumstances where it is appropriate or necessary to avail itself of these resources.
- The counseling center and the administration should assure there is a well-established and regular communication between the various departments of the institution, including the deans' offices, residential services, the health center, any disciplinary board or entities, and campus security, that allows all who could potentially come in contact with a student in crisis to raise concerns. A mechanism should be in place for developing an action plan to protect the affected student. These interactions between departments must be consistent with confidentiality strictures.
- There must be ongoing efforts to educate the entire campus community to recognize those struggling with psychiatric issues, the resources available to assist such individuals, and how and when to connect these individuals with the assistance they need.
- Preventive and developmental activities, including outreach, consultation, personal growth issues, and education activities, must be dynamic and ongoing. Counseling centers should be a visible presence at orientation, freshman seminars, activity fairs and campus residences.
- Counseling centers must be adequately funded. The financing of mental health services should be analyzed and issue of access balanced with funding. For example, the institutions should assure that no students will be turned away if they are unable to pay for services. A careful evaluation may reveal that counseling centers are even able to generate revenue for much needed services through co-pays.

- The counseling center's ability to appropriately manage clinical needs should be evaluated regularly and adjustments made to assure the most effective delivery of services to students. The importance of meeting student needs by providing immediately accessible appointments, phone and Internet consultations, evening and drop-in appointments should be considered and addressed. Some universities are experimenting with placing counselors in residences periodically in the evenings to encourage accessibility to services. Resources may be stretched by appropriate peer counseling programs, the use of graduate interns, group therapy, and developing self-help programs, such as pamphlets, videos, books, and access to Internet resources. Caseload management should be regularly evaluated and adjustments to staffing should be made when necessary. Diversity in counselors' background, culture and training also should reflect the composition of the student body.
- The administration must consider and adopt a policy for when and how to identify and contact students at risk while preserving confidentiality.
- The administration should provide an opportunity for parents to approach the institution's counseling center about their children's mental health concerns both as incoming students with a history of mental health treatment or with concerns that develop in the course of their college years.
- The counseling center's role in "bailing out" students, as in making arrangements for deferring assignments or exams or facilitating a change in residence, must be delineated, and the procedure for doing so clearly established.
- Whether and when disciplinary proceedings should be initiated against a student experiencing psychiatric symptoms should be determined.
- Disclosure and confidentiality rules should be reviewed and understood by everyone concerned with the counseled individuals. Policies, including student staffing at campus counseling centers, should be developed and reviewed for potential breaches of confidentiality.
- All policies addressing disclosure should identify to whom disclosure may be made under relevant circumstances.
- The administration and the counseling center should set a policy and procedure for when and how to obtain "prospective" disclosures from students authorizing the institution to contact family. The policy (and the disclosure forms) should also address the circumstances that would allow the use of these disclosures.
- There should be disclosure policies for immediate/emergency disclosures, and less immediate but nonetheless pressing disclosures. For example, students showing signs of an eating disorder that gradually becomes critical may be identified and the issue effectively addressed if disclosed well before the student reaches a crisis.
- A policy should be developed for evaluating and documenting alternatives to disclosure.
- A policy should be developed addressing circumstances when disclosure will not be appropriate and the alternatives available under these circumstances.
- Appropriate disclosure forms should be drafted, reviewed by legal counsel, and made a part of the policies and procedures.
- Counseling staff should be thoroughly educated regarding legal and ethical issues and should have access to legal counsel when necessary. Administration should consult with legal counsel whenever a question arises regarding a student's behavior on campus.

Conclusion

Universities and colleges must recognize the dramatic increase of those with psychiatric disorders on campus and their exposure to liability if they fail to act. It is essential that colleges and universities conduct a careful evaluation of their practices and policies, ideally in consultation with legal counsel who have expertise specific to these issues, to assure the protection of these students, the campus community, and the institution itself.

Endnotes

1. *The 2004 National Survey of Counseling Center Directors* (International Association of Counseling Services, Inc.). The survey included responses from 339 directors of college counseling centers, including 34 colleges and universities in New York State.
2. Bennett Kaplan & Maura Reed, *College Student Mental Health: Plan Designs, Utilization, Trends and Costs*, STUDENT HEALTH SPECTRUM, March 2004. Although some variations among campuses are noted, virtually all campuses reported a double-digit increase in utilization of psychological services over the ten-year reporting period.
3. The *Shin* case was settled in April 2006. The significance of the case is reflected in the fact that twenty-three universities and eight national higher education associations filed amicus briefs in the case. An administrator with the University of Maryland was quoted as saying the settlement "gives us more time in higher education to examine our policies . . . without the specter of legal fear that people have today." Marcella Bomardieri, *Parents Strike Settlement with MIT in Death of Daughter*, THE BOSTON GLOBE, April 4, 2006.

4. *The 2004 National Survey of Counseling Center Directors, supra* note 1.
5. There appears to be no formal analysis available of the causes of the increased incidence of mental illness on campus or of the actual number of students on campus with psychological issues. There has been a flurry of discussion in the press and professional journals and the information in this section is drawn from these sources: Suicide Prevention Resource Center, *Promoting Mental Health and Preventing Suicide in College and University Settings*, Newton, MA: Education Development Center (2004); Martha Anne Kitzrow, *The Mental Health Needs of Today's College Students: Challenges and Recommendations*, NASPA Journal, Vol. 41, No. 1 (Fall 2003); Peter Lake, Nancy Tribbensee, *The Emerging Crisis of College Student Suicide: Law and Policy*, Stetson Law Rev. Vol. XXXII (2002).
6. Kitzrow, *supra* note 5, 172–173.
7. Stephen Caulfield, Chickering's Fifth Leadership Forum: Depression on College Campus, Student Health Spectrum, Winter 2002. Summary of two forums with participation by a total of 22 colleges and universities. Quoting this characterization by a physician affiliated with the University of Virginia of the mission of counseling centers (as well as the student health service and the university) as the consensus of the participants.
8. Sara Schweitzer, *Case of the Hovering Parents: Universities Laying Ground Rules to Give Freshmen More Independence*, The Boston Globe, August 20, 2005; Justin Pope, *Hovering Parents Problematic for Colleges*, The Associated Press, August 29, 2005. This article describes an incident where parents contacted the school's administration to convey their child's dissatisfaction with the sanitary facilities on a trip to China, Jean Marie Angelo, Privacy or Peril? University Business, January 2004.
9. Karen W. Arenson, *The Dorms May be Great, But How's the Counseling?*, N.Y. Times, October 26, 2004, at F1.
10. Section C(2) of the Accreditation Standards promulgated by the International Association of Counseling Services provides:

> The confidential nature of the counseling relationship must be consistent with professional ethical standards and with local, state, provincial and federal guidelines and state statutes. Information should be released only at the request or concurrence of a client who has full and informed knowledge of the nature of the information that is being released. Appropriate information is then to be released selectively and only to qualified recipients. Instances of statutory limits to confidentiality and other appropriate restrictions (e.g., policies related to observation, audio and video taping) need to be clearly articulated and implemented only after careful professional consideration.

11. 45 C.F.R. § 164.501.
12. *The 2000 National Survey of Counseling Center Directors*, Appendix A.
13. 29 U.S.C. § 794 and 34 C.F.R. Pt. 104.
14. *Eiseman v. State of New York*, 70 N.Y.2d 175 (1987) (doctrine of *in loco parentis* is basis for holding that "colleges today in general have no legal duty to shield their students from the dangerous activity of other students," holding university had no duty to shield students from an ex-felon who was admitted under a special program); *Ellis v. Mildred Elley School, Inc.*, 245 A.D.2d 994 (3d Dep't 1997) (rejecting that college stood *in loco parentis* to students, giving rise to a special duty); *Rothbard v. Colgate University*, 235 A.D.2d 675 (3d Dep't 1997); *Talbot v. New York Institute of Technology*, 225 A.D.2d 611 (2d Dep't 1996).
15. Peter F. Lake, *The Rise of Duty and the Fall of* In Loco Parentis *and Other Protective Tort Doctrines in Higher Education Law*, 64 Mo. L. Rev. 1, 6 (1999).
16. *Id.* at 23.
17. *Mullins v. Pine Manor College*, 389 Mass. 47 (1983).
18. *Knoll v. Board of Regents of the Univeristy of Nebraska*, 258 Neb. 1, 601 N.W.2d 757 (1999); *Furek v. University of Delaware*, 594 A.2d 506 (Del. 1991).
19. Dana Levine, *Institute Will Pay Kruegers $6M for Role in Death*, The Tech, Vol. 120, No. 42, September 15, 2000 (reporting the settlement of a wrongful death claim filed by the parents of a student following a hazing incident at a fraternity on the campus of the Massachusetts Institute of Technology).
20. *Davidson v. University of North Carolina at Chapel Hill*, 142 N.C. App. 544 (2001) (university had a special relationship to injured cheerleader); *Kleinknecht v. Gettysburg College*, 989 F.2d 1360 (3d Cir. 1993) (there was a special relationship between college and student athlete who died due to a fatal heart arrhythmia during practice).
21. *Shin v. Massachusetts Institute of Technology*, 2005 Mass. Super. LEXIS 333 (2005); *Schieszler v. Ferrum College*, 236 F. Supp. 2d 602 (WD VA 2002).
22. Cases cited at *supra* note 11.
23. This narrative of the facts of the *Shin* case are drawn from the opinion of the Superior Court and from Deborah Sontag's article *Who Was Responsible for Elizabeth Shin?* The New York Times Sunday Magazine, April 28, 2002.
24. *The 2004 National Survey of Counseling Center Directors, supra* note 1.
25. *Id.*
26. Chronicle of Higher Education, Chronicle Forums, An Ounce of Prevention, August 5, 2005, et seq., *available at* http://chronicle.com/forums/colloquy/read.php?f=1&i=5393&t=5393, visited December 27, 2005.
27. Jason Feirman, *The New College Dropout*, Psychology Today, May/June 2005; Karen. W. Arenson, *Worried Colleges Step Up Efforts Over Suicide*, The New York Times, December 3, 2004; Daniel Mcginn and Ron Depasquale, *Dealing With Depression*, Newsweek Kaplan College Guide, 2004.

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April 13-14, 2007

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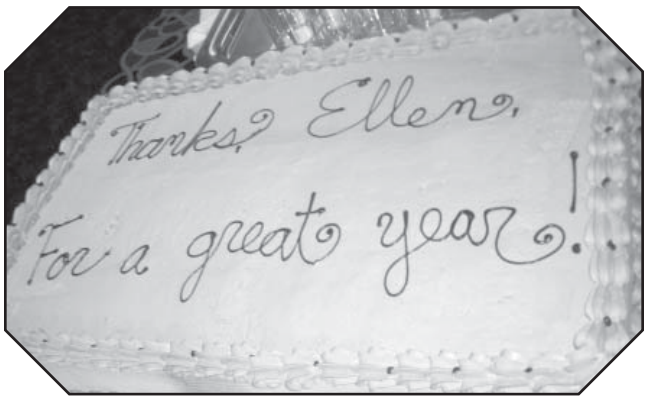

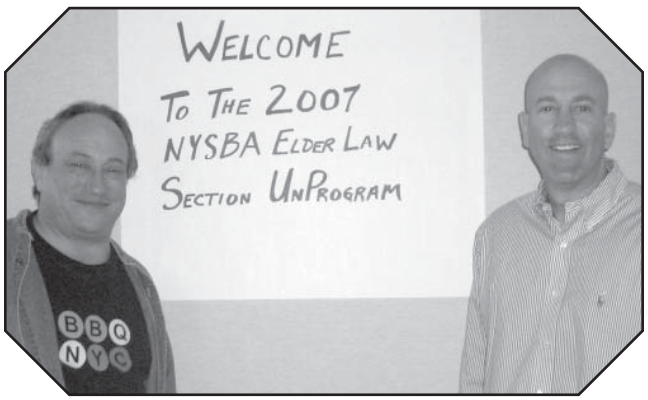

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Tucson Elder Law Attorney. We are committed to helping seniors, individuals with disabilities, and their families and supporters make informed choices guiding them through some of lifeâ€™s most important decisions. That may mean estate planning, special needs planning, guardianship, conservatorship, long-term care planning or probate. As Tucson Elder Law Attorney (s). Thatâ€™s what we know. Practice Areas. See all practice areas.