Elder Law Report

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Message from the Editor

Planning and paying for long-term care and the many legal issues relevant to it is the subject of this edition of the *Elder Law Report*. Understanding the options available to help pay the costs of long-term care is a challenge for all who are involved.

Our goal here is to make everyone's work easier. We hope that the information and guidance that follow will also serve as reminders that, as costly as long-term care may be, there are opportunities to access good health care without having to exhaust one's life savings. ■

Medicaid: Frequently Asked Questions

Q. My mother suffered a stroke several months ago. She has been managing with four hours of homecare five days a week that she has been paying for herself. My sisters and I believe her condition has worsened and that she now needs more hours of homecare. We are concerned that increasing her homecare will deplete her savings. Will Medicaid help her?

A. If your mother needs homecare and the costs are so significant that she will be spending down her life savings, she needs to know that she may be made eligible for Medicaid homecare services that will provide her with as much as 24-hours/7-days-a-week services at no cost to her. Such a plan will allow her to conserve her savings to help pay for expenses other than homecare. Expenses may include luxuries and necessities, such as vacations, theater and clothes as well as rent, food, telephone, electric, cable, transportation, etc.

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Free Program Now Available

The law firm is now offering a seminar, MEDICAID 2013!, for professionals only, to be presented at social service agencies, nursing homes, adult-day-care centers, hospitals, assisted-living facilities, and the firm's offices. There is no charge for this program, which is presented by Martin Petroff.

Topics covered include: choosing a managed long-term-care plan, Medicaid transfer-of-assets penalty rules, pooled-income trusts, the rules for primary residence, and supplemental-needs trusts for disabled persons.

To schedule a presentation at your office or to reserve a place for the same program at the law offices of Martin Petroff & Associates at 270 Madison Avenue, between 39th and 40th Streets, please call (212) 679-5800 or email jhorowitz@petroffelderlaw.com ■

Introduction To Medicaid Managed Long Term Care (MMLTC)

Managed long-term care is becoming a reality in New York State for all those older and disabled individuals who have been covered by Medicaid. In 2012 the program began to be phased in county by county. That process will continue through 2013.

Individuals are required to join a state-paid Medicaid, managed long-term-care plan. This Managed Care Organization (MCO) will coordinate services for participants and direct them to particular doctors, hospitals, out-patient facilities, nursing homes, etc.

This abrupt change in policy reflects a broadening consensus among the states that managed care is more efficient, both for patients and the state.

Mandatory Enrollment

Enrollment in a Medicaid Managed Long Term Care (MMLTC) plan is mandatory for persons who (1) are applying for or currently receiving certain Medicaid home-care or other community-based, long-term-care services; (2) are dually eligible (i.e., have Medicare and Medicaid); and (3) are 21 years of age or older.

MCO plans are insurance companies that are paid a monthly rate by New York State's Medicaid program for each person enrolled. The plans take over the work of the local Medicaid office which did a similar job in determining whether home care was needed and, if so, for how many hours.

Payment for an MCO plan is capitated, that is, the government pays a flat fee to the plan for each member it covers regardless of how many treatments or hours of care the plan provides to that member.

Two types of managed-care plans are available:

(1) Fully-capitated plans — the Program for All-Inclusive Care for the Elderly (PACE) plan and the Medicaid Advantage Plus plan — which cover ALL Medicaid and Medicare services (i.e., primary and long-term and acute care); and

(2) Partially-capitated plans currently recruiting members in New York City include GuildNet, CenterLight Healthcare, Independence Care System, Elderplan, Aetna, and the Visiting Nurse Service.

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Services Available...

- Home care, including:
  - Personal care (i.e., home attendant or housekeeping)
  - Certified home health agency services (home-health aide, visiting nurse, visiting physical or occupational therapist)
  - Private duty nursing
- Consumer Directed Personal Assistance Program (CDPAP)
- Adult day health care (i.e., medical model and social adult day care)

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Introduction To MMLTC *(continued from page 1)*

- Personal Emergency Response System (PERS)
- Nutrition (i.e., home-delivered meals or congregate meals)
- Home modifications
- Medical equipment such as wheelchairs, medical supplies, prostheses, orthotics, and respiratory therapy
- Physical, speech, and occupational therapy outside the home
- Hearing aids and eyeglasses
- Podiatry
- Audiology, including hearing aids and batteries
- Dental and optometry
- Prescription drugs
- Non-emergency medical transportation to doctors' offices and clinics (i.e., ambulette)
- Nursing-home care (covered by MLTC, but institutional budgeting and transfer-penalty rules apply — please see the article Medicaid: Frequently Asked Questions, on page 1).

Individual plans may cover additional services. It is imperative that a plan participant understand that the plan will not pay for these additional services if the provider is not in the plan or a referral from a plan provider is not obtained.

Federal law requires that the plans make services available to the same extent they are available to recipients of the former fee-for-service Medicaid, PACE, or Medicaid Advantage Plus plans.

The plans may not define covered services more narrowly than the Medicaid program. Significantly, personal-care services including those from 24-hour sleep-in to split-shift services are available!

Services Not Covered

Services not covered by partially-capitated plans include the consumer's primary care physician and other primary and acute medical care, including all doctors, all hospital inpatient and outpatient care, outpatient clinics, emergency room care, and mental-health care. Also not covered are laboratory and radiology tests, and prescription drugs. Such services are covered by Medicare.

Disenrollment

A member of a partially-capitated plan may disenroll at any time, for any reason, upon oral or written notice to the plan. Disenrollment will take effect the first day of the next month. However, if the individual enrolls in a new plan after the third Friday of the month, the move to the new plan will not be effective until the second month.

The individual will have to stay with his or her current plan until then.

Aid Continuing

Before an MLTC plan reduces or terminates services that were previously authorized either by the plan or that the individual received before mandatory enrollment, the plan member is entitled to a hearing. The State must ensure the plan member's due-process right to continue receiving services unchanged ("aid continuing"), pending that hearing.

Plan members may pay their excess monthly income into the plan or they may conserve their excess income using a pooled-income trust, discussed on this page.

The Consumer Directed Personal Assistance Program is available through the MLTC plans as it was under the former Medicaid home-care program. (Please see the article Medicaid Homecare: The Consumer In Charge, on this page.)

In conclusion, as the transition from the Medicaid home-care program to MLTC continues to unfold, please share with us your specific concerns, thoughts and suggestions regarding meeting the needs of older adults and the disabled by writing in your impressions to mbpetroff@aol.com. ■

Pooled Income Trusts & Medicaid Home Care

Disabled persons of any age receiving community Medicaid services — including home care, adult day care and prescription drugs — are now able to use virtually all of their income to pay for their living expenses by participating in a pooled-income trust. It is no longer necessary for consumers to contribute their "excess" income to the Medicaid system as a "spend-down." The pooled-income trust is proving to be a popular planning tool for persons in need of long-term health-care services for whom the excess-income option does not work because it would not allow them sufficient money to live in the community and qualify for Medicaid. The pooled-income trust works as follows:

- Suppose an individual has a monthly income of $1,800 in Social Security and pension income and is utilizing Medicaid home care and adult-day-care services. Under present (2013) Medicaid guidelines he is only allowed to keep $800 of that income.
- Currently his monthly surplus is $1,000 ($1,800 - $800 = $1,000). He is sending a check each month for that amount to the appropriate health-care provider as a contribution toward the cost of his care.
- After the individual joins the pooled-income trust his $1,000 check will be sent to the trust office. The individual will keep $800 as he does now. His expenses for rent, food, utilities, clothing, etc. will be paid by the trust according to instructions from the individual or his representative. The individual's Medicaid services will not be affected. The pooled-income trust contains the assets of a number of disabled individuals and is managed by a non-profit organization that maintains a separate account for each individual. It is effectively a supplemental-needs trust that receives the individual's monthly income and redistributes it on his behalf as directed by him or his representative. ■

Medicaid Homecare: The Consumer In Charge

Individuals who have an aide in place when entering the Medicaid homecare program may continue to employ that person within the Consumer Directed Personal Assistance Program (CDPAP). The program is available for elderly and disabled individuals who are able to direct their own care or have someone who can assist them in providing that direction. CDPAP provides an opportunity to obtain government financial assistance while maintaining a level of independence that is not possible when a government agency takes responsibility. Available services range from skilled private-duty nursing to personal care or homehealth aide services by paraprofessionals. The recipient or the person acting on the recipient's behalf assumes full responsibility for hiring (and firing), training and supervising the person or persons providing the services. ■

Supplemental Needs Trusts Defined

Supplemental-needs trusts are widely used planning tools for persons with disabilities. Such trusts, also referred to as special-needs trusts, are intended to enhance the lives of disabled individuals without jeopardizing their eligibility for Medicaid and Supplemental Security Income (SSI).

Supplemental-needs trusts pay for the personal needs of beneficiaries, including both necessities and luxuries. The trust may include cash, stocks, bonds, and a house, a condominium, or a cooperative residence. The following examples illustrate situations in which a supplemental-needs trust may be used:

1. A supplemental-needs trust may be established for the benefit of a disabled person under the age of 65, using that person's own funds, without incurring a penalty period for Medicaid and SSI eligibility. Upon the death of the disabled beneficiary, the State has a right to recover against the remaining funds in the trust for whatever Medicaid charges were incurred by the individual. The law provides, however, that there are no limits on the amount of trust income or principal that may be spent on behalf of the beneficiary during her lifetime.

2. A parent, family member, or friend may establish a supplemental-needs trust for a disabled person without risking the beneficiary's eligibility for public benefits. In such a case, Medicaid has no right to recover against any assets remaining in the trust upon the death of the beneficiary. Such assets may be distributed according to instructions included in the trust agreement by the individual who funded the trust.

3. A disabled person of any age may transfer his assets to a supplemental-needs trust for the benefit of another disabled person under the age of 65 without disqualifying himself for Medicaid home care or nursing home care. ■

Using The Durable Power Of Attorney

The durable power of attorney is one of the most powerful planning tools that an attorney can recommend to a client, not only for estate planning, but also for Medicaid and other public-benefits planning. When a person (the principal) signs a power of attorney, he gives another person (the agent) the power to act in his place and on his behalf in managing his assets and affairs. The agent's powers may be broad and sweeping so as to include almost any act which the principal might have performed himself.

On September 1, 2009, a new power-of-attorney law went into effect in New York State. All powers of attorney signed prior to that date remain effective. The new law eliminates all gift-giving authority of the agent except to continue the principal's history of gift-giving, and then not to exceed $500 per recipient. *Other gift-giving can only be accomplished through an additional document, the Statutory Major Gifts Rider. Using this supplemental form, the principal "may authorize major gift transactions and other transfers." The form requires that it be acknowledged and witnessed by two disinterested witnesses.*

A power of attorney can be either a "general" power of attorney, where the agent may perform almost any act the principal might have performed himself regarding the financial management of his affairs, or a "limited" power of attorney, where the agent has one or more specific powers, such as the power to sell a particular property to a particular purchaser at a particular time. A single principal may name one or more agents who can be authorized to act together or separately (alone without the signature of the other agent or agents).

In order to sign a power of attorney, the principal must have "capacity," which is defined by the statute as the "ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney...."

Every power of attorney executed on or after 9/1/09, is considered "durable" unless the document expressly states otherwise. That is, the power of attorney will endure the principal's incapacity unless it provides that it is a non-durable power of attorney to be terminated upon incapacity.

The great advantage of a durable power of attorney is that it remains in effect after the principal's incapacity. The agent, therefore, can act immediately upon the principal's incapacity to manage the principal's assets or to take various measures without initiating costly and time-consuming alternatives such as guardianships or trusts.

The power of attorney for asset management in the case of serious illness or disability is especially useful in situations where the person's assets may be modest and, accordingly, do not warrant the expense associated with other planning alternatives.

In a few states, the principal is allowed to delegate to the agent in the durable power of attorney various health-care powers in addition to control over financial matters. In New York State, however, a health-care proxy must be a separate document from a power of attorney. ■

Living Wills and Health Care Proxies

What is a health-care proxy?

Under New York law an individual may appoint someone she trusts — for example, a family member or close friend — to decide about treatment if she loses the ability to decide for herself. She can do this by using a health-care proxy in which she appoints her health-care agent to make sure that health-care providers follow her wishes. Her agent can also decide how her wishes apply as her medical condition changes. Hospitals, nursing homes, doctors and other health-care professionals must follow the agent's decisions as if they were the patient's. The individual can give her health-care agent as little or as much authority as she wants. She can allow the agent to decide about all health care or only certain treatments.

What is the difference between a living will and health-care proxy?

A living will is a written statement of an individual's wishes regarding medical treatment. The statement is to be followed if the individual is unable to provide instructions when medical decisions need to be made. A health-care proxy is significantly different from a living will in that it empowers another person (the agent) to make health-care decisions if the patient cannot do so herself.

Should I have both a living will and health-care proxy?

A living will has no provision for an agent ; it simply enables a person to express her own choices regarding medical treatment. Having both a living will and a health-care proxy makes sense.

Can an agent, acting under a health-care proxy, be legally or financially liable for health care decisions made on your behalf?

No. A health-care agent will not be liable for treatment decisions made in good faith. In addition, the agent cannot be held liable for the costs of care just because she is an agent.

Do you have to write an advance directive?

No. Signing a living will or health-care proxy is voluntary. No one can require an individual to complete either directive. ■

Medicare 2013 in a Nutshell

Editors' Note: It is important to remember that purely custodial care (the type of care that most persons at home or in nursing homes require) is not covered by Medicare or Medigap policies. The only home-care or nursing-home services that Medicare covers are for skilled nursing or rehabilitation. Long-term-care insurance and Medicaid are the major alternative sources for paying for custodial-care services.

Introduction: The Medicare program is a system of health insurance for the aged and disabled. It is administered by the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration. It consists of two basic units: Part A provides coverage for the costs incurred by eligible beneficiaries for inpatient hospital care, inpatient care in a skilled-nursing facility following a hospital stay, home health care and hospice services; Part B is a voluntary program in which eligible beneficiaries who pay a monthly premium are entitled to reimbursement for physician and other medical services and supplies. Parts C and D are reviewed below.

Eligibility: Primary Medicare eligibility is linked to Social Security retirement and disability benefits. Disabled persons and disabled widows/widowers under age 65 may also be eligible for Medicare. Some persons who are 65 years of age or older, but not otherwise eligible, may purchase this insurance by applying to Social Security.

Enrollment: The initial enrollment period begins 3 months prior to the month of the 65th birthday and continues 3 months after that. (There are substantial penalties for late enrollment.) A special enrollment period is available to the working aged and their spouses who delay enrollment because of primary, employer-based insurance.

Medicare Part A - Hospital Insurance

Inpatient Hospital Coverage: Medicare Hospital Insurance (Part A) will pay for all medically necessary inpatient hospital care for the first sixty days minus a deductible of $1,184 for each benefit period. For the remaining days a beneficiary must pay substantial co-payments, which may be covered under a Medigap policy (see discussion below). Major in-hospital services covered by Medicare Part A include a semi-private room, all meals, special-care units including the intensive-care and coronary-care units, regular nursing services, and drugs furnished by the hospital during the patient's stay.

Skilled Nursing Facility Care: Medicare will also pay for up to 100 days in a skilled-nursing facility. The first 20 days are covered, but for days 21 through 100 a $148.00 daily co-payment is required. The patient must have been hospitalized for at least 3 days and be admitted to the facility generally within 30 days after leaving the hospital.

Home Health Care: Medicare also provides home-health-care services for a beneficiary who is under a physician's plan of care, requires skilled-nursing care, and is essentially confined to home. Physical, occupational and speech therapy, and the services of a home-health aide are available. A prior hospital stay is not required.

Hospice Care: Medicare's hospice program includes both home care and inpatient care, when needed, and a variety of services not otherwise provided by Medicare. To be eligible, a Medicare beneficiary must be certified by a physician as terminally ill with a life expectancy of approximately 6 months or less. Those who choose hospice care receive non-curative medical and support services for their terminal illness. Regular Medicare continues to pay for medical treatments not related to the terminal illness.

Medicare Part B - Medical Insurance

Medicare Medical Insurance (Part B) covers a variety of medical services of particular importance to Medicare beneficiaries, including physician services in and out of the hospital, durable medical equipment, outpatient hospital services, physical, occupational and speech therapy, and ambulance transportation. Part B coverage is voluntary. Most Medicare beneficiaries decide to enroll in the program with their monthly premiums deducted from their Social Security checks. There is a monthly Part B standard premium of $104.90. Persons who file an individual tax return with annual income above $85,000 (or $107,000 for a married couple filing a joint tax return) will pay a Part B premium ranging from $146.90 to $335.70. There is an annual deductible of $147 which must be paid before Medicare benefits are reimbursed. Medicare pays 80% of the approved charges for services and the beneficiary is responsible for the 20% co-payment. Some Medicare supplemental insurance policies cover these charges. See Medigap Insurance below.

Limiting Charge: There is a cap imposed on the amount doctors may charge their Medicare patients for each service. In New York, doctors may not charge more than 5% above the Medicare-approved rate for most services.

Excluded Services under Part A and Part B: Some services not covered by Medicare Part A are private-duty nursing and, generally, a private room. Other services excluded under Medicare Part B are routine physical checkups, immunizations with some exceptions, eyeglasses or contact lenses, most dental care and hearing aids. Generally, Medicare will not pay for hospital or medical services abroad or for physician services on ship cruises beyond the territorial waters of the United States.

Medigap Insurance: Medicare beneficiaries generally decide to buy supplemental insurance (Medigap). At present, there are ten standard Medigap policies that may be offered by insurance companies. Plan A is a policy with core benefits that are included in the nine other plans. For further information, request a copy of the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* by calling Medicare (800) 633-4227 or Social Security (800) 772-1213 or visit the Medicare website at www.medicare.gov/publications/ search/view/viewpublist.asp.

Part C - Medicare Advantage Plans

Medicare Advantage plans are managed-care programs that are sometimes called coordinated care or prepaid plans or health maintenance organizations (HMOs). They might be thought of as a combination of insurance company and doctor/hospital. Like insurance companies, they cover health-care costs in return for a monthly premium which may be waived. Generally, the plans have "lock-in" requirements. This means that an enrolled member is locked into receiving all covered care from the doctors, hospitals, and other care providers who are affiliated with the plan. In most cases, if the enrollee goes outside the plan for

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Medicaid: FAQ *(continued from page 1)*

Q. My brother has dementia and needs round-the-clock homecare. I believe he has between $70,000 and $80,000 in assets. His Social Security and pension income is $2,000 per month. Currently, he is paying $700 a month for 10 hours of homecare a week and $850 for rent. He is just barely able to cover his other expenses. Can we protect his savings and income and still have him qualify for Medicaid homecare?

A. The answer is an emphatic "Yes!" to both parts of your question. Under the Medicaid program, the value of his assets: bank savings, stocks, bonds, etc., cannot exceed $14,400. However, the law permits him to reduce his assets down to the required limit and apply for Medicaid homecare for such services. If he gives away (i.e, transfers to an individual or to a trust) in any one month that portion of his assets above $14,400, he will be eligible resource-wise for free Medicaid homecare, day care, prescription drugs, etc. on the first day of the following month. Note: There is no penalty period for transferring assets to become eligible for non-institutional Medicaid. Medicaid monthly income limit is $800. In effect, your brother has $1,200 in monthly income that Medicaid characterizes as "excess." Medicaid will require him to contribute this amount to Medicaid to help cover his homecare expenses. However, if your brother joins a pooled-income trust he will be able to conserve almost his entire $2,000 monthly limit to pay his other expenses. (Please see the article on pooled-income trusts on page 2.)

Q. Would you please summarize the Medicaid rules under which it is possible to conserve approximately 50 percent of an individual's assets should that individual require nursing-home care?

A. Under the Medicaid law in New York State an individual may be eligible for Medicaid nursing-home coverage if his savings do not exceed $14,400 and all of his income except for a personal-needs allowance of $50 per month is paid to the facility to defray the cost of his care. If the individual has assets in excess of $14,400 he may transfer (i.e., give away) his assets to an individual or trust. For example: assume the individual has $114,400. If, in an attempt to become eligible for Medicaid-nursing-home coverage, he transfers away $100,000, leaving him with $14,400, he will incur a 10-month penalty during which time Medicaid will not pay for his nursing-home care.

Medicaid arrives at the penalty period by dividing the amount of money transferred ($100,000) by the average monthly cost of a nursing home in the county in which he lives. In the five counties that compose New York City, the average monthly cost is approximately $10,000, resulting in a 10-month penalty ($100,000 ÷ $10,000 = 10) during which time Medicaid will not pay for the Medicaid applicant's care in the nursing home.

In such circumstances, there is a way to preserve some assets. The person who received the original $100,000 would return 50 percent, that is, $50,000, to the Medicaid applicant. The Medicaid applicant is then deemed to have only transferred $50,000 and therefore incurs only a five-month penalty. The applicant uses the $50,000 returned to pay for his nursing-home care for five months. By the sixth month he has served his five-month penalty, is impoverished, and is eligible for Medicaid. The process requires the utilization of a promissory note or annuity in conformity with Medicaid law.

Q. Will Medicaid take our home if my wife or I should ever need Medicaid nursing home care or home care?

A. In most instances a home: a house, cooperative, or condominium, remains an exempt asset for purposes of determining initial Medicaid eligibility. However, ultimately Medicaid may impose a lien on the sale proceeds of the property for the amount Medicaid has spent on behalf of your wife. If your home is transferred to a non-exempt individual, a penalty period will be incurred during which time your wife will be ineligible for Medicaid nursing home coverage. Significantly, there is no penalty period if the home is transferred to a spouse; to a "caretaker" child who resided there for at least two years before his or her parent entered a nursing home and provided care to maintain the parent at home; to a child who is disabled, blind, or under age 21; or to a brother or sister who has an equity interest in the home and resided there for at least one year before the his or her sibling entered a nursing home.

Q. If my father transfers $14,000 to me and each of my three children this year, will those transfers count if he should need to apply for Medicaid nursing home coverage?

A. The transfers you are proposing are counter-productive for Medicaid eligibility but may be a useful for a person wishing to reduce the size of his taxable estate. You are referring to a tax-planning option which permits an individual to make gifts of $14,000 to any number of persons in any one year without filing a gift-tax return. Such gifts are exempt from gift and estate taxation, but they are not exempt under the Medicaid nursing-home rules. The transfer of $56,000 (4 persons x $14,000) will generate almost a six-month penalty during which time your father will not be eligible for Medicaid in a nursing home.

Q. I recently realized that I am eligible for Medicaid, but I already have Medicare. Can I have both at the same time?

A. Yes. As long as you meet Medicaid's income and asset limits, you can have both Medicare and Medicaid benefits, but Medicare will always be the primary payer and Medicaid will be the second payer. Medicaid can pay for many medical expenses not covered by Medicare, such as personal care at home, long-term nursing home care. or transportation to the doctor. ■

Assisted Living Program

An Assisted Living Program (ALP) serves persons who are medically eligible for nursing-home placement but serves them in a less-medically-intensive, lower-cost setting. ALPs provide personal care, room, board, housekeeping, supervision, home-health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home-health services, and the case management services of a registered professional nurse. To be eligible, both Medicaid recipients and private payers must be medically eligible for, and would otherwise require, placement in a nursing home due to the lack of a home or suitable home environment. However, eligible ALP residents must not require continual nursing care, be chronically bedfast or chairfast, or be impaired to the degree that they endanger the safety of other ALP residents.

ALP eligibility requires that applicants qualify under the financial limits for Medicaid community services. It is not necessary

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Medicare 2013 *(continued from page 4)*

services, neither the plan nor Medicare will pay. The enrollee will be responsible for the entire bill.

Part D - Medicare Prescription Drug Plans

Medicare pays, in part, for out-patient prescription drugs. All Medicare beneficiaries have the opportunity to enroll in a Medicare prescription drug plan sponsored by a private-sector company. New York has more than 30 different plans available to beneficiaries from the companies.

Part D plans charge a monthly premium, and many have a deductible to meet and co-payments or co-insurance requirements as well. Overall, there should be savings of 25-50% depending on the person's drugs and the plan's price and co-pays. After a period of shared drug costs are met, where the plan pays 75% of the costs, an enrollee goes into a period of non-coverage (nicknamed the "donut hole") where he is responsible for 100% of the cost of the drugs until he pays a total of $4,700 out-of-pocket. At that point, he pays 5% of his drug costs or a small co-payment for the rest of the calendar year and the monthly premium.

If the individual's annual income is less than $16,755 and resources less than $13,070 (for couples income less than $22,695 and resources less than $26,120) he may qualify for Extra Help, a program that reduces the Medicare Part D out-of-pocket costs. If the individual qualifies for Extra Help, the drug-plan premium could be free and the co-payments low for each prescription. Persons who qualify for Extra Help do not have the coverage gap, that is otherwise known as "the donut hole." With so many plans to choose from and the list of covered medications different from one plan to another, help is needed. The NYC Department for the Aging through its HIICAP unit has trained counselors at 2 Lafayette Street in Manhattan and at numerous sites across the City to provide assistance. Staff members are prepared to assist beneficiaries with their specific needs and choices, including Extra Help for low-income beneficiaries. Please call 311 for locations. ■

Assisted Living Program *(continued from page 5)*

for persons to qualify under the more complex and punitive rules for Medicaid nursing-home eligibility. An applicant with income in excess of the allowed monthly Medicaid rate may use a pooled-income trust to enhance his or her budget. The following is a partial list of New York State approved ALP providers in the New York City metropolitan area: Village at 46th & l0th, 510 West 46 Street, Manhattan, (212) 977-4600; Lott Residence, 1261 Fifth Avenue, Manhattan, (212) 534-6464; Boulevard ALP, 71-61 159 Street, Flushing, (718) 969-8102; Amber Court of Brooklyn, 650 East 104 Street, Brooklyn, (718) 649-0700; Westchester Center for Independent Living, 78 Stratton Street South, Yonkers, (914) 787-7400. Note that the number of facilities offering this program is expanding throughout New York State.

ALPs are regulated by the New York State Department of Health. The regulations require that the appropriateness of ALP services be determined by initial and periodic reassessments provided by the ALP. Facility operators are required to provide sufficient staff to perform case-management functions for assisted living residents and to ensure their health, safety, and well-being. ALPs are required to provide a staffing plan for review by the Department of Health. ■

ABOUT THE EDITOR: The law practice of Martin Petroff & Associates provides a broad range of services centered on the rights of the elderly and disabled. Martin Petroff, formerly staff attorney for health affairs at the New York City Department for the Aging, is a member of the Executive Committee of the New York State Elder Law Section. He is a member and director of the Long Term Care Community Coalition. He is also a member of the advisory council of the Henry Street Settlement House Senior Companion Program. The *Elder Law Report* provides an informative summary of current legal issues and new programs affecting disabled individuals and seniors. Those persons concerned about legal issues discussed in this publication are advised to consult an elder-law attorney. ATTORNEY ADVERTISING pursuant to NY DR2-101(f). Copyright © 2013. Martin Petroff & Associates. All rights reserved. ■