PLANNING FOR INCAPACITATED OR DISABLED CLIENTS AND FAMILY MEMBERS

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I. DISABILITY

Disability has no legal definition -- nor should it. We all require assistance with some aspect of our lives. Some people require more assistance than others do.

When representing a client with disabilities, focus upon what assistance the client requires and how you can facilitate the continuation or improvement of that assistance.

II. DEVELOPMENTAL DISABILITY

A "developmental disability" is distinguished from other disabling conditions in that it must occur, by definition, before the affected person reaches the age of 22 years. A developmental disability is expected to continue indefinitely and has a severe impact upon the ability of the affected individual to function independently in society. Future Planning on behalf of People with Developmental Disabilities, *A Guide for Estate Planners,* GAPS program, Association for Retarded Citizens of Oregon, 1990, page 6.

Developmental disabilities can result from mental impairments, physical impairments, or a combination of both. Generally, most people with moderate to severe cerebral palsy, mental retardation or autism are considered "developmentally disabled."

"The most significant factor which distinguishes people with developmental disabilities from those without handicaps is the degree of assistance that those with handicaps require in their daily lives. Although everyone requires assistance in some aspect of life, those with developmental disabilities often need a greater degree of help in more areas and for a longer period of time than do their non-handicapped peers. Those with physical disabilities often need prostheses or mechanical devices such as wheelchairs or braces. Those with mental impairments often need guidance to make important life decisions or otherwise exercise sound judgment. Because their handicaps are permanent, people with developmental disabilities generally need assistance through the remainder of their lives."

Future Planning, GAPS, above, pages 7-8.

III. PUBLIC BENEFIT PROGRAMS

Often, the assistance received by a disabled client comes in the form of various public assistance programs, such as Social Security, Medicare, Medicaid, and community programs. It is important that the attorney/planner be aware of the benefits the client is receiving and develop a plan that will continue or improve upon those benefits.

Eligibility for public benefits programs, such as Social Security retirement, Medicare, and Social Security disability are based only upon the beneficiary's "status," such as citizenship, age, disability, and/or work history.

Other public benefit programs, such as SSI and Medicaid, are "needs-based" benefits. Eligibility for these programs requires not only "status," but also specific levels of assets and income. In addition, the amount of assets and/or income available to the beneficiary can affect his or her ongoing eligibility or the amount and extent of benefits.

A. Social Security Benefits

Most often, when people speak of "Social Security benefits," they are referring to benefits under Title II of the Social Security Act, called "Old Age, Survivors, and Disability Insurance." Monthly Social Security benefits include: (1) checks for retired persons over 62, (2) disability checks for a worker who becomes severely disabled before 65, and (3) checks to the survivors of a deceased worker. 42 USC Section 301 et seq.; 42 USC Section 402(a), 423(a)(1).

Social Security benefits are based upon status, *not* upon financial need. Social Security is a public insurance benefit. Beneficiaries are not disqualified for having excess resources. Social Security beneficiaries are entitled to retain any amount of assets. Unearned income is not restricted. 42 USC Section 410.

Social Security benefits will be affected by the beneficiary's *earned* income, i.e., wages or net profits. It is important to determine the amounts of earned income allowed to the individual. Earned income over the allowable amount can result in reduced benefits and overpayment. 42 USC Section 402, 403.

For more information about Social Security Benefits, see OSB Elder Law CLE Handbook, Chapter 4.

B. Medicare

Medicare is a federal health insurance program for certain elderly and disabled individuals. The two parts, Part A (hospital insurance) and Part B (medical insurance), differ in their eligibility requirements and coverage. Part A covers primarily the cost of hospital, skilled nursing facility (maximum 100 days), home health, and hospice care

and is available to most recipients without payment of premiums. Part B covers many other health care expenses, such as physician services, diagnostic tests, and the use of medical equipment. Enrollment in Part B is optional and is purchased by paying a monthly premium, which usually is deducted automatically from the individual's Social Security check (in 2002, $54.00). Both Part A and Part B require payment of deductibles and copayments. 42 USC Section 1395 et seq.

Medicare is available to insured participants who are over 65 years old and receive Social Security or railroad retirement benefits. Beneficiaries under age 65 who are eligible for Social Security disability benefits and have been disabled for more than 24 months are also entitled to Medicare. 42 USC Section 1395l-2(a); 1395c. Medicare beneficiaries need to file claims to receive benefits. There is no requirement that a beneficiary report assets or income.

For more information about Medicare Benefits, see OSB Elder Law CLE Handbook, Chapter 5.

C. Supplemental Security Income (SSI)

Supplemental Security Income is a federal program of cash assistance for aged, blind, and disabled individuals who have little income and few assets. The program provides monthly checks from the federal government of (in 2002) up to $545 for an individual and up to $817 for a couple.

SSI is administered by the Social Security Administration (SSA). In Oregon, eligibility for SSI benefits (in most cases) automatically qualifies the recipient for Medicaid benefits.

The legal authority for the Supplemental Security Income program is contained in Title XVI of the Social Security Act, 42 USC Sections 1281-1385. HHS regulations implementing the program are found in 20 CFR Section 416.1100 et seq. Internal policy guidelines are found in the Program Operations Manual System (POMS), Section SI00810.100, et seq.

1. Who is Eligible for SSI? To be eligible for SSI, a beneficiary must be 65 or older, blind (vision no better than 20/200 even with glasses), or disabled (a physical or mental impairment that prevents a person from doing any substantial work and that is expected to last at least 12 months or result in death). He or she must be a citizen of the United States or a lawfully admitted alien. 42 USC Section 1382c(a)(1)-(3).

The individual's income and assets cannot exceed certain levels established by Congress. To be eligible for SSI, a single person cannot have "countable resources" worth more than $2,000, and a couple cannot have countable resources worth more than $3,000. The individual cannot have "countable income" in a month of more than the amount of the Federal Benefit Rate (FBR) for an individual of $545 or for a couple

of $817 (for 2002). 42 USC Section 1382(b).

2. Income. Income includes both "earned" and "unearned" income. 42 USC Section 1382a(a). Generally, earned income is wages paid from a job or the net earning from self-employment. It can also include payments from special work activity programs and certain sickness or disability benefits. 42 USC Section 1382a(a)(1).

Unearned income is, simply, all income that is not earned income. This includes anything an individual receives in the form of cash or otherwise that the individual can use to meet his or her needs for food, clothing, or shelter. 42 USC Section 1382a(a)(2).

Non-cash assets an individual receives constitute "in-kind income." This includes food, clothing, shelter, or anything that may be used to acquire these necessities. 20 CFR Section 416.1102. Thus, an individual receives in-kind support and maintenance when he or she receives food, clothing, or shelter directly without having paid for it or receives these items because someone else pays for it. 20 CFR Section 416.1130(b).

Items an individual receives that *cannot* be used as food, clothing, or shelter, or to obtain these necessary items, are *not* income. 20 CFR Section 416.1103. Therefore, it is not countable income for a trustee (or anyone other than the beneficiary) to make a payment directly to a third-party vendor for goods other than food, clothing, or shelter that benefit the individual. 20 CFR Section 416.1103(g), POMS Section SI 00810.010.

> **EXAMPLE:** W receives an airline ticket as a gift from her daughter who used her own credit card to charge the ticket. The airline ticket was not available to obtain food, clothing, or shelter. The gift of the ticket was not income to W. Soc Sec Rul 80-22, CE 1980 119. For the new rule, see 42 USC Section 1382a(b)(15), as added by Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, title VIII, Section 8011(a).

> **CAVEAT:** A different result would have been obtained in the above example if: (a) the ticket was not used by W, and (b) the ticket was not purchased with a credit card and could therefore be legally redeemed by W for cash.

The following is an illustrative list of items of in-kind support that may or may not be considered income.

a. Countable Income.

(i) Rent.

(ii) Mortgage.

(iii) Property taxes.

(iv) Heating.

(v) Gas.

(vi) Power.

(vii) Garbage.

(viii) Sewer.

(ix) Water.

(x) Fire insurance (if required by mortgage holder).

(xi) Clothing.

(xiii) Food (groceries).

(xiv) Meals.

b. Not Income.

(i) Medical care and services.

(ii) Medical insurance premiums.

(iii) Repair or replace items.

(iv) Personal care and therapy.

(v) In-home care and services.

(vi) Alternative medical treatments.

(vii) Education.

(viii) Travel.

(ix) Fire insurance (if not required by mortgage holder).

(x) Condo fees (unless garbage or utilities included).

(xi) Cable TV.

(xii) Telephone.

(xiii) Taxi vouchers.

(xiv) Bus tickets.

(xv) Subscriptions/dues.

(xvi) Companions.

(xvii) Persons to read for or travel with.

(xviii) Pets.

(xix) Case management.

(xx) Legal services.

(xxi) Spiritual needs.

(xxii) Memberships in groups.

(xxiii) Recreational desires/hobbies.

3. Resources. "Resources" are defined as "cash or other liquid assets," including real or personal property that an individual (or spouse) owns and could convert to cash to be used for support or maintenance. 20 CFR Section 416.1201(a).

In determining an individual's resources, the distinction between resources and income must be understood. An individual who receives an asset in a given month that may be used to meet his or her needs for food, clothing, or shelter receives income in that month. An asset that an individual already possesses in that month does not constitute income but is counted as a resource. POMS Section SI 00810.100(A).

EXAMPLE: Jane is employed and is paid $500 in May. She spends $300 and adds the remaining $200 to her savings account. Jane's income for May was $500. The $200 she saved becomes a resource in the next month.

SSI does not count certain kinds of assets in determining eligibility for SSI. These include:

a. One home;

b. Household goods and personal effects;

c. One automobile;

d. Term life insurance;

e. Property essential for self-support, including tools and equipment;

f. Cash received as replacement of lost or damaged property; and

g. Burial fund.

42 USC Section 1382b(a).

4. Trust Assets. A trust is treated as a resource if the beneficiary has *unrestricted* access to the principal. POMS Section SI 01120.105(A)(2).

Most special needs trusts *restrict* the beneficiary's access to the principal. The trust principal is not counted as a resource where the beneficiary's access is restricted, even where the trust agreement can be revoked by someone other than the beneficiary, the trust agreement provides that the beneficiary receive a regular specified payment from the principal for his or her use, or a representative payee or legal guardian is designated for bank accounts using the form "in trust for." POMS Section SI 01120.105(A)(2).

D. Medicaid

Medicaid is a joint federal-state program of medical assistance. Eligibility is based upon status (i.e., age, disability, or family) plus financial need. Unlike SSI, Medicaid does not pay cash grants to beneficiaries. Medicaid pays providers directly for health care and long-term care services rendered to eligible Medicaid recipients. Federal law provides the basic framework for the Medicaid program in 42 USC Section 1396 et seq. States are mandated to provide some services to certain groups of people. Other covered groups and services are optional. Oregon's applicable statutes and rules appear at ORS 414.025 et seq. and OAR Chapters 410, 411, and 461.

1. Who is Eligible for Medicaid?

a. Aged, blind or disabled individuals who receive SSI cash benefits are automatically eligible for Medicaid. OAR 461-135-710. See discussion of SSI eligibility above. "Aged" means 65 or older, and "disabled" means unable to perform any substantial work as a result of a medically proven physical or mental impairment, for at least one year. OAR 461-125-370.

b. Institutionalized individuals, or individuals who would be eligible for Medicaid if they were institutionalized and who receive in-home or community-based services under Oregon's Medicaid Waiver, referred to as "waivered services." OAR 461-135-760.

2. Income. To be eligible for Medicaid, an individual's income and assets cannot exceed the levels established for SSI eligibility. One important exception is for institutionalized individuals or individuals receiving waivered services. Institutionalized individuals whose income is at or below 300 percent of the SSI standard (in 2002, $545 x 3 = $1,635) are also eligible. OAR 461-135-750.

> **PRACTICE TIP:** Institutionalized individuals or those receiving waivered services whose income exceeds the income level can obtain Medicaid assistance by executing an "income cap trust." This Irrevocable Trust is funded with the individual's gross income and is distributed according to a specific formula, which allows for Medicaid eligibility (if otherwise eligible). OAR 461-145-540(10)(b). See also the most current elder law CLE materials.

3. Resources. Again, the resource limits are those used for the SSI program. Also, generally speaking, those assets which are exempt under SSI are also exempt for Medicaid eligibility. However, the Medicare Catastrophic Coverage Act (P.L. 100-360) eliminated the value limits on many exempt assets for individuals who began receiving long-term care after September 30, 1989. 42 USC Section 1396r-5(c)(5)(B).

One of the exceptions found in the Medicaid rules is for institutionalized individuals with spouses. To protect the financial well-being of the spouse at home, Medicaid will permit married Medicaid recipients to retain significantly more assets (and monthly income) than recipients who are single. These exceptions are contained in the spousal impoverishment rules found in 42 USC Section 1396r-5, which allow certain spouses to keep one-half of the couple's total assets, with a minimum of (in 2002) $17,856 and a maximum of $89,856. 42 USC Section 1396r-5, OAR 461-160-580.

> **PRACTICE TIP:** Practitioners have been successful obtaining more than the maximum resource allowance for a spouse by arguing that the additional resources are needed to provide more monthly income to the spouse. This procedure is referred to as a "revision of the Community Spouse's Resource Allowance (CSRA). 42 USC Section 1396r-5(e)(2)(C) and OAR 461-160-580(1)(f)(D). See also the most current elder law CLE materials.

> **CAUTION:** Medicaid eligibility can be denied or terminated if the individual irrevocably transfers assets to another person (not spouse) or to an Irrevocable Trust. Such a transfer will cause the individual to be ineligible for Medicaid benefits for a period of time. The state may inquire (referred to as "look back")

about transfers made to an individual during the past 36 months and about transfers to a trust for the past 60 months. This rule applies to Medicaid benefits, not to SSI benefits. 42 USC. 1396p(c)(1)(A)(B)(D)(E); OAR 461-140-210.

4. Trust Assets. Trusts funded with money contributed by third parties (parents, grandparents, children, friends, etc.) are governed by the same rules as SSI.

Trusts funded with money belonging to the individual or spouse are governed by the Medicaid trust rules found in 42 USC 1396P(d) and OAR 461-140-540. These rules apply if the assets of the individual were used to form all or part of the corpus of the trust and if the following individuals established the trust other than by Will:

a. The individual;

b. The individual's spouse;

c. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

d. A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

42 USC 1396p(d)(2)(A)(B); OAR 461-140-540(3)(5).

These trust rules apply *without regard to:*

a. The purposes for which the trust is established;

b. Whether the trustees have or exercise any discretion under the trust;

c. Any restrictions on when or whether distributions may be made from the trust, or

d. Any restrictions on the use of distributions from the trust. OAR 461-140-540(7).

In the case of a Revocable Trust:

a. The corpus is considered resources available to the individual;

b. Payments from the Trust to or for the benefit of the individual are considered income of the individual; and

c. Other payments from the Trust are considered assets disposed of by the individual for purposes of the transfer of assets rules (subject to the 60 months "look back"). 42 USC 1396p(d)(3)(A). OAR 461-140-540(8).

In the case of an Irrevocable Trust:

a. Under the new law if there are any circumstances under which payments from the Trust could be made to or for the benefit of the "individual,"

(i) The portion of the corpus of the Trust, or the income on the corpus, from which payment to the individual could be made shall be considered resources available to the individual; and

(ii) Payment from the corpus or income of the Trust shall be considered income of the individual; and

(iii) Payments for any other purpose are considered a transfer of assets by the individual (subject to the 60-month "look-back").

b. Any portion of the Trust from which, or any income on the corpus from which, no payment could under any circumstance be made to the individual is considered, as of the date of establishment of the Trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual for purposes of the asset transfer rules.

42 USC 1396p(d)(3)(B). OAR 461-140-540(9).

5. Exempt Trusts. The Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993") expressly allowed (created) certain trusts to be established and administered without adversely affecting the individual's Medicaid eligibility. They are as follows:

a. Trust for a Disabled Person Under 65. A trust for a "disabled person" (as defined under SSI rules) under age 65 containing that person's assets and established for that person's benefit by the person's parent, grandparent, legal guardian, or a court, will not be considered an asset, provided the state will receive all amounts remaining in the trust upon the death of the disabled person up to the amount of Medicaid assistance provided to this person by the state. OAR 461-145-540(8)(a). A more complete discussion of the "disability trust" can be found in part VI., "Planning for an Individual Already Receiving Public Assistance," below.

PRACTICE TIP: This trust is currently being used to hold assets of the individual, including an inheritance or an award from a personal injury case. These are commonly "special needs trusts." Remember that the remainder interest must go to the State of Oregon to pay for the Medicaid benefits received by the recipient during his or her lifetime. Fund the trust accordingly.

b. Trust for a Disabled Person Managed by a Nonprofit Association. Also contains provision for reversion to the state. *See* OAR 461-145-540(8)(c).

CAVEAT: At the time of this writing, there are no nonprofit associations in Oregon establishing or managing this type of trust.

For more information about Supplemental Social Security (SSI) Benefits, see OSB Elder Law CLE Handbook, Chapter 4.

IV. LONG-TERM CARE EXPENSES

The Average cost in the United States of a nursing home stay is $140.00/day. The Average nursing home stay is 2.5 years, with projected cost of $127,750. Oregon's daily cost is $142.00. Washington's daily cost is $177.
*(*Aging News Alert, MetLife Mature Market Group 12/8/98)

The average national lifetime cost of caring for a person diagnosed with Alzheimer's disease is $174,000
(Alzheimer's Association New, San Diego Chapter, Spring 2002.)

Many of our clients with significant incapacity or disability require some form of long-term care. Few clients or couples have enough income to pay for the high monthly cost of long-term care ($2,000 to $5,000).

By utilizing the state and federal laws governing eligibility for Medicaid, much can be done toward preserving the estate and/or preventing impoverishment of the spouse remaining in the community.

A. Long-Term Care Options And Costs

Long-term care needs can range from around the clock medical treatment to simply requiring assistance with the daily activities of life. In the past, a nursing facility was the only option for care outside the home. Today, Oregon leads the nation in providing alternatives to the traditional nursing home-type care.

1. Nursing Home Care. Nursing homes, licensed by the State, provide several different levels of nursing care to residents. These range from intensive nursing and

rehabilitative care for people with unstable medical conditions to routine care for people with chronic medical problems. Current estimated costs range from **$3250** to **$5000** per month, depending on the level of care needed.

2. Adult Foster Care. An adult foster home provides care to five or fewer residents. The operator or resident manager lives in the home. Personal care, cooking and cleaning are provided. Other types of care depend upon the qualifications and license of the provider. Estimated costs range from **$2000** to **$2750** per month.

3. Residential Care. Residential care facilities serve six or more residents and have staff on duty around the clock. Meals and housekeeping services are provided, but the amount of personal care and supervision varies.

"Assisted Living" is a particular type of residential care, with its own administrative rules. The focus is on providing care through a social model that emphasizes independence.

Estimated costs for residential care range from **$1500** to **$4000** per month.

4. In-home Services. A range of services can be provided at home, from a short visit to meet a particular need for assistance, to live-in help. In-home services, generally, are not licensed by the state, although some providers carry their own license. Estimated costs vary according to the hours of service and the type of provider used.

5. Adult Day Care. Adult day care is available in a variety of settings ranging from freestanding programs to nursing homes or senior centers. It often functions as respite care, to allow a regular caregiver, such as a spouse, to have a break or to continue working. Daily charges are now about **$40** to **$80**.

B. Who Pays For Long-term Care?

1. Health Insurance--Medicare. Health insurance, including Medicare, is primarily focused upon the payment of hospital and physician care for catastrophic illness or accidents. Patients must require skilled care (the services of a doctor or nurse available 24 hours a day). Medicare may cover a skilled care patient but only in a licensed nursing facility and only for a maximum of 100 days. (See discussion above.)

2. Long-Term Care Insurance. This is a new and growing industry that should be watched with interest and concern. Long-term care policies frequently contain limitations or exclusions that prevent them from being an effective mechanism for funding care for an extended period of time. Policies sold in Oregon must now include coverage for alternatives to nursing home care.

For more information about Long-Term Care Insurance, see OSB Elder Law

CLE Handbook, Chapter 8.

3. Private Pay. Currently, over half of the cost of long-term care in Oregon is paid from personal or family funds. The funds of both spouses are considered available to pay for care. The assets of adult children are not available assets unless they have signed as a guarantor for the nursing home expenses.

4. Medicaid. The Medicaid program is the second largest source of payment for long-term care in Oregon. Medicaid is a joint federal and state program. Medicaid covers the full range of long-term care services, including skilled, intermediate, and custodial care, adult foster home, and in-home services.

> **PRACTICE TIP:** Every estate planner needs a working knowledge of Medicaid and Social Security law. There are several planning techniques that may assist or may severely harm your client eligibility for public assistance benefits. For example, the transfer of a home from parent to child could make the parent ineligible for Medicaid for a period of three years or more.

B. Resources

1. *Counseling Elderly Clients,* OSB CLE, September 18, 1998.

2. *Foundations of Elder Law and Advanced Issues for Elder Law Practitioners,* OLI CLE, April 18, 1997.

3. Various materials for the National Academy of Elder Law Attorneys, 1604 North Country Club Road, Tucson, Arizona 85716, (602) 881-4005.

4. R. Pagnano and W. Fitzwater, "Special Needs Trusts," Chapter 10, *Administering Trusts in Oregon,* OSB Publication, 1995.

V. PLANNING FOR A FAMILY MEMBER ON PUBLIC ASSISTANCE BENEFITS (INCLUDING SPECIAL NEEDS TRUSTS)

Estate planning most often involves establishing a testamentary distribution of the client's property to the heirs and devisees. This process makes a number of assumptions: that the heirs are competent to manage the inheritance and make sound financial decisions, and that the heirs are capable of caring for themselves independently. These assumptions cannot be made if an heir is also a severely disabled or incapacitated person.

In addition, as discussed above, many disabled heirs receive public assistance

benefits. Some of these programs, such as Supplemental Social Security, Medicaid, subsidized public housing, and food stamps, are "needs-based" programs. In other words, one's eligibility is based upon one's financial need. A testamentary bequest or distribution to such a person will likely make him or her ineligible for the public benefit until the funds are liquidated.

Parents with adult disabled children have no legal duty to support that child. Once the child reaches majority (18 years), the parent's duty to provide room, support, and medical care terminates. Neither the state, county, nor a private facility can force a parent to provide support for an adult child who would otherwise be eligible for public assistance.

Planners for parents of adult disabled children should consider the following options.

A. Outright Bequest to the Adult Disabled Child

This is the simplest option but seldom the best. The beneficiary will receive the funds with no limitation and with no supervision. Also, if the beneficiary is receiving needs-based assistance, the beneficiary will be ineligible for the assistance until the funds are spent down.

This still may be the best option for a child who may be disabled but still capable of managing his or her own affairs.

B. Transfer to a Third Party

A common and simple method of planning is transfer to a third party outright. The third party would be a family member or friend who is committed to the disabled person and is trustworthy. In essence, the parent is funding a person who will step into the same role as the parent had--providing for the disabled person as needed.

The problem with this option is obvious. There is no legal method of requiring the third party to assist the disabled child. The bequest is the sole and unrestricted property of the third party. (That said, in most families, one or more family members would remain as committed to the disabled person, with the same care and concern as the parent.)

C. Transfer to a Trust

The parent could transfer to a trust established for the benefit of the adult disabled child. The trust could give the trustee discretion to make distributions of income and principal as the trustee determined necessary for the disabled person. The trust would be structured very similar to a testamentary trust established for minor children.

This arrangement will adequately provide for an incapacitated person who cannot manage his or her own financial affairs. It will not work for an incapacitated or disabled

person receiving public assistance benefits. As discussed below, if the trust assets can be paid or applied for food, clothing and shelter, the assets will be considered available to the disabled person and could disqualify the person for certain public benefits, such as Medicaid. However, if public assistance eligibility is not important or likely to be needed in the future, this option is sufficient.

D. Special or Supplemental Needs Trust

Most parents prefer to supplement rather that to replace the public assistance benefits their adult disabled child is receiving. One method of accomplishing this goal is transfer to a special needs or supplemental needs trust.

1. Definition. A grantor, who has no duty of support to the beneficiary, creates a nonsupport discretionary trust for the supplemental needs of the beneficiary.

2. Applicable Law. The state may count only the income and resources that are "available" to the public support applicant. *See* Soc. Sec. Act; Section 1109 and 1902(a)(17); Reg. 435.845 and 436.845. *See also CCH Medicare and Medicaid Guide* (1990), paragraph 14.311, p. 6171.

Resources available to the applicant do not disqualify him or her if they are not available for conversion into food, clothing, or shelter. *See* 20 CFR Section 416.1102; 416.1103; 416.1201(a).

Social Security regulations, 20 CFR Section 416.1201, list four requirements, all of which must be satisfied to render an asset a countable resource, as follows.

a. The recipient must have an *ownership interest* in the asset. For example, property loaned to the recipient is not a resource to him or her.

b. The individual must be *independently able to deal with the property.* Thus, property subject to legal dispute, or requiring the assent of a second person to withdraw or use (such as a bank account requiring two signatures), is not a resource.

c. The property must be *convertible to cash.* If as a practical matter the property cannot be sold, then it is not a resource regardless of its nominal or book value.

d. Though convertible to cash, *if availability is limited to uses other than those relating to food, clothing, and shelter,* the property is not a resource to the recipient.

See also Social Security Administration, Program Operations Manual (POM) Section 01121.105.

Oregon rules provide that "a resource is not available if the resource is an irrevocable or restricted trust and cannot be used to meet the basic monthly needs of the financial group." OAR 461-140-020 (3)(e).

Cases supporting the creation of trusts that provide for the supplementary needs of beneficiaries include *In re Emmons Will,* 59 N.Y.S.2d 264 (Sur. Ct. 1946); *In re Wright's Will,* 107 N.W. 2d 146 (Wis. 1961); *Matter of Holmquist Trust,* 357 N.W.2d 7 (Wis. Ap. 1984); *Snyder v. Dept. of Public Welfare,* 556 A.2d 31 (Pa. Commw. 1989); *Lang v. Com. Dept. of Public Welfare,* 528 A.2d 1335 (Pa. 1987); *Tidrow v. Dir. Mo. State Div. Family Serv.,* 688 S.W. 2d 93 (Mo. App. 1985); and see an unpublished administrative law judge opinion, Boston, Mass., reported in *The Elder Law Report,* vol. 2, no. 3, (1990), pp. 3 and 4, by Alex L. Moschella.

> **PRACTICE TIP:** *Case law* upholds (and often encourages) the use of special needs trusts by settlors with no duty of support. Problems arise when the document fails to adequately express the settlor's intent to provide for *other than* a beneficiary's basic support needs. Therefore, be sure to clearly express the settlor's intent to provide for the beneficiary's comfort and pleasure, while not jeopardizing the beneficiary's public support.

E. Administering a Special Needs Trust

Special needs trusts have a dual purpose: (1) to supplement, not replace, public benefits, and, more importantly, (2) to improve the overall quality of life of the beneficiary. The trustee is required to carefully balance these two objectives. The trustee must avoid making a distribution to the beneficiary that may violate the income or resource levels of the applicable public assistance program (usually SSI or Medicaid), while still maintaining a level of support that insures a good quality of life for the beneficiary.

As discussed above, it is necessary that the trustee of a special needs trust possess a full and working knowledge of the public assistance programs available to the beneficiary now and in the future.

The following are some general guidelines for trustees to consider when making distribution of income and/or principal to beneficiaries of special needs trusts.

1. Avoid Direct Distributions to the Beneficiary. Direct distributions of income or principal to the beneficiary will be considered income received by the beneficiary in that month. For Medicaid purposes, a direct distribution can result in an increased share of the cost for care. For SSI, the distribution can result in a dollar-for-dollar offset of the monthly benefit. 20 CFR Section 416.1123(a); OAR 461-140-540(9)(c).

2. Utilize the Exempt Resources Rules. As discussed above, there are certain resources (home, car, and medical equipment) that are exempt for the purposes of most public benefits programs. 42 USC Section 1382b(a).

The trustee should:

a. Not inadvertently convert an exempt asset into a nonexempt asset; and

b. Consider whether the trust can purchase an exempt asset and transfer ownership directly to the beneficiary. Depending on the value of the asset and the applicable public benefit program, the beneficiary's ownership of these assets will not affect eligibility.

3. Make Payments Directly to Vendors. The trustee should make payments, on behalf of the beneficiary, directly to the third-party vendor. Direct payments for goods other than food, clothing, or shelter are not *income* to the individual. 20 CFR Section 416.1103(g).

EXAMPLE: Money (cash) given to a SSI beneficiary by relatives to pay for the burial of her husband was income. The giver's intention that the money be used for burial expenses, coupled with the actual use of the money for that purpose, did not alter the availability of that money for the purchase of food, clothing, or shelter.

However, the value of the money used for repayment of burial expenses would not have been income to the beneficiary if the relatives had paid the sums directly to the funeral home. *Social Security Law and Practice,* Chap. 19.5.

F. Resources

1. D. Meyer, "Trusts,: Chapter 4, *Handling Claims for Minor and Disabled Plaintiffs: Coordinating All Aspects of the Case,* OLI CLE, April 10, 1998.

2. R. Pagnano and W. Fitzwater, "Special Needs Trusts," Chapter 10, *Administering Trusts in Oregon,* OSB Publication, 1995.

3. S. Ross, "The Special Needs Trust and Its Use in Estate Planning for Families with Disabled Children," *Estate Planning, Trust and Probate News,* No. 4, p. 7, 9, Spring 1987, State Bar of California.

4. C. Kruse, *Discretionary Trusts: Insulating Discretionary Trust Assets for Elders and Incapacitated Persons from Consideration by Medicaid and Other Public Support Providers,* 17 ACTEC NOTES, No. 1, Summer 1991, pp. 26-71. Also,

published in part, *Third Annual Symposium on Elder Law,* The National Academy of Elder Law Attorneys (1991).

VI. OPTIONS FOR AN INDIVIDUAL ALREADY RECEIVING PUBLIC ASSISTANCE BENEFITS (INCLUDING SPECIAL NEEDS TRUSTS)

What do you do when a client who is already receiving public assistance in the form of Medicaid or SSI benefits receives an inheritance or an award from a personal injury suit? As discussed in Chapter III above, the receipt of income and/or assets has the effect of making the client ineligible for benefits.

Unfortunately, the planning options for individuals currently applying for or already receiving Medicaid benefits are few. The two most common are: (a) spend down, and (b) the use of a "Disability" Trust.

A. Spend Down

The most common planning tool is the spend-down of resources. The client (or fiduciary) comes to your office with resources above the Medicaid resource limit ($2000). The excess resources can certainly be spent on the client's long-term care needs. However, you can also spend down the excess resources by purchasing additional "non-countable" (exempt) resources, by adding to the value of existing non-countable resources, or by purchasing services for fair market value. This is often a simple and effective way to improve the client's quality of life. Be creative. Thoughtful purchases like prepaid monthly flower arrangements or regular visits by a massage therapist to provide hand or foot massages can brighten moments in the day of person with decreasing capacity. There are many personal items and services that can make life easier, more comfortable, or pleasing.

Spending down often begins by purchasing or enhancing existing exempt resources. Some examples are as follows:

1. Purchasing a residence. A home is the place where the Medicaid applicant lives. A home can be a house, boat, trailer, mobile home, or other habitat. A home also includes the land on which the home is built and contiguous property (cannot be sold separately from the home). OAR 461-145-220.

2. Repairing/remodeling the existing residence.

3. Purchasing a car. The total value of a vehicle is excluded if it is used for necessary and continuing medical treatment. OAR 461-145-360. (This assumes, of course, that your client can drive or, at least, that someone else can drive for the client.)

4. Purchasing exempt personal property (appliances, clothing, home entertainment).

5. Purchasing medical equipment (hospital bed, mechanical chair, hearing aids, etc.).

6. Spending money on vacation and travel.

7. Purchasing burial goods and merchandise. Often referred to as the "hard goods" of burial, this includes burial space (including conventional grave sites, crypts, mausoleums, urns, and other repositories), headstone, opening and closing of the grave, caskets, liners, burial vaults, markers, and foundations. OAR 461-145-050 excludes the entire value of a burial space and burial merchandise owned by the client, and designated for the client, the client's spouse, minor and adult children, siblings, parents, and the spouse of any of these people.

8. Purchasing burial arrangements. Burial arrangements may include prepaid arrangements made with a licensed funeral director, burial insurance, and trust funds that make allowance for burial costs. Burial arrangements do not include a burial space or burial merchandise.

   Up to $1,500 each may be set aside as a burial fund for the client and the client's spouse. This includes cash or bank accounts if set aside and kept separate from the client's other resources. A burial fund may also be in the form of a revocable burial contract.

   Subtracted from the amount each client may set aside for a burial fund is:

   a. The face value of life insurance policies owned by the client that have already been excluded from resources; and

   b. The amount in an irrevocable burial trust or other irrevocable arrangement to cover burial costs. OAR 461-145-040 (6)(c).

   The interest earned on excluded burial funds, or increase in the value of excluded burial arrangements if left in the fund, is excluded. OAR 461-145-040 (6)(d). Also, there is no penalty if the client uses the excluded burial funds for any purpose other than burial costs. OAR 461-145-040 (6)(e).

   PRACTICE TIP: The total value of an irrevocable burial arrangement purchased prior to Medicaid eligibility is excluded. Therefore, a burial arrangement valued in excess of $1,500 can be purchased. Note, however, that burial arrangements purchased posteligibility are limited to $1,500.

B. A "Disability Trust"

The Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993") expressly allowed (created) certain trusts to be established and administered without adversely affecting the individual's Medicaid eligibility.

One example is a trust for a "disabled person" (as defined under SSI rules) under age 65, containing that person's assets and established for that person's benefit by the person's parent, grandparent, legal guardian, or the court. This trust has been referred to by several names, such as "disability trust," "under 65 trust," or "(d)(4)(a) trust" (after the federal statute that created it). The assets placed in this trust will not be considered "available" to the Medicaid recipient. However, an important requirement of the trust is that the state must receive all amounts remaining in the trust upon the death of the disabled person, up to the amount of Medicaid assistance provided to this person by the state. OAR 461-145-540(10)(a).

Funding the trust with resources belonging to the Medicaid recipient or spouse will not be considered a transfer of resources and will not incur a transfer penalty. OAR 461-140-242(4)(b).

The trust should be irrevocable with special needs language governing the distribution of income and principal.

Remember that the State of Oregon must be the first remainder beneficiary of the trust to the extent of Medicaid benefits paid. Secondary remainder beneficiaries can be anyone the life beneficiary would normally leave his or her estate to. The remainder beneficiaries must be specified by name, in order to prevent the Social Security Administration from treating the trust as revocable. POMS 01120.200-D-3.

> **PRACTICE TIP:** Disability trusts are excellent vehicles for the protection of an inheritance or personal injury settlement received by a Medicaid recipient. Remember, however, that since the remainder goes to the State of Oregon, you may not want to fund the trust with an amount of assets that will last beyond life expectancy. In cases involving substantial funds, a spend-down approach, culminating with the funding of a disability trust, may be wise.

C. Resources

1. D. Meyer, Trusts, *Handling Claims for Minor and Disabled Plaintiffs,* OLI CLE, April 10, 1998.

2. D. Meyer and T. Nay, "SSI and Medicaid Treatment of Trusts," *Advanced Issues for ElderLaw Practitioners,* OLI CLE, April 19, 1997;

3. Krichmar, "SSA Rules That (d)(4)(A) Trust Does Not Preclude SSI Eligibility," *The ElderLaw Report,* Vol. IX, Number 6, January 1998.

4. W. Fitzwater, "Planning for the Individual," Chapter 3, *Counseling Elderly Clients,* OSB CLE, September 18, 1998.

VII. DEFINING INCAPACITY

A. Generally

A client's legal competency to perform a particular act is a threshold question that must be one of the lawyer's first considerations. Lawyers who work in the growing fields of elder law and estate planning frequently face the question whether a client has the capacity to make legal choices. The lawyer should understand the standards for the capacity required to perform certain legal acts and what steps can be taken to maximize a client's independence.

Whether a person has the capacity to perform a particular act is examined at the time of the act. Even if several signs point to mental incompetence, it is possible for a person to have "lucid intervals" during which he or she has the requisite capacity to enter into a contract or make a testamentary disposition of property. *Uribe v. Olson,* 42 Or App 647, 651 (1979); *Gentry v. Briggs,* 32 Or App 45, 50 (1978). However, clear and convincing proof is required to show that a legal act is performed during a lucid interval. *Gentry v. Briggs,* 32 Or App at 50.

B. Testamentary Capacity.

For a person to have sufficient mental capacity, to make a valid Will, the person must:

1. Be able to understand the nature of the act;

2. Know the nature and extent of the person's property;

3. Know, without prompting, the claims of people who are or might be the natural objects of the person's bounty; and

4. Be aware of the scope and reach of the provisions of the document. *Kastner v. Husband,* 231 Or 133, 135-36 (1962).

The determination of a person's mental capacity to execute a Will is made at the time of signing a Will. *Id.* The same degree of mental capacity is necessary to revoke a Will as to execute one. *In re Dougan's Estate,* 152 Or 235, 253 (1936).

Mental competency to make a Will is determined at the precise moment that the Will is executed. *Gentry v. Briggs,* 32 Or App 45, 49, 573 P2d 322, *rev denied* 282 Or 189 (1978), *Ingraham v. Meindl,* 216 Or 373, 376, 339 P2d 447 (1959); *Whitteberry v. Whitteberry,* 9 Or App 154, 158, 496 P2d 240 (1972).

C. Contracts, Deeds, Lifetime Gifts, and Trusts.

A person must possess greater competency to execute a deed than to execute a Will. *First Christian Church v. McReynolds,* 194 Or at 72.

A person can enter into a valid contract if the person's reasoning ability enables the person to understand the nature and effect of the act. *Kruse v. Coos Head Timber Co.,* 248 Or 294, 306 (1967). Lack of capacity is not proved simply because a person is easily influenced and is a dependent person or because the person states that he or she does not understand a contract. *Id.* A person of below average intelligence can enter into a binding legal contract. The relevant question is whether the person is capable of understanding the act. *Id.* Conveying an inter vivos gift requires the same degree of capacity as making a contract. *Kugel v. Pletz,* 22 Or App 249, 251 (1975).

D. Capacity of Persons Subject to Guardianships and Conservatorship.

When is a person no longer capable of making decisions for him or herself?

After several years of experience as an elder law attorney, I have yet to find a more difficult question to answer or a more difficult decision for a family to make.

ORS 125.005 defines "incapacitated" as:

> "a condition in which a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person presently lacks the capacity to meet the essential requirement for the person's physical health or safety.
>
> 'Meeting the essential requirement for physical health and safety' means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is likely to occur."

ORS 125.005 defines "financially incapable" as:

> "a condition in which a person is unable to manage financial resources of the person effectively for reasons including, but not limited to, mental illness, mental deficiency, physical illness or disability, chronic use of drugs or controlled substances, chronic intoxication, confinement, detention by a foreign power or

disappearance.

'Manage financial resources,' means those actions necessary to obtain, administer and dispose of real and personal property, intangible property, business property, benefits and income."

"Incapacitated" persons who are unable to make decisions about their health and safety may require a court-appointed guardian. An inability to manage financial resources may require the appointment of a conservator. In both instances, the rights and the decision-making abilities of the person are substantially reduced.

Supreme Court Justice Douglass once said that we all have the "right to folly." Put another way, we all have the right to make the wrong decisions. The issue, therefore, is not whether we have made the wrong decision, but with what capacity the decision was made.

For example, is bouncing a few checks evidence of incapacity? Probably not -- if it were, we may all be in trouble. On the other hand, overdrafts during the past few months, together with an increased history of unpaid bills, misplaced funds, unexplained gifts, susceptibility to influence, and other related problems, may be evidence of an "inability to manage financial resources."

Except for the language of the statute, there are no clear rules for determining capacity. Each case must be evaluated independently. The court places weight on the opinions of doctors, psychologists, public social workers, private case managers, family, and friends (in my opinion, in that order). The court (or the court visitor) will attempt to contact all relevant parties to get an overall picture of the individual's capacity.

It is important to note, however, that a medical diagnosis of dementia (i.e., Alzheimer's, organic brain syndrome, etc.) does not by itself constitute a legal finding of incapacity. Until a court legally determines that the individual is incapacitated, that person retains all of his or her rights and decision-making abilities. He or she continues to have the "right to make the wrong decision." This includes the right to refuse assistance, case management, placement, medical treatment, and other forms of help. Until a finding of incapacity, the only hope is to convince the person to make the "right" decision.

QUERY: Can a person who is subject to a conservatorship change his or her will? ORS 125.455 allows a protected person "if mentally competent" to "make wills, change beneficiaries of life insurance and annuity policies and exercise any power of appointment or any elective right to share in the estate of a deceased person." Otherwise, the protected person "cannot convey or encumber the estate of the person or make any contract or election . . ."

QUERY: Can a person subject to a conservatorship change his or her Revocable Living Trust? If a protected person cannot "make any contract," can

that same person change a Revocable Trust? If Revocable Trusts are governed by the law of contracts, then arguably the answer is no. However, does it make sense that a protected person can change his or her Will but not his or her Revocable Living Trust?

D. Resources

1. Future Planning on Behalf of People with Developmental Disabilities, *A Guide for Estate Planners,* GAPS program, Association for Retarded Citizens of Oregon, 1990.

2. J. Cartwright and L. Ganzini, M.D., "Capacity," Chapter 5, *The Contested Estate Plan,* OLI CLE, July 24, 1998.

3. J. Cartwright, D. Dodson, M. Levelle, and W. Fitzwater, "Working with Varying Levels of Competency," Chapter 7, *Elder Law: Answers and New Directions,* OSB CLE July 26, 1996.

VIII. PLANNING AHEAD FOR INCAPACITY AND LONG-TERM CARE

"An ounce of prevention is worth a pound of cure."

The goal of estate planning is to allow our clients, as much as possible, to design and determine their future. Fewer people can now rely upon a close and supportive family to be there in times of need. Our clients must therefore rely upon advance planning, which includes the implementation of estate and incapacity planning tools.

Our job, as counselors, is to educate our clients and assist with the creation of those tools best suited to their particular circumstance (ounces of prevention), thereby doing all we can to prevent the high economic and emotional costs associated with developmental disability, incapacity, long-term care, and death (pound of cure).

The following is a summary of the areas that should be planned for and some of the tools available to facilitate a good advance plan.

Planning for incapacity is often overlooked, and yet there is a 65 percent chance that each of our clients will experience some period of incapacity and a 25 percent chance of suffering a long period of incapacity. The best method of planning is to use the following legal tools to appoint a surrogate or substitute decision-maker to assist the client when, and if, the time comes.

A. Planning Tools for Health Care Decisions

1. Advance Directive. The Advance Directive is your client's statement that if death is imminent, because of a terminal disease or injury, your client does not want artificial life support procedures used to postpone the natural moment of death.

In addition, your client can designate another person, a family member or friend (called "health care representative"), to act legally on behalf of your client to make health care decisions. The health care representative will be authorized to make any health care decision your client could have made (with some limited exceptions, i.e., sterilization). This includes the authority to withdraw life support procedures, such as respirators or artificial nutrition and hydration.

The Advance Directive replaces the "Directive to Physicians" and the "Health Care Power of Attorney." These two forms, if already signed, remain effective. However, after November 4, 1993, the new "Advance Directive" should be used.

2. Guardianship. A guardian may be appointed by the court when an individual lacks the capacity to make adequate decisions involving his or her care and safety. The guardian maintains full responsibility for the physical care and welfare of the ward. For example, the guardian may decide where the ward resides and what medical care the ward will receive.

The powers and duties of a guardian are contained in ORS Chapter 125. The powers of a guardian can be limited to specific actions. ORS 125.320. In fact, the current public policy is to impose the least restrictive alternative upon the ward. In practice, however, few guardianships are limited.

A temporary guardian can be appointed without notice and time for filing objections if the court determines that an emergency exists and that the welfare and life of the ward are at risk without the appointment of a guardian. ORS 125.600.

B. Planning Tools for Financial Decisions

1. Power of Attorney for Finances.

a. The client should consider obtaining a Power of Attorney for Finances that incorporates special language that allows transfers of assets for purposes of disability and Medicaid planning. Otherwise, if the client becomes incapacitated, the planning strategies available to the client are severely limited. A power to generally make gifts may not be adequate, particularly if the gifts are made by the attorney-in-fact to himself or herself. Without specific language authorizing transfers to the attorney-in-fact, the State of Oregon may take the position that the transfer was a breach of fiduciary duty and a fraudulent transfer. Also, other family members may question the transfer, particularly when the inheritance of potential heirs of the client might be affected.

b. There is a great danger of abuse inherent in giving such broad authority to an attorney-in-fact, and the client should be thoroughly advised of these dangers.

NOTE: If an attorney-in-fact has the power to give gifts to himself or herself, then the attorney-in-fact may be deemed to have a power of appointment.

c. Sample Language. Discuss the following with your client as potential additions to his or her durable power of attorney:

"Gifts. Make gifts and consent to split gifts on my behalf, whether outright, in trust, or in custodianship, to or for the benefit of my spouse (optional: descendants, and/or spouses of descendants.)"

"Gifts and Transfers. I authorize my Agent to make gifts to himself or herself, and to arrange for transfers of jointly held property of mine to his or her name alone, and when my Agent is acting in this way, I authorize my Agent to "self-deal" in this manner with my assets with my full prior approval and without any prohibition against self-dealing." (Most commonly used when spouse is agent.)

"Gifts and Transfers. I authorize my Agent to make any decisions which my Agent, in his or her own discretion, determines necessary for disposing of or transferring my property in order to effect the best result possible for my entitlement to public services or benefits."

"Joint Ownership. To convert joint assets into sole ownership of the other joint tenant, and also to liquidate any jointly held assets and to direct the investment holder to make the check to liquidate the distribution to the benefit of only one of the joint owners."

"Government Benefits. Perform any act necessary or desirable in order for me to qualify for and receive all types of government benefits, including Medicare, Medicaid, Social Security, veterans', and workers' compensation benefits."

"Nomination of Guardian and Conservator. To the extent permitted by state law, I nominate my Agent to act as my guardian and conservator if I become incapacitated."

2. Representative Payee. When a person becomes unable to manage his/her resources, several public programs (such as Social Security) provide for a representative payee or fiduciary to receive benefits on behalf of the beneficiary.

3. Revocable Living Trust. Revocable Living Trusts are a popular estate planning option, used primarily to provide back-up management in case of incapacity and probate avoidance. However, the typical Revocable Living Trust can work to the disadvantage of spouses who are doing Medicaid planning because the trust terms usually require the trustee to distribute the funds to an incapacitated spouse. If a couple anticipates the potential need for Medicaid planning they should consider executing a Revocable Living Trust (or revising their current Revocable Living Trust) with more flexible provisions. They may also consider a trust in the name of the well spouse only.

4. Conservatorship. A conservator may be appointed by the court if, based upon medical testimony, it is determined that the individual lacks the capacity to manage his/her financial resources. The conservator can be an individual or a bank. The conservator is empowered to take possession of the protected persons assets and income and provides for payment of the person's expenses. The conservator has all the powers that the person would individually possess to manage financial affairs.

A finding of incapacity is not required to implement a conservatorship. In fact, a client may request and consent to the appointment of a conservator. Conversely, if your client is incapacitated, he or she no longer has the ability to utilize the other tools listed above and the conservatorship may be necessary.

The procedures for the establishment of a conservatorship are similar to that of guardianship. (In fact, the two powers are often requested at the same time.) However, the conservatorship does not require the appointment of a court visitor.

C. Quality of Life Provisions

As estate planners, our priority has historically been planning of our client's death. The client's primary objective was to maximize the inheritance by reducing or avoiding taxes and probate expenses. Wills and trusts were the tools used most often to accomplish these goals.

Many attorneys are now seeing a change or "evolution" in client objectives. Clients now are less interested in maximizing an "inheritance" and more concerned with maximizing and preserving their personal autonomy and providing for their continued care and comfort.

Society has been changing. Many people are no longer able to rely upon a close and supportive family to be there in times of need. They are looking for other options and other means of protection. Attorneys are now being asked to find the legal mechanisms that will assure that the client's wishes for both personal care and asset management will be implemented. This becomes even more important when the client is faced with an incapacitating illness or injury.

Attorneys are beginning to use the Revocable Trust, the power of attorney, and other

documents as the tools to facilitate more options and, therefore, more protection for our clients. However, to do this, we must go beyond the normal estate planning philosophies (death and taxes) and look at the types of drafting options that can protect and preserve our client's quality of life.

For the past 20 years, the Revocable Living Trust has been increasing in popularity. The primary purpose of the Revocable Trust (or at least the focus of its marketing) has been to avoid the time and expense of probate. While this is an admirable goal, it is this author's opinion that the Revocable Trust can be, and should be, much more. (The following materials and drafting options also apply to the drafting of durable powers of attorney. For simplicity, the materials will focus upon the Revocable Trust.)

A properly drafted Revocable Living Trust can do more than avoiding probate. The Revocable Trust, in combination with powers of attorney and other documents (advance directive, etc.), can also afford our clients with more protection and more assurance that their wishes will be implemented.

The Revocable Trust can allow the client to be her own trustee and retain control over her finances for as long as possible -- hopefully, forever. If the client becomes incapacitated, a successor trustee appointed by him or her steps in to control the trust and provide for the client. The trustee must follow the client's instructions and directions. In this manner, the client is still able, as much as is possible, to control the management of his or her assets and personal care.

The Revocable Living Trust is flexible and can be tailored to the specific needs, desires, and financial resources of the client. This includes the ability to provide for the care and comfort of the settlor/beneficiary.

Specific instructions for care and comfort are even more important when the successor trustee is an institution (bank or trust company) or a family member who is very busy or geographically remote.

The following options should be discussed with the client and included in the trust document, if the client so desires:

1. Make clear the first priority of the successor trustee is to spend the client's money on the client, not necessarily save it as in inheritance for the heirs.

2. Specify that the client prefers to be cared for at home. Make it clear that the client prefers this, even if the cost of such care would be significantly greater than the cost of nursing or other community-based care.

3. Authorize the trustee to retain a geriatric care manager. Private case management services are becoming more available and more popular to assist trustees in the daily management and care needs of the beneficiary.

The geriatric care manager can assist with assessment and identification of the client's health and psychosocial concerns and make recommendations about the best method of addressing those concerns.

4. Authorize the trustee to retain a geriatric care manager to establish and supervise home care for the client.

5. Authorize the trustee to provide additional services and care monitoring if the client become hospitalized or requires placement in a long-term care facility.

6. Authorize the trustee to provide for other personal needs and comforts, such as:

    a. Recreation and travel;

    b. Companions;

    c. Spiritual concerns;

    d. Group affiliations;

    e. Legal representation; and

    f. Pets.

D. The Estate Plan of the Community Spouse

Consider the planning needs of a spouse whose husband or wife has become incapaciated or who faces long-term care. Discuss the following options with the "community spouse:"

1. Incorporate Special Needs Trust. The community spouse should consider changing his/her estate plan to include a special needs trust for the benefit of the spouse who needs long-term care, so that if he/she dies first the spouse who is receiving Medicaid will not be adversely affected. Distributions would be allowed for special needs. Note that this may not prevent the use of the spousal elective share.

NOTE: When an elderly person is receiving care in an extended care facility and the community spouse sees no benefit to creating a special needs trust for the institutionalized spouse, then one option is to leave the entire estate to descendants or other beneficiaries. **QUERY:** Can SPD require the institutionalized spouse to make a claim for his/her spousal elective share under ORS 114.105? The client should be advised that this may happen.

2. Including First and Second Families. Since joint assets may be shifted to the community spouse, in his/her name alone, it is important that he/she have a plan that includes the institutionalized spouse's descendants (or other intended beneficiaries) at death. Medicaid planning is not usually intended to cut out heirs. It may be advisable to obtain a clear written statement from the spouse who needs care about his/her desires so that there will be no questions after death. For example, should heirs be prepared to receive nothing if the surviving spouse (perhaps a step-parent) depletes the estate? Should the surviving spouse be required to leave a particular amount or percentage or a specific asset go to his/her children? The couple may even want to make a contract to make a Will which includes special provisions protecting all heirs.

E. Beneficiary Designations

As with all estate planning, it is critical to insure that the client has coordinated all beneficiary designations with the plan. For example, if all or a portion of the estate is intended to be paid to a special needs trust, then the client must name the trustee of the trust or the estate itself as the beneficiary.

> **PRACTICE TIP:** When working with an ill client (or spouse of an ill client), remember to suggest a review of the estate plan of extended family members, such as parents, adult children, siblings, and others. Often, an extended family member has established a plan that includes the ill client as a beneficiary. If the beneficiary is receiving or may soon be receiving long-term care and, especially, if Medicaid benefits are likely to help pay for care, the extended family member may choose to modify his or her estate plan and include the spouse or other family member. An even better option would be a special needs trust for the ill beneficiary (discussed below).
>
> **CAUTION:** While it is still ethical in Oregon to represent the couple for estate planning purposes, consider the possible conflict if you are asked in the future to do long-term care planning for **one spouse**. As discussed below, long-term care planning often involves transferring assets from the "ill spouse" into the sole name of the "well spouse." Clearly, this presents a "likely" conflict between the two parties. In Oregon, the conflict can be waived by a current, written, consent and disclosure signed by both parties. However, as often happens, one of the parties may no longer have the capacity to consent. In this event, the attorney **cannot** obtain consents and **cannot** provide representation. For the most recent information on this topic, see Oregon Elder Law Section Newsletters, Spring 2002 and Summer 2002.

F. Resources

1. R. Pagnano, "Estate Planning Tools for Elder Law Attorneys," Chapter 1, *Counseling Elderly Clients,* OSB CLE, September 18, 1998.

2. W. Fitzwater, "Drafting Quality of Life Provisions for Revocable Living Trusts and Powers of Attorney," Chapter 4A, *The Changing Face of Elder Law,* OSB CLE, July 30, 1994.

IX. WORKING WITH A QUESTIONABLY COMPETENT CLIENT

(*My thanks to Mike Levelle, of Duffy, Kekel LLP in Portland, Oregon, for the use of his materials in this chapter.)*

A. The Attorney-Client Relationship

A lawyer's professional responsibility as it relates to assessing a client's capacity is a very troubling area. One commentator aptly described capacity as "the black hole of legal ethics" and observed that "[m]any questions find their way into the capacity category, but few answers emerge." Margulies, *Access, Connection and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity,* 8 NATIONAL ACADEMY OF ELDER LAW ATTORNEY QUARTERLY 8 (1995).

Oregon and ABA ethical rules and guidelines provide some limited guidance for the lawyer in determining the competency of a client. Stevens, *Representing the Impaired Client,* 55 OR ST BAR BULL 31 (1995); Smith, *Representing the Elderly Client and Addressing the Question of Competence,* 14 J CONTEMP L 61 (1988). Under Oregon rules, to the extent practicable, a lawyer must endeavor to maintain a normal attorney-client relationship. *The Ethical Oregon Lawyer* (Or St Bar CLE 1991).

DR 7-101(c) provides an exception to the lawyer's duty to preserve client confidences and secrets. OSB Legal Ethics Op No 1991-41. The Oregon Code of Professional Responsibility provides:

> A lawyer may seek the appointment of a guardian or take other protective action which is least restrictive with respect to a client only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest, whether because of minority, mental disability, or for some other reason.

DR 7-101(c); *see also* Stevens, *supra.*

The *Draft Restatement (Third) of the Law Governing Lawyers* (1992) proposes that when a client's ability to make adequately considered decisions in connection with the representation is impaired, the lawyer must, as far as reasonably possible, maintain a normal client-lawyer relationship with the client and act in the best interest of the client. §35(1) (1992). The draft restatement also proposes that if the lawyer reasonably believes the client to be impaired, and no guardian or conservator has been appointed, the lawyer, with respect to a question within the scope of his or her representation,

should pursue the lawyer's reasonable view of the client's objectives or interests as the client would define them if able to exercise rational judgment on the question, even if the client expresses no wishes or gives *contrary* instructions. *Id.* §35(2).

In making a substitute judgment on a client's behalf, the lawyer must carefully consider the client's circumstances, problems, needs, character, and values, to the extent the lawyer can determine them. *Draft Restatement (Third) of the Law Governing Lawyers* §35 cmt d. If the client, when able to decide, had expressed views relevant to the decision in question, the lawyer should follow them, unless there is reason to believe that changed circumstances would change the client's views. *Id.*

> **NOTE:** Who is the decision-maker? "The attorney-client relationship is one of consent and agency. The attorney acts as agent for the client, *subject to the client's control.* Therefore, the client's autonomy and control of decision-making constitute the core of the relationship." Pope and Lindgren, *Ethical Dilemmas in ElderLaw: Working with Questionably Competent Clients,* THE ELDERLAW REPORT, May 1991.

Many clients, especially elderly clients, depend a great deal upon the advice of their attorney. However, the attorney's role is to advise, *not decide.* The attorney must therefore resist the temptation to *take over* the decision-making for the client. This is even more difficult when working with a questionably competent client. The above article is an excellent discussion of this concern and other ethical issues that may arise.

B. The Lawyer's Role in Assessing Capacity

The lawyer can take steps to maximize the chances of finding the requisite capacity of elderly or infirm clients. One step is for the lawyer to use a functional approach to determine capacity. In this approach, the lawyer assesses capacity by observing the client's decision-making process as it relates to the substance of the act to be taken. This approach contrasts with the conventional objective tests of capacity that are unrelated to the act. One commentator identifies six factors that can be applied in using the functional approach:

1. The client's ability to articulate reasoning behind the decision;

2. The variability of the client's state of mind;

3. The client's ability to understand the consequences of the decision;

4. The irreversibility of the decision;

5. The substantive fairness of the transaction;

6. Consistency of the act or transaction with the client's lifetime commitments.

Margulies, *supra* at 9.

NOTE: Some attorneys feel that they should use standardized tests to measure capacity. To that end, one author (attorney) has developed a test to assess the capacity of elderly clients before the execution of legal documents. *See* Brown, *Determining Client's Legal Capacity,* THE ELDERLAW REPORT, February 1993.

Examples of other ways to empower the elderly client include the following.

1. Meet privately with the client, possibly after an introduction by a family member or trusted friend if that person set up the initial meeting.

2. Create a relaxing and comfortable interview environment; converse about a topic that interests the client.

3. Conduct the interview at the client=s best time of day.

4. Encourage questions.

5. Reassure the client that one purpose of the meeting is for the attorney and the client to become acquainted. Remind the client that the client=s decisions, and not those of a family member, will control the outcome of the meeting.

6. Use indirect questions to assess capacity. Asking questions such as the identity of the President of the United States can be intimidating and put the client on the spot. Asking other equally topical questions in the course of seemingly casual conversation can be just as helpful without unsettling an already defensive or uncomfortable older client.

7. Take verbatim notes.

8. When preparing written materials for elderly clients, the lawyer should:

    a. Use short words, sentences, and paragraphs;

    b. Use active verbs; avoid passive voice;

    c. Avoid technical legal terms as much as possible; where unavoidable, define terms in non-technical language when they first appear;

    d. In a contract or other document, use the names of the parties; do not use legal role names such as "trustee" or "settlor" to identify parties;

e. Avoid double negatives;

f. Use various type sizes and spacing, paragraphs, numbering, and bold-facing or underlining to break the letter or document into easily readable sections.

Gorn, *A Guide to Representing Older Clients,* cited in 1 SERVING ELDERLY CLIENTS 5 (LRP Publications 1995).

The lawyer should be familiar with the community resources available to the elder client. If a lawyer concludes that a client may lack the capacity required to take the desired action, the lawyer should talk to the client about enlisting the help of a professional, such as a social worker, gerontologist nurse, family therapist, or similar practitioner with expertise and experience with the elderly. This course of action would promote the autonomy and safety of the client. By identifying any disorders and possible treatments, the attorney can promote the achievement of the client's goals to the greatest extent possible.

To prepare to deal with questions of client competency, a lawyer can take several steps:

1. Know the legal standards governing competency and incapacity and the legal distinction between the two;

2. Know the standards for appointment of a guardian or conservator;

3. Consult the applicable rules of professional conduct when confronted with a questionably competent client;

4. Understand the lawyer's role in assessing a questionably competent client; and

5. Develop and use techniques designed to empower the elder client.

The practitioner will always be required to employ his or her traditional estate planning analytical skills. However, with the aging of America's population and the significant transfer of wealth that will occur in the near future, the lawyer will be required to acquire a completely different set of skills to deal with the elderly client on a personal level.

C. Resources

1. J. Cartwright and L. Ganzini, M.D., "Capacity," Chapter 5, *The Contested Estate Plan,* OLI CLE, July 24, 1998.

2. J. Cartwright, D. Dodson, M. Levelle, and W. Fitzwater, "Working with Varying

Levels of Competency," Chapter 7, *Elder Law: Answers and New Directions,* OSB CLE July 26, 1996.

APPENDIX A – DEMOGRAPHICS

Are you prepared for the "Aging" of your clientele? The demographics below suggest that the number of your clients over 65 will double in the next 20 years. The "oldest old", those clients over the age of 85 will increase by 400% by the year 2040.

Here are a few of the statistics reflecting the changing demographic profile of the elderly population in the coming decades:

- The **"human tidal wave**" as the Census Bureau terms it, will "**change the face of America**" beginning in 2010. From 2010 to 2020, the number of those 65 years and older will increase from 40 million to 53 million. During the succeeding decade, the elderly population will expand by another 17 million, bringing the total elderly to 70 million in 2030 (more than the current populations of France and Belgium combined).

- The "**oldest old" (85+)** is the fastest-growing part of the population. (These individuals are least likely to be working and most likely to be in nursing homes or to be sick and dependent.) In 2000, there was an estimated 4.3 million persons over 85, about one quarter of whom live in nursing homes. This number is projected to reach 6 million by 2010. These numbers will skyrocket to 18.8 million by 2050 (more than the current population of Australia).

  (Please note: Over 45% of those over the age of 85 years suffer from a diagnosed dementia.)

- Generally, predictions are that the progressive concentration of elderly in the South and **West** will continue. The Census Bureau projects that the elderly population will double in seven western states by 2020. **Oregon** is expected to have the 4th highest concentration of elderly citizens in the United States.

- The number of **elderly needing nursing home care** will escalate to between 3.0 and 3.4 million in 2010, and reach between 4.3 and 5.3 million in 2030.

(For more information contact the U.S. Census Bureau or go online at www.census.gov/socdemo/www/agebrief.html.)

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