SENIOR LAW DAY
COLLABORATIVE

What you need to know to age smart
seniorlawday.info

Q&A Appendices

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How to use this guide

Senior Law Day Collaborative Q&As are intended to guide older adults and caregivers as they address issues related to aging and planning for the future. We suggest you review this information in the full before seeking out an elder law attorney or other professional, so that you are familiar with the terms and can be ready to ask questions specific to your needs.

At our website – seniorlawday.info – you will find:

- additional Q&As for review and download
- a library of recorded webinars on topics relevant to elders and caregivers
- an opportunity to get your specific questions answered via email or during our quarterly consultation events
- notice up upcoming educational programs

All services of the Collaborative are offered at no charge. Our goal is to help you get the answers you need so you can plan and move forward with confidence.

This Q&A is an excerpt from the 22nd edition of the Elder Law Q&A: An Introduction to Aging Issues and Planning for the Future written by Steven A. Schurkman Esq. and members of the Senior Law Day Collaborative.

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Appendix A

Health Care Proxy:

Appointing Your Health Care Agent in New York State

About the Health Care Proxy Form

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

1. This form shown on p. 131 gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

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

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

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

Who can be a health care agent?

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

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form shown on page 131, but you don't have to use this form.

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

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions.

As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

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

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

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

How will my health care agent make decisions?

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

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

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

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

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

Who will pay attention to my agent?

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

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

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so.

Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form; simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur.

Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically canceled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

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

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

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

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

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

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safety deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

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

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

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

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

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

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

Health Care Proxy Form Instructions

Item (1)

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

Item (2)

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

Item (3)

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

Item (4)

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

Simply write:
I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:
If I become terminally ill, I do/don't want to receive the following types of treatments...

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

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

I have discussed with my agent my wishes about and I want my agent to make all

decisions about these measures...

Below are examples of medical treatments you may wish to give your agent with special instructions (this is only a sample list):

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

Item (5)

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

Item (6)

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

Item (7)

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

Health Care Proxy

(1) I, ______________________________

hereby appoint ______________________________
(name, home address and telephone number)

____

____

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

(2) Optional: Alternate Agent

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

____

____

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

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

____

____

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

____

____

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

SAMPLE

(5) Your Identification *(please print)*

Your Name ______________________________

Your Signature ______________________________ Date ______________

Your Address ______________________________

(6) Optional: Organ and/or Tissue Donation

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

- ☐ Any needed organs and/or tissues
- ☐ The following organs and/or tissues ______________________________

  ____
- ☐ Limitations ______________________________

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

Your Signature ______________________________ Date ______________

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

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

Witness 1

Date ______________

Name *(print)* ______________________________

Signature ______________________________

Address ______________________________

____

Witness 2

Date ______________

Name *(print)* ______________________________

Signature ______________________________

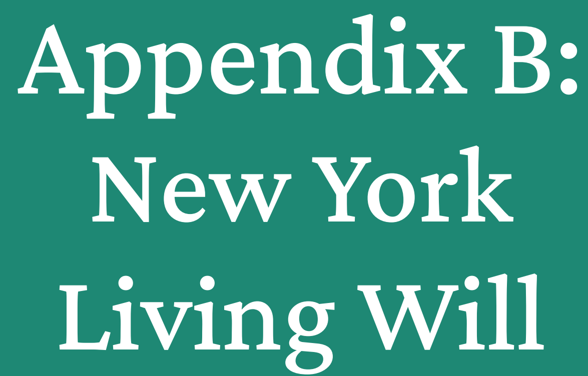
Address ______________________________

____

SAMPLE

Department of Health

1430 11/17



Appendix B: New York Living Will

APPENDIX B

NEW YORK LIVING WILL

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

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

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

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

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

Other instructions (insert personal instructions):

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

Signature:____

Address:____

Date:____

SAMPLE

Statement By Witnesses (Must be 18 or Older)

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

Witness:____

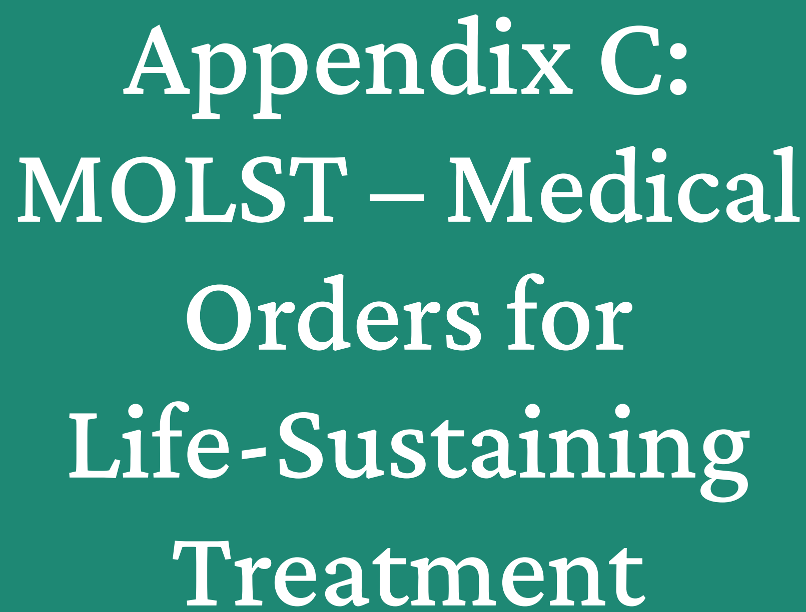
Address:____

Witness:____

Address:____

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

SAMPLE



Appendix C: MOLST – Medical Orders for Life-Sustaining Treatment

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

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

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

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

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

If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the physician (not a nurse practitioner or physician assistant) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

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

Check **one:**

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

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

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

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

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

SECTION C Physician/Nurse Practitioner/Physician Assistant Signature for Sections A and B

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE* PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT NAME DATE/TIME

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT LICENSE NUMBER PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

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

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

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SAMPLE

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

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

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. **If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped. Before stopping treatment, additional procedures may be needed as indicated on page 4.**

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

☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.

☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.

☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should not be checked if full CPR is checked in Section A.)

☐ **A trial period** *Check one or both:*

- ☐ **Intubation and mechanical ventilation**
- ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**

☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**

☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. **Additional procedures may be needed as indicated on page 4.**
Check one each for feeding tube and IV fluids:

☐ **No feeding tube**

☐ **A trial period of feeding tube**

☐ **Long-term feeding tube, if needed**

☐ **No IV fluids**

☐ **A trial period of IV fluids**

Antibiotics *Check one:*

☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.

☐ **Determine use or limitation of antibiotics when infection occurs.**

☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the physician/nurse practitioner/physician assistant or about other treatments not listed above (dialysis, transfusions, etc.).

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

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

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

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

Physician/Nurse Practitioner/Physician Assistant Signature for Section E

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE* PRINT PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT NAME DATE/TIME

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

SAMPLE

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on this MOLST Form

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

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

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician/Nurse Practitioner/Physician Assistant Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form

SAMPLE

Requirements for Completing the MOLST for Individuals with Intellectual or Developmental Disabilities

Completing the MOLST for individuals with I/DD who lack capacity to make their own health care decisions and do not have a health care proxy:

- The law governing the decision-making process differs for individuals with I/DD. Surrogate's Court Procedure Act (SCPA) Section 1750-b must be followed when making a decision for an individual with I/DD who lacks capacity and does not have a health care proxy.
- MOLST may only be signed by a **physician**, not a nurse practitioner or physician assistant.
- Completion of the **MOLST legal requirements checklist for individuals with I/DD**, including notification of certain parties and resolution of any objections, is **mandatory prior to completion of MOLST**. The checklist is available on the NYS OPWDD website.
- The checklist should be completed when an authorized surrogate makes a decision to **withhold or withdraw life sustaining treatment (LST)** from an individual with I/DD. There are specific medical criteria, included in Step 4 of the checklist. The individual's medical condition must meet the specified medical criteria **at the time the request to withhold or withdraw treatment is made**.
- **Trials** – whether or not a new checklist is required following an unsuccessful trial of LST depends on the parameters of the trial, as specified in Step 2 of the checklist. If Step 2 of the checklist has provided that a trial for LST is to end after a specific period of time or the occurrence of a specific event, it may not be necessary to complete a new checklist following the trial. However, if a trial period is open ended, and the authorized surrogate subsequently decides to request withdrawal of the LST, a new checklist would be required.
- The checklist and 1750-b process apply to individuals with I/DD, regardless of their age or residential setting.

SAMPLE

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

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

MOLST is generally for patients with serious health conditions. Physicians, nurse practitioners, and physician assistants should consider consulting with the patient about completing a MOLST form if the patient:

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

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

General Instructions

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

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

Completion of both the first and second pages of the MOLST form is strongly encouraged. However, the patient or decision-maker (i.e., a health care agent or surrogate) may not be physically or emotionally prepared to reach a decision concerning every treatment option on the form in a single meeting. Completion of only page 1 of the MOLST form (concerning CPR/DNR) is permissible, and page 2 (Section E) may be completed at a later time. If a patient or decision-maker can reach a decision on one or more treatment options, but not others, on page 2, the physician, nurse practitioner, or physician assistant may cross out the portion of the form with the treatment option(s)

for which there is no decision and write "Decision Deferred" next to those treatment option(s). If the patient or decision-maker reaches a decision concerning that treatment option(s) at a later time, a new form must be completed and signed by a physician, nurse practitioner, or physician assistant, indicating all of the patient's or decision-maker's decisions.

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

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

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

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

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

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

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

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

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

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

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

The checklists can be found on the Department of Health's website at:
https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

Review and Renewal of MOLST Orders

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

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

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

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

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

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

Document the outcome of the review in Section F

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

For more information about the MOLST Program, view the Department of Health's website at **https://www.health.ny.gov/professionals/patients/patient_rights/molst/** and the Compassion and Support website, Professionals section and the MOLST Training Center at www.CompassionAndSupport.org.

Glossary

"Adult" means any person 18 or older or any person who has married.

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

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

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

"Community" means not in a hospital, hospice or nursing home.

"Domestic partner" means a person who:

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

The following may not be a "domestic partner:"

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

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

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

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

"Mental hygiene facility" means, for purposes of these checklists, a facility operated or licensed by the Office of Mental Health (OMH) or the Office for People With Developmental Disabilities (OPWDD) as defined in subdivision six of section 1.03 of the Mental Hygiene Law; i.e., any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution or building, except that in the case of a hospital as defined in Article 28 of the Public Health Law it shall mean only a ward, wing, unit, or part thereof which is operated for the purpose of providing services for the mentally disabled. A mental hygiene facility also includes a community residence operated by or subject to licensure by OMH or OPWDD (MHL §1.03(28)).

"Nurse practitioner" means a licensed nurse practitioner.

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

"Physician" means a licensed physician.

"Physician assistant" means a licensed physician assistant.

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

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

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

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

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

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

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.
Any patient should be counseled to complete a health care proxy, if he/she has not already completed one.

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

___ Patient retains the capacity to choose a health care agent and completes a health care proxy.
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.

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

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

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

Step 5: Identify the decision-maker.

___ Patient is the decision-maker

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

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)
___ Community (see Glossary for definition)

Step 7: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one*:
This is Checklist # 1 (for patients who have medical decision-making capacity). If this is the appropriate checklist, proceed to Step 8 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

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

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

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

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

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

Step 8: Discuss goals for care with the patient. ___

Step 9: Patient has given informed consent.

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

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

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

___ Patient consented in writing.

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

___ Patient is in the community, patient consented verbally, and the attending physician, nurse practitioner, or physician assistant witnessed the consent.

Step 11: Physician, nurse practitioner, or physician assistant signature

___ The attending physician, nurse practitioner, or physician assistant signed the MOLST form.

Step 12: Notify director of correctional facility.

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

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

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

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

Complete each step and check the appropriate lines as indicated.

<u>Step 1</u>: Assess health status and prognosis. __

<u>Step 2</u>: Check all advance directives known to have been completed.

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

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

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

Document the result of patient counseling, if applicable. ***Check <u>one</u>***:

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

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

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

(A) Attending Physician/Nurse Practitioner/Physician Assistant Determination
Check <u>both</u>:

___ The attending physician, nurse practitioner, or physician assistant has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician, nurse practitioner or physician assistant's opinion regarding the cause and nature of the patient's incapacity as well as its extent and probable duration. The determination is documented in the patient's medical record.

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

___ (i) The attending physician, nurse practitioner, or physician assistant has determined that the patient's lack of medical decision-making capacity is *not due* to mental illness or a developmental disability; and

- __ A concurring physician, nurse practitioner, or physician assistant confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.

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

- __ A concurring physician, nurse practitioner, or physician assistant confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.
- __ One of the two practitioners who determined that the patient lacks medical decision-making capacity is a physician who is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

___ (iii) The attending physician, nurse practitioner, or physician assistant has determined that the lack of medical decision-making capacity *is due* to a developmental disability; and ***Check both***:

- __ A concurring physician, nurse practitioner, physician assistant, or clinical psychologist confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.
- __ The concurring physician, nurse practitioner, physician assistant or clinical psychologist is employed by a Developmental Disabilities Services Office (DDSO), or has been employed for a minimum of two years to render care and service in a facility operated or licensed by the Office for People With Developmental Disabilities, or has specialized training and two years' experience treating persons with developmental disabilities or has three years' experience treating persons with developmental disabilities. The determination by the concurring physician, nurse practitioner, physician assistant or clinical psychologist is documented in the medical record.

Step 5: Notify the patient *Check one*:

___ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient, orally and in writing (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend such notice.

Step 6: Identify the decision-maker:

__ The health care agent is the decision-maker.

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

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)
___ Community (see Glossary for definition)

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

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

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

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

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

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

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

Step 9: Discuss goals for care with the health care agent. ___

Step 10: Health care agent has given informed consent.

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

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

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

___ Health care agent has consented in writing.

___ Patient is in a hospital or nursing home, the health care agent consented verbally, and two witnesses 18 years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital or nursing home, have witnessed the consent.

___ Patient is in the community, health care agent has consented verbally and the attending physician, nurse practitioner, or physician assistant has witnessed the consent.

Step 12: Physician, nurse practitioner, or physician assistant signature

___ The attending physician, nurse practitioner, or physician assistant has signed the MOLST form.

Step 13: Notify director of correctional facility.

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

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

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

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

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

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

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

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

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

___ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy).

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

___ Patient lacks capacity to choose a health care agent.

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

(A) Attending Physician, Nurse Practitioner, or Physician Assistant Determination *Check both*:

___ The attending physician, nurse practitioner, or physician assistant has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's, nurse practitioner's, or physician assistant's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

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

___ (i) The attending physician, nurse practitioner, or physician assistant has determined that the patient's lack of medical decision-making capacity is ***not*** *due* to mental illness; and

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

___ (ii) The attending physician, nurse practitioner, or physician assistant has determined that the lack of medical decision-making capacity ***is due*** to mental illness (this does not include dementia); and ***Check <u>both</u>***:

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

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

<u>Step 5</u>: Notify the patient. *Check <u>one</u>*:

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

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

<u>Step 6</u>: Identify and notify the appropriate Public Health Law surrogate. *Check both:*

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

___ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
___ b. Patient's spouse, if not legally separated from the patient, or the domestic partner
___ c. Patient's son or daughter, age 18 or older
___ d. Patient's parent
___ e. Patient's brother or sister, age 18 or older
___ f. Patient's actively involved close friend, age 18 or older

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

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

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)

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

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

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

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

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

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

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

Step 9: Discuss goals for care with the Public Health Law surrogate. ___

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

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

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

__ (i) Treatment would be an extraordinary burden to the patient, **and** an attending physician, nurse practitioner, or physician assistant determines, with the independent concurrence of another physician, nurse practitioner, or physician assistant that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
- the patient is permanently unconscious.

__ (ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances; **and** the patient has an irreversible or incurable condition, as determined by an attending physician, nurse practitioner, or physician assistant with the independent concurrence of another physician, nurse practitioner, or physician assistant to a reasonable degree of medical certainty and in accordance with accepted medical standards.

__ **Special requirements for declining artificial nutrition and hydration in a hospital over the attending physician's, nurse practitioner's, or physician assistant's objection, and for certain life sustaining treatments in a nursing home, based on "irreversible or incurable condition" (clinical standard (ii) above)** *Note – These requirements do not apply to a decision for a patient in hospice or to a decision to withhold or withdraw life-sustaining treatment under clinical standard (i) above (death is expected within 6 months with or without treatment, or patient is permanently unconscious):*

__ In a hospital (other than a hospice), when the medical order involves the withdrawal or withholding of nutrition or hydration provided by means of medical treatment, and the attending physician, nurse practitioner, or physician assistant objects to the order, the ethics review committee (including a physician, nurse practitioner, or physician assistant who is not directly responsible for the patient's care) or an appropriate court has determined that the medical order meets the patient-centered and clinical standards.

__ In a nursing home, for MOLST orders other than a DNR order, the ethics review committee, (including at least one physician, nurse practitioner, or physician assistant who is not directly responsible for the patient's care) or an appropriate court has determined that the orders meet the patient-centered and clinical standards described above.

__ (iii) The concurring physician's, nurse practitioner's, or physician assistant's determination is documented in the medical record.

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

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

__ The surrogate consented in writing.

__ The surrogate consented verbally, and the attending physician, nurse practitioner, or physician assistant witnessed the consent.

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

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

Step 14: Physician, nurse practitioner physician assistant signature

__ The attending physician, nurse practitioner, or physician assistant signed the MOLST form.

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

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

Step 16: Notify director of correctional facility.

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

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

Under the Family Health Care Decisions Act, a patient who lacks capacity and who does not have a health care agent or surrogate may be enrolled in hospice with a plan of care that includes orders regarding the provision or withdrawal/withholding of life-sustaining treatment, if two physicians, nurse practitioners, or physician assistants and an Ethic Review Committee agree that the patient meets certain criteria (which are the same criteria that would apply to a decision by a surrogate under Checklist 3).

This checklist may also be used for a life-sustaining treatment decision for a patient who is already enrolled in hospice.

If the patient is not enrolled in Hospice, life-sustaining treatment may be withheld from a patient in a hospital or nursing home who does not have a health care proxy or a surrogate, only if a court makes the decision or two physicians, nurse practitioners, or physician assistants authorized by the facility concur that the patient would die imminently, even if the patient received the treatment, and that provision of the treatment would violate accepted medical standards.

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

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

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

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

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

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

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

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

(A) Attending Physician/Nurse Practitioner/Physician Assistant Determination (check both)

___ The attending physician, nurse practitioner, or physician assistant has determined in writing to a reasonable degree of medical certainty that the patient lacks the ability to understand and appreciate the nature and consequences of DNR and Life-

Sustaining Treatment orders, including benefits and burdens of and alternatives to such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's/nurse practitioner's/physician assistant's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

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

___ (i) The attending physician, nurse practitioner, or physician assistant has determined that the patient's lack of medical decision-making capacity is not due to mental illness; and

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

___ (ii) The attending physician, nurse practitioner, or physician assistant has determined that the lack of medical decision-making capacity is due to mental illness (this does not include dementia); and Check both:

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

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

Step 5: Notify the Patient. ***Check one:***

___ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend the information

Step 6: Determine that there is no Public Health Law Surrogate. ***Check both:***

___ The attending physician, nurse practitioner, or physician assistant, or someone acting on behalf of the attending physician, nurse practitioner, or physician assistant or the hospital or nursing home, made diligent efforts to contact a surrogate from the list below:

a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
b. Patient's spouse, if not legally separated from the patient, or the domestic partner
c. Patient's son or daughter, age 18 or older
d. Patient's parent
e. Patient's brother or sister, age 18 or older
f. Patient's close friend, age 18 or older

___ No surrogate was reasonably available, willing and competent to make medical decisions for the patient.

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

___ Hospital (see Glossary for definition)
___ Nursing Home (see Glossary for definition)
___ Hospice (i.e. for a patient already enrolled in hospice) (see Glossary for definition)

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

This is Checklist #4 for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at http://www.nyhealth.gov/professionals/patients/patient_rights/molst/.

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

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

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

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

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

Step 9: Identify patient goals for care based on patient's wishes, if known, or patient's best interests ___

Step 10: Consult with staff directly responsible for the patient's care ___

Step 11: Decision complies with the following patient-centered standards as determined by the physician, nurse practitioner, or physician assistant with independent physician, nurse practitioner, or physician assistant concurrence:

___ Decision is patient-centered, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. This assessment is assessment is based on the patient's wishes and best interests, not the decision-maker's, and includes consideration of:
o the dignity and uniqueness of every person;
o the possibility and extent of preserving the patient's life;
o the preservation, improvement or restoration of the patient's health or functioning;
o the relief of the patient's suffering; and
o any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Step 12: Decision complies with the following clinical standards as determined by the physician, nurse practitioner, or physician assistant with independent physician, nurse practitioner, or physician assistant concurrence. ***Check (i) and/or (ii), and (iii):***

__ (i) Treatment would be an extraordinary burden to the patient, and an attending physician/nurse practitioner/physician assistant determines, with the independent concurrence of another physician/nurse practitioner/physician assistant, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- o the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or
- o the patient is permanently unconscious.

__ (ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances; and the patient has an irreversible or incurable condition, as determined by an attending physician/nurse practitioner/physician assistant with the independent concurrence of another physician/nurse practitioner/physician assistant to a reasonable degree of medical certainty and in accordance with accepted medical standards.

Step 13: Ethics Review Committee:

___An Ethics Review Committee, composed as described below, reviewed the decision and determined that it was consistent with the standards in Steps 11 and 12:

- At least five members who have demonstrated an interest in or commitment to patient's rights or to the medical, public health, or social needs of those who are ill.
- At least three Ethics Review Committee members must be health or social services practitioners, at least one of whom must be a registered nurse and one of whom must be a physician, nurse practitioner or physician assistant.
- At least one member must be a person without any governance, employment or contractual relationship with the hospital.
- In a residential health care facility the facility must offer the residents' council the opportunity to appoint up to two persons to the Ethics Review Committee, none of whom may be a resident of or a family member of a resident of such facility, and both of whom shall be persons who have expertise in or a demonstrated commitment to patient rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a health care provider

Step 14: Documentation of Concurrence and Ethics Review Committee:

____ The concurring physician/nurse practitioner/physician assistant's determination is documented in the medical record.

____ The Ethics Review Committee determination is documented in the medical record.

Step 15: Physician/nurse practitioner/physician assistant signature

___ The attending physician/nurse practitioner/physician assistant has signed the MOLST form.

Step 16: Notify director of mental hygiene facility and Mental Hygiene Legal Services (MHLS).

___ For patients who are residents in, or are transferred from, a mental hygiene facility, the attending physician/nurse practitioner/physician assistant has notified the director of the facility and MHLS of the determination that the resident lacks medical decision-making

capacity and, that there is no surrogate or health care proxy and that the resident has MOLST orders.

Step 17: Notify director of correctional facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician/nurse practitioner/physician assistant has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity, that there is no surrogate or health care proxy and that the inmate has MOLST orders.

Checklist #5: Adult Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and MOLST Form is Being Completed in the Community

In the community, Public Health Law surrogates (surrogates selected from the surrogate list) can consent to a nonhospital DNR order or a nonhospital DNI order, on behalf of patients who lack medical decision-making capacity. If MOLST is being completed in the community for a patient who does not have a health care proxy, the physician, nurse practitioner, or physician assistant may issue medical orders to withhold life-sustaining treatment – other than DNR and DNI – only if there is clear and convincing evidence of the patient's wishes to refuse the treatment (see Glossary for definition of "clear and convincing evidence").

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

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

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

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

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

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

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

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

(A) Attending Physician, Nurse Practitioner, or Physician Assistant Determination *Check both:*

___ The attending physician, nurse practitioner, or physician assistant has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment orders*, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's, nurse practitioner's, or physician assistant's assessment the cause and extent of the patient's incapacity and the likelihood

that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

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

___ (i) The attending physician, nurse practitioner, or physician assistant has determined that the patient's lack of medical decision-making capacity is ***not*** *due* to mental illness; and

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

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

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

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

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

___ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has been given to the patient (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has not been given to the patient, because there is no indication of the patient's ability to comprehend the information.

Step 6: Identify and notify the appropriate Public Health Law surrogate for DNR/DNI order. Check *both:*

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

___ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
___ b. Patient's spouse, if not legally separated from the patient, or the domestic partner
___ c. Patient's son or daughter, age 18 or older
___ d. Patient's parent
___ e. Patient's brother or sister, age 18 or older
___ f. Patient's actively involved close friend, age 18 or older

___ The attending physician, nurse practitioner, physician assistant has notified at least one person on the surrogate list **highest in order of priority** who is reasonably available that he/she will make health care decisions related to DNR and/or DNI orders because the patient has been determined to lack medical decision-making capacity.

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

___ Community (see Glossary for definition)

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

This is checklist #5 for adults without medical decision-making capacity in the community, who do not have a health care proxy. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, find and complete the correct checklist. All checklists can be found on the Department of Health's website at https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

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

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

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

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

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

Step 9: Discuss goals for care with the Public Health Law surrogate. ___

Step 10: For DNR and/or DNI orders, surrogate has given informed consent *Check all:*

___ Surrogate has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.

___ Surrogate has consented to the DNR and/or DNI orders.

___ Surrogate's decision is *patient-centered*, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The surrogate's assessment is based on the patient's wishes and best interests, not the surrogate's, and includes consideration of:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;
- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and

- any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Step 11: Surrogate's DNR and/or DNI decision complies with clinical standards, as determined by the physician, nurse practitioner, or physician assistant with independent physician, nurse practitioner, or physician assistant concurrence *Check (i) and/or (ii) and (iii):*

___ (i) CPR and/or intubation would be an extraordinary burden to the patient **and** an attending physician, nurse practitioner, or physician assistant determines, with the independent concurrence of another physician, nurse practitioner, or physician assistant, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
- the patient is permanently unconscious.

___ (ii) The provision of CPR and/or intubation would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances, **and** the patient has an irreversible or incurable condition, as determined by an attending physician, nurse practitioner, or physician assistant with the independent concurrence of another physician, nurse practitioner, or physician assistant to a reasonable degree of medical certainty and in accord with accepted medical standards.

___ (iii) The concurring physician's, nurse practitioner's, or physician assistant's determination is documented in the medical record.

Step 12: For medical orders other than DNR and DNI, secure and document "clear and convincing evidence" of the patient's wishes. (If only DNR and/or DNI orders are entered on the form, go to Step 13.) *Check all:*

___ There is clear and convincing evidence (see Glossary for definition) of the patient's wishes, the evidence has been documented, and the documentation is in the medical record.

___ The Public Health Law surrogate has been notified and has been given an opportunity to present any additional evidence.

___ Check the "Based on clear and convincing evidence of patient's wishes" box in addition to the "Public Health Law Surrogate" box, if a medical order other than DNR and DNI is being issued based on clear and convincing evidence of the patient's wishes.

Step 13: Witness requirements are met. *Check one:*

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

___ The surrogate consented in writing.

___ The surrogate consented verbally, and the attending physician, nurse practitioner, or physician assistant witnessed the consent.

Step 14: If the surrogate is a close friend, verify the age and relationship with the patient.

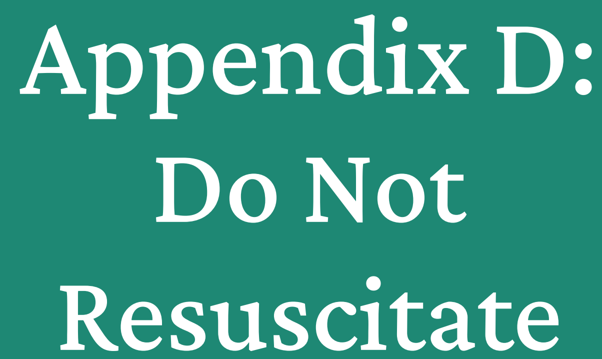
___ The surrogate is 18 or older and has signed a statement that he or she is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities,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

Step 15: Physician, Nurse Practitioner, Physician Assistant Signature

___ The attending physician, nurse practitioner, or physician assistant has signed the MOLST form.

Step 16: Notify Director of Correctional Facility.

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



Appendix D: Do Not Resuscitate

NEW YORK STATE DEPARTMENT OF HEALTH

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: ____________________

Date of Birth: ____________________

Do not resuscitate the person named above.

*Physician/Nurse Practitioner/
Physician Assistant Signature: ____________________

Print Name: ____________________

License Number: ____________________

Date: ____________________

It is the responsibility of the physician/nurse practitioner/physician assistant to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

SAMPLE

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.

For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.

DOH-3474 (8/20)

Appendix E:
Disposition of Remains
Appointment

Instructions: The form you complete (page 171 sample) requires two witnesses to watch you sign when finished. The witnesses must be at least 18 years or older and cannot be named as the agent or successor agent.

Step 1. Print your full name and address on the first line.

Step 2. On the next line, fill in the full name of the person you have chosen to be your agent above "Name of Agent."

Step 3. Under "Special Directions," list what you would like your agent to do, including your specific wishes concerning your funeral, burial, and/or cremation. If there are certain things that you do not want the agent to do, list them here.

Step 4. In the next section, check the first box if you have a pre-paid funeral plan (sometimes called a "pre-funded pre-need agreement") and print the name of the funeral home/company on the line below. Check the second box, if you do not have a pre-paid funeral plan.

Step 5. Fill in the name, address, and telephone number of your agent.

Step 6. Under "Successors," you may list an alternate person to act if your agent is unable or unwilling to act. Fill in the full name, address, and phone number of this person after "First Successor." In case the "First Successor" is also unable or unwilling to act, you can name a second alternate person by adding their information after "Second Successor."

Step 7. Before signing the form, review the form to make sure all the information is correct and reflects your wishes. Then, in the presence of your two witnesses, date and sign the form. Make sure the witnesses can see you sign the form. You do not need a notary.

Step 8. Under Witness Declarations, the witnesses should sign and print their names, and fill in their addresses and telephone numbers.

Step 9. Make a copy of the form for yourself and give the original to your agent.

Your agent should not sign the form now.

Your agent should sign the form only after you have passed away.

They will not have any authority to act under this document until after you have passed away and they have signed and dated the form.

Appointment of Agent to Control Disposition of Remains

I,____
(Your name and address)

being of sound mind, willfully and voluntarily make known my desire that, upon my death, the disposition of my remains shall be controlled by

____ .
(name of agent)

With respect to that subject only, I hereby appoint such person as my agent with respect to the disposition of my remains.

SPECIAL DIRECTIONS:

Set forth below are any special directions limiting the power granted to my agent as well as any instructions or wishes desired to be followed in the disposition of my remains:

____

____

____

____

____

Indicate below if you have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law for funeral merchandise or service in advance of need:

☐ No, I have not entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

☐ Yes, I have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

____
(Name of funeral firm with which you entered into a pre-funded pre-need funeral agreement to provide merchandise and/or services)

AGENT:

____
(Name)

____
(Address)

____
(Telephone Number)

SEE OTHER SIDE ▶

SAMPLE

SUCCESSORS:
If my agent dies, resigns, or is unable to act, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent to control the disposition of my remains as authorized by this document:

1. First Successor:____
(Name)

____
(Address)

____
(Telephone Number)

2. Second Successor:____
(Name)

____
(Address)

____
(Telephone Number)

DURATION:
This appointment becomes effective upon my death.

PRIOR APPOINTMENT REVOKED:
I hereby revoke any prior appointment of any person to control the disposition of my remains.

Signed this______________________day of___________,_____________.

____
(Signature of person making the appointment)

Statement by witness (must be 18 or older):
I declare that the person who executed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: ____
(Signature)

____
(Address)

Witness 2: ____
(Signature)

____
(Address)

ACCEPTANCE AND ASSUMPTION BY AGENT:
1. I have no reason to believe there has been a revocation of this appointment to control disposition of remains.
2. I hereby accept this appointment.

Signed this______________________day of___________,_____________.

____
(Signature of Agent)

SAMPLE

Appendix F: Power of Attorney

New York Statutory Short Form & Permissible Modifications

POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.nysenate.gov or www.nyassembly.gov.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

I, ____________________________ ____________________________
(name of principal) *(address of principal)*

hereby appoint:

____________________________ ____________________________
(name of agent) *(address of agent)*

____________________________ ____________________________
(name of second agent) *(address of second agent)*

as my agent(s).

SAMPLE

If you designate more than one agent above and you do not initial the statement below, they must act together.

(____) My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)
If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

_________________________ (*name of successor agent*)   ________________________ (*address of successor agent*)

_________________________ (*name of second successor agent*),   _________________________ (*address of second successor agent*)

If you do not initial the statement below, successor agents designated above must act together.

(____) My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications".

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications."

(f) GRANT OF AUTHORITY:
To grant your agent some or all of the authority below, either
(1) Initial the bracket at each authority you grant, or
(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

(____) (A) real estate transactions;

(____) (B) chattel and goods transactions;

(____) (C) bond, share, and commodity transactions;

(____) (D) banking transactions;

(____) (E) business operating transactions;

(____) (F) insurance transactions;

(____) (G) estate transactions;

SAMPLE

(____) (H) claims and litigation;

(____) (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five thousand dollars;

(____) (J) benefits from governmental programs or civil or military service;

(____) (K) financial matters related to health care; records, reports, and statements;

(____) (L) retirement benefit transactions;

(____) (M) tax matters;

(____) (N) all other matters;

(____) (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;

(____) (P) EACH of the matters identified by the following letters ______________________________.

You need not initial the other lines if you initial line (P).

(g) CERTAIN GIFT TRANSACTIONS: (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of $5,000 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), and/or to make changes to interest in your property, you must expressly grant that authorization in the Modifications section below. If you wish to authorize your agent to make gifts to himself or herself, you must expressly grant such authorization in the Modifications section below. Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. Your choice to grant such authority should be discussed with a lawyer.

(____) I grant my agent authority to make gifts in accordance with the terms and conditions of the Modifications that supplement this Statutory Power of Attorney.

(h) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including, but not limited to, language to limit or supplement authority granted to your agent, language to grant your agent the specific authority to make gifts to himself of herself, and /or language to grant your agent the specific authority to make other gift transactions and/or changes to interests in your property. Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. In this section, you may make additional provisions if you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, and you may define "reasonable compensation."

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial and fill in the section below:

(____) I wish to designate ____________________, whose address(es) is (are) ______________________, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

SAMPLE

(j) COMPENSATION OF AGENT(S):

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, and/or you wish to define “reasonable compensation”, you may do so above, under "Modifications".

(k) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION:

This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.
Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on _____________, 20__

PRINCIPAL signs here: ====> ______________________________________

STATE OF NEW YORK)
) ss:
COUNTY OF ____________)

On the ____ day of _________, 20__, before me, the undersigned, personally appeared _________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

____
Notary Public

(n) SIGNATURE OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Power of Attorney in my presence and in the presence of the other witness, or that the principal acknowledged to me that the principal’s signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Power of Attorney reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as an agent or as a permissible recipient of gifts.

_______________________________ _______________________________

Signature of Witness 1 *Signature of Witness 2*

SAMPLE

______________________________	______________________________
Date	*Date*
______________________________	______________________________
Print name	*Print name*
______________________________	______________________________
Address	*Address*
______________________________	______________________________
City, State, Zip Code	*City, State, Zip Code*

(o) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;
(2) avoid conflicts that would impair your ability to act in the principal's best interest;
(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;
(4) keep a record of all transactions conducted for the principal or keep all receipts of payments and transactions conducted for the principal; and
(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in the modifications section of this document or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest.

You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent: The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

SAMPLE

(p) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we, _________________________, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

In Witness Whereof I have hereunto signed my name on ________________________ 20__

Agent(s) sign(s) here: ==> ____

==> ____

STATE OF NEW YORK)
) ss:
COUNTY OF ___________)

On the _____ day of ___________, 20__, before me, the undersigned, personally appeared ____________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

____
Notary Public

(q) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I/we, _________________________, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

In Witness Whereof I have hereunto signed my name on ________________________ 20__

Successor Agent(s) sign(s) here: ==> ____

==> ____

SAMPLE

STATE OF NEW YORK)
) ss:
COUNTY OF ____________)

On the _____ day of __________, 20___, before me, the undersigned, personally appeared ____________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

____
Notary Public

SAMPLE

SUGGESTED LANGUAGE FOR PERMISSIBLE MODIFICATIONS

Cut and paste the desired modifications into the Modification Section (h) of the Power of Attorney. If the modification involves gifting, then the principal must also initial Section (g) CERTAIN GIFT TRANSACTIONS.

GUARDIAN PROVISION

If it becomes necessary to appoint a guardian of my person or property, I hereby nominate pursuant to New York Mental Hygiene Law § 81.17 ____________ to serve as guardian. If ____________ is for any reason unable or unwilling to serve as guardian, I nominate ____________ to serve as guardian.

GIFTING PROVISIONS

NB: If you're doing this for planning purposes for either health care coverage or for estate planning, please make the required provisions in the Modifications Section. Be aware that gift equalizing provisions could conflict with later planning requirements.

[Choose one provision only as they are inconsistent with each other]

I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

or

I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:

- (a) make gifts up to a specified dollar amount $___________
- (b) make gifts unlimited in amount;
- (c) make gifts to any person or persons;
- (d) make gifts to the following persons and/or organizations;

Gift Recipient Name or Class

SAMPLE

[*Make sure to exclude the witnesses*]

- (d) I grant specific authority for the following agent(s) to make the following gifts to himself or herself: This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

  [*Make sure to include the names of agents and successor agents that can make gifts to themselves*]

Make gifts in any of the following ways (edit where necessary)**:**

1. Gifting through banking transactions
Opening, modifying or terminating a deposit account in the name of the principal and other joint tenants; opening, modifying or terminating any other joint account in the name of the principal and other joint tenants; with respect to joint accounts existing at the creation of the agency, the authority granted hereby ***shall/shall not*** include the power to change the title of the account by the addition of a new joint tenant or the deletion of an existing joint tenant; opening, modifying or terminating a bank account in trust form as described in § 7-5.1 of the estates, powers and trusts law, and designate or change the beneficiary or beneficiaries of such account; with respect to totten trust accounts existing at the creation of the agency, the authority granted hereby ***shall/shall not*** include the power to add, delete, or otherwise change the designation of beneficiaries in effect for any such accounts; opening, modifying or terminating a transfer on death account as described in part four of article thirteen of the estates, powers and trusts law, and designate or change the beneficiary or beneficiaries of such account;

2. Gifting by changing beneficiary or modifying life insurance
Changing the beneficiary or beneficiaries of any contract of insurance on the life of the principal or annuity contract for the benefit of the principal; with respect to life insurance contracts existing at the creation of the agency, the authority granted hereby ***shall/shall not*** include the power to add, delete or otherwise change the designation of beneficiaries in effect for any such contract; procuring new, different or additional contracts of insurance on the life of the principal or annuity contracts for the benefit of the principal and designate the beneficiary or beneficiaries of any such contract; to apply for and to receive any available loan on the security of the contract of insurance, whether for the payment of a premium or for the procuring of cash, to surrender and thereupon to receive the cash surrender value, to exercise an election as to beneficiary or mode of payment, to change the manner of paying premiums, and to change or to convert the type of insurance contract, with respect to any contract of life, accident, health, disability or liability insurance as to which the principal has, or claims to have, any one or more of the powers described in this section; the authority granted hereby with respect to the contract of insurance ***shall/shall not*** include the power to add, delete or otherwise change the designation of beneficiaries in effect for any such contract;

3. Gifting by changing beneficiary or modifying retirement accounts
Designate or change the beneficiary or beneficiaries of any type of retirement benefit or plan; the authority granted hereby with respect to retirement benefits or plans ***shall/shall not*** include the authority to add, delete, or otherwise change the designation of beneficiaries in effect for any such

SAMPLE

retirement benefit or plan; creating, amending, revoking or terminating an inter vivos trust; and; opening, modifying or terminating other property interests or rights of survivorship, and designate or change the beneficiary or beneficiaries therein.

4. Gifting by establishing and funding a revocable or irrevocable lifetime trust or joining and funding a pooled trust

Create trusts, whether revocable or irrevocable, on my behalf; fund such trusts on my behalf or make transfers and additions to any trusts already in existence; withdraw income or principal on my behalf from any trust; exercise whatever trust powers or elections which I may exercise; This grant of authority shall include the ability of my agent(s) to create trusts or accounts naming himself, herself, or themselves, as the case may be, as the beneficiary(ies) of such trusts.

5. Conveyance of specific real property or a cooperative apartment

Convey all of my right, title and interest in the real property known as _____________ and the cooperative apartment known as ___________________, paying off any liens of the said premises, paying all expenses related to the sale of the said premises, including but not limited to filing fees, maintenance adjustments and legal fees, receiving all moneys resulting from the sale of the premises executing all documents necessary to accomplish the foregoing and doing all things necessary to effect the conveyance.

6. Making loans and executing promissory notes

Make loans and executing promissory notes.

A gift to an individual authorized by this subdivision may be made:

Outright, by exercise or release of a presently exercisable general or special power of appointment held by the principal; to a trust established or created for such individual; to a Uniform Transfers to Minors Act account for such individual (regardless of who is the custodian); or to a tuition savings account or prepaid tuition plan as defined under section 529 of the Internal Revenue Code for the benefit of such individual (without regard to who is the account owner or responsible individual for such account).

1. Grant specific authority for agent(s) to make the following gifts to himself or herself

I grant specific authority for the following agent(s) to make the following gifts to himself or herself:

Agents: ___________________________________

Gifts to the agents under this provision include all the powers, methods and manners as provided for gifting above.

2. Control over digital assets

The agent(s) shall have (a) the power to access, use, and control my digital devices, including but not limited to, desktops, laptops, tablets, storage devices, mobile telephones, smartphones, and any similar digital device that currently exists or may exist as technology develops for the purpose of accessing, modifying, deleting, controlling, or transferring my digital assets, including any content contained in an electronic communication therein, (b) the power to access, modify, delete, control, and transfer my

SAMPLE

digital assets, including the content contained in any electronic communication therein, wherever located and including but not limited to, my emails received, email accounts, digital music, digital photographs, digital videos, software licenses, social network accounts, file sharing accounts, financial accounts, banking accounts, domain registrations, web hosting accounts, tax preparation service accounts, online stores, affiliate programs, other online accounts, and similar digital items which currently exist or may exist as technology develops, and (c) the power to obtain, access, modify, delete, and control my passwords and other electronic credentials associated with my digital devices and digital assets described above. This authority is intended to constitute "lawful consent" to a service provider to divulge the contents of any communication under The Stored Communications Act (currently codified as 18 U.S.C. §§ 2701 et seq.), to the extent such lawful consent is required, and as agent acting hereunder shall be an authorized user for purposes of applicable computer-fraud and unauthorized-computer-access laws.

COMPENSATION OF AGENT

The agent(s) shall be compensated for services in handling my financial affairs at the same rate as that of an executor or administrator of an estate and may pay said compensation from the funds in *his/her* hands following the close of each calendar year or more frequently. The commission shall be calculated upon the amount of money received by *him/her* as income and upon income paid out, whether such income is derived from the corpus of the estate or from any other source, and also a commission for receiving and paying out corpus of the estate paid out during the period. The commissions on income and principal shall commence each year at the initial bracket. If agent is an attorney and performs any legal services for me, agent shall be entitled to reasonable attorney's fees apart from and in addition to the compensation provided for herein.

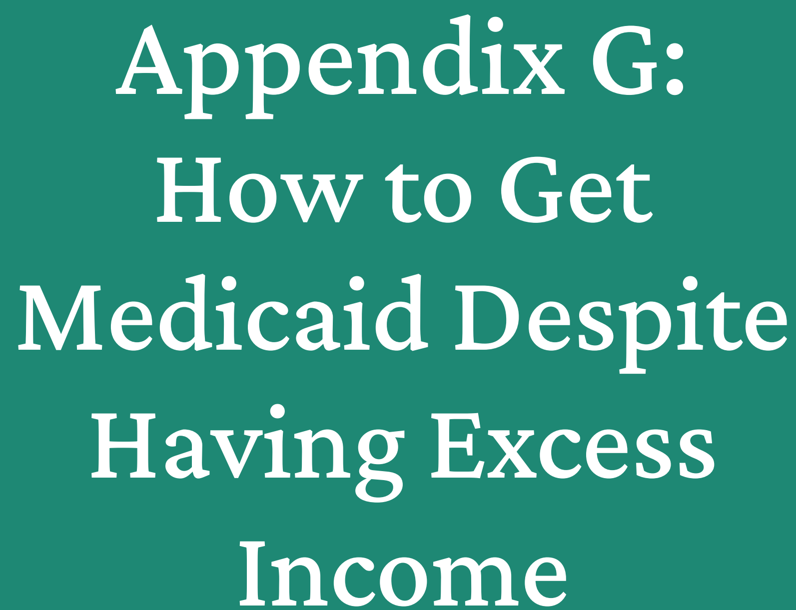
or

The agent(s) shall be compensated at a rate of $_____/hr. for services rendered pursuant to this power of attorney.

MONITOR

Unless reasonable cause exists to require otherwise, the agent(s) shall not be obligated by the monitor to provide financial details or accountings more frequently than annually.

SAMPLE



Appendix G: How to Get Medicaid Despite Having Excess Income

NYLAG
New York Legal Assistance Group

HOW TO USE A POOLED INCOME TRUST TO REDUCE YOUR MEDICAID "EXCESS INCOME" OR SPEND-DOWN (AGE 65+/DISABLED) (UPDATED 7/5/22)

See *Heads Up for 2023* on Page 2 – *BIG INCREASE in Income Levels*!

WHAT'S INSIDE THIS FACT SHEET

Who Needs a Pooled Income Trust? ....**pages 186-187**
Coming in 2023 – Higher Income Limits..**page 187**
Step 1 - How to enroll in a pooled trust ....**page 188**
Step 2 – Decide How Much to Deposit into the trust – with tips for married couples and to qualify for the Medicare Savings Program..**pages 189–191**
Step 3 – What to Submit to Medicaid for Approval of the Trust ....**page 192**
3A - Strategies for those also applying for Medicaid when submitting trust.................**page 192**
3B and C – What to Submit and Where to Submit it ....**pages 193-194**
Step 4 – **NEW JUNE 2022 –** Submit Disability Documents to the NY State Disability Review Unit (SDRU) When Requested..**page 194**
Step 5 – Follow-Up with DSS/HRA to correct errors after Medicaid re-budgeted...................**pages 195**
Frequently Asked Questions explaining what expenses the trust may pay for, now do you leave a pooled trust, and links to more information ....**pages 196–199**

WHO NEEDS A POOLED TRUST?

People age 65+, blind, or disabled can get Medicaid if they have limited assets and income under $934 for singles and $1,367 for couples (2022).[1] Income over these levels, after deducting the cost of Medicare Part B and other health insurance premiums, is the "spenddown" or "surplus income" or "excess income." Every month, one must first incur medical bills in an amount that equals the "spend-down" to qualify for Medicaid.[2] New applicants may meet their "spend-down" by using older bills incurred in earlier months.[3] But current recipients must "spend down" on current medical expenses every month. A pooled trust can eliminate the need to spend-down excess income
.

HEADS UP – HELP COMING IN 2023!!!!! See next page

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[1] $20/mo. per household of gross unearned income for disabled, aged and blind applicants is disregarded, along with over half of earned income. Some special higher income limits and disregards may reduce the spenddown– see www.wnylc.com/health/entry/222/. **See 2023 Heads Up on page 187.**

[2] 2 May use current medical expenses not paid by Medicaid or Medicare, including current over-the-counter expenses that a doctor prescribes as medically necessary. See http://wnylc.com/health/download/70/. And health.ny.gov/health_care/medicaid/excess_income.htm.

[3] 3 New applicants for Medicaid can meet the spend-down with:
- old unpaid and unreimbursed medical bills they still owe and paid bills for medical care received within the 3 months before they applied for Medicaid and
- the amounts that EPIC or ADAP paid for their prescription costs up to three months before they applied for Medicaid, in addition to the co-payments the client paid for these programs. See links In fn. 2.

In 2023, the Medicaid income limits will increase – to about $1,563 from $934 for singles and to $2,106 from $1,367 for couples. Most singles who now have a spend-down of $629 or less (and couples with a spenddown of $739) **will have NO spend-down in 2023**! Those with higher incomes will see their spend-down go down, allowing them to reduce how much they deposit into a pooled trust. We do not yet know how quickly Medicaid recipients will have their spend-down recalculated in 2023.

Info on how and when this change will take effect will be posted here when we learn about it - http://www.wnylc.com/health/news/90/.

Few people can afford to "spend-down" income to the Medicaid levels. **But even people with Medicare may need Medicaid because:**

1. Medicaid provides **long-term home care**, which is not paid for by Medicare, and which is very expensive when paid for out of pocket.
2. With Medicaid you automatically get **Extra Help**, the Low Income Subsidy that reduces costs of your Medicare Part D drug plan.
3. Medicaid also subsidizes some other **Medicare costs**.

***EXAMPLE* – HOW SPEND-DOWN IS CALCULATED**

Sally is age 67. Her gross Social Security is $1,935 per month. Her Medicare Part B premium of $170.10 is deducted from her check, so she receives $1,764.90. She also pays for an AARP Medigap Plan N policy of $211.25/mo. Sally's spend-down calculation is:

Total Income	**$1,955.35**	Gross Income
- 170.10		- Medicare Part B premium (2022)
- 20.00		- Disregard for aged, disabled (standard)
- 211.25		- AARP - Medigap premium (Plan N)
	- 401.35	**TOTAL DEDUCTIONS**
	1554.00	Countable net income
	- 934.00	- Medicaid level for ONE (2022)
	$ 620.00	**Spend-down or Excess Income - monthly**

Sally's rent is $850. Her utilities, phone, cable, food, transportation, clothing, household costs eat up all of her income. She can't afford her $620 spend-down! A pooled trust can help her in many ways described below. But - **in 2023,** when the Medicaid limit increases to about $1,563 for singles and to $2,106 for couples, Sally will have NO spend-down! (The exact income levels and spend-down will depend on how much the cost-of-living increases will be for Social Security and the Federal Poverty Level). So if she opens a trust now, she may be able close it down in 2023. See the FAQ for how to close a trust.

The Solution: People of any age – including 65+ -- who are disabled may enroll in a pooled "Supplemental Needs Trust" sponsored by a non-profit organization. There are many pooled trusts in New York State. This fact sheet uses one trust—operated by the Center for Disability Rights (CDR)—as

an example.[4] The Trust is open to any person who is "disabled" as defined by the Social Security laws. When you join the Trust, you agree to deposit with the Trust each month the amount of her "spend-down." Once the Trust documents are signed, and the local Medicaid program approves the Trust, Medicaid will change the budget so that the client has NO SPEND-DOWN. The Trust pay certain bills, such as rent, mortgage, electric, etc. from the money the client sends in each month. This is explained more below.

STEPS FOR ENROLLING IN A POOLED TRUST

There are five steps to enrolling into a pooled trust, each of which is explained below with forms available here: wnylc.com/health/entry/44/. The five steps are:

1. Enroll in the Pooled Supplemental Needs Trust (SNT)
2. Decide How Much to Deposit into the Trust
3. Submit Trust Documents and Request for Disability Determination to HRA/ local DSS– with the Medicaid application if not already on Medicaid
4. Upon request, Submit Disability Documents to State Disability Review Unit
5. Follow-Up and Ensure Medicaid Budgeting Is Done Correctly

✓ STEP 1 - Enroll in the Pooled Supplemental Needs Trust

The first step is to **choose and enroll in the pooled SNT**. Most pooled SNTs have a list of documents on their website, including FAQs and Procedures which you should read before enrolling. Look at their fees as well, which vary. There are many Pooled SNTs in New York - see wnylc.com/health/entry/4/.

Using the Center for Disability Rights (CDR) trust as an example, here is what you need to send CDR to enroll. All forms can be downloaded – see link in CDR entry on the list of trusts found at wnylc.com/health/entry/4/. All trusts have different enrollment fees and forms.

- Beneficiary Profile & Joinder Agreement - Fill out and sign – CDR and most trusts require the agreement by notarized. A legal guardian or person with Power of Attorney (POA) may sign the form if the POA authorizes it. This form may ask you how much you plan to deposit into the trust every month. For that – see **STEP 2** below.
- Disbursement/Withdrawal Form - For every expense that you want the trust to pay, you need to submit one of these forms and attach proof that the amount is due (e.g. a copy of your lease, monthly utility bill, credit card statement). See more about what expenses trusts will pay in Q&A page 197.

[4] Unofficial list of pooled trusts in New York at http://wnylc.com/health/entry/4/.

- ACH Request Form - If you want CDR to make automatic withdrawals from your bank account each month in the amount of your monthly SNT contribution. You can specify the day of the month that the withdrawal is made.
- FEE - Enrollment funds (check or money order) - Payable to CDR (minimum initial deposit is $240 but see below for advice about how much to send for your full monthly contribution). Every trust has different fees. For example, see the NYSARC Community Trust II Fee Schedule - nysarctrustservices.org/download_file/6/144/ and see other trusts at wnylc.com/health/entry/4/.
- CDR and the other trust organizations will take about 2 weeks to process your application, and if you are enrolled in their SNT, they will send you an Acceptance Letter. Keep that handy because you will need it in **Step Three**.

✔ STEP 2 - Decide How Much to Deposit into the Trust

Here are some tips for deciding how much to put into the trust each month.

The Bare Minimum – Actual Spend-down amount. At a minimum, deposit your actual spenddown. For example, if Sally (example on page 2 above) deposits $620 each month into the Trust, once Medicaid approves it, she will have NO spend-down. With this option, CDR keeps $20 as a monthly fee, and $600 is available to pay her bills.

Strategy Tip #1: Enough to pay full rent: It may make sense to put enough in the Trust each month for the Trust to pay her rent. If she puts her exact spend-down of $620 into the Trust, after the $20 monthly fee, the Trust can only pay $600 of her $850 rent. She would pay the balance of $250 separately to the landlord. Alternately, she can deposit $870 in the trust, which would include the $20 fee and the $850 rent. Some trusts, such as NYSARC, have a fee scale with higher fees for higher monthly deposits. The convenience of having the trust pay the whole rent may be worth making a larger monthly deposit.

Strategy Tip #2: Extra benefit of the Trust - Medicare Savings Program (MSP) – The pooled trust deposit not only reduces one's "countable" income for Medicaid, but also for the Medicare Savings Program. The MSP program pays the Medicare Part B premium—$170.10 in 2022—a savings that more than offsets the monthly Trust fee. For more info see tinyurl.com/NY-MSP-MRC and wnylc.com/health/entry/99. Once enrolled in an MSP, Medicaid pays her Part B premium, and her Social Security check will increase by $170.10. As a result, her spend-down will also increase by $170.10. If Sally wants to be in MSP, and also have no spend-down, she should increase her monthly trust deposit by $170.10 to $790.10. **In 2023**, when income limits increase, she will have a $-0- spend-down if she declines the MSP, and a spend-down of about $170/mo. if she enrolls in the MSP. See above.

For help determining how much to contribute each month to eliminate your spend-down, obtain the Medicare Savings Program, and ensure that all SNT fees and your bills are paid, use this Excel worksheet (wnylc.com/health/download/316/).

**** MSP TIP:** If you were contributing the extra $170.10 to the SNT when you submitted the trust and re-budget request or application to Medicaid, you will be retroactively enrolled in MSP once the trust is approved. You will be reimbursed for the Part B premiums you paid while contributing to the SNT. You must continue making your deposit in the SNT every month while the trust is awaiting approval at the Medicaid office.

**** APPLICATION TIP WITH MSP:** On the Medicaid application, write across the top of the first page that the client is applying for both Medicaid AND the Medicare Savings Program. The Medicaid office is required to screen the client for MSP anyway, but it helps to remind them. See GIS 05/MA-033, at http://tinyurl.com/L7AUSK. If trust is being submitted in NYC for someone who already has Medicaid, include Form MAP-751-W. See fn 8 in **Step 3.C.** on p. 194.

Strategy Tip #3: WARNING - Deposit only what you can routinely spend every month - Do not let the trust deposit accumulate! If you do not spend the money deposited each month into the Trust, and it accumulates, then you may be denied Medicaid to pay for nursing home care if you need it in the next five years. This is because income deposited into the trust but not spent by the time one enters a nursing home is considered a "transfer of assets." Transfers of assets made by someone age 65 or over can cause a delay (transfer penalty) in qualifying for Medicaid to pay for nursing home care. Fortunately, under New York State policy, placing income into a pooled Trust will not result in a transfer penalty for Medicaid coverage of nursing home care as long as the balance of the pooled Trust account does not accumulate.[5]

2022-23 WARNING – Stay tuned— the "lookback" and transfer penalty may be expanded beyond nursing home care, to delay eligibility for new Medicaid applicants seeking Managed Long term Care, other home care, or the Assisted Living Program. It is not yet clear whether deposits into a pooled trust will trigger a "transfer penalty" to delay home care when this change begins. See info at wnylc.com/health/news/85/.

Strategy Tip #4: Carefully read the trust's rules to make sure they will pay the bills you want them to pay. Generally a lease or utility bill must be in your name for the trust to pay it. Trusts will pay a credit card in your name, but may ask you to verify that each item on the bill was purchased *for you*. Trusts are not permitted to pay arrears on a credit card bill, or for an expense or gift for anyone else. Also, the SNT will never pay you – the Medicaid recipient -- directly. See more about what expenses a trust may pay in the Q&A on page 198.

Strategy Tip #5: If you don't have Medicare, don't reduce spend-down to ZERO- Keep a nominal spend-down. Why? For people who do not have Medicare, it may be advantageous to retain a minimal spend-down to avoid being required to enroll in a Medicaid Managed Care Plan. See wnylc.com/health/entry/166/. Currently, having a spend-down makes one exempt from having to enroll in a Managed Care Plan. (But – those who have Medicare and need home care are required to enroll in a Medicaid Managed Long Term Care (MLTC) plan even if they **do** have a spend-down.)

[5] NYS Dept. of Health GIS 08 MA/020, *Transfers to Pooled Trusts by Disabled Individuals Age 65 and Over* at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma020.pdf. (7/24/08). For more information on these rules, see http://wnylc.com/health/entry/38/.

Strategy Tip #6: Married couples - If both spouses need Medicaid, it may be possible for only one to establish a Trust account, depending on each of their respective incomes. This can spare the couple administrative fees and administrative hassle. Their combined income remaining after taking all deductions, and after the deposit into the Trust, must still be under the Medicaid couple income limit ($1,367/mo. in 2022). Please see the example below.

Married couples where only one spouse needs Medicaid should also consider two types of special budgets that might reduce or eliminate the spenddown, and obviate the need for a pooled trust – see http://www.wnylc.com/health/entry/222/#1%20married –

- Spousal Impoverishment -only if the Medicaid spouse is in an MLTC plan, receives Immediate Need home care, or is in the Nursing Home transition or TBI Waiver, OR
- Spousal Refusal -the non-Medicaid spouse's income and/or assets are not counted and the applicant is considered "single." WARNING – the county may sue the refusing spouse for support. Consult an experienced attorney.

***MARRIED COUPLE EXAMPLE* – Both are 65+ or Disabled & Need Medicaid**

Sally has the same income and insurance as in the example above, but is married to John whose gross income is $900.25. John and Sally also have the same AARP Medigap Plan N policy.

	$1955.35	Gross Income - Sally
	950.35	Gross Income - John
	2905.70	TOTAL GROSS INCOME
- 340.20		Medicare Part B premium ($170.10 x 2)
- 20.00		Disregard for aged, disabled ($20/ 1 or 2)
- 422.50		AARP Medigap premium (Plan N) (211.25 x 2)
	- 782.70	TOTAL DEDUCTIONS
	2123.00	Countable net income
	- 1367.00	Medicaid level for TWO (2022)
	756.00	**Spend-down as a couple – will be -0- in 2023!**
	+ 340.20	Extra for Medicare Savings Prog. (Part B x 2)
	$1096.20	**Total to deposit if both want MSP**

If they are applying as a couple, assuming they are both either disabled or 65+, it makes more sense for Sally to establish a trust, since John's income isn't high enough to deposit $1096.20, which is the full spend-down if they both want to enroll in an MSP and also have a $0 spenddown. Since John only has $950.35 in income, he may keep his entire income, and have Sally enroll in the Trust and deposit $1096.20 into the Trust, which eliminates the spend-down for both of them. **Warning:** if Sally was not disabled, then only John could enroll in the Trust. Both spouses may need to enroll for their combined deposits to meet their couple's spend-down.

WHAT IF -- one spouse is under age 65 and not disabled?

If John was age 62 and not disabled, but has the same income as above, while Sally is age 65+ --

- Sally's eligibility & spend-down would be based on a household size of TWO, counting John's income, but without deducting a Medicare & Medigap premium for him. Her spend-down is **$1477.55**, if she wants to enroll in an MSP.
- John would be in the **MAGI Medicaid** category, which also requires counting both spouses' income. Their combined income of $2905.70 is over the MAGI couple limit of $2,106 (2022), so he is not eligible for Medicaid. But he can qualify for the Essential Plan, which is similar to Medicaid.[6] He must apply for that separately on https://nystateofhealth.ny.gov/. He can get help applying – TEL (888) 614-5400 Or email: cha@cssny.org (Community Health Advocates)

✔ **STEP 3 - Submit Trust Documents and Proof of Disability to Local Medicaid Office – with Medicaid Application if you don't yet have Medicaid.**

Next, submit the trust documents to the local Medicaid office. If you do not yet have Medicaid with a spend-down, then submit the trust with a Medicaid application. New applicants must make a timing decision, discussed in **3.A.** If you already receive Medicaid, skip to **STEP 3.B.**

✔ ***STEP 3.A. TIMING - Decide whether to submit Trust documents with the Medicaid application or later, after the Medicaid application is filed.***

Even though most Medicaid applications should be decided within 45 days, an application submitted with a pooled trust takes 90 days because approval requires a determination of disability.[7] In reality, these applications take longer than 90 days. For this reason, some advocates prefer to wait and submit the trust after the Medicaid application has been approved, in hopes that the application will be approved within 45 days. See fn 7. Even though there would be a spend-down when Medicaid is initially approved without the trust, at least the Medicaid approval could get services started.

At least in New York City, there is an advantage of submitting the pooled trust along with the application**.** A 2019 class action settlement called Garcia v. Banks (wnylc.com/health/download/697/) requires NYC HRA to comply with the 90-day deadline to approve Medicaid applications submitted with a pooled trust for an applicant age 65+. http://www.wnylc.com/health/download/697/. While 90 days may still seem like a long time, it's a big improvement over past delays. However, the 90-day limit applies ONLY if the trust is submitted with the Medicaid application, not separately. If you have submitted a trust with a Medicaid application in NYC for someone age 65+ and a decision was not

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[6] See http://www.wnylc.com/health/entry/15/; http://www.wnylc.com/health/entry/195/ & https://info.nystateofhealth.ny.gov/essentialplan.

[7] The time limits are in federal regulations. See http://www.wnylc.com/health/entry/175/. (People under age 65 who are disabled usually receive Social Security Disability (SSD) benefits so do not need a determination of disability by Medicaid to get a pooled trust approved. **Proof of receipt of SSD until age 65 may also mean that no disability determination is needed for a pooled trust.**

made in 90 days, contact Garcia class counsel Nina Keilin ninakeilin@aol.com or Aytan Bellin Aytan.Bellin@bellinlaw.com.

Outside NYC, the 90-day time limit still applies to an application submitted with a trust for someone age 65+, but there is not a court order enforcing that time limit. The best strategy may vary in each county.

STATEWIDE TIMING STRATEGY TIP – Ask for Medicaid to be Approved with a Spenddown While Trust is Being Approved: Even if you submit the trust with your application, you can request HRA or your local Medicaid agency to first approve Medicaid with a spend-down, in order to get home care started, and to approve the pooled trust and re-budget the case later within 90 days. When you are approved for Medicaid with a spend-down, your Managed Long Term Care (MLTC) plan or other home care agency will bill you for your spend-down, which you are expected to pay to the plan or agency every month. You will probably be unable to do this because you are sending the money to the pooled trust. Explain to the plan or agency that your spenddown will eventually be retroactively reduced to ZERO when the Trust is approved. The agency will then be able to back-bill Medicaid for the spend-down amount. Some plans will ask for proof that you have submitted your trust to Medicaid for approval.

Applicants who want to enroll in MLTC must make this clear with the application, to make sure the proper codes are entered by the Medicaid office.

✔ **STEP 3.B. Documents to submit to HRA/ local Medicaid office to get Pooled Trust approved (NOTE CHANGE JUNE 2022):**

1. **Trust Documents:**
    a. **Master Trust Agreement**- Download on the trust's website
    b. **Beneficiary Profile Sheet and Joinder Agreement**, signed by both you and the trustee (CDR, for example) - The version sent to you with your Acceptance Letter will have the trustee's signature
    c. **Acceptance Letter from Trust**
    d. **Verification of Deposits -** If you are sending this paperwork more than a month after you were accepted into the SNT, you need to send proof that you have been making monthly deposits. You can call the SNT to ask for a statement. Many trusts have an online portal to download these verifications.
2. **NEW - Request for Disability Determination -** Starting June 2022, HRA only requires the DISABILITY DETERMINATION REQUEST (MAP-3177) instead of all the disability forms (now submitted in Step 4 below). Download MAP-3177 in several languages at https://www1.nyc.gov/site/hra/help/health-assistance.page (scroll down to Disability Determination Requests.) HRA will forward this to the **State Disability Review Unit (SDRU)**. You will submit the rest of the disability forms directly to the SDRU when they request them. See NEW STEP 4 below. This change was announced in HRA Medicaid Alert dated June 30, 2022, posted at http://www.wnylc.com/health/download/816/.

3. **NY State HIPPA Release** – OCA Official Form 960 - download at http://www.nycourts.gov/forms/Hipaa_fillable.pdf) **Fill** in **Box 8** and the **last line in Box 9.b.** with the name of your social worker, family member or attorney to authorize HRA or local Medicaid agency to talk with them about your case. Be sure to **INITIAL** the first blank in **9.b.** This form authorizes HRA to release info to you on status of re-budgeting.

4. **Cover letter** requesting HRA/DSS to approve the pooled trust, refer the disability determination to SDRU, and budget your Medicaid case with no spend-down. If you also submitted a Medicaid application with the trust, ask for approval of Medicaid too. See sample cover letter (http://www.wnylc.com/health/download/64) which you should customize. In your letter, also ask to be enrolled in the Medicare Savings Program (MSP) to have your Medicare Part B premium paid by Medicaid. See STEP 2 – **Strategy Tip 2** on p. 189 above. Explain that even though your spend-down increases when you join an MSP, you will still have a ZERO spend-down because you have been contributing the amount of the Part B premium to the SNT. Also see http://www.wnylc.com/health/entry/99/.

✓ 3.C. Where to Submit Trust Documents and Medicaid applications –

Each county has a Medicaid office in their Dept. of Social Services that accepts Medicaid applications and pooled trusts.

In **New York City**, during the COVID public health emergency, it is best to **FAX** all Medicaid applications and pooled trusts. If you receive or are applying to receive home care, MLTC, or the Assisted Living Program, write this on the top so your application and/or trust is routed to the Home Care Services Program.

- E-fax the Medicaid application with the pooled trust to **917-639-0732**.
- If you have an "Immediate Need" for home care and are applying for Medicaid with a pooled trust, additional forms are required. See fact sheet here http://www.wnylc.com/health/download/637/. E-fax the complete package to **917-639-0665**.
- **If you already have Medicaid** and are faxing just the pooled trust documents listed in 3.B. above, fax them to **917-639-0645**. Include form **MAP-751W** *Consumer/Provider Request to Change Information on File* (3/25/21) as a cover sheet.[8] Complete the top and CHECK the box on page 187 for *Medicare Savings Program evaluation* and the box on page 188 for Pooled Trust and check "Budgeting for New Trust Submission."
- After the COVID emergency ends, likely in 2022, for people submitting a trust in order to obtain Medicaid home care, MLTC, or Assisted Living Program, the same document packages described above will probably again be accepted in person or by mail to: HRA HCSP Central Medicaid Unit, 785 Atlantic Avenue, 7th Floor, Brooklyn, NY 11238. Certified mail is recommended if using mail.

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[8] Download MAP-751w at https://www1.nyc.gov/site/hra/help/health-assistance.page or as a fillable form at http://www.wnylc.com/health/download/770/.

✔ ***STEP 4 – Submit Disability Documents to the State Disability Review Unit (SDRU) When Requested.*** **New June 2022**

Before June 2022, you submitted these documents to NYC HRA in STEP 3 along with the pooled trust. HRA then transmitted them to the SDRU. Now, HRA will only transmit the new DISABILITY DETERMINATION REQUEST (MAP-3177) to the SDRU.[9] Start gathering and completing the following forms to submit when requested by the SDRU.[10]

1. **If you were approved for either SSDI or SSI benefits on the basis of a disability**, then just send a copy of your SSA Award Letter or SSA Disability Determination, or if you no longer have that award letter, request a benefit verification letter from the SSA - https://www.ssa.gov/myaccount/proof-of-benefits.html. Submit this proof of past SSD or SSI even if you turned age 65 and now receive Social Security based on age. Otherwise, you need to send the documents below for Medicaid to make a disability determination (http://www.wnylc.com/health/entry/134/)
2. **Medical Report for Determination of Disability** –**NEW FORM DOH-5143** replaces 486T form.[11] This form must be filled out by your primary care doctor or specialist. **NOTE:** Though no longer used, the old 486T form had numerous attachments that elicited information about different body systems, such as a musculoskeletal or cardiac impairments. You might ask the physician to complete the applicable attachment, though no longer required, or use it as a guide to show the applicant satisfies criteria for "meeting the listings" to be found disabled.[12]

    a. **12 months of Medical Records** – ask your doctor who signed the 486T form to provide 12 months of records from their office. See HRA Medicaid Alert (Jan. 2013) http://www.wnylc.com/health/download/402/. If you can, also submit records from any hospitalizations or nursing home stays in the past 12 month. You want to ensure that Medicaid has a full picture of your medical and psychological conditions for the disability determination.

3. **DOH-5139 - Disability Questionnaire NEW 8/2021,** replaces the DSS-1151 form. (health.ny.gov/forms/doh-5139.pdf) See HRA Alert 8/12/2021**,** download at wnylc.com/health/download/783/**.** This form can be filled out by you, a social worker or family member.

4. **New HIPPA form for Pooled Trusts – New August 2021** – **DOH-5173**.[13] Complete, sign and submit **one copy for EACH health care provider** listed on the Disability Questionnaire, filling in

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[9] This change was announced in HRA Medicaid Alert dated June 30, 2022, posted at http://www.wnylc.com/health/download/816/

[10] All of these forms can be downloaded at http://www.wnylc.com/health/entry/134 and at https://www.health.ny.gov/health_care/medicaid/reference/mdm/adult.htm

[11] See Dec. 2021 HRA Medicaid Alert - http://www.wnylc.com/health/download/799/)

[12] Step Three in the sequential evaluation process described in this article). http://wnylc.com/health/entry/134/.

[13] Download at https://www.health.ny.gov/forms/doh-5173.pdf (4/2016). See August 2021 HRA Medicaid Alert, available at http://www.wnylc.com/health/download/783/.

the name of the provider on **Line 7** and **9.b.** plus one signed and dated with the Provider information left blank. **INITIAL** the first blank in **9.b.** Form MAP-571e no longer required.

5. **Cover Letter –** explain to the SDRU why the documents show the individual meets the standards for disability. Use the NYS Medicaid Disability Manual as a guide for how to explain why you should be found “disabled” based on your specific disability(ies), using the "sequential evaluation process" for determining disability, the Listing of Impairments, and other guidelines explained in the Manual (http://www.health.ny.gov/health_care/medicaid/reference/mdm/).

✓ STEP 5 - Follow-Up and Ensure Medicaid Budgeting Is Done Correctly

The last step on this journey is to make sure that the Medicaid case is re-budgeted properly. Once you have submitted the SNT and disability documentation to your DSS, after the SDRU finds the individual disabled, the DSS/HRA then should send a written notice stating that your Medicaid case has been re-budgeted with no spend-down (and telling you that you are enrolled in MSP if you applied for it). *See note in STEP 3.A above about the 90-day limit if you submitted the SNT along with your Medicaid application.*

- Make sure that the **effective date** of this notice is correct - it should be the month that you first began making a contribution of your full spend down amount (+ $148.50 if you wanted MSP) to the trust.
- If it is not correct, you must **request a Fair Hearing** to appeal the notice for the date to be corrected (click here to request a hearing - otda.ny.gov/hearings/).

As you can see, this is one of the most complicated things you can do involving Medicaid. Many people find that it is worth hiring a private elder attorney (naela.org) or geriatric care manager (aginglifecare.org/) to help with this process. Some free legal services (lawhelpny.org/) may be available to help, also. For more in-depth information on SNTs, including how a SNT affects eligibility for other public benefits, see our Training Outline for Advocates (wnylc.com/health/download/9/).

FREQUENTLY ASKED QUESTIONS

Q: If my Social Security increases every year, will this increase my spend-down? Should I increase my trust deposits?

A: If income increases, the client must increase the amount placed into the trust each month. Also, some pooled trusts require a sort of “security deposit” – the equivalent of one month’s spend-down to be on deposit at all times. If Social Security or other income goes up, the client may have to increase this deposit as well. **NOTE that in 2023, the Medicaid income limits will increase significantly**, so the spenddown will likely decrease or even be eliminated.

Q: What bills may the Trust pay?

A: *WARNING: These rules are for people using a pooled trust solely for Medicaid only, not people who have SSI. If you have SSI and want to use a trust for a lawsuit settlement or other lump sum, the rules are different and more restrictive.*

The Trust may pay the client's rent, mortgage, maintenance, utility bills, credit card bills, as long as it makes the payments directly to the landlord, utility, or other third party. Such in-kind payments are not considered "income" for Medicaid purposes.[14] *The Trust may never give the client money directly*—not even to reimburse the client!

Rent or mortgage payments are the ideal expense for the trust to pay, since these expenses are consistent and most trusts will set up an automatic monthly payment. Some trusts will not put the client on automatic payment of rent or mortgage until the client has been enrolled and paid in the client's spend-down for 3 months. So during the first 3 months the client must make individual disbursement requests for the client's rent or mortgage. After that, ask for automatic payment.

Trusts vary on whether *utility and other bills* must be sent each month to the trust for payment, or whether bills on a budget plan with fixed monthly payments ("level billing") may be automatically paid by the trust, like rent.

Though the trust may pay bills only for the benefit of the Trust beneficiary (the client), and NOT for the client's family members or friends, *payments that incidentally benefit a third party* may be permissible, such as rent where the client's spouse benefits from the payment. The client needs the trust's permission to pay expenses that benefit a third party, such as paying the expenses for a travel companion of the beneficiary, or travel expenses for a close family member to visit the beneficiary.

Some trusts permit *reimbursement* to a family member or other individual who paid for a client's expense, such as paying rent or buying clothing, if receipts are submitted. However, they must contact the trust to get approval BEFORE making the expenditure to assure reimbursement. The client herself can never be reimbursed.

Some trusts will pay *credit card bills*, provided that the bill is in the client's name, and that there are no past due charges being carried forward. The actual monthly bill must be submitted for the Trust to verify that no cash withdrawals were made. The Trust has the right to inquire whether the expenses were for the benefit of the beneficiary and not for anyone else.

Trusts may not pay for gifts or charitable donations.

Funds in a trust may pay for a *pre-paid funeral agreement for the client while the client is alive*. Client may enter an installment plan for a funeral agreement with a funeral home and submit monthly installment bills to the trust to pay. *NO POOLED TRUST may pay for funeral expenses after the client dies*. This is a federal policy.

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[14] 18 NYCRR § 360-4.3(e)

Q: How does the client/beneficiary leave the Trust? There are a few ways:

A: i. *The client leaves the Trust when she dies*. Money left in the Trust when the client dies stays in the Trust for the benefit of other disabled persons. It may NOT be inherited by the client's family or heirs. Also, after the client's death, the Trust is very limited in what expenses it may pay for the client. The Trust may NOT pay funeral costs after the client's death. The Trust may NOT pay debts owed to third parties, such as paying off a mortgage, credit card debts, etc. The Trust also may NOT pay taxes due upon death, nor fees for administration of the estate. Some Trusts MAY pay current expenses due at the time of death, such as the rent and current bills.

ii. The client is permanently admitted to a nursing home. The type of Medicaid budget used for permanent nursing home care, called chronic care budgeting, does not allow the client to deposit income into a Trust to eliminate the spend-down. However, if the nursing home stay is short-term, the client can request that the nursing home submit a form to HRA/Medicaid certifying that she is expected to return home, and requesting "non-chronic" or "community budgeting." With that budgeting, continuing deposits into the pooled trust should be allowed. See more info and forms at http://www.wnylc.com/health/entry/117/. Once the nursing home stay is considered permanent, the client stops making further trust deposits. The client may still submit expense requests to the trust to use up any remaining funds, and then close the account.

*iii***.** *The client may leave any time by stopping making any further monthly deposits*. 2023 tip – when the income limits increase in 2023, if the client no longer has a spend-down, she can close her trust. See page 187 above. Beware that for some people, closing the trust will cause the spend-down to go up. At annual renewals, Medicaid will request proof that these deposits are being made. The spend-down is reduced only as long as the client submits verification of deposits (VOD) with the renewals. Also, even if the client stops submitting the trust deposits, the trust account remains open and the monthly fee will still be charged by the trust until the account is formally closed. The trust will draw on any remaining balance in the trust to pay that monthly fee until the account is depleted, and the account will be closed.

The trust must be notified in writing of any change in participation of the Trust in order to free up the remaining one month security deposit, if any.

Troubleshooting – Try your local Medicaid office to address delays or errors

CAUTION: As stated in STEP 5 above, you must request a fair hearing within 60 days after the date of the notice to correct any error on the spend-down, effective date, etc. Don't let the time limit run out while you are trying to informally advocate.

NYC HRA contacts:

- **HOME CARE CASES** – send secure e-mail to hcspinquiries@hra.nyc.gov
- **NON-HOME CARE CASES** –
    - Email undercareproviderrelations@hra.nyc.gov
      or call (929) 221-0868/69 Fax (718) 636-7847
    - Eligibility Information Services- Phone (929) 221-0865/66/67/68

ONLINE LINKS - Visit NY Health Access at nyhealthaccess.org

General info on supplemental needs trusts wnylc.com/health/14/

Training outline (updated Jan 2019) explaining Supplemental Needs Trusts (both individual and pooled). The Appendix explains how SNTs affect eligibility for many different public benefits. wnylc.com/health/download/9/

Forms & Procedures for Determining Disability wnylc.com/health/entry/134/

Contact List of Pooled Trusts in NYS wnylc.com/health/entry/4/

Federal, State and NYC authorities on pooled trusts wnylc.com/health/entry/128/

2019 Webinars on SNTs when receiving a lump sum wnylc.com/health/news/84/

Check for updates of this FACT SHEET at
wnylc.com/health/download/4/ and
wnylc.com/health/entry/44/.

New York Legal Assistance Group (NYLAG), Evelyn Frank Legal Resources Program

For intake please call or email: 212-613-7310 or eflrp@nylag.org

Monday 10 AM – 2 PM

FOR HELP – Contact a private elder attorney (www.naela.org) or geriatric care manager (https://www.aginglifecare.org/ to help with this process. Some free legal services (http://www.lawhelpny.org/) may be available to help also.

Appendix H:
Documents
Required for Medicaid
Application

_____ A. **Proof of Identity and Family Relationship – Required for Applicant and Spouse**

_____ Union Card

_____ Social Security Card

_____ Medicare Card

_____ One of the following:

Birth Certificate or Census Records or Baptismal Certificate or Certificate of Naturalization or passport or visa or driver license or non-driver identification card

_____ Military discharge papers

_____ Marriage Certificate or divorce/separation papers

_____ Death Certificate of spouse

_____ Private health insurance card and monthly premium bill (if applicable)

_____ Other

_____ B. **Residency an Living Arrangement – Required for Applicant and Spouse**

_____ Rent receipt and/or Lease

_____ Most current utility or telephone bill

_____ Deed to residence or co-op share certificates

_____ Other

_____ C. **Income – Required for Applicant and Spouse**

_____ Pension or pay stubs

_____ IRA monthly required minimum distribution payments

_____ Support payments – divorce or separation papers

_____ Award Letter for the following benefits:

( ) Social Security (call 1-800-772-1213) for income beneficiaries

( ) Military or Veterans Pensions

( ) Pension

( ) Railroad Retirement

( ) Insurance endowment

( ) Annuity

( ) New York State Disability

( )Worker's Compensation

______ Business records, if self-employed

______Past five (5) years of income tax returns, with 1099 Forms (as available)
(Only the most current return is needed for a home care application)

______ Other:____

______ D. **Resources – Required for Accounts/Stocks/Bonds/Policies bearing name of Applicant and Spouse**

______ All bank account statements (with all checks written), IRA account statements, mutual fund statements and investment account statements for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts*

______ All passbook bank accounts for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts

______ All checking account statement for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts (if home care application), including closed accounts with all the checks (front and back) in the amount of $2,000 and over*.

______ Life insurance policies and current cash value

______ Stock and Bond Certificates

______ Real estate deeds or co-op shares

______ Closing papers on property sales

______ Information about any pending lawsuits

______ Other:____

***All financial documentation must be accompanied by an explanation for the deposits and withdrawals over $2000. For example, if an account is closed, you must provide the bank name and account number that the funds were transferred to, proof of receipt by that account, and a closed account letter on bank letterhead.**

Appendix I: Access New York Health Care Medicaid Application With non-NYC supplements

access NY health care

Health Insurance

for Older Adults, People With Disabilities and Certain Other Populations

APPLICATION

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Assistors and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your family members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

PURPOSE OF THIS APPLICATION Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

PLEASE READ the entire application booklet before you begin to fill out the application. This application, along with Supplement A, must be filled out completely if you are 65 years old or older, certified blind, certified disabled or institutionalized, and/or if you are applying for coverage of nursing home care. Supplement A includes questions about your resources, such as money in the bank or property you own. This application is also used when applying through a provider, for individuals who are pregnant or under 19. If the application is for a pregnant person or child under 19, only Sections A thorough G, I, and J must be completed.

Any other Medicaid applicants must apply through NY State of Health. You can contact NY State of Health by visiting their website at https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.

Whenever you see the words SEND PROOF on the application refer to the "Documents Needed When You Apply for Health Insurance" section for a listing of acceptable supporting documents, pages 4-6.

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or an Assistor for an interview, but you **MAY** come in or contact an Assistor for help filling out this application. **You can get a list of Assistors where you got this application, or by calling 1-800-698-4543. You may also call the Medicaid help line at 1–800–541–2831. ALL HELP IS FREE.**
(1-877-898-5849 TTY line for the hearing impaired)
After you have completed this application please mail/return to the local department of social services in the county in which you reside.
https://www.health.ny.gov/health_care/medicaid/ldss.htm

SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

SECTION B Family Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include legal name before marriage, if this applies to the person. Also include city, state and country of birth. If a person was born outside of the United States, just write the country of birth.

- **Is this person pregnant?** If so, when is the baby due to be born? This information helps us determine the size of your family. A pregnant person counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, sibling, grandchild, etc.)
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, the Family Planning Benefit Program, or any other form of public assistance such as the Supplemental Nutrition Assistance Program (SNAP), we need to know which program. Also, tell us the identification number on the New York State Benefit Identification Card.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. To be eligible for health insurance, persons age 19 and over must be U.S. citizens or be lawfully present. If we are unable to verify your U.S. Citizenship and identity electronically through federal databases, we will need to see documentation of U.S. citizenship and identity. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.
- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

SECTION C | Family Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

SECTION D | Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. For some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective. We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

SECTION E | Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the mortgage amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

SECTION F | Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

SECTION G | Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months the bills were incurred. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with an Assistor to apply. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

If you are turning 65 within the next three months or you are 65 years of age or older, you may be entitled to additional medical benefits through the Medicare program. You are required to apply for Medicare as a condition of eligibility for Medicaid. Medicare is a federal health insurance program for people who are 65 or older and for certain people with disabilities regardless of income. When a person has both Medicare and Medicaid, Medicare pays first and Medicaid pays second. You are required to apply for Medicare if:

- You have Chronic Renal Failure (End Stage Renal Disease/ESRD) or Amyotrophic Lateral Sclerosis (ALS); **OR**
- You are turning 65 in the next three months or are already age 65 or older **AND** your income is at or below 120% of the federal poverty level (based on the family size for a single individual or married couple), or is at the Medicaid standard. If so, then the Medicaid program can pay your premium or reimburse your Medicare premiums. If the Medicaid program can pay or

reimburse your premiums, you will be required to apply for Medicare as a condition of Medicaid eligibility. Only citizens and lawful permanent residents who have lived in the U.S. continuously for five years must apply for Medicare. Many immigrants and non-citizens are not required to apply for Medicare.

SECTION H Parent or Spouse Not Living in the Family or Deceased

- **If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.**
- **If you are pregnant, you do not have to answer these questions until 60 days after the birth of your child.** All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of "good cause" is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- **If the applying parent** is not willing to provide this information, the applying child may still be eligible for Medicaid.

SECTION I Health Plan Selection

What is a Health Plan? If you are found eligible for Medicaid, you may be required to get your health care coverage through a Managed Care health plan. A Managed Care health plan will provide your care by working with a network of doctors, clinics, hospitals and pharmacies to provide its members with high quality health care. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular health and medical needs. If you want to keep the doctor you have, you need to pick a plan that works with your doctor. Managed Care health plans focus on preventive care so that small problems do not become big ones. If you need a specialist, your PCP can refer you to one in your plan's network.

Who Must Choose a Health Plan? MOST people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

How Do I Know What Health Plan to Choose and If I Can Enroll?
For Medicaid, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678,** or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYS Department of Health website at **www.health.ny.gov.** You can also enroll by phone, by calling **1-800-505-5678.**

NOTE: If you or a family member are found eligible for Medicaid, and are an American Indian/ Alaska Native you are not required to join a health plan. You **will** still be enrolled in the health plan you choose, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application. Remember to send the application to the local department of social services in the county in which you reside.

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Applicant Name ______________________ **Application Date** ______________________

*** Your enrollment cannot be completed until all NECESSARY items are received.** *If you need help getting any of these items, let us know.*
YOU DO NOT NEED TO SHOW US **ALL** OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. If we are unable to verify your U.S. Citizenship and identity electronically through federal databases, we will need to see documentation of U.S. Citizenship and identity. Please do not mail original U.S. Citizenship or identity documents. Copies of other documents needed to determine eligibility can be mailed with your application or dropped off at your local department of social services. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring documents.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- ☐ U.S. passport/card
- ☐ Certificate of Naturalization (DHS Forms N-550 or N-570)
- ☐ Certificate of U.S Citizenship (DHS Forms N-560 or N-561)
- ☐ NYS Enhanced Driver's License (EDL).
- ☐ Native American Tribal Document issued by a Federally Recognized Tribe

When none of the above documents are available, ONE document from the U.S. Citizenship list and ONE from the Identity list may be used to prove your citizenship and /or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

Documents with * next to it also show date of birth

U.S. Citizenship (Provide One)

- ☐ U.S. Birth Certificate*
- ☐ Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- ☐ Report of Birth Abroad (FS-240)
- ☐ U.S. National ID card (Form I-197 or I-179)
- ☐ Religious/School Records*
- ☐ Military record of service showing U.S. place of birth
- ☐ Final adoption decree
- ☐ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

AND

Identity (Provide One)

- ☐ State Driver's license or ID card with photo*
- ☐ ID card issued by a federal, state, or local government agency
- ☐ U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- ☐ School ID card with a photo (may also show date of birth)
- ☐ Certificate of Degree of Indian blood or other American Indian/Alaska Native tribal document with photo
- ☐ Verified School, Nursery or Daycare records (for children under 18) (may also show date of birth)
- ☐ Clinic, Doctor or Hospital records (for children under 18)*

If you do not have one of the documents that show your date of birth, you must also submit one of the following items:

- ☐ Marriage certificate
- ☐ NYS Benefit Identification Card

***Please return all necessary documents by:** ______________________ **or application may be denied.**

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove Immigration Status, Identity and your Date of Birth. You must prove all three.
Documents with * next to it also show date of birth

Immigration Status/Identity

- ☐ I-551 Permanent Resident Card ("Green Card")*
- ☐ I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document

- ☐ I-94 Arrival/Departure Record*
- ☐ USCIS Form I-797 Notice of Action

DOB/Identity, but require an additional immigration status document

- ☐ Visa
- ☐ U.S. Passport

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- ☐ Lease/ letter/ rent receipt with your home address from landlord
- ☐ Utility Bill (gas, electric, phone, cable, fuel or water)
- ☐ Property tax records or mortgage statement
- ☐ Driver's license (if issued in the past 6 months)
- ☐ Government ID card with address
- ☐ Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE SUCH AS UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you.

One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary

- ☐ Paycheck stubs
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Business/payroll records

Self-Employment

- ☐ Current signed and dated income tax return and all Schedules
- ☐ Records of earnings and expenses/ business records

Unemployment Benefits

- ☐ Award letter/certificate
- ☐ Monthly benefit statement from NYS Department of Labor
- ☐ Printout of recipient's account information from the NYS Department of Labor's website (www.labor.ny.gov)
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the NYS Department of Labor

Private Pensions/Annuities

- ☐ Statement from pension/annuity

Social Security

- ☐ Award letter/certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

Workers' Compensation

- ☐ Award letter
- ☐ Check stub

Child Support/Alimony

- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY EPPICard with printout
- ☐ Copy of child support account information from **www.childsupport.ny.gov**
- ☐ Copy of bank statement showing direct deposit

Veterans' Benefits

- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Affairs

Military Pay

- ☐ Award letter
- ☐ Check stub

Income from Rent or Room/Board

- ☐ Letter from roomer, boarder, tenant
- ☐ Check stub

Interest/Dividends/Royalties

- ☐ Recent statement from bank, credit union or financial institution
- ☐ Letter from broker
- ☐ Letter from agent
- ☐ 1099 or tax return (if no other documentation is available)

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or an adult in your family while you work, provide one of the following:

- ☐ Written statement from day care center or other child/adult care provider
- ☐ Canceled checks or receipts that show your payments

If you or your spouse are required to pay court ordered support you must provide the following:

- ☐ Court Order

Proof of health insurance, provide all that apply:

- ☐ Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- ☐ Health Insurance Termination Letter
- ☐ Medicare Card (Red, White and Blue Card)
- ☐ Confirmation of Medicare Application
- ☐ Medicare Award or Denial Letter

If you have medical bills in the last three months, provide all the following (if applicable):

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred, if different from the address listed in Section A of this application
- ☐ Medical bills for last three months, whether or not you paid them

Resources (only if you are age 65 or older, certified blind or disabled and have no children under age 21 living with you):

- ☐ Bank account statements: checking, savings, retirement (IRA and Keogh)
- ☐ Stocks, bonds, certificates statements
- ☐ Copy of Life Insurance policy
- ☐ Copy of burial trust or fund burial plot deed or funeral agreement
- ☐ Deed for real estate other than residence

Proof of Student Status for college students if employed:

- ☐ Copy of schedule
- ☐ Statement from college or university
- ☐ Other correspondence from college showing student status

ACCESS NY HEALTH CARE Medicaid

Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

SECTION A Applicant's Information

Please tell us who you are and how to contact you.

Legal First Name		Middle Initial	Legal Last Name		
Primary Phone # ☐ Home ☐ Cell ☐ Work ☐ Other	Another Phone # ☐ Home ☐ Cell ☐ Work ☐ Other		What Language Do You: Speak? Read?		
HOME ADDRESS of the persons applying for health insurance **SEND PROOF** ☐ Check here if homeless	Street		Apt.#		
	City	State	Zip Code	County	
MAILING ADDRESS of the persons applying for health insurance if different from above.	Street		Apt.#		
	City		State	Zip Code	
OPTIONAL: If there is another person you would like to receive your Medicaid notices, please provide this person's contact information. I want this contact person to:	Name		State		
Check all that apply: ☐ Apply for and/or renew Medicaid for me ☐ Discuss my Medicaid application or case, if needed ☐ Get notices and correspondence	Street		Apt.#	Zip Code	
	City		Phone #	☐ Home ☐ Cell ☐ Work ☐ Other	

Important Notice
Options Available to Applicants Who May Be Blind or Visually Impaired

If you are blind or visually impaired and require information in an alternative format, check the type of mail you want to receive from us. Please return this form with your application.

- ☐ Standard notice and large print notice
- ☐ Standard notice and data CD notice Standard notice and audio CD notice
- ☐ Standard notice and braille notice, if you assert that none of the other alternative formats will be equally effective for you
- ☐ If you require another accommodation, please contact your social services district.

APPLICATIONS FOR BENEFITS ADMINISTERED BY THE NEW YORK STATE MEDICAID PROGRAM (INCLUDING THE MEDICARE SAVINGS PROGRAM AND THE FAMILY PLANNING BENEFIT PROGRAM) ARE AVAILABLE IN LARGE PRINT AND DATA FORMATS. AUDIO AND BRAILLE VERSIONS OF THE APPLICATIONS ARE AVAILABLE FOR INFORMATIONAL PURPOSES ONLY.

SECTION B Family Information

If you live in the family, start with yourself. If you do not, start with any adults who live in the family. List the full legal names of the persons applying for or already receiving Medicaid **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for family members including: parents, step-parents, and spouses. You may provide information for other family members (for example, a dependent child under the age of 21). **Listing other family members may allow us to give you a higher eligibility level. Applicants who are pregnant or under age 19 may be eligible for insurance regardless of immigration status.** New York State ensures your right to access State benefits and/or services regardless of your sex, gender identity, or expression. If you would like to provide us with how you or your household members currently identify, please also select gender identity.

		Date of Birth **SEND PROOF** *Sex	**Gender Identity (optional)	Is this person applying for health insurance?	Is this person pregnant?	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. **SEND PROOF**	†Race/ Ethnic Group	††Received a service from the IHS, or other Indian Health Program?
1	Legal First, Middle, Last Name This person's birth name before they were married City State of Birth Country of Birth	__/__/____ ☐ Male ☐ Female	☐ Male ☐ Female ☐ Non-Binary/ Non-Conforming ☐ X ☐ Transgender ☐ Different Identity Describe your identity (optional).	☐ Yes ☐ No	☐ Yes ☐ No What is the due date? __/__/__	☐ Yes ☐ No	SELF	☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/______ MM DD YYYY ☐ Non-immigrant (Visa holder) ☐ None of the above		☐ Yes ☐ No
2	Legal First, Middle, Last Name This person's birth name before they were married City State of Birth Country of Birth	__/__/____ ☐ Male ☐ Female	☐ Male ☐ Female ☐ Non-Binary/ Non-Conforming ☐ X ☐ Transgender ☐ Different Identity Describe your identity (optional).	☐ Yes ☐ No	☐ Yes ☐ No What is the due date? __/__/__	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/______ MM DD YYYY ☐ Non-immigrant (Visa holder) ☐ None of the above		☐ Yes ☐ No

SEND PROOF Refer to the "Documents Needed When You Apply for Health Insurance" on pages 4-6, for a list of documents that prove Identity, Citizenship or Immigration Status.

*Sex: The sex you report here must be the same as what is currently on file with the Social Security Administration. The sex you report here is for our computer system's use only and will not appear on your benefit card or any other public-facing document. This is needed to process your application. If you identify differently you can add that information in the Gender Identity field provided.

**Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

†Race/Ethnic Group Codes (optional): **A** - Asian, **B** - Black or African-American, **I**- American Indian or Alaska Native, **P** - Native Hawaiian or other Pacific Islander, **W** - White, **U** - Unknown. Please also tell us if you are Hispanic or Latino - **H.**

††Have you ever received a service from the Indian Health Service (IHS), a Tribal Health Program, an Urban Indian Health Program or through a referral from IHS or one of these programs?

SECTION B | Family Information

Continued from previous page

	Date of Birth SEND PROOF *Sex	**Gender Identity (optional)	Is this person applying for health insurance?	Is this person pregnant?	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. SEND PROOF	†Race/ Ethnic Group	††Received a service from the IHS, or other Indian Health Program?
3 Legal First, Middle, Last Name This person's birth name before they were married City State of Birth Country of Birth	__/__/____ ☐ Male ☐ Female	☐ Male ☐ Female ☐ Non-Binary/ Non-Conforming ☐ X ☐ Transgender ☐ Different Identity Describe your identity (optional).	☐ Yes ☐ No	☐ Yes ☐ No What is the due date? __/__/__	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/______ MM DD YYYY ☐ Non-immigrant (Visa holder) ☐ None of the above		☐ Yes ☐ No
4 Legal First, Middle, Last Name This person's birth name before they were married City State of Birth Country of Birth	__/__/____ ☐ Male ☐ Female	☐ Male ☐ Female ☐ Non-Binary/ Non-Conforming ☐ X ☐ Transgender ☐ Different Identity Describe your identity (optional).	☐ Yes ☐ No	☐ Yes ☐ No What is the due date? __/__/__	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/______ MM DD YYYY ☐ Non-immigrant (Visa holder) ☐ None of the above		☐ Yes ☐ No
5 Legal First, Middle, Last Name This person's birth name before they were married City State of Birth Country of Birth	__/__/____ ☐ Male ☐ Female	☐ Male ☐ Female ☐ Non-Binary/ Non-Conforming ☐ X ☐ Transgender ☐ Different Identity Describe your identity (optional).	☐ Yes ☐ No	☐ Yes ☐ No What is the due date? __/__/__	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/______ MM DD YYYY ☐ Non-immigrant (Visa holder) ☐ None of the above		☐ Yes ☐ No

Is anyone in your household a veteran? ☐ Yes ☐ No If yes, name: ____________________

SEND PROOF Refer to the "Documents Needed When You Apply for Health Insurance" on pages 4-6, for a list of documents that prove Identity, Citizenship or Immigration Status.

*Sex: The sex you report here must be the same as what is currently on file with the Social Security Administration. The sex you report here is for our computer system's use only and will not appear on your benefit card or any other public-facing document. This is needed to process your application. If you identify differently you can add that information in the Gender Identity field provided.

**Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

†Race/Ethnic Group Codes (optional): **A** - Asian, **B** - Black or African-American, **I**- American Indian or Alaska Native, **P** - Native Hawaiian or other Pacific Islander, **W** - White, **U** - Unknown. Please also tell us if you are Hispanic or Latino - **H.**

††Have you ever received a service from the Indian Health Service (IHS), a Tribal Health Program, an Urban Indian Health Program or through a referral from IHS or one of these programs?

SECTION C | Family Income

Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

Earnings from Work: Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed, check here: ☐ If no earnings from work, check here: ☐

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (weekly, monthly)

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. If no unearned income, check here: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Contributions: Money from relations or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). If no contributions, check here: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Other: Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. If none, check here: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

If you or any applying adult in Section B does not have income, tell us who?

1. If there is no income listed above, please explain how you are living: (For example: living with friend or relative)
2. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? ☐ No ☐ Yes
   If yes: Your last job was: Date / / Name of Employer:
3. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? ☐ No ☐ Yes
   If yes: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate Name of Student: ____________________
4. Do you have to pay for childcare (or for the care of a disabled adult) in order to work or go to school? ☐ No ☐ Yes

   Child's/Adult's Name: How Much? $ How Often? (weekly, every two weeks, monthly)

   Child's/Adult's Name: How Much? $ How Often? (weekly, every two weeks, monthly)

   Child's/Adult's Name: How Much? $ How Often? (weekly, every two weeks, monthly)
5. If you are not eligible for Medicaid coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? ☐ No ☐ Yes
6. Are you or your spouse / other parent required to pay court ordered support? ☐ No ☐ Yes Who How Much? $

SECTION D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? **SEND PROOF** ☐ No ☐ Yes

   If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary. Complete the rest of this application and complete Supplement A.

   If no, and you have Chronic Renal Failure (End Stage Renal Disease/ESRD) or Amyotrophic Lateral Sclerosis (ALS),or you are 65 years of age or older, or turning age 65 within three months, and do not have Medicare, you must apply for Medicare and show proof of application. Some people are required to apply for MEDICARE as a condition of eligibility for Medicaid. Please reference pages 2 and 3 (Section G) for additional information regarding eligibility requirements.

Note: If you are applying for the Medicare Savings Program (MSP) only, go to Section G. You do NOT need to complete Supplement A.

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? **SEND PROOF** ☐ No ☐ Yes

   If yes, you must send a copy of the front and back of the insurance card with this application.

   Name of Insured (primary):

   Persons Covered:

   Cost of Policy:

   End date of coverage, if ending soon ____ / ____ / ____ (Month / Day / Year)

3. Does your current job offer health insurance? **We may be able to help pay for it.** ☐ No ☐ Yes

   If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

SECTION E Housing Expenses

1. Monthly housing payment such as rent or mortgage, including property taxes (just your share) $

2. If you pay for water separately how much do you pay? $ **SEND PROOF**

   How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

3. Do you receive free housing as part of your pay? ☐ No ☐ Yes

SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G.

1. Are you, or anyone who lives with you and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution? ☐ No ☐ Yes

   If yes, finish completing this application AND complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? ☐ No ☐ Yes

   If yes, finish completing this application AND complete Supplement A.

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

SECTION G | Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you. ☐ No ☐ Yes
   If yes, name:
   In which month(s) of the previous three months do you have medical bills?

SEND PROOF **of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☐ No ☐ Yes
   If yes, who?
   Which state?
   Which county?

4. Does anyone who is applying have a pending lawsuit due to an injury? ☐ No ☐ Yes If yes, who?

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☐ No ☐ Yes If yes, who?

SECTION H | Parent or Spouse Not Living in the Family or Deceased

Pregnant applicants and families who are applying only for their children are NOT required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? (If spouse or parent is deceased go to question 3.) ☐ No ☐ Yes If yes, name of applicant with deceased parent or spouse

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☐ No ☐ Yes
   If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐.

Child's Name:	**Name of parent living outside the home**	**Current or last known address:**	
		Street:	City/State:
	Date of Birth (if known): / /	SSN (if known):	
Child's Name:	**Name of parent living outside the home**	**Current or last known address:**	
		Street:	City/State:
	Date of Birth (if known): / /	SSN (if known):	

3. Is anyone applying still married to someone who lives outside the home? ☐ No ☐ Yes If yes, name of person applying who is still married:
   If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

Legal name of spouse living outside of the home:		**Current or last known address:**	
		Street:	City/State:
	Date of Birth (if known): / /	SSN (if known):	

SECTION I | Health Plan Selection

These questions help us determine which program is best for the applicants

If you are in receipt of Medicare, STOP skip this section.

IMPORTANT: Most people with Medicaid must choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call New York Medicaid CHOICE at 1-800-505-5678. You can also call or visit your local department of social services. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose. If you are an American Indian/Alaska Native you are not required to join a health plan; you can tell us you do not want to be in a health plan by calling or writing to your local department of social services or by checking this box ☐.

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

SECTION J | Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, the health plans indicated in Section I, the local department of social services, and the organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, or to evaluate the success of these programs. Each applying adult must sign this application in the space below.

I have read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page. I certify under penalty of perjury that everything on this application is the truth as best I know.

Date ____________ Signature of adult applicant or authorized representative for the applicant

Date ____________ Signature of adult applicant or authorized representative for the applicant

Health Care Proxy

The New York Health Care Proxy Law allows you to choose someone you trust to make health care decisions for you if you can't make them for yourself. This person is called a health care agent. You can learn more about the New York State Health Care Proxy Law and get the form for a health care agent (proxy form) on the New York State Department of Health website at: www.health.ny.gov/professionals/patients/health_care_proxy

To get a copy of the form mailed to you, call the New York State Medicaid Help Line at 1-800-541-2831.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid. I understand that this application and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the local department of social services. The local department of social services may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs, for which family members or I have applied, may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- I understand that Medicaid, will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.
- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for Medicaid will not be affected by my race, color, or national origin. I also understand that depending on the requirements of the program, my age, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid, they can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

Social Security Number (SSNs)

SSNs are required for all applicants, unless the person is a non-qualified non-citizen. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are not required for members of my family who are not applying for benefits. If my eligibility depends on the amount of resources owned by my spouse, resources can be verified if my spouse's SSN is provided. SSNs are used in many ways, both within local department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for their child(ren), to see if applicants can get medical support, to see if applicants can get money or other help, and to verify resources for applicants and their non-applying spouse. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

For Medicaid Applicants Only

- Release of Educational Records
  I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- Early Intervention Program
  If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.
- Reimbursement of Medical Expenses
  I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application and ending on the date I receive my Medicaid benefit card (Common Benefit Identification Card (CBIC)), I understand that reimbursement of medically necessary covered medical care, services and supplies will **only** be available if obtained from Medicaid enrolled providers and that reimbursement is limited to no more than the Medicaid rate or fee in effect at the time of service, even if I paid more. I understand that once I receive my Medicaid (CBIC) benefit card, I must visit only Medicaid enrolled providers or network providers of my Medicaid managed care plan to obtain covered care and services, that my provider must submit a claim to Medicaid or my Medicaid managed care plan to be paid for medically necessary services and that no reimbursement will be made for expenses I incur after that date and pay for myself.

Medicaid Managed Care

I have read how to find out what Medicaid managed care health plans are available to me in my county. I understand that if I, and any members of my family who are applying, are found eligible for Medicaid and are required to be in a managed care health plan, I and any eligible family members who applied, will be enrolled in the health plan I choose.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I understand that in Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in.

Release of Medical Information

I consent to the release of any medical information about me and any members of my family for whom I can give consent:

- By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid programs; and
- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

Notice of Nondiscrimination Policy

The New York Medicaid program complies with applicable Federal civil rights laws and state laws and does not discriminate on the basis of race, color, national origin, creed/religion, sex, age, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

If you believe that the New York Medicaid program has discriminated against you, you may file a complaint by going to: http://www.health.ny.gov/regulations/discrimination_complaints/ or, by emailing the Diversity Management Office at DMO@health.ny.gov.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

Accommodations

The New York Medicaid program provides free aid and services to people with disabilities to communicate effectively with us,
such as:

- TTY through NY Relay Service
- If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), and you reside in a county outside of New York City, please call your local department of social services. If you reside in the five boroughs of New York City, please call the Human Resources Administration's Office of Constituent Services at 212-331-4640. Or tell us in Section A on page 1 of this application.

The NY Medicaid Program also provides free language assistance services to people whose primary language is not English such as:

- Qualified interpreters
- Written information in other languages

If you need these services or for more information on Reasonable Accommodations, and you reside in a county outside of New York City, please call your local department of social services. If you reside in the five boroughs of New York City, please call the Human Resources Administration's Office of Constituent Services at 212-331-4640.

For Office Use Only

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information:	Employed By: (check one) ☐ Health Plan ☐ Local Department of Social Services ☐ Provider Agency ☐ Qualified Entities
X	Employer Name:

To be used by the local social services district

Eligibility Determined By:		Date:	Eligibility Approved By:	Date:
Center Office:		Application Date:	Unit ID:	Worker ID:
Case Name:	District:	Case Type:		Case #:
Effective Date:	MA Disposition Reason Code ☐ Denial Code ☐ Withdrawal Code	Proxy: ☐ No ☐ Yes	Registry #:	Ver:

Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care. This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through E must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections F through G.

A. Applicant and Spouse Information

1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

Is a person named above:

- Chronically ill? ☐ Yes ☐ No
  (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

- Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
  (If yes, send proof.)

- Interested in applying for the MBI-WPD program if disabled and working? ☐ Yes ☐ No
  The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code

2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		

City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home? ☐ Yes ☐ No

If **yes**, provide the following information:

Name of Facility		Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code

Is the applicant's spouse deceased? ☐ Yes ☐ No If **yes**, what is the date of death? _____ / _____ / _____

B. What Care and Services are you Applying for? (check the box that applies)

☐ **You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ **You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

This coverage includes the following services:*

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

☐ **You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

*You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care,** provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

You do not need to send proof of any other resources at this time. This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

C. Resources/Assets

INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the **"NONE"** box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care,** also list any accounts CLOSED in the **past 60 months;** include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more.
  Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): ☐ **NONE**

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): ☐ **NONE**

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$

3. Annuities, Stocks, Bonds, Mutual Funds: ☐ **NONE**

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$

4. Life Insurance Policies: ☐ NONE

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies: Date Cancelled	Cancelled Policies: Cash Out Value
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$

5. Burial Assets/Burial Contracts: (Include copies): ☐ NONE

a. Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

b. Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

c. Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes,** in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

d. Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? ______________________

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

e. Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? ______________________

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. ☐ NONE

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$
			$		$

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. ☐ NONE

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /

8. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

D. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No

2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No

   If **no,** is anyone living in the home? ☐ Yes ☐ No

   Who is living in the home? ___________________________

   How is this person related to you and/or your spouse? ___________________________

   If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

   Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility. **Send proof of legal impediment.**

3. Equity Value in Home:
   If you own your home, what is the equity value in your home? $ ___________________
   Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights (In or outside of New York State)

If **yes**, provide the following information:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.

F. Asset Transfers

1. Transfers

a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to either of the questions above, explain the transfer(s) below.
Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

c. Are you in the process of selling property? ☐ Yes ☐ No

d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No

If **yes,** when? ______________________________

e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No

If **yes,** when? ______________________________

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No

If **yes,** when? ______________________________

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? ☐ Yes ☐ No

If yes, send copy of agreement.

G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No

If yes, send complete copies of these returns including all schedules and attachments.

H. Important Information

Liens on Real Property

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

Annuities

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I. Certification and Authorization

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X ______________________________
SIGNATURE OF APPLICANT/REPRESENTATIVE

X ______________________________
DATE SIGNED

X ______________________________
SIGNATURE OF APPLICANT'S SPOUSE

X ______________________________
DATE SIGNED