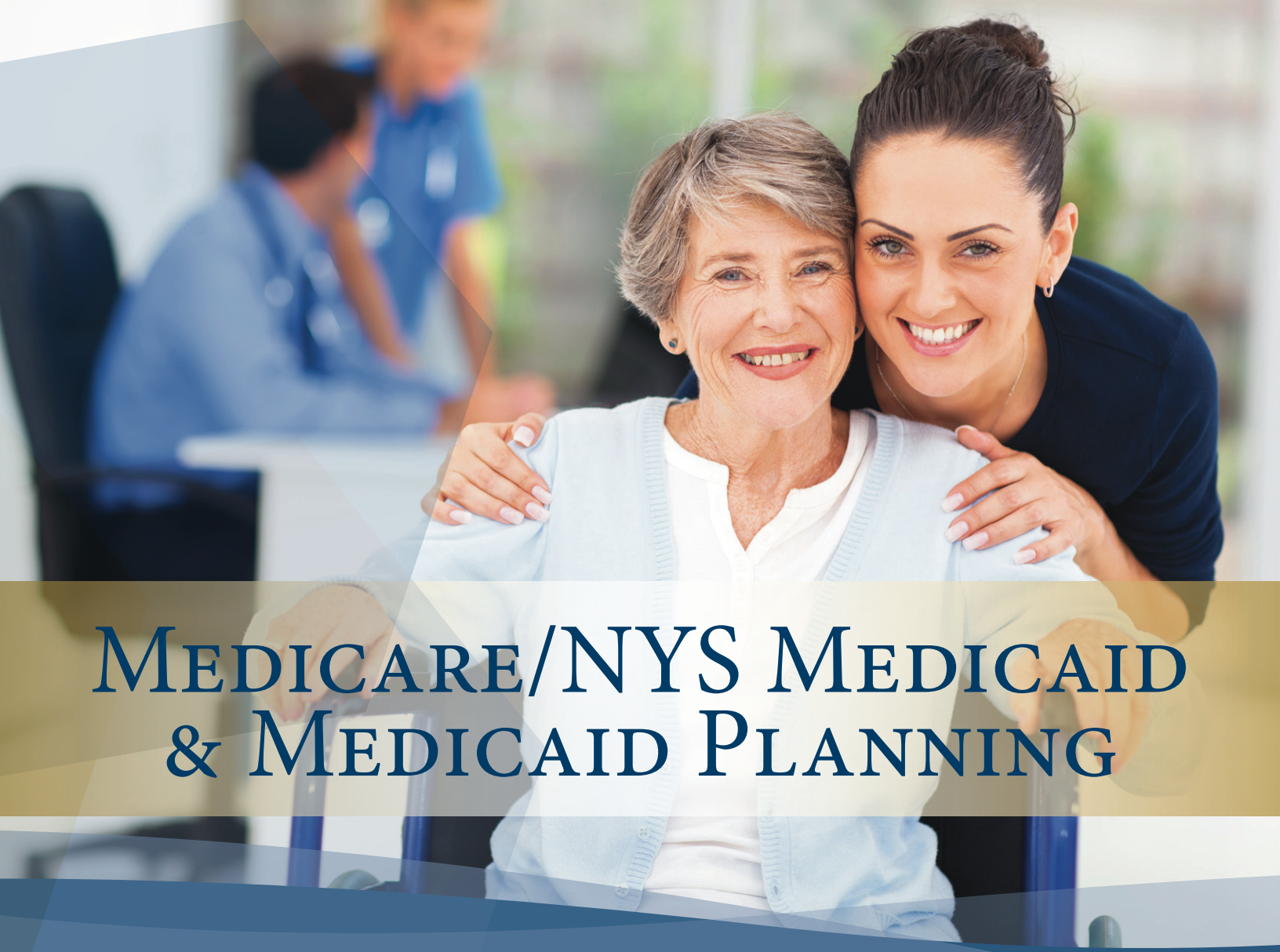

Medicare/NYS Medicaid & Medicaid Planning

Russo Law Group, P.C.

Estate Planning, Elder Law & Special Needs

"Our Experience is Your Protection"

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Elder Law, Special Needs & Estate Planning

Law Firm

January 2021

GUIDE TO GOVERNMENT BENEFITS
(Medicare/NYS Medicaid) and Medicaid Planning

This guide will provide a basic outline and ready reference guide of health care benefit programs, specifically Medicare and Medicaid in New York State. These governmental programs are available to various individuals including seniors, individuals with special needs and the financially needy subject to certain eligibility requirements and are in need of medical assistance.

The information provided in this guide is for reference purposes only. Consult with your attorney before undertaking any planning steps.

MEDICARE

MEDICARE is a federal health insurance program primarily for individuals who are age 65 or older, or in receipt of Social Security disability benefits for more than two (2) years. Individuals with end stage renal failure and ALS may be able to access Medicare benefits on an expedited basis.

PART A SERVICES

(a) Hospital Care: Medicare will cover 90 days a year for a single spell of illness, plus a 60 day lifetime reserve. There will be a deductible of $1,484 for each spell of illness and co-payments for days 61-90 for each spell of illness in the amount of $371 per day. The co-payment for days 91-150 is $742 per day.

(b) Nursing Home Care: There is a 3-day hospitalization requirement for 100 days of skilled nursing coverage per spell of illness. Days 1-20 are paid in full by Medicare; there is also a co-payment for days 21-100 in the amount of $185.50 per day.

(c) Home Health Care: Includes nursing care, home health aides, physical and occupational therapy, medical supplies and durable medical equipment.

Short-term home care may be covered by the Medicare Program provided that all of the following conditions are met:

(i) the services are ordered by and included in the plan of treatment established by the physician for the patient;

(ii) the services are required on an intermittent or part time basis;

(iii) the services must require the skills of a registered nurse (R.N.) or the services of a licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) and under the supervision of a R.N., or a home health aide.

If "skilled nursing care" is not required, Medicare <u>will</u> <u>not</u> provide coverage.

(a) <u>Hospice</u>: Part A covers hospice care for Medicare beneficiaries who are terminally ill and who are diagnosed as having a life expectancy of six months or less. Most services provided by a hospice are covered, including the services of doctors and prescription drugs. Hospice coverage is in lieu of all other Medicare benefits. There is no deductible or co-insurance.

(b) <u>Medicare Part A Buy-In</u>: The buy-in *monthly* premium for those persons not eligible for social security is $471 (less than 30 quarters of covered employment). The buy-in monthly premium with 30 quarters (but less than 40 quarters) is $259. There is no monthly premium buy-in for those with forty (40) quarters or more of covered employment.

NOTE: The above provisions reflect the amounts as of January 1, 2021.

PART B SERVICES

(a) Physician's Services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc. There is a $203 deductible per year and a 20 percent co-payment of the Medicare-approved charge.

(b) Clinical Laboratory Services such as blood tests.

(c) Home Health Care services if medically necessary for skilled care.

(d) Outpatient Hospital Treatment - unlimited benefit if medically necessary.

(e) Blood. There is a 3 pint deductible.

(f) The Medicare Part B monthly premium for new recipients is $148.50.*

NOTE: The above provisions reflect the amounts as of January 1, 2021.

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* Single beneficiaries with income over $88,000 and married beneficiaries with income over $176,000 will pay a higher premium. Monthly Part B premiums for high income beneficiaries will range from $207.90 to $504.90.

DENIAL OF MEDICARE - APPEAL RIGHTS

In the event there is a determination that one is not eligible for Medicare benefits, then there is a legal right to appeal that determination. There are time limitations on the right to appeal.

MEDICAID
(Under New York State Law)

MEDICAID is a joint federal and state program and the program and benefits vary state to state. Medicaid is subject to asset and income eligibility standards. Medicaid covers long-term care ("custodial care") which is not covered under Medicare or Medicare Supplemental Insurance. Absent Medicaid eligibility, long-term care must be paid for from your assets and income. Once eligible, Medicaid, as a payer of last resort, will pay for all unpaid expenses related to ongoing long-term care. Attached is a summary of the Medicaid program for a single individual.

WHO CAN QUALIFY? The aged (65 or older), as well as blind or disabled individuals, or children under age 21, who meet the income and resource Medicaid eligibility requirements may qualify for Medicaid. Others (including SSI recipients) may qualify by meeting the public assistance standards of eligibility.

ELIGIBILITY. The general requirements are as follows: the Medicaid applicant is allowed to have non-exempt assets up to $15,900 and a separate bank account known as a burial fund of up to $1,500, or life insurance with a face value up to $1,500. If the face value of the insurance is higher, then the actual cash value will be considered as an available resource.

In addition to the burial fund, burial space is also exempt. Burial spaces include, but are not limited to: a combination of such things as conventional grave sites, crypts, vaults, mausoleums, urns, caskets, and/or other repositories which are customarily and traditionally used for the remains of deceased persons. Headstones and any engravings, the cost of opening and closing the grave, plus perpetual care are considered part of a burial space.

Household furnishings and appliances of a homestead and one automobile are also exempt for purposes of Medicaid eligibility.

Homestead. In New York, a homestead with equity of $906,000 (for 2021) or less is exempt for purposes of Medicaid eligibility, as long as the residence qualifies as a "homestead". A "homestead" is defined as the primary residence occupied by a Medicaid applicant or his/her spouse, or his/her minor, certified blind or certified disabled child. Please note that a homestead may not be exempt from a recovery by the State upon the Medicaid recipient's demise. The new equity limit is only applicable for nursing home Medicaid benefits subject to several exceptions.

Joint Accounts. The Department of Social Services ("DSS") will treat assets held jointly as 100% owned by the Medicaid applicant. Proof that the joint owner contributed all or part of the joint account may overcome the presumption by Medicaid.

Revocable Trusts. Revocable Living Trusts of the applicant and applicant's spouse will be considered an available resource for purposes of Medicaid eligibility.

Irrevocable Trusts. Certain Irrevocable Trusts will be considered an available resource. A properly drafted Irrevocable Trust will not be considered an available resource for purposes of Medicaid eligibility. Transfers to Irrevocable Trusts are subject to the sixty (60) month look-back and penalty transfer rules.

COMMUNITY BASED HOME CARE (NON-WAIVERED ASSISTANCE)

(a) Transfer Penalty Rule. There is no transfer of assets penalty for community based home care. New York State has the option to adopt a penalty period in the future. Also, please note that if you transfer your assets and receive home care under Medicaid, and then later you require nursing home care, you will need to apply for benefits under the nursing home program. Any asset transfers will be subject to the nursing home look-back and transfer penalty rules then in place.

(b) Monthly Budget. The Medicaid recipient is entitled to retain income of $884 per month, plus $20 if he or she is 65 or older. The income budget number is not a cap. If the Medicaid recipient has income over the budget amount, he/she must spend down any excess income on unpaid medical expenses or to a qualified pooled income trust (see (d) below).

(c) Spousal Allowance. In New York, a community spouse (the spouse of the non- Medicaid applicant spouse) will be able to retain a certain level of resources and monthly income. The Community Spouse Resource Allowance (CSRA) is a minimum of $74,820 and a maximum of $130,380 (in 2021), depending upon the combined value of both spouses' assets. The community spouse's maximum monthly income allowance is $3,259.50 (in 2021). If the community spouse has less than $3,259.50 in monthly income, then the community spouse is entitled to a contribution from the income of the ill spouse to bring his or her income up to $3,259.50 per month.

(d) Pooled Income Trust. If the Medicaid applicant has monthly income in excess of the amount allowed ("excess monthly income"), the excess monthly income can be transferred to a Pooled Income Trust account for the benefit of the Medicaid applicant without a spend down of the excess monthly income. The use of this Trust for married couples is in flux and

you should seek clarification from one of our attorneys before establishing a Pooled Income Trust.

NURSING HOME CARE

(a) Transfer Penalty Rule. The transfer penalty rule is used to determine the period of time that someone will be denied Medicaid nursing home benefits as a result of giving assets away. There is no cap on the transfer of assets penalty as to Nursing Home Care under Medicaid.

If assets are transferred for less than full value, the Medicaid applicant/transferor may be ineligible for nursing home services under Medicaid for a period equal to the uncompensated value of the resource transferred, divided by the average regional monthly cost of a nursing home to a private pay resident. The average regional monthly cost in Nassau/Suffolk is $13,834 per month and in New York City is $13,037 per month and (in 2021). These amounts are revised annually by New York State. The penalty period will start to run as of the applicable transfer penalty start date for that transfer.

(c) Transfer Penalty Start Date. For transfers made on or after February 8, 2006, the start date of the transfer penalty is subject to very complex rules. Under the DRA rules, the penalty will begin to run when you are receiving long-term care in a nursing home, are "otherwise eligible" but for any transfers subject to a transfer penalty and file a Medicaid application.

(d) Spousal Transfer Exception. There is no transfer penalty for transfers (i.e., gifts) between spouses. A Medicaid applicant will not be denied Medicaid benefits as a result of transfers to his/her spouse.

However, if a spouse makes a transfer to a third party** during the look-back period, then the transfer will be considered a transfer by the Medicaid recipient spouse for Medicaid nursing home eligibility purposes.

(e) Certified Blind or Disabled Child Transfer Exception. There is no transfer penalty for transfers by a Medicaid applicant to his/her certified blind or disabled adult child. Transfers to a trust for the sole benefit of a disabled child will be exempt for purposes of the transfer penalty. Due to the complexity of these rules, the impact of any transfer on the child's benefits should be scrutinized, prior to implementation.

(f) Homestead Transfer Exception. A "Homestead" can be transferred without penalty to: a spouse; a child under the age of 21; a disabled child; a caregiver child who has resided with the parent for at least two years prior

** Subject to certain limited exceptions.

to the transfer; or a sibling of the owner who has lived with the owner for at least one year prior to the transfer and has an "equity interest" in the home.

(g) Trust Exception. Subject to certain requirements, there is no transfer penalty for transfers by a Medicaid applicant to a Special Needs Trust for a disabled individual under age 65, or to a Pooled Trust.

(h) Monthly Budget. Subject to spousal allowances, the Medicaid recipient must first use his/her own monthly income, less $50 per month, to pay for nursing home care; the unpaid balance will be paid by Medicaid.

(i) Spousal Allowances. In New York, a community spouse will be able to retain a certain level of resources and monthly income. The Community Spouse Resource Allowance (CSRA) is a minimum of $74,820 and a maximum of $130,380, depending upon the combined value of both spouses' assets. The community spouse's maximum monthly income allowance is $3,259.50. If the community spouse has less than $3,259.50 in monthly income, then the community spouse is entitled to a contribution from the income of the ill spouse to bring their income up to $3,259.50 per month.

NOTE: The above provisions reflect the amounts as of January 1, 2021.

(j) Spousal Refusal. The resources and income of a community spouse in excess of the spousal allowances will be deemed available to the Medicaid applicant spouse. If the community spouse has monthly income in excess of $3,259.50 and/or resources greater than the Community Spouse Resource Allowance, a spousal refusal must be filed or Medicaid will be denied. The law allows the community spouse to refuse to contribute excess resources and/or income to the Medicaid applicant spouse. This is known as "spousal refusal". In such event, said resources and/or income shall not be deemed available to the Medicaid applicant spouse for purposes of Medicaid eligibility, but may still subject the refusing spouse to a lawsuit as referred to above. The Department of Social Services ("DSS") has taken the position that it has the right, on behalf of the spouse residing in a nursing facility, to sue the community spouse for support and may also commence an action to seek the support.

SUBMISSION OF MEDICAID APPLICATION

Prior to filing a Medicaid application, you should contact us to review your situation as the Medicaid eligibility rules are very complex and any deviation may result in a determination of ineligibility.

ESTATE RECOVERY

New York State has the right to recover against the estate of a Medicaid recipient for Medicaid provided for the ten years prior to the recipient's death on or after the recipient attained age fifty-five (55), with certain exceptions.

Take steps now to protect your assets and preserve your dignity. Contact us for a planning meeting today!

Russo Law Group, P.C. advocates for and represents seniors and people with special needs and their families. Call us at (516) 683-1717 or visit us at www.VJRussoLaw.com for more information.

This guide including the Medicaid summary charts are merely informational and not legal advice. This guide was published in January 2021. The above information is based upon 2021 benefits and changes, unless otherwise stated. You should contact us for any changes or updates in the law. Future changes in law may render the above information inaccurate. If you have any questions regarding this guide or desire advice as to long-term care planning, please do not hesitate to call RUSSO LAW GROUP, P.C. at (516) 683-1717 or visit us at www.VJRussoLaw.com.

This guide is not a substitute for legal counsel.

MEDICAID SUMMARY
For a Single Individual (Age 65 or older)

	HOME CARE	NURSING HOME CARE
RESOURCES	1. $15,900 2. $1,500 Burial Fund or life insurance 3. Prepaid funeral expense 4. Residence exempt (with certain exceptions)	1. $15,900 2. $1,500 Burial Fund or life insurance 3. Prepaid funeral expense 4. Residence *IS NOT* exempt (subject to exceptions)
TRANSFERS	Transfer Penalty 30 month look-back for transfers to a Trust and transfers on or after October 1, 2020 for Home Care (Transfer Amount ÷ Average Regional Rate = # of months penalized) 2021 Regional Rates: $13,834 Long Island $13,037 New York City	Transfer Penalty* 60 month look-back for transfers to a Trust and transfers on or after February 8, 2006 for Nursing Home Care (Transfer Amount ÷ Average Regional Rate = # of months penalized) 2021 Regional Rates: $13,834 Long Island $13,037 New York City
MONTHLY INCOME BUDGET	1. Allowance of $884 plus $20 income exemption if 65 or older (as of 2021) 2. Excess to be applied to cost of medical care	1. $50 per month personal incidental allowance, set aside from income 2. Excess income to be paid to facility
SERVICES	Subject to individual needs assessment.	All services covered.

* The transfer penalty start date is subject to the rules under the Deficit Reduction Act of 2005.

NOTE: This chart is based on Medicaid law as of January 2021 and is for informational purposes only, and is not intended to be used as a source of legal advice. Since legal principles vary substantially in individual cases and in accordance with local laws and practice, it is recommended that you consult with Russo Law Group, P.C.

MEDICAID ELIGIBILITY - FOR HOME CARE
For a Married Couple
One Spouse Requiring Home Care (Age 65 or older)

	SPOUSE REQUIRING HOME CARE	**NON MEDICAID APPLICANT SPOUSE**
RESOURCES	1. $15,900 2. $1,500 Burial Fund or life insurance 3. Prepaid funeral expense 4. Residence Exempt (with certain exceptions)	1. Resource Allowance: $74,820 to $130,380 3. Spousal Refusal is necessary if assets exceed above level.
TRANSFERS by either spouse	30 month look-back for transfers to a Trust and transfers on or after October 1, 2020 for Home Care (Transfer Amount ÷ Average Regional Rate = # of months penalized) 2021 Regional Rates: $13,834 Long Island $13,037 New York City	30 month look-back for transfers to a Trust and transfers on or after October 1, 2020 for Home Care (Transfer Amount ÷ Average Regional Rate = # of months penalized) 2021 Regional Rates: $13,834 Long Island $13,037 New York City A transfer by the Non-Medicaid Applicant Spouse will subject the Medicaid Applicant Spouse to a transfer penalty
MONTHLY INCOME BUDGET	1. Allowance of $884 plus $20 income exemption if 65 or older (as of 2021). 2. Excess to be applied to cost of Medical care. 3. Pooled Income Trust can protect excess monthly income.	1. $3,259.50 per month – Spouse entitled to contribution from Medicaid applicant to bring income up to $3,259.50 per month (2021). 2. Spousal Refusal necessary if income exceeds above level.
SERVICES	Subject to individual needs assessment.	Not Applicable

NOTE: This chart is based on Medicaid law as of January 2021, and is for informational purposes only, and is not intended to be used as a source of legal advice. Since legal principles vary substantially in individual cases and in accordance with local laws and practice, it is recommended that you consult with Russo Law Group, P.C.

MEDICAID ELIGIBILITY - NURSING HOME CARE
For a Married Couple
One Spouse Requiring Nursing Home Care

	INSTITUTIONAL SPOUSE	COMMUNITY SPOUSE
RESOURCES	1. $15,900 2. $1,500 Burial Fund or life insurance 3. Prepaid funeral expense	1. Resource Allowance: $74,820 to $130,380 2. Residence exempt 3. Spousal Refusal necessary if assets exceed above level
TRANSFER PENALTY by either spouse 60 month look-back for transfers on or after February 8, 2006	**TRANSFER PENALTY** Transfer Amount ÷ Average Regional Rate = # of months penalized <u>2021 Regional Rates:</u> $13,834 Long Island $13,037 New York City The transfer penalty start date is subject to the rules under Deficit Reduction Act of 2005.	**TRANSFER PENALTY** Transfer Amount ÷ Average Regional Rate = # of months penalized <u>2021 Regional Rates:</u> $13,834 Long Island $13,037 New York City The transfer penalty start date is subject to the rules under Deficit Reduction Act of 2005. A transfer by the Community Spouse will subject the Institutionalized Spouse to a transfer penalty
TRANSFER between spouses	No transfer penalty	Consult your attorney regarding Spousal Allowances
MONTHLY INCOME BUDGET	1. $50 per month personal incidental allowance 2. Excess income to nursing home- unless community spouse is below $3,259.50 (2021).	$3,259.50 per month- Spouse entitled to contribution from Medicaid applicant to bring income up to $3,259.50 per month (2021). Spousal Refusal necessary if income exceeds above level
SERVICES	All services covered	Not Applicable

NOTE: This chart is based on Medicaid law as of January 2021, and is for informational purposes only, and is not intended to be used as a source of legal advice. Since legal principles vary substantially in individual cases and in accordance with local laws and practice, it is recommended that you consult with Russo Law Group, P.C.

DOCUMENTS REQUIRED FOR DETERMINATION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

The following documents, if applicable, are required for the applicant and spouse and any minor children under the age of 21.

A. Proof of identity and family relationships:

____ Social Security card or verification of number from the Social Security Administration

____ United States Birth or Baptismal Certificate or for those family members not born in the U.S.A.:

a. Certificate of Naturalization
b. United States Passport and/or Visa
c. Alien registration card

____ Military Discharge Papers
____ Marriage Certificate
____ Death Certificate of Spouse
____ Copy of prepaid funeral contract
____ Deed to Burial Plot

B. Health Insurance (copies of front and back of cards)

____ Medicare Card
____ Health Insurance Card
____ Verification of Health Insurance premiums

C. Residency and Living arrangement

____ Rent Receipt and/or lease
____ verification of Rental Income
____ 2 Utility Bills (most current)
____ Mortgage statement; property and school tax bills (most current)
____ 2 letters of residence, from other than relative, stating length of time at given address
____ Letter from person(s) you live with verifying that they supply room and board

D. Income

____ Pay Stubs for previous eight (8) weeks, if any
____ Statement of rental and/or room and board income
____ Support payments - divorce or separation papers
____ Award letter and/or photocopy of check stub for the following:

a. Social Security (Call 1-800-772-1213 or visit ssa.gov)
b. Railroad retirement, if applicable
c. Veterans
d. Pensions (letter showing gross and net pension on letterhead of union or employee benefits department)
e. Insurance endowments
f. N.Y.S. disability
g. Worker's Compensation

____ If self-employed; business book and records
____ Income tax returns (for the tax years of 20__ - 20__) or verification of non-filing from the IRS

E. Resources

____ Bank book(s) (including IRA, CD and money market accounts) for the past ___ months from _____, 20___ through current/closing (with documentation for all deposits and copies of all checks for $1,000 or more) through current/closing (and ongoing statements as they come in).
____ Bank/Checking account(s) – copies of all statements for the past ___ months from _____, 20___ (with documentation for all deposits and copies of all checks for $1,000 or more) through current/closing (and ongoing statements as they come in).
____ Trust Account(s) – copies of all statements for the past ___ months from _____, 20___ (with documentation for all deposits and copies of all checks for $1,000 or more) through current/closing (and ongoing statements as they come in).
____ Title page of Life insurance policies and a letter from carrier stating the current cash value.
____ Stocks and Bonds Certificates. If in a brokerage account, each statement for the past ___ months from _____, 20___ through current/closing (with documentation for all deposits and copies of all checks for $1,000 or more) through current/closing (and ongoing statements as they come in).
____ Real Estate Deeds to all properties
____ Long-Term Care Insurance Policy (entire policy)
____ Verification the LTC Insurance Policy is in payout status or verification claim for payout has been submitted

F. Medical Forms

____ DSS 486 "Physician's Statement for Determination of Disability" & DSS 1151 "Disability Interview" (if under 65 in NYC & Nassau County)
____ M11Q "Request for Home Care" (Home Care for New York City
*expires within 30 days of completion)

G. Other

____ Spousal Refusal
____ Authorization for Release of Health Information Pursuant to HIPAA
____ Authorization to Represent
____ NY Access & Supplement A Applications
____ Authorization for the Verification of Resources (Applicant)
____ Authorization for the Verification of Resources (Spouse)
____ Medicaid Authorized Representative Form (DOH-5247)
____ Submission of Application on Behalf of Applicant (DOH-5147)

Note: Medicaid and asset protection planning may be implemented to qualify an individual for Medicaid. One should seek the services of an experienced Elder Law attorney.

Home Care Assessment Tips

The key to maximizing Home Care hours through the Medicaid program is good documentation of your loved ones needs.

- ✓ Needs must be documented by the treating physician on the required medical forms: Form-M11Q in New York City;

- ✓ The treating physician must describe your family member's needs in detail on the required medical form. Details must include when and to what degree assistance is required with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

- ✓ For basic activities of toileting, ambulation, and transfer, the treating physician must describe the *type* of assistance needed such as hands-on care or verbal cuing and prompting. The treating physician must also indicate whether assistance with these tasks can be *scheduled*, or may occur at *unpredictable* times during the day or night.

- ✓ The treating physician must address any *recurring* needs that arise at particular times, such as assistance with feeding (which may be frequent with certain medical conditions such as diabetes) or with taking medication.

- ✓ The treating physician must address the medical reason for all stated needs. For example: frequent assistance needed with toileting due to the frequent need for urination resulting from diuretics, or the need for continued verbal cuing to use a walker, the cuing required due to dementia and walker is needed because of the high risk of falling and injury due to gait disorder and osteoporosis.

- ✓ In New York City, the treating physician must specify on the medical form the "span of time" during which these needs arise.

- ✓ The treating physician must explain in detail that there are no adequate alternatives and why the alternatives are not adequate. For example the physician must explain why the client cannot safely or appropriately use a commode or bedpan by herself at night.

- ✓ If the treating physician does not provide adequate detail of all needs, don't be afraid to insist that they revise their documentation to take into account all needs in exacting detail.

- ✓ The approval of 24-hour care is rare, and must be strongly advocated for. For a family member who requires 24-hour assistance (whether care is provided informally by another family member or in conjunction with personal care aids) the 24-hour needs must be specifically set forth in detail and thoroughly explained so that the exception that prohibits the use of task-based assessment for people with 24-hour needs can be invoked.

- ✓ Please note that the medical forms used in most local districts do not specifically elicit the detailed information needed to maximize home care hours from the treating physician. It is imperative that family members elicit this information from the physician and ensure its inclusion on the medical forms.

- ✓ Once a Medicaid approval is given, a mandatory assessment (the at-home assessment) is conducted by the county/local district nurse, to determine the home care needs of the applicant. Family members must insist that they be present during the at-home assessment. During this assessment, all needs of the applicant must be made known in exacting detail, taking into account scheduled and unscheduled day and nighttime personal care needs. Addressing these needs will ensure that a care plan is developed that meets all personal care needs.

- ✓ In addition, the family should submit other evidence to support the home care application. This evidence can include but is not limited to: independent evaluation by a nurse, social worker, physical therapist, or simply an affidavit by a family member, friend, or private home care aide who is familiar with the family member's personal needs.

- ✓ Finally, care must taken to avoid the "safety monitoring" trap. Assistance that is categorized as "safety monitoring" is not approved under the Medicaid program and no home care hours will be provided for this type of assistance. However, assistance to ensure the safe performance of recognized activities, such as to prevent falling, is not "safety monitoring", and must be provided. This type of assistance should be classified as assistance with ambulation or transfer not as "safety monitoring" which has the narrow definition of supervising a person who has dementia to prevent unsafe behaviors such as wandering.

- ✓ A family member who has and exhibits behaviors related to dementia can obtain care if the needed assistance is not mischaracterized as a stand-alone task of "safety monitoring" but as a form of verbal or physical assistance with the recognized task of ambulation.

- ✓ A family member who wanders may often need assistance with ambulation for other reasons such as, poor balance, gait disorders, arthritis, and other mobility impairments. These needs should always be cited as well to establish the need for assistance at unpredictable times and to justify the appropriate span of time.

- ✓ An effective care plan is one the meets your family members scheduled and unscheduled day and nighttime personal care needs, and provides you with Peace of Mind.

- ✓ Besides the medical forms, family members can present detailed information about the clients needs to Medicaid in other ways. At Russo Law Group, PC, we provide our home care clients with a supplemental home care form in addition to the required medical form to be completed by the treating physician that elicits the specific medical information needed to determine the client's needs.

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Prepared by:
Russo Law Group, P.C.
Attorneys and Counselors at Law

Offices: Garden City • Lido Beach • Islandia • Manhattan

Phone: 800-680-1717 | www.vjrussolaw.com

Russo Law Group, P.C.

Estate Planning, Elder Law & Special Needs

PHONE 800-680-1717

WEB www.vjrussolaw.com

Garden City
100 Quentin Roosevelt Blvd.,
Suite 102
Garden City, New York 11530

Lido Beach
250 Lido Boulevard
Lido Beach, New York 11561

Islandia
3740 Express Drive South
Islandia, New York 11749

Manhattan
485 Madison Avenue,
13th Floor
New York, NY 10022