

Chapter 12

WHEN YOU CAN'T MAKE THE DECISION: LIVING WILLS, POWERS OF ATTORNEY AND OTHER DISABILITY ISSUES

Most of us think of estate planning as something that really doesn't bear fruit until we're dead. But technology has changed all that. Modern medicine can now keep alive indefinitely many people who would have died a few years ago. Alive, but not necessarily able to take care of themselves. Nowadays, a good estate plan must take into account the possibility that you may someday be unable to care for yourself, make decisions, or even regain consciousness--but remain alive.

You may remember the Nancy Cruzan case, in which a Missouri woman injured in an auto accident suffered a head injury that rendered her unlikely to ever escape from an unresponsive, coma-like state. She had left no written instructions about what doctors were to do if she ever became so disabled. Her family wanted to discontinue intravenous feeding, but the hospital--and the state--refused to allow it. Finally, in June 1990, the U.S. Supreme Court ruled that although individuals do have the right to refuse medical treatment, they must express their wishes clearly enough to meet the standards set by the state in which they live.

The case of Jack Kevorkian, the Michigan doctor who assists people in committing suicides, indicates just how touchy and ambivalent our society remains about euthanasia (mercy killing) and the right to die.

Let's hope that you never have to face the choices that the Cruzan family and Kevorkian's patients faced. But there are more common and less spectacular cases in which you may have to let

someone else make important decisions for you because you aren't able to do so.

Twenty years ago, half of Americans died in institutions like hospitals or nursing homes; today, it's four out of five. The medical personnel in these institutions will look to you for instruction on whether to revive you or resuscitate you. If such procedures would only mean great pain for you and prolonged anguish for your family, or would leave you in a vegetative state, you mightn't want them performed. But you might not be in condition to refuse them. Or you may be in a situation where you want to live, but can't manage your affairs.

The courts have ruled that all mentally competent adults have the right to refuse medical care. If you're in a condition in which you can't communicate, and there is clear evidence of your wishes regarding treatment (such as a living will), those intentions must be obeyed. But the details get messy, because state laws vary widely on the subject. As a practical matter, your instructions must be written down, preferably in a formal document, if there is to be a good chance they will be obeyed. Even then, there's no guarantee.

What you're trying to avoid is the agonizing situation of your partner or children gathered around your hospital bed, asking each other and your doctor, "What would she want us to do?"--and you being unable to tell them.

There are some planning tools that can help. For financial matters, you can use trusts and durable powers of attorney to help you manage. For health care decisions, some states have **family consent laws** permitting other family members to make some health care decisions on your behalf. But in most states, no one, not even your spouse, has the legal right to make any kind of decision on your behalf; they might have to file a court petition to get it, and obtaining such **guardianships** or **conservatorships** can be expensive, time-consuming, and still not accomplish your wishes.

As a result, most states have adopted various forms of other legal devices to help your wishes

be carried out when you're incapable of making such important decisions. In considering these "lifetime planning" or "advance directive" documents, remember that they're only valid if made while you are competent--not when you've entered an advanced state of, say, Alzheimer's disease. Also, state laws about how these documents must be witnessed and created vary greatly. In some, they're just a matter of filling the blanks on a form; in others, you need a lawyer's help.

In most states, lawyers recommend that you make out a health care advance directive or a living will or a durable power of attorney for health care, tell your doctor and lawyer about these decisions and give a copy of each document to them to keep in your file. It's also a good idea to give one to the executor of your regular will. Even where states don't accept some of these tools as legally binding, they carry substantial moral weight with doctors and health care providers.

This chapter outlines some of the methods you can plan right now to manage your affairs when you might not be able to make decisions regarding your property, your medical treatment, even your life.

MANAGING YOUR PROPERTY

If you should become disabled, life goes on. Bills (rent, mortgage, utilities) must be paid. Form 1040 must be filed. If you own a business, you may want it to carry on without you. Your property must be managed.

You may expect your spouse to do all this for you, but what if he's killed or disabled in the same event that renders you unable to manage your affairs? What if he dies before you do? What if he's simply not capable of handling your affairs? Your estate plan must anticipate such a situation.

Joint tenancies and living trusts

One way to give someone else authority to manage your property is to put it into joint tenancy. This will give your co-owner the power to handle your property should you become disabled. In some cases (usually when a spouse is a joint tenant), this arrangement may be all you need to protect your property.

In many cases, though, such joint tenancies are a bad idea, or at least insufficient to take care of all possibilities; chapter two explains why. For families with sufficient assets, a better method is using a revocable living trust--see chapter five. You name yourself and someone you trust as co-trustees, transfer the assets that need managing (especially things like investments, rental property, and bank accounts) to the trust, give the co-trustee the powers over the assets you want (you can, for example, require that until you are incapacitated he or she obtain your approval before taking any action). If you become incapacitated, your co-trustee will manage the assets for you. In the event of your death, the assets can pass into your estate, continue in the trust, or be paid to a beneficiary. A properly written living trust is much more flexible than a power of attorney, and an irrevocable living trust can encourage your family and friends to make donations for your care. It can help cover needs not met by public entitlements like Medicaid without disqualifying you from receiving them.

However, a living trust may not be appropriate for your situation. And it can interfere with your eligibility for Medicaid assistance in paying for nursing home care, should you be eligible for it (see below).

Durable powers of attorney

For many people, a **durable power of attorney (DPA)** is the best protection against the consequences of becoming disabled. A DPA is a document in which one person (the **principal**) gives

legal authority to another person (the **agent**) to act on the principal's behalf. State laws vary, but a DPA generally has to be signed and notarized and state that it shall be "durable"; that is, that it will continue in effect after you become incapacitated. It terminates at your death or cancellation (you can cancel it at any time), or at a time you specify.

The DPA lets you appoint an agent (usually your spouse or child) to manage all or part of your business or personal affairs. The law does impose the responsibility on the agent to act as your **fiduciary**, but it might be difficult for you or your family to take him or her to court, and since this person can in effect do anything with your money, you should be sure to appoint someone you trust and in whose judgment and ability you have confidence.

A DPA's flexibility is one of its main advantages. You can limit the authority of the agent in the document, giving him or her as many or as few powers over your property as you wish, attaching conditions and so on. You should check with an attorney before executing a DPA.

MAKING TREATMENT DECISIONS

You now have several ways to prepare for the possibility that you may sometime be unable to decide for yourself what medical treatment to accept or refuse. This section discusses health-care powers of attorney, living wills, and health-care advance directives (which permit you to create a health-care power of attorney and living will in one document). [See Appendix B](#) for a sample health-care advance directive prepared by the American Bar Association, the American Medical Association, and the American Association of Retired Persons (AARP).

[Health care powers of attorney](#)

Remember, federal law now gives you the right to consent to or refuse any medical treatment, and to receive information about the risks and possible consequences of the procedure, about advance directives (such as living wills), and about life-sustaining medical care and your right to choose whether to receive it. No one else, not even a family member, has the right to make these kinds of decisions, unless you've been adjudged incompetent (see "Guardianships" below) or are unable to make such decisions because, for example, you're in a coma or it's an emergency situation. No one can force an unwilling adult to accept medical treatment, even if it means saving his or her life.

Society has gradually come to a rough consensus on these principles, and almost all medical providers follow them. Where difficulties still arise is when your wishes or intentions aren't clear. That's where the next two planning tools come in.

A special kind of durable power of attorney called a **health care power of attorney (HCPA)** is used to deal with health care planning. It allows you to appoint someone else to make health care decisions for you--including, if you wish, the decision to refuse intravenous feeding or turn off the respirator if you're brain-dead--if you become incapable of making that decision. The form can be used to make decisions about things like nursing homes, surgeries, and artificial feeding.

Obviously, decisions so important should be discussed in advance with your agent, who should be a spouse, child or close friend, and you should try to talk about various contingencies that might arise and what he or she should do in each case. A copy should be put in your medical record. Since it's so much more flexible than a living will, the HCPA is a very useful document that could save you and your family much anxiety, grief and money.

You can revise or revoke the HCPA or the living will at any time, including during a terminal illness, as long as you are competent. To change or revoke either document, notify the people you gave the copies to, preferably in writing.

It's a good idea to prepare the DPA, HCPA, and living will (see below) all at once, and make sure they're compatible with each other and the rest of your estate plan. These days, all should be regarded as essential components of any estate plan. Some attorneys advise using different people to serve as agents under your HCPA and your DPA. The former is usually a spouse, child or close relative who can make health care decisions; the latter, a lawyer or other money-wise friend, relative or professional competent to make business and financial arrangements. You can terminate the HCPA at any time.

Sidebar

QUESTIONS TO ASK YOURSELF BEFORE MAKING ADVANCE DIRECTIVES

1. What are my values?

These documents are tools to make sure your wishes are carried out. Some of the issues to explore (perhaps with your family, friends, minister, or doctor) include:

How important is independence and self-sufficiency in your life?

What role should doctors and other health professionals play in medical decisions that affect you?

What kind of living environment is important to you?

What role do religious beliefs play in such decisions?

How should your family and friends be involved, if at all, in these decisions?

2. Who should be my agent?

This is the person who will have great power over your health if you become incapacitated.

Whom can you trust to know what you would want if unexpected situations arise? Who will be able to handle the stress of making such decisions? (Remember, state laws sometimes prevent doctors and others from acting as agents in these circumstances.)

3. What guidelines should I impose?

You don't have to spell out every contingency; in fact, you need to leave your agent some flexibility if unexpected circumstances arise. But if you have specific intentions (not being kept alive by feeding tubes if you are brain-dead, for example) you can help your agent by writing those out.

4. How can I deal with reluctant doctors?

The medical establishment has been slow to recognize patients' rights to make these kinds of decisions in advance. If you have a regular physician or hospital, you might want to discuss these issues with them now to make sure your wishes, and those of your agent, will be carried out. (end sidebar)

Pulling the plug: living wills

A living will is a written declaration that lets you state in advance your wishes about the use of life-prolonging medical care if you become terminally ill and unable to communicate. It lets your wishes be carried out even if you become unable to state them. If you don't want to burden your family with the medical expenses (medical expenses in the last month of life average almost \$20,000) and prolonged grief involved in keeping you alive when there's no reasonable hope of revival, a living will typically authorizes withholding or turning off life-sustaining treatment if your condition is irreversible.

Living wills typically come into play when you are incapable of making and communicating medical decisions. Usually, you'll be in a state such that if you don't receive life-sustaining treatment (intravenous feeding, respirator), you'll die. If it's properly prepared and clearly states your wishes, the

hospital or doctor must abide by it, and will in turn be immune from criminal or civil liability for withholding treatment. Some people worry that by making out a living will, they are authorizing abandonment by the medical system, but a living will can state whatever your wishes are regarding treatment, so even if you prefer to receive all possible treatment, whatever your condition, it's a good idea to state those wishes in a living will.

Almost all states now have living will laws, but they are far from uniform. There are two kinds of living wills: **statutory** (for use in states that have living will laws) and **nonstatutory** for those that don't. Most of the states have so-called right to die laws, but provisions vary from state to state, and can be expected to change in coming years. In fact, in some states lawyers believe that people would be better off without a living will, since the statutory form forbids doctors from withdrawing nutrition and hydration (i.e., tube feeding)--a restriction you probably don't want. Many lawyers believe that in those states a power of attorney for health care is preferable to a living will. In any event check with your lawyer before proceeding.

A statutory living will tracks the language in the law of your state, and leaves little room for uncertainty if properly prepared. A nonstatutory living will follows generally accepted principles about the right to die and refuse treatment.

The form required for a valid living will differs in each state. We've provided a sample document in this chapter, but **IT MAY NOT BE LEGALLY VALID IN YOUR STATE!** Be sure to check with a lawyer or find out about your state's law by contacting Choice in Dying, 1-800-989-WILL (9455), website www.choices.org. (The organization is evolving into a new organization concerned more broadly with excellent end-of-life care. You can learn about Partnership for Caring by accessing www.partnershipforcaring.org.) If your state doesn't specify a particular form for a living will, Choice in Dying can send you a living will declaration that will keep you from being hooked

up to resuscitation machine. It must be signed by two witnesses, who cannot be your relatives, heirs, or doctor.

Usually, the decision to write a living will should be made after consulting with your doctor and lawyer. If you are writing a living will yourself, it's best to avoid general terms like "extraordinary treatment" in favor of more specific ones like "permanently unconscious."

Sidebar

IF I HAVE A LIVING WILL, DO I STILL NEED A HEALTH CARE POWER OF ATTORNEY

Absolutely.

- A HCPA appoints an agent to act for you; a living will doesn't.
- A HCPA applies to all medical decisions (unless you specify otherwise); most living wills typically apply only to a few decisions near the end of your life, and are often limited to use if you have a "terminal illness," which has become a slippery term.
- A HCPA can include specific instructions to your agent about the issues you care most about, or what you want done in particular circumstances.

Living wills are typically either vague ("I don't want to be kept alive if I'm a burden to anyone"-- what does that mean?) or so specific as to be inflexible. It's not a problem in drafting them; in the twilight world at the end of life, all lines are blurred, all colors are grey. It's simply impossible to predict every

possible contingency.

Since living wills are so limited, some lawyers recommend that you have both a living will and a HCPA to handle other kinds of disability, or grey-area cases where it's not certain that you're terminally ill, or your doctor or state law fail to give your wishes due weight. (A living will wouldn't have helped Nancy Cruzan, for instance, because she wasn't "terminally ill" and could have lived as long as 30 more years in a persistently vegetative state, but a health care power of attorney would have permitted a designated person to make the decision.)

Furthermore, the living will form you use may be outdated or otherwise inappropriate under your state's current law (those laws are changing fast). The form will may not address certain questions (or, as in the example above, may not conform to your wishes): do you want all treatment stopped, or just artificial respiration? What about provision of food and fluids through an uncomfortable nasogastric tube? It's difficult for any form to address all possible medical issues that may arise when you are unable to communicate your wishes. Better to have a trusted relative or friend make the call.

Finally, despite recent changes in laws, old habits die hard, and many doctors and nurses are still reluctant to turn off life support—even if that's what a patient wants. Surveys show that the medical establishment still routinely overtreats patients with no realistic hope of recovery, ignoring living wills, often angering and tormenting the dying person's loved ones. The most common cases of conflict: removing routine (as distinguished from "heroic") life-sustaining equipment like feeding tubes (as opposed to putting them in the first place). That's why you need an advocate appointed by your HCPA to press your intentions.

Even if you're not expected to die in the next few months, if there's no hope that you'll recover consciousness you may want to be allowed to die. But a living will won't force a reluctant doctor to do that; only the agent appointed through your HCPA can demand that step.

Sidebar

WHAT HAPPENS IF I DON'T HAVE A LIVING WILL OR HCPA?

It's likely that life sustaining treatment will be provided indefinitely even though you will never recover consciousness and will merely be kept alive but unresponsive. Sometimes this can go on for years, with severe emotional consequences for family members. There will also be a financial impact, either for your family or the government. If you don't have a living will or HCPA, someone else may be making the most important decisions of your life--or death. Yet most Americans still don't have advance directives like living wills or HCPAs.

Health-Care Advance Directives

[The second appendix to this book](#) provides a sample health-care advance directive prepared by AARP, the ABA, and the AMA. It not only permits you to name a health care agent and specify his or her powers (an HCPA), but it also provides instructions about end-of-life treatment (a living will). It also enables you to state in advance whether you want to donate organ at death, and permits you to nominate a guardian of your person should one be required.

Using this comprehensive single document obviously is more convenient and less prone to confusion than having several documents covering portions of your health-care wishes. It meets the legal requirements of most states. Even if it does not meet the requirements of your state, it may provide an

effective statement of your wishes if you cannot speak for yourself.

Guardianships and civil commitment

The goal of many of the devices described here is enable you to avoid court-appointed guardianships. The law authorizes courts to appoint guardians (or conservators) for adults adjudicated to be incompetent. These are usually used to protect people experiencing mental illness or retardation, who are senile, or who are addicted to drugs or alcohol. Depending on the law, there can be two kinds of guardians: **guardians of the estate**, who are authorized to manage property, and **guardians of the person**, who make medical and personal decisions for the incompetent person, known as a **ward**. (It's similar to the guardianships set up for children and discussed in chapter six.)

You establish a guardianship by petitioning a court to hold a competency hearing, at which testimony (usually medical) is introduced to prove the person can't handle his own affairs. If the court agrees, it appoints a guardian (usually the petitioner). The guardianship continues until the ward regains capacity to handle his own affairs, which seldom happens. The ward loses most civil rights, often including the right to make a binding contract, to vote, and to make medical decisions.

A guardian's power varies with the state and the court's decree; it may be broad or limited. The duties and responsibilities will be enumerated in the appointment document; usually a bond and inventory will be required and annual reports filed, and the guardian may receive a fee, which is often waived by family members.

Guardianships are relatively clumsy and inefficient ways of taking over decision-making power. For example, the guardian usually must get the court's permission before spending money or selling assets. Notice, public hearings or other red tape may be required. You should explore (with a lawyer's advice) the other possibilities listed in this chapter before undertaking one.

If you are afraid someone is seeking a guardianship over you against your wishes, you should see a lawyer. If you agree with the need for guardianship, you can ask the court to appoint a guardian of your choice. The best protection against involuntary guardianship, though, is to have a health care power of attorney and a durable power of attorney in place before someone tries to impose one on you.

The same goes for commitment to a mental hospital. State laws govern the circumstances in which someone may be involuntarily committed to institutional care. A court hearing is required; the standard is whether a person is dangerous to herself or others, or can't care for herself. A lawyer is usually appointed to represent the person whose commitment is sought. If you are committed to an institution, you retain certain rights, and it's likely that after treatment you will be released. If you feel someone is wrongly seeking to have you committed to an institution, see a lawyer immediately.

Organ donation

The Uniform Anatomical Gift Act, along with similar provisions in most state laws, sets forth your wishes about whether, after your death, you want your organs donated to help other people who may need them to survive. Donating your body or other organs to science or medicine has been called the greatest gift, as the thousands of people now on waiting lists to replace their failing organs would attest. You can direct hospitals to donate your organs by filling out a donor card, witnessed by two people, that's often attached to the back of your driver's license. The cards can be obtained at your state's motor vehicle department or by contacting The Living Bank in Houston, TX at 800-528-2971; website: www.livingbank.org. Doctors may also ask your family whether they will consent to organ donation on behalf of a terminally ill patient.

AIDS information

The devastating AIDS epidemic has raised all sorts of legal issues, including those relating to health care maintenance. Proper estate planning gives people with AIDS (PWAs) a sense of control over their lives and deaths that can help ease the trauma of the disease.

A person with AIDS needs three estate planning documents:

- a general power of attorney, which will give a trusted friend or relative authority to make decisions should the person become incompetent or restricted to a hospital or home;
- a health-care power of attorney, which designates someone to make health-care decisions and tells everyone your wishes regarding medical treatment;
- a will, which disposes of the rest of your property. This is especially important for gay men or women who want to make sure that non-family members are provided for.

A will can also provide for a guardianship of any children, which can be important if a family member challenges your wishes for your children. For example, the mother of a person with AIDS might not want his or her surviving partner to bring up her grandchild. However, a guardianship specified in your will can't assure that your wishes are carried out, because it's not binding on a court. So an **inter vivos guardianship** (set up in your lifetime) may be better, but that means you may have to give up control of the children before your death. If you anticipate a challenge to a guardianship, it's a good idea to execute an affidavit expressing your desires and stating why other possible guardians are inappropriate. The complexity of such issues make the help of a lawyer essential.

It's vital for a gay PWA to give his lawyer a list of family members and be sure he understands who will and won't inherit property via the will or other estate-planning documents.

SPECIAL NOTE FOR ELDERLY AMERICANS--AND THEIR CHILDREN

America is getting older. Because of the baby boom and other demographic changes, the number of Americans over age 65 will double over the next 40 years; 14 million of them will have Alzheimer's disease. By 2050, elderly will number 67 million, 22% of the population. These changes have spawned a whole new legal specialty called "elder law." This book isn't the place to discuss the whole panoply of elder law issues, but estate planning makes up a significant component of legal concerns for the elderly.

Older Americans have mostly small estates, often poorly organized. Too many widowed spouses are left impoverished, often by poor estate planning. Even so, people 65 and older hold more than \$5 trillion in wealth, and almost a third of Americans are leaving estates worth more than \$50,000—double the number thirty years ago. Clearly, many older Americans need to use money management estate planning devices.

While it sounds cold-blooded to say it, the children of aging Americans also have a stake in their elders' estate planning, since most of the fruits pass unto them.

Most of the protective devices described in this chapter can be especially valuable to elderly Americans. A good estate planning attorney can advise you on the best mix of such devices. Other good strategies that might benefit older Americans include:

- **Nursing home insurance.** If you buy it before age 65, the premiums can be relatively affordable. Your children might be able to help you with the payments; after all, every penny saved from insurance increases their inheritance, which might otherwise be drained by nursing home costs.
- **Lifetime gifts.** These are briefly described in chapter eight. It's better not to sell stock to obtain money for cash gifts, because if the stocks have appreciated since you bought them, you have to pay tax on the profit when you sell. Better to let the kids inherit the stock, because they won't have

to pay taxes on the increased value until the property is sold. Give the gifts to your child only, not to her and her spouse, because if there's a divorce, she should be able to keep the entire gift as her separate property.

- **Prenuptial or postnuptial agreements** for second marriages, especially if you or your new spouse have children from previous marriages. See chapter seven for more.
- **Living trusts**. See the discussion above and in [chapter five](#), and the section on Medicaid estate planning below.

[See chapter seven, Special Considerations](#), for more information on estate planning for the elderly. The most important thing, however, is that you go to an estate or elder law attorney and plan your estate. Make the hard calls about which children or relatives you want in charge of your health care decisions, financial arrangements (they may be different people), and so on. Explain to your family why you are designating each relative (and not designating others) for each job--not because you love any of them more than any of the others, but because certain people are better for certain jobs. Realize that your children are going to be afraid that, as you age, you might "squander" (in their eyes) their inheritance in Las Vegas, on a new, young spouse or "friend," or a religious cult or smooth-talking evangelist. Listen to their concerns, but explain that you have a right to do with your money what you will.

Medicaid Estate Planning

Nursing home costs can be devastating on a family. Planning ahead can make a big difference.

Competent Medicaid planning helps an individual who is unable to pay for long-term care properly meet the Medicaid financial eligibility requirements. Planning may also slow the depletion of your estate or preserve some of it for your spouse or dependants.

Medicaid planning usually focuses on families who realistically have no other choice but to rely on Medicaid. Few people would opt for Medicaid if other choices were available, because of disadvantages, including less provider choice, limitations in available care, discrimination against Medicaid recipients and intrusive involvement of the state in your finances and health care. Medicaid planning uses legally permitted options under Medicaid to preserve assets and try to assure your survivor some financial security.

Unfortunately, most of the self-help advice regarding Medicaid planning is fraught with danger. Even with competent advice tailored to your needs, Medicaid planning is not easy. The goal here is to introduce you to the types of planning strategies, and not to provide a do-it-yourself cookbook.

Transfers of assets. Transfers of property for less than full **consideration** (i.e., giving property away in whole or part), except for transfers between spouses, can result in a period of ineligibility for Medicaid benefits. When you apply for Medicaid, you must disclose any transfer made within the last thirty-six months (sixty months for certain transfers involving trusts). Such transfers trigger a period of ineligibility that varies from location to location (see sidebar, below).

Under a new law, effective January 1, 1997, **certain transfers may also be a crime under Federal Medicaid fraud provisions**. If you knowingly dispose of assets to qualify for Medicaid, *and* doing so results in a period of ineligibility for Medicaid, you could face criminal penalties of up to \$10,000 in fines and one year in jail. Dubbed the **Granny goes to jail** law, it probably won't be aggressively applied, but it creates considerable anxiety among seniors trying to do legitimate planning. Correct advice and consultation in planning are a must.

Sidebar: Example of Transfer of Asset Penalty:

If Mr. Jones lives in an area where the average monthly cost of nursing home care is \$3000 per month, and he gives away \$90,000 on January 1, 1997, he is disqualified from Medicaid until July 1, 1999 (i.e., 30 months). This is calculated as follows: $\$90,000 \div \$3000 = 30$ months (or two years, six months). Under the new Medicaid transfer criminal provision, effective in 1997, Mr. Jones could be subject to a criminal penalty if he made the transfer to become eligible for Medicaid, and he applies for Medicaid and becomes subject to a period of disqualification. He must wait at least 30 months, and possibly 36 months (the full look back period) to apply for Medicaid in order to avoid the criminal penalty.

One rule of thumb when transferring property for less than full consideration, for purposes of Medicaid planning, is to retain enough assets to be able to pay for nursing home care for the duration of the penalty period. However, this is only a generalization. Every situation is different.

Use of trusts. Irrevocable trusts are another planning tool to help manage the cost of long-term care. Trusts that can be revoked by the creator of the trust are considered countable assets by Medicaid and have no impact on Medicaid eligibility. However, irrevocable trusts, if created at least **sixty months** prior to applying for Medicaid (the "look-back" period for trusts) may help establish Medicaid eligibility while slowing down the depletion of your estate, if the discretion of the trustee to

distribute income and principle is sharply limited. Federal law also recognizes certain trusts created for the benefit of persons with disability under sixty-five. Generally, parents who are planning for the long-term care of an adult, disabled child may want to consider this type of trust.

An irrevocable **Miller trust** (named after a legal case) is relevant to persons living in "income cap" states. The problem faced by some persons in these states is that their income may be just over the Medicaid income cap but less than the amount needed to pay privately for a nursing home bed. To remedy this hardship, federal law requires these states to exempt (for purposes of Medicaid eligibility) trusts created for their benefit if the trust is composed only of pension, Social Security or other income, and if at the individual's death the state is reimbursed by the trust for all Medicaid assistance paid on behalf of the individual. These trusts work by paying out a monthly income just under the Medicaid cap and retaining the rest. The result is that most of the individual's income, supplemented by Medicaid, goes toward payment of the nursing home. The remainder of the person's income remains in the trust until his or her death. The accumulated residue is then paid to Medicaid.

Other limited trust arrangements may be helpful in some cases, but they all require careful assessment and advice and a good dose of caution and remember that Congress periodically changes the rules, so your strategy may have to change.

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