Post-Divorce Probate Litigation and Resource Protection Issues for Adult Disabled Children: Maximizing Government Benefits[1]

Is the problem of maximizing benefits for adult disabled children of divorce worth the time of the domestic relations attorney? From a practical perspective as attorneys, the question subdivides into two additional queries: how often does the problem arise? And, in any case in which it does arise, how significant is it?

To get a handle on the scope of the problem, some statistics may be useful. Of 2,800,00 women over age 15 in Massachusetts, over 350,000 were either separated or divorced. Of 2,500,000 men over age 15, 230,000 were either divorced or separated.[2] That's 580,000 persons currently in potential need of post-divorce assistance.

Of that number, how many have children? One estimate is that of divorcing couples, 40% have children.[3] And how many of those have adult children (ages 21-64) with a disability that is severe enough to warrant special planning around benefits issues? If we assume that the prevalence of such persons is the same for divorced and intact families, the number in Massachusetts would be about 8.6%. However, given the extent to which the stresses of parenting a child with a disability may take a toll on a marriage, the number could be substantially higher, probably depending on the severity of the disability.[4] If 40% of divorced couples have children and

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[1] Prepared by Donald N. Freedman for "Probate and Estate Issues in Divorce Law," Massachusetts Continuing Legal Education, Inc., April 24, 2012.

[2] US Census Bureau, Selected Social Characteristics in the United States, 2006-2010 American Community Survey 5-Year Estimates. Figures rounded.

[3] Schmitz, H. (April 2011). Helping Families Deal with Divorce and Separation Workshop presented at 2011 DoD/USDA Family Resilience Conference, Chicago, IL.

[4] According to a recent study, while divorce rates of 80% and higher have been mentioned in the media, the question of the relative prevalence of divorce among couples with or without children with disabilities has not yet been well addressed by empirical research. Several studies evidence the expected increased risk of divorce; others have shown little

8.6% (conservatively) of the children have a disability, then at any point in time about 20,000 parents of disabled adult children stand potentially in need of post-divorce assistance. And as for any parents committed to support a adult disabled child, the difference in financial exposure may vary from $100,000 per year or more without benefits, to nominal supplemental support, with best use of benefits.

As a legal matter, what is a parent's obligation for the support of an adult child with a disability in Massachusetts in the context of divorce? Ordinarily, child support in Massachusetts terminates at 18, at 21 if a child is domiciled with parent, or at 23 if a child is enrolled in an education program. G. L. c. 208, Section 28. Statutory divorce law here provides no exception to these age limitations in the case of a child with a disability (in contrast to the situation in twenty-nine other states).[5] However, at least with respect to an adult child under guardianship, the law in the Commonwealth now appears to be well-settled that the probate court does have jurisdiction to compel a financially-able non-custodial divorced parent to contribute to the support of his or mentally incapacitated adult child pursuant to its general equity power to decide all matters *relative to persons placed under guardianship*. Feinberg vs. Diamant, 378 Mass. 131, 134-136, 389 N.E.2d 998 (1979), citing G.L. c. 215, § 6 (see Appendix I). Emphasis added. See also Siai vs. Saia, 58 Mass.App.Ct. 135, 788 N.E.2d 577 (2003), footnote 4 (in which the court explains its refusal to provide postminority support under circumstances that the "the daughter has not been placed under the wife's guardianship.")

The holding in Feinberg is expansive and protective of the interests of disabled adult children of divorce. Its limitation to matters relative to

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impact. The first national study of divorce of parents of children with an autism spectrum disorder (ASD) found that the prevalence of divorce among such parents was 25.53%. ASDs are "lifelong neurodevelopmental disorders involving a triad of impairments in communication, social reciprocity and increases in repetitive/restricted interests and behaviors." The Relative Risk and Timing of Divorce in Families of Children with an Autism Spectrum Disorder, by Hartley, et al., in the Journal of Family Psychology 2010, Vol. 24, No. 4, 449-457.

[5] Morgan, Laura W., "The Duty to Support Adult Disabled Children," from supportguidelines.com (2000); and National Conference of State Legislatures research.

persons placed under guardianship is understandable, as the limitation is explicitly set out in G.L. c. 215, Section 6(v): "all matters relative to guardianship or conservatorship." The limitation is troubling nonetheless as a matter of public policy. While some disabled persons are under guardianship, most are not. For guardianship to be appropriate, the individual must be an "incapacitated person,"

> "one who for reasons other than advanced age or minority, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance." Section 5-101(9).

In a similar vein, to warrant the appointment of a conservator, the individual must be a "person to be protected" in that

> "the person is unable to manage property and business affairs effectively because of a clinically diagnosed impairment in the ability to receive and evaluate information or make or communicate decisions, even with the use of appropriate technological assistance, or because the individual is detained or otherwise unable to return to the United States; and the person has property that will be wasted or dissipated unless management is provided or money is needed for the support, care, and welfare of the person or those entitled to the person' support and that protection is necessary or desirable to obtain or provide money." Section 5-407.

In either case, guardianship of conservatorship, the operative factor warranting the appointment is the inability to receive and evaluate information or make or communicate decisions to the extent substantially degrading the individual's capacity to self-protect.

While many persons who are disabled by intellectual limitations, other developmental disabilities and severe mental illness may meet these criteria, the overwhelming majority of people with disabilities do not. While

no less capable of supporting themselves through work, and thus no less needy of support, the happenstance that their disability is physical rather than mental leaves them outside the circle of protection offered by the probate court.

Wholly apart from the question of the power of the court to compel support, many divorced parents by agreement assume responsibility for child support beyond age limits otherwise set by law, given the evident life-long needs of a child with a severe disability. "Where the parties have, through mutual agreement, made provision for their children past age twenty-one, and desire that the agreement (after approval by the judge), be incorporated in the judgment, we think the incorporated agreement may be enforced by means of a contempt proceeding." Kotler vs. Spaulding, 24 Mass. App. Ct. 515 (1987).

Aside from financial ability to provide support, what should one consider in determining an appropriate level of support? This is a complex question in that the nature and extent of the needs of an adult child with disabilities, whether for educational, residential, therapeutic, social or vocational support, range across a broad spectrum. Furthermore, needs are likely to change over time as the individual ages, particularly in the direction of deepening need. Also the availability of government services and benefits is likely to diminish, given recent trends and signals. Given these dynamics, the general rule of planning is that parent's support be utilized, to the extent possible, to supplement rather than supplant government services and benefits. See, for example, "Planning for the Incapacitated Child" by Ken E. Shulman, in *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. 4th ed. 2012). However, many considerations wholly apart from benefits are also pertinent to planning and should be taken into account to advance the ultimate objectives of the support in the individual case, whether support is in the form of voluntary or court-ordered child support or in the form of discretionary distributions by a trustee to or for the benefit of the disabled beneficiary. Often central among these consideration is the appropriateness of providing support in a way that does not diminish the individual's sense of self-esteem and autonomy. As

an illustration of the interplay of benefits- and non-benefits-related considerations, see the appended "letter of intent" drafted by the author for analogous circumstances – the guidance of the trustees of a trust for a beneficiary with rather severe and persistent mental illness.

Plans and practices involving child support for adults with disabilities may fall short of benefits maximization in two basic ways. First, some support payments, while well-intended, may be unnecessary in that the goods or services for which payments are made are or may be available under government programs. Second, other payments may result in a needless and wasteful offset in government support.

How the support-paying parent is to work in this benefits environment is the question on which we hope to provide at least general guidance in this paper. The array of benefits to which a given beneficiary may be currently or potentially eligible is broad and variable over time, and the details of financial eligibility criteria are frequently changed and reinterpreted. A solution to eligibility for one program may adversely affect another; overall cost-benefit analysis involving both financial and personal factors is essential. Furthermore, the individual's personal needs, capabilities and preferences should ordinarily to be taken into account in considering the extent and manner or support. To meet the ultimate purposes of the support – typically to maximize the quality of life of the individual, and NOT to conserve resources for later generations – the support-payer must do much more than strive to avoid or minimize benefits conflicts.

The government benefits that are the subject of this paper are those that are most often encountered in practice: (1) Social Security Disability Insurance Benefits; (2) Medicare (and associated Medicare Part D prescription drug benefits and private Medicare supplement "Medigap" insurance); (3) MassHealth (as Medicaid is called in Massachusetts); (4) Supplemental Security Income (SSI); and (5) federal and state rent subsidy programs referred to popularly as "Section 8." Below, I will briefly describe each of the programs, and then summarize how each program is affected by different kinds of support payments.

1. **Social Security Disability Insurance (SSDI) Benefits:**

For individuals who become disabled as adults, this program provides monthly cash benefits to individuals age 18 and older who have worked long enough and recently enough in jobs covered by Social Security, and who are unable to work ("to engage in substantial gainful activity") due to a severe physical or mental impairment lasting or expected to last at least a year.

For adults disabled prior to age 22, without a work record of their own, benefits may also be payable based on the work record of a parent who worked in jobs covered by Social Security and who is retired, disabled or deceased. Thus, a disabled individual (unless married) may become eligible for SSDI benefits later in life, at the disability, retirement of death of a parent.

The monthly benefit amount is based on past earnings. The average amount in October 2011 was $1,011. More important than the cash benefits in many cases is automatic eligibility for Medicare (ordinarily starting the 25th month after the start of cash benefits, and with Medicare eligibility to participate in the Medicare-subsidized Part D prescription drug program.

Special Implications for the payer:

a. If a beneficiary is not working at the threshold "substantial gainful activity" level as defined by Social Security, currently $1,000 per month, then explore whether the reason may be a physical or mental impairment, and whether the other requirements for eligibility are met. Note that many attorneys will evaluate and represent Social Security Disability claimants on a contingent fee basis. Obviously, cash and medical care from a government agency may forestall the need for expenditures for the same purposes by the parent.

b. With many benefit programs, payments to or for the benefit of the beneficiary, if done without planning and full knowledge of the regulations involved, may have an adverse effect on the level of benefits or even eligibility altogether. However, this is not the case with SSDI. While WORK income, as evidence of capacity for work, may affect eligibility, UNEARNED income in the form of cash distributions from a trust or other source has no effect on eligibility or level of benefits. Similarly, eligibility is subject to no limitation on the beneficiary's assets. Therefore, if SSDI is the only benefits program for which the trust beneficiary is currently or potentially eligible, the payer need not be limited in making payments.

2. **Medicare:**

This is the federal health insurance program for people on Social Security Disability Insurance Benefits (including Childhood Disability Benefits) for at least two years (with a few exceptions), as well as for people receiving Social Security retirement benefits. Medicare covers basic hospital and medical services, subject to co-payments and deductibles. Perhaps the most significant gaps are in coverage for medication and for more than very limited nursing home services, mostly for a limited time after a hospitalization of at least three days. Ordinarily, no premium is charged for Part A benefits (hospital, skilled nursing and rehabilitation services). The 2012 monthly premium for most Part B beneficiaries is generally $99.90.

> **Special Implications for the Payer:** In considering paying for medical treatment (including a stay in a skilled nursing or rehabilitation facility and home care), the Payer should ascertain whether the treatment or placement is covered by Medicare. The provider is usually the best practical source of information on whether a service is routinely covered by Medicare.

3. **Medicare-Related Insurance:**

People on Medicare may enroll in certain other insurance programs that are subject to Social Security requirements but operated by private insurance companies. These include "**medi-gap**" **insurance** that pays part or all of Medicare co-payments and deductibles; **Medicare Advantage plans** that provide all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage, plus often other benefits such as vision, hearing, dental and wellness programs, and in many cases also prescription drugs coverage; and so-called "Part D" **Prescription Drug plans**. The array of choices within these categories is daunting, but making the right choice at the right time will ensure that the Payer pays no more than necessary for medical and related services. I will describe each of these coverages briefly.

a. **"Medi-gap" Insurance:**

This popular type of health insurance is intended to supplement or fill in at least some of the gaps in benefits provided under Medicare. The gap filling, however, is basically limited to meeting obligations for co-payments and deductibles, and generally does not pay for services not covered by Medicare or increase the duration or frequency of services covered by Medicare. Generally speaking, Medi-gap policies do not provide for long-term nursing home care. The "Medex" policies, offered by Blue Cross-Blue Shield in Massachusetts, are examples of medi-gap health insurance, as are group policies offered through AARP.

Special Implications for the Payer:

a. The Payer should not automatically pay Medicare deductibles and co-pays. Instead, the trustee should make sure all medical providers bill both Medicare and the medigap plan for all services, before paying any portion of the cost of a medical service or device.

b. In considering paying a Medicare deductible or co-pay, the payer should first ascertain whether the treatment is covered by the individual's medigap insurance. The provider is usually the best practical source of information on this. If the child is also eligible for MassHealth (which ordinarily pays the Medicare Part B premium, co-insurance and deductibles), the question should arise as to whether the private medi-gap coverage is necessary at all. If the individual's providers participate in both Medicare and MassHealth, the individual may have nothing to gain from medigap insurance. However, if preferred providers participate in Medicare but not MassHealth, maintaining the medigap coverage may be the only away to avoid the need to change providers.

b. **Medicare Advantage Plans**

Under these (Medicare Part C) plans, Medicare pays a fixed amount to the company offering the plan, and the plan provides defined services otherwise covered by original Medicare, medi-gap and often prescription drug plans. Most plans are organized as health maintenance organizations (HMO's) or preferred provider organizations (PPO's). Plans charge different premiums, deductibles and out-of-pocket costs.

Special Implications for the Payer:

The beneficiary's decision to stay with original Medicare (with or without medi-gap supplementation) or enroll (or disenroll) in a Medicare Advantage Plan can have important implications for coverage of his medical care and thus on the extent of his need for support.

c. **Medicare Prescription Drug Program**

Since 2006, recipients of Medicare have had the option of enrolling with private insurance companies for subsidized prescription drug coverage. The program is also referred to as "Medicare Part D." While each participating insurance company must meet certain federal standards, the details of coverage vary widely, as to **premiums** (the basic cost of coverage), **deductibles** (the amount that must be paid each year before benefits are paid), **co-insurance** requirements (the amount that must be paid for each prescription, and perhaps most importantly, **formularies** (the drugs covered by the particular plan).

Special Implications for the Payer:

a. If a beneficiary is eligible for Part D participation but has not enrolled, or if he is enrolled but not in a plan that is appropriate given his specific medication needs, the Payer may be called on to pay more than is necessary. The Payer should therefore

screen, or arrange for a screen, to determine that the beneficiary is appropriately insured.

b. Also, individuals with total annual income under $16,245 and assets under $12,510 are eligible for a low-income subsidy that reduces or eliminates annual premiums, deductibles, prescription co-insurance and any gap in coverage (the "donut hole"). Thus, distributions directly to the individual may affect his eligibility for the subsidy.

c. Lastly, Medicare beneficiaries who are also eligible for MassHealth ("dual eligibles") are entitled to the subsidy even if their income and assets exceed these levels. See discussion of MassHealth eligibility, below.

4. **MassHealth/Medicaid:**

Medicaid, or **MassHealth** as the program is called in Massachusetts, pays for a broad range of medical services for people with disabilities and others in financial need. Under MassHealth, the state, operating under federal guidelines, pays for covered services to eligible "members," and then the federal government reimburses the state for a portion of these expenditures. While the focus of MassHealth is on medical, hospital and nursing home services, MassHealth also provides (1) a broad range of home and community based residential and non-residential programs; (2) work- and life-training services primarily for people with intellectual and other developmental disabilities through the Day Habilitation program; (3) non-medical personal support through the Personal Care Attendant program; (4) psychiatric day hospital programs for persons with mental illness; (5) assisted living services through the Group Adult Foster Care program; (6) group residence services for people with intellectual and other developmental disabilities; (7) premium assistance with private health insurance; (8) within limits, payment of the Medicare Part B premium, co-insurance and deductibles; (9) private in-patient psychiatric hospital services for persons under age 21 or over age 65, as well as other

services which may be very important for persons with disabilities. ***MassHealth/Medicaid is the single most important resource for most people with disabilities in Massachusetts.*** It is thus the most important resource for Payers to maximize.

The structure of the MassHealth program is complex, in reflection of its varied missions and of the often conflicting interests of its members and participating providers. A detailed accounting of the program is vastly beyond the scope of this paper, but a summary may be useful, primarily to illustrate the varied ways that eligibility and benefits may be impacted by parental support.

MassHealth has five basic coverage types, two of which, MassHealth Standard, and MassHealth CommonHealth, are specifically pertinent to adults with disabilities. Within each of these coverage types, however, MassHealth funds many special programs, subject to different financial and clinical criteria. The following are the most important programs under MassHealth Standard.

- **MassHealth Standard/Nursing Home** is for disabled persons of any age who meet certain clinical standards and are placed for long-term care (ordinarily more than 30 days) in a nursing facility. There is no income limitation on eligibility; however, aside from deductions for personal needs ($72.80), health insurance and a few others, the balance of income must be paid to the nursing facility as "patient-paid amount."

- **MassHealth Standard/Community** is for disabled persons under age 65 not living in a nursing facility or needing nursing facility services. To be and remain eligible, the individual's income cannot exceed 133% of the federal poverty level (currently $1,201). Thus, cash distributions to the beneficiary are permitted as long as the individual's total income from all sources does not exceed the stated level. Payments made directly to the vendor or provider for goods and services for the individual ("in-kind income") are NOT counted as

income for MassHealth eligibility services. Also, there is no limitation on the individual's assets.

- **MassHealth Standard/Waiver Programs** are for persons who are living in settings other than nursing homes (e.g., at home, in some assisted living placement, in most community residence programs under contract with the Department of Developmental Services – formerly the Department of Mental Retardation) but whose need for care and supervision is such that they would be institutionalized were it not for their receiving certain services in such relatively non-institutional settings. Income limitations vary, but are generally more liberal than in other MassHealth programs. On the other hand, most are subject to a $2,000 cap on assets. These are some of the more important programs:

    - **The Kaleigh Mulligan Program**, to enable very severely disabled children under the age of 18 to remain at home. The child may have no more than $2,000 in assets and a deductible is required to the extent that the child's income in excess of $72.80. However, there is no limitation on in-kind support by a trust; and since the income and assets of the parents are disregarded, trust distributions to the parents for the benefit of the child should not affect eligibility.

    - **The Home- and Community-Based Waiver program**, for disabled individuals over age 60 who would need nursing home placement without certain services administered by the Executive Office of Elder Affairs at home. The income limitation for eligibility without a deductible is 300% of the federal poverty level (currently $2,708 for an individual). Higher income individuals may establish eligibility after meeting a deductible.

    - **The Program of All Inclusive Care for the Elderly (PACE)** is a comprehensive program designed to keep frail, older individuals who clinically qualify for nursing home services living in the

community. Disabled individuals age 55 – 64 qualify, as to elders age 65 and older. The income limitation for eligibility without a deductible is 300% of the federal poverty level (currently $2,708 for an individual). Higher income individuals may establish eligibility after meeting a deductible.

- **Group Adult Foster Care** pays for a portion of the cost of assisted living for persons age 22 and older who fit certain clinical profiles and who live in GAFC-participating facilities.

- **The Home- and Community-Based Waiver for Persons with Mental Retardation** is for persons clinically determined to have mental retardation/developmental disabilities and who would be institutionalized unless he or she receives two or more services administered by the Department of Developmental Services (DDS) in the community. This waiver applies to many residents of community residences operated by non-profit agencies under contract with the DDS. The income limitation for eligibility without a deductible is 300% of the federal poverty level (currently $2,708 for an individual). Higher income individuals may establish eligibility after meeting a deductible.

- **MassHealth/CommonHealth**. An individual with disabilities whose income is over the limit for MassHealth Standard (currently $1,207) may nonetheless qualify for MassHealth under special eligibility rules in either of two ways:

  a. By showing that he or she is working at least forty hours per month. In this case, neither assets nor income affect eligibility, although at some point (about $13,500 per year depending on family size in total income from all sources – work, government benefits, and support payments) the state will charge a premium for coverage. At typical total levels of income just somewhat over the threshold, the premium is nominal; or

b. By showing that he or she has incurred (though not necessarily paid) a certain level of qualified medical or rehabilitation expenses within a single six-month period. The amount of expenses that must be met is called the *CommonHealth one-time deductible.* What is important for Payers is that, for individuals in this category, once the deductible has been met, eligibility is unaffected by the individual's future asset and income levels. However, as with CommonHealth for Working Disabled Persons, premiums on a sliding scale may be assessed.

Special Implications for the Payer:

While the details of a distribution plan for a given individual will depend on many factors, direct cash payments that leave total income within allowable limits (generally $1,207 per month for persons not in health care facilities or certain other residential programs) will not adversely affect the individual's eligibility or level of support. Income beyond allowable limits will be problemmatical. At worst, it may render him ineligible for benefits altogether. In other cases, it may require the meeting of an impractically high deductible. In yet other cases, it may inflate MassHealth deductibles and premiums. On the other hand, what MassHealth calls "in-kind income" – payments by a payer directly to vendors for any goods or services provided to the individual – generally have no effect on eligibility or level of benefits. Thus, the planning of the mode and not just the amount of support payments is critical in this context to avoid needless expenditures on medical or rehabilitative services otherwise available as a matter of right, without cost to the individual.

5. **Supplemental Security Income:**

This Social Security program pays monthly cash benefits to persons of any age who are disabled, aged, or blind, and whose income and asset come within certain limits. Only for persons under age 18 and living at home are the assets and income of the parent(s) also taken into account. If a person is eligible for SSI, he or she is also automatically ("categorically") eligible for MassHealth (Medicaid). The disability standard for adults is the same as for SSDI. Basic benefit levels are based on living arrangement, and are composed of a basic "federal benefit rate" of $698 (for 2012) and in Massachusetts and many other states, a state supplement. Maximum 2012 benefits in Massachusetts are as follows: $812.39 for a disabled individual living alone; $728.40 for an individual living in a "shared living expense" placement (such as a group home); $552.92 for an individual living in someone else's household (such as the home of a family member); and $1,152.00 for an individual in an assisted living placement.

Special Implications for the Payer

a. Regular support payments or other forms of "unearned income" (including cash benefits from SSDI) received directly by the individual (or his or her legal guardian) in excess of $60 per calendar quarter offsets SSI benefits dollar-for-dollar.

b. Support payments directly to third parties for anything other than for food or for shelter (including rent, light, heat) are <u>not</u> counted as unearned income.

c. Payments by the trustee directly to third parties for food and shelter will, if the individual is living independently, result in a reduction of SSI benefits by $231.33 (or less if the actual value of the contribution is less. This is called the "Presumed Value Rule." For example, an individual living independently would ordinarily be eligible for $812.39 in SSI benefits. If, however, the Payer is paying monthly rent of $1,500 on the individual's

behalf, then the monthly SSI grant is reduced by $231.33, to $581.06.[6]

6. **Section 8 and other rental-housing subsidy programs:**

The federal **"Section 8"** voucher program is the best known but really only one of a number of federal and state rental subsidy programs for people of low income, including elders and persons with disabilities. These programs are administered on a day-to-day basis by local public housing authorities and by regional non-profit agencies under contract with the state. (In Boston and 26 surrounding communities, the regional entity is the Metropolitan Boston Housing Partnership.) Programs similar to Section 8 include the tenant-based MRVP program, and the state Alternative Housing Voucher Program (AVHP) (only for non-elder persons with disabilities). The key governmental agencies responsible for policy and oversight are the federal Department of Housing and Development and (primarily) the state Department of Housing and Community Development.

An individual with a voucher may live in any apartment owned by a landlord who has agreed to participate in the program. The tenant pays no more than 30% of his income as rent; and the housing authority pays the landlord the difference, up to an agreed level. A person with a voucher may use it in any community in the Commonwealth. (In fact, a Section 8 voucher can be used anywhere in the United States.) There is currently a freeze on the issuance of new vouchers. Vouchers now become available only if a holder dies or leaves the program. Therefore, there is a waiting list for benefits, and so early application should be considered.

There is no asset limit on eligibility. Income limits (including regular support, other cash benefits, and investment income, but less certain deductibles) vary with the median income of the community; for

[6] The determination by the trustee that payment of the rent is appropriate and in the beneficiary's best interest, despite the partial reduction in the SSI grant, is a good example of the balanced assessment that the payer must make in this context, and that the support order or agreement must allow. For the order or agreement to bar distributions which have ANY adverse impact on benefits would result in the support arrangement being ineffective in avoiding homelessness.

Watertown, for example, the annual income limit for the voucher program is now $34,230.

Special Implications for the Payer:

Partly reflecting the facts that (1) Section 8 is administered by independent local housing authorities, (2) the applicable law is not very clear, and (3) the treatment of income is quite different from that under MassHealth and SSI, our question of how a payer should most effectively handle support payments on behalf of a Section 8 participant is particularly difficult.

As noted above, the distinction that is so important for MassHealth purposes is between direct payments to the individual and indirect ("in-kind") payments to others for the individual's benefit. For MassHealth purposes, in-kind payments are ignored. For SSI, depending on the purpose of the payment, it will have either a limited or no effect. However, for Section 8, whether the payment is direct or in-kind has no significance. Instead, the distinction is between payments that are "regular" income and those that can be characterized as "temporary, nonrecurring or sporadic income (including gifts)." 24 CFR § 5.609(c)(9). The limiting terms are not defined. How distant in time must payments be to be sporadic. For how brief a time to be temporary? How different in amount to be nonrecurring? Certain other exemptions apply, including payments for medical or social services and health insurance.

The good news about income determinations under Section 8 is that unless total income exceeds a fairly generous level (in most areas in Massachusetts in excess of $32,000), payments treated as income affect rent but not on a dollar-for-dollar basis. The addition of $750 in support, for example, will raise the individual's rent by $225. One can certainly envision circumstances in which the overall cost-benefit analysis would support such a trade-off.

With Section 8, planning strategies may be explored to maximize the efficiency of support payments, depending on the individual's personal and financial circumstances. One can thus envision a strategy involving sporadic lump sum distributions to the individual, for him to hold (either outright or in a revocable trust), invest and spend down on his needs over a protracted period. Recall that having assets in excess of $2,000 is disqualifying, among the programs listed above, only for SSI and MassHealth for people who are institutionalized or receiving services under a waiver. Many disabled people are not eligible for SSI anyway (typically because their income from SSDI is high enough to render then income-ineligible for SSI) and most MassHealth recipients under age 65 are not subject to asset limitations at all. Each case ultimately comes down to an assessment of potential trade-offs in eligibility. If I have to choose between Section 8 and SSI, for example, which is worth the more to the beneficiary?

Appendix 1

M.G.L. c. 215, Section 6.

The probate and family court department shall have original and concurrent jurisdiction with the supreme judicial court and the superior court department of all cases and matters of equity cognizable under the general principles of equity jurisprudence and, with reference thereto, shall be courts of general equity jurisdiction, except that the superior court department shall have exclusive original jurisdiction of all actions in which injunctive relief is sought in any matter growing out of a labor dispute as defined in section twenty C of chapter one hundred and forty-nine.

Probate courts shall also have jurisdiction concurrent with the supreme judicial and superior courts, of all cases and matters in which equitable relief is sought relative to: (i) the administration of the estates of deceased persons; (ii) wills, including questions arising under section twenty of chapter one hundred and ninety-one; (iii) trusts created by will or other written instrument; (iv) cases involving in any way the estate of a deceased person or the property of an absentee whereof a receiver has been appointed under chapter two hundred or the property of a person under guardianship or conservatorship; (v) trusts created by parol or constructive or resulting trusts; **(vi) all matters relative to guardianship or conservatorship;** and (vii) actions such as one described in clause (11) of section three of chapter two hundred and fourteen and of all other matters of which they now have or may hereafter be given jurisdiction. They shall also have jurisdiction to grant equitable relief to enforce foreign judgments for support of a wife or of a wife and minor children against a husband who is a resident or inhabitant of this commonwealth, upon an action by the wife commenced in the county of which the husband is a resident or inhabitant. They shall, after the divorce judgment has become absolute, also have concurrent jurisdiction to grant equitable relief in controversies over property between persons who have been divorced. They shall also have

jurisdiction of an action by an administrator, executor, guardian, conservator, receiver appointed as aforesaid or trustee under a will to enjoin for a reasonable period of time the foreclosure, otherwise than by open and peaceable entry, of a mortgage on real estate, or the foreclosure of a mortgage on personal property, which real estate or personal property is included in the estate or trust being administered by such fiduciary, if in the opinion of the court the proper administration of the estate or trust would be hindered by such foreclosure. They shall also have jurisdiction, concurrent with the superior court, of proceedings in which equitable relief is sought under sections seven to twelve, inclusive, of chapter one hundred and seventeen and section twenty-six of chapter one hundred and twenty-three.

Notwithstanding any contrary or inconsistent provisions of the General Laws, procedure in cases in the probate court within the jurisdiction granted by this section shall be governed by the Massachusetts Rules of Civil Procedure.

Appendix 2

Illustrative Letter of Intent

As the Settlors of the John Smith Special Needs Trust, dated _____, we, John's parents, are writing to memorialize our intentions for the trust in the hope that in so doing we will be able to provide guidance to the trustees on how the trust might best and most sensitively be used in John's best interest over his lifetime. However, particularly in recognition of the fact that John's needs and circumstances, as well as programs and treatments to meet his needs, are likely to change, we want to be clear that we do not intend that the thoughts reflected in this document be deemed incorporated into the trust or be considered explicitly or implicitly binding on the trustees or in any way limiting of their discretion as set out in the trust itself. We are trying through this instrument to establish a general sense of direction, and nothing more.

The first principle underlying our personal and financial efforts on John's behalf have been that John have the unconditional right to a life which is as fulfilling as possible, and that this right shall not be diminished by his having a severe and long-term mental illness, a condition compounded by common public misapprehensions of it.

We begin by acknowledging the obvious fact that John has very substantial and complex needs, in relation to residential, social, vocational and rehabilitation services, as well as for general financial support. Also, John's needs are likely to change over time, as the illness, treatment alternatives, and available services evolve, in ways that are now difficult or impossible to forecast, over the course of what will hopefully be a full normal life span.

How are those needs to be met? Given the limited financial resources of his family, and thus the limited size of the trust, the trust in itself will not have the capacity to serve as the primary resource in meeting John's needs. What is the role of the trust in relation to other potential resources? What are those resources?

We fully expect that John will be able to play a significant role in his own financial support. John is intelligent and motivated, and engenders confidence and good will in people with whom he has the opportunity to establish relationships, including employment relationships. However, as hopeful as we might be, neither the Trustees nor we should assume that John will be capable of financial independence in the future, if for no other reason than that his education and early work history have been too interrupted.

We see that John has no practical alternative but to rely on governmental entitlements as the primary available resource for him in meeting his needs. However, it is our assessment that governmental programs presently available for the support of persons with mental illnesses contain

many gaps which, if not addressed, would greatly reduce the possibility of John maintaining himself in a manner consistent with basic human dignity with adequate opportunities for self-actualization. Furthermore, while governmental support and benefits for persons with mental illnesses have expanded in some areas over the past years, they have retracted in others. Given the retrenchment in public commitment and expenditures in recent years, the trustees should not, in planning for John's lifetime, assume that even the current array of services and supports is likely to be maintained.

John's strengths may themselves place his entitlements at risk. John is not so severely incapacitated that he will never be able to work productively. We expect the Trustees to support John's efforts to become more self-sufficient, and, if appropriate, provide incentives to John to be productive. We understand that efforts at self-sufficiency may adversely affect his entitlements, but feel that the potential benefit to John of successful work attempts is worth the risk of loss of benefits.

Based on the foregoing considerations, we are convinced that the Trust must be maintained and utilized in a flexible, and conservative manner, to remain responsive to future developments and needs. Furthermore, and central to the manner of implementation of the trust, it is only through the efficient use of both family and governmental resources that John's needs can be met over his lifetime. It was not our intent or expectation in establishing this trust that it can or should be used to meet John's basic life needs on an on-going basis, but rather, that it be utilized primarily as a supplemental resource, taking into account John's own income, assets and governmental benefits into account, as well as all other factors bearing on his needs. Therefore, the trustees should distribute or apply trust principal and income primarily to supplement, but not to supplant, what benefits and services John may from time to time be eligible to receive by reason of his health or physical or other factors, under policies of insurance and from federal, state, and local governmental sources.

On the other hand, while many of the foregoing considerations dictate restraint in making distributions on John's behalf, we want to be very clear that the trustees should not take into account the potential future interests of the remaindermen, those who are to receive whatever is left in the trust upon its termination, in making decisions on distribution.

Payment for services such as the following (not intended to be exhaustive or necessarily appropriate under all circumstances, but rather by way of example) would we feel fulfill the long-term purposes of the trust:

1. Premiums, deductibles and co-insurance payments required of any applicable public or private program or policy of insurance under which John may from time to time be entitled to assistance.

2. That portion of medical, hospital, therapeutic, counseling, and other expenses not paid by any applicable public or private program or policy of insurance under which John may from time to time be entitled to assistance.

3. The costs of specific medical or surgical procedures, treatments, medication, and appliances not within the coverage of any applicable public or private program or policy of insurance under which John may from time to time be entitled to assistance, including, without limitation, foreign hospital services; treatment deemed experimental or unnecessary; services not qualifying for payment by reason of the relationship of the provider to the primary beneficiary; and services not qualifying for payment because the cost of which is deemed unreasonable, in excess of prevailing charges or cost containment restrictions, or otherwise excessive.

4. The costs of non-traditional care, support and therapies not within the coverage of any applicable public or private program or policy of insurance under which John may from time to time be entitled to assistance.

5. Continuation of care and treatment beyond the time, frequency, cost or other limitations for coverage within any applicable public or private program or insurance policy under which John may from time to time be entitled to assistance.

6. Services and associated room and board expenses in a care, treatment or other residential or day facility or placement, or from a specific provider, which does not qualify for financial participation under any applicable public or private program or policy of insurance under which John may be entitled to assistance.

7. Expenses associated with activities and services of a personal or recreational nature which do not qualify for financial assistance under any applicable public or private program or policy of insurance under which John may from time to time be entitled to such assistance, including, without limitation, travel, transportation, recreation, vacation, pastoral care, companion services, custodial care, personal care, personal comfort items or services, respite services, day care services, and home maintenance services.

8. Expenses associated with case management, social work, legal services, accounting, financial planning, real estate management and investment services, for which public support is not ordinarily available.

We also ask the trustees to take other, more personal and subjective considerations into account in deciding how best to use the trust to John's advantage.

John's insight into the nature and extent of his mental illness is presently limited. He isn't fully able to foresee the likely consequences of all his actions, nor reach back in memory to apply past experience to decisions about his current and future needs. Sometimes, he chooses a course of action solely to please others, without taking his own long-term interests

into account. Thus, John's decisions and judgments cannot always be trusted as the products of reasoned deliberation.

However, John is very intelligent. He is aware how others see and treat him, and sensitive to perceived slights. He is responsive to expectations. In other words, if he is treated with respect, as a decision-maker, he will more likely respond appropriately than if he is treated merely as the object of decisions of others. Therefore, the trustees need to be aware that it is very important for John to be involved in decision-making about his life, treatment and circumstances to the maximum extent appropriate. Specifically, the trustees should consult with John and take his personal goals, objectives and preferences into account in deciding how to use the trust for his benefit.

While John may not have the judgment and insight to assume full responsibility for the long-term management of substantial resources, he is not incapable of managing smaller amounts within shorter time-frames, such as within the structure of a budget with regularized receipts and scheduled payments. With structure, guidance and monitoring, he has shown the interest, responsibility and organizational skill to save and spend wisely and properly – at times in an even more controlled manner than is strictly required. We see the increase in John's capacity to manage at least a portion of his funds as being an important objective for John's rehabilitation and growth, and one to which the operation of the trust can either contribute or undercut.

John reacts positively to success. Feeling good about success in any sphere of his life may well find reflection in other spheres. To give him an opportunity to succeed necessarily entails the necessity of giving him some choices that he may or may not always make well. One cannot learn without risk. We understand that trustees are risk-averse by nature of their fiduciary responsibilities. However, we very much want the trustees to see their fiduciary responsibilities as extending beyond the question how most conservatively to handle the management and investment of the trust. While judicious handling will certainly be needed for the trust to serve its purposes over John's lifetime, the trustees must keep foremost in mind that the essential purpose of the trust is not conservation per se, but John's security and advancement as a functioning, social, productive and happy human being. The advancement of those objectives is the trustees' ultimate fiduciary responsibility. And if satisfying that responsibility entails risk, such as distributing some funds from the trust directly to John with the understanding and intention that John manage the funds to meet his needs – ceding to him a degree of control and autonomy – even at the risk of bad judgments in the use of the funds – that would be consistent with our intent.

A key challenge to the trustees will be to exercise their ultimately authority as softly as possible. Their authority is ultimate in deciding on how the trust is to be utilized for John. However, if the trust is to be successful in its mission, the trustees will have to exercise this authority with the greatest discretion. Otherwise, the operation of the trust may undercut

John's sense of himself as an autonomous and responsible adult and what we see to be the ultimate goal of his treatment. we therefore feel that it is essential that the trustees consult frequently with whomever may be the members of John's treatment team from time to time, such as his psychopharmacologist, therapist, rehabilitation specialist, social worker and residential support staff, for two purposes. The first is to better ensure that trustee decisions on the use of the trust, the goods and services it purchases on John's behalf, are most appropriate to meeting our objectives for John as set out in this letter. And the second is to guide the manner in which the trustees relate to John, not paternalistically, but with respect and dignity, giving all appropriate weight to his personal wishes and preferences.

_____
Mother

_____
Father