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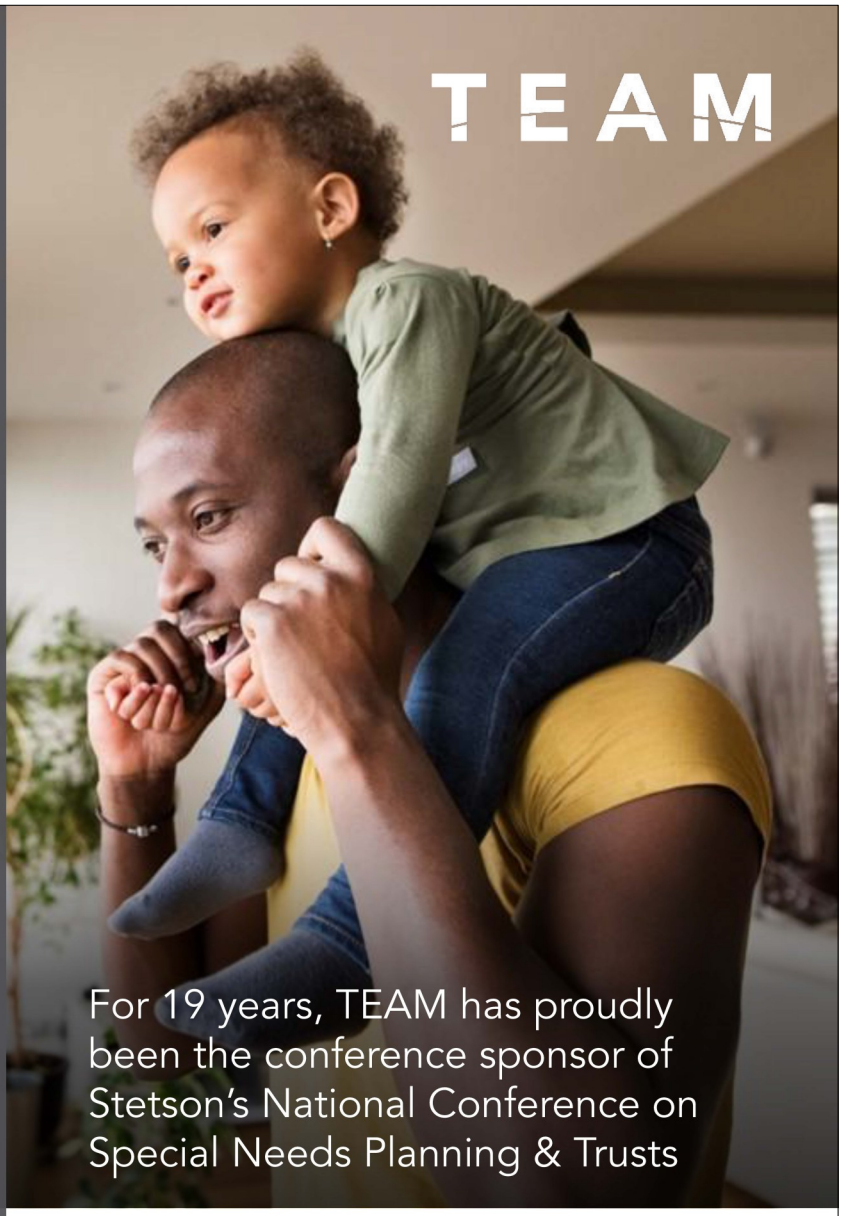
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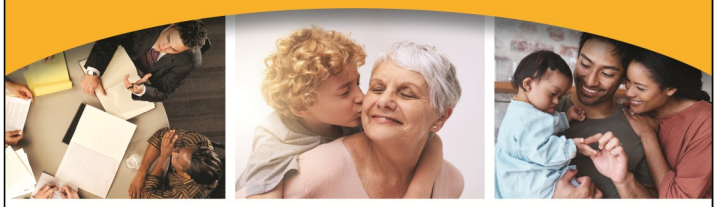
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3. MEDICAL COST PROJECTIONS

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NOTICE/WARNING

This presentation contains images and statements that some might find disturbing or inappropriate.

Kindly consider the historical context and educational relevance of these images and statements.

2



A Life of Dignity, Meaning, and Purpose Requires Advocacy

- Early intervention services
- Free appropriate public education
- Protection, promotion, and enforcement of civil rights
- Community based residential supports and services
- Meaningful work and community engagement with necessary support
- Access to affordable and quality health care
- Income maintenance benefits
- Voting rights reform
- Protection from abuse and neglect
- Self determination and supported decision-making

3

Current Landscape

The political climate threatens the safety net created over the past 70 years.

These are not right/left issues.

They are right/wrong issues.

Policy decisions have real life consequences.

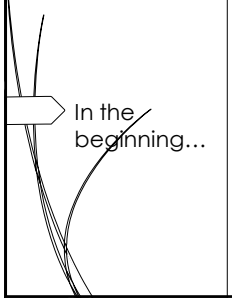
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The Achievements in Disability Policy didn't just happen.

They were fought for, not given.

Let's review this together,
and take a step back in time...

5



In the beginning...

- **Institutional model of care** – policy based on flawed views of worth of people with disabilities and other members of society viewed as "less than"
- **Eugenics philosophy** – 60,000 individuals are estimated to have been involuntarily sterilized between 1907-1970s
- **Non-therapeutic human experimentation**

6

The Beginnings of a Movement

Post WWII – Baby Boomer era, parents began organizing services and supports on their own.

The Arc movement, which is now the largest human rights and civil rights organization in the nation supporting individuals with IDD, was born.

The Kennedy Administration ushered in the first federal initiative regarding persons with intellectual disabilities.

7

Federal Recognition of Intellectual Disability

- Family Driven – Eunice Kennedy Shriver
- Amendment to Social Security Act to Promote Maternal Health and Planning Initiatives
- President's Commission on Intellectual Disability
- Thought Leadership



8

Institutional Reform – Stopping Human Warehousing

- The Last Disgrace - Geraldo Rivera
- Christmas In Purgatory – Burton Blatt – newspaper articles – political reaction – public revulsion
- Federal Class Action Suits
- Development of community-based services and supports



9

Notable Landmark Legislative Protections

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- Rehabilitation Act of 1973 – Nixon
- Supplemental Security Income Act (1974) – Nixon
- Individual with Disabilities Education Act (IDEA) (1975) – Ford
- Developmental Disability Assistance and Bill of Rights Act (DD Act) (1975) – Ford
- Americans with Disabilities Act (ADA) (1988) – Bush
- OBRA '93 (1993) – Clinton
- The Affordable Care Act (ACA) (2010) – Obama

10

Disability Advocacy Superpower!

Collaboration and Persistence

- Consortium for Constituents with Disabilities
- Multiple organizations working as a broad-based coalition
- Grass roots network providing information to develop policy
- Real time alerts – calls to action
- Legal advocacy – amicus briefs



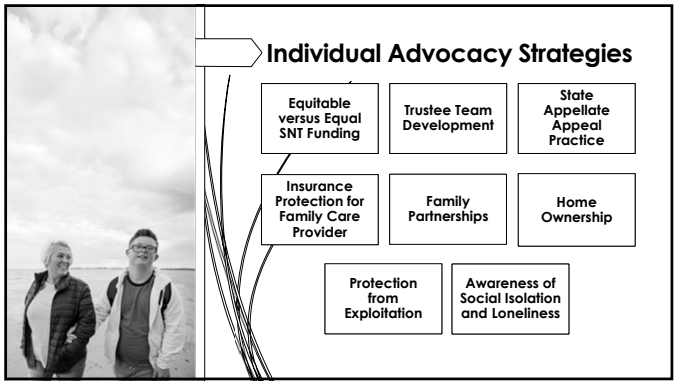
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The Arc of the United States

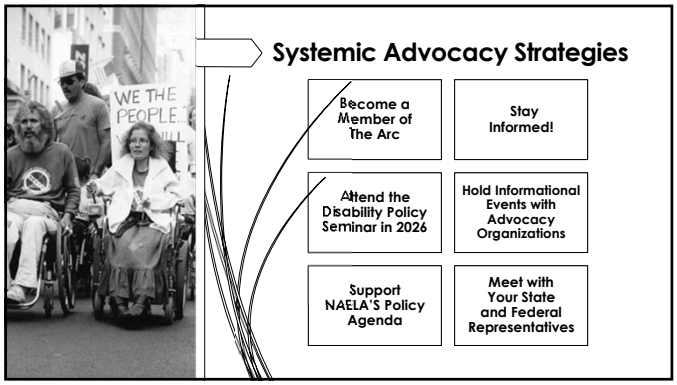
The Arc

- Leads collaboration with other disability rights groups
- Public policy advocate for over 70 years
- Legal advocacy
- Position Statements
- Disability Policy Seminar
- Over 600 state and local chapters
- Services to individuals and their families in all stages of life

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Individual Advocacy Strategies
Equitable versus Equal SNT Funding
Trustee Team Development
State Appellate Appeal Practice
Insurance Protection for Family Care Provider
Family Partnerships
Home Ownership
Protection from Exploitation
Awareness of Social Isolation and Loneliness

13


Systemic Advocacy Strategies
Become a Member of The Arc
Stay Informed!
Attend the Disability Policy Seminar in 2026
Hold Informational Events with Advocacy Organizations
Support NAELA'S Policy Agenda
Meet with Your State and Federal Representatives

14


The Arc
The Arc is fighting to protect disability rights, and the services people need to thrive in school, access quality health care, work, and live independently in their communities.
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Where Child Support Meets Special Needs - A Survey of Current Law

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A Survey of the Law in 2025

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2025 National Conference on Special Needs Planning and Special Needs Trusts

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D. *In re Ramsey County ex rel. Pierce County, Wis*., 645 N.W.2d 747 (Minn.App. 2002). 42

Appendix A Child Support For Adult Disabled Child - Summary of Cases and Statutes in 50 States Plus District of Columbia That Answer Questions Posed in the Accompanying Paper

Appendix B Special Needs Trusts and Child Support - Summary of Cases and Statutes in 50 States Plus District of Columbia That Answer Questions Posed in the Accompanying Paper

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Where Child Support Meets Special Needs
~
A Survey of the Law in 2025

Written and Presented by
Craig C. Reaves, CELA
Kansas City, Missouri

This paper is an update to a paper written by the author in 2013 and presented that Fall at the Stetson University College of Law National Conference on Special Needs Trusts. It is accompanied by two spreadsheets that address the questions posed below for every State in the United States plus the District of Columbia, plus they contain citations to relevant cases and statutes for each State.

It has been an interesting process to update these materials and see what has changed over a twelve year period. Overall, the trend of these changes is encouraging. Generally, legislatures and courts have taken steps to clarify and strengthen what adult children who have a disability are entitled to receive from parents who are responsible for paying child support. Some of the questions left dangling in 2013 have been addressed, and some new questions have appeared.

While much work and time has been invested in research for this paper, and the goal of everyone involved was to make it as current and accurate as possible,[1] it would not surprise any of us if there are new statutes and cases that are not mentioned in the attached spreadsheets. The law is an ever flowing river and we dipped into it earlier this year to catch what we could as it relates to the topic of this paper. The author welcomes gentle and helpful corrections, clarifications, and additions.

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[1] Needless to say, this paper required a lot of research to gather all of the information contained in the accompanying spreadsheet. For the work of updating this information in 2025, the author would like to thank Professor Rebecca C. Morgan at Stetson University College of Law, and the following students for their assistance with research for this paper: from Stetson University School of Law - Rachel A. Steinke, Elizabeth A. Campbell, Kylie L. Kempe, and Megan D. Lynch, and from the University of Missouri - Kansas City School of Law, John View.

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The questions addressed in these materials are:

1. Can a parent be required to pay child support for an adult child who has a disability?

2. If so, can a parent be required to pay child support for an adult child who was not disabled before reaching majority age or becoming emancipated?

3. Must legal action to request child support for an adult child be commenced before the child reaches majority age?

4. If a parent is required to pay child support, can public benefits the child is receiving be used to offset or reduce the parent's contemporaneous obligation to pay child support?

5. Can trust assets or income be used to offset or reduce a parent's child support obligation owed to a child who is a beneficiary of the trust?

6. Can child support payments be made directly to a child's special needs trust to avoid reduction in the child's SSI or Medicaid benefits?

7. Can a special needs trust be garnished for unpaid child support owed by the beneficiary of the trust?

8. Does it violate the sole benefit rule if a self-settled special needs trust directly pays the child support obligation owed by the beneficiary of the trust?

9. Do distributions from a special needs trust count as income to a trust beneficiary when calculating how much child support the trust beneficiary owes?

As should be expected, the answers to these questions differs among the States, and many States have not dealt with all of these questions yet. Despite this, there are apparent

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trends across the States. Also, since 2013 there have been quite a few statutes adopted, along with a few court cases, that address these questions.

So, let us begin. The first question addressed is:

1. Can a Parent Be Required to Support an Adult Child Who Has a Disability?

The answer to this question begins in the common law of England and America.

> As Judge Prettyman stated, the term "common law" means "a system of law not formalized by legislative action, not solidified but capable of growth and development at the hands of judges." *Linkins v. Protestant Episcopal Cathedral Found.*, 87 U.S.App.D.C. 351, 354–55, 187 F.2d 357, 360–61 (1950).[2]

A. The Common Law - Support of Minor Children

From the earliest of times it has been agreed that parents have a duty to support their minor children. Sir William Blackstone in his *Commentaries of the Laws of England* (1765 - 1769) said, "The duty of parents to provide for the maintenance of their children is a principle of natural law; an obligation...laid on them not only by nature herself, but by their own proper act, in bringing them into the world. ... By begetting them, therefore, they have entered into a voluntary obligation to endeavor, as far as in them lies, that the life which they have bestowed shall be supported and preserved."[3]

In America, James Kent[4] in his *Commentaries on American Law* (1826 - 1830) wrote, "The wants and weaknesses of children render it necessary that some person maintains them,

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[2] Nelson v. Nelson, 548 A.2d 109, 112 (D.C. 1988).

[3] 1 BLACKSTONE'S COMMENTARIES, Ch. 16,I,1.

[4] James Kent was the first Professor of Law at Columbia College and Chief Justice of the New York Supreme Court in the early 1800's. Quoting from Wikipedia, "His Commentaries on American Law (based on lectures first delivered at Columbia in 1794, and further lectures in the 1820s) became the formative American law book in the antebellum era (published in 14 editions before 1896) and also helped establish the tradition of law reporting in America. He is sometimes called the "American Blackstone". See https://en.wikipedia.org/wiki/James_Kent_(jurist).

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and the voice of nature has pointed out the parents as the most fit and proper persons. The laws and customs of all nations have enforced this plain precept of universal law. ... The obligation on the part of the parent to maintain the child continues until the latter is in a condition to provide for its own maintenance, and it extends no further than to a necessary support. The obligation of parental duty is so well secured by the strength of natural affection, that it seldom requires to be enforced by human laws. According to the language of Lord Coke, it is 'nature's profession to assist, maintain, and console the child.' ... The father is bound to support his minor children, if he be of ability, even though they have property of their own;..."[5]

B. The Common Law - Support of Adult Children

But what about adult children? Is there a duty imposed on a parent to support an adult child?

Blackstone's answer was, "No person is bound to provide a maintenance for his issue, unless where children are impotent and unable to work, either through infancy, disease, or accident; and then is only obliged to find them with necessaries...".[6]

However, despite Blackstone's commentary, it was statutory law that formed the basis for a parent's responsibility to support an adult child in England. And this responsibility was based on the need to control paupers and vagrants, not on the natural laws of a parent caring for a child.

The Elizabethan Poor Law, found in 43 Elizabeth 1, Chapter 2 (1601), established the laws for relief of the poor and became the foundation of American common laws relating to welfare and family relations. It firmly established the principle that it is the public's responsibility to maintain those who are destitute, not just the responsibility of the church and religious organizations. This law came about because the religious institutions that had assumed this responsibility in the past were losing their power and wealth and, as a result, their ability to properly care for the poor. While consolidating more power in the central

[5] 2 KENT ON AMERICAN LAW, Lecture 29.

[6] 1 BLACKSTONE'S COMMENTARIES, Ch. 16,I,1.

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government, this law delegated most authority and decision making to the local governments and communities. It built on and supplemented existing programs run by religious organizations and local communities. It also helped establish the government as the more powerful entity and provide another reason for taxes to be levied.[7]

The court in *Pocialik v. Federal Cement Tile Co.*, 97 N.E.2d 360, 362-363 (Ind.App. 1951) *en banc*, described the early English law this way:

> Appellants argue that by the common law of England there was a duty upon parents to support their defective adult children. We find, however, that the common law of England did not so provide prior to the settlement of Jamestown, nor did it so provide over three centuries later. The only obligation was that which might be imposed under the statute of 43rd Elizabeth, ch. 2, entitled, 'An Acte for the Releife of the Poore.' Section 6 thereof provides: 'And be it further enacted, That the Father and Grandfather, and the Mother **363 and Grandmother, and the Children of everie poore olde blind lame and impotente person, or other poore person not able to worke, beinge of a sufficient abilitie, shall at their owne Chardges releive and maintaine everie such poore person, in that manner and accordinge to that rate, as by the Justices of the Peace of that Countie where such sufficient persons dwell, or the greater number of them, at their generall Quarter Sessions shalbe assessed; upon paine that everie one of them shall forfeite Twentie shillings for everie monethe whiche they shall faile therein.' Under this statute an assessment and order of the justices was a condition precedent to the existence of any liability at all. *Coldingham Parish Council v. Smith*, 1918, 2 King's Bench Division 90; *Borchert v. Borchert*, 1946, 185 Md. 586, 45 A.2d 463, 162 A.L.R. 1078; *Eversley, The Law of Domestic Relations*, p. 515 (London 2d ed. 1896).[8]

The concept of a parent's responsibility to support an adult child so the child does not become a pauper was carried over to America. James Kent described it this way,

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[7] For an excellent description of the development of the English common law, see Jacobus tenBroek, CALIFORNIA'S DUAL SYSTEM OF FAMILY LAW: ITS ORIGIN, DEVELOPMENT AND PRESENT STATUS, PART I, 16 Stan. L. Rev. 257 (March 1964). *See also* In re Marriage of Cady & Gamick, 105 Cal. App. 5th 379, 392, 325 Cal. Rptr. 3d 856 (2024)(contains a summary of the history of Elizabethan poor laws and how it was incorporated into laws across the United States).

[8] Pocialik v. Federal Cement Tile Co., 97 N.E.2d 360, 362-363 (Ind.App. 1951) en banc.

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> The legal obligation of the father to maintain his child, ceases as soon as the child is of age, however wealthy the father may be, unless the child becomes chargeable to the public as a pauper."[9]
>
> In 2 Kent's Commentaries on American Law (1884) 190, it is stated: "The wants and weaknesses of children render it necessary that some person maintains them, and the voice of nature has pointed out the parent as the most fit and proper person. The laws and customs of all nations have enforced this plain precept of universal law. * * * The obligation on the part of the parent to maintain the child continues until the latter is in a condition to provide for its own maintenance * * *.[10]

Early American courts saw a distinction between English common law and the Americanized version of common law that evolved in the United States. Whereas in England the duty of a parent to support a child was based on statutes to prevent the child from being a pauper (and, thus, cause the government and religious organizations to spend money to maintain), in America it was based on something else. For example, in 1886 the Iowa Supreme Court said,

> The obligation of parents to support their children at common law is somewhat uncertain, ill defined, and doubtful. Indeed, it has been said that there is no such obligation. *Mortimore v. Wright*, 6 Mees. & W. 488. But we are not prepared to say that this rule has been adopted in this country, and it should be conceded, we think, that, independent of any statute, parents are bound to contribute to the support of their minor children,....[11]

C. The Law Today in the United States

In addition to supporting minor children, most courts in the United States today also find that a parent has a duty to support an adult child who is unable (as opposed to unwilling) to self-support. These decisions are based on either the court's interpretation of an applicable statute or the common law. The reasons normally employed to justify this view

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[9] 2 Kent on American Law, Lecture 29.

[10] Castle v. Castle, 473 N.E.2d 803, 806 (Ohio 1984)(quoting from 2 Kent Commentaries on American Law).

[11] Johnson v. Barnes, 29 N.W. 759 (Iowa 1886).

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revolve around the child being so disabled that he or she is not capable of adequate self-support.

One of the earliest cases in the United States concerning the duty of a parent to provide for an adult child with a disability was *Cromwell v. Benjamin*, 41 Barb. 588 (N.Y.Sup.Ct. 1863). In this case the court compared the duty of a father to his minor and "invalid" adult child to the same duty a husband owes to his wife.[12] The court found the father to be liable to the owner of a store that provided necessaries to his wife, minor son and adult daughter who, "although a few years past her majority, was unmarried and a member of his family, and who, as appeared by testimony in the case, was an invalid unable to support herself by her labor." *Cromwell*, *Id.* at 41.

Carrying on the English common law requirement that a parent may be held responsible for the support of an adult child to prevent the child from becoming a pauper, many courts and statutes define "disability" in the context of an adult child's inability to adequately self-support. This was described in *Ex parte Cohen*, 763 So.2d 253 (Ala. 1999) as,

> Other courts have defined "disability" in economic terms, i.e., as an adult child's inability to adequately provide for his or her economic needs because of a mental or physical infirmity. See, e.g., *Presley v. Presley*, 65 Md.App. 265, 500 A.2d 322 (1985), in which the court held that an adult child who was mildly retarded and who was able to earn only $14,200 per year was disabled within the meaning of the Maryland statute and therefore was entitled to support from her noncustodial parent. The *Presle*y court stated that the duty of support arises "when the child has insufficient resources and, because of mental or physical infirmity, insufficient income capacity to enable him to meet his reasonable living expenses." 65 Md.App. at 277, 500 A.2d at 328. See, also, *256 *Hanson v. Hanson*, 425 Pa.Super. 508, 625 A.2d 1212 (1993), holding that whether a court was to order support for a disabled adult child

[12] "It is a settled principle in the law of husband and wife, that by virtue of the marital relation, and in consequence of the obligations assumed by him upon marriage, the husband is legally bound for the supply of necessaries to the wife, so long as she does not violate her duty as wife; that is to say, so long as she is not guilty of adultery or elopement. The husband may discharge this obligation by supplying her with necessaries himself or by his agents, or giving her an adequate allowance in money, and then he is not liable to a tradesman who, without his authority, furnishes her with necessaries; but if he does not himself provide for her support, he is legally liable for necessaries furnished to her by tradesmen, even though against his orders. (2 Smith's Lead. Cas. 440.)" Cromwell v. Benjamin, 41 Barb. 588 (N.Y.Sup.Ct. 1863) at 588.

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> depended on whether the child was physically and mentally able to engage in profitable employment and whether such employment was available to that child at wages upon which the child could support herself. The Hanson court held that a child who because of her handicaps was able to earn only $2,850 annually was entitled to postminority support.[13]

A Missouri court ruled in *Mason v. Mason*[14] that whether a child was disabled sufficiently to trigger a child support obligation was based on the child's ability to earn a living. In this case the court held that the applicable statute (Rev. Stat. Mo. § 452.340) required that the child's disability "must actually render the child unable to earn a living in any type of job." The court concluded that the child's "lack of commitment towards college or employment would, therefore, not in and of itself, signal that the child has special needs requiring extraordinary support." *Mason, Id*. at 637.

In some states, filial support laws are used to impose an obligation on a parent to support an adult child who is unable to support himself.[15] For example, in *Sininger v. Sininger*, 479 A.2d 1354 (Md. 1984) the Maryland Supreme Court applied such a statute when it ruled that a parent had a duty to support an adult child even though the child became disabled after being emancipated. The current version of this statute is MD Code, Family Law § 13-102 (2024) which says, "(a) If a destitute adult child is in this State and has a parent who has or is able to earn sufficient means, the parent may not neglect or refuse to provide the destitute adult child with food, shelter, care, and clothing." It goes on to say, "(b) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year, or both."

D. Duty Imposed on Divorced Parents Does Not Violate the Constitution

A court order requiring a parent to financially support an adult child is normally imposed only on parents who have divorced. Some divorced parents have argued that this is a violation of their Constitutional equal protection rights because divorced parents are being

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[13] Ex parte Cohen, 763 So.2d 253, 255-256 (Ala. 1999)

[14] Mason v. Mason, 873 S.W.2d 631 (Mo.App.E.D. Div. 3 1994).

[15] *E.g.,* Carpy v. Carpy, No. A135261 (Cal.App. 1st Dist. Div.1 August 28, 2013)(Held duty imposed on parent by Cal. Fam. Code § 3910 continues after parent's death).

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treated differently than parents who are married. This argument has consistently been rebuffed by the courts.[16]

The rationale legislatures and courts often use to require a divorced non-custodial parent to pay money towards the support of his or her children is as follows: When parents divorce, the children of the marriage usually live primarily with one parent (the "custodial parent") while the other parent (the "non-custodial parent") lives elsewhere. If the non-custodial parent does not pay money back into the custodial household, through alimony or maintenance to the former spouse and/or child support, the children are deprived of the income and other financial support that the non-custodial parent would have brought into the household if the divorce had not occurred. So the purpose of requiring the non-custodial parent to pay child support is so that the children receive an amount of financial support that is similar to what the children would have experienced had the parents not divorced.

E. Agreements to Continue Child Support for Adult Child Will Be Honored

Divorced parents can always agree that child support will continue to be paid for an adult child. This would typically occur in the Separation Agreement or Decree of Divorce entered into by the parents when the divorce was finalized. The author did not find one case that invalidated such an agreement between the divorcing parents. On the contrary, some statutes[17] and many cases[18] refer to the parents' ability to enter into such an agreement.

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[16] *E.g.*, Hanratty v. Hanratty, A10-1346, 2001 WL 891178 (Minn.App. 2011); Bailey v. O'Hare, 2006 WL 164917, 2006-Ohio-239 (Ohio App. 2 Dist. 2006); Riggs v. Riggs, 578 S.E.2d 3 (S.C. 2003); Childers v. Childers, 575 P.2d 201 (Wash. 1978).

[17] *E.g.*, Colorado - C.R.S. § 14-10-115(13)(a) ("For child support orders entered on or after July 1, 1997, unless a court finds that a child is otherwise emancipated, emancipation occurs and child support terminates without either party filing a motion when the last or only child attains nineteen years of age unless one or more of the following conditions exist: (I) The parties agree otherwise in a written stipulation after July 1, 1997.").

Fla. Stat. Ann. § 61.13(1)(a)1.a (child support terminates on a child's 18th birthday unless . . . "continued support is otherwise agreed to by the parties.").

Ohio Rev. Code Ann. § 3119.86(A)("The duty of support to a child imposed pursuant to a court child support order shall continue beyond the child's eighteenth birthday only under the following circumstances:...(2) The child's parents have agreed to continue support beyond the child's eighteenth birthday pursuant to a separation agreement that was incorporated into a decree of divorce or dissolution.").

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It is when such an agreement does not exist that the courts are required to look to the governing statutes, case law, or the common law to justify forcing the non-custodial parent to continue paying child support for an adult child.

2. Can a Parent be Required to Pay Child Support For An Adult Child Who Was Not Disabled Before Reaching Majority Age or Becoming Emancipated?

Another way to ask this question is, can a parent be required to pay child support for an adult child who did not have a disability when the child reached majority age or became emancipated, but later became disabled?

Of the courts that have considered this question, the majority have ruled that an adult child must have incurred his or her disability before the child reaches the age of majority or is otherwise emancipated. For example, the Arkansas Supreme Court said, "We have held the duty to support a child does not cease at majority *if* the child is mentally or physically disabled in any way *at* majority and needs support." *Towery v. Towery*, 685 S.W.2d 155, 157 (Ark. 1985) (emphasis in original).

A. Definitions of Emancipation

The words used to describe the time when a parent's duty to support a child stops is "emancipation," and when the child is "emancipated." The age of majority adopted by the

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La. Rev. Stat. § 9:315.22.D(3) ("Nothing in this Subsection shall limit a parent's ability to agree to provide continued support or the court's power to determine whether an agreement to provide additional support has been made").

See also, M.C.L.A § 552.605b(5) (Michigan); N.D. Cent. Code Ann. § 14-09-08.2.6.

[18] *E.g.,* Penny v. Penny, 785 So.2d 376, 378 (Ala.Civ.App. 2000) "In Alabama, the general rule is that a trial court has no jurisdiction to require a parent to provide support for a child who has reached the age of majority. See Beavers v. Beavers, 717 So.2d 373 (Ala.Civ.App.1997). Whitten v. Whitten, 592 So.2d 183 (Ala.1991). However, there are exceptions to the general rule. The first exception is where the noncustodial parent has agreed to provide support for the child past the age of majority." (emphasis added); O'Connor v. O'Connor, 594 N.E.2d 1081 (Ohio App. Tenth Dist. Franklin County 1991).

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state is typically the starting point for this. In most states, this age is 18,[19] although in some states the age is later for child support purposes.[20] When a child is deemed to be "emancipated" can happen before or after the age of majority if certain circumstances occur.

Many courts have addressed the issue of whether a child under the age of majority is emancipated for child support purposes. One of the more colorful descriptions comes from the Illinois Supreme Court in the 1920 case of *Iroquois Iron Co. v. Industrial Commission*. Here the court said,

> Generally speaking, when a child arrives at the age of majority the parent is no longer under legal obligation to support him. On the other hand, the parent is usually under a legal obligation to support his minor children. When a child who is physically and mentally able to take care of himself voluntarily abandons the parental roof and leaves its protection and influence and goes out to fight the battle of life on his own account, the parent is no longer under legal obligation to support him. [citation omitted] If a boy has attained an age at which he is capable of supporting himself, neither justice, reason, nor the law requires the parent to maintain him in idleness. Emancipation is inferred where the child contracts for his services and collects and uses his own earnings. [citation omitted] . . . Emancipation works a severance of the filial relation as completely as if the child were of age. Whether there has been an emancipation is a question of fact, but what is emancipation is a question of law.[21]

All states have statutes requiring a non-custodial parent to pay child support for a minor child until a time when it is no longer deemed necessary, *i.e*., when the child is

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[19] The states that do not use age 18 for the age of majority are: Alabama (Ala. Code § 26-1-1(a)) (age 19); Nebraska (Neb. Rev. Stat. § 43-2101)(age 19); Mississippi (Miss. Code Ann. § 1-3-27 ("The term "minor," when used in statute, except as otherwise provided by law, shall include any person, male or female, under twenty-one (21) years of age. If a statute refers to the ability to enter into a contract affecting personal property or real property, "minor" shall mean any person, male or female, under eighteen (18) years of age."));

[20] *E.g.*, Colo. Rev. Stat. § 14-10-115(13) (age 19); D.C. Code § 46-101(age 21, which is based on common practice in court, not explicitly in this code section); Ind. Code § 31-16-6-6(a)(age 19); MD Code, General Provisions, § 1-401 (age 19); N.Y. Fam. Ct. Act § 413(1)(a)(age 21)

[21] Iroquois Iron Co. v. Indus. Comm'n, 294 Ill. 106, 108-109, 128 N.E. 289, 290 (Ill. 1920)

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"emancipated." State statutes use different definitions of emancipation, but they generally deem a minor child under the age of majority to not be emancipated.

However, there are exceptions to this. Some of these are if the child has married,[22] joined the military,[23] is convicted of certain crimes,[24] or permanently left the parental home and becomes self-supporting.[25] Some state statutes move the emancipation date out to ages ranging from nineteen to twenty-six if the child is attending some type of school.[26] And some state statutes continue to treat an adult child as not being emancipated if the child has a disability and, as a result, cannot self-support.[27]

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[22] *E.g.*, Colorado - C.R.S § 14-10-115(13)(a)(IV)("If the child marries, the child shall be considered emancipated as of the date of the marriage. If the marriage is annulled, dissolved, or declared invalid, child support may be reinstated."); Indiana - Ind. Code § 31-16-6-6(b)(2); South Dakota - SDCL § 25-5-24(1)("Has entered into a valid marriage, whether or not such marriage was terminated by dissolution").

[23] *E.g.*, Colorado - C.R.S § 14-10-115(13)(a)(V)("If the child enters into active military duty, the child shall be considered emancipated."); Ind. Code § 31-16-6-6(b)(1); Va. Code Ann. § 16.1-333(i); SDCL § 25-5-24(2) ("Is on active duty with any of the armed forces of the United States of America").

[24] Mississippi - Miss. Code Ann. § 93-11-65(8)(a)(iv) ("Is convicted of a felony and is sentenced to incarceration of two (2) or more years for committing such felony").

[25] *E.g.*, Va. Code Ann. § 16.1-333(ii).

[26] *E.g.,* Arizona - A.R.S. § 25-320.F ("If a child reaches the age of majority while the child is attending high school or a certified high school equivalency program, support shall continue to be provided during the period in which the child is actually attending high school or the equivalency program but only until the child reaches nineteen years of age unless the court enters an order pursuant to subsection E of this section."); Ark. Code Ann. 9-12-312(a)(5)(A)(" The court may provide for the payment of support beyond the eighteenth birthday of the child to address the educational needs of a child whose eighteenth birthday falls prior to graduation from high school so long as such support is conditional on the child remaining in school."); Colorado - C.R.S. § 14-10-115(13)(a)("For child support orders entered on or after July 1, 1997, unless a court finds that a child is otherwise emancipated, emancipation occurs and child support terminates without either party filing a motion when the last or only child attains nineteen years of age unless one or more of the following conditions exist:(III) If the child is still in high school or an equivalent program, support continues until the end of the month following graduation. A child who ceases to attend high school prior to graduation and later reenrolls is entitled to support upon reenrollment and until the end of the month following graduation, but not beyond age twenty-one. "); Illinois - 750 Ill. Comp. Stat. Ann. § 5/513; Indiana - Ind. Code § 31-6-6-6(a); Mass. Gen. Laws ch. 208 § 28; W.Va. Code § 48-103(b).

[27] *E.g.*, Arizona - A.R.S. § 25-320.E. ("Even if a child is over the age of majority when a petition is filed or at the time of the final decree, the court may order support to continue past the age of majority if all of the following are true: 1. The court has considered the factors prescribed in subsection D of this section. 2. The child is severely mentally or physically disabled as demonstrated by the fact that the child is unable to live independently and be self-supporting. 3. The child's disability began before the child reached the age of majority.").

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B. The Emancipation Rationale

Whether there is a statute on point or not, many courts have determined that a child has never been emancipated, no matter what the age of the child, because of the child's disability. This is referred to as the "emancipation rationale," which has been described as "the duty to support a disabled child into adulthood continues because the disability prevents the child from ever becoming emancipated. The reasoning is that because the child is incapable of emancipation, he remains a minor and the obligation continues until the condition changes. ***once a child becomes an emancipated adult the obligation of parental support cannot be resumed.*** The fact that the child was incapacitated during his minority is crucial to the emancipation rationale." *Sininger v. Sininger*, 479 A.2d 1354, 1356-1357 (Md. 1984).

This rationale was expanded in the case of *Casdorph v. Casdorph*, 460 S.E.2d 736 (W.Va. 1995) where the West Virginia Supreme Court faced the question of "whether a parent has

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Ark. Code Ann. § 9-12-312(a)(5)(B) ("The court may also provide for the continuation of support for an individual with a disability that affects the ability of the individual to live independently from the custodial parent.").

Cal. Fam. Code § 3910(a) ("Each parent of a child has an equal responsibility to maintain, to the extent of their ability, their child of whatever age who is incapacitated from earning a living and without sufficient means.").

Colorado - C.R.S § 14-10-115(13)(a)(III) ("If the child is mentally or physically disabled, the court or the delegate child support enforcement unit may order child support, including payments for medical expenses or insurance or both, to continue beyond the age of nineteen;").

Conn. Gen. Stat. Ann. § 46b-84(c) ("The court may make appropriate orders of support of any child with intellectual disability, as defined in section 1-1g, or a mental disability, as defined in section 46a-51, or who is physically disabled, as defined in section 46a-51, who resides with a parent and is principally dependent upon such parent for maintenance until such child attains the age of twenty-one. . . .").

See also, Fla. Stat. Ann § 743.07; Ga. Code Ann. § 19-6-15.1; H.R.S. § 580-47(a); 750 Ill. Comp. Stat. Ann. 5/513.5(a); Ind. Code § 31-16-6-6(a)(2); Iowa Code Ann. § 598.1(9); Ky. Rev. Stat. Ann. § 405.020(2); La. R.S. § 9:315.22.1; Md. Code, Family Law § 13-101; Minn. Stat. § 518A.26.5; Rev. Stat. Mo. § 452.340.4; Nev. Rev. Stat. § 125B.110; N.J. Stat. Ann. § 2A:34-23.a; N.Y. Fam. Ct. Act § 413-b (but only until age 26); Ohio Rev. Code. § 3119.11; 43 Okla. Stat. § 112.1A.B; 23 Pa. C.S. § 4321(3); R.I. Gen. Laws § 15-5-16.2(b); S.C. Code Ann. § 63-3-530(A)(17); Tenn. Code Ann. § 36-5-101(k); Texas Fam. Code § 154.001(a)(4); Utah Code Ann. § 81-6-101(7)(c) and § 81-6-104(1); Va. Code Ann. § 20-124.2.C and § 16.1-278.15.A; W. Va. Code § 48-11-102(b); Wyo. Stat. Ann. § 14-2-204(a)(i).

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a duty to support a child who becomes disabled subsequent to reaching the age of majority where the child has continually remained dependent upon either one or both parent(s) since attaining the age of majority.*" Casdorph, Id.* at 740.

After discussing the concept of "emancipation," the *Casdorph* court concluded that since the child had never married nor moved out on her own and she remained dependent on her mother for support after she reached the age of majority until the time of the automobile accident that caused her disability, she was really never "emancipated" and, therefore, the father had a continuing duty to support her. It was other factors, not the disability, that caused the child to not be emancipated.

The *Casdorph* court laid out an emancipation rationale roadmap for courts to use when trying to determine if a child has been emancipated:

> In making the determination of whether a disabled child was emancipated at the time the disability occurred, the trial court should examine the facts and circumstances of each case, giving consideration to the following factors, as well as any others germane to the issue of emancipation: 1) whether the child continually resided in the home of one of his/her parents; 2) whether the child continually remained dependent on his/her parent(s) for financial support; and 3) whether the child has ever married. Furthermore, prior to awarding post-majority child support, the trial court should first determine that the child, after the onset of the mental and/or physical disability, remains unemancipated.[28]

The Arkansas Supreme Court applied the emancipation rationale in *Towery v. Towery*, 685 S.W.2d 155 (Ark. 1985), although the result was no child support was ordered to be paid because the child became disabled after he was emancipated. While firmly supporting the idea that a parent owes a duty of support to a child until the child is emancipated, even if the child is over the age of majority, the court concluded that the child became disabled after he was emancipated and, therefore, the father could not be held liable for child support unless there was a statute that imposed such a duty. Similar results were reached in *Pocialik v. Federal Cement Tile Co.*, 121 Ind.App. 11, 97 N.E.2d 360 (1951), *Breuer v. Dowden*, 207 Ky. 12, 268 S.W. 541 (1925), and *Keenan v. Keenan*, 440 So.2d 642, 645

[28] Casdorph v. Casdorph, 460 S.E.2d 736, 742 (W.Va. 1995).

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(Fla.App. 5 Dist.1983) (where the court said, “While we firmly believe that parents, divorced or undivorced should provide their children with as much formal education as each child can absorb and the parents can afford, this court cannot create a *legal duty* to do so where none exists. That power rests in the legislature.”(emphasis in original)).

If a state does not have a statute that imposes a duty to support an adult child with a disability, then the courts will either hold that the non-custodial parent does not have to continue financially supporting an adult child who has a disability, or the court will find such a duty to support an adult child in the common law of the State, often by pointing out that in the State’s child support statute the word “child” is not defined by age.

For an example of a court finding the latter, consider *Ex parte Brewington*, 445 So.2d 294, (Ala. 1963) where the Alabama Supreme court said,

> Although we appreciate the decision of the Court of Civil Appeals which follows the general rule announced in *Reynolds*, supra,[29] this Court concludes that the decision of the trial court is the result which accords with the legislature's intent in this instance. To the extent that *Reynolds*, supra, is inconsistent with this holding, it is specifically overruled.
>
> An analysis of the Alabama cases reveals that *Reynolds*-type decisions were based on the position that, absent a statute or agreement, no common-law authority existed to impose upon a non-custodial parent the obligation to support his adult child. However, the majority trend is to recognize an exception to this rule when the adult child is so mentally and/or physically disabled as to be unable to support himself. See e.g. *Kruvant v. Kruvant*, 100 N.J.Super. 107, 241 A.2d 259 (1968); *Fincham v. Levin*, 155 So.2d 883 (Fla.App.1963); *Wells v. Wells*, 227 N.C. 614, 44 S.E.2d 31 (1947); *O'Malley v. O'Malley*, 105 Pa.Super. 232, 161 A. 883 (1932).
>
> The Court in *Reynolds* based part of its decision on *Murrah v. Bailes*, 255 Ala. 178, 50 So.2d 735 (1951), which held that the term “children” as used in § 30-3-1 was clearly meant to apply only to minor children. The statute, however, does not express such a limitation, and such a narrow interpretation is unacceptable. In the frame of reference of the present case,

[29] Author’s Note: Reynolds v. Reynolds, 149 So.2d 770 (Ala. 1963) held that the statute providing for child support only applied to minor children, so a court could not order a parent to support an adult child.

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we believe the legislature intended that support be provided for dependent children, regardless of whether that dependency results from minority, or from physical and/or mental disabilities that continue to render them incapable of self-support beyond minority.

Thus, we adopt the reasoning of the New Jersey Superior Court in the case of *Kruvant v. Kruvant*, supra, where the facts were similar to those of the case at bar. The case involved an appeal by a divorced husband from orders of the lower court reopening and modifying provisions for support of his son contained in a divorce decree. The husband argued that the New Jersey court did not have the jurisdiction under New Jersey's divorce statutes to order support for an adult child. The New Jersey court, however, said of its divorce statute:

> [It] contemplates support for the children of divorced parents who, but for the divorce, would have continued to be entitled to the support of their father. It stems from the presumed inability of such children, by reason of their minority, to provide for themselves. Children who are unable to care for themselves because of their minority are no less entitled to the court's solicitude when they continue to suffer, after they have attained their majority, from a physical or mental disability which continues to render them incapable of self-support. Normal instincts of humanity and plain common sense would seem to dictate that in such cases the statutory obligation of the parent should not automatically terminate at age 21, but should continue until the need no longer exists. 67 C.J.S. *Parent and Child* § 17, p. 704 (1950); 39 Am.Jur., *Parent and Child*, § 40, p. 645, § 69, p. 710 (1942). However, we do not believe that the Legislature in enacting N.J.S. 2A:34-23, N.J.S.A., intended to confer jurisdiction upon the court to compel a husband or wife to support a child suffering from a disability which did not exist at the time of his attaining his majority but came about some time later. 100 N.J.Super. at 113, 241 A.2d at 265-266.

Further, we take note of the case of *Strom v. Strom*, 13 Ill.App.2d 354, 142 N.E.2d 172 (1957), where an Illinois court observed that the Illinois divorce statute did not specifically refer to children who are minors and held that where care is necessary to equip the child for adult life and the financial

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> circumstances of the father are adequate, equity can continue its jurisdiction to compel support of an adult child.
>
> Moreover, in addition to our expanded interpretation today of the term "children" in the Alabama child support statute, we *297 recognize a duty imposed on parents to support their children who continue to be disabled beyond their minority. Accordingly, as urged by our Court of Civil Appeals, we follow the reasoning of our sister state, Florida, as expressed in the case of *Fincham v. Levin*, *supra,* at 884:
>
> > [Appellant] cites the annotation in 1 A.L.R.2d at page 914 in support of the proposition that the common law went no further than to impose on parents the duty of supporting their minor children, and that as a general rule there is no obligation on the part of a parent to support an adult child. This is unquestionably the rule with respect to able-bodied children. However, the same annotation (at page 921) reflects that most jurisdictions hold that where a child is of weak body or mind, unable to care for itself after coming of age, the parental rights and duties remain practically unchanged and the parent's duty to support the child continues as before. We concur with the trial court and *Perla v. Perla*, [58 So.2d 689 (Fla.1952)], in adopting that view.

End of quotation from *Ex parte Brewington, supra* at 296-297.

Of course, not all courts have adopted the position espoused by the *Brewington* court. For an example of a court refusing to find a common law duty for a parent to support an adult child absent a statute on point, see *Crane v. Crane*, 170 S.E.2d 392 (Ga. 1969) where the Supreme Court of Georgia said,

> the right in an adult child to recover support beyond the age of 21 is barred by Code ss 74-104 and 74-105, which provide *607 together that a father's obligation to provide for the maintenance, protection and education of his child ceases when the child becomes 21 years of age. There is no exception provided for and this court cannot make any. The General Assembly might conceivably make an exception as to children who are born mentally ill and remain so beyond majority or who become ill later on in life and remain so after reaching majority. *Crane*, *Id.* at 606-607.

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It is noteworthy that in 2024 Georgia enacted statutes Ga. Code Ann. §§ 19-6-15.1 and 19-6-15.2 to respond to the last sentence of the above quote from the *Crane* case. A portion of the first of these statutes is quoted in Section 2.C, below.

Another example is the Kansas Supreme Court in *Arche v. U.S. Dept. of Army*, 247 Kan. 276, 798 P.2d 477 (1990) where the court said,

> [u]nder the earliest common law a parent was not responsible for the care of an adult incompetent child. That common-law rule was modified by our earlier decisions and by statutory law. Then, in 1967, the legislature reinstated the early common-law rule that a parent would not be liable for the support, care, and maintenance of an adult incompetent child who was in a state hospital. After careful study, and in light of the economic realities of our present society, we conclude that we should follow the lead of the Kansas Legislature and modify our decisional law. Accordingly, we hold that a parent is no longer required by law to provide support for an adult incompetent child in this state.[30]

The Kentucky Appeals Court summarized its rule this way,

> [w]e deduce the rule to be that a parent is not liable for the debts of his adult child in the absence of a statute to the contrary, unless the child is in such a feeble and dependent condition physically or mentally as to be incapable of supporting himself; that if at the time the child becomes of age he is physically and mentally sound and able, if willing, to make and earn his own support, the parent is not liable for his debts or obligations thereafter contracted, even though he should later become sick or mentally unbalanced and therefore incapacitated to earn a livelihood. If, however, the child at the time of his arrival at the age of 21 is sick or otherwise incapacitated to earn a living for himself, and is, at the time, living in the home of the parent as a member of the household, the parent is liable for necessaries furnished him.[31]

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[30] Arche v. U.S. Dept. of Army, 247 Kan. 276, 291, 798 P.2d 477, 486 (Kan. 1990).

[31] Breuer v. Dowden, 268 S.W. 541, 542 (Ky.App. 1925).

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C. Statutes Imposing Duty to Support Adult Child

If a state has a statute that imposes a duty to support an adult child with a disability, then a court considering whether a non-custodial parent must continue to pay child support for an adult child will have an easy task ordering the continuation of child support payments if the child's condition satisfies the statutory requirements.

Some states have a statute that address this. For example, consider the following:

> **Arizona Revised Statute 25-320.E** says. "Even if a child is over the age of majority when a petition is filed or at the time of the final decree, the court may order support to continue past the age of majority if all of the following are true: . . . 2. The child has severe mental or physical disabilities as demonstrated by the fact that the child is unable to live independently and be self-supporting. 3. The child's disability began before the child reached the age of majority."
>
> **Florida Statute Annotated 743.07(2)** says, "This section shall not prohibit any court of competent jurisdiction from requiring support for a dependent person beyond the age of 18 years when such dependency is because of a mental or physical incapacity which began prior to such person reaching majority...").
>
> **Georgia Code Annotated § 19-6-15.1** says, "(a) As used in this article, the term "dependent adult child" means an unmarried individual who has reached the age of majority and is incapable of self-support as a result of a physical or mental incapacity that began before the individual reached the age of majority. (b) A legal proceeding may be brought to establish support for a dependent adult child. Such proceeding shall be brought in accordance with Code Section 19-6-26 and may be brought by the following:
>
> (1) Either parent;
> (2) A nonparent custodian;
> (3) A guardian appointed to receive support for the dependent adult child whose benefit the support is ordered; or
> (4) The dependent adult child for whose benefit the support is ordered or his or her agent under a durable power of attorney
>
> **Illinois Compiled Statutes § 750 Ill. Comp. Stat. Ann. 5/513.5(a)** says in part, "The court may award sums of money out of the property and income of

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either or both parties or the estate of a deceased parent, as equity may require, for the support of a child of the parties who has attained majority when the child is mentally or physically disabled and not otherwise emancipated."

Missouri Revised Statute 452.340.4 says, "If the child is physically or mentally incapacitated from supporting himself and insolvent and unmarried, the court may extend the parental support obligation past the child's eighteenth birthday."

New Jersey Statute 2A:34-23.a says in part, "The obligation to pay support for a child who has not been emancipated by the court shall not terminate solely on the basis of the child's age if the child suffers from a severe mental or physical incapacity that causes the child to be financially dependent on a parent. The obligation to pay support for that child shall continue until the court finds that the child is relieved of the incapacity or is no longer financially dependent on the parent. However, in assessing the financial obligation of the parent, the court shall consider, in addition to the factors enumerated in this section, the child's eligibility for public benefits and services for people with disabilities and may make such orders, including an order involving the creation of a trust, as are necessary to promote the well-being of the child.

As used in this section "severe mental or physical incapacity" shall not include a child's abuse of, or addiction to, alcohol or controlled substances."

Texas Family Code Ann. § 154.302 says in part, "(a) The court may order either or both parents to provide for the support of a child for an indefinite period and may determine the rights and duties of the parents if the court finds that:

(1) the child, whether institutionalized or not, requires substantial care and personal supervision because of a mental or physical disability and will not be capable of self-support."

3. Must Legal Action to Request Child Support for an Adult Child Be Commenced Before the Child Reaches Majority Age?

A. Courts are Split

The courts are split on the answer to this question. For example, in Alabama the action can be brought after the child is no longer a minor as long as the disability had onset while the child was a minor. The Alabama appeals court said it this way,

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> [I]f a mentally or physically dependent child continues to be disabled beyond minority and support is needed and the non-custodial parent is able to contribute toward that need, the duty to support can be enforced through proceedings such as were instituted in the present case, although the original divorce judgment contained no provision for that child's support and the trial court did not expressly retain the right to order such support in the future. The age of such a disabled child at the time of the divorce or at the time that the *Brewington* support duty is sought to be enforced is immaterial as long as the disability occurred during the child's minority and continues thereafter [citation omitted].[32]

Often this issue arises when a parent files a motion to modify a previous child support order. If so, the petitioner will be required to comply with the statute describing the criteria to be met in order to modify a previous child support order. For example, the Supreme Court of Missouri has held that a mother could file a motion to modify child support even though the child had already reached the age of majority because the mother had met the criteria of the statute allowing a modification.[33]

B. State Statutes Addressing This Question

Some states have statutes that directly address this question. For example, consider the following:

> **Arizona Revised Statute § 25-320.E** says, "Even if a child is over the age of majority when a petition is filed or at the time of the final decree, the court may order support to continue past the age of majority if all of the following are true:
>
> 1. The court has considered the factors prescribed in subsection D of this section.
> 2. The child has severe mental or physical disabilities as demonstrated by the fact that the child is unable to live independently and be self-supporting.
> 3. The child's disability began before the child reached the age of majority.

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[32] Martin v. Martin, 494 So.2d 97, 100 (Ala. Civ. App. 1986).

[33] Lueckenotte v. Luecknotte, 34 S.W.3d 387 (Mo. 2001) and R.S.Mo. 452.340.4.

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Hawaii Revised Statute § 580-47(a) says, in part, "Provision may be made for the support, maintenance, and education of an adult or minor child and for the support, maintenance, and education of an incompetent adult child whether or not the petition is made before or after the child has attained the age of majority."

Illinois Statute § 750 ILCS 5/513.5(a) says, "An application for support for a non-minor disabled child may be made before or after the child has attained majority."

Louisiana Revised Statute § 9:315.22.1.B says, "An action under this Section to establish an initial award of child support may be filed regardless of the age of the child."

New Hampshire Revised Statute Annotated § 461-A:14,IV says, in part, "If the parties have a child with disabilities, the court may initiate or continue the child support obligation after the child reaches the age of 18."

Oklahoma Statute 43 Okla. Stat. § 112.1A.D.1 says, "A suit under this section may be filed:

a. regardless of the age of the child, and
b. as an independent cause of action or joined with any other claim or remedy provided by this title."

Other times this issue arises when the adult child, or someone on the child's behalf, brings an action for support against a parent under the state's filial statute.[34]

C. Who Has Standing to Sue Parent for Child Support?

A related question is who has standing to bring a legal action against a parent for the support of an adult child. While it is sometimes held that the custodial parent may initiate such an action by invoking the jurisdiction of the court deciding the divorce proceeding,[35] a

[34] *E.g.*, Carpy v. Carpy, No. A135261 (Cal.App. 1st Dist. Div.1 August 28, 2013).

[35] *E.g.*, Martin v. Martin, 494 So.2d 97 (Ala. Civ. App. 1986); Ruiz v. Ruiz, 783 So.2d 361 (Fla. 5th Dist. App. 2001); Gregory v. Gregory, 259 P.3d 914 (Okla.App.Div. 1 2011).

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more common view is that the adult child, or someone acting on his or her behalf, must initiate the action if it has not been previously decided by the divorce court.[36]

This was addressed by statute in Georgia. Effective July 1, 2025, Georgia enacted a statute authorizing this action to be brought by: "(1) Either parent; (2) A nonparent custodian; (3) A guardian appointed to receive support for the dependent adult child whose benefit the support is ordered; or (4) The dependent adult child for whose benefit the support is ordered or his or her agent under a durable power of attorney."[37]

4. Can Public Benefits a Child Is Receiving Be Used to Offset or Reduce a Parent's Contemporaneous Obligation to Pay Child Support?

This question relates to all children receiving child support, whether an adult or a minor. The answer to this question varies depending on what public assistance the child is actually receiving.

A. Social Security

The majority of courts that have considered this question have held that Social Security payments received by a child because of the death, disability, or retirement of the parent obligated to pay child support (often referred to as the "obligor") can be taken into account when calculating the amount of the parent's support obligation for that child. This is true whether the child is receiving Social Security Disability Income or Social Security as a dependent child.

The rational usually employed by a court when taking Social Security being received by the child into account when calculating the parent's child support obligation is that these payments are not mere public benefits available to anyone, but have been earned by the obligor parent while he or she worked and paid into the Social Security system.

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[36] *E.g.*, Brown v. Brown, 714 So.2d 475 (Fla. 5th Dist. App. 1998); Hastings v. Hastings, 841 So.2d 484 (Fla. 3d Dist. App. 2003); Taylor v. Bonsall, 875 So.2d 705 (Fla. 5th Dist. App. 2004)("the right to support for an adult dependent child belongs to the child and not the parent").

[37] Ga. Code Ann. § 19-6-15.1.

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> "Payments prescribed by the Social Security Act are not gratuities or matters of grace; they are not public assistance or welfare payments. *Anderson v. Powell*, 235 Ga. 738, 221 S.E.2d 565 (1975). Social security benefits are from funds earned in part by the individual who throughout his working life has contributed to the benefits by deductions from his wages." *McClasky v. McClasky*, 543 S.W.2d 832, 834 (Mo.App.E.D. 1976).
>
> "The use of social security payments to satisfy a child-support obligation is merely a change in the manner of payment; the nature of the funds is the same." *McClasky*, *Id*. at 834

In *Miller v. Miller*[38] the Supreme Court of Alaska described it this way,

> Courts have been careful to point out that, unlike welfare and other forms of public assistance, social security benefits represent contributions that a worker has made throughout the course of employment; in this sense, benefits represent earnings in much the same way as do annuities paid by an insurance policy:
>
> *577 The payments prescribed by them [the Social Security Act] are not gratuities or matters of grace; they are not public assistance; they are not welfare payments. On the contrary, the law created a contributory insurance system, under which what in effect constitute premiums are shared by employees and employers. Consequently, in spirit at least, if not strictly and technically, the employee, who throughout his working life has contributed part of the premiums in the form of deductions from his wages or salary, should be deemed to have a vested right to the payments prescribed by the statutory scheme, which in effect comprises the terms of the insurance policy. He has earned the benefits; he is not receiving a gift. *Schmiedigen v. Celebreeze*, 245 F.Supp. 825, 827 (D.D.C.1965).[39]

Courts that have not allowed Social Security being received by the child to be taken into account when calculating the child support amount often do so because such an action

[38] Miller v. Miller, 890 P.2d 574, 576-577 (Alaska 1995).

[39] *Id.* at 576-577.

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would retroactively modify the child support decree[40] or would cause an inequitable result.[41] These decisions are usually not based on the courts rejection of the above-described rationale.

B. How Social Security Received by a Child is Treated

There are three ways that courts treat Social Security or Social Security Disability benefits received by a child though a parent's Social Security account. Some courts treat these benefits as a direct dollar-for-dollar offset against the parent's child support obligation.[42] Other courts add the amount of such benefits received by the child to the parent's income first (which increases that parent's child support obligation) and then treat the Social Security received by child as though paid by parent.[43] Still other courts treat the Social Security received by the child as the child's income which proportionately reduces both parents' child support obligations.[44]

The same is not true if the Social Security being received by the child is not based on the Social Security account of the parent who is required to pay child support. In that case the parent is not allowed any credit for the Social Security paid to the child.[45] The rational used by the courts is the inverse of the rationale used to allow a credit if the Social Security being received is as a result of the Social Security account of the parent who owes the child

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[40] Chase v. Chase, 444 P.2d 145 (Wash. 1968).

[41] Arnoldt v. Arnoldt, 554 N.Y.S.2d 396 (1990); Ouelltte v. Ouellette, 687 A.2d 242 (Me. 1996) ("the trial court should consider the impact of the child's receipt of social security benefits. The trial court, however, may deviate from the guidelines only if it finds that their application would be inequitable or unjust", *Ouellette, Id.* at 243).

[42] *E.g.,* Binns v. Maddox*,* 327 So.2d 726 (Ala.App. 1976*);* Holmberg v. Holmberg, 578 N.W.2d 817 (Minn.App. 1998).

[43] *E.g.,* Jenkins v. Jenkins, 704 A.2d 231 (Conn. 1998)("social security dependency benefits paid to the minor children of the plaintiff's first marriage and credited against his child support obligation must be included in the plaintiff's gross income for purposes of determining the amount of his child support obligation under the guidelines." *Jenkins, Id.* at 595).

[44] *E.g.,* In re Marriage of Quintana, 30 P.3d 870, 871 (Colo.App.2001).

[45] *E.g.,* Wilson v. Stenwall, 868 P.2d 1317 (Okla.App.Div. 3 1992)(parent not entitled to credit for SS received by child as result of other parent's entitlement)

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support obligation. Since the other parent did not contribute to the Social Security account being used to pay the child, no credit against the child support obligation is allowed.

C. Supplemental Security Income

The courts consistently view this differently if the child is receiving Supplemental Security Income (SSI) rather than Social Security.[46] This is succinctly expressed by one court as follows:

> We find that plaintiff is misinterpreting the relationship between his support obligation and the supplemental security income. The supplemental income payments are intended to insure a minimum level of income for persons who are over age 65, or blind, or disabled, who do not have sufficient income and resources to maintain a standard of living at the established federal minimum income level. Title 42, Section 1381, U.S.Code; 20 C.F.R., Section 416.110. The amount of supplemental income an eligible individual will receive is based on his income and resources. Title 42, Section 1381a, U.S.Code. In calculating an individual's income, if the individual is a child the support he receives from an absent parent is to be considered. Title 42, Section 1382a(b)(9), U.S.Code.[FN*] There is a redetermination of eligibility and the amount of benefits at frequent intervals. Title 42, Section 1382(c)(1); 20 C.F.R., Section 416.222. The supplemental security income payments are intended to supplement other income, not substitute for it. The amount of supplemental security income received is modified as the amount of the recipient's other income changes, not vice versa.[47]

But an exception to this holding can be found in *In re Marriage of Trichak*, 863 P.2d 585 (Wash.App.Div.1 1993) where the court ruled that SSI received by a child is income to the child and can be used when calculating the child support obligation of a parent.

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[46] Lightel v. Myers, 791 So.2d 955 (Ala. Civ. App. 2000); In re Marriage of Thornton, 802 P.2d 1194 (Colo.App. 1990); Ford v. Ford, 816 So.2d 1193 (Fla.App.2.Dist. 2002); In re Marriage of Benson, 495 N.W.2d 777 (Iowa App. 1992); Matter of Marriage of Emerson, 850 P.2d 942 (Kan.App. 1993); State ex rel. Dept. of Social Services Div. of Child Support Enforcement v. Kost, 964 S.W.2d 528 (Mo.App. W.D. 1998); Lewis v. Department of Social Services, 61 S.W.3d 248 (Mo.App. W.D. 2001); Oatley v. Oatley, 387 N.E.2d 245 (Ohio App. 1977); Nelson v. Nelson, 454 N.W.2d 533(S.D. 1990); Hawkins v. Peterson, 474 N.W.2d 90 (S.D. 1991); Bennett v. Com., Virginia Dept. of Social Services Div. of Child Support, 472 S.E.2d 668 (Va.App. 1996); Rinaldi v. Dumsick, 528 S.E.2d 134 (Va.App. 2000).

[47] Oatley v. Oatley, 387 N.E.2d 245, 246 (Ohio.App. 1977).

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5. Can Trust Assets or Income be Used to Offset or Reduce a Parent's Child Support Obligation Owed to a Child Who is a Beneficiary of the Trust?

There are not many court decisions on this question, especially when the focus is narrowed to child support for an adult child who has a disability. More broadly, most courts have held that income from a trust that directs the trustee to support or provide maintenance for the beneficiary will be taken into account for child support calculation purposes. On the other hand, if the trust grants the trustee discretion to distribute for the special needs of the beneficiary, then trust income and principal will be ignored for child support calculation purposes. This occurs even if the trust is a self-settled d4A trust. Some of these cases are summarized below.

A. Cases Holding Trust Assets Do Not Reduce Obligor Parent's Child Support Obligation

1) *Lewis v. Department of Social Services*, 61 S.W.3d 248 (Mo.App. W.D. 2001). The *Lewis* case provides the best discussion of the issues and rationale used by a court to ignore the income from a **self-settled d4A special needs trust** when determining a father's child support obligation.

In *Lewis*, the child (Jennifer) sustained a traumatic brain injury while she was a minor. A personal injury lawsuit settlement was placed in a self-settled d4A special needs trust for Jennifer's benefit. After Jennifer reached the age of majority, her father petitioned the court to take the d4A trust into account when calculating his child support obligation.

The court began its analysis by saying, "Whether income from a trust should be included in determining appropriate amount of child support depends upon the type of trust involved and intent of settlor." *Lewis*, *Id.* at 256.

After reviewing the law and rational concerning a self-settled d4A special needs trust and determining that this trust was established to "supplement, rather than supplant, the benefits to which [Jennifer] would otherwise be entitled," the court said, "To find that this trust is available for the ordinary support and maintenance of Jennifer's

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everyday expenses would be contrary to the intent and purpose of this trust." *Lewis*, *Id.* at 258.

The court analogized distributions from the d4A trust to SSI benefits (which the court had held in an earlier case were not to be countable as income to the child for child support calculations[48]). As such, the court held in *Lewis* that the income from the d4A trust was not to be considered when determining the child support obligation of trust beneficiary's father.

> The special needs trust established for Jennifer as a result of the medical malpractice claim and the monthly income received from the trust do not diminish Mr. Lewis's child support obligations. The trust represents additional income, used to defray the extraordinary expenses that are required in meeting Jennifer's special needs. See id. Those special needs were not considered when the presumptive amount, reflected in Form 14, was calculated. Thus, this court affirms the Division's determination that Jennifer's income from the special needs trust does not make the presumptive correct child support amount unjust or inappropriate.[49]

2) *Adu-Tutu v. Adu-Tutu,* 1 CA-CV 11-0262, 2012 WL 1964568 (Ariz. App. 1st Div. 2012). In this case the court refused to reduce a father's child support obligation even though there was a **self-settled d4A special needs trust** established for the benefit of the child.

When the parents divorced in 1996 they had one adult child who was severely disabled and required 24-hour care. The child was the beneficiary of a self-settled d4A special needs trust that had total assets of $155,000. The father argued that the special needs trust made the child self-sufficient so he no longer qualified for child support.

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[48] State ex rel. Dep't of Soc. Servs. Div. of Child Support Enforcement v. Kost, 964 S.W.2d 528 (Mo.App.1998).

[49] Lewis v. Department of Social Services, 61 S.W.3d 248, 259 (Mo.App. W.D. 2001).

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The father wanted the special needs trust to be depleted before the father was required to continue paying child support. The court disagreed and said,

> The only support available to the child comes from Father's child support payments and what Mother provides. Once Father passes away, the only asset available to support the child will be the Trust. Yet, Father currently has a sizable income and can afford to pay child support in addition to his own expenses. We cannot say the trial court abused its discretion in seeking to prolong the Trust assets as long as Father is financially able to provide support to his disabled child. In fact, this is consistent with 'the primary intention' of the Trust 'to provide for continuing conservation and enhancement of the assets.'[50]

3) ***Cutts v. Trippe,*** **57 A.3d 1006 (Md. App. 2012).** This case addressed whether a trust established for the benefit of an adult child with a disability was sufficient to cause the child to not be eligible for child support because the child was not "destitute" as a result of the assets in the trust. The record is not clear what type of trust was involved in this case. All that is known is that the adult child with a disability ("Sarah") was the beneficiary and her mother was the trustee. The trustee had discretion whether to make distributions to or for the benefit of Sarah.

The obligor father argued on appeal that Sarah was not a "destitute adult child" as defined by statute because of the trust. According to the appeals court, "A "destitute adult child" is defined as "an adult child who: (1) has no means of subsistence; and (2) cannot be self-supporting, due to mental or physical infirmity." FL § 13–101(b)."[51]

The court found that the trust did not constitute a "means of substance" because the trust assets were not currently available to Sarah. The trial court had found that Sarah had no right to access the trust funds, and no trust funds had ever been disbursed to Sarah. As a result, the appellate court held that the trust had no bearing on Sarah's current need for support. Therefore, Sarah was a "destitute adult child" and the father was required to contribute to her support, as required by the statute.

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[50] Adu-Tutu v. Adu-Tutu, 1 CA-CV 11-0262, ¶ 25, 2012 WL 1964568 (Ariz. App. 1st Div. 2012).

[51] Cutts v. Trippe, 57 A.3d 1006, 1010 (Md. App. 2012).

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B. Statute Excluding Trust Distributions for Child From Calculation of Parent's Child Support Obligation Owed to the Child

In Oklahoma, statute 43 O.S.A. § 118B.B.4 excludes the following from the definition of gross income when calculating the amount of child support that an obligor parent may owe, "The income of the child from any source including, but not limited to, trust income and social security benefits drawn on the disability of the child."[52] (emphasis added)

C. Cases Holding Trust Distributions Can be Offset Against Obligor Parent's Child Support Obligation:

1) *Carmody v. Carmody*, 230 So.2d 40 (Fla. 1st Dist. App. 1970). In the 1970 case of *Carmody v. Carmody* the court took the income from a trust into account when calculating the child support obligation of the child's father.

When the parents entered into a divorce decree they had a seventeen year old child who was the beneficiary of a trust with total assets of $133,000 that was "as a result of permanent injuries suffered in an automobile accident." The court does not describe this trust other than to say it pays income for the benefit of the child. However, since this case was decided before SSI existed and long before the advent of 42 U.S.C. § 1396p(d)(4)(A), it clearly was not a trust authorized by this statute even though by today's standards it was a self-settled trust.

The appeals court upheld the lower court's order that the $300/month paid to the custodial mother from the trust was ample for the child's support, so the father was not required to pay any child support. The appeals court specifically said, "We do not hold that the husband is relieved of all duty to support the disabled child. We do hold *42 that this record supports the Chancellor's order as to the question of child support." *Carmody, Id.* at 41-42.

2) *In re Marriage of Drake, 62* Cal.Rptr.2d 466 (Cal.App.2d Dist. 1997). Not surprisingly, when a court was faced with the question of whether income from a third

[52] 43 O.S.A. § 118B.B.4.

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party-settled *support* trust established by an adult child's mother should be counted in the child support calculation, the court included such income.

The adult child was diagnosed with paranoid schizophrenia at age 21, ten years after the parents divorced. The child lived with his mother, who established a third party-settled *support* trust for the child's benefit. When the mother died she left money to this support trust. The child's father challenged the child support he was ordered to pay. One of the father's arguments was that the income from the support trust should directly discharge or offset the father's duty to pay child support for his child. The court disagreed and, since the money in the support trust came from the mother, the trust income was treated as though it was the mother's income, rather than an independent source of income of the child's. This had the effect of reducing the amount of child support the father had to pay since some of the cost of supporting the child was coming from the "mother," *i.e*., the trust. However, the trust income was not a direct offset of the father's child support obligation.

3) *Hohenberg v. Hohenberg*, 703 S.W.2d 555 (Mo. Ct. App. 1985). The question in this case was whether income earned on assets held in trusts established for minor children of the divorcing couple should be taken into account when determining the amount of child support the obligor parent should pay. There were multiple trusts involved, some established by the obligor parent, some by both parents, and some by grandparents. The court held, "We conclude, therefore, that a trial court is not free to disregard the income and assets of the children in determining the child support obligation of the husband. While the emphasis of such an award is upon father's primary responsibility for support the statute also mandates consideration of the financial resources of the child."[53]

[53] Hohenberg v. Hohenberg, 703 S.W.2d 555, 558 (Mo. Ct. App. 1985).

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6. Can Child Support Payments be Made Directly to a Child's Special Needs Trust to Avoid Reduction of the Child's SSI or Medicaid Benefits?

The answer to this question is "yes" if the payments are to a self-settled special needs trust. Some states even have a statute allowing this. But first, to put in context why this is important, consider a beneficiary of a self-settled special needs trust who is receiving SSI benefits.

A. The Problem - Child Support is "Income"

Child support payments made directly to the child are "income" for SSI eligibility purposes. In addition, because of the deeming rules, child support payments made to a parent who has a duty to support the child are deemed to be income to the child.[54] As a result, child support payments will cause a reduction of the child's SSI, or if large enough, loss of SSI. This may also negatively impact the child's eligibility for Medicaid.

B. The Solution - Child Support Ordered to be Paid Direct to Trust

On the other hand, if child support payments are ordered by a court to be paid directly into a self-settled special needs trust established for the benefit of the child that complies with 42 U.S.C. § 1396p(d)(4)(A) or (d)(4)(C), then the child support is not deemed to be received by the child and these means-tested public benefits are not negatively impacted.

C. What the POMS Says

This is explicitly authorized by the POMS, as follows,

> A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, unless an SSI income exclusion applies or the assignment is irrevocable. We consider assignment of payment by court orders to be irrevocable. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not

[54] 20 C.F.R 416.1161; POMS SI 01320.001.

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> income. Also, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable. For more information on SPB annuities, see SI 01120.201J.1.e. (emphasis added)[55]

D. State Statutes Allowing This

Some states have enacted statutes that allow child support payments for a child who is disabled to be made directly to a special needs trust established for the benefit of the child who is the subject of the child support payments. For example, in 2019 Texas added sub-section (c) to Texas Family Code Ann. § 154.302. This sub-section says,

> (c) Notwithstanding Subsection (b), a court that orders support under this section for an adult child with a disability may designate a special needs trust and provide that the support may be paid directly to the trust for the benefit of the adult child. The court shall order that support payable to a special needs trust under this subsection be paid directly to the trust and may not order the support be paid to the state disbursement unit. This subsection does not apply in a Title IV-D case.[56]

Other states with similar statutory authority to direct child support into a trust for the benefit of the child are New York, New Jersey, Georgia, and California. Citations to those statutes can be found in Appendix B, the SNT Trust Chart at the end of these materials.

7. Can a Special Needs Trust Be Garnished for Unpaid Child Support Owed by the Trust's Beneficiary?

The remainder of these materials focus on the situation where the beneficiary of a special needs trust is the parent who owes child support.

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[55] POMS SI 01120.200G.1.d. This POMS Section is located in an area of the POMS dealing with third party-settled trusts. However, since child support payments are usually deemed to belong to the child, it is common practice that a self-settled special needs trust that complies with 42 U.S.C. § 1396p(d)(4)(A) or (d)(4)(C) should be used as the receptacle for court ordered child support payments.

[56] Texas Fam. Code Ann. § 154.306(c).

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No court has held that a special needs trust can be garnished or required to pay a child support obligation owed by the beneficiary of the trust. However, distributions from such a trust are another matter.

A. Recent Case Applying Florida's Version of U.T.C. § 503 to a Self-Settled Special Needs Trust

The District Court of Appeal of Florida, Second District, in the 2019 case of *Alexander v. Harris*,[57] held that a self-settled special needs trust established under 42 U.S.C. § 1396p with funds from a liability action brought as a result of injuries received in a car accident was liable for a continuing garnishment for past due child support owed by the beneficiary of the trust who was the father of the child. The court said,

> Although the court cannot compel a disbursement from a trust, "[i]f disbursements are wholly within the trustee's discretion ... [and] the trustee exercises its discretion and makes a disbursement, that disbursement may be subject to the writ of garnishment." [citation omitted] Whether the disbursements are paid directly to the beneficiary or to third parties for his benefit is immaterial to whether they may be garnished.[58]

The court based its decision on Florida Statute § 736.0503, which is based on Uniform Trust Code (UTC) § 503. Citing this statute, the Court said, "See § 736.0503(3) ("[A] claimant against which a spendthrift provision may not be enforced may obtain ... an order attaching present or future distributions to or for the benefit of the beneficiary." (emphasis added)."[59]

The court reversed the lower court and remanded "for entry of continuing writ of garnishment directed to discretionary distributions from the special needs trust."[60]

B. Uniform Trust Code § 503

The Uniform Trust Code § 503, entitled "Exceptions to Spendthrift Provision" says, in part,

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[57] Alexander v. Harris, 278 So. 3d 721 (Fla. Dist. Ct. App. 2019).

[58] *Id.* at 722.

[59] *Id.*

[60] *Id.* at 724.

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> (a) In this section, "child" includes any person for whom an order or judgment for child support has been entered in this or another State.
>
> (b) A spendthrift provision is unenforceable against:
>
> (1) a beneficiary's child, spouse, or former spouse who has a judgment or court order against the beneficiary for support or maintenance; ...
>
> (c) A claimant against which a spendthrift provision cannot be enforced may obtain from a court an order attaching present or future distributions to or for the benefit of the beneficiary. The court may limit the award to such relief as is appropriate under the circumstances.[61]

The Comment to U.T.C. § 503 says, in part,

> The exception in subsection (b)(1) for judgments or orders to support a beneficiary's child or current or former spouse is in accord with Restatement (Third) of Trusts Section 59(a) (Tentative Draft No. 2, approved 1999), Restatement (Second) of Trusts Section 157(a) (1959), and numerous state statutes. It is also consistent with federal bankruptcy law, which exempts such support orders from discharge. The effect of this exception is to permit the claimant for unpaid support to attach present or future distributions that would otherwise be made to the beneficiary. Distributions subject to attachment include distributions required by the express terms of the trust, such as mandatory payments of income, and distributions the trustee has otherwise decided to make, such as through the exercise of discretion. Subsection (b)(1), unlike Section 504, does not authorize the spousal or child claimant to compel a distribution from the trust. Section 504 authorizes a spouse or child claimant to compel a distribution to the extent the trustee has abused a discretion or failed to comply with a standard for distribution.[62]

According to the Uniform Law Commission,[63] all but fourteen states have enacted a version of the uniform trust code. If those states follow the reasoning of the *Alexander v. Harris*

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[61] UNIF. TR. CODE § 503 (UNIF. LAW COMM'N amended 2018, Comments updated most recently 2025).

[62] *Id.,* Comment.

[63] *See* https://www.uniformlaws.org/committees/community-home?CommunityKey=193ff839-7955-4846-8f3c-ce74ac23938d.

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case, the vast majority of the States will effectively allow distributions from self-settled special needs trusts to be garnished.

Note that this is not requiring the trust to directly pay the child support nor allowing the person entitled to the child support to garnish the trust assets or income. Instead, this allows any distributions made by the trustee to or for the benefit of the beneficiary to be intercepted and garnished by the person who has a judgement requiring the beneficiary of the trust to pay child support.

C. Oklahoma Statutes

The Oklahoma Discretionary and Special Needs Trust Act contains three statutes that directly address whether a trust established for a beneficiary who is an obligor parent can be liable for child support owed by the beneficiary. Applicable sections of these statutes are quoted below.

1) 60 Okl. St. Ann. § 175.87. This statute sets forth the general rules regarding whether a creditor of a beneficiary of a trust can attach trust assets to pay the debt. It says, in part,

> A. If a trust created on or after November 1, 2010, contains a spendthrift provision, a creditor shall not attach present and future mandatory distributions from the trust. A creditor shall wait until a distribution is received by a beneficiary before attachment. However, an exception creditor may attach present and future mandatory distributions for child support.[64] (emphasis added)

2) 60 Okl. St. Ann. §175.88. This statute applies to a trust where the trustee is directed to support the beneficiary. It says, in part,

[64] 60 Okl. St. Ann. § 175.87.A.

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> 3. The only exception creditor under the Oklahoma Discretionary and Special Needs Trust Act is a child of a beneficiary who has a judgment or court order against the beneficiary for support;[65]

3) 60 Okl. St. Ann. § 175.89. This statute applies to a trust where the trustee has discretion to distribute to or for the benefit of the beneficiary. This statute says, in part,

> 1. A discretionary interest is neither a property interest nor an enforceable right to a distribution; it is a mere expectancy; provided, however, a beneficiary holding a discretionary interest has an equitable interest to bring an action against the trustee within the judicial review standard of paragraph 4 of this section. No creditor, regardless of whether the Oklahoma Discretionary and Special Needs Trust Act provides for any exception creditors, shall attach, require the trustee to exercise the trustee's discretion to make a distribution, or cause a court to judicially sell a discretionary interest;[66] (emphasis added).

8. Does it Violate the Sole Benefit Rule if a Self-Settled Special Needs Trust Directly Pays the Child Support Obligation Owed by the Trust's Beneficiary?

A slightly different twist on the previous question arises when a beneficiary of a self-settled special needs trust (d4A or d4C) wants the trustee to pay child support obligations of the beneficiary (as opposed to fighting the court order imposing the child support obligation and requiring garnishments to be pursued).

The question then becomes, does it violate the "sole benefit rule" (and potentially jeopardize the beneficiary's eligibility for SSI and Medicaid benefits) if the trustee voluntarily distributes from the trust to satisfy a court order requiring the beneficiary to pay child support?

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[65] 60 Okl. St. Ann. §175.88.3.

[66] 60 Okl. St. Ann. § 175.89.1.

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A. What is the Sole Benefit Rule?

The "sole benefit rule" was originally promulgated by The Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services (CMS)) in November 1994 when it issued Transmittal 64 as guidance for the recently passed 42 U.S.C. § 1396p(d)(4)(A) and ((d)(4)(C). Self-settled special needs trusts were authorised by this law. Section (d)(4)(A) required the trust be "established for the benefit of" the trust beneficiary and Section (d)(4)(C) required the trust to be "established solely for the benefit of" the trust beneficiary.[67]

The Social Security Administration (SSA) later included this language in the Social Security Program Operations Manual System (POMS) in § SI 01120.201F. In 2019, the SSA revised this Section of the POMS and essentially changed this to the "primary" benefit rule. This POMS Section now contains examples of distributions from a self-settled special needs trust to third parties that do not violate the sole benefit rule as long as the distribution primarily benefits the trust beneficiary.

This is in line with the what the court said in *In re Estate of Skinner*.[68]

> Based upon a review of the regulatory definitions and the common law principles of trust law, the reasonable interpretation of the "sole benefit" rule for a U.S.C. § 1396p(d)(4)(A) trust is that: 1. The trust must have no primary beneficiaries other than the disabled person for whom it is established. 2. The trust may not be used to effect uncompensated transfers or other sham transactions. For example, the sole benefit provision would be violated if the beneficiary's parents funded the trust with the assets of the beneficiary and then had the beneficiary give the money to her parents in a sham transaction. 3. The trust is one in which the trustee does not have a duty to balance the fiduciary benefit to the beneficiary with a duty to ensure that funds remain for creditors such as Medicaid or for contingent beneficiaries. 4. When trust assets are used for investments, the financial and legal benefit of these transactions must remain with the trust.

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[67] § 3259.7 and 3257.B.6 of Transmittal 64.

[68] In re Estate of Skinner, 787 S.E.2d 440, 451 (N.C. Ct. App. 2016), rev'd sub nom. Matter of Skinner, 370 N.C. 126, 804 S.E.2d 449 (2017)

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B. There is No Official Guidance

Currently, there is no official guidance or case law on this. However, there are good arguments that a trust paying the beneficiary's child support obligation does not violate this rule.

C. Arguments This Does Not Violate the Sole Benefit Rule

Set forth below are some of the arguments that the sole benefit rule is not violated if the trustee of a trust for the benefit of the person who owes child support satisfies the beneficiary's child support obligation by paying the child support directly from the trust.

1) Sole Benefit Rule Has Been Modified - It is Now Essentially the Primary Benefit Rule: As a result of the 2019 revision of POMS SI 01120.201.F, the "sole benefit rule" now focuses on whether a distribution from the trust is for the "primary benefit of the trust beneficiary." For example, the POMS now says the following when describing how to determine if the sole benefit rule has been violated by a trust distribution.

> The key to evaluating this provision is that, when the trust makes a payment to a third party for goods or services, the goods or services must be for the primary benefit of the trust beneficiary. You should not read this so strictly as to prevent any collateral benefit to anyone else. For example, if the trust buys a house for the beneficiary to live in, that does not mean that no one else can live there, or if the trust purchases a television, that no one else can watch it. On the other hand, it would violate the sole benefit rule if the trust purchased a car for the beneficiary's grandchild to take the beneficiary to their doctor's appointments twice a month, but the grandchild was also driving it to work every day.[69]

As a result, if distributions from the trust primarily benefit the beneficiary, even if they also benefit the child, they should not violate the sole benefit rule.

[69] POMS SI 01120.201F.3.a, first bullet point.

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2) Beneficiary Benefits from Payment of Child Support Obligation: Payment of the beneficiary's child support obligation from the trust benefits the beneficiary for many reasons, some of which are listed here. Paying the beneficiary's child support obligations from the trust (i) saves the beneficiary, and probably the trust, money because the beneficiary will not need to hire lawyers to represent the beneficiary in legal actions attempting to force the beneficiary to pay the child support judgment, (ii) allows the beneficiary to avoid criminal prosecution for failure to pay child support, (iii) helps the beneficiary maintain connection and possibly a relationship with the beneficiary's child, (iv) reduces the beneficiary's stress that could result from legal and financial pressure for failure to pay child support, and (v) helps protect the reputation of the beneficiary by avoiding the social stigma of being viewed as a "dead beat" parent.

3) No Federal Law Prohibits Distribution to Pay Child Support: In *Alexander v. Harris* the beneficiary of a self-settled special needs trust established to comply with 42. U.S.C. § 1396p argued that his public assistance benefits would be jeopardized under federal law if child support payments were made from his trust. The court rejected that argument and said,

> We can find no federal law or regulation expressly addressing the garnishment of a special needs trust to satisfy a support obligation. To the extent that 42 U.S.C. § 1396p discusses support payments and eligibility, subsection (c)(2)(B)(iii) states that "[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that ... the assets ... were transferred to ... the individual's child."[70]

4) POMS Allows Payment from a Trust to a Beneficiary's Creditor: POMS SI 01120.201.I.1.d contains an example allowing a trust to pay a creditor of the trust beneficiary. This example describes a credit card bill owed by the trust beneficiary. The only issue addressed is whether the debt was incurred for shelter items for the beneficiary, in which case the payment may result in a reduction in the beneficiary's SSI because of receipt of in-kind support and maintenance.

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[70] Alexander v. Harris, 278 So. 3d 721, 723 (Fla. Dist. Ct. App. 2019).

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9. Do Distributions from a Special Needs Trust Count as Income to a Trust Beneficiary When Calculating How Much Child Support the Trust Beneficiary Owes?

While not directly holding that a special needs trust is liable for child support ordered to be paid by the trust beneficiary, some courts have held that distributions from a special needs trust impact the amount of child support the beneficiary owes. Four of these cases are summarized below. In each case a different argument was made by the beneficiary who was responsible for paying the child support.

In addition, there are other cases and three statutes (Florida, Oregon, and Texas) cited in Appendix B, the SNT Trust chart at the end of these materials.

A. *Mazyk v. Cozze*, 2012 WL 6115682 (N.J.Super.A.D. 2012). In this case the unmarried father of a minor child, suffered a traumatic brain injury before his child was born. A lawsuit settlement of $1,200,000 was placed in a self-settled special needs trust for his benefit. Cozze appealed from a lower court ruling that the income from the trust was income to him for purposes of calculating his child support obligation. The appeals court upheld the lower court ruling. The court said, "in order to take advantage of certain Medicaid benefits, Cozze voluntarily gave up the settlement assets by creating the self settled Trust. The trial judge recognized that those assets are not available to satisfy Cozze's child support obligations. However, the distribution of those assets is a resource which the trial judge appropriately considered available for support."[71]

B. *Myers v. Myers*, 2006-Ohio-5360, 2006 WL 2925353 (Ohio App. 6 Dist. 2006). Mother was injured in an accident and lawsuit proceeds were placed in a self-settled d4A special needs trust. Mother argued that distributions from the d4A trust should not be included in her "gross income" for computation of her child support obligations. Her argument was that a d4A trust is a federally sanctioned device to shelter funds from being included as countable assets for purposes of Medicaid eligibility and they should be afforded the same protection in a child support proceeding. The court disagreed and said, "Nevertheless, we find no authority that a special needs trust supercedes or in any other way influences areas of the law outside Medicaid. Absent an express statutory exemption,

[71] Mazyk v. Cozze, 2012 WL 6115682, 4 (N.J.Super.A.D. 2012).

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we must conclude that income from a special needs trust is "trust income" and, as such, is expressly included in "gross income" for purposes of child support computations...".[72]

C. ***Mencer v. Ruch,*** **928 A.2d 294 (Pa.Super. 2007)**. Father was the beneficiary of a "supplemental needs trust created pursuant to New York state law from the proceeds of a personal injury action." Father argued that any distributions from the trust are not income to him for child support purposes because he has no ability to control the payments. Despite being accepted by the lower court, this court rejected that argument.

Father also argued that distributions from the trust cannot be used in calculating his child support because the law does not allow the trustee to pay child support from the trust. To this the court said, "we are not placing any child support obligation upon the trust; rather, we are holding that the actual distributions from the trust to Father are income for purposes of calculating Father's child support obligation pursuant to Pennsylvania law. Father, rather than the trustee, is obligated to pay the child support. We must leave for a different day the question of whether the trust principal can be attached*299 for purposes of any arrearages that may accrue as the result of our decision herein."[73]

D. ***In re Ramsey County ex rel. Pierce County, Wis.*****, 645 N.W.2d 747 (Minn.App. 2002)**. In *Ramsey* there was a special needs trust established for the benefit of the father who was responsible for paying child support, but the issue decided by the court concerned whether in-kind support and maintenance received from the father's parents should be counted as "income" to the father for purposes of calculating his child support obligation.

In this case the father was disabled, was receiving Social Security Disability benefits, and was the beneficiary of a "supplemental needs trust" created by his parents (it is not clear if the trust is self-settled or third party-settled). The father lived with his parents who provided in-kind support and maintenance to him. The court held that in-kind support from the father's parents should not be counted as "income" to the father for calculation of the father's child support obligation.

It is expected that the analysis used in this case could be expanded to apply to in-kind support and maintenance being provided by a special needs trust or a person other than the parents.

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[72] Myers v. Myers, 2006-Ohio-5360, 2006 WL 2925353, ¶ 25 (Ohio App. 6 Dist. 2006).

[73] Mencer v. Ruch, 928 A.2d 294, 298-299 (Pa.Super. 2007).

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Appendix A

Child Support For Adult Disabled Child

Summary of Cases and Statutes in 50 States Plus District of Columbia That Answer Questions Posed in the Accompanying Paper

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State	Parent May Be Required to Pay CS for Adult Child Sufficiently Disabled	Disability Must Onset Before Majority Age, or Emanci-pation	Request for Adult CS Must Occur before Majority Age	Public Benefits Can Be Offset Against CS	Statutes	Cases
Alabama	Yes - Mandated by common law (Case 1, 11)	Yes - Case 1, 2, 3, 4, 5	No - Case 2, 5	**Yes**, for SSD from Soc Sec account of parent required to pay CS (Rule 32(B)(9)(a),Case 6, 7, 10, 13); Not from other person's work history (Case 15); Not for arrearage (Case 12); **No** - for SSI (Rule 32(B)(9)(b); Case 8, 13)	Rule 32-Child Support Guidelines § (9)-2023 (Alabama Rules of Judicial Administration; not a statute, but a Alabama Supreme Court Rule to guide courts)	1. *Ex parte Brewington* , 445 So.2d 294 (Ala. 1983); 2. *Martin v. Martin* , 494 So.2d 97 (Ala. Civ. App. 1986); 3. *Elliot v. Bretherick,* 555 So.2d 1109 (Ala.Civ.App.1989); 4. *Self v. Self,* 685 So.2d 732 (Ala.Civ. App. 1996); 5. *Ex parte Cohen,* 763 So.2d 253 (Ala. 1999)(To award [Brewington] support, the trial court must (1) determine that the adult child is not capable of earning an income sufficient to provide for his or her reasonable living expenses and (2) that the adult child's mental or physical disability is the cause of his or her inability to earn that income); 6. *Binns v. Maddox* , 327 So.2d 726 (Ala.App. 1976); 7. *Bowden v. Bowden* , 426 So.2d 448 (Ala.Civ.App. 1983)(intrepreting North Carolina law); 8. *Lightel v. Myers* , 791 So.2d 955 (Ala. Civ. App. 2000); 9. *Penny v. Penny* , 786 So.2d 376 (Ala.Civ.App. 2000); 10. *W.R. v. C.R* ., 75 So.3d 159 (Ala. Civ. App. 2011)(payments from a third-party source may be offset against a child-support obligation if those third-party payments are intended to be a substitute for the parent's income, but no offset was available if the third-party payments are intended to be a supplement to the parent's or parents' income); 11. *Knepton v. Knepton* , 199 So.3d 44 (Ala.Civ.App. 2015)(*Brewington* remains good law); 12. *Windham v. State ex rel. Windham* , 574 So.2d 853 (Ala.Civ.App 1990)(SS payments not credited to arrearage); 13. *Adams v. Adams* , 107 So.3d 194 (Ala.Civ.App. 2012); 14. *Goldman v. Goldman* , 197 So.3d 487 (Ala.Civ.App. 2015); 15. *Herbert v. Stephenson* , 574 So.2d 835 (Ala.Civ.App. 1990)

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Alaska	Yes	Must onset prior to emancipa-tion but presumption of emancipa-tion may be overcome by evidence that an adult child is incapable of self support by reason of physical or mental disability. (Case 1)	No - Case 1, 3, 4	Yes, for SSD from Soc Sec account of parent required to pay CS (Case #2, 5 - credits SS payments to child prior to motion to modify)	**AS 25.20.030** - "Each parent is bound to maintain the parent's children when poor and unable to work to maintain themselves. Each child is bound to maintain the child's parents in like circumstances."	1. *Streb v. Streb,* 774 P.2d 798 (Alaska 1989); 2. *Miller v. Miller* , 890 P.2d 574 (Alaska 1995)(for purposes of analysis, there is no reason to distiguish between SS retirement and SS disability benefits); 3. *Sanders v. Sanders* , 902 P.2d 310 (Alaska 1995); 4. *Daum v. Daum,* 518 P.3d 718 (Alaska 2022); 5. *Pacana v. State* , 941 P.2d 1263 (Alaska 1997)(credited SS benefits paid to dependant children from obligor's SS account against CS arrearages accrued prior to obligor's motion to modify CS)

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Arizona	**Yes,** ARS 25-320.E.2 (adult child must have "severe" disablity demonstrat-ed by inability "to live indepen-dently and be self-supporting") (example of not proving this in Case 5)	Yes - Statute 1	No - Statute 1; Case 4	**Yes**, Az. Child Sup. Guidelines X(B) - offset SS from SS account of parent paying CS; but not for SSI, child's own SSD, or SS from other parent; Case 2, 3	**1.**A.R.S. 25-320.E **2**.A.R.S. 25-809.F **3.**Arizona Child Support Guidelines § X.B (2022 version)	1. *Adu-Tutu v. Adu-Tutu,* 1 CA-CV 11-0262, 2012 WL 1964568 (Ariz. App. 1st Div. 2012); 2. *Lopez v. Lopez* , 609 P.2d 579 (Ariz. 1980); 3. *Keefer v. Keefer* , 239 P.3d 756 (Ariz.App.Div.1 2010); 4. *Mendoza v. Mendoza* , 177 Ariz. 603, 605, 870 P.2d 421, 423 (Ct. App. 1994); 5. *Gersten v. Gersten* , 2013 WL 267625 (Ariz. Ct. App. 2013)

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Arkansas	Yes, Statute A.C.A. 9-12-312(a)(6)(B)	Yes - Cases 1 & 8	No, if there is a material change in circum-stances (Case 5, 6)	Yes - Case 3, 4, 7 (SSD offset). But equitable consider-ations applicable when consider-ing credit for past due CS (Case 6)	**A.C.A. 9-12-312(a)(6)(B)** "The court may also provide for the continuation of support for an individual with a disability that affects the ability of the individual to live independently from the custodial parent."	1. *Towery v. Towery,* 685 S.W.2d 155 (Ark. 1985)("We have held the duty to support a child does not cease at majority *if* the child is mentally or physically disabled in any way *at* majority and needs support"); 2. *Kimbrell v. Kimbrell,* 884 S.W.2d 268 (Ark. 1994); 3. *Bagley v. Williamson,* 269 S.W.3d 837 (Ark.App.2007); 4. *Cash v. Cash* , 353 S.W.2d 348 (Ark. 1962); 5. *Guthrie v. Guthrie* , 2015 Ark. App. 108 (Ark. Ct. App. 2015); 6. *Miller v. Ark. Office of Child Support Enforcement* , 458 S.W.3d 733 (Ark. Ct. App. 2015); 6. *Grays v. Arkansas Office of Child Support Enforcement* , 289 S.W.3d 12 (Ark. 2008); 7. *Arkansas Dept. of Hum. Servs. v. Hardy* (871 S.W.2d 352 (Ark. 1994)("It would be incongruous to hold that a father is relieved of child support because his child is receiving public assistance as a result of the father's failure to pay the full amount of child support."), *Id.* at 356; 8. *Warner v. Warner* , 2019 Ark. App. 60, 572 S.W.3d 6, (2019).

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California	Yes, Statute 1		No, adult child can bring action under 3910 any time	Yes, Statute 2; Case 5 (SSD from Soc Sec account of parent required to pay CS}	**1. Cal. Fam. Code 3910** (Parents have "equal responsibility to maintain, to the extent of their ability, a child of whatever age who is incapacitated from earning a living and without sufficient means"); **2. Cal. Fam. Code 4504(b);** **3. Cal.Fam. Code 3901** (Child support until earlier of completing 12th grade or age 19)	1. *Paxton v. Paxton* , 89 P. 1083 (Cal. 1907); 2. *Chun v. Chun,* 235 Cal.Rptr.553 (Cal.App.3d Dist. 1987); 3. *In re Marriage of Drake,* 62 Cal.Rptr.2d 466 (Cal.App.2d Dist. 1997); 4. *Carpy v. Carpy* , No. A135261 (Cal.App. 1st Dist. Div.1 August 28, 2013)(Held duty imposed on parent by CFC 3910 continues after parent's death); 5. *In re Marriage of Denney* , 115 Cal.App.3d 543 (Cal.App. 2nd Dist. Div.4 1981); 6. *In re Marriage of Cady & Gamick* , 105 Cal. Aoo. 5th 379 (Cal. Ct. App. 2024)(contains history of California Family Code § 3910 and Welfare and Instituions Code § 12350); 7. *In re Marriage of Drake* , 194 Cal. Rptr. 3d 252 (Cal.App. 4th Dist. 2015), as modified (Oct. 27, 2015)("Under section 3910(a), which governs adult child support, the court considers two factors. One—is the adult child incapacitated from earning a living, which is not disputed here. Two—does the adult child have sufficient means, which is disputed here.") *Id.* at 257.

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Colorado	Yes, Statute 1 and case law	Probably yes, (Statute 1 says CS can be ordered "to continue" beyond age 19)		**Yes**, for SSD from Soc Sec account of parent required to pay CS (Statute 2) & Case 5, 6, 7); **No** - for SSI - Case 2	**Colorado - C.R.S. 14-10-115** - **1. (13)(a)(II)** (if "child is mentally or physically disabled" child is not emancipated and CS can be ordered to continue beyond age 19); **2. (11)(c)** (SS benefits received monthly) and **(d)**(lump sum SS benefits)	1. *Koltay v. Koltay,* 667 P.2d 1374 (Colo. 1983); 2. *In re Marriage of Thornton,* 802 P.2d 1194 (Colo.App. 1990)(does not allow SSI received by child to reduce fathers CS payments); 3. *In re Marriage of Salas,* 868 P.2d 1180 (Colo.App. 1994); 4. *In re Marriage of Cropper,* 895 P.2d 1158 (Colo.App. 1995); 5. *In re Marriage of Robinson* , 652 P.2d 454 (Colo.App. Div. III. 1982); 6. *In re Marriage of Meek* , 669 P.2d 628 (Colo.App. Div. III 1983); 7. *In re Marriage of Anthony-Guillar* , 207 P.3d 934 (Colo.App.Div. IV 2009)

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Connecticut	Yes, but only until age 26 if court orders are issued on or after October 1, 2023. Earlier orders only require until age 21 (Conn. Gen. Stat. Ann. 46b-84(c) as amended in 2023)			**Yes**, SS received by child is included in income of obligor parent and offset (Cases 3 and 4); Case 2 was **No** but bad actions by father may have skewed the result.	**Conn. Gen Stat. Ann. 46b-84(c)**	*1. Loughlin v. Loughlin,* 889 A.2d 902 (Conn. App. 2006) *aff'd* . 910 A.2d 963 (Conn. 2006); 2. *Fowler v. Fowler* , 244 A.2d 375 (Conn. 1968); 3. *Jenkins v. Jenkins* , 704 A.2d 231 (Conn. 1998)("social security dependency benefits paid to the minor children of the plaintiff's first marriage and credited against his child support obligation must be included in the plaintiff's gross income for purposes of determining the amount of his child support obligation under the guidelines." *Jenkins* at 595); 4. *Tarbox v. Tarbox* , 853 A.2d 614 (Conn.App. 2004) ("[Social Security} dependency benefits paid directly to a child who has reached the age of majority, rather than to the custodial parent, do not fulfill the obligations of court-ordered child support." *Tarbox* at 616)

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Deleware	Yes, if child unable to support self (see Statute and Cases)				**Del. Code. Ann. Tit. 13, §503** - Duty to support a Poor Person	1. *Dalton v. Clanton,* 559 A.2d 1197 (Del. 1989); 2. *H. v. V* ., No. CK16-01125, 2018 WL 824203(Del. Fam. Ct. Jan. 31, 2018)("The question that must be answered in applying Section 503 is not whether a poor person is currently being supported by one parent sufficient to protect the state's treasury. The question is whether a poor person, without any support from either parent, can avoid state assistance. If he or she cannot, the duty is triggered as to both parents, who are equally situated as to priority, with the extent of the duty determine only after a trial.) *Id* ., at 4.
District of Columbia	Yes, common law duty (Case 1)					1. *Nelson v. Nelson,* 548 A.2d 109 (D.C. App. 1988); 2. *Harmatz v. Harmatz,* 457 A.2d 399 (D.C. App. 1983); 3. *Nelson v. Nelson,* 379 A.2d 713 (D.C. App. 1977); 4. *Negretti v. Negretti,* 621 A.2d 388 (D.C. App. 1993)

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Florida	Yes, Statute 1 and Cases	Yes, Statute 1; Case 7, 17, 18	Yes, Cases 6, 7, 8, 9, 14, 15	**Yes**, for SSD, Statute 3 at (2)(d) and (10)(b), but not direct offset; instead must factor into CS amount (Case 5, 10, 11, 12, 13); cannot be used to satisfy CS arrearage prior to SS bensfits starting (Case 16); **No** for SSI (Case 13 and Statute 3 at (11)(a)2)	**Fla. Stat. Ann.** **1.** 743.07, **2.** 61.13, and **3.** 61.30	1. *Perla v. Perla* , 58 So.2d 689 (Fla. 1952)("Generally, the obligation of a parent to support a child ceases when the child reaches majority, but an exception arises when the child is, from physical or mental deficiencies, unable to support himself."; 2. *Fincham v. Levin* , 155 So.2d 883 (Fla. 1st Dist.App. 1963)(affirming the dicta in *Perla* , "...where a child is of weak body or mind, unable to care for itself after coming of age, the parental rights and duties remain practically unchanged and the parent's duty to support the child continues as before."); 3. *Carmody v. Carmody,* 230 So.2d 40 (Fla. 1st Dist. App. 1970); 4. *Fagan v. Fagan,* 381 So.2d 278 (Fla. 5th Dist. App. 1980); 5. *Sever v. Sever,* 684 So.2d 313 (Fla. 1st Dist. App. 1996); 6. *Brown v. Brown,* 714 So.2d 475 (Fla. 5th Dist. App. 1998); 7. *Ruiz v. Ruiz,* 783 So.2d 361 (Fla. 5th Dist. App. 2001); 8. *Hastings v. Hastings,* 841 So.2d 484 (Fla. 3d Dist. App. 2003); 9. *Taylor v. Bonsall* , 875 So.2d 705, 709 (Fla. 5th DCA 2004; 10. *WIlliams v. Williams* , 560 So2d 308 (Fla.1st DCA 1990)(SS received by child because parent receiving SS retirement benefits added to income, then credited against CS obligation); 11. *Wallace v. Dept. of Rev. ex rel. Cutter* , 774 So.2d 804 (Fla.App.2.Dist. 2000)(SS received by child because parent receiving SSD added to parent's income, then credited towards CS); 12. *Sealander v. Sealander* , 789 So.2d 401 (Fla.4th DCA 2001); 13. *Ford v. Ford* , 816 So.2d 1193 (Fla.App.2.Dist. 2002); 14. *Loza v. Marin* , 198 So. 3d 1017, 1021 (Fla. Dist. Ct. App. 2016); 15. *Phagan o/b/o L.D.P. v. McDuffee* , 296 So. 3d 957 (Fla. Dist. Ct. App. 2020); 16. *Kirwan v. Kirwan.* 606 S.W.2d 771 (Fla.5th DCA 1992); 17. *Miller v. Smart* , 636 So.2d 836 (Fla. 5th Dist. Ct.App. 1994); 18. *Skelly v. Skelly* , 300 So.3d 342 (Fla. 5th Dist. Ct. App. 2020)

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Georgia	Yes - Case #1 held no, but Statutes 1 and 2 enacted in 2024 changed this	Yes, Statute 1 § (a)	Yes, if there was CS order in place before child is 18. If not, then can be filed anytime after child is 17 and 6 months old. Statute 1	Maybe. Cases 3, 4 allowed offset for SSD from Soc Sec account of parent required to pay CS. But Statute 2 may override this (See *** in Cases Column)	**Ga. Code Ann. § 1.** 19-6-15.1. and **2.** 19-6-15.2. These statutes also authorize court to order CS paid to self-settled d4A or d4C special needs trusts	1. *Crane v. Crane,* 170 S.E.2d 392 (Ga. 1969); 2. *Mullinax v. Mullinax,* 216 S.E.2d 812 (Ga. 1975) (Can take cost of care of child with disability into account when calculating alimony amount); 3. *Horton v. Horton* , 132 S.E.2d 200 (Ga. 1963); 4. *Perteet v. Sumner* , 269 S.E.2d 453 (Ga. 1980); 5. D*ep't of Hum. Res. v. Prince,* 198 Ga. App. 329, 330, 401 S.E.2d 342, 343 (1991)(distinguished *Horton* and *Perteet* cases; those said SSD paid to child from SS account of parent paying CS could be offset; in *Prince* the SS from account of deceased mother not allowed to be offset against father's CS obligation) ========== *** **Ga. Code Ann. § 19-6-15.2(d**) says, "The support provided pursuant to this Code section shall be in addition to and not in lieu of the benefits or assistance a dependent adult child may receive from a source other than his or her parents. No duty created pursuant to Code Section 19-6-15.1 nor any other provisions of this Code section shall impact the eligibility of a dependent adult child to receive the maximum benefits provided by any federal, state, local, and other governmental and public agencies."

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Hawaii	Yes, Statute	No	No, Statute 580-47(a)(See *** in Cases column) and Case 1	Yes, rebut-table presumption for SSD from Soc Sec account of parent required to pay CS (Case 2); but not for arrearage arrising prior to obligor's entitlement to benefits (Case 3)	**H.R.S. 580-47**	*1. Jaylo v. Jaylo,* 125 Hawai'i 369 (2011); 2. *Child Support Enforcement Agency v. Doe* , 990 P.2d 1158 (Haw.App. 1999)*;* 3. *Clark v. Clark* , 134 P.3d 625 (Haw.App. 2006)("dependent social security benefits may not be credited against child support arrearages accruing before the claimant's entitlement to the benefits.". *Id* at 636)(it does not matter whether the obligor's SS benefits were from *disability* or *retirement* of the obligor). ========== *** **H.R.S. § 580-47(a)** . . "Provision may be made for the support, maintenance, and education of an adult or minor child and for the support, maintenance, and education of an incompetent adult child regardless of whether the petition is made before or after the child has attained the age of majority.". . .
Idaho	No					*State ex rel. Cromwell v. Panzeri,* 76 Idaho 211, 280 P.2d 1064 (1955)

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Illinois	Yes	Yes, See Statute § (a) and Case 6	No, See Statute § (a) and Case 6	Yes, Statute § (b) allows court to consider financial resources of child, including SSI, HCBS, and any other State, federal, or local benefit; Yes also for SSD from Soc Sec account of parent required to pay CS (Case 4, 5)	**750 Ill. Comp. Stat. Ann. 5/513.5** (enacted effective 1-1-2016)	1. *In re Marriage of Taylor, 89* Ill.App.3d 278, 411 N.E.2d 950 (1980); 2. *Strom v. Strom,* 13 Ill. App.2d 354, 142 N.E.2d 172 (1957); 3. *Freestate v. Freestate,* 244 Ill.App. 166 (1927)(Applied common law principal of parent supporting child who has a disability and unable to support self); 4. *In re Marriage of Henry* , 622 N.E. 2d 803 (Ill.Dec. 1993); 5. *Childerson v. Hess* , 555 N.E.2d 1070 (ILL.App. 1990); 6. *In re Marriage of Moriarty* , --- N.E.3d ---, 2024 IL App (1st) 230270, 2024 WL 1340211 (Ill.App. 2024)

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Indiana	Yes, Statute § (a)(2)	Yes, Case # 7		**Yes**, for SSD (Case # 8, 9); **No** for SSI (Case #6). See also Case #4 rejecting lower court decision that required CS to be reduced by amount child provides for own support.	**Ind.Code 31-16-6-6**	1. *Zakrocki v. Zakrocki* , 60 N.E.2d 745 (Ind.App. 1945); 2. *Caddo v. Caddo,* 468 N.E.2d 593 (Ind.App. 1984); 3. *Free v. Free,* 581 N.E.2d 966 (Ind.Ct.App. 1991); 4. *Lea v. Lea,* 601 N.E.2d 1214 (Ind. 1998); 5. *Dennison v. Dennison,* 696 N.E.2d 88 (Ind.App. 1998); 6. *Kyle v. Kyle* , 582 N.E.2d 842 (Ind.App. 1991); 7. *Pocialik v. Federal Cement Tile Co.* , 97 N.E.2d 360 (Ind.App. 1951)(en banc); 8. *Patrick v. Patrick* , 517 N.E.2d 1234 (Ind.App. 1988); 9. *Poynter v. Poynter* , 590 N.E.2d 150 (Ind.App. 1992);

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Iowa	Yes, Statute 2 and comon law (Case 6, 8)	Yes, Case 4		**Yes**, for SSD from Soc Sec account of parent required to pay CS (Statute 3 and Case 7, 8) **No** - for SSI (Case 2)	**Iowa Code Ann**. **1. § 252A.3** (" The parents are severally liable for the support of a dependent child eighteen years of age or older, whenever such child is unable to maintain the child's self and is likely to become a public charge."); **2. § 598.1(9)**("may include support for a child of any age who is dependent on the parties to the dissolution proceedings because of physical or mental disability"); **3. § 598.22C**	1. *Monroe County v. Abegglen,* 105 N.W. 350 (Iowa 1905); 2. *In re Marriage of Benson,* 495 N.W.2d 777 (Iowa App. 1992); 3. *In re Marriage of Nelson,* 654 N.W.2d 551 (Iowa 2002); 4. *In re Marriage of Allen* , 662 N.W.2d 373; 2003 WL 554498 (Iowa App. 2003)*; 5. State ex rel Moore v. McCampbell* , 786 N.W.2d 519 (Iowa App. 2010); 6. *Davis v. Davis* , 246 N.W.2d 266 (Iowa 1954); 7. *Potts v. Potts* , 240 N.W.2d 680 (Iowa 1976); 8: *Newman v. Newman* , 451 N.W.2d 843 (Iowa 1990); 8. *In re Marriage of Davis* , 462 N.W.2d 703 (Iowa App. 1990);

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Kansas	No, Case 1 and Statute		Yes, Case 2, but statute limits to age 18, unless in high school, then stops at age 19	**Yes,** for SSD from Soc Sec account of parent required to pay CS (Case 4, 6, 7); but not for arrearage (Case 9); **No**, for SSI (Case 5); **No** for SS received by child from someone other than CS obligor (Case 8)	K**SA 23-3001(b)** (formerly 60-1610)	1. *Arche v. U.S. Dept. of Army,* 798 P.2d 477 (Kan. 1990)("...under the earliest common law a parent was not responsible for the care of an adult incompetent child. That common-law rule was modified by our earlier decisions and by statutory law. Then, in 1967, the legislature reinstated the early common-law rule that a parent would not be liable for the support, care, and maintenance of an adult incompetent child who was in a state hospital. After careful study, and in light of the economic realities of our present society, we conclude that we should follow the lead of the Kansas Legislature and modify our decisional law. Accordingly, we hold that a parent is no longer required by law to provide support for an adult incompetent child in this state." *Arche* at 486); 2. *In re Marriage of Funk* , 107 P.3d 447 (Kan.App. 2005); 3. *In re Marriage of Doney and Risley,* 41 Kan.App.2d 294, 201 P.3d 770 (Kan.App 2009); 4. *Andler v. Andler* , 538 P.2d 649 (Kan. 1975); 5. *Matter of Marriage of Emerson* , 850 P.2d 942 (Kan.App. 1993); 6. *In re Marriage of Martin* , 95 P.3d 130 (Kan.App. 2004); 7. *In re Marriage of Stephenson & Papineau* , 302 Kan. 851, 877, 358 P.3d 86, 100 (2015)(contains summary of cases concerning offsetting SSD to child from SS account of parent paying CS); 8. *In re Marriage of Beacham* , 867 P.2d 1071 (Kan.App. 1994); 9. *Matter of Marriage of Williams,* 900 P.2d 860 (Kan.App. 1995)

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Kentucky	Yes, Case 1	Yes, Case 8		**Yes**, for SSD from Soc Sec account of parent required to pay CS (Case 5, 6, 9); but not for arrearage (Case 10). **Possible**, for SSI (Case 7)	**Ky.Rev.Stat.Ann. 405.020(2)**("The father and mother shall have the joint custody, care, and support of their children who have reached the age of eighteen (18) and who are wholly dependent because of permanent physical or mental disability. If either of the parents dies, the survivor, if suited to the trust, shall have the custody, care, and support of such children.")	1. *Crain v. Mallone, 130 S.W. 67 (Ky. 1908);* 2. *Abbot v. Abbot,* 673 S.W.2d 723 (Ky.App. 1983)(a wholly dependent child is not emancipated by operation of law at the age of eighteen, and her parents' support obligation continues even after the child reaches the age of majority.); 3. *Nelson v. Nelson,* 287 S.W.3d 667 (Ky.App. 2009); 4. *Culver v. Culver,* 2013 WL 375595 (Ky.App. 2013); 5. *Hamilton v. Hamilton* , 598 S.W.2d 767 (Ky.App. 1980); 6. *Board v. Board,* 690 S.W.2d 380 (Ky. 1985); 7. *Barker v. Hill* , 949 S.W.2d 896 (Ky.App. 1997); 8. *Breuer v. Dowden* , 268 S.W. 541 (Ky.App. 1925) ("a parent is not liable for the debts of his adult child in the absence of a statute to the contrary, unless the child is in such a feeble and dependent condition physically or mentally as to be incapable of supporting himself; that if at the time the child becomes of age he is physically and mentally sound and able, if willing, to make and earn his own support, the parent is not liable for his debts or obligations thereafter contracted, even though he should later become sick or mentally unbalanced and therefore incapacitated to earn a livelihood. If, however, the child at the time of his arrival at the age of 21 is sick or otherwise incapacitated to earn a living for himself, and is, at the time, living in the home of the parent as a member of the household, the parent is liable for necessaries furnished him." at 542); 9. *Artrip v. Noe* , 311 S.W.3d 229 (Ky. 2010); 10. *Miller v. Mille* r, 929 S.W.2d 202 (Ky.App 1996)

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Lousiana	Yes, see statute 2	Yes, see statute 2; Disability does not include substance abuse or addiction	No, see statute 2	Yes, for SSD from Soc Sec account of parent required to pay CS (Case 4, 5, 6); SSI is not income of custodial parent (Case 7)	**La. R.S. § - 1. 9:315.22** and **2. 9:315.22.1** (effective 1-1-2025)	1. *Mayeaux v. Mayeaux,* 536 So.2d 836 (La.App 1stCir. 1988). 2. *In re Tutorship of Blanque,* 700 So.2d 1077 (La.App. 5th Cir. 1997) *writ denied sub nom. Tutorship of Blanque,* 706 So.2d 979 (La. 1998), 3. *Hester v. Hester,* 874 So.2d 859 (La.App. 4th Cir. 2004); 4. *Dunbar v. Dunbar* , 276 So.2d 358 (La.App. 4th Cir. 1973); 5. *Folds v. Lebert* , 420 So.2d 715 (La.App. 1982); 6. *McCloud v. McCloud* , 544 So.2d 764 (La.App.3 Cir. 1989); 7. *Richard v. Richard* , 930 So.2d 156 (La.App.4.Cir. 2006)(SSI receivd by child cannot be counted in custodial parent's income)

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Maine	Yes, if agreed to in divorce settlement (Case 4). Yes, if not agreed to in a divorce proceeding if statute requires. See Case 1 (but the statute was later repealed).			No, for SSI; see Statute 1 and case 4. Yes, SS received by child should be a factor (Statute 2 and Case 2; but see Case 3)	**1. 19-A M.R.S. 2001(5)(G); 2. 19-A M.R.S. 2107** (Must credit SS received by child if "a result of obligor parent's disability")	1. *Baril v. Baril,* 354 A.2d 392 (Me. 1976)(appears to be good law, but relies on statute that was later repealed); 2. *Lund v. Lund,* 927 A.2d 1185 (Me. 2007); 2. *Ouellte v. Ouellette* , 687 A.2d 242 (Me. 1996)("the trial court should consider the impact of the child's receipt of social security benefits. The trial court, however, may deviate from the guidelines only if it finds that their application would be inequitable or unjust", *Ouellette* at 243); 3. *Wong v. Hawk* , 55 A.3d 425 (Me. 2012)(Statutory offset of SS received by child not allowed because obligor parent retired, not disabled); 4. *Weston v. Weston,* 40 A.3d 934 (Me. 2012)("support" includes custodial parent's provision of physical and emotional support, in addition to financial support)(SSI received by child is not considered, citing statute 1);

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Maryland	Yes, Case 1, 2, 3 and Statute 3	No, Case 3, 4		**Yes**, for SSD from Soc Sec account of parent required to pay CS (Case 5) See also Statute 1 (requires offset of child support paid if beneit received by child is from obligor parent's account)	**Md. Code, Family Law §** **1. 12-204(j)**; **2. 13-101** (See ******* in Cases column) **3. 13-102(a)** (See **+++** in Cases column)	1. *Borchert v. Borchert* , 45 A.2d 463 (Md. 1946); 2. *Smith v. Smith* , 176 A.2d 862 865 (Md.App. 1962)("It is significant, we think, that at the first opportunity after the Borchert decision further legislative action was in fact taken. At its 1947 session the Legislature enacted an act.... making it a criminal offense for a parent, possessing the means, to fail to provide for a destitute adult child where mental or physical infirmity makes it impossible for the child to care for itself. The passage of this act is a clear indication of legislative intent to place failure to support an incapacitated child on equal footing with failure to support a minor child.") 3. *Sininger v. Sininger* , 479 A.2d 1354 (Md. 1984); 4. *Presley v. Presley,* 500 A.2d 322 (Md.Spec.App. 1985); 5. *Cutts v. Trippe* , 57 A.3d 1006 (Md.Spec.App. 2012); 6. *Anderson v. Anderson* , 700 A.2d 844 (Md.App. 1997); 7. *Fizzaland v. Zahn* , 97 A.3d 184 (Md. App. 2014)(contains discussion of what is required to be a destitute adult child); ==========**Statute_Wording**========== ***** 13-101** "destitute adult child" means "an adult child who: (1) has no means of subsistence, and (2) cannot be self-supporting, due to mental or physical infirmity " ========== **+++ 13-102(a)** "If a destitute adult child is in this State and has a parent who has or is able to earn sufficient means, the parent may not neglect or refuse to provide the destitute adult child with food, shelter, care, and clothing."

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Mass.	Yes, Case 1, but child was under guardianship (see Case 6)			Yes, for SSD from Soc Sec account of parent required to pay CS (Case 3, 4, 5)	**MA. G.L. c. 208, § 28** (" The court may make appropriate orders of maintenance, support and education of any child who has attained age eighteen but who has not attained age twenty-one and who is domiciled in the home of a parent, and is principally dependent upon said parent for maintenance." Age expands to 23 if child pursuing education not beyond undergraduate.	1. *Feinberg v. Diamant,* 389 N.E.2d 998 (Mass. 1979); 2. *Viccaro v. Milunsky,* 551 N.E.2d 8 (Mass. 1990); 3. *Cohen v. Murph* y, 330 N.E.2d 473 (Mass. 1975); 4. *Rosenberg v. Merida* , 697 N.E.2d 987 (Mass. 1998); 5. *Schmidt v. McCulloch-Schmidt* , 11 N.E. 3d 1009 (Mass. App. Ct. 2014)(SSDI received by child from custodial parent's Social Security account is income to custodial parent for calculation of child support obligation of non-custodial parent, but is not offset against non-custodial parent's child support oblitation); 6. *Vaida v. Vaida,* 19 N.E. 3d 423 (Mass. App. Ct. 2014)(child support cannot continue after age 23, as required by G.L. c. 208, § 28. Court can use equity to extend beyond that age, but only if child is under guardiandhip)

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Michigan	No, not after child is 19 and 1/2 years old (Statute 1)			Yes, if paid to custodial parent for SSDI for child from Soc Sec account of parent required to pay CS (Case 3, 6), but not if paid directly to the child (Case 4) or from SS account of custodial parent (Case 7)	**1. M.C.L.A. § 552.605b.** **2.** *See also* **Michigan Child Support Formula Manual § 3.07(A)(2)** ("Determine the monthly (SS) benefit amount that is attributable to the payer and that the support recipient receives for the children and then subtract that amount from the total child support obligation.")	1. *Smith v. Smith* , 447 N.W.2d 715 (Mich. 1989); 2. *Cross v. Cross* , 279286, 2008 WL 5003016 (Mich.App. 2008); 3. *Frens v. Frens* , 478 N.W.2d 750 (Mich.App. 1991); 4. *Jenerou v. Jenerou* , 200 Mich.App 265 (1993); 5. *Paulson v. Paulson* , 254 Mich.App 568 (2002); 6. *Fisher v. Fisher* , 276 Mich.App 424 (2007); 7. *Gusmano v. Gusmano* , 2011 WL 4424417 (Mich. Ct. App. 2011)(SSDI for disabled child from SS account of custodial parent cannot be offset against child support obligation of non-custodial parent)

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Minnesota	Yes, if "incabable of self-support) (see Statute 1)	Not clear answer, but CS order can be modified if "terms are unreason-able or unfair" because something "(2) substantian-tially increased… need of… the child" (Minn. Stat. 518.39.2)	No, but cannot reopen prior judgment unless comply with statute, Case 2	**Yes**, for SSD from Soc Sec account of parent required to pay CS (Statute 2 and Case 5, 6). Contra is Case 4, but unusual facts may explain that.	**Minn.Stat. § - 1. 518A.26.5** ("Child means … an individual who, by reason of physical or mental condition, is incapable of self-support."); **2. 581A.31** (how SS is treated; **3. 518A.39** (how to modify child support awards)	1. *McCarthy v. McCarthy* , 222 N.W.2d 331 (Minn. 1974); 2. *Krech v. Krech* , 624 N.W.2d 310 (Minn.App. 2001); 3. *State ex rel. Jarvela v. Burke* , 678 N.W.2d 68 (Minn.App. 2004), *review denied* (Minn. July 20, 2004); 4. *Hanratty v. Hanratty* , A10-1346, 2001 WL 891178 (Minn.App. 2011) (Constitutional equal protection argument denied); 5. *Holmberg v. Holmberg* , 578 N.W.2d 817 (Minn.App. 1998); 6. *In re Ramsey County ex rel. Pierce County, Wis* ., 645 N.W.2d 747 (Minn.App. 2002)(Father receiving SSD and is beneficiary of SNT established by his parents, who support him. No further discussion of SNT, but appears to be third party-settled. In-kind support from parents (father lived with parents) was not counted as "income" to father for calculation of father's CS obligation.); 7. *In Re Dakota County* , 866 N.W.2d 905, (Minn. 2015)(description of how CS amount is altered when SS benefits received).

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Mississippi	There is no statutory or common law duty to support an emancipat-ed child (Case 8, which dis-tinguishes Case 7 on the facts)	No, CS order may be modified when there is change in circum-stances unanticipat-ed at time CS order issued, and one of the reasons cited is the "health and special needs of the child, both physical and psycho-logical" (Case 1 at 215)		**Yes,** for SSD from Soc Sec account of parent required to pay CS (Case 5, 6, 9, 10); **No,** for SSI (Case 9)	**Miss. Code Ann. § 1. 93-5-23**; **2. 93-11-65(8**) (duty of support of child terminates at emancipation, which happens at age 21 unless child is emancipated earlier)	1. *Adams v Adams* , 467 So.2d 211 (Miss.1985); 2. *Duncan v. Duncan* , 556 So.2d 346 (Miss. 1990); 3. *Little v. Little* , 878 So.2d 1086 (Miss.App. 2004); 4. *Broome v. Broome* , 75 So.3d 1132 (Miss.App. 2011); 5. *Hays v. Alexander* , 114 So.3d 704 (Miss. 2013); 6. *Mooneyham v. Mooneyham* , 420 So.2d 1072 (Miss. 1982); 7. *Ravenstein v. Ravenstein* , 167 So. 3d 210, 214 (Miss. 2014); 8. *Burrell v. Burrell* , 289 So. 3d 749, 754 (Miss. Ct. App. 2020); 9. *Hammett v. Wood* s, 602 So.2d 825 (Miss. 1992); 9. Bradley V. Holmes, 561 So.2d 1034 (Miss. 1990); 10. *Chapman v. Ward* , 2 So.3d 790 (Miss.App 2008);

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Missouri	Yes, Statute and caselaw	Yes, Case 9, 11, 12	No, Case 9, 4, 11	**Yes**, for SSD from Soc Sec account of parent required to pay CS (Case 13, 15, 18, 19, 20- adult child). ===== **No**, for SSI (Case 16, 17)	**R.S.Mo. § 452.340.4** ("If the child is physically or mentally incapacitated from supporting himself and insolvent and unmarried, the court may extend the parental support obligation past the child's eighteenth birthday.")	1. *Fower v. Fower Estate* , 448 S.W.2d 585 (Mo. 1970); 2. *In re Marriage of D.R.S* ., 817 S.W.2d 615 (Mo.App.S.D. 1991); 3. *Heider v. Heider* , 822 S.W.2d 446 (Mo.App.E.D. 1991); 4. *Racherbaumer v. Racherbaumer* , 844 S.W.2d 502 (Mo.App.E.D. 1992); 5. *Harris v. Rattini* , 855 S.W.2d 410 (Mo.App.E.D. 1993); 6. *Mason v. Mason,* 873 S.W.2d 631 (Mo.App.E.D. 1994); 7. *Speight v. Speight* , 933 S.W.2d 879 (Mo.App.W.D. 1996); 8. *King v. King* , 969 S.W.2d 903 (Mo.App.W.D. 1998); 9. *Bright v. Bright* , 989 S.W.2d 196 (Mo.App.S.D. 1999); 10. *Clark v. Clark* , 20 S.W.3d 562 (Mo.App.W.D. 2000); 11. *Lueckenotte v. Lueckenotte* , 34 S.W.3d 387 (Mo. 2001); 12. *Hicks v. Quednow* , 197 S.W.3d 217 (Mo.App.W. D. 2006); 13. *McClasky v. McClasky* , 543 S.W.2d 832 (Mo.App.E.D. 1976); 14. *Hohenberg v. Hohenberg* , 703 S.W.2d 555 (Mo.App.E.D. 1985); 15. *Weaks v. Weaks* , 821 S.W.2d 503 (Mo. 1971); 16. *State ex rel. Dept. of Social Services Div. of Child Support Enforcement v. Kost* , 964 S.W.2d 528 (Mo.App. W.D. 1998); 17. *Lewis v. Department of Social Services,* 61 S.W.3d 248 (Mo.App. W.D. 2001)("Whether income from a trust should be included in determining appropriate amount of child support depends upon type of trust involved and intent of settlor." Lewis, at 256)("The special needs trust established for [the beneficiary] as a result of the medical malpractice claim and the monthly income received from the trust do not diminish [the father's] child support obligations."...[the beneficiary's] income from the special needs trust does not make the presumptive correct child support amount unjust or inappropriate." *Lewis* , at 258); 18. *Adams v. Adams* , 108 S.W.3d 821 (Mo.App.W.D. 2003); 19. *Holtgrewe v. Holtgrewe* , 155 S.W.3d 784 (Mo.App.E.D. 2005); 20. *Smith v. Smith,* 202 S.W.3d 83 (Mo.App.E.D. 2006)

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Montana	No duty to pay statutory CS (all cases), but is duty to support disabled adult child (Case 1, applying Statute; supported by Case 7)	No cases found, but Statute does not limit when child becomes unable to provide self-maintenance		Yes, for SSD from Soc Sec account of parent required to pay CS (Case 5, 6)	**Mont. Code Ann. § 40-6-214** ("It is the duty of the father and the mother of any poor person who is unable to provide self-maintenance by work to maintain that person to the extent of the parent's ability.")	1. *In re Guardianship of M.A.S* ., 266 P.3d 1267 (Mont. 2011); 2. H*urley v. Hurley* , 721 P.2d 1279 (Mont. 1986); 3. *Herrig v. Herrig* , 648 P.2d 758 (Mont. 1992); 4. I*n re Marriage of Perkins* , 908 P.2d 208 (Mont. 1995) (All cased hold no duty to pay child support after age of majority unless there has been a voluntary agreement to do so, but Case #1 imposes duty on parent to support child who is unable to provide self-maintenance through work); 5. *In re Marriage of Durbin,* 823 P.2d 243 (Mont. 1991); 6. *In re Marriage of Cowan,* 928 P.2d 214 (Mont. 1996); 7. *North Pacific Ins. Co. v. Stunky* , 338 P.3d 56 (Mont. 2014)

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Nebraska	No, unless the parents agree. "[a]s a general rule, absent agreement of the parties, a Nebraska district court cannot order a party to pay child support beyond the age of majority." (Case 11 at 606)			Yes, for SSD from Soc Sec account of parent required to pay CS (Case 5, 6, 8, 12; Allot-ments under Service-men's Depen-dents Act, Case 7). But SS paid because of child's disability are not used to offset CS obliga-tion (Case 8. 9, 10)	**Neb. Rev. Stat. § 1. 42-364; 2. 42-371.01(1)** ("An obligor's duty to pay child support for a child terminates when (a) the child reaches nineteen years of age... unless the court order for child support specifically extends child support after such circumstances.)	1. *Waldbaum v. Waldbaum* , 107 N.W.2d 407 (Neb. 1961); 2. *Meyers v. Meyers,* 383 N.W.2d 784 (Neb. 1986); 3. *Zetterman v. Zetterman,* 512 N.W.2d 622 (Neb. 1994); 4. *Henderson v. Henderson* , 653 N.W.2d 226 (Neb. 2002) (all cases enforce statute requiring CS for only minor children - those unmaried under age 19); 5. S*chulze v. Jensen* , 214 N.W.2d 591 (Neb. 1974); 6. *Hanthorn v. Hanthorn* , 460 N.W.2d 650 (Neb. 1990); 7. *Hopwood v. Hopwood* , 100 N.W.2d 833 (Neb. 1960); 8. *Brewer v. Brewer* , 509 N.W.2d 10 (Neb. 1993); 9. *Johnson v. Johnson* , 862 N.W.2d 740 (Neb. 2015); 10. *Burcham v. Burcham* , 886 N.W.2d 536 (Neb. Ct. App. 2016); 11. *Radmanesh v. Radmenesh* , 996 N.W.2d 592 (Neb. 2023); 12. *Hartman v. Hartman* , 622 N.W.2d 871 (Neb. 2001)

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Nevada	Yes	Yes, required by Statute	No (Case 2)	Child's SS benefit received because of CS obligor's SS account to be offset against the obligor's payment (Nevada Child Support Guide-lines); Child is self-supporting if public assistance is sufficient to meet the child's needs (Statute § 2)	**Nev. Rev. Stat. § 125B.110** ("1. A parent shall support beyond the age of majority his or her child with a handicap until the child is no longer handicapped or until the child becomes self-supporting. The handicap of the child must have occurred before the age of majority for this duty to apply.")	1. *Edgington v. Edgington* , 80 P.3d 1284 (Nev. 2003); 2. *Davitian-Kostanian v Kostanian* , 534 P.3d 700 (Nev. 2023)

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New Hampshire	Yes, but only until age 21 or no longer qualifies as a child with a disability, as defined in RSA 186-C:2, I, who is receiving special education or special education and related services as identified by the child's school district. (statute)	Yes, but based on old statute (Case 1)	Case 1 held Yes, but based on old statute. 2013 revision of statute states "If the parties have a child with disabilities, the court may initiate or continue the child support obligation after the child reaches the age of 18."	Yes, for SSD from Soc Sec account of parent required to pay CS (Case 2, 3, 4)	**N.H.Rev.Stat.Ann. 461-A:14** Effective 7-1-2025 - (IV..."If the parties have a child with disabilities, the court may initiate or continue the child support obligation after the child reaches the age of 18. No child support order for a child with disabilities may continue after the child reaches age 21 or no longer qualifies as a child with a disability, as defined in RSA 186-C:2, I, who is receiving special education or special education and related services as identified by the child's school district. .")	*1. In re Jacobson* , 842 A.2d 77 (N.H. 2004) (Statute relied on was repealed in 2005. New statute 461-A:14.IV and IV-a allows initiation or continuation of CS after child with a disability reaches age 18. 2013 amendment cuts off all child support at age 21, but 2024 amendment extends if child is receiving special ed and related services as identified by the child's school district. Also, termination of child support is deemed to be substantial change of circumstances for purposes of modification of child support under RSA 458-C-7); 2. *Griffin v. Avery* , 424 A.2d 175 (N.H. 1980); 3. *In re Angley-Cook* , 855 A.2d 431 (N.H. 2004) 4. *In re State ex rel. Taylor* , 904 A.2d 619 (N.H. 2006)

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New Jersey	Yes, based on common law and statutes 1, 2	Yes, Cases 1, 5 and Statute 2 § b.(1)(c) ("the child has a physical or mental disability, as determined by a federal or State government agency, that existed prior to the child reaching the age of 19 and requires continued child support. ")	Yes, Case 1 and Statute 1 and also see Statute 2	Yes, for SSD from Soc Sec account of parent required to pay CS (Case 4). But Statute 1 lists "the child's eligibility for public benefits and services" as one factor for the court to consider.	**N.J. Stat. Ann. § 1. 2A:34-23.a** - "The obligation to pay support for a child who has not been emancipated by the court shall not terminate solely on the basis of the child's age if the child suffers from a severe mental or physical incapacity that causes the child to be financially dependent on a parent. The obligation to pay support for that child shall continue until the court finds that the child is relieved of the incapacity or is no longer financially dependent on the parent." See also *** in Cases column. **2. 2A:17-56.67. 1.a(2)**	1. *Kruvant v. Kruvant,* 100 N.J.Super.107 (App.Div. 1968); 2. *Mascuillo v. Mascuillo* , A-3392-08T2, 2010 WL 256024 (N.J.Super. App.Div. 2010); 3. *Mazyk v. Cozze* , 2012 WL 6115682 (N.J.Super.A.D. 2012)("in order to take advantage of certain Medicaid benefits, Cozze voluntarily gave up the settlement assets by creating the self settled Trust. The trial judge recognized that those assets are not available to satisfy Cozze's child support obligations. However, the distribution of those assets is a resource which the trial judge appropriately considered available for support." *Mazyk,* at 4); 4. *Pasternak v. Pasternak* , 708 A.2d 1235 (N.J.Super. 1997); 5. *Turkheimer v. Burke* , No. A-1819-14T1, 2017 WL 244104 (N.J. Super. Ct. App. Div. Jan. 20, 2017)(Burden on party seeking to continue child support after child reaches majority to prove child is not emancipated) ========== *** **Statute 1 says** "As used in this section "severe mental or physical incapacity" shall not include a child's abuse of, or addidtion to, alcohol or controlled substances."

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New Mexico	Yes, under common law, not statute (Case 1)	Yes, Cases 1, 2	A child is not emanci-pated if severly disabled before reaching age of majority (Cases 1, 2)	Yes, for SSD from Soc Sec account of parent required to pay CS (Cases 3, 4), but not if Soc Sec is child's benefit rather than received through a parent (Case 5)		1. *Cohn v. Cohn* , 934 P.2d 279 (N.M.App. 1996); 2. *Fitzgerald v. Valdez* , 427 P.2d 655, 659 *dicta* (N.M. 1967); 3. *Mask v. Mask* , 620 P.2d 883 (N.M. 1980); 4. *Romero v. Romero* , 682 P.2d 201 (N.M.App. 1984); 5. *Gonzales v. Shaw* , 428 P.3d 280 (N.M.App. 2018)

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New York	Yes, until age 26 if "develop-mentally disabled," resides with person seeking support, and principally dependant on such person for mainten-ance (Statute 1); Prior case held No (Case 3)	Yes, prior to age 22 to meet definition of Develop-mentally Disabled (Statute 3)	Possibly No. Statutes 1 and 2 impose no such restriction	No, Case 4, 5, 7, 8, 9; It is only one factor to consider (Case 6, 7)	**1. N.Y. Fam.Ct.Act (FCA)§413-b** (see description in second column of this chart); **2. FCA §415** (requires support of child under age 21 even if child is receiving public assistance or institutionalized); **3. N.Y. MHY, Title A, Art. 1, § 103(22)** - (Definition of "developmentally disabled" includes requirement of onset prior to age 22)	1. *Cromwell v. Benjamin* , 41 Barb. 558 (N.Y.Sup.Ct. 1863)(Imposed common law duty on parent to support adult child who "was an invalid unable to support herself by labor"); 2. *Halstead v. Halstead* , 239 N.Y.S. 422 (1930); 3. *Beiter v. Beiter* , 539 N.Y.S.2d 271 (N.Y.Sup.Ct. 1989); 4. *Hollister v. Whalen* , 663 N.Y.S.2d 918 (1997); 5. *In Matter of Graby v. Graby* , 664 N.E.2d 488 (N.Y.App. 1996). 6. *Arnoldt v. Arnoldt* , 554 N.Y.S.2d 396 (1990); 7. *Weymouth v. Mullin* , 42 A.D.2d 681, 839 N.Y.S.2d 600 (N.Y.App.3D New York 2007); 8. *Bouie v. Joseph* , 935 N.Y.S.2d 276 (N.Y.App.Div.2.Dept. 2012); 9. *Holeck v. Beyel* , 145 A.D.3d 1600, 43 N.Y.S.3d 816, 817 (2016)

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North Carolina	Case 1 held Yes under the common law. However, Statute 1 changed this to No. But may be required to pay CS past age 18 if child under age 20 and not graduated HS; or if child is enrolled in cooperative high school program, CS stops after completion of 4th year or enrollment (See Statute)				**N.C. Gen. Stat. Ann. §** **1.** 50-13.4(c); **2.** 50-13-8	1. *Wells v. Wells* , 227 N.C. 614, 22 S.E.2d 31 (N.C. 1947) (applying the common law rule that parent has duty to support adult child who suffers from mental or physical incapacity); 2. *Yates V. Dowles* , 93 N.C.Aoo. 787, 370 S.E.2d 79 (1989)(explains how 1971 amendment to Statute #2 removes original requirement that followed *Well* s and eliminted duty to support adult disabled child) ; 3. *Hendricks v. Sanks* , 545 S.E.2d 779 (N.C.App. 2001); 4. *Martin v. Martin,* 636 S.E.2d 340 (N.C.App. 2006)(no duty to support adult child, but agreement to do so will be enforced); 5. *Swink v. Swink* , 6 N.C.App. 161, 169 S.E.2d 539 (1969)(spendthrift trust established by will of deceased grandmother for the benefit of non-custodial parent can be breached for purpose of paying CS owed by trust's beneficiary)

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North Dakota	Possibly, under filial statute 3 (see analysis in Case 1)			Yes, Statute requires offset (Statute 4)(See also Case 3, 4); Prior caselaw was default presumption is that SSD from Soc Sec account of parent required to pay CS (Case 2)	**N.D. Cent. Code Ann. §** **1.** 14-09-08; **2.** 14-09-08.2; **3.** 14-09-10; **4. N.D. Admin. Code** - **Child Support Guidelines § 75-02-04.1-02.10** - Payment of children's benefits made to or on behalf of child not living with obligor must be credited as payment toward obligor's obligation in month intending to cover, but not towards any other month.	*1. Wiedrich v. Wiedrich* , 179 N.W.2d 728 (N.D. 1970)(interpreting filial statute 14-09-10); 2. *Guthmiller v. Guthmiller* , 448 N.W.2d 643 (N.D. 1989); 3. *Tibor v. Bendrick* , 593 N.W.2d 395 (N.D. 1999); 4. *Davis v. Davis* , 780 N.W.2d 707 (N.D. 2010)

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Ohio	Yes, Statutes 1, 2, 3 and common law duty (Case2). Child must be mentally or physically disabled and incapable of self-supporting (Statute 2 and Case 15)	Yes, Case 2	No, Statute 1 (effective 3-20-2025) Split in Districts: **No** - Cases 3, 6, 7, 8. **Yes** - Case 10	**Yes**, for SSD from Soc Sec account of parent required to pay CS (Case 12, 13, 14) and for arrearage from time child's SS benefit recrived, but not arrearage accrued prior to SS benefit (Case 20); **No,** for SSI (Cases 1, 2) and Adoption subsidy (Case 17)	**Ohio Rev. Code § 1.** 3119.11; **2.** 3119.86 ; **3.** 3109.20 (all effective 3-20-2025)	1. *Oatley v. Oatley* , 387 N.E.2d 245 (Ohio App. 6th Dist. 1977); 2. *Castle v. Castle* , 473 N.E.2d 803 (Ohio 1984); 3. *Abbas v. Abbas* , 715 N.E.2d 613 (Ohio App. 7th Dist. 1998); 4. *Yost v. Yost* , 2003 WL 21652172, 2003-Ohio-3754 (Ohio App. 4th Dist. 2003); 5. *Bailey v. O'Hare* , 2006 WL 164917, 2006-Ohio-239 (Ohio App. 2 Dist. 2006)(constitutional equal protection argument rejected); 6. *Wiczynski v. Wiczynski,* 2006 WL 456762, 2006-Ohio-867 (Ohio App, 6th Dist. 2006); 7. *In re Edgell* , 2010 WL 5550224, 2010-Ohio-6435 (Ohio App. 11 Dist. 2010); 8. *Donohoo v. Donohoo,* 2012 WL 3893784, 2012-Ohio-4105 (Ohio App. 12th Dist. 2012); 9. *In re Palcisco* , 2012 WL 6727405, 2012-Ohio-6134 (Ohio App. 11th Dist. 2013) appeal not allowed, 986 N.E.2d 1-22 (Ohio 2013); 10. *Geygan v. Geygan* , 973 N.E.2d 276 (Ohio App. 10th Dist. 2012); 11. *Myers v. Myers* , 2006-Ohio-5360, 2006 WL 2925353 (Ohio App. 6 Dist. 2006); 12. *Williams v. Williams* , 727 N.E.2d 895 (Ohio 2000); 13. *Marder v. Marder* , 2008 WL 2168415 (Ohio App. 12 Dist. 2008); 14. *Alexander v. Alexander* , 2009 WL 3681670 (Ohio App. 10 Dist. 2009); 15. *Fenstermaker v. Fenstermaker* , 57 N.E.3d 206 (Ohio App. 2015); 16. *Clay v. Clay* , 190 N.E.3d 40 (Ohio App. 2022)(describing the codification of common law rule in Castle and refusing to apply doctrine of res judicata to child support modification cases); 17. *Million v. Million* , 2020 WL 5989214 (Ohio App, 2nd Dist. 2020); 18. *Patton v. Patton* , 742 N.E.2d 619 (Ohio 2001); 19. *Styer v. Styer* , 2006 WL 319248 (Ohio App, 3rd Dist. 2006); 20. *Pride v. Nolan* , 511 N.E.2d 408 (Ohio App, 1st Dist. 1987)

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Oklahoma	Yes, Statute 1 and Case law	Yes, Statute 1, Case 1	No - Statute 1 and Case 1	**Yes**, for SSD from Soc Sec account of parent required to pay CS (Statute 3 and Case 3, 4, 5); **Possibly**, Case 1 dictum; SS received by child from SS account not belonging to either parent is income of child, not applied to either parent (Case 2)	**43 Okla. Stat. §** **1.** 112.1A.; **2.** 118B.B.4; **3**. 118B.F	*1. Gregory v. Gregory* , 259 P.3d 914 (Okla.App.Div. 1 2011). 2. *Gambill v. Gambill* , 137 P.3d 685 (Ok.Civ.App.Div.2 2006); 3. *Baker v. Baker* , 923 P.2d 1198 (Ok.Civ.App.Div.3 1996); 4. *Wilson v. Stenwall,* 868 P.2d 1317 (Okla.App.Div. 3 1992)(parent not entitled to credit for SS received by child as result of other parent's entitlement); 5. *Nibs v. Nib* s, 625 P.2d 1256 (Okla. 1981)

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Oregon	Yes, common law and statute (filial law), but only by direct action by child, not as child support		No, Case 1	No, but unusual facts in the case (see Case 2). Possibly, see Case 3	**O.R.S. §109.010** ("Duty of support. Parents are bound to maintain their children who are poor and unable to work to maintain themselves; and children are bound to maintain their parents in like circumstances.")	*1. Haxton by Haxton v. Haxton* , 705 P.2d 721 (Or. 1985)(excellent discussion of common law requiring parents to support children, whether minor or adult and unable to provide for self-support); 2. *Matter of Marriage of Cope* , 631 P.2d 781 (Or. 1981)(court refused to allow SS payments paid for child based on father's SS earnings to be offset against father's CS obligation. Father had not sought modification, and years later asked that child's SS be credited against father's CS obligation that had accrued because payments were not run through the state's CS processing agency.); 3. *Matter of Marriage of Lawhorn* , (850 P.2d 1126 (Or.App. 1993)("The trial court did err, however, in simply assuming that the social security benefits automatically offset the parents' child support obligations. They may or may not, depending on the facts of each case. The proper procedure is for the trial court to consider the effect of the receipt of the social security benefits on the needs of the child. Then, if appropriate, the court may make "a written finding or a specific finding on the record" that, because of the social security benefits, the presumed obligation dictated by the guidelines is "unjust or inappropriate." *Lawhorn,* at 229); 4. *Shelley v. Shelley* , 354 P.2d 282 (Or. 1960).
Penn.	Yes, statute and Cases 1, 2, 3, 4, 5 (caselaw based on common law and statute)	Yes, Case 3, 5, 9	No, Case 5	Yes, for SSD from Soc Sec account of parent required to pay CS (Case 6, 7)	**23 Pa. C.S. § 4321(3)** ("Parents may be liable for the support of their children who are 18 years of age or older")	1. *Com.ex rel. Cann v. Cann* , 418 A.2d 403 (Pa.Super. 1980); 2. *Crawford v. Crawford* , 633 A.2d 155 (Pa.Super. 1993); 3. *Heitzman-Nolte v. Nolte,* 837 A.2d 1182 (Pa.Super. 2003); 4. *Kotzbauer v. Kotzbauer,* 937 A.2d 487 (Pa.Super. 2007); 5. *Style v. Shaub,* 955 A.2d 403 (Pa.Super. 2008); 6. *Children & Youth Services v. Chorgo* , 491 A.2d 1374 (Pa.Super. 1985)(Parent receiving Social Security Disability); 7. *Preston v. Preston* , 646 A.2d 1186 (Pa.Super. 1994)(Parent receiving Social Security Retirement)(rebuttable presumption that a credit for SS received by child is offset against parent's CS obligation); 8. *Mencer v. Ruch* , 928 A.2d 294 (Pa.Super. 2007); 9. *Hanson v. Hanson* , 625 A.2d 1212 (Pa. Super. 1993); 10. *Ricco v. Novitski* , 874 A.2d 75 (Pa.Super. 2005)

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Rhode Island	Yes, by Statute 1	Yes, by Statute 1	No, by Statute 1	Yes, Case 3	**1. R.I. Gen. Laws 15-5-16.2(b)**	1. *Siravo v. Siravo,* 424 A.2d 1047 (R.I. 1981)(not extended by Pierce v. Pierce based on statute in force at that time, which was later changed); 2. *Pierce v. Pierce* , 770 A.2d 867 (R.I. 2001)(the version of Statute 15-5-16(b) that was in effect when this opinion was written was changed in 2009 to remove the age 21 limitation and allow CS to be extended after age 19 for a child "with a severe physical or mental impairment still living with or under the care of a parent,"...); 3. *Pontbriand v. Pontbraind* , 622 A.2d 482 (R.I. 1993)
South Carolina	Yes, by Statute and case law	In *Riggs* (Case 3) the disabiity was diagnosed after age 18, but was genetic and the court found it existed prior to age 18 and as a result the child was never emanci-pated. See also Case 5	No, Case 2 (based on the facts) and Case 5	Yes, for SSD from Soc Sec account of parent required to pay CS (Case 4)	**S.C.Code Ann. § 63-3-530(A)(17)** (formerly cited as 20-7-420(17)) (See applicable portion of Statute in Cases column)	1. *Peterson v. Smith* , 415 S.E.2d 431 (S.C.App. 1992); 2. *Morris v. Morris* , 517 S.E.2d 721 (S.C.App. 1999); 3. *Riggs v. Riggs* , 578 S.E.2d 3 (S.C. 2003)(court rejected constitutional equal protection argument that a married parent has no legal obligation to support an adult disabled child and therefore a divorced parent cannot ordered to do so); 4. *Justice v. Scruggs* , 332 S.E.2d 106 (S.C.App. 1985); 5. *Smith v. Doe* , 623 S.E.2d 370 (S.C. 2005)(action for CS instituted when child was 34, but her condition manifested at birth); 6. *Crenshaw v. Thompso* n, 311 S.E.2d 742(S.C.App. 1984)(child support ordered under "exceptional circumstances" when child severely injured in auto accident two weeks after high school graduation) **==========Statute Quote ==========** ("[t]o provide for child support past age eighteen when there are physical or mental disabilities of the child or other exceptional circumstances that warrant the continuation of child support beyond age eighteen for as long as the physical or mental disabilities or exceptional circumstances continue.")

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South Dakota	No			**Yes**, for SSD from Soc Sec account of parent required to pay CS (Case 4, 5); and can be used for CS arrearage. but not from child's SS account (Case 5), and **No** - for SSI (Case 3)	**SDCL §** **1.** 25-5-18.1 **2.** 25-7-9	1. *Birchfield v. Birchfield* , 417 N.W.2d 891, 895 (S.D.1988); 2. *Miller v. Jacobsen* , 714 N.W.2d 69 (S.D. 2006) (court may not impose duty to support a child beyond age of 18, or 19 if enrolled full-time in high school; however, former spouses are free to agree to provide support beyond age 19); 3. *Nelson v. Nelson* , 454 N.W.2d 533(S.D. 1990); 4. *Hawkins v. Peterson* , 474 N.W.2d 90 (S.D. 1991); 5. *Crago v. Donovan* , 593 N.W.2d 726 (S.D. 1999)

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Tennessee	Yes, Statute 1. if a child is "severly disabled and living under the care and supervision of a parent"	Yes, required by Statute 1	Yes, or at least must continue an existing CS order (Case 3, 4, 5)	Yes, based on Child Support Guidelines (2 under Statutes); See also Case 6	**1. Tenn. Code Ann. 36-5-101(k); 2.** Child Support Guidelines, Rule 1240-2-4-.04 1(xiv) and 5	1. *Sayne v. Sayne* , 284 S.W.2d 309 (Tenn.Ct.App. 1955)(recognized common law duty to support adult disabled child); 2. *Bryan v. Leach* , 85 S.W.3d 136 (Tenn.App. 2001); 3. *In re Conservatorship of Jones,* 2004 WL 2973752 (Tenn.Ct.App. 2004); 4. *Corder v. Corder* , 231 S.W.3d 346 (Tenn.App. 2006); 5. *Ratcliff v. Neal* , 2024 WL 4885448 (Tenn.Ct.App. 2024); 6. *Kipping v. Kipping,* 186 Tenn 247 (Tenn. 1948)(allowed military payments to soldier's child to be offset against the soldier's CS obligation).
Texas	Yes, Statute 1	Yes, required by Statute 2 § (a)(2)		Yes for SSD received by child due to obligor parent's retire-ment (Case 4) and disability (Case 5). No for SSD backpay received by child (Case 6)	**Texas Fam. Code 1.** 154.001(a)(4); **2.** 154.005; **3.** 154.302; **4.** 154.306; **5.** 154.309; [**NOTE**: H.B. No. 4509 introduced March 12, 2025 will amend these statutes if passed. See Case 8]	1. *Red v. Red* , 536 S.W.2d 431 (Tex.Civ.App. 14th Dist. 1976); 2. *In re J.M.C.* , 395 S.W.3d 839 (Tex.App. Tyler 2013); 3. *Lake v. Lake* , 899 S.W.2d 737 (Tex.App. Dallas 1995)("We specifically do not decide the issue of whether an obligor parent would be entitled to a child support credit for social security disability or retirement payments a minor child might receive", *Lake* at 740, FN. 8); 4. *In Interest of Allsup* , 926 S.W.2d 323 (Tex.App. Texarkana 1996); 5. *In re Rich,* 993 S.W.2d 272 (Tex.App. San Antonio 1999); 6. *Attorney General of Texas v. Stevens* , 84 S.W.3d 720 (Tex.App. Houston (1st Dist.)); 7. *In Interest of C.J.N.-S.* , 2018 WL 1870730 (Tex.App. Corpus Christi-Edinburg 2018) (determination adult child is incapable of self-support as defined in Statutes); 8. *In Interest of D.C.* , 549 S.W.3d 136 (Tex. 2018)(while denying a petition for review of a lower court order that a parent must provide financial support to an adult child for an indefinite period of time, the Texas Supreme Court pointed out that Statute 154.302 is woefully sparse in describing what proof is required to satisfy its requirements, and the court stated either legislation is required or the court will take it upon itself to provide "guidance how "detailed and specific" the evidence must be to meet section 154.302's standards.")

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Utah	Yes, Statutes 1 and 2; Cases 1, 2, 4	Case 4 says this is undecided; also nothing in the statutes enacted in 2024 requires disability onset prior to emanci-patation	No, see Case 4 and 3; also nothing in the statutes enacted in 2024 requires anything more than change in circum-stances	Yes, by Statute 4 § (8) and Statute 5; also see Statutes 3 and 4. See also Case 3 (crediting SSD received by child to parent whose SS earnings were used)	**Utah Code Ann. § 1.** 81-6-101(7)(c) **2.** 81-6-104(1); **3.** 81-6-202(6)(e) **4.** 81-6-203(6), (7), and (8); **5.** 81-6-204(6) See *** in Cases column for description.	1. *Dehm v. Dehm* , 545 P.2d 525 (Utah 1976); 2. *Garrand v. Garran* d, 615 P.2d 422 (Utah 1980); 3. *Doyle v. Doyle* , 221 P.3d 888 (Utah App. 2009); 4. *Wadman v. Wadman,* 532 P.3d 1015 (Utah App. 2023) ========== ***1*** S.B. 95 passed in the 2024 General Session recodified U.C.A § 78B-12 (Utah Child Support Act) and moved it to U.C.A. § 81-6 (Utah Domestic Relations Code, Chapter 6, Child Support). This change was effective 9-1-2024. ***2*** U.C.A. § 81-6-101(7)(c) added to the definition of "child" the following, "son or daughter of any age who is incapacitated from earning a living and, if able to provide some financial resources to the family, is not able to support self by own means." ***3*** U.C.A. § 81-6-104(1) says, "(a) Every child is presumed to be in need of the support of the child's parents. (b) Every parent shall support their child. (c) Nothing in this chapter relieves a parent of the primary obligation of support for the parent's child."

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Vermont	No, statute 1; Case 2			Yes, for SSD from Soc Sec account of parent required to pay CS (Cases 3, 4. 5)	**1. 15 V.S.A. 658** (subsection (c) limits child support to the later of: age of majority or termination of secondary education). (In 2007 subsecton (g) was added giving court authority to extend CS to age 22 for disabled child. This sunsetted on July 1, 2012); **2. 1 V.S.A. § 173** (age of majority is 18)	1. *Rowell v. Town of Vershire,* 19 A. 990, 62 Vt. 405 (Vt. 1890); 2. *Morancy v. Morancy* , 800 A.2d 435 (Vt. 2001); 3. *Davis v. Davis* , 449 A.2d 947 (Vt. 1982); 4. *Louko v. McDonald* , 22 A.3d 433 (VT. 2011); 5. *Cantin v. Young* , 770 A.2d 449 (Vt. 2000)(distinguishes joint custody and sole custody cases when determining amount of SS benefits paid to children that is included in calculation of amount of CS each parent owes)

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Virginia	Yes, Statutes 1 and 2	Yes, Statute 1 and 2		**Yes**, for SSD from Soc Sec account of parent required to pay CS (Statute 3; Case 1, 2). ===== **No**, for SSI (Case 3, 4, 6).	**Va. Code Ann. § 1**. 20-124.2.C; **2.** 16.1-278.15.A; **3.** 20-108.2.C	*1. Com., Dept. of Social Services, Div. of Child Support Enforcement, ex rel. v. Skeens,* 442 S.E.2d 432 (Va.App. 1994); 2. *Whitaker v. Colbert,* 442 S.E.2d 429 (Va.App. 1994); 3. *Bennett v. Com., Virginia Dept. of Social Services Div. of Child Support* , 472 S.E.2d 668 (Va.App. 1996); 4. *Rinaldi v. Dumsick* , 528 S.E.2d 134 (Va.App. 2000)(overruled by Humphries v. Buchannan); 5. *Germek v. Germek* , 537 S.E.2d 596 (Va.App. 2000); 6. *Humphries V. Buchannan* , 900 S.E.2d 550 (Va.App. 2024)

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Washington	**No**, "[t]here is no Washing--ton State case law which actually recognizes and enforces a cause of action for legal support of an emanci-pated disabled child." Case # 7			**Yes**, court has discretion to offset SS from Soc Sec account of parent required to pay CS (Case 4); SSI received by child can be applied to reduce CS obligation of parent (Case 6)	**RCW §** **1.** 26.09.100; **2.** 26.19.075(c) (iii) and (iv) ("special needs of disabled children" is reason to deviate from standard CS calculation); **3.** 26.44.020 (defines "child" as person under age 18 years)	*1. Schultz v. Western Farm Tractor Co.,* 190 P. 1007 (Wash. 1920) (Court recognized the common law duty of parents to support "defective children, whether the defect be mental or physical. To these he owes a continuing obligation of support, which ceases only when the necessity for support ceases." Case involved dividing estate of deceased father to adult crippled child who had been supported by the deceased father; it did not involve child support); 2. *Van TInker v. Van Tinker,* 229 P.2d 333 (Wash. 1951) (although the court recognizes the duty of a parent to support an adult child who has a disability, such duty cannot be enforced through the original divorce proceeding); 3. *Childers v. Childers* , 575 P.2d 201 (Wash. 1978) (court also rejected a constitutional equal protection argument); 4. *Chase v. Chase* , 444 P.2d 145 (Wash. 1968); 5. *In re Marriage of Maples* , 899 P.2d 1 (Wash.App.Div.2 1995)(SSD paid to child is treated as income to parent, which raises parent's income, then can be offset against CS obligation); 6. I*n re Marriage of Trichak* , 863 P.2d 585 (Wash.App.Div.1 1993)(SSI received by child is income to child and can be used when calculating CS obligation of parent); 7. *Fisher v. United States* , 28 Fed. Cl. 88, 95 (1993)

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West Virginia	Yes, Case 1, 2; Statute 1	No, Case 3		Yes, if Soc Sec received by child from account of parent paying CS (Statute 2 § (a)); Statute 2 § (b) (treatment of SSD received) and § (b) (if child receiving SSI and CS would cause reduction, no CS shall be paid); Case 5 discusses SSI; Case 4 discusses VA benefits	**W. Va.Code §** **1.** 48-11-103 ((b) Nothing herein shall be construed to abrogate or modify existing case law regarding the eligibility of handicapped or disabled children to receive child support beyond the age of eighteen); **2.** 48-13-603	1. *James G. v. Caserta* , 332 S.E.2d 872 (W.Va. 1985)("Under the common law where a child is incapable of supporting himself because of physical or emotional disabilities, the parents' obligation to support continues beyond the child's age of majority." Syllabus point 10); 2. *Kinder v. Schlaegel* , 404 S.E.2d 545 (W.Va. 1991); 3. *Casdorph v. Casdorph* , 460 S.E.2d 736 (W.Va. 1995); 4. *Duke v. Richards* , 600 S.E.2d 182 (W.Va. 2004); 5 *Michael S. v. Angela S* ., 2024 WL 1256192 (W.Va. App. 2024) (interprets Statute 2 (b) and finds any SSI being received by child does not reduce child support to zero, it merely reduces child support. But child support is prohibited if it exceeds SSI amount and would reduce SSI zero).

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State	Parent May Be Required to Pay CS for Adult Child Sufficiently Disabled	Disability Must Onset Before Majority Age, or Emanci-pation	Request for Adult CS Must Occur before Majority Age	Public Benefits Can Be Offset Against CS	Statutes	Cases
Wisconsin	No, Statute and Case 1			Yes, Case 3, 4; Statute 2, for SSD paid to child from obligor parent's Soc. Sec. account	**Wis. Stat. §** **1.** 767.511(4) limits CS to 18, or 19 if still in highschool; **2.** 767.59(1r)(d)	1. O*'Neill v. O'Neill* , 117 N.W.2d 267 (Wis. 1962) (statutes do not allow child support after minority); 2. *Bliwas v. Bliwas* , 178 N.W.2d 35, 36 (Wis. 1970) ("As applied to a severely handicapped offspring, the application of the statute may be harsh. As applied to secondary education of any child, which nowadays customarily goes beyond the age of twenty-one, it may have become unrealistic. But the public policy set is for the legislature to establish, and for the legislature alone to amend or change.") 3. *Burger v. Burger* , 424 N.W.2d 691 (Wis. 1988)(credited Soc Sec received by children against monthly CS obligaion, not arrears); 4. *Paulhe v. Riley* , 722 N.W.2d 155 (Wis.App. 2006)
Wyoming	Yes, Case 1 and Statute 1 ("Mentally or physically disabled and thereby incapable of self support")			Yes, if Soc Sec received by child from account of parent paying CS (Statute 3, Case 3); See also Case 2	**Wyo.Stat. Ann. §** **1.** 14-2-204(a)(i); **2.** 20-2-301; **3.** 20-2-304(e)	*1. Kamp v. Kamp* , 640 P.2d 48 (Wyo. 1982); 2. *Hinckley v. Hinckley* , 812 P.2d 907 (Wyo. 1991)(Receipt of SD by child from account of non-custodial parent is but one factor for cout to take into consideration in determing amount of CS; not an automatic offset of CS obligation); 3. *Groenstein v. Groenstein* , 104 P.3d 765 (Wyo. 2005)((2)as a matter of first impression, benefits paid to child of disabled parent through Social Security Disability Insurance (SSDI) are to be included in parent's gross income for child support purposes; (3) as a matter of first impression, SSDI benefits that are paid to child are to be credited to parent's child support obligation when initially calculating obligation"); 4. *Bagley v. Bagley* , 311 P.3d 141 (Wyo. 2013); 5. *O'Roake v. State ex rel. Dep't of Fam. Servs., Child Support Enf't Div* ., 494 P.3d 482 (Wyo. 2021); 6. *Swaney v. State, Dep't of Fam. Servs., Child Support Enf't* ,256 P.3d 514 (Wyo. 2011) (backpay SSD benefits paid to adult disabled child do not reduce CS arrearages owed by obligor parent; instead they belong to the child)

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Appendix B

Special Needs Trusts and Child Support

Summary of Cases and Statutes in 50 States Plus District of Columbia That Answer Questions Posed in the Accompanying Paper

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Alabama					
Alaska					
Arizona	No - Case 1				1. Adu-Tutu v. Adu-Tutu, 1 CA-CV 11-0262, 2012 WL 1964568 (Ariz. App. 1st Div. 2012)
Arkansas					
California	No - Case 3		Yes, Statute	Cal. Fam. Code § 3910(b)	3. In re Marriage of Drake,62 Cal.Rptr.2d 466 (Cal.App.2d Dist. 1997)("trust will run dry long before David dies if the full burden of supporting David falls upon it, raising the prospect that David will become a public charge" [and not have "sufficient means"])
Colorado					
Conn.					
Deleware					
District of Columbia					

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Florida	Yes - Case 3	Yes - Case 19, based on Statute 1		1. Fla. Stat. Ann. § 736.0503	3. Carmody v. Carmody, 230 So.2d 40 (Fla. 1st Dist. App. 1970); 19. Alexander v. Harris, 278 So.3d 721 (Fla.2d DCA 2019). Based on Florida Statute § 736.0503 (wich is based on § 503 of the Uniform Trust Code) the court held that a 42 U.S.C. § 1396p trust with a spendthrift clause was subject to continuing guarnishment for child support owed by the trust's beneficiary. ("Although the court cannot compel a disbursement from a spendthrift trust, if disbursements are wholly within the trustee's discretion and the trustee exercises its discretion making a disbursement, that disbursement may be subject to a writ of garnishment for child support for beneficiary's child."... "Whether the disbursements from a spendthrift trust are paid directly to the beneficiary or to third parties for his benefit is immaterial to whether they may be garnished to enforce child support order for beneficiary's child."
Georgia			Yes, Statute 1 § (e) and Statute 2 § (c)	**Ga. Code Ann.** **1.** 19-6-15.1 and **2.** 19-6-15.2	
Hawaii					
Idaho					
Illinois			Yes, § (a)	750 I.C.S.A. § 5/513.5	
Indiana					
Iowa					
Kansas					

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Kentucky					
Lousiana					
Maine					
Maryland	No - Case 5				5. Cutts v. Trippe, 57 A.3d 1006 (Md.Spec.App. 2012)
Mass.					
Michigan					
Minnesota		See Case # 6			6. In re Ramsey County ex rel. Pierce County, Wis., 645 N.W.2d 747 (Minn.App. 2002)(Father receiving SSD and is beneficiary of SNT established by his parents, who support him. No further discussion of SNT, but appears to be third party-settled. In-kind support from parents (father lived with parents) was not counted as "income" to father for calculation of father's CS obligation.)
Mississippi					
Missouri	No, nor are distribu-tions from d4A trust count-able as income to adult child (Case #17)				17. Lewis v. Department of Social Services, 61 S.W.3d 248 (Mo.App. W.D. 2001)("Whether income from a trust should be included in determining appropriate amount of child support depends upon type of trust involved and intent of settlor." Lewis, at 256)("The special needs trust established for [the beneficiary] as a result of the medical malpractice claim and the monthly income received from the trust do not diminish [the father's] child support obligations."...[the beneficiary's] income from the special needs trust does not make the presumptive correct child support amount unjust or inappropriate." Lewis, at 258)
Montana					

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Nebraska					
Nevada					
New Hampshire					
New Jersey		Distribu-tions from self-settled SNT are "income" to trust bene. For calc. of bene's CS obligation (Case 3)	Statute allows court order "involving the creation of a trust"	N.J. Stat. Ann. § 2A:34-23.a	3. Mazyk v. Cozze, 2012 WL 6115682 (N.J.Super.A.D. 2012)("in order to take advantage of certain Medicaid benefits, Cozze voluntarily gave up the settlement assets by creating the self settled Trust. The trial judge recognized that those assets are not available to satisfy Cozze's child support obligations. However, the distribution of those assets is a resource which the trial judge appropriately considered available for support." Mazyk, at 4)
New Mexico					
New York			Yes, Statute	N.Y. Fam. Ct. Act §413-b.4 (reproduced in Cases Column)	4. The court shall have discretion to order the payor party to make support payments either to the petitioner or to the trustee of an "exception trust" as defined in 42 U.S.C. 1396p(d)(4)(A) and (C), clause (iii) of subparagraph two of paragraph (b) of subdivision two of section three hundred sixty-six of the social services law, and section 7-1.12 of the estates, powers and trusts law if such direction would assist in maximizing assistance to the child.

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
North Carolina		See Case 5 (spend-thrift trust breached to pay CS owed by bene-ficiary. This was not a SNT)			5. Swink v. Swink, 6 N.C.App. 161, 169 S.E.2d 539 (1969)(spendthrift trust established by will of deceased grandmother for the benefit of non-custodial parent can be breached for purpose of paying CS owed by trust's beneficiary)
North Dakota					
Ohio		Distributions from self-settled SNT are "income" to trust bene. For calc. of bene's CS obligation (Case 11). Case 19 holds spend-thrift trust (not SNT) is not liable for bene's CS obligation			11. Myers v. Myers, 2006-Ohio-5360, 2006 WL 2925353 (Ohio App. 6 Dist. 2006); 19. Styer v. Styer, 2006 WL 319248 (Ohio App, 3rd Dist. 2006)

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Oklahoma	Income received by child from a trust is excluded from CS calculation (Statute 2)	60 O.S.A. § 60-175.88.3 allows enforcement of CS order against a support trust for benefit of person who owes CS duty. This does not apply to discretion-ary trust (60-175.89)		2. 43 O.S.A. 118B.B	
Oregon		Yes for Spendthrift trust - Case #4; O.R.S. § 130.310 UTC 503 allows CS claims against a beneficiary of a spend-thrift trust to be pursued against the trust. Not SNT specific.		O.R.S. § 130.310 UTC 503	4. Shelley v. Shelley, 354 P.2d 282 (Or. 1960).

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Penn.	No - Case 10	Distributions from self-settled SNT are "income" to trust bene. For calc. of bene's CS obligation (Case 8)			10. Ricco v. Novitski, 874 A.2d 75 (Pa.Super. 2005); 8. Mencer v. Ruch, 928 A.2d 294 (Pa.Super. 2007)
Rhode Island					
South Carolina					
South Dakota					
Tennessee					
Texas		Statute 2 allows court to order CS payments to child of a beneficiary of a spend-thrift trust. If the trust is discretion-ary, can only be made from income, not principal	Yes, Statute 3 § (c)	**V.T.C.A.Fam. Cd.** **2.** 154.005 (quoted in Cases column); **3.** 154.302 (enacted in 2019) [NOTE: H.B. No. 4509 introduced March 12, 2025 will amend these statutes if passed]	Sec. 154.005. PAYMENTS OF SUPPORT OBLIGATION BY TRUST. (a) The court may order the trustees of a spendthrift or other trust to make disbursements for the support of a child to the extent the trustees are required to make payments to a beneficiary who is required to make child support payments as provided by this chapter. (b) If disbursement of the assets of the trust is discretionary, the court may order child support payments from the income of the trust but not from the principal.
Utah					
Vermont					

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State	SNT Can Be Offset Against CS	SNT Liable for Bene's Obligation to Pay CS	Statute Allows CS Payment to Trust	Statutes	Cases
Virginia			Yes, Statutes 1 and 2	**Va. Code Ann. §** **1.** 16.1-278.15.A; **2.** 20-124.2C ***** See ***** applicable section from both Statutes in Cases column	******* **"**Upon request of either party, the court may also order that support payments be made to a special needs trust or an ABLE savings trust account as defined in § 23.1-700."
Washington					
West Virginia					
Wisconsin					
Wyoming					

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Presented by Ken Brown and
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October 23, 2025

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2025 Supplemental Security Income (SSI) Program Update

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New SSI Trust Policy – Undue Hardship
POMS SI 01120.203, Exceptions to Counting Trusts Established on or after January 1, 2000

INTRODUCTION

On August 26, 2025, SSA issued Transmittal 104 to POMS SI 01120.203, Exceptions to Counting Trusts Established on or after January 1, 2000. (See Appendix A) The transmittal contains three new exceptions to counting a trust as a resource based on undue hardship.

> Section 1613(e) of the Social Security Act sets forth rules for counting trusts (established with the assets of an individual on or after 01/01/00) as resources along with exceptions to those rules if a trust meets one of the Medicaid trust exceptions. However, when a trust does not meet a Medicaid trust exception, SSA has the authority to waive applying the rules when such application would cause an undue hardship to the individual in certain circumstances. We are updating our policy to include three additional circumstances for undue hardship application.

The three new undue hardship exceptions relate to:

- a trust that contains funds in a Medicare Set-Aside Arrangement (MSA) for purposes of compliance with the Medicare Secondary Payer (MSP) Act;
- an SSA error results in a trust deficiency that cannot be remedied; and
- a policy-compliant special needs trust or a subaccount of a policy-compliant pooled trust is transferred to a noncompliant pooled trust or special needs trust and the trust beneficiary is not responsible for the transfer.

This is in addition to the current existing undue hardship exception when counting a trust as a resource would cause ineligibility for SSI and the individual would be deprived of food or shelter without SSI payments and has limited available funds.

UNDUE HARDSHIP – MEDICARE SET-ASIDE ARRANGEMENT (MSA)

Undue Hardship

Undue hardship exists if a trust containing funds in a Medicare Set-Aside Arrangement (MSA) would be a countable resource under section 1613(e) and the MSA funds may only be used for certain medical expenses consistent with the Medicare Secondary Payer (MSP) Act.

Medicare Secondary Payer (MSP) Act

Under the MSP Act, Medicare may not pay for a beneficiary's medical expenses when payment has been made (or can reasonably be expected to be made) under a workers' compensation law or plan, an automobile or liability insurance policy or plan, or under no fault insurance (see 42 U.S.C. § 1395y(b)(2)(A)(ii)).

Medicare Set-Aside Arrangement (MSA)

An MSA is a financial agreement that allocates a portion of an award, judgment, or settlement to pay for all future medical expenses related to the relevant injury or illness, for purposes of complying with the MSP Act. The use of the MSA funds must be legally restricted to such medical expenses that are covered and otherwise reimbursable by Medicare. The funds must also be depleted before Medicare will pay for future Medicare-covered expenses related to the individual's relevant injury or illness that exceed the set-aside amount. There may be cases in which funds in an MSA are placed in a trust.

For additional information, see the CMS factsheet at Appendix B or the following link: https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements.

Application of the Undue Hardship Waiver

We will apply undue hardship under this provision with respect to the portion of a trust containing an MSA when all of the following criteria are met:

- An MSA is established for the benefit of the SSI applicant or recipient or their spouse.

- Funds in the MSA are placed in a trust or the MSA is administered by a third party such that it is considered a legal instrument or device similar to a trust (see SI 01120.201G).

- The trust (or legal instrument or device similar to a trust) containing the MSA funds would be a countable resource under section 1613(e) and results in the individual's ineligibility for SSI due to excess resources.

- The MSA contains the necessary legal restrictions on the use of the MSA funds for certain medical expenses (i.e., medical expenses related to the relevant injury or illness that would be covered by Medicare).

- The individual signs a statement for the file and submits all relevant documentation related to the MSA, including documentation that shows how the MSA was created and that the MSA contains the necessary legal restrictions on the use of the MSA funds.

Suspension of Resource Counting

The portion of a trust containing an MSA is not counted as a resource under section 1613(e) (see SI 01120.201) in any month for which counting it would cause undue hardship under this application.

Resource Counting Resumes

Resource counting resumes for any month(s) for which it would not result in undue hardship, such as if the MSA was dissolved or depleted or the legal restrictions on the use of MSA funds to certain medical expenses were removed.

Undue hardship is a month-by-month determination; however, this application only requires reviews periodically. The MSA may be reviewed during periodic reviews of the record, such as redeterminations, and the individual is responsible to notify SSA if there is any change regarding the MSA consistent with their reporting responsibilities.

Example

An SSI recipient received a workers' compensation settlement of $15,000 due to a work-related injury. The $15,000 was allocated for future medical services related to that injury for purposes of the MSP Act and these funds must be depleted before Medicare will pay for treatment related to the injury. The $15,000 was then placed in an MSA trust that is restricted to medical expenses related to the injury. The CS requests a copy of the settlement agreement and the MSA trust documents, any additional documentation that will show the legal restrictions on the use of the funds, an accounting of the funds, and how the funds are administered.

The CS determines the MSA trust would be a countable resource under section 1613(e). However, because the MSA trust funds are restricted to certain medical expenses (i.e., medical expenses related to the relevant injury that would be covered by Medicare), the CS determines that undue hardship applies in this scenario. The CS obtains the individual's statement and notes the system to reflect the MSA trust does not count as a resource under section 1613(e). The CS also determines that the MSA trust is not a resource under SI 01120.200.

UNDUE HARDSHIP – AGENCY ERROR RESULTED IN UNCORRECTABLE TRUST DEFICIENCY

Undue Hardship Definition

Undue hardship exists, in limited circumstances, if an SSA error results in a trust deficiency that cannot be remedied.

Application of the Undue Hardship Waiver

SSA will apply undue hardship under this provision when all of the following criteria are met:

- There is an error by SSA;
- The trust has a deficiency that would result in the trust's being a countable resource under section 1613(e);
- There is a clear causal connection between SSA's error and that trust deficiency;
- The trust deficiency does not result in a potential benefit that substantially reduces the hardship to the individual;
- The trust deficiency cannot be corrected; and
- Substantive relief cannot otherwise be provided.

Suspension of Resource Counting

The irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) in any month for which counting the trust would cause undue hardship under this application.

Resource Counting Resumes

Resource counting under section 1613(e) resumes only if the circumstances change such that the criteria under this section are no longer satisfied. The individual is responsible for notifying SSA if there is any change regarding the trust consistent with their reporting responsibilities. Although undue hardship is a month-by-month determination, this application does not require monthly or periodic reviews due to the criteria.

Example

A thirty-year-old SSI recipient received a $7,000 inheritance and established an irrevocable special needs trust through their legal guardian, who is also their spouse and representative payee (RP). The trust was intended to meet a Medicaid trust exception and was reported to the field office. The CS determines that the trust is a countable resource because it contains a noncompliant early termination provision. However, the CS does not issue a notice (as required under SI 01120.204) that explains the problematic provision in the trust and the policy regarding it.

The RP requests reconsideration and inquires as to why the trust does not meet the Medicaid trust exception. The field office affirms the initial determination and simply states the trust is countable without further explaining or providing the notice required by policy.

The RP appeals the decision to an ALJ and attempts to fix the trust; however, the amended trust doesn't resolve the early termination issue. The ALJ decides the trust is still noncompliant due to its deficient early termination provision, notes the applicable policy, and finds it is a countable resource. The RP realizes the trust's deficiency upon reading the ALJ's decision; however, the recipient passes away two weeks later, and the trust can no longer be amended.

In this example, the SSA error was the field office's failure to provide the proper notice required by policy. The RP tried to determine the trust's deficiency and amended the trust; however, the RP didn't have an explanation as to what provision of the trust was problematic or what policy was at issue, so the amendment didn't correct it, which is the causal connection between the error and the trust's deficiency. There is no indication that the trust deficiency resulted in a potential benefit that substantially reduced the hardship to the individual. Finally, due to the recipient's death, the trust can no longer be amended and there is no way to provide substantive relief other than through this undue hardship provision.

UNDUE HARDSHIP – ASSETS TRANSFERRED UPON EARLY TERMINATION FROM A COMPLIANT POOLED TRUST OR SPECIAL NEEDS TRUST TO A NONCOMPLIANT POOLED TRUST OR SPECIAL NEEDS TRUST

Undue Hardship Definition

Undue hardship exists, in certain circumstances, when, upon early termination, assets in a pooled trust subaccount or a special needs trust that was previously determined to be policy-compliant are transferred to a noncompliant pooled trust or special needs trust and the beneficiary is not responsible for the transfer.

See POMS SI 01120.199 for policy related to early termination.

Application of the Undue Hardship Waiver

We will apply undue hardship under this provision when all of the following criteria are met:

- A pooled trust subaccount or a special needs trust was previously determined to meet a Medicaid trust exception and not to be a countable resource (under SI 01120.203 and SI 01120.200).

- The assets in the pooled trust subaccount or special needs trust are transferred to a secondary pooled trust or special needs trust that is intended to meet a Medicaid trust exception (see SI 01120.203), but the secondary trust was not previously evaluated and is subsequently determined to be noncompliant with our policy.

- The SSI applicant or recipient is not responsible for the transfer to the secondary, noncompliant trust or the circumstances related to the early termination and the transfer.

Suspension of Resource Counting

The secondary irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) due to undue hardship for 120 days in order to allow the trust to be amended or the assets to be transferred to a policy-compliant trust.

- The 120-day period begins on the day SSA informs the applicant, recipient, or representative payee via written notification that the secondary trust contains provisions that must be amended in order to qualify for a Medicaid trust exception.
    - If the written notification is mailed, instead of hand-delivered, then the applicant, recipient, or representative payee is considered to be informed five days after the mailing date.
    - We permit a good cause extension if it is requested with evidence that the disqualifying issue cannot be resolved within the 120-day period (for example, if a court must amend the secondary trust and there is a waiting period to get on the court docket).
- The technician follows the recontact controls provided in SI 01120.203H.4.

Resource Counting Resumes

Undue hardship is a month-by-month determination; however, this application only requires a review when the 120-day period (plus any good cause extension) expires. If the secondary trust is not amended to conform with SSA policy requirements or the assets are not transferred to a policy-compliant trust within 120 days (plus any good cause extension), then undue hardship under this provision will no longer be met and resource counting of a trust will generally resume, subject to our policy, at the beginning of the following month.

Example

An SSI recipient has a subaccount in a pooled trust that was previously determined to meet the Medicaid trust exception for pooled trusts and not be a countable resource under our policy (SI 01120.203 and SI 01120.200). However, the pooled trust dissolved, and the trustee transferred the subaccount to a secondary pooled trust intended to meet a Medicaid trust exception. Although the secondary pooled trust's master trust agreement expressed that its terms were intended to form a pooled trust that complied with section 1917(d)(4)(C), the agency determines the secondary pooled trust is not compliant with our policy due to a deficient early termination provision; so, it does not meet a Medicaid trust exception. The technician sends the required written notice to the SSI recipient, who notifies the trustee regarding the matter, and the technician tickles the issue for review in

120 days. The trust is amended to address the issue and conform with our policy within 100 days. The technician does not count the subaccount as a resource due to undue hardship and satisfying the requirements of SI 01120.200 for the first three months and does not count it as a resource due to the Medicaid trust exception and satisfying the requirements of SI 01120.200 for the months thereafter.

Regulations - Proposed Rule Changes

RESCIND THE BURDENSOME USE RESTRICTIONS OF DEDICATED ACCOUNTS

SSA is proposing to update its dedicated account policy to allow dedicated account funds to be used for the recipient's "current maintenance." Rescinding the Burdensome Use Restrictions of Dedicated Accounts, (RIN 0960-A192). This is a significant departure from current policy, which prohibits the use of these funds for maintenance.

Dedicated Accounts Are Currently Limited Tool

Congress created dedicated accounts in 1996 as part of the Personal Responsibility and Work Opportunity Act. *See* Social Security Act 1631(a)(2)(F)(i); 20 C.F.R. §416.546; 20 C.F.R. §416.640. When SSA owes a child more than six times the federal benefit rate for back benefits (approximately $5,800 in 2025), that child or the child's parent or payee must open a separate bank account at a financial institution before they can receive any of that money. Moreover, once the account is established, the money can only be used on a narrow list of expenditures, excluding most daily expenses. SSA Section 1631(a)(2)(F); 20 C.F.R. §416.640(e). The money remains subject to the limited restrictions even after the child reaches the age of 18.

Dedicated Accounts have restrictions that differ from the treatment of other SSI benefits.

Dedicated Accounts Must be in a Financial Institution

The regulations state that when a child is owed more than six times the federal benefit rate for back benefits (approximately $5,800 in 2025), the money must be paid into an account maintained as described in 416.640(e), which requires opening a checking, saving or money market account in a financial institution. If the child, child's parent or payee is unbanked and cannot open an account, SSA will not release the money but are supposed to find a replacement payee. This can be challenging and mean that some children do not get access to their past-due benefits.

Severe Restrictions on Expenditures from Dedicated Accounts

Dedicated account funds can only be used for the benefit of the child, and:

- "(i) Medical Treatment and education or job skills training;

- (ii) If related to the child's impairment(s), personal needs assistance; special equipment; housing modification; and therapy or rehabilitation; (or)
- (iii) Other items and services related to the child's impairment(s) that we deem appropriate. The representative payee must explain why or how the other item or service relates to the impairment(s) of the child."

20 C.F.R. §416.640(e). SSA sub-regulatory policy clarifies that the money may not be used for any other items including, significantly, for basic maintenance costs like food, housing, clothing and personal items unrelated to the child's impairments, outside emergencies. POM GN 00602.140. If the parent or representative payee misuses the funding – even if it is used to meet the child's needs – they must repay SSA the misapplied funds. There is an exception, however, to allow the funding to be to prevent the child from becoming malnourished or homeless.

These restrictions are stunningly stringent. If a parent of a child who receives SSI uses the funds for a snowsuit, formula, or a taxi to a medical appointment—none of that would be permissible. Moreover, it will expose the family to serious consequences including asking the parent to pay back those funds to SSA. Once she does, these funds are not returned to the account, but are lost to the family.

Dedicated Accounts are Intensely Monitored

SSA is supposed to monitor the use of dedicated accounts. Representative payees must sign a Form SSA-552 to acknowledge they understand the restrictive uses of this funding and their responsibilities. Moreover, parents or payees are expected to "keep records and receipts of all deposits to, and expenditures from, dedicated accounts." POMS GN 00602.140. They are supposed to complete a SSA-6233-BK to report deposits and expenditures. Parents and payees spend hours keeping and collecting receipts and completing these forms. SSA estimates it costs them 4 million dollars to monitor dedicated accounts. Office of Inspector General, *Dedicated Accounts for Supplemental Security Income Recipients,* SSA, A-04-21-51031 at 2 (Sept. 2023).

Moreover, if a parent or payee would like to use some of the funds for "other items and services related to the child's impairment(s)," SSA policy encourages the parent or payee to inquire about the appropriateness of the purchase with SSA Field Office staff before making the purchase. POM GN 00602.140. Field Office staff are directed to determine whether the expenditure is sufficiently related to the impairment on a case-by-case basis and provide a notice with appeal rights if they deny the use. POMS GN 00602.140. This is a time-intensive process for SSA staff and beneficiaries. This process also introduces significant inequities because Field Office staff have and employ a lot of discretion in approving or denying requests to use this money.

Dedicated Accounts are Outdated

Congress created dedicated accounts in 1996 as part of the Personal Responsibility and Work Opportunity Act, and has not updated its dedicated account regulations since

2011. *See* Social Security Act 1631(a)(2)(F)(i); 20 C.F.R. §416.546; 20 C.F.R. §416.640. There have been repeated bipartisan calls for their elimination.[4] Six prior SSA Commissioners (acting and confirmed) publicly supported eliminating dedicated accounts, and Commissioner Astrue described them as "labor intensive and confusing to the public."[1] In 2003, the Senate Finance Committee recommended broadening dedicated account expenditures for "any purpose that is for the good of the beneficiary."[6] Presidents Bush, Obama and Trump all included dedicated account reforms in their annual budget requests.

Since the last update, Congress passed both the ABLE Act of 2014 and the ABLE Age Adjustment Act (part of Secure 2.0) in 2023, creating tax advantaged savings accounts for people with qualifying disabilities. ABLE accounts and dedicated accounts are conceptually similar and often serve overlapping customers. Both types of accounts represent policy initiatives to ensure people with disabilities have resources available to address their needs. *See* POMS SI 1130.740; GN 00602.140. In a 2014 Senate Finance Hearing before the Subcommittee on Taxation and IRS Oversight, Senator Michael Enzi (R-WY) explained that ABLE accounts were intended to allow people with disabilities and their families to plan how to use resources to meet their "unique emotional and financial obligations . . . whether it's paying for specialized care [or] a better quality of life." This rationale applies equally to dedicated accounts.

ABLE defines "qualified disability expenses" (QDEs) broadly in statute and corresponding SSA policy to include expenses associated with education, housing, transportation, health, and importantly, "basic living expenses." POMS SI 01130.740B.8. In stark contrast, dedicated account funds can only be used for a narrow range of expenses tied to the recipient's medical impairment, and SSA's rules prohibit the funds from being used for basic living necessities like housing, food and clothing. *Compare,* POMS SI 01130.40 *with* 20 C.F.R. §416.640(e). It is incoherent from a policy standpoint that permissible expenditures from these conceptually similar financial accounts—both serving people with disabilities and sometimes used by the same families—vary so significantly. The divergent definitions of permissible expenditures reflect a shifting understanding of what constituents a social determinant of health. When dedicated accounts were first created, discussions on preserving health and supporting disability centered around access to traditional public health and medicine. Now, it is widely acknowledged that social determinants of health also include environmental factors such access to safe housing and nutritious food.[3]

Rescinding Burdensome Use Restrictions of Dedicated Accounts Benefits Beneficiaries and SSA

[1] SSA Comm'r Apfel, Comments accompanying proposed "Social Security Amendment of 2000," (July 9, 2000) available at https://www.ssa.gov/legislation/SS%20Amendments%202000.pdf; SSA Comm'r Barnhart, Comments accompanying proposed "Supplemental Security Income Program Amendment of 2022" (Sept. 2, 2002) available at https://www.ssa.gov/legislation/Bills/SSIAmend2002.pdf; SSA Comm'r Astrue, Lette to Honorable Pelosi and Honorable Chaney (May 20, 2008), https://www.ssa.gov/legislation/Social%20Security%20Amendments%202008.pdf.

This change will relieve burdens on families. It does not resolve all the barriers created by dedicated accounts (families, for example, still will likely have to be banked to get these funds) but will realign the use of these accounts with modern expectations. Even with SSA's instructions, many families find the severe expenditure restrictions unintuitive. They use the funds to pay for pressing daily needs, which subjects them to risk of needing to repay SSA, and sometimes delay in receipt of additionally owed dedicated account funds. Allowing families to use this funding to meet essential daily needs including buying food, paying towards housing, and clothing more closely aligns policy to expectations.

This update will also reduce the administrative burden on SSA. SSA has been spending more than 4 million dollars a year monitoring dedicated accounts. Office of Inspector General, *Dedicated Accounts for Supplemental Security Income Recipients,* SSA, A-04-21-51031 at 2 (Sept. 2023); Testimony by Comm'r Barnhart Before the House Ways and Means Subcommittee on Human Resources on The Supplemental Security Income (SSI) Program (Apr. 29, 2004). Yet, OIG has reported over four reports that SSA has continued to make errors, including following its policies regarding monitoring these accounts. Id. at 3. By loosening expenditure restrictions, monitoring these accounts will likely be less time-intensive.

This update may improve program efficiency. OIG also estimated that SSA underpaid 300 million dollars to 50,000 qualifying children and often significantly delayed payments to families. OIG, A-04-21-51013. By broadening expenditures, it will be easier for SSA to administer this program and avoid these errors.

IN-KIND SUPPORT AND MAINTENANCE (ISM) POLICY – RESCISSION OF CHANGES OF THE DEFINITION OF A PUBLIC ASSISTANCE HOUSEHOLD

Changes Under the 2024 Final Rule

In 2024, SSA published 3 final regulations dealing with ISM that were effective on September 30, 2024.

- SSA modified regulations at 20 CFR 416.1130(b) to **omit food** from the calculations of In-kind Support and Maintenance.
- SSA revised 20 CFR 416.1130 to **modify the definition of when a "business arrangement"** exists from one where the amount of monthly required rent equals or exceeds the current market rental value to one where the amount of monthly required rent equals or exceeds the Presumed Maximum Value (PMV).
- SSA adopted 3 changes in 20 CFR 416.1142(a):
    - Revised the definition of "public assistance household" to clarify that this is a term of art and only applies to SSA programs.
    - **Added Supplemental Nutrition Assistance Program (SNAP) to the list of Public Income Maintenance (PIM) programs**.
    - Changed the definition of a PA household to one which has both an SSI recipient or applicant and **at least one other household member** receiving a listed PIM payment.

See Appendix C for a copy of the final regulations related to public assistance households.

Public Assistance (PA) Household Policy

SSA assumes that an applicant or recipient who lives in a PA household does not receive any ISM from other household members. Therefore, an SSI applicant or recipient who lives in a PA household cannot be subject to the Value of the One-Third Reduction (VTR) rule (see SI 00835.200). If the household receives outside ISM, or if the SSI applicant or recipient receives ISM from a source outside the household, the ISM is subject to valuation under the Presumed Maximum Value (PMV) rule.

A **PA household** is one that contains a Supplemental Security Income (SSI) applicant or recipient, and at least one other household member who receives one or more of the listed public-income maintenance (PIM) or PA payments.

PIM Payments

PIM payments (or PA payments) are payments made under:

- Title IV-A of the Social Security Act—Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF) (For AFDC see SI 00830.400 and for TANF see SI 00830.403);
- Title XVI of the Social Security Act (SSI, including federally administered State supplements and State administered mandatory supplements);
- The Refugee Act of 1980 (payments based on need) (SI 00830.645);
- The Disaster Relief and Emergency Assistance Act (SI 00830.620);
- General assistance programs of the Bureau of Indian Affairs (SI 00830.800);
- State or local government assistance programs based on need (SI 00830.175);
- U.S. Department of Veterans Affairs programs (payments based on need) (SI 00830.300); or
- Effective only as of 09/30/2024 - The Supplemental Nutrition Assistance Program (SNAP) (SI 01801.005).

Why the Regulation was Changed in 2024

Since the establishment of the PA household policy in 1980, the landscape of means-tested public benefit programs has changed significantly.

- Aid to Families with Dependent Children (AFDC) (entitlement) replaced by Temporary Assistance to Needy Families (TANF) (block grant) in 1997.
- Between 1980 and 2022 there was an 82% decrease in AFDC/TANF recipients.
- There was an 81% decrease in VA needs-based pensions over the same period.

Between 1980 and 2022, there had been no change in public assistance household policy despite:

- 100% increase in Supplemental Nutrition Assistance Program (SNAP) recipients.
- 70% increase in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) recipients.
- 75% increase in Medicaid recipients.
- 65% increase in HUD housing assistance recipients.
- Low Income Home Energy Assistance Program (LIHEAP) recipients fluctuate, but generally up.

For comparison, there was a 50% increase in SSI recipients for the comparable period.

Adding SNAP (and considering other, more inherently in-kind benefits like Medicaid) reflects the shift in public participation for in-need individuals from using income supports that are purely cash assistance programs (such as those under our prior regulations) toward voucher-based or in-kind support programs.

Additionally, SNAP eligibility and receipt has relatively low State variability. SNAP is a nationwide program with relatively uniform eligibility standards. This will contribute to a more straightforward operational and systems rollout of the new policy, and greater consistency in recipients' experiences across States.

SNAP participation overlaps to a great extent with participation in other means-tested programs. Expanding the definition of a PA household to include SNAP would capture about 67 percent of SSI recipients who are also living in households currently participating in Medicaid, HUD public housing and voucher programs, or LIHEAP. SNAP, as an entitlement program, does not have a cap on enrollment as does the TANF program. SNAP recipient eligibility is also certified for relatively longer time periods, resulting in lower workload. These changes will reduce administrative burdens for SSI applications and recipients, as well as for SSA.

Added Impact – Deeming

In the SSI program, Deeming is the process of considering a portion of another person's income to be the income of an SSI applicant or recipient. This is the cases with eligible and ineligible spouses, eligible children and ineligible parents and eligible aliens and ineligible alien sponsors.

SSA's policy excludes from deeming the amount of any public income-maintenance (PIM) payments an ineligible parent or spouse receives under the programs listed in the PA household definition, any income that those programs counted or excluded in determining the amount of the PIM payments they received, and any income of the ineligible spouse or parent that is used by a PIM program to determine the amount of that program's benefit to someone else.

Adding SNAP to the list of PIM payments decreased the amount of income that is deemed to SSI recipients from an SSI-ineligible spouse or parent who is receiving SNAP benefits, any

income that was counted or excluded in figuring the amount of the SNAP benefits would not be deemed to the SSI applicant or recipient.

Shift From "Every" to "Any" Other Member of the Household

In the final regulation, SSA adopted a change to consider an SSI applicant or recipient to be residing in a PA household if the SSI applicant or recipient and *any other* (as opposed to *every*) additional household member receives public assistance. This allows SSA to rely on other agencies who already make household determinations. The prior rule, which SSA is reverting to, is detrimental when household members are ineligible due to reasons other than need (citizenship, time limits, immigration status, etc.). In making the 2024 change, SSA found it reasonable to infer that when 2 members of household qualify for PIM payments, all members of the household are low-income.

Proposed Rescission

As part of the Spring 2025 Unified Agenda, SSA announced its intent to rescind the regulatory changes to the definition of a public assistance household. The Abstract of the proposal reads:

> We propose to rescind the final rule *Expand the Definition of a Public Assistance Household* (final rule), by removing the Supplemental Nutrition Assistance Program (SNAP) from the list of public income maintenance (PIM) payments. We further propose to adopt our former longstanding definition of a *public assistance household*, according to which every household member has to receive a PIM payment for the household to constitute a public assistance household. We propose to revert to our former policy to promote program integrity and because the benefits derived from the final rule do not outweigh the significant burdens and costs associated with its implementation.
>
> The benefit of deregulation would be increased program integrity. Additionally, rescission of the final rule would be appropriate under E.O. 14219 secs. 2(a)(iv).

The regulation is currently at the Proposed Rule Stage, pending approval from the Office of Management and Budget, and has not been published as a Notice of Proposed Rulemaking in the Federal Register. Once adopted, the policy would revert to the regulation in place since 1980.

Why the Change is Being Made Now

Based on statements made in the Abstract, the policy change is being rescinded because it is perceived to cost too much. We will have to wait for the NPRM to be published to see if SSA conducted a cost/benefit analysis, but we do have the fiscal impact analysis from the prior final regulation.

SSA estimated that implementation of the rule would result in a total increase in Federal SSI payments of $15 billion over fiscal years 2024 through 2033. It was clearly the most expensive of the three In-kind Support and Maintenance (ISM) changes that were effective on September 30, 2024 at nearly 10 times the cost of omitting food from ISM.

It was estimated that in FY 2033 roughly 277,000 Federal SSI recipients (4 percent of all SSI recipients) will have an increase in monthly payments compared to current rules, and an additional 109,000 individuals (1 percent increase) will receive Federal SSI payments who would not have been eligible under current rules. However, some individuals may have a decrease in SNAP benefits due to increased SSI payments.

In a comparison between the other two ISM regulations that were effective on the same date we note the following:

Regulatory Change	Program Costs FY 2023-2033	Administrative Costs FY 2024-2033
Omit Food as ISM	$1.6 billion	$26 million savings*
Rental Subsidy Change	$837 million	$10 million savings*
PA Household Change	$15 billion	$83 million cost

* Partially offset by implementation costs

IMPROVEMENTS TO THE DISABILITY ADJUDICATION PROCESS: SEQUENTIAL EVALUATION PROCESS (MEGA-REG)

SSA's Spring 2025 regulation agenda includes a policy proposal claiming to improve the disability adjudication process, due out in December 2025. Improvements to the Disability Adjudication Process: Sequential Evaluation Process *(*RIN 0960-A167) (emphasis added) The regulatory agenda does not contain much detail, only that SSA is

> proposing improvements to the disability adjudication process to ensure disability programs remain[] current and can be more efficiently administered. This includes policy updates to occupational data sources and optimizing their use to serve customers and preserve the trust fund.

(emphasis added). While it is impossible to know what such an obliquely written regulation means, experts believe this refers to SSA's effort to both update outdated occupational data as well as change how it considers age, education, and other eligibility factors. Such a sweeping policy update would impact multiple regulations and could result in the largest benefit cut based on eligibility in the programs history—which is why advocates are referring to it as the Mega-Reg.

Section 223(d)(2)(A) and Section 1614(a)(3)(B) of the Social Security Act specify that

> An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), ''work which exists in the national economy'' means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(emphasis added). In other words, central to disability adjudications is not only answering the question of whether someone has severe medical impairment, but whether that impairment would prevent them from engaging in competitive work when considered in conjunction with their age, education, work experience and considering what work exists in the economy. Social Security policy directs that when considering whether someone can do work, SSA adjudicators should typically consider the person's abilities to do that work on a sustained basis, in an ordinary (unaccommodated) work setting, for 8 hours a day, 5 days a week, or an equivalent work schedule. SSR 96-8p; POMS DI 24510.057.

Currently, SSA relies on occupational information from the Dictionary of Occupational Titles (DOT) to make these determinations. Since the DOT has not been updated since 1992, there is broad, bicameral, agreement that SSA needs to update the occupational sources. SSA has been preparing to adopt the Bureau of Labor Statistics' Occupational Requirements Survey (ORS) to replace the DOT since 2012. This update is not one-to-one. ORS data differs significantly from DOT data, so any update will require changes to SSA policy, including new regulations and sub-regulatory guidance.

Because this proposal explicitly mentions updating occupational data in order to "preserve the trust fund," experts are concerned SSA is planning to change its treatment of age, education and other eligibility factors in a fashion that will conserve resources by limiting eligibility. This mirrors a proposal leaked during President Trump's first administration to the Wall Street Journal published a leaked version of a similar rule. Kate Davidson, *Trump Administration Weighs Tighter Requirements for Disability Payments*, Wall Street Journal (Jan. 10, 2020). Mark Warshawsky, a former SSA official that served during President Trumps first term, has also spoken and written extensively about this proposal. *See e.g.* Mark Warshawsky, *Modernizing, Simplifying and Reforming Federal Disability Programs* AEI (Feb. 12, 2025).

Importantly, this proposal may lessen the impact that SSA considers age to have on employability, among other changes. Currently, SSA considers how an individual's age, education, and skills interact with their residual functional capacity to work through the use of Medical Vocational Guidelines, often called the vocational "grids." These guidelines help adjudicators evaluate claims by considering a combination of factors: RFC, age, education and work experience. The grids are structured as tables that outline different

vocational profiles and indicate whether a person is eligible for benefits based on these characteristics.

Age plays a critical role in the grids, because SSA recognizes that the ability to adapt to new work decreases with age. The guidelines divide age into categories using terminology that has not been updated in many years:

- Younger person (under 50)
- Closely approaching advanced age (50-54)
- Advanced age (55-59)
- Closely approaching retirement age (60 and older)

For example, a disabled person aged 55 with limited education and no transferable skill may be found eligible for benefits even if they could technically perform sedentary work because the grids presume older individuals face barriers to vocational adjustment. In contrast, a younger person with the same limitations might be expected to adapt to other work and denied benefits.

Another change being considered is how SSA defines work. SSA is rumored to be considering a new definition of work that would incorporate remote work and consider someone to be working if they could work 30, rather than 40 hours a week.

The grids provide guidance on how to incrementally consider different types of factors at once. Moreover, while some criticize the grids as outdated and overly simplistic, it is clear this framework provides consistency and efficiency. The research supports its continued use. As the population ages, the number of older Americans with work-related limitations has grown, even as the share of people with limitations remains stable. While remote work is more common than in the past, it remains a work benefit that is not universally available and should not be assumed when thinking about nationally available competitive positions.

Jack Smalligan from the Urban Institute published a paper on September 18, 2025, which does a good job explaining how nuanced judgements about how education, age and past-work experiences could increase, decrease, or keep stable the number of Americans found eligible for disability benefits. Jack Smalligan, *Updating Social Security Disability* (Sept. 2025), (See Appendix D) also available at, https://www.urban.org/author/jack-smalligan. Moreover, he estimates that if SSA changes how it treats age and other factors as suggested in the leaked proposal, it would reduce SSDI eligibility by as much as 20 percent overall, and 30 percent among older ages. Id. at 10. This could total as much as 500,000 fewer SSDI beneficiaries and 80,000 fewer widow and children receiving benefits. Considering that this rule would also increase denials of new applicant, Smalligan estimates this change could amount to 82 billion in denied benefits between 2026-2035.

CHANGING SSA WAIVER OF OVERPAYMENT RECOVERY RULES AND TITLE II OVERPAYMENT WITHHOLDING RATE

Background - The Overpayment Process

An overpayment occurs when you receive more money than you should have been paid. Overpayments can occur for many reasons, like when someone does not timely report work or other changes that can affect benefits or when an individual chooses to continue receiving payments during an appeal. Each person's situation is unique, and overpayments are handled on a case-by-case basis. Social Security is required by law to adjust benefits or recover debts when people receive payments they weren't entitled to.

If an overpayment happens, SSA will notify you and your representative payee, if you have one, by mail. Overpayment notices explain why you've been overpaid, your overpayment amount, your repayment options, and your appeal and waiver rights.

Appeal and Waiver Rights

If you don't agree that you've been overpaid, or believe the amount is incorrect, you can file an appeal using form SSA-561 Request for Reconsideration. Your appeal must be in writing and explain why you think you have not been overpaid, or why you think the amount is incorrect. You can get the form online or by calling SSA. To file an appeal online, visit secure.ssa.gov/iApplNMD/start.

You have 60 days from the date you received the original overpayment notice to file an appeal. SSA will assume you received this notice 5 days after the date on it, unless you show SSA that you didn't get it within the 5-day period. You must have a good reason for waiting more than 60 days to ask for an appeal.

If you believe you shouldn't have to pay the money back, you can request that SSA waive collection of the overpayment. You must submit form SSA-632 Request for Waiver of Overpayment Recovery, which you can get online or by calling SSA.

Note: If you think you are not at fault and your overpayment is $2,000 or less, you can request a waiver by calling Social Security. They may be able to quickly process your request by phone.

There's no time limit for filing a waiver as long as you prove that both:

- The overpayment wasn't your fault.
- Paying it back would cause you financial hardship or would be unfair for some other reason.

SSA may ask you to give them proof of your income and expenses. They will stop collection of the overpayment until they make a decision on your request for an appeal or waiver.

Options for Repaying

If you agree that the overpayment occurred and that the overpayment amount is correct, you have options for repayment.

If you're receiving Social Security benefits, SSA will withhold 50% of your benefit each month (effective 04/25/2025). If you're receiving Supplemental Security Income (SSI), generally they will withhold 10% of the maximum federal benefit rate each month. SSA will begin withholding your Social Security benefits or SSI payments approximately 60 days after they notify you of the overpayment.

If you can't afford this, you may ask them to take less from your benefit each month. You also have the option of paying back the overpayment at a rate greater than 50%.

SSA may recover an overpayment of Social Security benefits from your monthly SSI payment if you are no longer receiving Social Security benefits; or they may recover an SSI overpayment from your monthly Social Security benefits if you are no longer receiving SSI payments. If you aren't receiving benefits, you should do one of the following:

- Visit www.pay.gov and search for "Social Security" to pay by credit card, debit card, or bank account.
- Using your bank's online bill pay feature, to make a payment to "Social Security Administration."
- Send SSA a check for the entire amount of the overpayment within 30 days.
- Contact them to set up a plan to pay back the amount in monthly installments.

If you are not receiving benefits or become delinquent in your repayment agreement, SSA can recover the overpayment from your federal income tax refund or from your wages if you're working. Be aware that they will also report the delinquency to credit bureaus. Also, they can recover overpayments from future Social Security benefits or SSI payments.

Recent Overpayment Policy Changes

In October 2023, SSA launched a review of its overpayment policies and procedures. As a result, it recently issued a number of changes:

- Reduction in default recovery withholding rate;
- Shifting burden of proof as to whether claimant was at fault;
- Extension of time for repayment plans; and
- Enhanced overpayment waiver process.

Default Overpayment Recovery Rate

Prior to March 25, 2024, the default overpayment recovery rate was 100 percent of the recipient's monthly benefit.

On March 25, 2024, SSA issued Emergency Message (EM) 24011 (See Appendix D). Effective on that date, SSA decreased the default Title II overpayment recovery withholding rate from 100 percent of the monthly Social Security benefit to 10 percent of the benefit or $10, whichever is greater.

NOTE: Section 1631(b)(1)(B) of the Act generally provides that the rate of adjustment of payment to recover SSI overpayments will be the lesser of:

- Ten percent of the recipient's total monthly income (countable income plus SSI and State supplementary payment) (usually equal to the FBR); or
- The recipient's entire monthly benefit.

On April 25, 2025, SSA issued EM 25029 (reissued as EM 25029 REV on August 28, 2025) (See Appendix E). Effective on that date, SSA increased the default Title II overpayment recovery withholding rate from 10 percent of the monthly Social Security benefit to 50 percent of the benefit.

When SSA determines that an individual receiving Title II benefits is overpaid, they send them a notice requesting a full and immediate refund, and inform them of their right to request a waiver of recovery or request a reconsideration of the overpayment.

If the overpaid individual does not:

- repay,
- request a waiver, or
- request a reconsideration

prior to the end of the 60-day due process period, SSA will, in most cases, automatically recover the overpayment by withholding 50 percent of their Title II monthly benefit credited amount. They will recover the overpayment by withholding until the overpayment is fully recovered.

NOTE: Certain recovery payments are not eligible for the 50 percent rate, e.g., situations of fraud or similar fault, misuse of benefits, and penalties.

EM 25029 REV also states that "[i]f an overpaid individual has a prior overpayment and incurs a new overpayment, all outstanding overpayments will default to the 50 percent benefit withholding rate once withholding for the new overpayment begins (unless a lower repayment rate is separately negotiated or there is fraud or similar fault).

The 50 percent withholding rate applies to matured overpayments beginning [08/25] and later (excluding fraud or similar fault and cross program recovery). If the 10 percent withholding rate was previously in place on the prior overpayment (because the relevant overpayment notice indicated the default withholding rate would be 10 percent), the 10 percent withholding rate applies to overpayment recovery actions through [07/25]."

Additionally, if SSA issued an overpayment notice prior to April 25, 2025, the individual will retain the 10 percent withholding rate unless they incur a new overpayment. If they incur a new overpayment, all overpayments will default to the 50 percent withholding.

Request for a Lower Rate

If a beneficiary requests a repayment plan with a rate lower than 50%, a representative will approve the request if it allows recovery of the overpayment within 60 months – a recent 2-year increase from the previous policy of only 36 months. If the beneficiary's proposed rate would extend recovery of the overpayment beyond 60 months, the individual must complete an SSA-634 form (income, resource, and expense summary) in order for SSA to make a determination.
(SSI recipients don't have to provide a summary since SSA has this information.)

EM-24011 E. stated in the NOTE that:

"The request for a 10 percent overpayment recovery rate will take priority over the recent change to procedure requiring the collection of overpayments within 60 months (GN 02210.030). Individuals will default to 10 percent withholding even if the amount collected will not facilitate recovery within 60 months."

EM-25029 REV does not address this issue with the new withholding rate, so I will assume that this policy will continue.

Withdrawal of Proposed Regulatory Changes

Beginning with the Fall 2022 version of the Unified Agenda of Regulatory and Deregulatory Action, SSA listed a proposed regulations change to simplify regulations related to overpayment recovery and make the overpayment waiver process simpler. The Abstract from the Fall 2024 version of the Unified Agenda reads:

> We propose to revise our rules relating to recovery of overpaid Social Security payments or benefits ("overpayment debt"). We propose to codify simplifications to procedures for demonstrating eligibility for waiver of recovery of overpayment debt. We also propose to explain our default rate of withholding when recovering overpayments from Title II benefit payments.
>
> In addition, we are conducting a broad review of overpayment policies and may propose further revisions as a result of the review. Our overall goal is to ensure that overpayment recovery does not unduly burden those in underserved, vulnerable, or marginalized communities.
>
> The development of this regulation was informed by correspondences, meetings, and a listening session with advocacy groups representing claimants and beneficiaries. Advocacy partner feedback has been critical in helping us to formulate new overpayment policies. For example, as a part of its commitments to DOJ's Legal Aid Interagency Roundtable initiative, the Agency hosted a virtual listening session with legal aid organizations on June 8, 2023 wherein stakeholders identified numerous challenges associated with

navigating overpayment recovery processes. Sixteen individuals, all from organizations, registered for the event.

In the Spring 2025 version of the Unified Agenda, the Trump Administration has deleted the long-term proposal to simplify the overpayment and waiver process with no explanation.

APPENDICES

APPENDIX A

POMS Transmittal Sheet – TN 104 and POMS SI 01120.203G.

POMS Recent Change

Effective Dates: 8/26/2025
Identification Number: SI 01120 TN 104
Intended Audience: See Transmittal Sheet
Originating Office: ORDP OISP
Title: Identifying Resources
Type: POMS Full Transmittals
Program: All Programs
Link To Reference:

PROGRAM OPERATIONS MANUAL SYSTEM

Part SI – Supplemental Security Income

Chapter 011 – Resources

Subchapter 20 – Identifying Resources

Transmittal No. 104, 08/26/2025

Audience

FO/TSC: CS, CS TXVI, CSR, CTE, DRT, FR, OA, OS, RR, TA, TSC-CSR;

Originating Component: OISP

Effective Date: Upon Receipt

Background

Section 1613(e) of the Social Security Act sets forth rules for counting trusts (established with the assets of an individual on or after 01/01/00) as resources along with exceptions to those rules if a trust meets one of the Medicaid trust exceptions. However, when a trust does not meet a Medicaid trust exception, SSA has the authority to waive applying the rules when such application would cause an undue hardship to the individual in certain circumstances. We are updating our policy to include three additional circumstances for undue hardship application.

Summary of Changes

SI 01120.203 Exceptions to Counting Trusts Established on or after January 1, 2000

We made minor language changes throughout to clarify current policy.

We rearranged the content in subsection G to provide an introduction and separate guidance for each circumstance regarding undue hardship.

- In doing so, the original circumstance regarding deprivation of food or shelter with limited funds largely contained the same language, but it was placed in its own subsection (Subsection G.4).

- We added a new circumstance regarding a Medicare Set-Aside Arrangement and instructions regarding it in Subsection G.1.

- We added a new circumstance regarding a trust deficiency issue and instructions regarding it in Subsection G.2.

- We added a new circumstance regarding a transfer issue and instructions regarding it in Subsection G.3.

We made minor revisions to subsection K to include cross references to G for the new hardship circumstances. We rearranged steps 3 and 4 in the chart to improve the workflow.

We also made minor changes in subsections H and K to specify that the undue hardship circumstance at issue in those subsections involved the circumstance regarding deprivation of food or shelter with limited funds.

* * * * *

G. Policy for waiver for undue hardship

Section 1613(e) of the Social Security Act (Act) sets forth rules for counting as resources trusts established with the assets of an individual on or after 01/01/2000 (see generally SI 01120.201),

along with exceptions to those rules if a trust meets one of the Medicaid trust exceptions in section 1917(d)(4)(A) or (C) of the Act for special needs trusts or pooled trusts, respectively. However, when a trust does not meet a Medicaid trust exception, SSA has the authority to waive applying the rules when such application would cause an undue hardship to the individual in certain circumstances.

For purposes of the trust provisions of section 1613(e) of the Act, there are four circumstances wherein undue hardship may be found:

1. the trust contains funds in a Medicare Set-Aside Arrangement (MSA) for purposes of compliance with the Medicare Secondary Payer (MSP) Act;

2. an SSA error results in a trust deficiency that cannot be remedied;

3. a policy-compliant special needs trust or a subaccount of a policy-compliant pooled trust is transferred to a noncompliant pooled trust or special needs trust and the trust beneficiary is not responsible for the transfer; and

4. the individual would be deprived of food or shelter without SSI payments and has limited available funds.

Each of these four circumstances is discussed in more detail below. If all of the required criteria are met for a circumstance, then undue hardship applies for purposes of the trust provisions of section 1613(e) (SI 01120.201).

Note: Qualifying for an undue-hardship waiver only applies to counting a trust under the statutory provisions of section 1613(e) of the Act (see SI 01120.201 through SI 01120.203). A trust that meets the requirements for undue hardship to apply must still be evaluated under SI 01120.200 to determine if it is a countable resource.

1. Undue Hardship - Medicare Set-Aside Arrangement (MSA)

a. Definitions

i. Undue Hardship

Undue hardship exists if a trust containing funds in a Medicare Set-Aside Arrangement (MSA) would be a countable resource under section 1613(e) and the MSA funds may only be used for certain medical expenses consistent with the Medicare Secondary Payer (MSP) Act.

Note: The undue hardship waiver only applies to the MSA funds and not to any other assets in the trust.

ii. Medicare Secondary Payer (MSP) Act

Under the MSP Act, Medicare may not pay for a beneficiary's medical expenses when payment has been made (or can reasonably be expected to be made) under a workers' compensation law or plan, an automobile or liability insurance policy or plan, or under no fault insurance (see 42 U.S.C. § 1395y(b)(2)(A)(ii)).

- Essentially, the MSP Act requires that Medicare be the secondary payer when another entity has the primary responsibility of paying for medical care, such as in cases involving workers' compensation and liability insurance.

iii. Medicare Set-Aside Arrangement (MSA)

An MSA is a financial agreement that allocates a portion of an award, judgment, or settlement to pay for all future medical expenses related to the relevant injury or illness, for purposes of complying with the MSP Act. The use of the MSA funds must be legally restricted to such medical expenses that are covered and otherwise reimbursable by Medicare. The funds must also be depleted before Medicare will pay for future Medicare-covered expenses related to the individual's relevant injury or illness that exceed the set-aside amount. There may be cases in which funds in an MSA are placed in a trust.

General additional information regarding MSAs can be located via a CMS website (see https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements).

b. Application of the undue hardship waiver

i. Applicability

We will apply undue hardship under this provision with respect to the portion of a trust containing an MSA when all of the following criteria are met:

- An MSA is established for the benefit of the SSI applicant or recipient or their spouse.
- Funds in the MSA are placed in a trust or the MSA is administered by a third party such that it is considered a legal instrument or device similar to a trust (see SI 01120.201G).
- The trust (or legal instrument or device similar to a trust) containing the MSA funds would be a countable resource under section 1613(e) and results in the individual's ineligibility for SSI due to excess resources.
- The MSA contains the necessary legal restrictions on the use of the MSA funds for certain medical expenses (i.e., medical expenses related to the relevant injury or illness that would be covered by Medicare).
- The individual signs a statement for the file and submits all relevant documentation related to the MSA, including documentation that shows how the MSA was created and that the MSA contains the necessary legal restrictions on the use of the MSA funds.

Note: The individual's statement (SSA-795) should reflect:

1) the MSA is restricted to medical expenses related to the relevant injury or illness that would be covered by Medicare; and

2) they understand they must report any changes regarding the MSA's restrictions or report if the MSA ceases to exist.

For example, the SSA-795 may state: "As shown in the submitted workers' compensation settlement agreement dated January 5, 2025, this MSA is restricted to medical expenses related to the relevant injury—a broken right arm—that would be covered by Medicare. I understand that I must report any changes regarding the MSA's restrictions or report if the MSA ceases to exist."

ii. Suspension of resource counting

The portion of a trust containing an MSA is not counted as a resource under section 1613(e) (see SI 01120.201) in any month for which counting it would cause undue hardship under this application.

iii. Resource counting resumes

Resource counting resumes for any month(s) for which it would not result in undue hardship, such as if the MSA was dissolved or depleted or the legal restrictions on the use of MSA funds to certain medical expenses were removed.

Undue hardship is a month-by-month determination; however, this application only requires reviews periodically. The MSA may be reviewed during periodic reviews of the record, such as redeterminations, and the individual is responsible to notify SSA if there is any change regarding the MSA consistent with their reporting responsibilities.

Note: Please refer all cases that may fall under this undue hardship circumstance to your regional office (RO). If necessary, the RO staff will seek guidance from the central office or OPLaw.

c. Example

An SSI recipient received a workers' compensation settlement of $15,000 due to a work-related injury. The $15,000 was allocated for future medical services related to that injury for purposes of the MSP Act and these funds must be depleted before Medicare will pay for treatment related to the injury. The $15,000 was then placed in an MSA trust that is restricted to medical expenses related to the injury. The CS requests a copy of the settlement agreement and the MSA trust documents, any additional documentation that will show the legal restrictions on the use of the funds, an accounting of the funds, and how the funds are administered.

The CS determines the MSA trust would be a countable resource under section 1613(e). However, because the MSA trust funds are restricted to certain medical expenses (i.e., medical expenses related to the relevant injury that would be covered by Medicare), the CS determines that undue hardship applies in this scenario. The CS obtains the individual's statement and notes the system to reflect the MSA trust does not count as a resource under section 1613(e). The CS also determines that the MSA trust is not a resource under SI 01120.200.

2. Undue Hardship - Agency Error Resulted in Uncorrectable Trust Deficiency

a. Undue Hardship Definition

Undue hardship exists, in limited circumstances, if an SSA error results in a trust deficiency that cannot be remedied.

b. Application of the undue hardship waiver

i. Applicability

We will apply undue hardship under this provision when all of the following criteria are met:

- There is an error by SSA;
- The trust has a deficiency that would result in the trust's being a countable resource under section 1613(e);
- There is a clear causal connection between SSA's error and that trust deficiency;
- The trust deficiency does not result in a potential benefit that substantially reduces the hardship to the individual;
- The trust deficiency cannot be corrected; and
- Substantive relief cannot otherwise be provided.

ii. Suspension of resource counting

The irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) in any month for which counting the trust would cause undue hardship under this application.

iii. Resource counting resumes

Resource counting under section 1613(e) resumes only if the circumstances change such that the criteria under this section are no longer satisfied. The individual is responsible for notifying SSA if there is any change regarding the trust consistent with their reporting responsibilities. Although undue hardship is a month-by-month determination, this application does not require monthly or periodic reviews due to the criteria.

Note: Please refer all cases that may fall under this undue hardship circumstance to your regional office (RO). If necessary, the RO staff will seek guidance from the central office or OPLaw.

c. Example

A thirty-year-old SSI recipient received a $7,000 inheritance and established an irrevocable special needs trust through their legal guardian, who is also their spouse and representative payee (RP). The trust was intended to meet a Medicaid trust exception and was reported to the field office. The CS determines that the trust is a countable resource because it contains a noncompliant early termination provision. However, the CS does not issue a notice (as required under SI 01120.204) that explains the problematic provision in the trust and the policy regarding it.

The RP requests reconsideration and inquires as to why the trust does not meet the Medicaid trust exception. The field office affirms the initial determination and simply states the trust is countable without further explaining or providing the notice required by policy. The RP appeals the decision to an ALJ and attempts to fix the trust; however, the amended trust doesn't resolve the early termination issue. The ALJ decides the trust is still noncompliant due to its deficient early termination provision, notes the applicable policy, and finds it is a countable resource. The RP realizes the trust's deficiency upon reading the ALJ's decision; however, the recipient passes away two weeks later, and the trust can no longer be amended.

In this example, the SSA error was the field office's failure to provide the proper notice required by policy. The RP tried to determine the trust's deficiency and amended the trust; however, the RP didn't have an explanation as to what provision of the trust was problematic or what policy was at issue, so the amendment didn't correct it, which is the causal connection between the error and the trust's deficiency. There is no indication that the trust deficiency resulted in a potential benefit that substantially reduced the hardship to the individual. Finally, due to the recipient's death, the trust can no longer be amended and there is no way to provide substantive relief other than through this undue hardship provision.

3. Undue Hardship - Assets Transferred Upon Early Termination from a Compliant Pooled Trust or Special Needs Trust to a Noncompliant Pooled Trust or Special Needs Trust

a. Undue Hardship Definition

Undue hardship exists, in certain circumstances, when, upon early termination, assets in a pooled trust subaccount or a special needs trust that was previously determined to be policy-compliant are transferred to a noncompliant pooled trust or special needs trust and the beneficiary is not responsible for the transfer.

b. Application of the undue hardship waiver

i. Applicability

We will apply undue hardship under this provision when all of the following criteria are met:

- A pooled trust subaccount or a special needs trust was previously determined to meet a Medicaid trust exception and not to be a countable resource (under SI 01120.203 and SI 01120.200).
- The assets in the pooled trust subaccount or special needs trust are transferred to a secondary pooled trust or special needs trust that is intended to meet a Medicaid trust exception (see SI 01120.203), but the secondary trust was not previously evaluated and is subsequently determined to be noncompliant with our policy.
- The SSI applicant or recipient is not responsible for the transfer to the secondary, noncompliant trust or the circumstances related to the early termination and the transfer.

ii. Suspension of resource counting

The secondary irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) due to undue hardship for 120 days in order to allow the trust to be amended or the assets to be transferred to a policy-compliant trust.

- The 120-day period begins on the day SSA informs the applicant, recipient, or representative payee via written notification that the secondary trust contains provisions that must be amended in order to qualify for a Medicaid trust exception.
    - If the written notification is mailed, instead of hand-delivered, then the applicant, recipient, or representative payee is considered to be informed five days after the mailing date.
    - We permit a good cause extension if it is requested with evidence that the disqualifying issue cannot be resolved within the 120-day period (for example, if a court must amend the secondary trust and there is a waiting period to get on the court docket).
- The technician follows the recontact controls provided in SI 01120.203H.4.

iii. Resource counting resumes

Undue hardship is a month-by-month determination; however, this application only requires a review when the 120-day period (plus any good cause extension) expires. If the secondary trust is not amended to conform with our policy requirements or the assets are not transferred to a policy-compliant trust within 120 days (plus any good cause extension), then undue hardship under this provision will no longer be met and resource

counting of a trust will generally resume, subject to our policy, at the beginning of the following month.

Note: Please refer all cases that may fall under this undue hardship circumstance to your regional office (RO). If necessary, the RO staff will seek guidance from the central office or OPLaw.

c. Example

An SSI recipient has a subaccount in a pooled trust that was previously determined to meet the Medicaid trust exception for pooled trusts and not be a countable resource under our policy (SI 01120.203 and SI 01120.200). However, the pooled trust dissolved, and the trustee transferred the subaccount to a secondary pooled trust intended to meet a Medicaid trust exception. Although the secondary pooled trust's master trust agreement expressed that its terms were intended to form a pooled trust that complied with section 1917(d)(4)(C), the agency determines the secondary pooled trust is not compliant with our policy due to a deficient early termination provision; so, it does not meet a Medicaid trust exception. The technician sends the required written notice to the SSI recipient, who notifies the trustee regarding the matter, and the technician tickles the issue for review in 120 days. The trust is amended to address the issue and conform with our policy within 100 days. The technician does not count the subaccount as a resource due to undue hardship and satisfying the requirements of SI 01120.200 for the first three months and does not count it as a resource due to the Medicaid trust exception and satisfying the requirements of SI 01120.200 for the months thereafter.

4. Undue Hardship - Deprivation of Food or Shelter and Limited Funds

a. Definitions

i. Undue Hardship

For purposes of the trust provisions of section 1613(e) of the Act, undue hardship exists in a month if:

- failure to receive SSI payments would deprive the individual of food or shelter; and
- the individual's available funds do not equal or exceed the Federal benefit rate (FBR) plus any federally administered State supplement.

Note: Inability to obtain medical care does not constitute undue hardship for SSI purposes, although it may under a State Medicaid plan.

ii. Loss of shelter

For purposes of undue-hardship waiver in the context of section 1613(e) of the Act, an individual would be deprived of shelter if:

- they would be subject to eviction from their current residence, if SSI payments were not received; and
- there is no other affordable housing available, or there is no other housing available with necessary modifications for the disabled individual.

iii. Available funds

In determining the individual's available funds, we include:

- Income

  - All countable income, including the value of in-kind support and maintenance (ISM), received in the month(s) for which undue hardship is an issue; and
  - All income excluded under the Act received in the month(s) for which undue hardship is an issue.
  - Do not include SSI payments received or items that are not income, per SI 00815.000.

For a list of unearned and earned income exclusions, respectively, see SI 00830.099 and SI 00820.500.

Note: The receipt of ISM, in and of itself, does not preclude a finding of undue hardship.

- Resources

  Resources include the following:

  - All countable liquid resources as of the first moment of the month(s) for which undue hardship is at issue (for a definition of liquid resources, see SI 01110.300); and
  - All liquid resources excluded under the Act as of the first moment of the month(s) for which undue hardship is at issue (for a list of resource exclusions under the Act, see SI 01130.050).
  - Do not include non-liquid resources or assets determined not to be a resource, per SI 01120.000.

  SSI benefits retained into the month following the month of receipt are counted as a resource for purposes of determining available funds.

  Refer to subsections H and K for procedures on developing and following up on a finding of undue hardship due to deprivation of food or shelter and limited funds.

b. Application of the undue hardship waiver

i. Applicability

We will apply undue hardship under this provision only when all of the following criteria are met:

- an irrevocable trust would be a countable resource under section 1613(e) and result in the individual's ineligibility for SSI due to excess resources;
- the trust specifically prohibits disbursements, or prohibits the trustee from exercising their discretion to disburse funds, from the trust for the individual's support and maintenance;
- the individual alleges (or information in the file indicates) that not receiving SSI would deprive the individual of food or shelter, with their statement subsequently obtained for the file; and
- the individual's total available funds are less than the FBR plus any federally administered State supplement.

Note: If the trust is revocable by the individual, the undue-hardship requirements for this circumstance cannot be met because the individual can access the trust funds for their support and maintenance.

ii. Completing the individual's statement (SSA-795)

The individual's statement (SSA-795) should reflect:

1) failure to receive SSI payments would deprive them of food or shelter;

2) their total available funds are less than the FBR plus any federally administered State supplement;

3) they will promptly report any changes in their income or resources; and

4) they understand they may be overpaid if, for any month, available funds exceed the FBR plus any State supplement or if other situations change.

iii. Suspension of resource counting

An irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) in any month for which counting the trust would cause undue hardship.

iv. Resource counting resumes

Resource counting of a trust resumes for any month(s) for which it would not result in undue hardship.

c. Example

Frank filed for SSI in 3/2017 as an aged individual. In 2/2017, Frank received an insurance settlement from an accident that was placed in an irrevocable trust. After

determining that Frank met the other requirements for undue hardship (including a prohibition on the trustee from disbursing any funds for his support and maintenance), the claims specialist determined Frank's available funds. Frank receives $450 in title II benefits per month. Frank's only liquid resource is a bank account that has $500 in it. The total of $950 in available funds ($450 in title II benefits and $500 in the bank account) means that undue hardship does not apply in 3/2017, because that amount exceeds the 2017 FBR of $735. (His State has no federally administered State supplement.)

Frank comes back into the office in 6/2017 and presents evidence that he has spent down the $500 in his bank account on living expenses in the past three months. As of 6/2017, Frank has no liquid resources, and Frank's income total of $450 is below the FBR ($735 for 2017). Frank meets the undue hardship test for 6/2017 (which is Frank's E02 month). The trust does not count as Frank's resource under section 1613(e) in that month. It also is not a resource under SI 01120.200. If Frank's situation does not change, he qualifies for an SSI payment in 7/2017.

APPENDIX B

Workers' Compensation Medicare Set Aside Arrangements

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that allocates a portion of a workers' compensation settlement to pay for future medical services related to the workers' compensation injury, illness, or disease. These funds must be depleted before Medicare will pay for treatment related to the workers' compensation injury, illness, or disease.

All parties in a workers' compensation case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving cases that include future medical expenses. The recommended method to protect Medicare's interests is a WCMSA.

The amount of the WCMSA is determined on a case-by-case basis. To assist you in determining if a WCMSA is reasonable, please review Section 15.1 (Criteria) in the *WCMSA Reference Guide*. The guide contains information for attorneys, Medicare beneficiaries, claimants, insurance carriers, representative payees, and WCMSA vendors and is available in the Downloads section at the bottom of this page.

When to submit a WCMSA for CMS Review

While there are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review, submission of a WCMSA proposal is a recommended process. More information on this process can be found on the WCMSA Submissions page (https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements/submission.)

If you choose to submit a WCMSA for review, CMS requires that you comply with its established policies and procedures. CMS will only review WCMSA proposals that meet the following criteria:

- The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
- The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00

For more information on Review Thresholds, please see Section 8.1 (Review Thresholds) of the *WCMSA Reference Guide* available in the Downloads section found at the bottom of this page.

If you decide to submit a WCMSA for review, it can be submitted electronically through the WCMSA Portal (https://www.cob.cms.hhs.gov/WCMSA/) (WCMSAP) or by paper/CD through the mail. The portal submission is the recommended approach for submitting a WCMSA as it is significantly more efficient than sending this information via the mail. For more information about this application, please see the WCMSAP page (https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements/portal.)

Note: For general information on CMS's Coordination of Benefits & Recovery activities, please see the COB&R page (https://www.cms.gov/medicare/coordination-benefits-recovery/overview.)

APPENDIX C

(Click on the hyperlink below to see the full Final Regulation.)

Expand the Definition of a Public Assistance Household

Document Citation: 89 FR 28608

Final Rule, Expand the Definition of a Public Assistance Household ((April 19, 2024)

Summary: We are finalizing our proposed rule to expand the definition of a public assistance (PA) household for purposes of our programs, particularly the Supplemental Security Income (SSI) program, to include the Supplemental Nutrition Assistance Program (SNAP) as an additional means-tested public income-maintenance (PIM) program. We are also revising the definition of a PA household from a household in which every member receives some kind of PIM payment to a household that has both an SSI applicant or recipient, and at least one other household member who receives one or more of the listed PIM payments (the *any other* definition). If determined to be living in a PA household, inside in-kind support and maintenance (ISM) would no longer need to be developed. The final rule will decrease the number of SSI applicants and recipients charged with ISM from others within their household. In addition, we expect this rule to decrease the amount of

income we would deem to SSI applicants and recipients because we will no longer deem as income from ineligible spouses and parents who live in the same household: the value of the SNAP benefits that they receive; any income that was counted or excluded in figuring the amount of that payment; or any income that was used to determine the amount of SNAP benefits to someone else. These policy changes reduce administrative burden for low-income households and SSA.

APPENDIX D

Updating Social Security Disability

Regulatory Changes Could Significantly Reduce Eligibility for Benefits, Particularly among Older Workers

Jack Smalligan

September 2025

The Social Security Administration directs two important disability programs: Social Security Disability Insurance (SSDI), which is vital for older workers with significant work-restricting impairments who have yet to reach full retirement age, and the Supplemental Security Income (SSI) program, which provides critical income support to the elderly and children and adults with severe disabilities earning little or no income or assets. SSDI and SSI share the same criteria for determining disability eligibility. However, these programs rely on outdated occupational data that threaten the validity and quality of disability decisions. To address this, SSA is drafting a proposed rule to adopt and implement modernized occupational data in the disability determination process. It is also considering changes to other standards and processes used to determine eligibility, including how much weight the age of a claimant should be given in the disability decision.[1] The forthcoming regulation could lead to substantial reductions in program eligibility, particularly among older working adults.

The Social Security Administration (SSA) has been working across administrations to update the occupational data needed to make disability claims decisions and to develop guidance and procedures for data use. Bipartisan consensus supports modernizing data on work in the economy and functional job requirements. However, the debate centers on how to apply those data and how age should influence eligibility. On some key questions, like the need to adopt modernized data on work in the economy and functional requirements of jobs, different Administrations have agreed on the need for change and source of new data to be used. However, on other questions, like how that data is used and how age should be factored into disability decisions, the views and policy goals of policymakers differ significantly. These differing views could have enormous impact

on program eligibility and benefit payments for millions of people, particularly workers over the age of 50.

The goal of this brief is to clarify the key technical issues under consideration by policymakers at the SSA. We discuss the alternative policy approaches to the forthcoming proposed rule, Improvements to the Disability Adjudication Process: Sequential Evaluation Process,[2] relevant research, and estimates of the potential impact on program participation and spending. Three primary components to the anticipated regulation follow:

- The replacement of the outdated Dictionary of Occupational Titles (DOT) with data from the Bureau of Labor Statistics' (BLS) Occupational Requirements Survey (ORS), which has been underway for many years with bipartisan support
- The implementation of the ORS, including establishment of various thresholds for determining how many jobs exist in the economy at different skill and exertional levels
- Changes to the treatment of age, education, and other elements as eligibility factors, which is separate from the transition from the DOT to ORS

These changes will involve nuanced judgments about how education and past work experience affect an individual's ability to work given their age, and whether enough jobs are available that match the individual's functional capabilities. Overall policy goals are likely to drive decisionmaking on these technical details. One view, championed by Mark Warshawsky, a former Trump administration policy official at SSA, argues that program spending should be reduced and age should be given less weight in the determination process based on increases in longevity and changes in the nature of work (Warshawsky 2023). Wall Street Journal reporting based on a draft version of the rule under the first Trump administration, as well as writings by Mark Warshawsky and conversations with former SSA staff knowledgeable of the draft rule suggest the proposed regulation could reduce eligibility for new applicants to the SSDI program dramatically, potentially by as much as 20 percent overall, and up to 30 percent among older age groups through these changes (Warshawsky and Marchand 2015).[3] The potential impact on the SSI program is unclear. Conversely, Biden administration officials considered research on the negative outcomes for people denied benefits under the current process as evidence of the need to maintain or increase program eligibility, especially for older workers.[4]

To illustrate the potential impact of the anticipated regulation, we estimate the effect of a policy that reduces SSDI eligibility by 10 percent and find that it would result in roughly 500,000 people losing SSDI eligibility by the end of 10 years, including 80,000 widows and children. In addition, another 250,000 beneficiaries would lose eligibility for some of the 10-year period. This would result in

approximately $82 billion in benefits being denied over 10 years, as well as reductions in eligibility for Medicare, Medicaid or both.[5] The loss of health insurance is especially troubling for a population that disproportionately has serious medical challenges. These reductions would have implications not only for individual beneficiaries and applicants, but also broader effects on labor force participation, poverty rates, and the health and economic security of workers. For older workers denied benefits and unable to earn a steady income, they may resort to claiming retirement benefits at the earliest age of 62, resulting in a lifetime benefit that is 30 percent lower than what they would have received had they qualified for SSDI.

What Key Issues Surround Updating the Disability Eligibility Process?

Regulatory updates to the disability determination process would likely focus on how SSA implements requirements under the Social Security Act to consider an individual's age, education, and work experience in making eligibility decisions. It is likely that any proposed rule on this topic would be very large and complex, consisting of many interrelated and technical changes. However, the impact of the regulation will be guided by policy decisions on three key elements:

- Should SSA replace the DOT with data from the BLS's ORS?
- How should SSA implement data from the ORS to determine disability eligibility?
- How, and to what extent, should age be considered in assessing an individual's ability to perform work in the economy?

The overarching policy goals of the SSA in these three areas will determine how the regulation impacts the size of the program and its beneficiaries—namely whether it will increase, decrease, or achieve a net neutral impact on participation and spending. In the following sections, we discuss each of these areas and how alternative policy approaches would alter expected outcomes, including relevant research and evidence.

Issue 1: Adopting Modernized Data on Work in the Economy

To determine whether an individual is considered disabled (see box 1 on the next page), SSA needs current data on occupations in the economy and their requirements. The Social Security Act's definition of disability includes both medical and vocational criteria. To qualify, applicants must have a severe and long-lasting or terminal medical condition that renders them unable to work above a subsistence wage. The final step of deciding whether a claimant is eligible for

benefits requires SSA to determine the individual's residual functional capacity (RFC), essentially what types of mental and physical activities the claimant could still perform given their age, education, and work experience. Once that determination is reached, SSA attempts to find "work which exists in the national economy," including "work which exists in significant numbers either in the region where such individual lives or in several regions of the country."[6]

Currently, SSA relies primarily on the Department of Labor's (DOL) DOT to determine what work exists. In this step of the process, SSA does evaluates if a person is capable of doing the same work they previously did. If they are determined to be unable to do their prior work, SSA uses the person's RFC to assess whether they can perform a comparable or less physically or mentally demanding job. However, using the DOT does not provide a modern catalog of today's jobs because DOL stopped updating it over 30 years ago.[7] Using outdated data poses risks to the integrity of the disability determination process and validity of its decisions. An adjudicator can use the presence or absence of jobs to incorrectly deny or grant benefits to an applicant. The issue has been highlighted in the media, where for example, individuals were reportedly denied benefits because of the availability of jobs like nut-sorter and dowel inspector, which do not exist in large numbers in the national economy anymore, if at all.[8] SSA has taken action to remove some of the most obviously out-of-date jobs from the DOT.[9] Aside from this, the DOT also excludes any new occupations that have emerged since 1991, which is before the advent of the internet, the modern tech sector, and other major employment shifts.

BOX 1

Social Security Disability Determination Process

The Social Security Administration (SSA) uses a **five-step sequential evaluation process** to determine whether an individual qualifies for disability benefits under the Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) programs. Before beginning this process, SSA determines whether an individual is eligible for SSDI, SSI, or both programs based on past work history, recent earnings, total income, and assets, depending on the program.

- **Step 1.** SSA's assesses whether the applicant is engaging in substantial gainful activity (SGA). SSA defines SGA as earnings above $1,620 a month in 2025 for non-blind individuals, an amount that is indexed annually to average wage growth.[10] Individuals engaging in SGA are generally not considered disabled.
- **Step 2.** An applicant's claim is reviewed to determine whether the applicant has a severe medically determinable disability that significantly limits their ability to perform basic work activities.
- **Step 3.** SSA checks whether it meets or equals a listing in the SSA's Listing of Impairments, which would automatically qualify the applicant for disability

and allow SSA to approve the claim without the need to advance to steps 4 and 5. The medical listings expedite the approval of applicants whose impairment can be judged to be disabling based on medical evidence alone, avoiding the need for an individualized assessment of their ability to work.

- **Step 4.** If the disability does not meet or equal a listing, SSA evaluates the applicant's residual functional capacity (RFC) to determine whether they can perform any of their past relevant work.
- **Step 5.** If the disability does not meet or equal a listing, the final step assesses whether they can adjust to other work that exists in significant numbers in the national economy, considering their age, education, and work experience. This step involves a vocational analysis and may include input from vocational experts.

Source: Wixon, Bernard and Alexander Strand, Identifying SSA's Sequential Disability Determination Steps Using
Administrative Data, Research and Statistics Note No. 2013-01 (released June 2013)
https://www.ssa.gov/policy/docs/rsnotes/rsn2013-01.html

Beginning in 2012, SSA contracted with the BLS to survey employers and explore creation of a new survey, database of occupations, and physical and mental job requirements to increase accuracy in disability determinations based on legal requirements.[11] The goal was to create a database flexible enough to accommodate future changes to jobs and their associated occupational and vocational requirements. To achieve these objectives, BLS fielded the ORS,[12] which includes three phases of data collection, including an initial proof of concept test and two national waves of employer surveys to collect the physical, mental, and vocational job requirements SSA needs. BLS releases ORS data to the public, with limitations to protect the confidentiality of employers.

Although there is broad agreement on the need for this update, its impact will depend on its implementation. The DOT and ORS are different enough from each other in origin, methodology, and application that the use of ORS could dramatically affect overall eligibility as well as the composition of the beneficiary population but in the aggregate, it is unclear that shifting from the DOT to the ORS will alone significantly impact base eligibility.

Issue 2: Implementing the Occupational Requirements Survey

Replacing the DOT with the ORS will involve many technical decisions that, together, could be used to significantly alter the number and type of approved claims for disability benefits. These technical decisions will be guided by high-level policy decisions and goals. Statements by former Trump officials suggest that reducing costs in the disability program are an overriding policy objective (Warshawsky 2023), aligning with other unprecedented reductions in government spending. However, research that examines outcomes among applicants who are denied

disability benefits under current program rules shows that most go on to experience worsening employment, health, and financial outcomes. In addition, the lengthy application and appeals process itself often keeps people out of work for months.

Below we identify four issues involved in implementing ORS that will likely be addressed the regulation and could be used to alter the net effect of the regulation on disability eligibility. We then discuss research on outcomes for denied applicants.

Number and Mix of Jobs Available in the Economy

Eliminating the DOT and incorporating ORS would remove outdated jobs and add newer ones and provide more data on which jobs are available in significant numbers. SSA must determine whether a given job exists in sufficient numbers in the economy for it to be included in the list of available jobs used in step 5 of the disability determination process. To do that, SSA must decide how many available jobs is "sufficient," how to define the job categories, and whether being able to perform only one job available in sufficient numbers is enough to deny someone benefits. SSA can also change how it defines the region in which a person works; some jobs may only be available in isolated geographic areas. How should those be treated?

Cognitive Requirements

ORS provides more granular data on the mental and cognitive demands of jobs. After the first wave of the ORS survey, SSA realized that it did not have enough data on the mental requirements of jobs to implement the ORS. SSA defines two types of functional limitations—exertional and nonexertional. SSA defines an exertional limitation as "an impairment-related limitation that reduces the capacity to sit, stand, walk, lift, carry, push, or pull" (Social Security Administration 2014d). It considers all other limitations "nonexertional" limitations, which relate to cognitive tasks, emotional and psychological functioning, sensory abilities, manipulative or postural tasks, and environmental tolerances. In 2024, BLS published the second wave with the additional needed details. This enhanced detail, along with new adjudication guidance, may influence how SSA evaluates claims involving mental health conditions— either as a primary impairment or as a co-occurring condition with physical disabilities. Improved data on mental requirements could lead to more accurate and equitable determinations.

Thresholds for Functional Requirements

ORS offers detailed information on functional job demands, but SSA must establish thresholds and decision rules to determine when an individual's RFC is sufficient to do a particular job. This could greatly affect how many people are found to be disabled. If a claimant has an exertional limitation that prevents them from being able to perform heavy lifting, should they be considered capable of getting a job

where 50 percent of the positions require it? What about an occupation where heavy lifting is required in 25 percent of positions? Or 75 percent? These thresholds can be adjusted to make the program eligibility more or less strict.

Intersecting Functional Requirements

SSA must account for wide variation in the functional requirements of jobs: jobs with the same title can require very different functions. The ORS occupation dataset that SSA is using is challenging because while it shows what proportion of jobs that require each skill in isolation, it does not show how they might combine in a particular position. So, for example, if a person can perform light work, but cannot work outdoors, and a position requires both, job prevalence data alone may not provide a clear answer to whether they can perform the job. More broadly, ORS data show a substantial number of "unskilled" jobs in the economy in terms of educational or training requirements, with 34.1 percent having job requirements that can be learned in one month or less. ORS data also show that 29.3 percent of jobs require only sedentary demands, but SSA often needs to know whether a substantial number of jobs are both unskilled and sedentary. These types of jobs are the ones that individuals with disabilities are most often able to perform in the economy. In preliminary findings, Weaver (2025) examines the ORS data and finds that a simple assumption that the unskilled and sedentary job characteristics are uncorrelated would lead to an erroneous assumption that 10.0 percent of jobs are unskilled and sedentary, whereas
BLS has published findings that only 3.6 percent of jobs are unskilled and sedentary.[13]

Outcomes among Denied Disability Claimants and Similar Disabled Workers

Existing research shows that applicants denied disability benefits under the current process experience very poor health and economic outcomes, and raising eligibility standards would likely worsen these harms. Using 2014 survey data on adults ages 18 to 66, Weaver (2021, p. 1) estimates that about 24 million people have applied for Social Security disability benefits at some point, with roughly equal shares ultimately allowed and denied. Denied applicants were found to have only slightly better health than beneficiaries and relative to the overall working-age population, much higher rates of poor health, poverty, and limited earnings.

Denied applicants are unlikely to return to work. Hyde, Wu, and Gill (2018) specifically look at individuals ages 50 and older who are denied at steps 4 and 5 of the eligibility process. They find that five years after the initial decision, only 10 to 20 percent of denied applicants are working, whereas five years prior to the initial denial decision, between 85 and 95 percent of these claimants were working. Johnson and Gosselin (2018) use the Health and Retirement Study to track older individuals and find that about one-half of fully employed workers ages 51 to 54 experience an employer-related involuntary job separation after age 50. The separation substantially reduces earnings for years or leads to long-term

unemployment, often draining their retirement savings and leading to long-term economic hardship.

Adults who develop a work-limiting disability are also more likely to exit the labor market and experience financial hardship and poverty. For the overall working age population, Mudrazija and Smalligan (2019) find that each year, on average, 4.2 percent of adults ages 18 to 62 who are in the labor force report developing a new work-limiting health condition or experience a new health shock. Within two years, these workers are three times more likely to have left the labor force than other workers.
More than half of them do not receive any form of public assistance and do not report being retired. Within six years, over one-third of this group does not receive any public assistance. Poverty rates almost double within two years following the onset of their health issue. Those who do receive some form of public assistance are more likely to see their incomes stabilize while those who do not receive benefits see their economic status erode.

Deshpande, Gross, and Su (2021, p. 151) use SSA administrative records and the variations in disability determination rules related to age to consider key markers of financial distress, including bankruptcy, foreclosure, eviction, and home sale. They find these adverse financial events peak around the time of disability application. They also estimate that a "disability allowance reduces the likelihood of bankruptcy by 20 percent, foreclosure by 33 percent, and home sale by 15 percent."

A denial for disability benefits can also impact the work requirements in other support programs. Some applicants rely on means-tested assistance, such as the Supplemental Nutrition Assistance Program. However, the Supplemental Nutrition Assistance Program has work requirements that a disability applicant may be unable to satisfy. While the Supplemental Nutrition Assistance Program provides an exemption for people with disabilities, in many states, the person must have qualified for a disability benefit like SSDI or SSI to automatically meet the standard for the exemption (Bergh and Rosenbaum 2023).

Issue 3: Factoring Age into Disability Determinations

In addition to updating data and thresholds used in the disability determination process, it is likely that SSA will also propose changes to the way the age of a claimant is factored into disability determinations.
The Social Security Act explicitly requires SSA to consider age as a factor in determining disability. While the occupational requirements of jobs and the role of age in an individual's ability to work are related, SSA could implement changes solely to the occupational requirements without changing any of its age thresholds. However, changes to reduce the role of age as a determination factor, via changes to the "grids" we discuss below, are expected to be one of the main issues in SSA's

rulemaking under the Trump administration. This approach has been written about by a former SSA policy official who has argued that age should be given very little, if any, weight in disability decisions (Warshawsky 2023) and reported by the *Wall Street Journal*, which obtained a copy of the unpublished rule during the first Trump administration.[14]

Currently, SSA considers how an individual's education, age, and skills interact with the residual functional capacity they have due to their serious disability through use of Medical-Vocational Guidelines, often called the vocational "grids."[15]

SSA's grids form a framework used in the final step of the disability determination process—after a person has been found to have a significant medical impairment—to assess whether a claimant can adjust to other work in the national economy. With the adjudicator having found the claimant to be *medically* eligible in these steps, they determine *vocational* eligibility (i.e., whether those medical impairments preclude substantial work). These guidelines help adjudicators evaluate claims by considering a combination of factors: RFC, age, education, and work experience. The grids are structured as tables that outline different vocational profiles and indicate whether a person is eligible for benefits based on these characteristics.

Age plays a critical role in the grids because SSA recognizes that the ability to adapt to new work decreases with age. The guidelines divide age into categories using terminology that has not been updated in many years:

- Younger person (under 50)
- Closely approaching advanced age (50–54)
- Advanced age (55–59)
- Closely approaching retirement age (60 and older)

For example, a disabled person age 55 with limited education and no transferable skills may be found eligible for benefits even if they could technically perform sedentary work because the grids presume that older individuals face greater barriers to vocational adjustment. In contrast, a younger person with the same limitations might be expected to adapt to other work and thus be denied benefits.

The grids also categorize physical limits of an individual into five categories from "sedentary" to "very heavy" and an individual's education into categories from "unable to read" to "being a high school graduate or having more education." For jobs, the educational grid also categorizes jobs in terms of the amount of training required from "unskilled" (i.e., only a short demonstration needed) to "over 10 years of training."[16]

The grids provide guidance on how to incrementally consider different types of factors at once. For example, the grid recommends that a disabled person 50 or older with seven or fewer years of education who can only do sedentary, unskilled work should be awarded benefits. However, the grid does not recommend that an individual with the same age and education who can do nontransferable semi-skilled work be awarded benefits. The grid provides recommendations for over 80 configurations of these factors.[17] It gets progressively easier for people with physical limitations and limited education or skilled work to get benefits as they get older.

There are many cases where the grid cannot give guidance on a determination, particularly when non-exertional limitations are present. In addition, the grids have been criticized as overly simplistic and out of date. However, it is unclear that the fundamental framework of the grids is dated, as the grids provide a simplified framework for making complicated eligibility decisions in the context of a large federal agency where adjudicators are considering several million individuals a year. And while the grids may increase consistency and efficiency, decisions are ultimately left to the adjudicators reviewing the cases.
While SSA may propose to reduce age as a factor in the forthcoming rule, others have argued that eligibility should be increased for workers with disabilities who are approaching age 62, the early retirement eligibility age (Primus, Watson, and Smalligan 2025).

Age and Disability

As the population ages, the *number* of older Americans with work-related limitations has grown even as the *share* of older people with a limitation remains stable. From 1997 to 2017, the number of adults reporting a health-related work limitation increased from 2.8 million to 5.4 million for people ages 55 to 61 and from 1.7 million to 3.1 million for people ages 62 to 65 (Smalligan, Williams, and Boyens 2019).

Disparities persist in the proportion of older workers with disabilities based on racial and ethnic background and education level. For people who were 62 to 65 in 2017, 27 percent of non-Hispanic Black people and 26 percent of Hispanic people reported health-related work limitations, compared with 19 percent of non-Hispanic white people (Johnson 2018).

While SSDI protects many older disabled workers, many others take early retirement with dramatically reduced monthly benefits. Roughly 15 percent of retirees between 1992 and 2011 reported that they involuntarily retired, with half of this group attributing the decision to poor health (Seligman 2014). Moreover, people who retired early because of a health issue were just as likely to be receiving retirement benefits rather than disability benefits. A substantial portion of early retirees who had health issues were very similar to those receiving SSDI or SSI (Bound and Waidmann 2011). Frietag (Forthcoming) uses administrative data in

Washington State to track SSI applicants in the years before being affected by the grid-related age adjustments and finds two-thirds of older SSI recipients were detached from the formal labor force in the five years prior to being awarded SSI benefits and 40 percent experienced at least three months of homelessness.

Reducing age as a factor would push more older disabled workers to take early retirement benefits instead of SSDI, which can significantly reduce their monthly benefit, permanently undermining their retirement security. SSDI is based on past earnings and is intended to provide an unreduced benefit to workers who are forced to stop working and would otherwise have been penalized for experiencing a severe disability late in life. Without SSDI, older workers who claim retirement benefits at age 62, the earliest eligibility age, would have their benefit reduced by 30 percent compared with their SSDI benefit for the rest of their life, a reduction that also affects benefits paid to eligible spouses, widows, and dependent children.

Potential Impact on Eligibility and Spending

SSA's expected rule could substantially reduce the size of the SSDI program.[18] As discussed above, the regulation could reduce SSDI eligibility by as much as 20 percent overall, and as much as 30 percent among older age groups (Warshawsky and Marchand 2015).[19] We modeled the effects of a hypothetical 10 percent reduction in allowance rates on applicants for SSDI, an intermediate scenario that could occur if SSA tightens the eligibility criteria for claimants who are ages 50 or older. The expected impact of the regulatory changes would grow over time as more new applicants are subject to the new rules. We used data and projections from SSA's statistical reports and SSA's Office of the Chief Actuary[20] to estimate the number of beneficiaries entering and exiting the program each year from 2026 to 2035. We then estimated the impact of a 10 percent lower allowance rate and found that it would result in 500,000 fewer beneficiaries on SSDI and 80,000 fewer widows and children would be receiving benefits due to the SSDI eligibility of a spouse or parent.[21] Additionally, there would have been another 250,000 people denied SSDI benefits who would have otherwise received SSDI beneficiaries during *some* portion of the 10 years (even if they would have exited the program before the 10th year due to death, medical improvement, increased work activity, or transition to Social Security retirement benefits). Overall, the affected beneficiaries would have been denied over $82 billion in benefits over this period, as well as eligibility for Medicare, Medicaid or both. For many individuals, loss of this health insurance would have even greater impact on their quality of life than the loss of cash benefits.

These estimates focus on new applicants because current beneficiaries are usually protected from changes in eligibility rules because the Social Security Act requires that SSA determine a beneficiary has medically improved compared with when originally determined eligible. However, SSA may decide to modify how this requirement is executed and that could mean many current beneficiaries would also

be affected. Given the uncertainty on this point, the impact is not included in our estimates.

The last time an administration attempted to significantly restrict eligibility occurred in the early 1980s, when the Reagan administration initiated more reviews of existing recipients and sent termination notices to hundreds of thousands of beneficiaries. The proposed restrictions being considered would likely represent an even larger change in the number of SSDI recipients, the biggest change to SSDI since the program was established. Despite the Reagan administration efforts to reduce the programs in the 1980s, a combination of court decisions protecting beneficiaries and legislation enacted by Congress ultimately resulted in a substantial expansion of the programs (Berkowitz and DeWitt 2013).

Disability Programs Participation Has Declined And Denial Rates are High

The disability rule changes would be introduced after years of declining participation, historically high backlogs of people waiting for claims decisions, and research showing poor outcomes for workers denied benefits. New claims for SSI and SSDI declined from a peak of 3.3 million in 2011 to 2.3 million in 2024. Overall program participation has declined as a consequence. For SSDI, the number of worker beneficiaries reached a peak of nearly 8.6 million in 2011 and decreased to fewer than 7.4 million by the end of 2023.[22] For SSI, adult disabled beneficiaries peaked at more than 5.6 million in 2011 and decreased to fewer than 5.3 million by the end of 2023.[23]

In the current determination process, two-thirds of claimants are denied at the initial review stage, yet approximately 44 percent of those denied claimants who appeal are ultimately awarded benefits.[24] The awards are not made until after several additional levels of review and months or years of delay. In addition, SSA currently faces a backlog of nearly 1 million claims waiting review at the initial stage, roughly twice as many claims as before the COVID-19 pandemic, and hundreds of thousands more claims are waiting to have an initial denial reconsidered (Boyens and Smalligan 2024). These long wait times for claims decisions impose costs on beneficiaries and the agency.

Conclusion

SSA is considering the most significant changes to the SSDI and SSI programs to date. While widespread agreement has been reached on the need to update data on jobs available in the economy and their functional requirements, adopting that data involves numerous technical policy updates that, taken together, can act to significantly alter program eligibility. In addition, the SSA may change the extent to which age is factored into the disability decision, which would have a dramatic negative impact on the number of applicants granted disability benefits.

If repeated, the approach begun in the Trump administration's first term could result in unprecedented cuts to disability eligibility and benefits—especially for those over age 50—on the premise that longer life expectancy extends working years. Evidence from denied applicants shows many do not return to work, receive little other income support, and experience declines in health and financial stability. Because gains in life expectancy are uneven, further tightening of an already strict program would likely worsen outcomes overall and increase poverty, hardship, and mortality.

Policymakers must also consider how tightening the Social Security disability program will affect older workers and retirement security. Reducing SSDI and SSI means more people will be forced to claim Social Security earlier, reducing not only their own retirement benefits but also those of their spouses, widows, and dependent children.

Notes

[1] For background on the programs see the following publications from the Center on Budget and Policy Priorities,
"Chart Book: Social Security Disability Insurance," updated February 28, 2025, https://www.cbpp.org/research/social-security/social-security-disability-insurance-0; and "Policy Basics: Supplemental Security Income," updated March 20, 2024, https://www.cbpp.org/research/socialsecurity/supplemental-security-income.

[2] Improvements to the Disability Adjudication Process: Sequential Evaluation Process (RIN: 0960-AI67), accessed September 10, 2025, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202504&RIN=0960-AI67.

[3] Kate Davidson, "Trump Administration Weighs Tighter Requirements for Disability Payments." *Wall Street Journal*, January 10, 2020, https://www.wsj.com/articles/trump-administration-weighs-tighter-requirementsfor-disability-payments-11578686424.

[4] Information on the policy options under consideration during the prior Trump and Biden administrations was obtained through confidential interviews with former SSA staff who worked on the draft regulations.

[5] Author's estimate based on a hypothetical reduction in allowances of 10 percent in new allowances for SSDI.
Estimate used data on awards, denials, allowances and program terminations from SSA including "Actuarial Study No. 125," Office of the Chief Actuary, Social Security Administration, August 2020,

https://www.ssa.gov/OACT/NOTES/pdf_studies/study125.pdf; "Annual Statistical Report on the Social Security Disability Insurance Program, 2023," Social Security Administration, Office of Retirement and Disability Policy, October 2024, https://www.ssa.gov/policy/docs/statcomps/di_asr/2023/di_asr23.pdf; "The 2025 Annual Report of the Board of Trustees of the Federal OASDI Trust Funds," Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, Social Security Administration, June 18, 2025, https://www.ssa.gov/OACT/TR/2025/index.html; "Annual Statistical Supplement to the Social Security Bulletin," Social Security Administration, December 2024, https://www.ssa.gov/policy/docs/statcomps/supplement/2024/supplement24.pdf.

Given a range of uncertainties a similar estimate was not made for SSI.

[6] Social Security Act, Title II, §223. [42 U.S.C. 423]. https://www.ssa.gov/OP_Home/ssact/title02/0223.htm.

[7] "Dictionary of Occupational Titles (DOT) Library," US Department of Labor, Office of Administrative Law Judges, accessed August 1, 2025, https://www.dol.gov/agencies/oalj/topics/libraries/LIBDOT.

[8] Lisa Rein, "Social Security Denies Disability Benefits Based on List with Jobs from 1977," *Washington Post*, December 27, 2022, https://www.washingtonpost.com/politics/2022/12/27/social-security-job-titles-disabledapplicants-obsolete/

[9] Jeffrey Buckner, "Social Security Updates Occupations List Used in Disability Evaluation Process." SSA Blog, June 24, 2024, https://blog.ssa.gov/social-security-updates-occupations-list-used-in-disability-evaluationprocess/

[10] Blind claimants have a higher SGA level of $2,700. Both levels are indexed to wage growth.

[11] "Occupational Information Systems Project," Social Security Administration, accessed August 1, 2025, https://www.ssa.gov/disabilityresearch/occupational_info_systems.html.

[12] "Occupational Requirements Survey (ORS)," US Bureau of Labor Statistics, accessed August 1, 2025, https://www.bls.gov/ors/.

[13] "Strength and SVP 1–2: ORS Factsheet," US Bureau of Labor Statistics, accessed Month Day, 2025, https://www.bls.gov/ors/factsheet/strength-svp-1-and-2.htm.

[14] Kate Davidson, "Trump Administration Weighs Tighter Requirements for Disability Payments," *Wall Street Journal*, January 10, 2020, https://www.wsj.com/articles/trump-administration-weighs-tighter-requirementsfor-disability-payments-11578686424.

[15] Social Security Administration, "Appendix 2 to Subpart P of Part 404—Medical-Vocational Guidelines," accessed

September 10, 2025, https://www.ssa.gov/OP_Home/cfr20/404/404-app-p02.htm; and "DI 25025.035 Tables No. 1, 2, 3, and Rule 204.00," accessed September 10, 2025, https://secure.ssa.gov/apps10/poms.nsf/lnx/0425025035.

[16] Social Security Administration, "Appendix 2 to Subpart P of Part 404—Medical-Vocational Guidelines."

[17] There are many cases where the grid cannot direct a determination, particularly when non-exertional limitations are present.

[18] The potential impact of the regulation on SSI is unclear and not estimated here.

[19] Kate Davidson, "Trump Administration Weighs Tighter Requirements for Disability Payments." *Wall Street Journal*, January 10, 2020, https://www.wsj.com/articles/trump-administration-weighs-tighter-requirementsfor-disability-payments-11578686424.

[20] Authors estimates. See "Actuarial Study No. 125," Office of the Chief Actuary, Social Security Administration, August 2020, https://www.ssa.gov/OACT/NOTES/pdf_studies/study125.pdf; "Annual Statistical Report on the Social Security Disability Insurance Program, 2023," Social Security Administration, Office of Retirement and Disability Policy, October 2024, https://www.ssa.gov/policy/docs/statcomps/di_asr/2023/di_asr23.pdf; "The 2025 Annual Report of the Board of Trustees of the Federal OASDI Trust Funds," Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, Social Security Administration, June 18, 2025, https://www.ssa.gov/OACT/TR/2025/index.html; "Annual Statistical Supplement to the Social Security Bulletin," Social Security Administration, December 2024, https://www.ssa.gov/policy/docs/statcomps/supplement/2024/supplement24.pdf.

[21] Some individuals are concurrently eligible for both SSDI and SSI. For purposes of these estimates these individuals are included in the SSDI impacts.

[22] "Annual Statistical Report on the Social Security Disability Insurance Program, 2023," Section 1.B, Table 3, Social Security Administration, August 13, 2025, https://www.ssa.gov/policy/docs/statcomps/di_asr/2023/sect01b.html#table3

[23] "Annual Report of the Supplemental Security Income Program, 2024," Table IV.B9, Social Security Administration, May 30, 2024, https://www.ssa.gov/OACT/ssir/SSI24/ssi2024.pdf.

[24] Authors estimates using data from Table 3.22 in the SSA FY 2026 Congressional Justification as well as prior research.

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He analyzes the interactions across disability, retirement, and paid leave policy. Previously, he was deputy associate director at the Office of Management and Budget. Serving five administrations since 1990, Smalligan developed policies that have been incorporated into many pieces of legislation. In 2012, he was a visiting fellow at the Brookings Institution, where he analyzed the Social Security Disability Insurance program. Smalligan received a master's degree in public policy from the University of Michigan.

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APPENDIX E

EM - Emergency Message **Effective Date**: 03/25/2024

Identification Number:	**EM-24011 SEN**
Intended Audience:	All RCs/ARCs/ADs/FOs/TSCs/PSCs/OCO/OCO-CSTs
Originating Office:	ORDP OISP
Title:	**Change in Title II Overpayment Default Rate of Benefit Withholding**
Type:	EM - Emergency Messages
Program:	Title II (RSI)
Link To Reference:	See References at the end of this EM.

SENSITIVE – NOT TO BE SHARED WITH THE PUBLIC

Retention Date: October 25, 2024

A. Purpose

The purpose of this Emergency Message (EM) is to provide interim guidance and inform technicians that we are changing the existing policy and procedure for recovering a Title II overpayment. Policy has been to default to full benefit withholding to recover a Title II overpayment. Effective March 25, 2024, we will apply a default 10 percent withholding rate, or $10.00 per month, whichever is more, to an overpaid individual's monthly benefit amount. This policy change only applies to legally defined overpayments and does not apply to individuals who have been convicted of fraud or who have a similar fault determination.

B. Background

This update to SSA policy will reduce the financial hardship experienced by overpaid individuals, who are in full benefit withholding (i.e., LAF D) or repaying at a rate of greater than 10 percent, as well as individuals who will need to repay an overpayment

created on or after April 15, 2024.

C. New Procedure

When we determine that an individual receiving Title II benefits is overpaid, we will still send them a notice requesting a full and immediate refund, and inform them of their right to request a waiver of recovery or request a reconsideration of the overpayment. If the overpaid individual does not repay, request a waiver, or request a reconsideration prior to the end of the 60-day due process period, we will, in most cases, automatically recover the overpayment by withholding 10 percent of their Title II monthly benefit credited (MBC) amount, or $10 per month, whichever is more. We will recover the overpayment by withholding until the overpayment is fully recovered.

In most situations, technicians will not need to take manual action on new overpayments that are created on or after April 15, 2024. Most of the newly posted Title II overpayments will default to the 10 percent benefit withholding for recovery, on the first day of the July Current Operating Month (COM), which is June 26, 2024.

We will issue a one-time notice to all overpaid individuals, who are currently repaying an overpayment at a rate greater than 10 percent, giving them the option to request a lower rate of recovery. For manual overpayment notices requiring fill-ins, we will make corresponding updates to paragraphs in the Manual Adjustment, Credit, and Award Process (MADCAP) system, AURORA, and the Document Processing System (DPS). Technicians should use the applicable paragraphs for all new manual overpayment notices.

NOTE: All new overpayments will have a due process recovery date of COM plus three months, which replaces the existing policy of COM plus two months. Extending the due process recovery date will help SSA ensure that overpaid individuals are afforded the 60-day due process period, as well as provide Systems time to implement the actions required to align with the new policy. The change in due process recovery date of COM plus three months will apply to all future overpayments.

IMPORTANT: This policy change only applies to legally defined overpayments, as described in GN 02201.001, and does not apply to certain records or overpayments (see Section F.).

D. Guidance for New Overpayments Created on or After April 15, 2024

For most situations, technicians will not need to take manual action on new overpayments that are created on or after April 15, 2024.
The required $10.00 minimum withholding rate will remain in effect for most individuals. For examples on how the automatic 10 percent and $10.00 minimum withholding will be applied to new overpayments, see below:

- If the overpaid individual’s total monthly benefit credited (MBC) is $1,200.00, and

they do not have any Medicare involved, we will withhold $120.00 per month, which is 10 percent of their total monthly benefit.

- If the overpaid individual's total monthly benefit credited (MBC) is $50.00, and they do not have any Medicare involved, we will withhold $10.00 per month.

In some situations, technicians may need to complete manual inputs for withholding in the Debt Management System (DMS). For an example of when the 10 percent and $10.00 minimum withholding will not be applied automatically to a new overpayment, see below:

- If the overpaid individual's total monthly benefit credited (MBC) is $180.70, and they are paying a monthly SMI premium of $174.70, we must prioritize the beneficiary's Medicare premiums (i.e., Parts B, C, and D as explained in GN 02602.025C.3.). For this example, technicians will only input a recovery amount of $6.00 per month. In situations such as these, the $10.00 minimum will not apply since there is not enough money left to meet the minimum withholding requirement after deducting SMI.

There may be some situations, involving Medicare, where we are unable to input any overpayment recovery. See the below example:

- If the overpaid individual's total monthly benefit credited (MBC) is $50.70, and they are responsible to pay a monthly SMI premium of $174.70 (LESSDO cases), we will continue to prioritize the beneficiary's Medicare premiums (i.e., Parts B, C, and D as explained in GN 02602.025C.3.). Their full MBC of $50.70 will be applied towards the monthly SMI premium. In situations such as these, we will be unable to recover the overpayment.

If an overpaid individual contacts SSA requesting an overpayment recovery rate greater than 10 percent, accept the request and complete the input in DMS. Use the following remarks to annotate the request in DMS:

> "BIC XX requested benefit withholding reduction to <enter amount> on MM/DD/YY"

******** (Redacted Section)

E. Guidance for Existing Overpayments with a Recovery Rate Greater than 10 Percent

Overpaid individuals, who are repaying an overpayment with a recovery rate greater than 10 percent, will be given the option to request that we reduce their recovery amount to 10 percent, or $10.00 per month, whichever is more. Requests to reduce overpayment recovery amounts for ***existing*** overpayments will require manual inputs in DMS.

Overpaid individuals may request that we reduce their existing overpayment recovery rate by contacting the 800# or their local field office for assistance. Unless an exclusion applies (see Section F.), technicians should accept the request and annotate the MBR with a Special Message (SPMSG) using the below language. For guidance on creating a Special Message (SPMSG), please refer to MS 05206.026.

> "BIC XX requested benefit withholding reduction to default 10% on MM/DD/YY"

Technicians will manually calculate the 10 percent withholding amount that will be deducted from the overpaid individual's benefit.

*****(Redacted Section)

NOTE: The request for a 10 percent overpayment recovery rate will take priority over the recent change to procedure requiring the collection of overpayments within 60 months (GN 02210.030). In other words, individuals will default to 10 percent withholding even if the amount collected will not facilitate recovery within 60 months.

*****(Redacted Section)

NOTE: If the individual has a settlement agreement with the Office of the Inspector General (OIG) or the United States Attorneys' Office (USAO) and the overpaid individual, consult GN 02201.055 and GN 02230.055B.

Direct all program related and technical questions to your Regional Office (RO) support staff or Program Service Center (PSC) Operations Analysis (OA) staff. RO support staff or PSC OA staff may refer questions or problems to their Central Office contacts.

Reference:

- GN 02201.001 - What is a Title Overpayment
- GN 02201.009 – Notification of a Title II Overpayment
- GN 02201.050 – Overpayment Fraud Referral
- GN 02201.055 – Overpayment Recovery after Fraud Conviction
- GN 02210.001 – Overpayment Recovery by Benefit Adjustment
- GN 02210.030 – Request for Change in Overpayment Recovery Rate, Form SSA-634
- GN 02230.055 – Civil Monetary Penalty (CMP) – Posting

- MS 01106.015 – Establish Offset (Debtor) (DROA)
- MS 01106.016 – Establish Offset (OLP) (DROL)
- MS 05206.026 – Special Message (SPMSG)
- SM 00610.710 - Overpayment Recovery Will Continue Past 2049
- SM 00610.715 - Recovery of an Overpayment when the Overpaid Person is in Ledger Account File Status (LAF) Current Pay (C) or Deferred (D)

APPENDIX F

Emergency Message - Change to Title II Overpayment Default Benefit Withholding Rate to 50 Percent Withholding

Effective Dates:	08/28/2025 - Present
Identification Number:	EM 25029 REV
Intended Audience:	All RCs/ARCs/ADs/FOs/TSCs/PSCs/OCO/OCO-CSTs
Originating Office:	LP OISP
Title:	**Change to Title II Overpayment Default Benefit Withholding Rate to 50 Percent Withholding**
Type:	EM - Emergency Messages
Program:	Title II (RSI)
Link To Reference:	See References at the end of this EM.

Retention Date: 01/28/2026

Summary of Changes

Section B

- Updated the background for clarity.

Section C

- Clarified the policy.
- Updated the language for clarity.

Section D

- Moved previous information in section D to section E.
- Added instructions to address reconsideration requests for overpayment notices issued prior to April 25, 2025.

- Added instructions to address waiver requests for overpayment notices issued prior to April 25, 2025.

Section E

- Moved previous information from section D to this section.

A. Purpose

The purpose of this Emergency Message (EM) is to provide technicians with instructions for processing overpayment reconsideration and waiver requests after we changed the default Title II overpayment benefit withholding rate from 10 percent to 50 percent. In April 2025, we provided interim guidance and informed technicians that we changed our policy for the default 10 percent benefit withholding rate to recover a Title II overpayment. Effective April 25, 2025, overpayment notices provided a default Title II overpayment benefit withholding rate of 50 percent of the monthly benefit.

B. Background

When we determine an individual receiving Title II benefits is overpaid, we send them a notice requesting a full and immediate refund and inform them (among other information) of their right to request reconsideration or waiver of recovery. We do not begin withholding right away, which provides overpaid individuals time to request a reconsideration or waiver. We will withhold up to 50 percent of their Title II benefit payment (if there is no fraud or similar fault) until we fully recover the overpayment.

Any new Title II overpayment determination will have the default 50 percent benefit withholding rate automatically applied for overpayment notices sent beginning April 25, 2025, which was the first day of COM 05/2025. If an overpaid individual has a prior overpayment and incurs a new overpayment, all outstanding overpayments will default to the 50 percent benefit withholding rate once withholding for the new overpayment begins (unless a lower repayment rate is separately negotiated or there is fraud or similar fault). In addition, we have updated the Title II initial overpayment notice benefit withholding language. This language replaces 10 percent withholding with 50 percent withholding of the monthly payment beginning with notices sent on or after April 25, 2025.

C. Instructions for new overpayments

For most situations, technicians **do *not*** need to take manual actions on new overpayments that are created on or after April 25, 2025. The 50 percent benefit withholding will begin automatically without manual action.

If the overpayment warrants manual posting, you have two options for posting an overpayment manually to the individual’s record. You may use either the Manual Adjustment, Credit, and Award Data Entry (MACADE) system or the Debt Management

System (DMS). For more information about posting an overpayment via MACADE, refer to SM 00865.000. For more information about posting an overpayment via DMS, refer to MS 01102.003.

Once you have determined that we overpaid the individual, post the overpayment to their record with a recovery date (DPRD) of the COM plus 3 months (Using COM plus 3 months ensures all individuals have at least 60 days to appeal before withholding begins). You ***must*** notify the individual, in writing, by sending an overpayment notice. For information about the overpayment notice, refer to GN 02201.009.

When an overpaid individual has a prior overpayment and incurs a new overpayment, all outstanding overpayments will default to the 50 percent benefit withholding rate when withholding for the new overpayment begins (unless there is fraud or similar fault). If the individual contacts us to request a reconsideration or a waiver, we will stop collection activity until we make a determination on their request. Use the PCOPT6900 via Aurora in the initial overpayment notice.

The default 50 percent withholding rate applies to matured overpayments beginning COM 08/2025 and later (excluding fraud or similar fault and cross program recovery). If the 10 percent withholding rate was previously in place on the prior overpayment (because the relevant overpayment notice indicated the default withholding rate would be 10 percent), the 10 percent withholding rate applies to overpayment recovery actions through the COM 07/2025.

For any partial withholding requests, continue to follow normal processing procedures for 2073 cases as outlined in SM 00610.710, Overpayment Recovery Will Continue Past 2073.

Note: Upon processing a re-entitlement or reinstatement with a prior overpayment, remember to use the underpayment to reduce or recover the overpayment, if applicable.

Important: The 50 percent withholding rate does not impact Title XVI overpayment recovery policies. The Title XVI overpayment recovery rate will remain at 10 percent. For more information on Title XVI overpayments, refer to SI 02220.001. For more information on cross program recovery, refer to GN 02210.008.D and SI 02220.020A.7.

D. Individual requests a reconsideration or waiver of their overpayment

An overpaid individual or their representative may request a reconsideration if they disagree with the fact or amount of an overpayment. If we affirm the initial overpayment determination, review the date on the overpayment notice to determine when we issued the notice. If we issued a notice prior to April 25, 2025, they will retain the 10 percent withholding rate when we resume overpayment recovery unless they incur a new overpayment. If the overpaid individual incurs a new overpayment, all overpayments will default to 50 percent withholding as discussed in Sections A and B of this EM. If we

issued a notice of the overpayment on or after April 25, 2025, we will apply the default 50 percent rate.

When the 10 percent withholding rate applies, modify NL 00703.119, "Reconsideration Affirms Overpayment Determination (Reconsideration Only Requested)—Refund Requested and Adjustment Proposed" before sending the notice to the individual using these steps:

1. Select the 3100A or 3104B in the creation path, as applicable.

2. Review the notice universal text identifiers (UTIs) and remove the 3100A or 3104B, as applicable.

3. Add this language where you removed the 3100A using the applicable fill-ins in NL 00703.119.B: "*If we do not receive your refund within 30 days, we plan to recover the overpayment by withholding 10 percent of your total monthly benefit or $10 (whichever is more) starting with the payment you will receive about *F2. If the total benefit is less than $10, we will withhold the entire benefit. We will continue withholding benefits until we fully recover the overpayment.*" **OR**

Add this language where you removed the 3104B using the applicable fill-ins in NL 00703.119.B: "*To recover the overpayment, we will withhold 10 percent of the payment you will receive *F1 until we recover the overpayment. We will do this starting with the payment *F2 will receive on or about *F3.*"

4. After the #Signature UTI, add a new line using #CTenclosure, and select the Refund Envelope.

5. Review the notice to ensure the correct language and Refund Envelope enclosure appears.

6. Send the notice to print.

7. Annotate the reconsideration disposition on the DMS Fact/Amount Appeal Disposition (DRAD) screen, per MS 01106.011 and on the DMS Remarks (RMKS) screen, per MS 01109.003.

8. Add a special message on the MBR with the reconsideration determination per GN 03102.425.C.

9. Complete the SSA-662, Reconsideration Determination per GN 03102.450.

If we reverse the initial overpayment determination, refer to GN 03102.425.B and GN 02201.025.

An overpaid individual or their representative may request a waiver. If we deny the waiver request, review the date on the overpayment notice to determine when we issued the notice. If we issued the notice prior to April 25, 2025, they will retain the 10 percent withholding rate when we resume overpayment recovery unless they incur a new overpayment. If the overpaid individual incurs a new overpayment, all overpayments will default to 50 percent withholding as discussed in Sections A and B of this EM. We will also apply the 50 percent withholding rate when we resume recovery if we issued notice of the overpayment on or after April 25, 2025. For information on processing waiver requests, refer to GN 02250.000. Before you can deny a waiver, you must follow the instructions in GN 02270.000.

E. Instructions for individuals convicted of fraud and similar fault determinations

Technicians ***must*** thoroughly review the MBR, ROAR, DMS, and all other electronic files to determine if any of the following applies:

- Fraud conviction
- Similar fault determination
- Court-ordered restitution
- Civil monetary penalties

If the individual has been convicted of social security fraud, been ordered by a criminal court to pay restitution to SSA, or been imposed with civil monetary penalties, or if the agency has determined the individual committed similar fault in obtaining benefits, technicians ***must*** set the fraud indicator to "Y" (for yes), on the specific ROAR event involving fraud, similar fault, court-ordered restitution, or civil monetary penalties. For instructions on inputting the fraud indicator, refer to MS 01102.003.
If you are developing fraud or similar fault, do not set the fraud indicator to "Y." Instead, follow guidance outlined in GN 02201.050B and GN 02201.050C.

NOTE: If the individual has a settlement agreement with the Office of the Inspector General (OIG) or the United States Attorneys' Office (USAO), follow guidance outlined in GN 02201.055 and GN 02230.055B.

Direct all program and technical related questions to your management.

References:

GN 02201.009 – Notification of a Title II Overpayment

GN 02201.025 – Title II Overpayment Reconsideration Request

GN 02201.050 – Overpayment Fraud Referral

GN 02201.055 – Overpayment Recovery After Fraud Conviction

GN 02210.001 – Overpayment Recovery by Benefit Adjustment

GN 02210.008 – Cross Program Recovery (CPR) from Monthly Title II, Title VIII, and Title XVI Benefits to Recover Other Program Overpayments

GN 02210.030 – Request for Change in Overpayment Recovery Rate, Form SSA-634

GN 02230.055 – Civil Monetary Penalty (CMP) – Posting

GN 03102.425 – Reconsideration Notices of Determination

GN 02250.000 – Waiver Provisions for Title II and Title XVI Overpayments

GN 02270.000 – Personal Conference Procedures When Waiver Cannot be Approved - Table of Contents

MS 01106.011 – Fact/Amount Appeal Disposition (DRAD)

MS 01106.015 – Establish Offset (Debtor) (DROA)

MS 01106.016 – Establish Offset (OLP) (DROL)

MS 01109.003 – Remarks (RMKS)

SI 02220.020 – Cross Program Recovery (CPR) of SSI Overpayments from Monthly Title II Benefits

STETSON LAW

2025 National Conference on Special Needs Planning and Special Needs Trusts

2025 Supplemental Security Income (SSI) Program Update

Presented by Ken Brown
and
Jennifer Burdick

October 23, 2025

STETSON UNIVERSITY

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Outline of Today's Presentation

SSA Program Update

- New SSI Trust Policy – Undue Hardship Exceptions
- Regulations - Proposed Rule Changes
  - Rescind the Burdensome Use Restrictions of Dedicated Accounts
  - ISM - Recission of Changes to the Definition of a Public Assistance Household
  - Disability Mega-Reg
  - Changing SSA Waiver of Overpayment Recovery Rules and Title II Overpayment Withholding Rate

2

New SSI Trust Policy – Exceptions for Undue Hardship

3

New SSI Trust Policy – Undue Hardship

Section 1613(e) of the Social Security Act sets forth rules for counting trusts as resources along with exceptions to those rules if a trust meets one of the Medicaid trust exceptions.

When a trust does not meet a Medicaid trust exception, SSA has the authority to waive applying the rules when such application would cause an undue hardship to the individual in certain circumstances.

4

Undue Hardship - Deprivation of Food or Shelter and Limited Funds

Traditional Undue Hardship

For purposes of the trust provisions of section 1613(e) of the Act, undue hardship exists in a month if:

- failure to receive SSI payments would deprive the individual of food or shelter; and
- the individual's available funds do not equal or exceed the Federal benefit rate (FBR) plus any federally administered State supplement.

Note: Inability to obtain medical care does not constitute undue hardship for SSI purposes, although it may under a State Medicaid plan.

5

New Undue Hardship Exceptions

On August 26, 2025, SSA issued Transmittal 104 to POMS SI 01120.203, Exceptions to Counting Trusts Established on or after January 1, 2000. The transmittal contains three new exceptions to counting a trust as a resource based on undue hardship. These exceptions relate to:

- a trust that contains funds in a Medicare Set-Aside Arrangement (MSA) for purposes of compliance with the Medicare Secondary Payer (MSP) Act;
- an SSA error results in a trust deficiency that cannot be remedied; and
- a policy-compliant special needs trust or a subaccount of a policy-compliant pooled trust is transferred to a noncompliant pooled trust or special needs trust and the trust beneficiary is not responsible for the transfer.

6

Medicare Set-Aside Arrangement (MSA)

Undue Hardship

Undue hardship exists if a trust containing funds in a Medicare Set-Aside Arrangement (MSA) would be a countable resource under section 1613(e) and the MSA funds may only be used for certain medical expenses consistent with the Medicare Secondary Payer (MSP) Act.

Medicare Secondary Payer (MSP) Act

Under the MSP Act, Medicare may not pay for a beneficiary's medical expenses when payment has been made (or can reasonably be expected to be made) under a workers' compensation law or plan, an automobile or liability insurance policy or plan, or under no fault insurance (see 42 U.S.C. § 1395y(b)(2)(A)(ii)).

7

Medicare Set-Aside Arrangement (MSA)

- An MSA is a financial agreement that allocates a portion of an award, judgment, or settlement to pay for all future medical expenses related to the relevant injury or illness, for purposes of complying with the MSP Act.
- The use of the MSA funds must be legally restricted to such medical expenses that are covered and otherwise reimbursable by Medicare.
- The funds must also be depleted before Medicare will pay for future Medicare-covered expenses related to the individual's relevant injury or illness that exceed the set-aside amount.
- There may be cases in which funds in an MSA are placed in a trust.

8

Application of the Undue Hardship Waiver

SSA will apply undue hardship under this provision with respect to the portion of a trust containing an MSA when **all of the following 5 criteria** are met:

- An MSA is established for the benefit of the SSI applicant or recipient or their spouse.
- Funds in the MSA are placed in a trust or the MSA is administered by a third party such that it is considered a legal instrument or device similar to a trust (see SI 01120.201G).
- The trust (or legal instrument or device similar to a trust) containing the MSA funds would be a countable resource under section 1613(e) and results in the individual's ineligibility for SSI due to excess resources.

9

Application of the Undue Hardship Waiver

- The MSA contains the necessary legal restrictions on the use of the MSA funds for certain medical expenses (i.e., medical expenses related to the relevant injury or illness that would be covered by Medicare).
- The individual signs a statement for the file and submits all relevant documentation related to the MSA, including documentation that shows how the MSA was created and that the MSA contains the necessary legal restrictions on the use of the MSA funds.

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How the Exception Works

- The portion of a trust containing an MSA is not counted as a resource under section 1613(e) **in any month** for which counting it would cause undue hardship under this application.
- Resource counting **resumes** for any month(s) for which it would not result in undue hardship, such as if the MSA was dissolved or depleted or the legal restrictions on the use of MSA funds to certain medical expenses were removed.
- **Undue hardship is a month-by-month determination**; however, this application only requires reviews periodically.
  - The MSA may be reviewed during periodic reviews of the record, such as **redeterminations**, and
  - **The individual is responsible to notify SSA** if there is any change regarding the MSA consistent with their reporting responsibilities.

11

Agency Error Resulted in Uncorrectable Trust Deficiency

SSA will apply undue hardship under this provision when **all of the following 6 criteria** are met:

- There is an error by SSA;
- The trust has a deficiency that would result in the trust's being a countable resource under section 1613(e);
- There is a clear causal connection between SSA's error and that trust deficiency;

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Agency Error Resulted in Uncorrectable Trust Deficiency

- The trust deficiency does not result in a potential benefit that substantially reduces the hardship to the individual;
- The trust deficiency cannot be corrected; and
- Substantive relief cannot otherwise be provided.

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How the Exception Works

- The irrevocable trust is not counted as a resource under section 1613(e) **in any month** for which counting the trust would cause undue hardship under this application.
- Resource counting under section 1613(e) **resumes** only if the circumstances change such that the criteria under this section are no longer satisfied.
  - **The individual is responsible for notifying SSA** if there is any change regarding the trust consistent with their reporting responsibilities.
  - Although undue hardship is a month-by-month determination, this application **does not require monthly or periodic reviews** due to the criteria.

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Example

- A thirty-year-old SSI recipient received a $7,000 inheritance and established an irrevocable special needs trust through their legal guardian, who is also their spouse and representative payee (RP). The trust was intended to meet a Medicaid trust exception and was reported to the field office.
- The Claims Specialist (CS) determines that the trust is a countable resource because it contains a noncompliant early termination provision.
- However, the CS does not issue a notice (as required under SI 01120.204) that explains the problematic provision in the trust and the policy regarding it.

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Example (Continued)

- The RP requests reconsideration and asks why the trust does not meet the Medicaid trust exception. The field office simply affirms the initial determination and states the trust is countable without explaining or providing the notice required by policy.
- The RP appeals the decision to an ALJ and attempts to fix the trust; the amended trust doesn't resolve the early termination issue. The ALJ decides the trust is still noncompliant due to its deficient early termination provision, notes the applicable policy, and finds it is a countable resource.
- The RP realizes the trust's deficiency upon reading the ALJ's decision; but the recipient passes away two weeks later, and the trust can not be amended.

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Explanation of Example

- In this example, the SSA error was the field office's failure to provide the proper notice required by policy.
- The RP tried to determine the trust's deficiency and amended the trust; however, the RP didn't have an explanation as to what provision of the trust was problematic or what policy was at issue, so the amendment didn't correct it, which is the causal connection between the error and the trust's deficiency.
- There is no indication that the trust deficiency resulted in a potential benefit that substantially reduced the hardship to the individual.
- Finally, due to the recipient's death, the trust can no longer be amended and there is no way to provide substantive relief other than through this undue hardship provision.

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Assets Transferred Upon Early Termination from a Compliant Pooled Trust or Special Needs Trust to a Noncompliant Pooled Trust or Special Needs Trust

Undue hardship exists, in certain circumstances, when:

- upon early termination;
- assets in a pooled trust subaccount or a special needs trust that was previously determined to be policy-compliant;
- are transferred to a noncompliant pooled trust or special needs trust; and
- the beneficiary is not responsible for the transfer.

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Application of the Undue Hardship Waiver

SSA will apply undue hardship under this provision when **all of the following 3 criteria** are met:

- A pooled trust subaccount or a special needs trust was previously determined to meet a Medicaid trust exception and not to be a countable resource (under SI 01120.203 and SI 01120.200).
- The assets in the pooled trust subaccount or special needs trust are transferred to a secondary pooled trust or special needs trust that is intended to meet a Medicaid trust exception (see SI 01120.203), but the secondary trust was not previously evaluated and is subsequently determined to be noncompliant with trust policy.

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Application of the Undue Hardship Waiver

- The SSI applicant or recipient is not responsible for the transfer to the secondary, noncompliant trust or the circumstances related to the early termination and the transfer.

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How the Exception Works

The secondary irrevocable trust is not counted as a resource under section 1613(e) (see SI 01120.201) due to undue hardship for 120 days in order to allow the trust to be amended or the assets to be transferred to a policy-compliant trust.

- The 120-day period begins on the day SSA informs the applicant, recipient, or representative payee via written notification that the secondary trust contains provisions that must be amended in order to qualify for a Medicaid trust exception.
  - If the written notification is mailed, instead of hand-delivered, then the applicant, recipient, or representative payee is considered to be informed five days after the mailing date.
  - SSA permits a good cause extension if it is requested with evidence that the disqualifying issue cannot be resolved within the 120-day period (for example, if a court must amend the secondary trust and there is a waiting period to get on the court docket).

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How the Exception Works

Undue hardship is a **month-by-month determination**; however, this application **only requires a review when the 120-day period (plus any good cause extension) expires**.

If the secondary trust is not amended to conform with the trust policy requirements or the assets are not transferred to a policy-compliant trust within 120 days (plus any good cause extension), then undue hardship under this provision will no longer be met and resource counting of a trust will generally resume, subject to our policy, **at the beginning of the following month.**

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REGULATIONS - Proposed Rule Changes:

Rescind the Burdensome Use Restrictions of Dedicated Accounts

23

Rescind the Burdensome Use Restrictions of Dedicated Accounts

- SSA is proposing to update its dedicated account policy to allow these funds to be used for "current maintenance."
- This is a significant and welcome development.

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What are Dedicated Accounts?

- Created in 1996 as part of the Personal Responsibility and Work Opportunity Act.
- When a child receives more than six-times the federal benefit rate, (appx. $5,800 in 2025) in past-due benefits, that child's parent/payee **must** open a separate bank account before they can receive any of that back payment.
- Once the account is established, the money in the account can only be used on a narrow list of expenses (excluding most daily expenses). Those restrictions remain even after the child reaches the age of 18.
- SSA Act Section 1631(a)(2)(F); 20 C.F.R. 416.640(e)

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Dedicated Accounts: Narrow Expenditures

Permissible
- Medical treatment
- Education
- Job skills training
- Personal needs equipment or special equipment
- Housing modification
- Therapy
- Rehabilitation
- **Other items and services related to the impairment**

Not permissible:
- Items or services not listed
- Repayment of OPs
- **Basic maintenance costs (food, housing clothing and personal items) not related to child's impairment.**

The Social Security Act at 1631(a)(2)(F); POMS GN 00602.140

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Dedicated Accounts: Closely Monitored

"Must Monitor"

- GN 00602.140 says SSA "must monitor" the payee's use of dedicated accounts, thus requiring retention of all receipts of deposits to and expenditure from the account.
- **Form SSA-6233:** 8 page report required of payees annually to justify deposits to and expenditures from the dedicated account.
- **Individualized inquiries:** SSA encourages parents/payees to ask in advance before making an expenditure in the "other" category--what is allowed is discretionary, varies a lot, and not typically reviewable.
- SSA estimates it costs them *at least* 4 million dollars to monitor dedicated accounts. Office of Inspector General, *Dedicated Accounts for Supplemental Security Income Recipients,* SSA, A-04-21-51031 at 2 (Sept. 2023).

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Dedicated Accounts: Outdated

- No updates since 2011.
- Six prior SSA Commissioners have called for their elimination—Commissioner Astrue described them as "labor intensive and confusing to the public."
- Senate Finance Committee recommended broadening the expenditures as far back as 2003.
- Defines "disability expenses" in a manner that is inconsistent with the ABLE Act of 2014 and the ABLE Age Adjustment Act (2023).

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Obstacles Related to Dedicated Accounts

- **Access to banking:** The account must be a checking, savings, or money market account at a financial institution and must be separate from the account receiving monthly SSI benefits for the same child.
- **Installment policy:** past-due benefits are subject to SSA installment rules (meaning if they get more than 3x FBR, benefits are paid out in 3 installments over 18 months). If parents cannot prove proper use of one installment, SSA won't release the next one.
- **Lack of information:** to families regarding proposed expenditures.
- **Bias:** Overly narrow interpretation of the POMS regarding use of funds.
- **Duration:** Narrow expenditure limits continue even after the child reaches majority.

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Obstacles Related to Dedicated Accounts

High Error Rate:
September 2023 OIG report indicates that SSA did not accurately and timely pay dedicated funds in 86 out of the 100 sampled children. They estimate SSA did not:

- Accurately pay $27 million in dedicated funds to 5,100 children.
- Timely pay $305 million in dedicated funds to representative payees of 50,000 children.

2010 OIG report reported that SSA **withheld about $35 million in past-due benefits** to kids because they did not confirm establishment of a dedicated account.

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Obstacles Related to Dedicated Accounts

Very Burdensome to Administer:

- Due to high-risk of error, **SSA requires employees to manually review cases before releasing past-due dedicated funds.**
- SSA monitors these accounts by soliciting and reviewing SSA-6233-BK forms, where parents annually documents all deposits to and expenditures from dedicated accounts.
- Also, families are encouraged to ask SSA staff before making purchases by calling or visiting Field Offices.
- **2023 GAO report indicates SSA spends $ 4 million a year monitoring these accounts**
- In 2003, Commissioner Barnhart estimated that eliminating dedicated accounts would save $25 million over 10 years

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SSA Proposal to Update Dedicated Accounts

- Spring 2025 Unified Agenda of Regulatory and Deregulatory Actions
- RIN 0960-A192
- SSA is proposing to update the regulations to allow recipients and representative payees to use these funds for "the recipient's current maintenance."
- Notice of Proposed Rulemaking (NPRM) currently noted as April 2026.

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In-kind Support and Maintenance (ISM) Policy - Recission of Changes to the Definition of a Public Assistance Household

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Recission of Changes to the Definition of a Public Assistance Household

What is ISM?

Support and maintenance is not defined in the Social Security Act.

- SSA now defines it in regulations at 20 CFR 416.1130(b) as "any **shelter** that is given to you or that you receive because someone else pays for it."
- Prior to September 30, 2024, ISM included receipt of "any **food or shelter**."
- Prior to March 9, 2005, support and maintenance included the receipt of **food, clothing or shelter**.

It is considered income because someone else, either within or outside of the individual's household is paying for it.

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Recent SSA Regulatory Actions

In 2024, SSA published 3 final regulations dealing with ISM that were effective on September 30, 2024.

- SSA modified regulations at 20 CFR 416.1130(b) to **omit food** from the calculations of In-kind Support and Maintenance.
- SSA revised 20 CFR 416.1130 to **modify the definition of when a "business arrangement**" exists from one where the amount of monthly required rent equals or exceeds the current market rental value to one where the amount of monthly required rent equals or exceeds the Presumed Maximum Value (PMV).
- SSA adopted 3 changes in 20 CFR 416.1142(a):
  - Revised the definition of "public assistance household" to clarify that this is a term of art and only applies to SSA programs.
  - **Added Supplemental Nutrition Assistance Program (SNAP) to the list of Public Income Maintenance (PIM) programs.**
  - **Changed the definition of a PA household to one which has both an SSI recipient or applicant and at least one other household member receiving a listed PIM payment.**

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Public Assistance (PA) Household Policy

SSA assumes that an applicant or recipient who lives in a PA household does not receive any ISM from other household members. Therefore, an SSI applicant or recipient who lives in a PA household cannot be subject to the Value of the One-Third Reduction (VTR) rule.

A **PA household** is one that contains a Supplemental Security Income (SSI) applicant or recipient, and at least one other household member who receives one or more of the listed public-income maintenance (PIM) or PA payments.

PIM payments (or PA payments) are payments made under:

- Title IV-A of the Social Security Act—**Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF);**
- Title XVI of the Social Security Act (**SSI**, including federally administered State supplements and State administered mandatory supplements);
- **The Refugee Act of 1980** (payments based on need)
- **The Disaster Relief and Emergency Assistance Act**;
- **General assistance programs of the Bureau of Indian Affairs;**
- **State or local government assistance programs based on need;**
- **U.S. Department of Veterans Affairs programs** (payments based on need); or
- Effective only as of 09/30/2024 - **The Supplemental Nutrition Assistance Program (SNAP).**

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Justification for the 2024 Policy Change

Since the creation of the SSI program in 1972 and establishment of the PA household policy in 1980, the landscape of means-tested public benefit programs has changed significantly.

- Aid to Families with Dependent Children (AFDC) (entitlement) replaced by Temporary Assistance to Needy Families (TANF) (block grant) in 1997.
- Between 1980 and 2022 there was an 82% decrease in AFDC/TANF recipients.
- There was an 81% decrease in VA needs-based pensions over the same period.

- 100% increase in Supplemental Nutrition Assistance Program (SNAP) recipients.
- 70% increase in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) recipients.
- 75% increase in Medicaid recipients.
- 65% increase in HUD housing assistance recipients.
- Low Income Home Energy Assistance Program (LIHEAP) recipients fluctuates, but generally up.
- For comparison - 50% increase in SSI recipients.

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Bonus Time - Deeming

- "Deeming" is the process of considering a portion of another person's income to be the income of an SSI applicant or recipient.
- SSA's current policy excludes from deeming the amount of any public income-maintenance (PIM) payments an ineligible parent or spouse receives under the programs listed in the PA household definition, any income that those programs counted or excluded in determining the amount of the PIM payments they received, and any income of the ineligible spouse or parent that is used by a PIM program to determine the amount of that program's benefit to someone else.
- Adding SNAP to the list of PIM payments will decrease the amount of income that is deemed to SSI recipients from an SSI-ineligible spouse or parent who is receiving SNAP benefits, any income that was counted or excluded in figuring the amount of the SNAP benefits would not be deemed to the SSI applicant or recipient.

09/26/24 – POMS SI 01320.141 Deeming: Public Income Maintenance Payments

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Recission of Changes to the Definition of a Public Assistance Household

As part of the Spring 2025 Unified Agenda, SSA announced its intent to rescind the regulatory changes to the definition of a public assistance (PA) household. The Abstract of the proposal reads:

> We propose to rescind the final rule *Expand the Definition of a Public Assistance Household* (final rule), by removing the Supplemental Nutrition Assistance Program (SNAP) from the list of public income maintenance (PIM) payments. We further propose to adopt our former longstanding definition of a *public assistance household*, according to which every household member has to receive a PIM payment for the household to constitute a public assistance household. We propose to revert to our former policy to **promote program integrity** and **because the benefits derived from the final rule do not outweigh the significant burdens and costs associated with its implementation**.
>
> The benefit of deregulation would be increased program integrity. Additionally, **rescission of the final rule would be appropriate under E.O. 14219 secs. 2(a)(iv)**.

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Recission of Changes to the Definition of a Public Assistance Household

Based on statements made in the Abstract, the policy change is being rescinded because it is perceived to cost too much.

Regulatory Change	Program Costs FY 2023-2033	Administrative Costs FY 2024-2033
Omit Food as ISM	$1.6 billion	$26 million savings*
Rental Subsidy Change	$837 million	$10 million savings*
PA Household Change	$15 billion	$83 million cost

* Partially offset by implementation costs.

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Recission of Changes to the Definition of a Public Assistance Household

IMPACT OF THE CHANGE

Based on SSA estimates published in support of the regulation change, rescission of the regulation will have the following impacts:

- Roughly 277,000 Federal SSI recipients (4 percent of all SSI recipients) will have a decrease in monthly payments compared to current rules, and
- An additional 109,000 individuals (1 percent) will be ineligible for Federal SSI payments they would have been eligible for under current rules.

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EXECUTIVE ORDER 14219

Sec. 2. Rescinding Unlawful Regulations and Regulations That Undermine the National Interest.

(a) Agency heads shall, in coordination with their DOGE Team Leads and the Director of the Office of Management and Budget, ... review all regulations ... for consistency with law and Administration policy [and] identify the following classes of regulations:

(iv) regulations that implicate matters of social, political, or economic significance that are not authorized by clear statutory authority;

(d) The Administrator of [the Office of Information and Regulatory Affairs] OIRA shall consult with agency heads to develop a Unified Regulatory Agenda that seeks to rescind or modify these regulations, as appropriate.

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Statutory Authority for Regulations

Three sections of the Social Security Act give the Commissioner of Social Security broad statutory authority to issue regulations.

Sec. 205. [42 U.S.C. 405] (a) The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

Sec. 1631 [42 U.S.C. 1383] (d)(1) The provisions of section 207 and subsections (a), (d), and (e) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.

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Improvements to the Disability Adjudication Process: Sequential Evaluation Process (Disability Mega-Reg)

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Improvements to the Disability Adjudication Process: Sequential Evaluation Process (Mega-Reg)

- Proposed Rule 0960-AI10 (the Mega-Reg)
- Vague description: "We are proposing improvements to the disability adjudication process to ensure our disability program remains current and can be more efficiently administered. This includes proposing policy updates to occupational data sources and optimizing their use to serve our customers and preserve the trust funds."
- NPRM expected December 2025.

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Mega-Reg

Experts believe this proposal contemplates:

- Updating outdated occupational data; and
- Changing how SSA treats critical factors such as:
  - Age;
  - Education and experience;
  - The definition of "substantial gainful activity."

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Mega-Reg: Impact

Estimates are that it will reduce the SSDI program by between 20-30%, with the impact on SSI less clear.

What does this mean?

- Reducing SSDI eligibility by 10% would mean 500,000 losing SSDI benefits over 10 years, including 80,000 widows and children. Additionally 250,000 would lose benefits for part of the 10 years.
- **Possibly the largest decrease in eligibility in the programs history.**

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Mega-Reg Occupational Data

- Dictionary of Occupational Titles (DOT) hasn't been updated since 1992.
- SSA has had an agreement with the Bureau of Labor Statistics Occupational Requirement Survey (ORS) since 2012 to update it.
- Data is not the same – any update would require some policy changes.

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Mega-Reg: Substantial Gainful Activity

Touchstone of disability analysis.

Defined by 20 CFR 404.1572

- (a) "substantial work activity" = "work that involves doing significant physical or mental activities."
- (b) "gainful" = "that you do for pay or profit."

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Mega-Reg: Substantial Gainful Activity

How is SGA measured?

- By value:
  - 2025 for non-blind individuals SGA = $1620/month
  - 2025 for blind individuals SGA = $2700
- Social Security policy also looks at time.
  The ability to work in an **ordinary (unaccommodated) work setting, for 8 hours a day, 5 days a week**, or an equivalent work schedule. SSR 96-8p; POMS DI 24510.057.

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Mega-Reg: Other Factors

Section 223(d)(2)(A) and **Section 1614(a)(3)(B)** of the Social Security Act specify that:
An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work **but cannot, considering his age, education,** and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work . . .

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Age: GRIDS

SSA has guidelines that use a GRID to consider how age, education, and work experience impacts the ability to transition to new work.
Age plays a critical role. Age classifications:

- Younger person (under 50)
- Closely approaching advanced age (50-54)
- Advanced age (55-59)
- Closely approaching retirement age (60 and older)

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Age: GRIDS

Policy currently recognizes that older individuals face barriers transitioning to new work:

- Person A: limited education, no transferrable skills, can do sedentary work, and is 35 = not disabled.
- Person B: Person A: limited education, no transferrable skills, can do sedentary work, and is 55 = disabled.

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What's Next?

On Oct. 5, 2025, Washington Post published an article describing this rule, including changing how age is a factor in disability adjudications from sources within SSA: https://wapo.st/4h0SAIM

The White House responded by denying there will be any changes to the disability adjudication in Newsweek on October 6, 2025: https://www.newsweek.com/white-house-responds-to-social-security-change-report-10832069. Notably, the White House spokesperson's categorical denial is at odds even with SSA's statement in the same article, noting SSA is looking to propose "policy updates to occupational data sources and optimizing their use to serve customers and preserve the trust fund."

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Changes in Title II Overpayment Recovery

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Changes in Overpayment Recovery

When SSA determines that an individual receiving Title II benefits is overpaid, they send them a notice requesting a full and immediate refund, and inform them of their right to request a waiver of recovery or request a reconsideration of the overpayment.

If the overpaid individual does not:

- repay,
- request a waiver, or
- request a reconsideration

prior to the end of the 60-day due process period, SSA will, in most cases, automatically recover the overpayment by withholding a percentage of their Title II monthly benefit credited amount. They will recover the overpayment by withholding until the overpayment is fully recovered.

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Changes in Title II Overpayment Recovery

On March 25, 2024, SSA issued Emergency Message (EM) 24011.

Effective on that date, SSA decreased the default Title II overpayment recovery withholding rate from 100 percent of the monthly Social Security benefit to 10 percent of the benefit or $10, whichever is greater.

NOTE: Section 1631(b)(1)(B) of the Social Security Act generally provides that the rate of adjustment of payment to recover SSI overpayments will be the lesser of:

•Ten percent of the recipient's total monthly income (countable income plus SSI and State supplementary payment)(usually equal to the FBR); or

•The recipient's entire monthly benefit.

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Changes in Title II Overpayment Recovery

On April 25, 2025, SSA issued Emergency Message (EM) 25029 (reissued as EM 25029 REV on August 28, 2025).

Effective on that date, SSA increased the default Title II overpayment recovery withholding rate from 10 percent of the monthly Social Security benefit to 50 percent of the benefit.

Certain recovery payments are not eligible for the 50 percent rate, e.g., situations of fraud or similar fault, misuse of benefits, and penalties.

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Changes in Title II Overpayment Recovery

EM 25029 REV states that "[i]f an overpaid individual has a prior overpayment and incurs a new overpayment, **all outstanding overpayments will default to the 50 percent benefit withholding rate once withholding for the new overpayment begins** (unless a lower repayment rate is separately negotiated or there is fraud or similar fault).

The 50 percent withholding rate applies to matured overpayments beginning **[08/25] and later** (excluding fraud or similar fault and cross program recovery). If the 10 percent withholding rate was previously in place on the prior overpayment (because the relevant overpayment notice indicated the default withholding rate would be 10 percent), **the 10 percent withholding rate applies to overpayment recovery actions through [07/25]."**

Additionally, if SSA issued an overpayment notice prior to April 25, 2025, the individual will **retain the 10 percent withholding rate unless they incur a new overpayment**. If they incur a new overpayment, all overpayments will default to the 50 percent withholding.

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Changes in Title II Overpayment Recovery

Request for a Lower Rate

If a beneficiary requests a repayment plan with a rate lower than 50%, a representative will approve the request if it allows recovery of the overpayment within 60 months – a recent 2-year increase from the previous policy of only 36 months. If the beneficiary's proposed rate would extend recovery of the overpayment beyond 60 months, the individual must complete an SSA-634 form (income, resource, and expense summary) in order for SSA to make a determination.

EM-24011 E. stated in the NOTE that:
"The request for a 10 percent overpayment recovery rate will take priority over the recent change to procedure requiring the collection of overpayments within 60 months (GN 02210.030). Individuals will default to 10 percent withholding even if the amount collected will not facilitate recovery within 60 months."

EM-25029 REV does not address this issue with the new withholding rate, so I will assume that this policy will continue.

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Withdrawal of Proposed Regulatory Changes

Beginning with the Fall 2022 version of the Unified Agenda of Regulatory and Deregulatory Action, SSA listed a proposed regulations change to simplify regulations related to overpayment recovery and make the overpayment waiver process simpler. The Abstract from the Fall 2024 version of the Unified Agenda reads:

> We propose to revise our rules relating to recovery of overpaid Social Security payments or benefits ("overpayment debt"). We propose to codify simplifications to procedures for demonstrating eligibility for waiver of recovery of overpayment debt. We also propose to explain our default rate of withholding when recovering overpayments from Title II benefit payments.
>
> In addition, we are conducting a broad review of overpayment policies and may propose further revisions as a result of the review. Our overall goal is to ensure that overpayment recovery does not unduly burden those in underserved, vulnerable, or marginalized communities.

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Withdrawal of Proposed Regulatory Changes

In the Spring 2025 version of the Unified Agenda, the Trump Administration has deleted the long-term proposal to simplify the overpayment and waiver process with no explanation.

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2025 Supplemental Security Income (SSI) Program Update

Questions?

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Thursday
October 23, 2025

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Sex, Drugs, and Rock & Roll

Atypical Beneficiary Distribution Requests

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Megan Brand, Executive Director
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"Cause it's always been a matter of trust!" Billy Joel, "Matter of Trust," *The Bridge* (1986)

Introduction

Trustees have a daunting task when considering discretionary distributions from a trust. Most requests are fairly standard and follow a somewhat predictable pattern. However, just as quickly as the fiduciary feels that they have seen it all, they receive a request that puts them in unchartered waters, often outside of their comfort zone. When we couple discretionary distribution requests with ever-changing trust laws and public benefits regulations, a fiduciary can quickly become perplexed. Rash decisions, inaction, or action contrary to current case law can subject the fiduciary and their beneficiary (as well as the financial assets of both parties) to enhanced scrutiny and potential litigation.

Even exemplary trustees and their counsel may have to deny certain discretionary distribution requests. But there are often alternatives to outright denial or petitioning a court for instruction. Our overall mission as fiduciaries should be to come up with solutions that make the most financial sense for our beneficiaries[1] while promoting independence and empowering them to lead fulfilling lives.

[1] Throughout this paper, the authors use the terms "beneficiary" or "beneficiaries." For brevity, the authors have chosen not to add "protected person," "ward," or "principal" where "beneficiary" or "beneficiaries" is used. Please be advised that the case law and statutory authority pertaining to a request by a beneficiary, protected person, ward, or principal may differ slightly or greatly depending on the fiduciary relationship of Trustee/Beneficiary, Conservator/Protected Person, Guardian/Ward, and Principal/Agent.

A trustee or fiduciary is charged with many responsibilities and tasks, but above all else, a fiduciary has the duty of loyalty to the beneficiary. This duty is especially relevant in the administration and drafting of Special Needs Trusts (SNT), also known as Disability Trusts or Supplemental Needs Trusts.

SNT trustees are fortunate to advocate for one of the most underserved but most deserving populations in the country. SNT trustees can make a truly significant and tangible difference in their beneficiaries' lives. But the ever-changing public benefits landscape, audit requirements from state and federal agencies, new tax regulations, and liability risk can be complex and overwhelming. That's in addition to serving a diverse clientele that requires and deserves a hands-on approach.

In this paper, the authors aim to share lessons we've learned in our duty as drafters, planners and fiduciaries. This paper will address how and from whom discretionary distribution requests are made, sole benefit impact, discretionary distribution language drafting and implications, beneficiary expectation setting, distribution funding mechanisms and beneficiary-specific lifetime budgetary planning.

I. "I woke up in a SoHo doorway, a policeman knew my name." The Who, "Who Are You" (*title track*), (1978)

Framework Development

Using a framework for the evaluation of discretionary distributions maintains consistency and fairness to the beneficiary and facilitates/enables recordkeeping in the event of discovery. Never

forget that the primary duties of any fiduciary are loyalty and impartiality. Such a framework, however, does not necessarily mean that similar requests from different beneficiaries, or even from the same beneficiary at different times, will result in the same outcome. Each beneficiary and their unique circumstances must be evaluated.

For each beneficiary request, one of the first steps is determining its appropriateness for the individual. It is helpful if the fiduciary knows the beneficiary and their circumstances well. However, should the fiduciary not be able to personally evaluate the needs of the individual, a case/care manager, trust protector/advisor, investment advisor or CPA may be asked to do so. Often, a fiduciary may rely on recommendations from a beneficiary's family member or close friend. Both fiduciaries and drafting attorneys must take extra care to maintain the confidentiality of the beneficiary's protected information and to avoid inadvertently violating attorney-client privilege. However, there may be times when it is in the beneficiary's best interests to waive attorney-client privilege so that the fiduciary can better meet the beneficiary's needs. In these cases, the fiduciary and attorney should fully advise the beneficiary on the implications of waiving attorney-client privilege and potentially ask them to sign a written waiver.

A fiduciary should document all facets of the discretionary distribution request and decision-making process; the who, what, why and when. One of the most telling pieces of information in any situation is who made the request. For example, if a new "player" suddenly enters the life of the beneficiary, this could be one of the first signs of exploitation or undue influence. As we know, most fiduciaries are employed to prevent the exploitation of a vulnerable population, such as the aging, people with disabilities or incapacitated persons. Note that most fiduciaries are mandatory reporters of potential elder abuse (a term which includes abuse of people with disabilities).

The *what and why* are equally important factors in the decision making process. Consider this example from one of our practices:

> A trust beneficiary called his trustee and requested a sex reassignment surgery. Rather than simply deny the request, the trustee began to ask questions. He learned that the beneficiary wanted to become a female because he wanted to live on the main floor of his home. The trustee was surprised to hear this because the beneficiary had always lived on the main floor of his trust-owned home. The trustee probed further and learned that the beneficiary had recently taken in two female roommates, who had told him he had to live in the basement because only women could live on the main floor. The beneficiary's proposed solution was to have a sex reassignment surgery. The trustee evicted the female roommates, and the beneficiary was again allowed to live on the main floor of his home.

Accordingly, it is always a good idea to ask more questions when a trustee receives a request that seems out of the ordinary because there may be circumstances under the surface that need to be discovered. So take the time to ask about the what and the why behind the request in order to learn more.

When the request is made or how frequently it is made is another important factor. Time is one of the best tools for a fiduciary or attorney advising a fiduciary. Following an initial conversation regarding a request, a beneficiary may often change their mind or rescind the request. Sometimes there are beneficiaries who, due to the nature of their disability or incapacity, make requests so

frequently that the fiduciary learns to only follow up on the requests that are repeatedly made. This isn't the best practice for either the fiduciary or the beneficiary. In either of these scenarios: the beneficiary who changes their mind frequently or the beneficiary who knows no boundaries, it is important for the fiduciary to develop beneficiary-specific strategies for handling these requests. In the former situation, the fiduciary will need to know that a follow-up is necessary before following through with the disbursement. In the latter scenario, the fiduciary needs to set firm boundaries around communication. There is not a one size fits all approach to these situations.

Lastly, beyond the who, what, why and when is to ensure that there is proper documentation. An opinion from a professional working with the beneficiary can be a valuable resource. But, a letter of opinion from an attorney does not have to be the only source of protection or solution that a fiduciary may seek. A medical professional, for instance, has a different relationship with the beneficiary and can provide insight into the person's needs. Furthermore, an approval or denial in writing from a professional can go a long way in justifying any expenditure and is highly recommended to properly document the fiduciary's file. And as a side note, if appropriate, the beneficiary might sign a Health Insurance Portability and Accountability Act (HIPAA) release to give a fiduciary access to their applicable medical records to help keep the fiduciary better informed about the beneficiary's medical needs that underlie the requests for disbursements..

II. "Got to be good looking 'cause he's so hard to see." The Beatles, "Come Together," *Abbey Road*, 1969

Expectation Setting

Building a working relationship between the SNT trustee, the drafting or advising attorney, and the beneficiary is critical to establishing a manageable and efficient fiduciary practice. Cooperative relationships between the trustee and beneficiary also significantly reduce the trustee's risk of litigation. It's important to remember that many SNTs are funded from personal injury or medical malpractice judgments or settlements; therefore, the SNT beneficiary is no stranger to an attorney's office.

At the same time, the SNT attorney and trustee should never lose sight of their importance; the population they serve desperately needs the oversight and attention of a diligent fiduciary and counsel.

Managing beneficiary expectations from the outset of the fiduciary-attorney relationship pays huge dividends throughout the relationship's lifetime. The adage "you never get a second chance at a first impression" certainly applies to how the team should conduct initial meetings and discussions with the beneficiary. Managing risk from the beginning can be accomplished by setting achievable expectations and short-term and long-term goals for the trust.

One should never assume that the beneficiary (or any other non-fiduciary) automatically knows all of the issues surrounding public benefits and SNT administration. Trust administration can seem mysterious to a beneficiary not engaged with its overall processes. That's why developing a common understanding of the issues is invaluable. For example, explaining the vagaries of common trust terms and how different agencies use public benefits language can immediately put the beneficiary and the trustee on the same side of the table.

Another way to foster mutual understanding with a beneficiary is to refer to common "enemies". By the time an SNT usually funds, the beneficiary is likely frustrated with the red tape of local

public benefits agencies. A sensible trustee can use these shared experiences to their advantage when having to deny certain discretionary distribution requests or in other challenging aspects of the SNT's administration.

It's also important to address beneficiaries' emotional concerns, given the inevitable apprehension that will develop in the beginning stages of any trust's administration. It is very trying for a beneficiary who has been in total control of their assets to turn over day-to-day money management to a third party. The beneficiary's "hot button" items may be anything from investment management to public benefits retention, trust law, or tax regulations. A prudent trustee will manage these beneficiary concerns throughout the trust's administration and relate similar experiences they've had with other beneficiaries. However, this is only possible if they have taken the time to discover and discuss the source of the beneficiary's distress.

In initial meetings, the trustee should strive to engage the beneficiary in all aspects of the trust's administration. Typically, if the beneficiary feels like a part of the overall process, the inevitable bumps and hurdles throughout the SNT's lifetime are easily cleared together. An initial intake meeting should focus on the beneficiary's benefits, disability and lifetime estate planning, as well as their goals for the trust, and personal hobbies and passions - all of which should be recorded for future use.

The trustee should also focus on the beneficiary's short-term goals for the trust, such as the inevitable request for the purchase of a house and/or vehicle, while establishing a monthly and annual budget. The trustee can use this budget as the basis for a trust longevity projection. Seeing depletion rates in hard-and-fast numbers often makes a big impact on how the beneficiary thinks about their budget.

At the beginning of the relationship, the trustee should also focus on the beneficiary's long-term goals - what the authors call "optimal outcomes." As planners, we should learn about beneficiaries' ultimate goals for their trusts, whether it's to provide for their lifetime, start a business, provide for college expenses, pay for annual vacations or leave a legacy or inheritance for their desired remainder persons (as applicable after considering Medicaid recovery).

Having these conversations with the beneficiary and, more importantly, recording them for future use, can help manage the beneficiary's disappointment if a discretionary distribution is denied. For example, the conversation between beneficiary and trustee will be more congenial when they can say, "I'm sorry, but your SNT cannot afford to purchase you a Ferrari and then send you to college in five years, which you stated was one of your goals for your trust." Bringing these discussions back to common ground is essential in managing a beneficiary's expectations.

In general, change in a beneficiary's lifestyle will always be difficult, especially for the population served by SNT planners. The trustee will almost inevitably face situations wherein the beneficiary's parents facilitated or paid for every one of the beneficiary's requests for funds (or at least, that is what the beneficiary would have the trustee believe). In cases where the beneficiary's parents acted as payment facilitator and also as settlor of the trust and are now deceased, it is not uncommon for the beneficiary to protest having a trust at all, saying things like "Mom and Dad are just trying to control me from beyond the grave." In most of these cases, there are usually very good reasons for the trust's existence: public benefits qualification, inheritance/remainder person concerns or beneficiary spendthrift issues.

That said, the trustee can use this situation to their advantage in managing the beneficiary's expectations by explaining that the trustee is bound by the four corners of the trust document and that the settlor is no longer available to discuss discretionary distribution provisions.

III. "Circumstance has forced my hand, to be a cut-priced person in a low-budget land." The Kinks, "Low Budget," *title track*, (1979)

Budgeting

An SNT beneficiary will never achieve their goals or have their trust last as long as possible without appropriate planning. Both long-term and short-term budgeting are crucial to any beneficiary's investment strategy. The advising attorney and trustee will have to work across multiple disciplines, such as social work, psychology, and fiduciary representation, to fully complete the beneficiary's plan. Considerations should include the goals and needs of the beneficiary, their unique family dynamics, whether the beneficiary has diminished capacity or special needs, and the special circumstances of their lives. Of course, the trustee should also factor in public benefits the beneficiary may be receiving, is entitled to or may be eligible for in the future.

The superb trustee and attorney should also educate and advocate for their beneficiaries. To do so, they may require the services of other professionals: case managers, public benefits planners, agents under power of attorney, conservators and/or guardians, and investment managers. It is important to remember that certain professionals involved in the beneficiary's planning procedure may not be entitled to confidential beneficiary information. Although there is a good

faith effort to approach these issues in a cooperative manner, trustees and attorneys should recognize potential confidentiality and evidentiary issues.

A thorough assessment of a beneficiary's situation should occur before a plan is finalized. In addition to a standard annualized budget for a beneficiary, the following factors should be addressed:

- Beneficiary disability and its specific costs and planning factors
- Life expectancy
- Lifestyle/hobbies
- Age
- Employment (current and future)
- Cost of living
- Tax situation (current and future)
- Beneficiary education
- Beneficiary investment knowledge or experience
- Beneficiary risk tolerance
- Life Care Plan ("LCP")
- Waiver program eligibility
- Community Support Programs eligibility (e.g., HUD, SNAP, etc.)
- Potential future funding opportunities (family lifelong planning [testamentary] or inheritance;

  additional settlements or awards)

Often overlooked in planning for beneficiary needs is a review of the beneficiary's current resources. Drafting attorneys should take into account all facets of the beneficiary's financial situation before a trust vehicle is finalized. For example, if a structured settlement annuity is part of the trust's funding (both initial and ongoing), it should be factored into the beneficiary's spending plan. Or if a beneficiary has legacy 529 Plans, a conversion to an ABLE account may be most appropriate (see ABLE Financial Planning Act). When funding a beneficiary's SNT share in testamentary situations, the trustee may discover substantially appreciated legacy assets from a third party. In this case, a consultation with a tax professional or investment advisor may be warranted in order to capture any step-up in tax cost basis opportunities or develop a prudent liquidation or rebalancing strategy that will not be overly onerous to the beneficiary.

Ideally, the planner and trustee should also budget for professional costs and fees for the beneficiary. Such costs may include trustee fees, investment advisory fees, tax preparation fees (both for the trust and the beneficiary as applicable), case management fees and attorney fees. In the final stages of beneficiary financial planning, the drafting attorney and trustee should do a cost-benefit analysis of all needs and desires of the beneficiary from the trust as well as other sources. For example, the beneficiary may wish to pay privately for in-home caregivers, even though such services may be available to them through a Medicaid waiver program. A prudent trustee will review such expenditures with an eye towards trust longevity, even if the beneficiary is insistent otherwise.

Recent case law suggests it is the SNT trustee's duty to research all avenues of paying for such requests before approval in order to protect the trust's longevity. In *Liranzo v. LI Jewish Education/Research*, No. 28863/1996 (N.Y. Sup. Ct. June 25, 2013), a corporate trustee privately paid for caregivers and other services that may have been available to the beneficiary through

public benefits programs. These payments were made at the request of the minor beneficiary's parent. The trust was quickly depleted, and the trustee sought relief from the court when the trust became uneconomical to retain. The court concluded that the trustee should have sought out all available alternative avenues to pay for such services and directed the trustee to reimburse the trust almost $176,000. Although there were other factors in *Liranzo*, this case certainly speaks to the affirmative duty of the trustee to protect a trust's longevity as well as seek out all available public benefits for a beneficiary as appropriate. The same cost-benefit analysis should be applied in determining how to pay for beneficiary requests. A prudent planner will properly research the most appropriate avenue (i.e., ownership versus lease) to pay for certain expenses, such as adaptive equipment, accessible vehicles and housing.

IV. "You're still young, that's your fault, there's so much you have to know…."

Cat Stevens, "Father and Son," *Tea for the Tillerman*, (1970)

Trusts for Minors/Sole Benefit

A key element of any SNT being administered for a beneficiary receiving public benefits is the "sole benefit rule." The Social Security Administration (SSA) has traditionally held that all discretionary distributions from an SNT must be for the sole benefit of the beneficiary. Any other parties receiving an incidental or ancillary benefit from such distributions must contribute their pro rata share to any such purchase or distribution. However, trust administration under these guidelines has proven nearly impossible in some situations. For instance, when a trustee prudently purchases a big-screen television for a beneficiary with deteriorating eyesight who lives with their parents, are the parents not supposed to watch television with their child? Or are

they supposed to contribute a hypothetical 34% toward the purchase because they have tracked their household television viewing trends?

Thankfully, the SSA's Program Operations Manual System (POMS) Section SI 01120.201.F.3.a now establishes a new "primary benefit" rule recognizes that others might inherently receive an incidental benefit from trust distributions. Under this revision, the SSA now acknowledges that incidental or ancillary benefit is acceptable if the purchase was made primarily to satisfy the needs of the trust beneficiary. Some examples reviewed in this POMS section illustrate that people other than the beneficiary may reside in a home owned by the trust under certain circumstances.

In another scenario, an automobile that is purchased by the trust (but is titled in the name of a non-beneficiary and driven daily by that person) would not be considered for the primary benefit of the SNT beneficiary, even though the automobile is used to transport the beneficiary twice a month to medical appointments.

A prudent trustee will always exercise an abundance of caution before making a distribution for the support or maintenance of a primary beneficiary's minor children, particularly if the beneficiary's issue is not specifically mentioned in the discretionary distribution provisions by the drafting attorney (SNT or otherwise). The trustee must be careful not to supplant the parental duty of support of a minor child to avoid running afoul of case law or other beneficiaries or remainder beneficiaries, such as Medicaid and/or Social Security. This is especially true when administering a trust for the sole benefit of a minor beneficiary and considering a discretionary distribution that will also benefit the beneficiary's parents.

Typically, a trustee or court will define parental support obligations as providing food, clothing, shelter, basic care and education. Parental obligations end once the child reaches the age of majority. Interestingly, there is case law to the contrary. In *McElrath v. Citizens & Southern National Bank*, 229 Ga. 20, 189 S.E.2d 49 (1972), the court found that the drafter's discretionary distributions provision instructing that the trustee "shall use a sufficient amount of the income to provide for the grandchild's support, maintenance and education ..." was a directive to use the income for the support, maintenance and education of the minor children, regardless of the parental obligation of support.

Restatement (Third) of Trusts (*Restatement of the Law Third, Trusts*, American Law Institute © 2003) ("Restatement Third") comment e(3) states that "the presumption is that the trustee should take into account the parental duty to support the child under state law. If the trustee makes a distribution for the benefit of the child, it is really benefiting the parent. The trustee may exercise discretion to distribute for benefits that fall outside the parental obligations." This example makes it clear that drafters and fiduciaries must always carefully consider discretionary distribution requests vis-a-vis the sole benefit rule.

V. "Send lawyers, guns and money - get me out of this!" Warren Zevon, "Lawyers, Guns and Money," *Excitable Boy*, (1978)

"Hey, Joe. Where you goin' with that gun in your hand?" Jimi Hendrix, "Hey Joe," *Are You Experienced*, (1967)

Firearms:

Firearms may benefit the owner for many reasons. Hunting may be a source of food or a social or familial activity. Many proponents of firearms advocate the importance of possession for personal security and individual liberty. Some beneficiaries may feel physically vulnerable, and thus firearm possession may be of utmost importance to them.

That said, the consideration of a firearm purchase for a person with a mental illness or diminished capacity must be considered thoroughly. The ownership of a firearm by a person with mental illness is illegal under federal law. Pursuant to 18 U.S.C. § 922(d), it is unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing or having reasonable cause to believe that such person "has been adjudicated as a mental defective or has been committed to any mental institution." In addition, the vast majority of states have laws regarding possession of firearms by people with mental illness. Many states have enacted "red flag" laws, which permit police or family members to petition a state court to order the temporary removal of firearms from a person who may present a danger to others or themselves. Often, these red flag petitions are tied to the firearms owner's potential mental illness. Not surprisingly, the definition of mental illness varies from state to state. When defining mental illness, some states disallow possession of firearms for those who have been adjudicated incapacitated, others look at the adjudication of mental illness or court-ordered mental health treatment, and some look at the admittance to a treatment facility for drugs and/or alcohol. Also, a handful of states look at the person being found not guilty of a crime due to reason of insanity.

Any fiduciary contemplating a firearm purchase should be well versed in 18 U.S.C. § 922(d), the federal Firearm Possession Prohibition statute. The fiduciary should also consider "constructive possession" (*U.S. v Booth*, et.al. 111 F.3d 2 [1st Cir. September 1997]) or the beneficiary's access to firearms, potentially in an unmonitored or unsecured estate asset. When weighing a

beneficiary's distribution request for a firearm, never dismiss the potential danger presented by firearms to people other than the beneficiary. Consider the recent Aurora Theater shooting case (Colorado). Sandy and Lonnie Phillips, the mother and stepfather of victim Jessica Ghawi, sued the companies that supplied James Holmes with ammunition and body armor. The Phillipses claimed that the suppliers sold the goods to Holmes over the internet, without ever seeing his face or addressing his state of mind, thus making them negligent. The suit did not ask for damages, only for an injunction requiring dealers to stop their "negligent and dangerous business practices." Denver U.S. District Court sided with the dealers and dismissed the case (*Phillips v. Lucky Gunner, LLC*, No. 14-CV-02822-RPM, 2015WL 1499382 (D. Colo. Mar. 27, 2015)). The court also ruled that the dealers are entitled to fees and costs from the Phillipses.

To the best of our knowledge and research, there has not yet been a case brought against a fiduciary for purchasing a firearm for a beneficiary who then committed a crime. However, avoiding potential litigation and ensuring the safety of both the beneficiary and the public must be weighed in any potential firearm purchase.

VI. "But I would not feel so all alone…." Bob Dylan, "Rainy Day Women #12 and #35," *Blonde on Blonde*, (1966)

Marijuana:

Since the authors are from Colorado, we would be remiss not to review the possibility of discretionary distributions for medicinal marijuana. (Please note that the topic of trust distributions for the use of recreational marijuana will not be covered here.) Even in states that have approved medicinal marijuana, there may still be consequences to the beneficiary for

using marijuana, which need to be carefully considered by the trustee when deciding whether to approve such expenditures. For example, should a beneficiary use marijuana while on probation or parole, it could be grounds for re-arrest. As such, a prudent trustee must consider/examine all aspects of a beneficiary's life before making a distribution for medicinal marijuana. As discussed previously, a trustee has the duty of loyalty and impartiality to their beneficiary. The trustee's own values as they relate to marijuana must be set aside when a beneficiary makes a request for its purchase.

Many sources cite the following benefits of marijuana:

- Treatment of glaucoma
- Reversal of the carcinogenic effects of tobacco and improvement of lung health
- Epileptic seizure control
- Decreased symptoms of a severe seizure disorder called Dravet syndrome
- Potential cancer abatement
- Decreased anxiety
- Reduced progression of Alzheimer's disease
- Easement of multiple sclerosis pain
- Easement of pain, severity and recurrence of muscle spasms
- Lessened side effects and increased effectiveness of hepatitis C treatment
- Treatment of inflammatory bowel diseases
- Relief from arthritis discomfort
- Boosted metabolism
- Improvement in the symptoms of lupus, an autoimmune disorder
- Increased creativity

The inherent clash between state and federal laws regarding marijuana is particularly difficult for trustees to navigate, especially if a beneficiary receives public benefits. For example, public housing authorities (the program traditionally known as HUD or Section 8) follow federal regulations and do not allow marijuana use, regardless of laws in individual states. The same applies to recipients of SNAP Benefits (food stamps). Also, given that some states have passed laws authorizing drug testing for public assistance recipients, fiduciaries must be aware how easily beneficiaries could lose eligibility for government benefits due to marijuana use.

In addition, a trustee might approve discretionary distributions for marijuana and then discover later they have unintentionally caused the beneficiary to be terminated from their place of employment. In 2015, Colorado's Supreme Court ruled that medicinal marijuana user Brandon Coats, who was fired by Dish Network after testing positive for marijuana use, had no recourse for losing his job. While Dish Network agreed that Mr. Coats wasn't "high" on the job, they explained they acted in accordance with their company-wide zero-tolerance drug policy (*Coats v. Dish Network, LLC, 350 P. 3d 849 (Colo. 2015)*).

Similar rulings have been decided in California, Montana and Washington. It is not unimaginable that if Mr. Coats had a trust, the trustee who had issued a discretionary distribution for his medicinal marijuana could potentially be liable for his lost wages and/or medical benefits.

VII. "Roam if you want to, Roam around the world." The B-52's, "Roam," *Cosmic Thing*, (1989)

Elective Surgery, Supplemental Medical Care, Medical or Dental Care outside of the U.S.

Elective surgery, supplemental medical care or medical/dental care outside of the U.S. must be carefully evaluated by the trustee. If a fiduciary is considering such a request, it is important to seek a Medicare and/or Medicaid (as applicable) denial before making the decision to approve or deny a request. Also, the fiduciary should certainly obtain a medical opinion letter advocating for the surgery or medical care in order to properly document their files and defend against future potential litigation. Evaluating medical providers outside of the US could be much more difficult for the fiduciary considering differing regulations and requirements. Potential considerations should be recommendation from a primary physician, references from the provider, insurance coverage, online reviews, etc. and then if everything checks out, proceeding with extreme caution.

Gender Affirming Care

Gender affirming care can have significant benefits for those who receive them. In fact, disallowing a treatment/surgery to someone with gender dysphoria may cause depression, low self-esteem and difficulty forming social relationships. The trustee's concern must be balanced with ensuring the well-being of the beneficiary along with examining the long-term impact any choice may have. In a situation with gender affirming care the trustee may be asked to assist financially with social or medical transitioning. Socially transitioning is the process of the person adopting the name, pronouns and gender expression (like clothing, hairstyle etc) that match their identity. It is important that the trustee be supportive in this process, including understanding that gender specific clothing is not a sole benefit issue. This can be a major organizational shift if there has been a strong policy on purchasing gender conforming clothing to prove sole benefit. A recent study published in the journal *Pediatrics* followed 317 socially transitioned children as

their authentic gender for more than year and found that almost 95% continued to identify as transgender five years later. Doctors interviewed for an ABC news story regarding the study agreed with the findings with one saying that he is "always surprised by anecdotal reports that transgender youth frequently retransition because it's not what he's seen on a large scale in his medical practice".[2] Medical transitioning is when there is medical involvement like hormone treatment, gender affirming surgery etc. It would be wise for the trustee to obtain a medical opinion letter advocating for the treatment in order to properly document their files. This includes understanding the potential of co-existing psychiatric disorders and treatment that may be needed. The National Library of Medicine documents a peer reviewed study regarding the surgery and the mental health concerns.[3]

If a trustee is considering a request for any type of gender affirming medical care, it is important to seek a Medicare and/or Medicaid (as applicable) denial before making the decision to approve or deny a request. Section 1557 of the Affordable Care Act prohibits discrimination based on sex, but states have recently moved to implement restrictions on gender affirming health care, especially for youth. As of May 2023 at least 18 states have passed laws or policies that restrict gender affirming care for people under the age of legal majority and at least 14 others are considering or have introduced bills. While opponents of such legislation see this as an infringement on the rights of families to make their own health decisions, supporters believe that

[2]Abcnews.go.com (2023, August 15) Most Children who have socially transitioned still identify as transgender years later:Study https://abcnews.go.com/Health/children-socially-transitioned-identify-transgender-years-study/story?id=84450021

[3] Ncbi.nem.nih.gov (2023, September 18) /Transexual attractions and sexual reassignment surger: Risks and potential risks https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771004/#:~:text=In%20a%202015%2C%20Boston%20study,lethal%20intent%2C%20and%20both%20inpatient

people should wait until they are legal adults to make these decisions. It is clear this is a divisive issue.

This leads us to the question of if a trustee should consider the impact it may have on their business. The recent "Bud Light Effect" has shown that anti-transgender beliefs can have significant impact on one's business. Although a trustee will not necessarily be advertising their support of the transgender community as Bud Light did with Dylan Mullvaney, a transgender activist, the beneficiary getting the support from their trust may. A disclosure by the beneficiary on social media that their trust helped them in their care can have potential backlash from those that do not agree with gender affirming care. The solution may be simple, to reply as you would with anyone who makes a negative statement regarding your organization online. That may mean staying silent or having a prepared statement. This should be considered proactively and then reviewed in real time as an incident develops.

VIII. "Blackbird singing in the dead of night..." The Beatles, "Blackbird," *The White Album*, (1968)

Animals

Animals, especially those serving as pets, are very important to many people and the people we serve with disabilities are no different. In fact, the people we serve may have even greater need for animals that are characterized as a service or emotional support animal. As with any disbursement request, one must consider the budget and other factors outlined in the framework discussed earlier, bearing in mind that people sometimes become emotionally tied to their animals in a way that makes it difficult to make rational decisions about their care. A trustee

must evaluate all of the factors that are relevant before making a decision about the animal and the expenses surrounding it.

IX. "This is the end, my only friend, the end." The Doors, "The End," *Live at The Matrix*, (1967)

Conclusion

A beneficiary who is engaged is always more likely to refer the trustee's and attorney's services to friends and family. The engaged beneficiary is also more willing to work through issues collaboratively with their trustee and counsel.

Conversely, the disgruntled or unengaged beneficiary is more likely to speak poorly about the trustee and attorney in the community (falsely or otherwise) and "game the system" in regard to their public benefits. Additionally, the unengaged beneficiary will frequently lead with litigation, inevitably contacting a different attorney for trustee dispute resolution. No one wins in this situation; it simply drives up costs to the trust, which is ultimately to the beneficiary's financial detriment.

The work done by an SNT attorney and trustee [OR ...done by SNT attorneys and trustees] is significant and honorable. It is absolutely vital to the community of people with disabilities and essential for the advancement of their rights and the enhancement of their quality of life. As practitioners in this arena, we are able to make tangible differences in our clients' lives. We are extremely proud and humbled to be counted among the ranks of elder law attorneys and trustees.

Resources and Acknowledgements

Sex, Drugs, and Rock & Roll. Atypical Beneficiary Requests, CBA-CLE (2015 Elder Law Retreat). Megan Brand, Marco Chayet, Peter Wall.

Hartley Goldstone, Navigating The Trustscape ™

Just Say No! Don't Leave Your Client in Dire Straits with Outdated Discretionary Distribution Language, CBA-CLE (2016 Estate Planning Retreat). Kelly Dickson Cooper, Peter Wall.

Trust Distributions and Drafting: Perspective from Our Gigs, PFAC-Professional Fiduciaries Association of California, August, 2020

Please note that the views and opinions expressed herein are not necessarily those of CFPD, Chayet and Danzo or True Link Financial, or any of their subsidiaries

STETSON UNIVERSITY

2025 National Conference on Special Needs Planning and Special Needs Trusts

Sex, Drugs, and Rock n' Roll!!:

Atypical Beneficiary Distribution Requests

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1

"I woke up in a Soho doorway, a policeman knew my name..."

Duty of Loyalty
- Act in the best interest of the person you serve
- "the essence of the fiduciary relationship" (J.C. Shepherd, *The Law of Fiduciaries 48*) (1981))

Duty of Care/Prudence
Act reasonably as any prudent person would
- Note: When someone has held themselves out as a professional in certain areas, a higher standard of care applies (esp. in litigation).
- *Harvard College v. Amory* 26 Mass. ((9 Pick.) 446 (1830)) - "Observe how [people] of prudence, discretion, and intelligence manage their own affairs, not in regard to speculation, but in regard to the permanent disposition of their funds, considering the probable income, as well as the probable safety of the capital to be invested."

Duty to Account
Accountings/reportings to beneficiaries, remainder persons, interested parties, courts, public benefits agencies, etc.

fi-du-ci-ar-y (fi-dōō-shē-ĕr-ē): n. "One, such as an agent of a principal or a company director, that stands in a special relation of trust, confidence, or responsibility in certain obligations to others."

Latin: fiduciarius, from fiducia – "trust"

Ramsey v. Boatmen's First Nat'l Bank of K.C., N.A., 914 S.W.2d 384, 387 (Mo.App.W.D.1996) —

Trustees are fiduciaries "of the highest order" and are required to exercise "a high standard of conduct and loyalty in administration of [a] trust." The duty of loyalty "precludes self-dealing," which in most cases would be considered a "breach of fiduciary duty."

2

2

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)



Framework for decision making:

Appropriateness for the individual
- Identify the need.
- *Who* is requesting the distribution?
  - - Beware of new "players"
  - - Supported Decision-Making
- Mandatory reporting
- Opinion of beneficiary advocate - outside counsel, case/care manager, investment advisor, family member?
- *When* is the request made or frequency of the request.
- Fiduciary internal policy & procedure.

3

3

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)

Framework for decision making:

Values Check

- Personal experience
- Religious upbringing
- Moral context
- Paternalism (as fiduciaries we are not mom & dad)
- Opinion of outside professional

4

4

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)

Framework for decision making:

Relation to Disability

- Impact on public benefits
- State vs. federal regulations

Financial Plan/Budget

- Current request vs. future needs
- SNTs = wasting trusts
- "Optimal Outcomes"
- Trust longevity projections
- Tax implications

5

5

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)

Framework for decision making:

Professional Input

- Outside resources to consider:
  - PSNT Board/Committee
  - Medical Professional
  - Social Worker
  - Mental Health Provider
  - Case/Care Manager
  - Trust Protector/Advisor
  - Family Members
  - Outside Counsel
- Get recommendation in writing
- Note: Consider obtaining a HIPAA release from beneficiary

6

6

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)



Support Options for Decision

Cross discipline advisors
- Medical Professionals
- Care/Case Managers
- Beneficiary Friends or Family or other Supports
- Fellow fiduciaries
- PSNT Board Committee

External advisors
- Letter of Opinion from Attorney or other professional well versed in this area (Ex: Criminal Law Attorney)
- Medical Professional who specializes (Ex: Psychiatrist or Psychologist)

Court Intervention
- Petition for instruction
- Request for a Guardian Ad Litem

BEST PRACTICE TIP: ALL DECISIONS SHOULD BE DOCUMENTED IN WRITING

7

7

"I woke up in a Soho doorway, a policeman knew my name..."
"Who Are You"-(title track), The Who (1978)



Support Options for Decision

Use of disinterested Party
- Ask for a review of the situation and objective opinion or alternative solution
- Ex: Require a hunter's safety course and recommendation from the instructor that the beneficiary can safely handle a firearm
- Supported Decision-Maker

Use of a Trust Protector/Advisor
- Typically, an advocate for the beneficiary
- Knows/understands the beneficiary better than the trustee
- Doesn't necessarily relieve the trustee of liability

8

8

"Got to be good looking 'cause he's so hard to see...."
The Beatles, "Come Together", Abbey Road (1969)



Expectation Setting

- Build bridges, not walls
  - SNT beneficiaries are no stranger to attorney's offices
- Struggles with loss of control
- Common language development
- Common enemies?
  - Parents/settlors
  - Public benefits
- Optimal Outcomes
  - Short-term: passions, hobbies, goals
  - Long-term: college, vacations, home purchase
  - Document for future reference

9

9

"Circumstance has forced my hand, to be a cut-priced person in a low-budget land...."

The Kinks, "Low Budget", (title track), (1979)

Budgeting

- Disability
- Age
- Life Expectancy
- Public Benefits
- Lifestyle/Hobbies
- Employment (current or future)
- Cost of living
- Tax situation
- Education
- Investment knowledge and experience
- Risk Tolerance
- Budget (short-term and long-term)

BEST PRACTICE TIP: Review no less than annually

- Life Care Plan

BEST PRACTICE TIP: Obtain plaintiff and defendant LCP

- Waiver Programs
- Lifestyle/Hobbies
- Community Support Programs / (e.g. HUD)
- Future Funding/Inheritance

BEST PRACTICE TIP: Discount heavily

10

10

"Circumstance has forced my hand, to be a cut-priced person in a low-budget land...."

The Kinks, "Low Budget", (title track), (1979)

***Liranzo v. LI Jewish Education/Research*, No. 28863/1996 (N.Y. Sup. Ct. June 25, 2013)**

- Corporate trustee paid for caregivers that may have been available through different public benefits programs at the request of the minor beneficiary's parent
- Trust was quickly depleted
- Court found that trustee should have sought out all available avenues to pay for services, ordered trustee to reimburse trust $176,000



11

11

"Where you goin' with that gun in your hand...."

Framework

- Appropriateness for individual
- Need
- Relation to disability
- Professional opinion
- Financial impact
- Budget
- Optimal Outcomes
- Federal vs. State laws
- Trust language review
- Case law
- Trustee policy & procedure
- Values check

Joe

- Asks for a firearm for self-defense
- Has recently filed a grievance against his mental health provider
- Liability?
- Caught his "old lady messin' around with another man"

Mitch Mitchell

- Asks for adaptive equipment to go target shooting with his brother, uncle and father
- This is one of the only activities he can actively participate in with "the guys" in his family
- Has Cerebral Palsy and uses a wheelchair

12

12

"Where you goin' with that gun in your hand...."

Jimi Hendrix, "Hey Joe", Are You Experienced (1967)



Framework

- Appropriateness for individual
- Need
- Relation to disability
- Professional opinion
- Financial impact
- Budget
- Optimal Outcomes
- Federal vs. State laws
- Trust language review
- Case law
- Trustee policy & procedure
- Values check

Benefits of owning a firearm

- Hunting to provide food or for recreation
- Personal Protection
- Collector's items

18 U.S.C. § 922(d) - unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing or having reasonable cause to believe that such person "has been adjudicated as a mental defective or has been committed to any mental institution."

- Majority of States have varying laws re: Possession of Firearms by People with Mental Illness

Trustee should consider "constructive possession" and their liability in purchasing firearms. (CT Supreme Court case in which gun-maker Remington Outdoor Co. –used in Sandy Hook shooting-was accused of marketing military style guns to civilians. Case settled for $73M)

Other Liability

- *U.S. v Booth, et.al.* 111 F.3d 2 [1st Cir. September 1997] – constructive possession
- *Phillips v. Lucky Gunner, LLC*, No. 14-CV-02822-RPM, 2015WL 1499382 (D. Colo. Mar. 27, 2015)

13

13

"Plucked her eyebrows on the way, shaved her legs and then he was a she...."

Framework

- Appropriateness for individual
- Need
- Relation to disability
- Professional opinion
- Financial impact
- Budget
- Optimal Outcomes
- Federal vs. State laws
- Trust language review
- Case law
- Trustee policy & procedure
- Values check

Lou

- Middle aged male beneficiary with limited capacity
- Calls trustee and counsel requesting a gender reassignment operation
- No interested party had heard this request in the past
- Trust owned home
- Beneficiary had taken in two female renters
- Beneficiary lived in the basement
- Renters told beneficiary that only females could live upstairs

14

14

"Plucked her eyebrows on the way, shaved her legs and then he was a she...."

Lou Reed, "Walk On The Wildside", Transformer (1972)



Framework

- Appropriateness for individual
- Need
- Relation to disability
- Professional opinion
- Financial impact
- Budget
- Optimal Outcomes
- Federal vs. State laws
- Trust language review
- Case law
- Trustee policy & procedure
- Values check

- Gender dysphoria causes severe depression, low self-esteem
- Federal law prohibits health insurance companies from discriminating against transgender people, and it bars insurers from denying coverage based on pre-existing conditions. Many states are following suit through policy or case law.
- Medicaid coverage of gender-affirming care varies wildly from state to state
- Medicare covers a variety of gender-affirming services.
- Social Transitioning (name, pronouns, gender expression)
  - Consider intake paperwork, names in your database, distributions for clothing and personal care items
- Trustee may wish to seek a written opinion from a Medical Professional that also documents the risks of the SRS (including the potential for co-existing psychiatric disorders and treatment that may be needed)

15

15

"Plucked her eyebrows on the way, shaved her legs and then he was a she...."

Lou Reed, "Walk On The Wildside", Transformer (1972)



Framework

- Appropriateness for individual
- Need
- Relation to disability
- Professional opinion
- Financial impact
- Budget
- Optimal Outcomes
- Federal vs. State laws
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- Trustee policy & procedure
- Values check

Considerations:

- Seek Medicare and/or Medicaid denial before making the distribution for SRS from trust.
- Age matters: as of July 2025, 27 states have passed bans on gender-affirming care for minors.
- "Bud Light Effect". A trustee would likely not advertise their support of certain distributions, but a beneficiary may! (Ex: Instagram/Facebook Post: I want to thank [PSNT Org.] for making my reassignment surgery possible.) Be prepared with a statement for media.

16

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"But I would not feel so all alone...."

Framework

- Appropriateness for individual
- Need
- Relation to disability
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Mary Jane

- Requests Medicinal Marijuana
- Has a Spinal Cord Injury
- Doctor prescribed
- Resides in California
- Employed by national corporation
- Lives in HUD/Section 8 Housing

Bud

- Requests recreational marijuana
- Resides in Colorado
- Unemployed
- Sub-account funded from inherited IRA
- Trustee has "never inhaled"

17

17

"But I would not feel so all alone...."

Bob Dylan, "Rainy Day Women #12 and #35", Blonde on Blonde (1966)



Framework

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- State vs. Federal Law
  - *Cooperative Federalism and State Marijuana Regulation*, 85 U. Colo. L. Rev. 1105 (2014)
  - *Coats v. Dish Network, LLC*, 2015 CO 44, (June 15, 2015)
- Probation/Parole
  - Use of marijuana constitutes re-arrest
- *DeCambre v Brookline Housing Authority* (D.Mass, No. 14-13425-WGY, March 25, 2015)
- Benefits
  - Public Housing Agencies prohibit use of "illegal drugs" as defined at the federal level
  - SNAP benefits

18

18

"But I would not feel so all alone...."

Bob Dylan, "Rainy Day Women #12 and #35", Blonde on Blonde (1966)



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A Business Insider article cites the following benefits of marijuana:

- Treatment of glaucoma
- Reversal of the carcinogenic effects of tobacco and improvement of lung health
- Epileptic seizure control.
- Decreased symptoms of a severe seizure disorder known as Dravet's Syndrome
- Potential cancer abatement
- Decrease of anxiety
- Reduced progression of Alzheimer's disease
- Easement of multiple sclerosis pain
- Easement of pain, severity and recurrence of muscle spasms
- Treatment of inflammatory bowel diseases
- Relief from arthritis discomfort
- Improvement in the symptoms of Lupus, an autoimmune disorder

19

19

"But I would not feel so all alone...."

Bob Dylan, "Rainy Day Women #12 and #35", Blonde on Blonde (1966)



Framework

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*source: National Conference of State Legislators, 20254

20

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"I loved you since I knew you, I wouldn't talk down to ya...."

Framework

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Stewart

- Father of disabled young girl
- Requests $300 in singles from daughter's trust
- Lives next to Bare Assets Gentlemen's Club

Andy

- Requests funds from sub-account to travel to Nevada
- Requests $2,000 distribution to Cat House, Inc. (also in Nevada)
- Has ABLE account with plenty of funds available

Gordon Matthew

- Consistently has adult movies charged to his cable account bill, submitted to trustee for payment
- Trust owned home

21

21

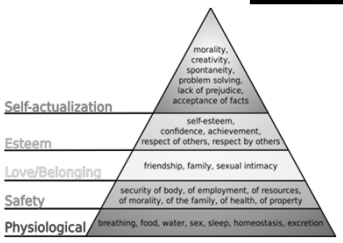
"I loved you since I knew you, I wouldn't talk down to ya...."

The Police, "Roxanne", Outlandos d'Amour (1978)



Framework

- Appropriateness for individual
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22

22

"I loved you since I knew you, I wouldn't talk down to ya...."

The Police, "Roxanne", Outlandos d'Amour (1978)



Framework

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- Everyone has the human need for touch, companionship
- See "Right To Intimacy" – Catherine Seal & Michael Kirtland
- Prostitution is legal in only a few rural counties in Nevada
- *In re Irrevocable Supplemental Needs Trust of Collins*, A04-1018, 2004 WL 2858079 (Minn. Ct. App. Dec. 14, 2004)
- Alternatives:
  - Internet
  - Massage
  - Adaptive exercise
  - Snuggle party
  - Any social activity

23

23

"With two cats in the yard, life used to be so hard...."

Crosby, Stills, Nash & Young, Deja Vu (1970)



Framework

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David

- Male beneficiary
- Married (wife is employed)
- Paraplegic as a result of an accident
- Said accident funded trust
- Paralysis prevents ability to conceive
- Requests trustee to pay for cost of surrogacy

24

24

"With two cats in the yard, life used to be so hard…."

Crosby, Stills, Nash & Young, Deja Vu (1970)



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- Sole benefit
- Split cost between beneficiary and wife?
- Trustee obligation to consider viability of care to the child - financially or otherwise?

25

25

"You're still young, that's your fault, there's so much you have to know…."

Framework

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Yusuf

- 8 years old
- Severe seizures and mobility restrictions
- Hydrotherapy has worked wonders
- Weak immune system
- Parents ask trustee to install pool at their home (2016)
- Parents own home (mortgage)
- No budgetary/trust longevity concerns

26

26

"You're still young, that's your fault, there's so much you have to know…."

Cat Stevens, "Father and Son", Tea for the Tillerman (1970)



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Sole Benefit: POMS SI 01120.201

- Incidental/Ancillary Benefit: POMS SI 01120.201.F.3

R3 §50, comment e(3): "the presumption is that the trustee should take into account the parental duty to support the child under state law. If the trustee makes a distribution for the benefit of the child, it is really benefiting the parent. The trustee may exercise discretion to distribute for benefits that fall outside the parental obligations."

***McElrath v.Citizens & Southern National Bank*, 229 Ga. 20, 189 S.E.2d 49 (1972)**

- "sufficient amount of the income to provide for the grandchild's support, maintenance and education…" was mandatory direction to the trustee to use the income for the support, maintenance and education of the minor children regardless of the parental obligation of support

27

27

"There's a lady who's sure all that glitters is gold...."
Led Zeppelin, "Stairway to Heaven", Led Zeppelin IV (1971)

Framework
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Implementation
- Ask for the request in writing
- Utilization of case managers, outside professionals
- Cross-discipline sounding boards
- "No, but...."
  - Approve different expenditure to free up beneficiary personal funds
  - Document decision in writing
  - Give a thorough explanation of "why"
    - Cite trust document, public benefits regulations, trust law, etc.
  - Appeal process?

28

28

"This the end, my only friend, the end...."
The Doors, "The End", Live at The Matrix (1967)



Audience Submissions:
- Male beneficiary bought Victoria's Secret items frequently. When denied for sole benefit concerns, he replied "but it is for my benefit" to see his girlfriend wearing the items
- Replacing beneficiary's teeth with canine teeth
- Emotional Support Pig
- Over $8,000 in power tools to build a $200 chicken coop
- Purchase of a wife in Thailand
  - SSDI, Medicare and Medicaid - trustee did cost benefit analysis and determined loss of Medicaid was appropriate (spousal deeming)
  - Beneficiary was required to live in Thailand for a month (per Thailand regulations)
  - Outside resources to cover the wife's expenses
  - Beneficiary changed his mind after all this work was complete
- Pole dance pole in group home room
- Phone sex
- Crime scene clean-up
- Emotional Support Monkey

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2025 National Conference on Special Needs Planning and Special Needs Trusts

THANK YOU!

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STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Thursday
October 23, 2025

Making it Work: Income Strategies to Protect Your Client's Benefits Eligibility

STETSON LAW

Center for Elder Justice

Access and Justice For All®

Making it *Work:* Income Strategies to Protect Your Client's Benefits Eligibility



STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts
Boot Camp: Understanding and Accessing Long-Term Supports & Services
Thursday, October 23, 2025 | 1:30 p.m. – 2:20 p.m. Breakout Session 1

Elizabeth A. Moran, JD
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1

Why Income Strategies Matter

- Protecting the Client's Financial Stability
- Legal & Ethical Duty to Provide Accurate, Strategic Counsel
- Empowering Clients Toward Greater Independence
- Navigating Complex, Interconnected Systems
- Preventing Legal & Financial Problems Down the Road
- Positioning Attorneys as Trusted, Holistic Advisors

2

The Problem: Work vs. Benefits

- Many clients believe they must choose between financial independence and benefits
- Fear of losing critical supports often discourages work
- Strategic planning allows clients to earn income while preserving eligibility

3

Key Benefits Programs

- **SSI** (Supplemental Security Income)
  - Needs-based, resource & income limits.
  - $2,000 individual resource limit (excluding certain assets), $3000 for a couple.
  - Countable income affects monthly payment.
- **SSDI** (Social Security Disability Insurance)
  - Not means-tested; based on work history.
  - Earnings can affect eligibility after Trial Work Period.
- **Medicaid & Medicare**
  - Medicaid: linked to SSI in most states; income/resources can affect eligibility.
  - Medicare: linked to SSDI; less affected by income but can be impacted at certain thresholds

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4

Work Incentives & Income Exclusions

- **SSI-Specific Exclusions**
  - General Income Exclusion ($20) and Earned Income Exclusion ($65 + ½ of remainder). *Example: earning $885 leads to only $400 counted income.*
- **Student Earned Income Exclusion** for under-22 students.
- **IRWEs** (Impairment-Related Work Expenses)
  - Deductible from earnings, reducing countable income.
- **BWE** (Blind Work Expenses).
- **SSDI Work Incentives**
  - Trial Work Period: up to 9 months to test work without losing benefits.
  - Extended Period of Eligibility: 36 months afterward, benefits can restart if earnings drop.
  - Expedited Reinstatement: fast-track reinstatement within 5 years if disability stops work.

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ABLE Accounts

- Annual contribution limit: $19,000 (2025)
- ABLE to Work allows additional contributions
- Funds up to $100,000 excluded from SSI resource limits
- Ideal for diverting earnings to stay under resource thresholds
- Can be used in tandem with trusts & other asset protection tools

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6

Practical Strategies for Advising Clients

- Earnings planning, phased or part-time work
- Layering IRWE, exclusions, and ABLE contributions
- Documentation & reporting
- Explore model scenarios with state-specific worksheets
- Interdisciplinary collaboration
- Ensure clients understand reporting responsibilities

7

Reporting & Documentation

- Timely reporting to SSA and Medicaid is essential
- Provide reporting checklists to avoid overpayments
- Keep records of work expenses, ABLE contributions, and SSA communications

8

Ethics & Advocacy Considerations

- Attorneys' role in informed decision-making.
- Effective Communication Considerations
- Advocate with SSA/Medicaid administration offices when work incentives are misapplied
- Equity concerns and barriers to employment (real or perceived): ensuring clients aren't discouraged from work.

9

Practical Tools & Planning

Work Incentives Planning & Assistance (WIPA) Programs, https://choosework.ssa.gov/findhelp
- Ticket to Work, funded by SSA; staffed by Community Work Incentives Coordinators (CWICs). Provides free benefits counseling and help interpret SSA work rules for individuals considering work. Attorneys can collaborate with WIPA counselors for complex cases.

State Medicaid Manuals & Waiver Guidance
- Each state administers Medicaid differently. Review your state's Medicaid Eligibility Manual and Home & Community-Based Services (HCBS) Waiver documents. These contain rules on income disregards, special earned income exclusions, and how Medicaid interacts with SSI eligibility in your state.

ABLE National Resource Center (ANRC), https://www.ablenrc.org/
- Comprehensive state-by-state ABLE program planning resources and toolkits which include:
  - Model trust language for incorporating ABLE contributions or linking special needs trusts.
  - Contribution strategies to coordinate with SSI and Medicaid resource rules.
  - ABLE-to-Work provisions, with guidance on how to advise working beneficiaries who want to save more.
- Many state ABLE programs have legal guidance pages and comparison charts. Examples:
  - Ohio, https://www.stableaccount.com/
  - Oregon, https://oregonablesavings.com/
  - Florida, https://www.ableunited.com/

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Resources and References 1 of 2

Social Security Act (42 U.S.C. § 1381 et seq. for SSI; § 401 et seq. for SSDI), **https://www.ssa.gov/regulations/**
- Establishes the legal framework for benefits, income exclusions, and eligibility.

Code of Federal Regulations (CFR), https://www.ecfr.gov/
- **SSI**: 20 C.F.R. §§ 416.101 – 416.1400
- **SSDI**: 20 C.F.R. §§ 404.101 – 404.1599
- Includes definitions of "earned income," exclusions, IRWE, trial work periods, extended eligibility, and more.

Program Operations Manual System (POMS), https://secure.ssa.gov/poms.nsf/home!readform
- The SSA's internal policy manual used by claims representatives.
- Covers every aspect of work incentives, income counting, ABLE accounts, and exclusions in detail.
  - SI 00820.500 – Earned income exclusions for SSI
  - SI 01130.740 – ABLE accounts & resource exclusions
  - DI 10501 – Work activity development and evaluation for SSDI
  - DI 13010.210 – Trial Work Period and Extended Period of Eligibility procedures

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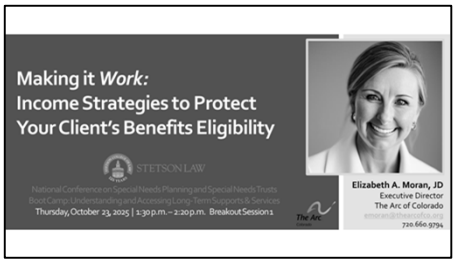
Resources and References 2 of 2

- **SSA Red Book, https://www.ssa.gov/redbook/**
  - **Official SSA publication** on employment supports and work incentives.
  - Written for beneficiaries, advocates, and professionals.
  - Includes practical examples, income exclusion charts, and explanations of SSI/SSDI work rules.
- **ABLE National Resource Center (ANRC), https://www.ablenrc.org/**
  - Provides state-specific and federal guidance on ABLE accounts, eligibility, contribution limits, and how ABLE interacts with SSI/Medicaid.
  - Includes comparison tools for state ABLE programs and legal interpretations.
- **National Academy of Elder Law Attorneys (NAELA)**
- **Special Needs Alliance (SNA)**
- **National Disability Rights Network (NDRN)**
- **State Protection & Advocacy Agencies**

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Thank You!


Making it *Work:*
Income Strategies to Protect
Your Client's Benefits Eligibility
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STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Thursday
October 23, 2025

Crowdfunding and Public Benefits

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CROWDFUNDING IN SPECIAL NEEDS PLANNING

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In 2010, the now popular crowdfunding website GoFundMe was created. To date, it remains among the largest platforms for individuals hoping to raise funds for themselves or others. Let's look back at what, exactly, is crowdfunding, and how it impacts disabled individuals.

Crowdfunding offers an opportunity for individuals or small businesses to raise money without seeking a loan from a bank or contributions from a large donor. Perhaps the individual is undergoing medical treatment and cannot afford the cost, or a business is looking to raise capital but does not have the collateral necessary to secure a loan. In such cases, crowdfunding opens the door for fundraising. Given the prevalence of social media today, such fundraisers are often met with tremendous success. This success can likely be attributed to the old adage that every bit counts.

Consider GoFundMe's "Year in Help" for 2024 (https://www.gofundme.com/c/gofundme-2024-year-in-help): two donations were made every second, on average, and more than forty-two million donations were made to individuals (more than twenty-three million were made to charity).

This all sounds fantastic! But, what does it have to do with special needs planning?

Consider Bonnie, an 82 year old woman in declining health. She is undergoing cancer treatment, among other things, and the cost of her medication has become too much for her to afford on a fixed monthly income. Her daughter asked if she can start a fundraiser for her mom to offset some of this cost. The problem is that mom may need a nursing home as a result of her treatment, which will mean an application for Medicaid is looming.

Consider Italo, a young man in his 20s who is confined to a wheelchair due to muscular dystrophy. His mom is able to push his current wheelchair, but wouldn't it be nice for him to ambulate independently? The cost of an electric wheelchair can be as high as $4,000 (some even

more). How will he afford that? He is on Medicaid and Supplemental Security Income, and the funds for the chair he wants are certainly not coming from the government.

For an individual who is elderly or disabled, access to means-tested government benefits such as Medicaid and Supplemental Security Income are paramount.

Medicaid and Supplemental Security Income ("SSI") are two programs upon which elderly, disabled and impoverished individuals may rely to meet their daily needs for services and supports.

Eligibility for SSI is based on disability, and the program is structured to provide a monthly stipend to cover shelter costs (42 USC 1381). The current federal stipend is $967 for an individual who lives alone. Certain states offer a supplement to this, but most are under $100.

Medicaid is a health insurance program at its core, and is jointly funded by the federal (42 USC 1396, et. seq.) and state governments. This means that while each state is receiving federal funding for its Medicaid program, it is up to the state to determine the rules and regulations that apply (provided that the requirements are not more restrictive than the federal requirements for eligibility). Because the Medicaid programs are governed state by state, the rules are different state to state. Unless a state's program expanded its Medicaid eligibility rules, an individual is not eligible for Medicaid if he or she has more than $2,000 in non-exempt resources in his or her name. There are income rules associated with Medicaid eligibility as well, but these vary state to state. Similarly, to establish or maintain eligibility for SSI, an individual cannot have more than $2,000 in his or her name. Other means-tested programs, such as Supplemental Nutrition Assistance ("SNAP") or section 8 housing, also have specific rules regarding income and resources.

It is important to remember that for many disabled individuals, their eligibility for Medicaid is directly connected to their SSI benefit. This is because if an individual is eligible for

SSI, he or she has $2,000 or less in resources and is disabled (as defined by the Social Security Administration). Thus, he or she is categorically eligible for Medicaid. Thus, losing SSI will also mean losing Medicaid and, while the individual can independently qualify for Medicaid, there may be a lapse in coverage.

Ultimately, the role of the elder or special needs law attorney is to ensure that the elderly or disabled individual does not, unintentionally, jeopardize the means-tested benefits upon which he or she relies for medical insurance, housing costs, food or other daily living expenses.

To date, there are no known publications by the Social Security Administration that specifically address crowdfunding, or rules that disregard funds raised on this platform when considering an individual's resources. Medicaid programs across the states have recognized the funds raised as either income or a resource, depending upon whether the funds have been distributed or are held in the account; whether others have access to the funds or if only the disabled individual can access and control the money; and whether the disabled individual began the fundraiser himself or herself or if it was started on his or her behalf. In most cases, a fundraiser will raise more than the permissible $2,000, thereby jeopardizing the individual's means-tested benefits, and potentially negating the assistance the donors were trying to provide.

There are alternatives, however, that should be considered by anyone seeking to start a fundraiser on behalf of an individual receiving (or anticipated to receive) means-tested government benefits.

A Special Needs Trust is an exception trust permitted under federal law (42 USC 1396p(d)(4)(A)), funded with assets from the beneficiary, such as an inheritance or a settlement from a lawsuit. This type of trust is often called a first party or self-settled trust. A Supplemental Needs Trust is a third party trust funded with assets from someone other than the beneficiary.

In addition to the source of funding, there are distinct differences between the two trusts.

A first party trust must be for the benefit of a disabled individual who is under the age of sixty-five. If the individual has capacity, he or she can establish the trust on his or her own. If not, the trust can be established by a parent, grandparent, legal guardian or the court. The trust must include a payback provision which states that upon the beneficiary's death, any funds remaining in the trust will be used to pay back Medicaid for medical assistance provided during the beneficiary's lifetime. Finally, the trust must be funded with assets held by the beneficiary. Common sources include an inheritance or a legal settlement. As noted, this trust can be established pursuant to federal law, so the trust must be compliant with the federal statute. Certain states also have specific requirements for first party trusts and so compliance with local law will ensure approval and will avoid any gap or delay in coverage as a result of the funding of the trust. If the disabled individual is considering a fundraiser for himself or herself, he or she should consider a Special Needs Trust instead, provided he or she meets the requirements outlined.

A third party trust must also be for the benefit of a disabled individual, but there is no age requirement on the funding because the assets used to fund the trust do not belong to the disabled individual. This trust is most often used in estate planning for a parent or grandparent of an individual with special needs, and can be incorporated so that the disabled individual does not need to be disinherited. There is no requirement for a pay back provision under a third party trust and so it is best practice to avoid comingling the funds held in a third party trust and a first party trust. Thus, if the individual setting up the fundraiser for the disabled individual is a "third party", he or she should consider establishing a Supplemental Needs Trust instead.

In either case, whether the family establishes a first party trust or a third party trust, if the trust is properly drafted and administered then the funds held will not be considered available to

the disabled beneficiary and thus his or her benefits (or eligibility for same) will be maintained. In both cases, the trust must be used for the primary benefit of the disabled individual, and only to supplement, not supplant, the individual's means-tested benefits.

For certain families, the use of a trust is not practical. Perhaps they do not have a trustee to name, or perhaps the amount to be contributed to the trust is too small to warrant the expense of setting up the trust. In these cases, the family can consider a pooled trust or an ABLE account.

Pooled trusts are also considered exception trusts under federal law (42 USC 1396p(d)(4)(C)). These trusts can be first party or third party, but rather than being managed and administered by an individual trustee, the trustee is a not-for-profit organization. Here, too, the funds held will not be considered available to the disabled individual, and can only be used to supplement, not supplant, the individual's means-tested benefits.

The Achieving a Better Life Experience (ABLE) Act was signed into law in 2014 (P.L. 113–295) to provide disabled individuals an opportunity to save their money in order to cover qualified disability expenses. The individual must have been disabled prior to the age of 26[1] and must be disabled at the time the account is established (and when contributions and distributions are made). An ABLE account is subject to annual and cumulative limits. Contributions can be made consistent with the annual gift tax exclusion ($19,000 in 2025). Each state is able to set its own lifetime maximum for contributions, though for SSI purposes, only $100,000 is disregarded. Distributions are tax free if made for qualified disability expenses, which include but are not limited to education, housing, transportation, assistive technology, funeral and legal expenses (26 USC 529A(e)(5)). ABLE accounts do include a payback provision.

[1] This will increase to 46 as of January 1, 2026.

Other, possibly more creative, solutions include a (very) carefully timed spenddown which may permit the funds raised to be used to cover a particular cost, or payment to the vendor directly. For example, if Italo's friends raised the $4,000 needed for his wheelchair by January 15, then purchasing – i.e. paying for – the wheelchair by January 31 may avoid a lapse in his coverage. There are also certain crowdfunding sites that manage the funds directly, and thus bypass any contributions to the disabled individual. It is not immediately clear whether these monies would still be considered "available", or treated as "unearned income", for purposes of the individual's benefits.

In most fundraisers, the funds raised can be withdrawn by the person raising the funds and/or by the beneficiary. Once withdrawn, there is no mechanism in place to guarantee that the funds raised are spent for the purpose they were raised. For example, once Italo receives the funds, no one is checking to see that he purchased his wheelchair. Perhaps, instead, he bought his mom a new couch. The beneficiary, or his or her legal representative, must monitor the fundraiser so that any funds raised are deposited into the beneficiary's account and then spent in the month of receipt. Otherwise, what would be considered income is going to be treated as a resource and thus potentially impact eligibility for means-tested benefits such as Medicaid and SSI. In fundraisers where only the beneficiary has access to the funds, the entire fundraiser will likely be considered an available resource, regardless of the timing of distributions. If the beneficiary ultimately decides to establish a Special Needs Trust for the funds raised, it is important that the fundraiser end as soon as the trust is established and funded.

Timing and transparency are critically important when starting or managing a fundraiser for a disabled individual.

Consider Ruth, a disabled woman who was turning 65 when she received a lump sum settlement from a law suit against a nursing home. Because she had not yet turned 65, she was able to establish a Special Needs Trust and direct the proceeds to the trust. Her benefits were preserved. However, she later discovered a GoFundMe account that had been set up for her by a long time friend living in Alaska. The fundraiser was started to raise money for assistive technology that was not covered by Medicaid. Unfortunately, by the time Ruth learned of the fundraiser, she had turned 65. She could no longer contribute the funds raised into her Special Needs Trust. Instead, they had to be released and paid to Medicaid as a partial payment on the lien. Otherwise, Ruth would have lost her Medicaid coverage and would have been personally responsible for her cost of care in the nursing home.

Crowdfunding can, in many cases, enhance the life of someone in need of financial assistance. Whether to start a company, pay for a wedding or funeral, take a trip or go to college, many life events require the support of others. However, for the elderly and disabled, the potential impact on means-tested benefits is enormous, and so proper planning is absolutely necessary. An understanding of the individual's means-tested benefits, and familiarity with federal and state laws pertaining to those benefits, will ensure that funds are properly raised, and properly spent, so that the individual receives the assistance he or she needs and maintains eligibility for crucial benefits.

Crowdfunding in Special Needs Planning

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October 2025

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Means Tested Government Benefits

- Medicaid
  - Jointly funded federal and state program
  - Health insurance for the elderly, disabled and impoverished
- Supplemental Security Income ("SSI")
  - Eligibility is based on disability, and the program is structured to provide a monthly stipend to cover shelter. The current resource allowance to establish financial eligibility is $2,000.
  - Someone who is eligible for SSI is categorically eligible for Medicaid.
  - The current stipend amount is $967 (for an individual who lives alone).
    - Certain states offer a supplement to this amount.

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New Jersey Medicaid, By the Numbers

• Resource Allowance	$2,000
• Monthly Income Cap	$2,901
• Community Spouse Resource Allowance Minimum	$31,584
• Community Spouse Resource Allowance Maximum	$157,920
• Monthly Maintenance Needs Allowance Minimum	$2,643.75
• Monthly Maintenance Needs Allowance Maximum	$3,948
• Excess Shelter Allowance	$793.13
• Utility Allowance	$878
• Penalty Divisor	$12,283.57 /month

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New York Medicaid, By the Numbers

- Resource Allowance (65+, blind, disabled) $32,396
  - For those under 65 and no Medicare, there is no resource allowance
- Income Allowance in the Community $1,800
  - This number shifts for those under 65 and not receiving Medicare
- Maximum Community Spouse Resource Allowance $157,920
- Minimum Community Spouse Resource Allowance $74,820
- Monthly Maintenance Needs Allowance $3,948
- Regional Rate for calculation of penalty
  - $14,273 in NYC
  - $14,165 in Northern Metropolitan (Rockland, Westchester, etc.)

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Florida Medicaid, By the Numbers

- Resource Allowance $2,000
- Monthly Income Cap $2,901
- Community Spouse Resource Allowance Minimum $31,584
- Community Spouse Resource Allowance Maximum $157,920
- Monthly Maintenance Needs Allowance Minimum $2,555
- Monthly Maintenance Needs Allowance Maximum $3,948
- Shelter Allowance $766
- Penalty Divisor $10,438 /month

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Georgia Medicaid, By the Numbers

- Resource Allowance $2,000
- Monthly Income Cap $2,901
- Community Spouse Resource Allowance Minimum $31,584
- Community Spouse Resource Allowance Maximum $157,920
- Monthly Maintenance Needs Allowance $3,948
- Penalty Divisor $10,965 /month

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Massachusetts Medicaid, By the Numbers

• Resource Allowance	$2,000
• Monthly Income Cap	$2,901
• Community Spouse Resource Allowance Minimum	$31,584
• Community Spouse Resource Allowance Maximum	$157,920
• Monthly Maintenance Needs Allowance Minimum	$2,643.75
• Monthly Maintenance Needs Allowance Maximum	$3,948
• Shelter Allowance	$793.13
• Penalty Divisor	$13,450.50 /month

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More Means Tested Government Benefits

- Developmental Disabilities
  - Enrollment is necessary to obtain the Home and Community Based Waiver, which covers services and supports in the community including residential placement.
- Section 8 Housing
  - Housing assistance reduces the monthly rental obligation to the landlord.
- SNAP
  - Monthly benefit to be used for food and other household groceries for low income families, the elderly and the disabled.

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Special and Supplemental Needs Trusts

- A Special Needs Trust is funded with assets from the beneficiary, such as an inheritance or a settlement from a lawsuit (called a first party or self-settled trust)
- A Supplemental Needs Trust is funded with assets from someone else (called a third party trust).
- Distributions from the trust are made in the sole and absolute discretion of the trustee, and cannot be made directly to the beneficiary.
- The funds held in the trust should **supplement, not supplant** any means-tested government benefits. This means that distributions are to be made to cover expenses not otherwise covered by Medicaid or SSI.

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First Party Trusts

- The trust must:
  - Be for the benefit of a disabled individual (as defined in the Social Security Law) under the age of 65;
  - Be established by the individual (if he/she has capacity), a parent, grandparent, legal guardian or the Court;
  - Include a payback provision which states that upon the beneficiary's death, any funds remaining in the trust will be used to pay back Medicaid for medical assistance provided during the beneficiary's lifetime; and
  - Must be funded with the beneficiary's assets (common sources of funding include a windfall from inheritance or a court settlement).

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First Party Trusts

- Medicaid and SSA must be notified upon the creation and funding of the trust.
  - The trust is reviewed to ensure that it comports with existing federal and state law, and that the State's remainder interest is protected.
- The trust can be funded with resources and/or income of the beneficiary (and is often used to shelter surplus income).
- Trust is created pursuant to federal law so the draftsperson must ensure compliance with the federal statute.
- Trusts should also be compliant with the state regulations.
- There is a requirement to produce an annual accounting for Medicaid.

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Third Party Trusts

- This trust is funded with assets from anyone other than the beneficiary. If there is another family member or friend who wishes to leave something to the disabled beneficiary, then the trust should be drafted as an irrevocable trust and should provide that the trustee can accept additions to the trust from other sources other than the Grantor.
- There is no pay-back provision since it is funded with the assets of a third party.
- Draft with flexibility. If there is significant wealth in the family, then the parents may consider a pot trust/sprinkle provision to allow for distributions to others. Trigger provisions may also be appropriate in the event there is potential that another beneficiary has or will have special needs.
- Powers of Appointment and Crummey rights of withdrawal should not be included for the disabled beneficiary.

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Third Party Trusts

- "Rule of thumb" in drafting: trust should be drafted in such a way that the trustee's discretion is restricted from making distributions that may impact the beneficiary's eligibility for benefits.
- The trustee can be provided with authority to make shelter distributions even if such a distribution would impact the beneficiary's eligibility for benefits, so long as such a distribution is in the beneficiary's best interest. It is up to the draftsperson to include this language.
- There should be an "opt out" provision – if the trustee is given this broad distraction, and if an agency decides that the discretion renders the trust available, then the trustee's discretion to make these distributions will cease.

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Third Party Trusts

- There is no "right" amount for funding a supplemental needs trust.
- It is important not to underfund the trust so that the disabled individual has sufficient funds for his or her lifetime to meet his or her needs.
- Be careful not to overfund the trust. If the beneficiary's daily living expenses and care costs are covered by government benefits, then an equal share of the estate, especially if it is a wealthy family, may be too much.
- Using life insurance may be a good way to fund the trust. It is best to use non-retirement accounts to fund the trust. If the client must use retirement assets, then the draftsman must be sure to set up the trust to qualify as a designated beneficiary.

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Pooled Trusts

- The trust must be managed and administered by a not-for-profit organization.
- A pooled trust can be either a first party or a third party trust.
  - The same payback provisions apply to first party trusts.
  - Many pooled trust companies permit a distribution to remainder beneficiaries upon the disabled beneficiary's death, but will require a percentage of the trust to remain with the pooled trust organization.

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ABLE Accounts

- An individual who is disabled prior to the age of 26 and who is receiving SSI or SSDI (or who has a disability certification from the SSA) is eligible to contribute to an ABLE account on his or her own behalf.
  - This is increasing to "disabled prior to the age of 46" on January 1, 2026
- Individual must be disabled at the time the account is established and when contributions/distributions are made.
- Third parties can contribute to an ABLE account for the benefit of a disabled individual as well, but these contributions are considered completed gifts for tax purposes.
  - There is a pay-back provision here.

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ABLE Accounts

- Funds held can cover Qualified Disability Expenses, such as basic living expenses and housing costs.
  - taxes are deferred and distributions are on an income tax free basis if made for qualified disability expenses.
- It is important to be mindful of the annual exclusion amount ($19,000 in 2025) and the contribution limit of the state in which the account is established.
- $100,000 is disregarded for SSI purposes.

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Effect of Distributions from SNT on Means-Tested Government Benefits

- Distributions should not be made to the disabled beneficiary, and cash should not be given to him or her as such distributions will be considered income and may jeopardize eligibility for Medicaid.
- Distributions that are used for food or shelter will result in a reduction of the SSI benefit by a maximum of one-third.
- Recurring distributions for household expenses may be considered income for purposes of Section 8 housing, even if expenses are paid directly to the vendor.
- Payments directly to the vendor will preserve SNAP benefits.

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What is Crowdfunding?

- Crowdfunding is a platform for individuals looking to raise money for themselves or others.
  - Kickstarter
  - GoFundMe
  - Fundable
- Different sites offer crowdfunding for different life events
  - Starting a business
  - Medical expenses
- Some sites are geared to small donors, and others to large contributors.

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What Are the Risks?

- Beneficiary's access to the funds raised or outright distributions of the contributed funds
  - Recall income and asset limits
  - Medicaid and SSI may consider these accounts "available"

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What Are the Benefits?

- Assistance with medical expenses not covered by Medicaid or SSI
- Costs covered for handicap accessible modifications (home, car, etc.)
- Purchase of assistive technology devices
- Contribution to education or recreational expenses

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What Can We Do Instead?

- First Party SNT
- Pooled Trust
- ABLE Account
- Third Party fundraising
- Spend down
- Direct payment to vendors

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Examples

- Bonnie, a woman in her 80s undergoing cancer treatment. Certain medications were not covered by her insurance and her daughter started a GoFundMe to help.
- Italo, a man in his 20s, who was confined to a wheelchair and wanted to raise funds for a new electric wheelchair.

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QUESTIONS?

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Ethical Practice in Elder Law and Special Needs Law: Preventing Mistakes Before They Become Claims

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Malpractice in Elder & Special Needs Law: Navigating the Ethics Rules

Introduction

Elder law and special needs planning demand legal precision and ethical vigilance. Because clients are often vulnerable and family dynamics are complex, malpractice claims frequently arise from blurred boundaries and overlooked duties. This handout examines how four key rules—1.1, 1.2, 1.7, and 1.14—intersect with malpractice risk, with the full text of each rule included for reference.

What is Malpractice?

Legal malpractice occurs when an attorney fails to exercise the ordinary skill, prudence, and diligence that a reasonably competent lawyer would use under similar circumstances. It may arise from negligence, breach of fiduciary duty, or violation of professional rules. In elder law and special needs practice, malpractice often results in financial loss, loss of benefits, or improper curtailment of a client's rights.

Rule 1.1 – Competence

> ***ABA Model Rule 1.1:***
> ***A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.***

The competency of an attorney is not measured merely based on experience. A very experienced lawyer can lack competence, and a very inexperienced attorney can attain competence. Comment 2 to Rule 1.1 makes it clear that an attorney "need not necessarily have special training or prior experience to handle legal problems of a type with which the lawyer is unfamiliar. A newly admitted lawyer can be as competent as a practitioner with long experience." Competence requires knowledge, skill, thoroughness, and preparation. In elder and special needs practice, failure here often leads directly to malpractice.

Competency goes hand in hand with Rule 1.3, which states that "a lawyer shall act with reasonable diligence and promptness in representing a client." This rule is especially applicable when representing an older adult.

Cases:
Barefoot v. Jennings 8 Cal. 5th 822 (2020): disinherited beneficiary has standing to challenge a trust amendment based on incompetency, undue influence or fraud.

In Utah State Bar v. Jardine, 289 P.3d 516 (Utah 2012), the court recognized that when the attorney was asked to review the will and trust of a client who was elderly and in poor health, the matter could not be delayed.

In re Morse, 7 A.3d 1259 (N.H. 2010), an experienced attorney was disbarred in part because it took 5 years and 12 motions for extension to settle an estate.

Rule 1.2 – Scope of Representation & Authority

> ***ABA Model Rule 1.2(a):***
> ***(a) Subject to paragraphs (c) and (d), a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer may take such action on behalf of the client as is impliedly authorized to carry out the representation. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision, after consultation with the lawyer, as to a plea to be entered, whether to waive jury trial and whether the client will testify.***

Determining who is the client is crucial in elder law and special needs planning. The identity of the client may become an issue because in many situations, other people will be "present" in the representation. Other people can be "present" in a variety of ways even if the person is not physically in the room. The most obvious way is when another person makes the appointment to meet with the attorney, accompanies the older adult to meetings with the attorney, or pays for the representation. Other individuals may be "present" because they will be directly benefited by the decisions of the client, such as beneficiaries to a will. And still other

individuals may be "present" in the representation because they have a role in the client's decision-making.

Attorneys may also face malpractice claims when they:

1. Relying solely on an agent's instructions without confirming the principal's intent or capacity.

2. Fail to verify the validity or scope of the POA document,

3. Ignore red flags such a family disputes, recent changes in estate plans, or signs of undue influence.

Attorneys can face liability when the stop communicating with the client. The ability and willingness to communicate with the client is an essential characteristic of an attorney. Model Rule 1.4 defines the communication duties of an attorney:

(a) A lawyer shall:

> (1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e) is required by these Rules; reasonably consult with the client about the means by which the client's objectives are to be accomplished;
>
> (3) keep the client reasonably informed about the status of the matter;
>
> (4) promptly comply with reasonable , and respond to requests from the client for information; and
>
> (5) consult to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." Rule 1.14(b)

According to comment 1 to Rule 1.4, the duty of communication revolves around the information needed for the "client to effectively participate in the representation." The need to communicate with older clients is especially crucial as some clients may have physical, mental, or emotional barriers to understanding the information from the attorney. The elder law attorney must be able to communicate effectively to provide that information. The Rules recognize that the amount and nature of the information provided may differ depending on the client. Comment 6 to Rule 1.4 recognizes that "[o]rdinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity." Additionally, comment 7 to Rule 1.4 notes that there may be circumstances when

the attorney may "be justified in delaying transmission of information when the client would be likely to react imprudently to an immediate communication." It is clear under comment 7 that an attorney cannot delay transmission of information merely for the attorney's own interest. Some would say that the most fundamental need of a client for effective communication is "time and talk."

Cases:

Attorney Grievance Commission of Maryland v. Coppola, 19 A.3d 431 (Md App. 2011): Attorney violated ethics rules when he took direction from children that lead to the forgery of estate planning documents.

In re Disciplinary Proceedings Against Strasburg, *452 N.W.2d 152 (Wis. 1990):* Attorney suspended for 2 years for permitting persons other than his clients to direct the work he performed on his clients' behalf, neglecting clients' legal matters and failing to communicate with them prior to taking action on their behalf, representing conflicting interests without fully disclosing the conflict and without obtaining client consent, charging clearly excessive fees, becoming verbally abusive and threatening legal action to collect a fee prior to completing a client's legal work and billing and collecting costs from clients in excess of amounts actually incurred.

Rule 1.7 – Conflicts of Interest

ABA Model Rule 1.7:
a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

(1) the representation of one client will be directly adverse to another client; or

(2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law;

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

(4) each affected client gives informed consent, confirmed in writing.

Conflicts are pervasive in family-based planning. Representing multiple generations risks divided loyalties and claims of undue influence. Most conflicts in elder law are not directly adverse conflicts as defined in Model Rule 1.7(a)(1), but rather materially limiting conflicts as defined in Model Rule 1.7(a)(2). However, conflicts can arise in a variety of ways in elder law. First, the attorney may be called to undertake joint or common representation in an estate planning context. The elder law attorney should be alert to conflicts that may arise when she proceeds to take protective action. Elder law attorneys also must be circumspect when asked to take on additional roles in the representation, such as acting as the fiduciary, trustee, or guardian, or being named in the will as a beneficiary.

Cases:

In re Wyatt's Case, 982 A.2d 396 (N.H. 2009): Attorney disciplined based on representation of the fiduciary and beneficiary.

In the MATTER OF DISCIPLINARY PROCEEDINGS AGAINST Laura R. SCHWEFEL, 474 N.W.2d 456 (Wisc. 2022): Attorney discipline due to conflict with her personal interests.

Rule 1.14 – Clients with Diminished Capacity

ABA Model Rule 1.14:
(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

Clients may have diminished ability to make decisions, but the lawyer must still maintain as normal a relationship as possible. All attorneys regardless of their practice may on occasion encounter clients with diminished capacity. However, elder law attorneys, because of the nature of their practice and clients, routinely will encounter clients with diminished or diminishing capacity. Capacity issues can arise in three general ways: the capacity to retain the attorney, the capacity to give informed consent to the action that the client is undertaking, and the capacity of the client who is the subject of litigation, such as in a guardianship. A thorough understanding of Model Rule 1.14 (and the state-specific variations) is essential for an elder law and special needs planning attorney. The Rule can be broken down into two general issues: (1) maintaining a normal attorney-client relationship, and (2) when and how to take protective action.

Although Rule 1.14 addresses clients with diminished capacity, throughout the representation, an attorney must be assured that the client has capacity. Initially, the client must have contractual capacity (see additional discussion on contractual capacity in Chapter 3) to hire the attorney. If the attorney determines that the client lacks the capacity to retain the attorney, the attorney cannot proceed with the representation. However, the attorney can take emergency measures to protect the individual even though the attorney does not represent the individual. Comment 9 to Model Rule 1.14 suggests three important considerations:

(1) Is the individual in danger of imminent and irreparable harm to his health, safety, or financial interests?

(2) Is there no one else who can act on the individual's behalf?

(3) Is the action only reasonably necessary to maintain the status quo and prevent the harm?

The test for capacity is a functional test. Comment 6 to Model Rule 1.14 states that in determining the client's capacity, the attorney should consider:

> [1] The client's ability to articulate reasoning leading to a decision;
>
> [2] Variability of the client's state of mind;
>
> [3] The client's ability to appreciate the consequences of their decision;
>
> [4] The substantive fairness of this decision; and
>
> [5] The consistency of this decision with the client's known long-term commitments and values.

The client's capacity is to be judged based on the client's ability to understand the issues surrounding the particular action the client wishes to take. So, for example, the capacity required to sign a will differs from the capacity to sign a contract. Therefore, a client may have capacity to sign a will but not the capacity to hire the attorney. The capacity requirements are defined by the substantive laws of the states regarding the validity of the document or decision made.

As suggested by Comment 1 to Rule 1.14, capacity is not an all or nothing proposition. The comment states: "In particular, a severely incapacitated person may have no power to make legally binding decisions. Nevertheless, a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being." Additionally, a client may fluctuate between capacity and incapacity based on a variety of factors.

An attorney may use a variety of methods of assessing capacity, keeping in mind that the attorney is not diagnosing the client's health or cognitive status. The attorney is merely determining whether the client has the capacity required by the substantive law. A must-have for every elder law attorney is *Assessment of Older Adults with Diminishing Capacities: A Handbook for Lawyers* (ABA Comm'n. on Law and Aging, and Am. Psychological Assn. 2nd ed. 2021). The handbook contains a checklist for assessing capacity for the different services that attorneys provide.

As Rule 1.14(a) provides, an attorney is required to maintain a normal client-attorney relationship as reasonably possible, for those clients with diminished capacity. This may mean that the attorney may need to vary the way the attorney typically conducts a client interview, the amount of time spent, the attorney's communication style, the time and length of the interview, and more.

Cases:

Carey v. Hartz, 256 N.E.3d 469 (Ill. App. 1 Dist. 2024): Legal malpractice case based on failure to assess client's mental capacity when the attorney observed signs of diminished capacity.

Wood v. Jamison, 167 Cal. App. 4th 156 (2008): Attorney held liable for assisting in a transaction that defrauded an elderly woman for failing to recognize client's vulnerability and lack of capacity.

Privity in Malpractice Claims

Under some circumstances, a lawyer may be held liable to non-client, third-party beneficiaries. Liability to third parties in this context depends on whether the jurisdiction in which the lawyer rendered legal services adheres to the strict privity doctrine or whether it allows third parties to proceed against the lawyer under either a negligence theory, a third-party beneficiary contract claim or a combination of the two.

Strict Privity Doctrine

At one time the prevailing view was that of strict privity. Under the privity rule, a lawyer is held liable only to the client and not to beneficiaries or intended beneficiaries. The jurisdictions adhering to this doctrine have refused to grant standing to non-client beneficiaries under either a negligence or third-party beneficiary contract theory. The primary reasons given to justify this doctrine have been:

- Absent strict privity, clients would lose control over attorney-client relationships, and lawyers would be subject to almost unlimited liability.
- Allowing a broad cause of action against a lawyer would create a conflict of interest between the client and third-party beneficiaries during the estate planning process, thereby limiting the lawyer's ability zealously to represent his or her clients.
- Suits by disappointed beneficiaries could cast doubt on the deceased testator's intentions.

A few states still adhere to the strict privity rule, including Colorado, Nebraska, New York, Ohio and Alabama. *See, e.g., Baker v. Wood, Ris & Hames, P.C.*, 364 P.3d 872 (Col. 2016); *Swanson v. Ptak*, 682 N.W.2d 225 (Neb. 2004); *Robinson v. Benton*, 842 So.2d 631 (Ala. 2002); *Matter of Estate of Pascale*, 644 N.Y.S.2d 887 (1996); *Lewis v. Star Bank, N.A., Butler County*, 630 N.E.2d 418 (Ohio App. 1993); *Deeb v. Johnson*, 566 N.Y.S.2d 688 (1991); *Simon v. Zipperstein*, 512 N.E.2d 636 (Ohio 1987)

(but see below regarding third-party claims in trust and estate administration); *see, also, Golden v. Cook*, 293 F.Supp.2d 546 (W.D. Pa. 2003) (finding that a lawyer did not owe a duty to the beneficiaries under Pennsylvania law, notwithstanding the absence of the strict privity doctrine). Texas generally adheres to the strict privity doctrine, *Barcelo v. Elliott*, 923 S.W.2d 575 (Tex. 1996), but allows an executor to bring a malpractice claim against a decedent's estate planning lawyer on the estate's behalf. *Belt v. Oppenheimer, Blend, Harrison & Tate, Inc.*, 192 S.W.3d 780 (Tex. 2006).

Lack of Privity No Defense

Courts in other states have held that the lack of privity between an estate or trust beneficiary and the lawyer for the fiduciary is generally not a defense to a legal malpractice claim against the fiduciary's lawyer. In Ohio, where privity is an effective defense in the estate planning context, it usually is not a defense in an action brought by an estate's beneficiaries against the fiduciary's lawyer. *Lewis v. Star Bank, N.A., Butler County*, 630 N.E.2d 418 (Ohio App. 1993); *Elam v. Hyatt Legal Services*, 541 N.E.2d 616 (Ohio 1989). Arizona, California, Florida, Illinois, Maryland, Michigan, Minnesota, Nevada, North Carolina, Oklahoma, Pennsylvania, Rhode Island and Washington are among the other states whose laws refuse to apply the privity defense in this circumstance. See, *e.g.*, *Steinway v. Bolden*, 460 N.W.2d 306 (Mich. App. 1990); *In re Estate of Halas*, 568 N.E.2d 170 (Ill.App. 1991); cases cited *infra*; *but see Jewish Hosp. v. Boatman's Nat'l Bank*, 633 N.E.2d 1267 (Ill.App. 1994) (lawyer owes professional obligations to estate and not to the beneficiaries in handling probate administration due to the potentially adversarial relationship between the interests of the estate and the interests of the beneficiaries). Nevertheless, courts consistently find that no duty is owed by a fiduciary's lawyer to the beneficiaries of an estate or trust under these circumstances.

The most common tests used to determine whether a lawyer who renders services at the request of a fiduciary owes a duty to a non-client beneficiary are the "multi factor balancing" test and the "third-party beneficiary" test. Cases illustrating these tests are discussed below.

Multi-Factor Balancing Test

In *Goldberger v. Kaplan, Strangis and Kaplan*, 534 N.W.2d 734 (Minn.App. 1995), the court applied the multi-factor balancing test to determine if the lawyer for the executor owed a duty to non-client beneficiaries. In this case the court concluded: (a) the appellants were merely incidental beneficiaries of the lawyer's services; (b) that, until an estate closes, injury to an estate beneficiary is uncertain; (c) an incentive to bring a malpractice suit against the lawyer rests with the executor; and

(d) allowing the beneficiaries' claim would place an undue burden on the legal profession because such claims could subject the lawyer to a conflict of interest. The conflict of interest would arise whenever the interests of the executor, acting on behalf of the estate, were to conflict with the interests of the suing beneficiary.

In *Goldberg v. Frye*, 266 Cal. Rptr. 483 (Cal.App. 1990), the court denied the estate beneficiaries' claim because the estate administrator and the lawyer did not enter their relationship intending to affect the estate beneficiaries. Furthermore, the court stated that "it would be very dangerous to conclude that the lawyer, through performance of his service to the administrator...subjects himself to claims of negligence from the beneficiaries." The court also stated that the beneficiaries are entitled to a fair administration by the fiduciary, but the fiduciary's lawyer does not owe them a duty.

In *Trask v. Butler*, 872 P.2d 1080 (Wash. en banc 1994), the court utilized a modified multi-factor balancing test to conclude that a lawyer representing a former executor did not owe a duty either to the estate or to the estate's beneficiaries. This modified approach initially determines whether the plaintiff is an "intended beneficiary of the transaction to which the advice pertained" and then analyzes the factors under the balancing test. The court found no duty existed for the following reasons: (a) the beneficiaries and the estate itself were not intended to benefit from the relationship between the executor and the lawyer but, rather, were incidental beneficiaries; (b) the heirs of the estate could institute an action against the executor for breach of fiduciary duty; and (c) the conflict of interest a lawyer would encounter in deciding whether to represent the executor, the estate or the beneficiaries would unduly burden the legal profession.

Third Party Beneficiary Test

In *Ferguson v. Cramer*, 709 A.2d 1279 (Md. 1997), the court applied the third-party beneficiary test and held that no duty was owing by an estate's lawyer to the beneficiaries because the beneficiaries could not establish an attorney-client relationship. The court found that the benefit to the beneficiaries from the executor's lawyer was only incidental. The court concluded that, where the executor's conduct falls below the applicable standard of care, the beneficiaries might sue the executor but not the executor's lawyer. This remains true even where the executor hires a lawyer and relies on his or her advice. *See, also, Neal v. Baker*, 551 N.E.2d 704 (Ill.App. 1990) (dismissing an estate beneficiary's claim because the scope of the lawyer's representation involved matters that were adversarial as to the beneficiary in that she was contesting the lawyer's decision to require her to pay

inheritance taxes. Also, the contract between the executor and the lawyer was intended primarily to benefit the executor and the estate and not the beneficiaries).

Willful Misconduct

The majority rule is different, however, when the lawyer has engaged in conduct that is more intentional than negligent. Thus, in *Pierce v. Lyman*, 1 Cal.App.4th 1093 (1991), superseded by statute on other grounds, 85 Cal.App.4th 382 (2000), the court held that trust beneficiaries may bring an action against the lawyers for the former trustees where the lawyers intentionally aided and abetted the trustees in the trustees' breach of their fiduciary duties. Such activities allegedly included "active concealment, misrepresentations to the court, and self-dealing for personal financial gain." *See, also, Weingarten v. Warren*, 753 F.Supp. 491 (S.D.N.Y. 1990) (applying New York law, the federal district court held that a trust's remainder beneficiaries stated a cause of action against the trustee's lawyer individually for breach of fiduciary duty and as executor of the trustee's estate for alleged conversion of trust assets. However, the court held that the beneficiaries could not assert a cause of action for malpractice against the lawyer). Sometimes, a negligent representation action is an alternative theory available to third parties. *See, e.g., Riggs Nat'l Bank v. Freeman*, 682 F.Supp. 519 (S.D. Fla. 1988).

ETHICAL PRACTICE IN ELDER LAW AND SPECIAL NEEDS LAW: PREVENTING MISTAKES BEFORE THEY BECOME CLAIMS

"Malpractice in elder law isn't usually a bomb—it's a tripwire."

Ethical Tripwires: Rules 1.1, 1.2, 1.7, 1.14

1

- **Identify common malpractice risks** in elder law and special needs practice, including those arising from diminished capacity, undue influence, and client confidentiality challenges.
- **Analyze ethical dilemmas** specific to representing aging clients and clients with disabilities, with reference to relevant professional conduct rules.
- **Recognize the warning signs** of potential liability, including conflicts of interest and inappropriate third-party involvement in client decision-making.
- **Apply risk-reduction strategies** and best practices using real-world scenarios to prevent ethical breaches and malpractice claims.
- **Enhance ethical decision-making** and client advocacy by developing a proactive approach to managing capacity, consent, and communication challenges.

OBJECTIVES

2

- Failure to exercise the skill, prudence, and diligence that lawyers of ordinary skill would use.
- Can arise from negligence, breach of fiduciary duty, or violation of professional responsibility rules.
- Often tied to financial harm or loss of client rights.

WHAT IS LEGAL MALPRACTICE?

Malpractice Focus

3

ELEMENTS OF A MALPRACTICE CLAIM

- Duty: Attorney-client relationship established.
- Breach: Lawyer failed to meet standard of care (e.g., competence, loyalty).
- Causation: Breach caused harm to client.
- Damages: Client suffered actual financial or legal harm.

Malpractice Focus

4

WHO CAN SUE FOR MALPRACTICE?

- Doctrine of Privity traditionally blocked such actions
  - Interject undesirable self-protective reservations in to the attorney's counseling role.
  - Prevent attorney "from devoting entire energies to his client's interest."
  - "Undue Burden on the profession."
- Recent trend--Courts holding attorney responsible.
  - Foreseeable effect on a third party
  - Fiduciary/Agency principal
  - Third party beneficiary principle
  - Balancing test that considers the predictability and certainty of harm, the defendant's culpability and the extent of the third party's justified reliance on the defendant's conduct.
  - Consider Restatement (third) of Law Governing Lawyers §51

5

WHY ELDER & SPECIAL PRACTICE IS HIGH-RISK

- Complex interplay: Medicaid, tax, disability law
- Clients with diminished capacity
- Families with conflicting goals
- Stakes: financial security & benefit



6

RULE 1.1 – COMPETENCE

- Keep current: Medicaid / SNT rules shift often
- Thoroughness: gather financial/medical data
- Example: "Simple trust" = benefits lost
- Malpractice risk: incompetence = client harm

Skills + Specialized Knowledge + Diligence = Competency

7

RULE 1.2 – SCOPE OF REPRESENTATION

- Who is the client? Senior? Child? Both?
- Define objectives & means clearly
- Avoid overreach—document client choices
- Communication
- Example: Child hires you, but mom's wishes ignored

8

RULE 1.7 – CONFLICTS OF INTEREST

- Families ≠ one happy unit—check conflicts!
- Parent v. child inheritance disputes
- Consent ≠ cure-all
- Conflict with Attorney
- Example: Planning for parents + child with disabilities → later disputes = liability

9

- Maintain 'normal' relationship as far as possible
- Assess & document capacity
- Protective actions: only when necessary
- Example: Helping client w/ dementia sign trust = malpractice minefield

RULE 1.14 – DIMINISHED CAPACITY

10

- Engagement letters: crystal clear
- Conflicts check = map family interests
- Document, document, document
- Collaborate with experts (finance, medical, social work)

PRACTICAL MALPRACTICE AVOIDANCE

11



12

STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Thursday
October 23, 2025

Can't You Decant?

STETSON LAW

Center for Elder Justice

Access and Justice For All®

STETSON LAW

2025 National Conference on
Special Needs Planning and Special Needs Trusts
October 23, 2025

CAN'T YOU DECANT?

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I. Introduction

Can't you decant?? The short answer is Yes! . . . But . . . . The name itself seems to imply we can't - De-"cant"-ing – but we can if we cognizant of our state statutes/common law and federal law relating to public benefits eligibility. The concept of decanting a trust is often compared to the decanting of a fine wine, ad nauseam. But I have to admit, it's the best way to conceptualize decanting a trust. So, here's my wine reference - decanting a trust isn't just a legal maneuver, it's a bit like uncorking a complex wine. You need to consider the structure of the trust you are decanting, the appropriate time to decant, and what type of trust you're pouring into. So, let's unbottle the truth about decanting. In this presentation, I will focus primarily on decanting from a self-settled SNT to another self-settled SNT (aka D4A trusts or first-party SNT's). For clarity, I will refer to the trust being decanted as the "first trust" and the new trust as the "second trust". I will make some references to third party trusts but it is not my focus as decanting a third party trust is less risky and draws less scrutiny from SSA.

II. What is Decanting?

Decanting refers to the process by which an existing irrevocable trust may be transferred or "poured into" another trust with more favorable or updated terms, without the need for court approval. In other words, trust decanting is changing an irrevocable trust to better match new circumstances. Generally, irrevocable trusts are inflexible documents that may be amended or modified only under certain circumstances, such as to accommodate a change in the law that may affect the public benefits of a disabled individual. Decanting allows a trustee to address or fix issues or circumstances that were not contemplated when the existing irrevocable trust was created. The decanting concept applies to special needs trusts. Although other legal mechanisms

exist to "fix" an irrevocable trust, many require court intervention or assents by the beneficiaries, both of which can be time-consuming, expensive and fruitless.

III. When Is Decanting Appropriate?

Decanting is initiated by the trustee of the first trust, acting with the guidance of counsel. The trustee of the second trust may be the same individual or entity but this is not a requirement. Decanting a special needs trust is fundamentally a strategy to preserve the beneficiary's eligibility for public benefits. It becomes especially relevant when circumstances evolve in ways the settlor could not have anticipated at the time of the trust's creation. For instance, when the trust has been in place for decades and the beneficiary's needs have shifted significantly.

The following is a detailed list of common decanting scenarios:

1. **Correct Drafting Errors or Ambiguities**
   - Clarify vague distribution standards
   - Remove language that inadvertently grants the beneficiary control
2. **Update Trustee Provisions**
   - Appointing successor or co-trustees
   - Change trustee provisions
   - Adding trust protector roles or administrative agents
   - Refine trustee powers to improve flexibility or oversight
3. **Respond to Changed Circumstances**
   - Adjust for the beneficiary's evolving medical, financial, or residential needs
   - Update for shifts in available public benefits
   - Adapt to relocation of the beneficiary or trustee to a new state with different trust laws
   - Add language to support future modifications, decanting, change of situs
4. **Modernize Administrative Terms**
   - Incorporate clearer standards for discretionary distributions
   - Update notice, accounting, or reporting provisions
   - Add a spendthrift provision
   - Bring older trusts into compliance with updated state and federal statutes
   - Update to comply with revised public benefits eligibility/compliance requirements and tax laws

5. **Preserve Public Benefits Eligibility**
    - Remove provisions that risk triggering SSA's resource-counting rules
    - Ensure the trust remains irrevocable and retains the Medicaid payback clause (for self-settled SNT's)
    - Avoid SSA early termination triggers
6. **Consolidate or Segregate Trust Assets**
    - Merge multiple trusts for administrative efficiency
    - Create separate subtrusts for distinct purposes (e.g., housing, therapy, education)

IV. Legal Authority for Decanting Special Needs Trusts

A. Statutory vs. Common Law Authority

The benefit of statutory law over common law is that statutory law provides clear authority (for the most part) to decant with procedural instructions as to the trustee's authority and notice requirements, among other things. In contrast, common law is limited and subject to judicial interpretation which can be vague and case specific. Decanting in statutory law states tends to be less risky and uncertain as opposed to common law states.

Currently 41 states have decanting statutes and 9 do not. Of the 41 states with decanting laws, 26 of them have special needs trust provisions. My state of Massachusetts is one of the 9 don't-have states, but we do have legislation currently under consideration. Eventually I think it will pass. For now, we have some scant case law as guidance. For those states like Massachusetts, without a statute, a trustee should consider whether their state allows decanting pursuant to common law or whether they may change the trust situs to a state with a decanting statute to accomplish their goal. For states with their own decanting statute, be sure to look for any guidance on prerequisites to decanting. Regardless of whether a state allows decanting by statute or common law, the trust instrument itself should first be carefully reviewed to determine what authority the trustee may or may not have to decant. This is also important because generally decanting statutes operate as default rules, not binding requirements. The trust

instrument itself typically governs if it sets forth contrary or more detailed terms than the statute does.

B. The Uniform Trust Decanting Act (UTDA)

The UTDA is the foundation for most of the decanting statutes found today. The Act was created by the Uniform Law Commission (ULC) and approved in 2015. [1] It was created to provide states with a uniform method to decant, permit flexibility, maintain the grantor's intent, and to prevent abuse of the trustee's discretion.[2] Currently, 19 states have adopted the UTDA while 23 states have their own variation. The UTDA, Section 13(b) authorizes decanting of special needs trusts provided that the trustee of the first trust has discretionary authority of principal, the second trust is a special needs trust that benefits the disabled beneficiary, and the decanted trust will further the purpose of the first trust.

C. Key Fiduciary Considerations:

Decanting a special needs trust demands heightened attention to fiduciary standards. A trustee should consider all of the following in determining whether decanting is the best option:

1. Fiduciary Duty:

- **Duty of Loyalty**: The trustee must act solely in the best interest of the disabled beneficiary. Any decanting must preserve eligibility for public benefits (e.g., SSI, Medicaid) and avoid self-dealing or conflicts of interest.
- **Duty of Prudence**: Trustees must exercise care, skill, and caution. Consider documenting the decision to decant with a memorandum outlining the rationale, risks, and benefits.
- **Duty of Impartiality**: If other beneficiaries exist (e.g., remainder beneficiaries), the trustee must balance their interests, especially if the new trust alters future distributions. State law should be consulted as to whether the interest of remainer beneficiaries can be altered in the decanted trust. Under the UTDA, the interest of a beneficiary, other than the disabled beneficiary, must be "substantially similar" to their interest in the first trust.

[1] The Uniform Law Commission (ULC) is a non-partisan body of legal professionals appointed by U.S. jurisdictions to draft model laws that promote clarity and consistency in state statutory frameworks.
[2] The Uniform Trust Decanting Act, A Summary, Uniformlaws.org

- **Preservation of Intent**: The trustee must honor the settlor's original intent, particularly if the trust was designed to protect a disabled beneficiary's access to public benefits. Decanting should not introduce provisions that jeopardize this purpose.

Best Practice: Include a fiduciary analysis in the trustee's file, showing that the decanting enhances the beneficiary's protection, aligns with the trust's purpose, and complies with applicable law.

2. Notice requirements

Determine the amount of notice required under state law and to whom it must be given. Under the UTDA 60 days' notice is required. Generally (and it is good practice), written notice should be provided to the following:

- The settlor(s), if living
- The current beneficiary (or their legal representative)
- Remainder beneficiaries
- Co-trustees and any trust protector or advisor
- State Medicaid agencies, depending on jurisdiction and trust type (especially if the trust is first-party and subject to payback provisions)
- Social Security, if beneficiary(ies) is eligible for or receives SSI

Notice must include:

- The intent to decant
- A copy of the existing trust
- A copy of the proposed new trust
- Specify the proposed effective date (consult state/common law for timing)

3. Court involvement (if any)

Regardless of whether the authority is statutory, common law or stated in the trust instrument, generally a trustee can exercise the decanting power without consent or court approval. However, a trustee or beneficiary could seek court intervention under the following circumstances:

- Determine/clarify who is entitled to notice
- Determine whether notice was proper, if required

- Approve or authorize trustee's authority to decant, if necessary
- Provide instructions to trustee (e.g., clarify ambiguities in law, confirm/clarify authority to decant
- Settle disputes between trustees and/or beneficiaries
- Provide any potential relief under state or common law
- Decanting testamentary trusts

4. Change of situs

A trustee may consider changing the trust's situs to take advantage of more favorable laws in another state. For example, a more flexible decanting statute (or a state that has a decanting statute for those in a common law state), more flexible trust laws, or stronger asset protection.

To do this, the trustee must consider two key factors:

- Does the trust document allow for changing the situs?
- What does the current state and the new state require to make the change legally valid? (e.g., does the new state require an in-state trustee or some other nexus to the state)

If the trust is silent as to whether the trust situs may be changed, most state statutes and the UTDA permit it unless the trust specifically precludes it. Be mindful of a rule against perpetuity violations in the new state. Not all states enforce this rule but they may have a variation of it (Massachusetts repealed the rule against perpetuities in 2008). The rule against perpetuities limits how long a trust can last, typically requiring that interests vest, if at all, within a certain period of time (e.g., 21 years after the death of a measuring life). Violating this rule can render future interests void, undermining the trust's long-term structure.

V. State-by-State Comparison of Decanting Laws

States differ in how much flexibility their decanting statutes allow. The chart below provides a current (as of August 2025) state-by-state comparison highlighting which states have decanting statutes (which has grown significantly in the last 10 years) and those that don't. It also highlights the notice requirements as well as which states have a specific carve out for special needs trusts, making decanting of SNT's less risky and ambiguous. Note that while most

states mandate notice, none require prior consent (except Ohio with regard to testamentary trusts), and some are silent on the matter altogether. Although Massachusetts is a common law state, we do not require notice or consent of a beneficiary.

Some jurisdictions permit decanting even when the original trust instrument is silent on the matter, while others require express authorization within the trust document. In all cases, the decanting process must comply with the specific procedural and substantive requirements set forth in the applicable state statute. The variations between states are a consideration when contemplating the trust's transfer to another jurisdiction.

State Statute Comparison Chart[3]

State	Decanting Legislation	Statute	State Adopted UTDA?	Prior Notice Required?	Prior Consent Statutorily Required?	Is There a Special Needs Trust Section?
Alaska	Yes	Alaska Stat. Ann. §§ 13.36.157 to 13.36.159	No	Yes, Unless Grantor exempts	No	Yes
Alabama	Yes	Ala. Code §§ 19-3D-1 to 19-3D-29	Yes	No	No	Yes
Arkansas	Yes	Ark. Code Ann. § 28-73-818	No	No	No	Yes
Arizona	Yes	A.R.S. § 14-10819	No	Silent	Silent	No
California	Yes	Cal. Prob. Code §§ 19501 to 19530	Yes	Yes	No	Yes

[3] State Decanting Laws Chart, Practical Law Checklist w-022-0638 and ArentFoxSchiff state summary chart. Thank you to Tim Snead for creating the last row showing whether each state has a special needs trust provision.

Colorado	Yes	Colo. Rev. Stat. Ann. §§ 15-16-901 to 15-16-931	Yes	Yes	No	Yes
Connecticut	Yes	Conn. Gen. Stat. Ann. 45a-545a to 45a-545cc	Yes	Yes	No	Yes
D.C.	Yes	D.C. Code §§ 19-1901 to 19-1929	Yes	Yes	No	Yes
Delaware	Yes	12 Del. C. § 3528	No	Silent	Silent	No
Florida	Yes	§ 736.04117, Fla. Stat.	No	Yes	Silent	Yes
Georgia	Yes	O.C.G.A. § 53-12-62	No	Yes	No	No
Hawaii	No	N/A	N/A	N/A	N/A	N/A
Iowa	Yes	Iowa Code Ann. § 633A.4215	No	No	Silent	No
Idaho	No	N/A	N/A	N/A	N/A	N/A
Illinois	Yes	760 ILCS 3/1201 to 3/1227	Yes	Yes	No	Yes
Indiana	Yes	Ind. Code § 30-4-10-1 to 30-4-10-60	Yes	Yes	No	Yes
Kansas	Yes	K.S.A. 58-5101 to 58-5130	Yes	Yes	No	Yes
Kentucky	Yes	KRS 386.175	No	Yes	No	No
Louisiana	No	N/A	N/A	N/A	N/A	N/A
Massachusetts	Proposed	N/A	N/A	N/A	N/A	N/A
Maryland	Yes	Md. Code Ann., Est. & Trusts §§ 14-601 to 14-625	Yes	Yes	No	Yes

Maine	Yes	18-B M.R.S.A. §§ 1201 to 1229	Yes	Yes	No	Yes
Michigan	Yes	MCL 556.115a	No	Yes	Silent	No
Minnesota	Yes	Minn. Stat. Ann. § 502.851	No	Yes	No	Yes
Missouri	Yes	§ 456.4-419, RSMo	No	Yes	Silent	Yes
Mississippi	No	N/A	N/A	N/A	N/A	N/A
Montana	Yes	Mont. Code Ann. §§ 72-39-101 to 72-39-303	Yes	Yes	No	Yes
North Carolina	Yes	N.C.G.S. §§ 36C-8B-1 to 36C-8B-30	Yes	Yes	No	Yes
North Dakota	Yes	N.D.C.C. §§ 59-16.1-01 to 59-16.1-17	No	Yes	No	Yes
Nebraska	Yes	Neb. Rev. St. §§ 30-4501 to 30-4529	Yes	Yes	No	Yes
New Hampshire	Yes	N.H. RSA § 564-B:4-418	No	No	No	No
New Jersey	No	N/A	N/A	N/A	N/A	N/A
New Mexico	Yes	NMSA 1978, §§ 46-12-101 to 46-12-129	Yes	Yes	No	Yes
Nevada	Yes	NRS 163.556	No	No	No	Yes
New York	Yes	N.Y. EPTL § 10-6.6	No	Yes	No	Yes
Ohio	Yes	Ohio R.C. 5808.18	No	Yes	No, unless testamentary trust	No
Oklahoma	Yes	Okla. Stat. tit. 60, §§ 175.701 to 175.719	No	Yes	No	Yes
Oregon	No	N/A	N/A	N/A	N/A	N/A

Pennsylvania	No	N/A	N/A	N/A	N/A	N/A
Rhode Island	Yes	R.I. Gen. Laws § 18-4-31	No	Yes	Silent	No
South Carolina	Yes	S.C. Code Ann. § 62-7-816A	No	Yes	No	No
South Dakota	Yes	SDCL 55-2-15 to 55-2-21	No	No	No	No
Tennessee	Yes	T.C.A. § 35-15-818	No	Silent	Silent	No
Texas	Yes	Tex. Prop. Code Ann. §§ 112.071 to 112.087	No	Yes	No	No
Utah	No	N/A	N/A	N/A	N/A	N/A
Virginia	Yes	Va. Code Ann. §§ 64.2-779.1 to 64.2-779.25	Yes	Yes	No	Yes
Vermont	Yes	14A V.S.A. §§ 1401 to 1429	Yes	Yes	No	Yes
Washington	Yes	RCW 11.107.010 to 11.107.080	Yes	Yes	Silent	Yes
Wisconsin	Yes	Wis. Stat. §§ 701.1301 to 701.1327	Yes	Yes	No	Yes
West Virginia	Yes	W. Va. Code §§ 44d-8b-1 to 44d-8b-31	Yes	Yes	No	Yes
Wyoming	Yes	Wyo. Stat. Ann. § 4-10-816(a)(xxviii), (b)	No	Silent	Silent	No

VI. Tax and Benefits Consequences

A. Income Tax Implications

- **Grantor vs. Non-Grantor Status**
  Decanting may inadvertently shift the trust's classification. If the first trust is a grantor trust and the second trust lacks the necessary powers (e.g., retained power to substitute assets), it could become a non-grantor trust, triggering different tax treatment and reporting obligations.
- **Carryover Basis and Tax Attributes**
  Assets transferred to the new trust generally retain their original basis and holding period. However, if decanting is deemed a taxable event (e.g., due to beneficiary changes), this could trigger gain recognition or loss of favorable tax attributes.
- **Non-taxable if**: The second trust is a continuation of the first one and authorized by law or the trust document.
- **Taxable if**: The trust has liabilities exceeding asset basis or converts from grantor to non-grantor during the grantor's life.
- **State Tax Strategy**: Trustee may move the trust's situs to a state with no income tax to reduce annual tax burdens. Some state statutes allow the situs of the trust to be changed without restrictions.

B. Gift and Estate Tax Risks

- **Gift Tax**: Triggered when a beneficiary consents to a trust modification, decanting, or restructuring that results in a reduction of their beneficial interest, the IRS may treat that consent as a taxable gift to the other beneficiaries.
- **Estate Tax**: Generally self-settled trusts are grantor trusts so assets will be includable in their estate for estate tax purposes.

VII. How Does the Social Security Administration (SSA) Treat Decanted Trusts?

A. Decanting From a Self-Settled SNT to a Second Self-Settled SNT

Although decanting has gained significant traction over the past decade as a flexible estate planning tool, the treatment of a decanted trust by SSA remains unpredictable and case dependent. Even when decanting is permitted under state law, the lack of consistent SSA guidance means the second trust may still face adverse treatment under SSA's resource-counting rules.

The SSA evaluates decanting under its early termination policy found at POMS SI 01120.199. This section applies to self-settled trusts and pooled trusts.[4] It does not apply to third party SNT's as those are established with assets of a third party, not the disabled individual's assets and do not require compliance with the early termination policy set forth in SI 01120.199. It does, however, apply in circumstances where an irrevocable trust (a non-special needs trust) is decanted to a self-settled trust. In that case, SSA will apply the early termination policy but will focus on the substance of the second trust**,** not the first trust, and will apply the full review criteria under POMS SI 01120.201.[5]

POMS SI 01120.199D.7 defines decanting as follows:

> Trust decanting generally refers to the distribution or transfer of trust property from one trust to one or more other trusts, usually with more favorable terms. Decanting ***may*** involve the early termination of the first trust, or the effect of decanting ***may*** be materially the same as the effect of an early termination. In such a situation, we generally evaluate the decanting provision under the instructions on early termination in this section. However, decanting can be complex and can vary depending on applicable State law. It may be appropriate for the RO to seek input from OPLaw. (emphasis added).

When evaluating whether a decanted trust constitutes an early termination of the original self-settled special needs trust, SSA focuses its analysis on the following factors[6]:

1. Whether the decanting results in a distribution of assets during the beneficiary's lifetime that bypasses the required Medicaid payback provision.

2. After reimbursement to the state Medicaid agency and any administrative expenses allowed under SI 01120.199E.3[7], the remaining trust funds may only be distributed to or for the sole benefit of the trust beneficiary.

3. The trust beneficiary cannot possess the power to terminate the trust. This power must be exercised by the Trustee or some other individual or entity.

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[4] POMS SI 01120.199A

[5] POMS SI 01120.201outlines the criteria SSA applies to evaluate trusts established on or after January 1, 2000 to determine whether they are countable resources for SSI purposes.

[6] See POMS SI 01120.199E.1

[7] The only administrative expenses allowed under POMS SI 01120.199E.3 are state and federal taxes payable due to the trust termination and reasonable fees and administrative expenses related to the termination of the trust.

SSA's determination hinges on whether the second trust materially alters the first trust's protective structure. Even if the decanting is valid under state law, any provision that enables premature access, circumvents Medicaid recovery, or grants the beneficiary the power to terminate, may be treated as an early termination event, jeopardizing SSI eligibility. In addition to the above considerations, presumably the trust beneficiary would have to be under age 65 to decant to a self-settled trust pursuant federal law.[8]

There is a limited exception to the early termination policy. Under SI 01120.199E.2, if the early termination clause in the first self-settled SNT "allows solely for a transfer of the beneficiary's assets to a secondary section 1917(d)(4)(A) . . . trust of which the same individual is the beneficiary", then the elements of early termination do not need to be met, provided that the early termination clause contains specific limiting language that "precludes the early termination from resulting in disbursements other than to the [second self-settled SNT] or to pay administrative expenses listed in SI 01120.199E.3"[9] The effect of the limited exception means that a self-settled SNT may contain a decanting provision without a Medicaid reimbursement clause or the other elements of the early termination policy so long as the specific terms of the limited exception are present in the decanting provision.

Below I've provided a synopsis of the primary factors SSA considers when reviewing decanted self-settled SNT's.

[8] See 42 U.S.C 1396p(d)(4)(A)
[9] See footnote 7, supra.

SSA Primary Factors for Determining Early Termination via Decanting of Self-Settled Trusts

Factor	SSA Focus	Implication
Who receives the remaining assets	examines whether the decanted trust allows assets to be distributed to anyone other than the state Medicaid agency upon termination.	If assets can go to the beneficiary or third parties before death, bypassing reimbursement to Medicaid, SSA may treat the trust as a countable resource.
Timing of termination	looks at whether the trust can be terminated during the beneficiary's lifetime.	Early termination during life without preserving Medicaid recovery rights raises red flags.
Control over termination	assesses who has authority to terminate the trust (e.g., beneficiary, trustee, court).	If the beneficiary has direct or indirect control, the trust may be deemed accessible and countable.
Preservation of Medicaid payback provision	checks whether the decanted trust retains the original payback clause.	Omission or dilution of this clause may result in disqualification.
Continuity of irrevocability	verifies that the new trust remains irrevocable.	If the decanted trust is revocable, it may be treated as a resource.
Substantive changes to trust terms	reviews whether the decanting altered distribution standards, remainder beneficiaries, or administrative powers.	Omission or dilution of this clause may result in disqualification.

B. Avoiding the Early Termination Policy When Decanting from a Self-Settled SNT

The SSA's decanting policy is vague and ambiguous. It does not definitively state whether its application of the early termination policy to decanting is mandatory. Rather, it appears to be subjective, indicating that decanting "***may*** involve the early termination of the first trust,"[10] or it ***may*** have the material effect of early termination. This makes decanting a self-settled SNT risky and fraught with uncertainty. The end result of which could be the loss of SSI benefits for the beneficiary or depletion of the SNT if the Medicaid payback provision is invoked.

[10] See POMS SI 01120.199D.7

So, what can trustees and counsel do to steer clear of having the early termination policy applied to the decanting of a self-settled SNT? Consider structuring the decanting to resemble a modification, amendment to, or restatement, instead of a termination of the first trust, thereby preserving continuity and minimizing disruption of public benefits. Support for the proposition that the SSA may treat a decanted trust as a modification or amendment to the first trust can be found in POMS SI 01120.202A.1.a.[11] The relevant language states:

> "Evaluate all trusts where an applicant, recipient, or spouse alleges an interest in a trust that needs a resource determination (***such as a new or amended trust***) in all initial claims and post eligibility events." (emphasis added).[12]

The section proceeds to outline:

> "For PE events [post eligibility], do not reevaluate the trust resource determination (of a trust that has previously been reviewed) unless there is ***new and material evidence, such as an amendment to the trust*** or a clarification or change in policy that may affect the trust resource determination."[13]

To effectuate a modification of the first trust, apply the following:

3. Consult state law to determine if modification or amendment is permissible.
4. Retain the name of the first trust. This also avoids having to retitle the assets which can appear as a distribution and this a termination.
5. Retain the taxpayer identification number of the first trust.
6. Retain the same beneficiaries and remainder beneficiaries.
7. Preserve the Medicaid payback provision.
8. The trust must be irrevocable.
9. Avoid language that implies termination, revocation or beneficiary control.
10. Document the intent and rationale for the decanting or modification, emphasizing continuity of protective provisions.

The key is to ensure that any modification preserves the first trust's protective framework without introducing substantive changes. Given SSA's deference to state trust law and the fact that SI 01120.202A.1.a appears to give effect to properly executed trust amendments, trustees in states that authorize decanting by modification (whether by statute or common law) may reduce the risk of triggering the early termination policy. I venture to say that even if a state statute or common law is silent as to modification, it is worth considering.

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[11] POMS SI 01120.202A.1.a which governs the development and documentation of trusts established on or after January 1, 2000.
[12] Id.
[13] Id.

C. Decanting Clauses in Self-Settled Trusts

While decanting does seem possible under the SSA regulations if their early termination policy is met, it is not well-settled yet. The idea of having a decanting provision in a self-settled trust sounds appealing but may do more harm that good if not properly drafted to comply with SSA's requirements. The risk of losing SSI and Medicaid benefits for the beneficiary may outweigh the convenience of having a decanting provision in the trust. Consider leaving out a decanting provision in self-settled SNT's or craft the language very carefully.

D. Additional Materials on Decanting

The SSA does give us some guidance in the form of Regional Chief Counsel (RCC) opinions.[14] These opinions are state-specific and limited in circumstances, some of them relate to pooled trusts, but at least offer some insight into the mind of the SSA relative to decanting. The following is a very brief overview of some of these opinions and are provided for your reading pleasure (or as a sleep aid).

1. PS 18-106 Does an early termination clause in a Special Needs Trust meet SSA policy requirements for continued eligibility for SSI? (at POMS PS 01825.026G, (Minnesota)). In this case, the RCC distinguished early termination from decanting under the Minnesota decanting statute because the assets of the first trust were transferred to the second trust after early termination.

2. PS 20-068 Analysis of the Sixth Alaska Amendment to the Secured Futures Pooled Special Needs Trust Agreement, dated October 23, 2019 (at PS 01825.002B. (Alaska)), the RCC equates an early termination "rollover" with decanting without discussion of when the asset transfer takes place. (See following paragraph, noting the requirement for the POMS limiting language as required in SI 01120.199E.2.)

   "An early-termination provision need not satisfy these three criteria if it solely allows for the "**decanting**" of a beneficiary's assets from one pooled trust under 42 U.S.C. § 1396p(d)(4)(C) to another 42 U.S.C. § 1396p(d)(4)(C) trust. POMS SI 01120.199.F.2. However, the trust must specify that, in such a trust-to-trust transfer, the only permissible disbursements are the transfer of sub-account funds to the secondary trust and the payment of allowable administrative expenses. POMS SI 01120.199.F.2"

[14] The term RO refers to a Regional Officer and the term OPLAW refers to Office of Program Law. A Regional Officer oversees field operations across a geographic area, ensuring compliance with federal policies and coordinating service delivery. The Office of Program Law provides legal guidance on SSA's benefit programs, drafts regulations, and ensures that agency policies align with federal law.

3. PS 20-064 Analysis of the [Amended] National Foundation for Special Needs Integrity Pooled Trust for the State of Idaho (at PS 01825.015 (Idaho)) applies certain early termination requirements to decanting. The RCC applied the early termination "rollover" requirements to decanting as follows:

   "The amended NFSNI Trust clarifies a problematic termination clause in the earlier version. Specifically, language in that Trust agreement allowed for decanting, but did not specify such decanting must be to another 42 U.S.C. § 1396p(d)(4)C) trust, as is required. After amendment, the termination clause now specifies decanting to "a not-for-profit pooled special needs trust in compliance with 42 U.S.C. § 1396p(d)(4)(C)." Master Trust, art. 16.1 (as amended). This clarification means that the Trust now satisfies the sole benefit requirement."

4. PS 21-006 Analysis of Life Enrichment Trust's Oregon Pooled Trust (at PS 01825.041A. (Oregon)) applies early termination "rollover" requirements to decanting (See following paragraph).

   "The 2017 Trust contains an early termination provision that does not violate the sole benefit criteria. The early termination provision has two parts. Master Trust Agreement, "Amendment or Termination of the Trust." First, if it becomes impossible or impractical to carry out the purpose of the trust, then the trustee may, in its discretion, choose to terminate the trust. Id. The trustee will first try to transfer the funds to another qualifying 42 U.S.C. § 1396p(d)(4)(C) trust. Id. This **decanting** provision satisfies the requirements of POMS SI 01120.199.E.2, which states that a decanting clause must contain specific language that precludes disbursement of funds to anything other than a qualifying 42 U.S.C. § 1396p(d)(4)(C) trust or to pay allowable expenses. Here, the decanting provision provides that the funds of the trust, without qualification or limitation, will be transferred to a qualifying trust."

VII. Alternatives to Decanting

- Trust modification via court petition
- Non-judicial settlement agreements
- Powers of appointment or amendment clauses
- Creating a new supplemental trust and merging assets

VIII. Conclusion

The bottom line is, yes! You can decant. But it depends on your specific circumstances and be aware of your state's decanting statute, case law (even if you live in a state with a statute as sometimes statutes and case law conflict), the social security POMS, and how they all converge.

Effective Dates: 05/24/2024 - Present

TN 100 (08-24)

SI 01120.199 Early Termination Provisions and Trusts

A. When to apply the policies in this section

This section applies to:

- **special needs trusts** intending to meet the requirements for exception to resource counting under section **1917(d)(4)(A)**of the Social Security Act (Act) (see SI 01120.203); and
- **pooled trusts** intending to meet the requirements for exception to resource counting under section **1917(d)(4)(C)** of the Act (see SI 01120.203).

This includes trusts that:

- are newly formed; or
- have not been previously excepted from resource counting under section 1917(d)(4)(A) or 1917(d)(4)(C) of the Act; or
- were previously excepted from resource counting under section 1917(d)(4)(A) or section 1917(d)(4)(C) of the Act, but that need to be amended for continued exception.

Trusts cannot be excepted under section 1917(d)(4)(A) or 1917(d)(4)(C) of the Act unless their early termination provisions meet the requirements in this section.

Trusts that were previously determined to meet the requirements for exception continue to be excepted, provided they are amended to conform with the requirements of this section within 90 days. For more information on the 90-day amendment period, see SI 01120.201K.2. For more information on the manual notice to send if the trust still does not conform with the policy requirements within 90 days, see SI 01120.204D.

B. Case processing alert for early termination provisions and trusts

Trusts are often complex legal arrangements involving State law and legal principles that require legal counsel. Therefore, the following instructions may be sufficient only to recognize that an issue is present that you should refer to the regional office (RO) for possible referral to the Office of Program Law (OPLaw). When in doubt, discuss the issue with the RO staff or submit the inquiry via vHelp.

C. What is an early termination provision?

An early termination provision allows a trust to terminate before the death of the beneficiary. Commonly, such provisions provide for termination of the trust when, for example, the beneficiary is no longer disabled or otherwise becomes ineligible for Supplemental Security Income (SSI) and Medicaid, or when the trust no longer contains enough assets to justify its continued administration.

D. Defining terms for trusts

1. Trust

A trust is a property interest whereby property is held by an individual or entity (e.g., a bank) called the trustee, subject to a fiduciary duty to use the property for the benefit of another (i.e., the beneficiary).

2. Trust established with the assets of an individual

We consider a trust to be established with the assets of an individual if any assets of the individual or spouse were transferred to the trust other than by a will. To determine what we consider an "asset," see SI 01120.201B.1.

3. Grantor

A grantor, also referred to as a settlor or trustor, is the individual who provides the trust principal or corpus. The grantor must be the owner of, or have a legal right to, the property or otherwise be qualified to transfer it. For more information on grantors, see SI 01120.200B.3.

4. Trustee

A trustee is a person or entity that holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for their or its own benefit.

5. Trust beneficiary

A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but has an equitable ownership interest in it. As equitable owner, the beneficiary has certain rights that will be enforced by a court because the trust exists for their benefit. The beneficiary receives the benefits of the trust, while the trustee holds the title and duties. A beneficiary has certain rights relative to the trust, such as to enforce mandatory provisions of the trust, to demand an accounting, and to sue to remove the trustee. The trustee owes certain duties, such as loyalty and attention, to the beneficiary.

6. Trust principal

The trust principal is the property that is placed in trust by the grantor and held by the trustee, subject to the rights of the beneficiary. It includes any earnings on the trust. It is also called "the corpus of the trust."

7. Decanting

Trust decanting generally refers to the distribution or transfer of trust property from one trust to one or more other trusts, usually with more favorable terms. Decanting may involve the early termination of the first trust, or the effect of decanting may be materially the same as the effect of an early termination. In such a situation, we generally evaluate the decanting provision under the instructions on early termination in this section. However, decanting can be complex and can vary depending on applicable State law. It may be appropriate for the RO to seek input from OPLaw.

8. Other definitions

For other definitions applicable to this section, see SI 01120.200B.

E. Policy for early termination provisions

Apply the following policies to early termination provisions in trusts intending to comply with section 1917(d)(4)(A) or 1917(d)(4)(C) of the Act.

1. Criteria for determining whether an early termination provision is acceptable

A trust that contains an early termination provision may not be excepted from the SSI resource counting rules at section 1613(e) of the Act unless it satisfies the requirements in either section 1917(d)(4)(A) or section 1917(d)(4)(C). Additionally, the trust must satisfy the resource counting rules in SI 01120.200D and SI 01110.100B in order not to be a countable resource. To meet those requirements, all of the following criteria must be met:

- Upon early termination (i.e., termination prior to the death of the trust beneficiary), the State(s), as primary assignee, would receive all amounts remaining in the trust at the time of termination up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s); and

- Other than payment for the administrative expenses listed in SI 01120.199E.3 in this section and in SI 01120.201F.4, no individual or entity other than the trust beneficiary may benefit from the early termination (i.e., after reimbursement to the State(s), **all** remaining funds are disbursed so as solely to benefit the trust beneficiary); and

- The early termination provision gives the power to terminate to an individual or entity other than the trust beneficiary.

NOTE: For trusts that are excepted from resource counting under section 1917(d)(4)(C) as a pooled trust and do not contain an early termination provision, it is permissible for the trust to retain amounts remaining in the individual's account upon the death of the individual. For more information, see SI 01120.203D.8.

2. Exception for transfers to a secondary trust upon early termination

An early termination provision in a section 1917(d)(4)(A) special needs trust or section 1917(d)(4)(C) pooled trust does not need to meet the above criteria if the provision allows solely for a transfer of the beneficiary's assets to a secondary section 1917(d)(4)(A) or section 1917(d)(4)(C) trust of which the same individual is the beneficiary.

The early termination provision must contain specific limiting language that precludes the early termination from resulting in disbursements other than to the secondary section 1917(d)(4)(A) or section 1917(d)(4)(C) trust or to pay for the administrative expenses listed in SI 01120.199E.3 in this section and in SI 01120.201F.4.

3. Allowable administrative expenses paid from the trust

The following types of administrative expenses may be paid from the trust prior to reimbursement of medical assistance to the State(s):

- Taxes due from the trust to the State(s) or Federal government due to the termination of the trust; and

- Reasonable fees and administrative expenses associated with the termination of the trust.

For more information about allowable and prohibited expenses, see SI 01120.203E.

F. Procedure for the development and documentation of trusts

For instructions on how to develop and document the trusts to which this section applies, see SI 01120.202.

G. Examples of trust evaluations and determinations

The following examples are illustrative of situations you may encounter.

- Do not rely solely on the analysis provided in the examples in making determinations in a specific case, as laws vary from State to State and the language of individual trust documents may warrant different treatment from that given in an example.

- Refer to applicable regional instructions and consult your RO as necessary. Also, be aware of the implications that the trust may have for Medicaid eligibility - see SI 01730.048.

1. Unacceptable early termination provisions

EXAMPLE 1: A special needs trust contains an early termination provision stating that, upon early termination, all assets remaining in the trust will be distributed to the trust beneficiary. The provision gives the trustee or the trust beneficiary the power to terminate.

Treatment: This early termination provision is unacceptable for two reasons. First, upon early termination, the trust does not provide first for reimbursement to the State(s) for the amount of medical assistance paid on behalf of the trust beneficiary. Second, the early termination provision gives the trust beneficiary the power to terminate the trust.

EXAMPLE 2: A pooled trust established in State X contains an early termination provision stating that, upon early termination, State X will receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State X Medicaid plan. After reimbursement to State X, any remaining funds will be distributed evenly among the other sub-accounts in the pooled trust. The provision gives the trustee the power to terminate.

Treatment: This early termination provision is unacceptable for two reasons. It restricts Medicaid payback to State X rather than requiring payback to any State(s) that paid medical assistance on behalf of the trust beneficiary. It also allows for individuals or entities other than the trust beneficiary (i.e., the other pooled trust sub-accounts) to benefit from the early termination.

2. Acceptable early termination provisions

EXAMPLE 1: A special needs trust contains an early termination provision stating that, upon early termination, the State(s) will first be reimbursed for the amount of medical assistance paid on behalf of the trust beneficiary, and any remaining assets will be distributed to the beneficiary. The provision gives the trustee the power to terminate.

Treatment: This early termination provision is acceptable because it meets all three criteria in SI 01120.199E.1 in this section.

EXAMPLE 2: A pooled trust contains an early termination provision stating that, upon early termination, trust assets may solely be transferred to a secondary section 1917(d)(4)(A) trust, or a secondary section 1917(d)(4)(C) trust, where the beneficiary of the original trust also is the beneficiary of the secondary trust.

Treatment: This early termination provision does not meet the regular criteria for an acceptable early termination provision outlined in SI 01120.199E.1 in this section. However, it meets the exception to the regular criteria, set out in SI 01120.199E.2 in this section, by allowing solely for a transfer of the beneficiary's assets to a secondary section 1917(d)(4)(A)

trust, or a secondary section 1917(d)(4)(C) trust, of which the same individual is the beneficiary.

H. References

- SI 01120.200 Trusts – General, Including Trusts Established Prior to 1/1/00, Trusts Established with the Assets of Third Parties and Trusts Not Subject to Section 1613(e) of the Social Security Act
- SI 01120.201 Trusts Established with the Assets of an Individual on or after 1/1/00
- SI 01120.202 Development and Documentation of Trusts Established on or after 1/1/00
- SI 01120.203 Exceptions to Counting Trusts Established on or after 1/1/00
- SI 01150.100 What is a Resource Transfer
- SI 01150.121 Exceptions – Transfers to a Trust
- SI 01730.048 Medicaid Trusts

Program Operations Manual System (POMS)

Effective Dates: 10/31/2017 - Present

TN 83 (05-24)

SI 01120.202 Development and Documentation of Trusts Established on or After 01/01/00

A. Procedure for trust development

1. General development for written trusts

a. When to evaluate trust documents

Evaluate all trusts where an applicant, recipient, or spouse alleges an interest in a trust that needs a resource determination (such as a new or amended trust) in all initial claims (IC) and posteligibility (PE) events.

For PE events, do not reevaluate the trust resource determination (of a trust that has previously been reviewed) unless there is new and material evidence, such as an amendment to the trust or a clarification or change in policy that may affect the trust resource determination. However, evaluate all potential income implications, such as those of trust distributions and payments. For resource status changes in PE events, see SI 01120.201K.

b. Review the trust document(s)

Obtain a copy of the trust document (the original trust document is not required) and any related document(s) and review the document(s) to determine whether the:

- individual is the grantor, trustee, or trust beneficiary;
- trust was established before, on, or after 01/01/00;
- assets were transferred into the trust before, on, or after 01/01/00;
- trust was funded with assets of the individual or third parties or both;

CAN'T YOU DECANT?

STETSON LAW
2025 Nation Conference on
Special Needs Planning and Special Needs Trusts

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INTRODUCTION "CAN'T YOU DECANT?"

- Yes . . . But . . .
- Some Considerations
  - State Statutes and Common Law
  - Public Benefits
  - Tax Implications
  - Trust Instrument
- Focus on decanting from a self-settled trust to another self-settled trust

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WHAT IS DECANTING?

- Process by which a trustee may transfer or "pour over" an irrevocable trust another irrevocable trust
- Typically, without the need for court approval (State specific)
- Applicable to special needs trusts

3

When Is Decanting Appropriate?

- Initiated by the trustee to:
  - Preserve beneficiary's benefits
  - Correct drafting errors or ambiguities
  - Update trustee provisions
  - Respond to Changed Circumstances
  - Modernize
  - Consolidate or segregate trust assets

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Statutory vs. Common Law Authority

- Statutory
  - Clear authority with procedural instructions
  - Less risky as opposed to common law
  - 41 States have decanting statutes
  - 26 of them have special needs trust provisions
- Common Law
  - Relies on judicial interpretation
  - Vague and case specific
- Default rules - trust itself governs in most cases

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The Uniform Trust Decanting Act (UTDA)

- Created by the Uniform Law Commission in 2015 to provide guidance to states on:
  - Uniform method to decant
  - Permit flexibility in decanting
  - Maintain settlor's intent
  - Prevent abuse of trustee's discretion
- Adopted by 19 states while 23 have their own variation.

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KEY FIDUCIARY CONSIDERATIONS:

- Fiduciary duty
- Notice requirements
- Court involvement (if any)
- Change of situs

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FIDUCIARY DUTY

- Duty of loyalty to the beneficiary
- Duty of prudence to exercise care, skill and caution
- Duty of impartiality to balance the interest of all beneficiaries
- Preserve Settlor's intent
- Best practice – include fiduciary analysis in trust file showing decanting in best interest of beneficiary

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NOTICE REQUIREMENTS

- Consult state or common law:
  - Is notice required and
  - To whom
- Generally, written notice to the following:
  - Settlor, if living
  - Current beneficiary (or legal representative)
  - Remainder beneficiaries
  - Co-trustees, trust protector
  - State Medicaid agency (if required)
  - Social Security (if required)

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COURT INVOLVEMENT

- Generally, not necessary
- Trustee or beneficiary could seek court intervention:
  - Determine/clarify who is entitled to notice & was it proper
  - Approve or authorize Trustee authority to decant
  - Provide instructions to Trustee (clarify ambiguities)
  - Settle disputes among Trustees or beneficiaries
  - Provide relief under statutory or common law
  - Decant a testamentary trust

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CHANGE OF SITUS

- Take advantage of more favorable decanting laws in another state
- Review trust for authority to change situs
- Consult state statute for authority
- Watch out for the rule of perpetuity
  - Violation can render future trust interest void, undermining trusts long term structure

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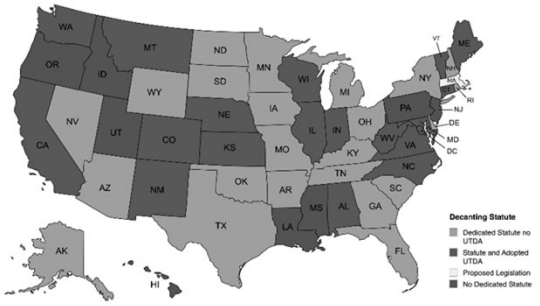
STATE-BY-STATE COMPARISON

- Number of states with decanting statutes has grown in the last 10 years
- Detailed chart in materials – key points:
  - 41 states with decanting statutes
  - 26 have carve out for special needs trusts
  - 9 are common law states (no statute)
  - 1 has legislation pending (Massachusetts)
  - Most states mandate notice
  - None require prior consent (except Ohio-testamentary trusts)

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STATE BY STATE COMPARISON



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SOCIAL SECURITY CONSIDERATIONS

SSA defines decanting in POMS SI 01120.199D.7:

Trust decanting generally refers to the distribution or transfer of trust property from one trust to one or more other trusts, usually with more favorable terms. Decanting ***may*** involve the early termination of the first trust, or the effect of decanting ***may*** be materially the same as the effect of an early termination. In such a situation, we generally evaluate the decanting provision under the instructions on early termination in this section. However, decanting can be complex and can vary depending on applicable State law.

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SOCIAL SECURITY CONSIDERATIONS

- SSA treatment of decanting is unpredictable and case specific
- SSA evaluates decanting under its early termination policy under POMS SI01120.199
- Applies only to self-settled and pooled SNT's
- SSA does not require 3rd party SNT compliance with the early termination policy

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Social Security Considerations

- SSA Early Termination Factors Applied to Decanting:
  - Did decanting result in distribution to beneficiary that bypassed the required Medicaid payback provision
    - Depends on whether SSA considers the 2nd trust terminated or modified
  - After Medicaid payback & admin expenses listed in SI 01120.199E.3, remaining funds may only be distributed to/for sole benefit of beneficiary (this provision must be in the second trust)
  - Beneficiary cannot possess the power to terminate the trust. (this provision must be in the 2nd trust)

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Social Security Considerations

Factor	SSA Focus	Implication
Who receives the remaining assets	examines whether the decanted trust allows assets to be distributed to anyone other than the state Medicaid agency upon termination.	If assets can go to the beneficiary or 3rd parties before death, bypassing reimbursement to Medicaid, SSA may treat the trust as a countable resource.
Timing of termination	looks at whether the trust can be terminated during the beneficiary's lifetime.	Early termination during life without preserving Medicaid recovery rights raises red flags.
Control over termination	assesses who has authority to terminate the trust (e.g., beneficiary, trustee, court).	If the beneficiary has direct or indirect control, the trust may be deemed accessible and countable.
Preservation of Medicaid payback provision	checks whether the decanted trust retains the original payback clause.	Omission or dilution of this clause may result in disqualification.
Continuity of irrevocability	verifies that the new trust remains irrevocable.	If the decanted trust is revocable, it may be treated as a resource.
Substantive changes to trust terms	reviews whether the decanting altered distribution standards, remainder beneficiaries, or administrative powers.	Omission or dilution of this clause may result in disqualification.

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Social Security Considerations

- Limited Exception to Early Termination Policy:
  - POMS SI 01120.199E.2
  - Applies when the 1st SNT's early termination clause only allows transfer to a 2nd self-settled trust for the same beneficiary.
  - The clause must include limiting language that:
    - Prohibits disbursements except to the 2nd SNT or for administrative expenses listed in SI 01120.199E.3.
  - Early termination criteria under SI01120.199E.1 do not apply.
  - Result: A self-settled SNT ***may*** include a decanting provision without a Medicaid payback clause, as long as the limited exception terms are satisfied.

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CIRCUMVENT EARLY TERMINATION POLICY

- Decant to modify or amend vs. termination
  - Consult state law – modification/amend permissible
  - Retain name of 1st trust
  - Retain same TIN
  - Preserve Medicaid payback provision
  - Retain irrevocable status
  - Avoid language that implies termination or beneficiary control
  - Document the intent to decant – emphasize continuity of protective provisions

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CIRCUMVENT EARLY TERMINATION POLICY

- Support for SSA treatment of decanted trust as a modification or amendment.
  - POMS SI 01120.202A.1.a
    - "Evaluate all trusts where an applicant, recipient, or spouse alleges an interest in a trust that needs a resource determination (***such as a new or amended trust***) in all initial claims and post eligibility events." (emphasis added).

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DECANTING CLAUSE IN SELF-SETTLED SNT

- Decanting under SSA regs possible but still uncertain
- Including a decanting provision in a self-settled trust can be risky if not carefully drafted.
- Risk of jeopardizing SSI and Medicaid benefits.
- The risks may outweigh the benefits of convenience.
- Consider omitting decanting provisions in self-settled SNTs or draft with extreme care.

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ALTERNATIVES TO DECANTING

- Trust modification via court petition
- Non-judicial settlement agreements
- Powers of Appointment/limited amendment clauses
- Creating a new supplement trust and merging assets

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CONCLUSION

- The Bottom Line – Yes! You can decant . . . But proceed with caution.
- Case specific
- Consult your state's law
- Consult POMS

THANK YOU!

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October 23, 2025

Medicaid's Right to Reimbursement and Special Needs Trusts

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I. Introduction: Beginning at the End

When discussing special needs trusts with a client, one normally begins with distinguishing a third-party special needs trust from a first party special needs trust. Assuming the focus of the discussion is on first party special needs trusts, the foregoing would follow with the requirements to establish a first party special needs trust, one of which is to provide for reimbursement to Medicaid on termination of the trust. Although Medicaid's right to reimbursement from a first party special needs trust would no doubt be discussed with a client, it may not be given the attention it is due. This discussion is going to instead begin with and primarily focus on all things termination as it relates to a first party special needs trust. Hopefully, at the conclusion of the discussion, one will have a greater appreciation for the importance of beginning at the end, that is, ensuring that those contemplating a first party special needs trust arrangement enter into it knowingly when it comes to what happens at the time the trust terminates.

II. In the Beginning, . . .

How can it be that first party special needs trusts were codified more than thirty years ago?! It bears reviewing the originating legislation and developments in the law that have since followed with an eye towards the language surrounding termination of these trusts and Medicaid's right to reimbursement.

A. Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

OBRA '93 carved out three critical exceptions to the newly penalized transfers into irrevocable trusts and the countability of the income and assets of such trusts pursuant to 42 U.S.C. § 1396p(d)(4), all of which require reimbursement to Medicaid on their termination as follows:

1. Under subsection (A), a "disabled under age 65" must provide that **the State will receive all amounts remaining in the trust upon the death of such individual up**

to an amount equal to the total medical assistance paid on behalf of the individual. A "disabled under age 65" trust arguably contends with reimbursement to Medicaid upon the death of the beneficiary more frequently than the other exempt trusts.

2. Under subsection (B), an "income-only or Miller" trust must provide that **the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual**. An "income-only or Miller" trust as this trust is commonly known or referred to is the least likely of the three exempt trusts to have anything remaining in the trust upon its termination.

3. Under subsection (C), a "pooled" trust must provide that, **to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.** A majority of "pooled" trusts retain some portion or all amounts remaining upon the death of the beneficiary and, as such, reimbursement to Medicaid may not be at issue or, if so, limitedly so.

B. HCFA Transmittal 64[1]

This famous transmittal of the Health Care Financing Administration ("HCFA") now Center for Medicare and Medicaid Services ("CMS") was published as guidance for State Medicaid Manual Chapter 3 Eligibility Sections 3257 to 3259.8, which sections addressed the transfer of assets and treatment of trusts post-OBRA '93. With regards to Medicaid's right to

[1] The State Medicaid Manual | CMS. As recently as 2024, this manual was also available on the Department of Health and Human Services website but no longer is.

reimbursement from one of the exempt trusts established pursuant to 42 U.S.C. § 1396p(d)(4), the guidance of the transmittal essentially parrots the statute.

C. Foster Care Independence Act of 1999

OBRA '93 only affected eligibility for long-term care Medicaid. For the decade that followed, it was unclear whether the Supplemental Security Income ("SSI") program recognized special needs trusts. The Foster Care Independence Act of 1999 caught up with Medicaid by not only providing for penalties for uncompensated transfers by SSI recipients,[2] but also adopting and mirroring the Medicaid special needs trust exceptions.[3]

D. SSA's Programs Operations Manual System (POMS)

The SI POMS has gone through many iterations when it comes to special needs trusts and termination or Medicaid payback language, with the most substantial overhaul being in 2009. As it stands, the POMS is protective of Medicaid's interests and requires a first party special needs trust to provide for repayment to the State Medicaid program all amounts remaining (but in the case of a pooled trust, only to the extent not retained by the trust) at the time of termination up to an amount equal to the total amount of medical assistance paid on behalf of the individual.[4] The POMS broadly contemplates termination of a first party special needs trust and reimbursement to Medicaid and does not limit it to time of death but at any time during the lifetime of the beneficiary.

III. First Party/Self-Settled SNT Termination Provisions

A. Early Termination Provisions

Federal Medicaid law and regulations expressly provide for reimbursement to Medicaid from a special needs trust at time of death only[5] while the SSA, as just noted, requires such a trust

[2] 42 U.S.C. § 1382b(c)(1)(A)(iv).
[3] 42 U.S.C. § 1382b(c)(1)(C)(ii)(IV).
[4] POMS SI 01120.203.B.8 and C.1.
[5] *See* 42 U.S.C. § 1396p(d)(4)(A)-(C) and HCFA Transmittal 64 at *supra* note 1.

to also provide for reimbursement to Medicaid in the event the trust is terminated during the lifetime of the beneficiary.[6] In so doing, the SSA speaks to why a special needs trust may provide for early termination, implying that these are the only permissible reasons for early termination: The beneficiary is no longer disabled or otherwise becomes ineligible for SSI and Medicaid, or the trust no longer contains enough assets to justify its continued administration.[7] As such, specifically referencing the foregoing in an early termination provision may be advisable. One must also be mindful of and include in an early termination provision of a special needs trust the limitations imposed by the POMS on the payment of administrative expenses (i.e., state and federal taxes due, reasonable fees and administration expenses associated with the termination of the trust).[8] What happens next if, after reimbursing Medicaid and paying administrative expenses as permitted, trust assets remain? They must be paid to the trust beneficiary![9]

Despite federal Medicaid law and regulations limiting Medicaid's right to reimbursement from a special needs trust to time of death, some state Medicaid programs, Arizona's for one, have gone astray in also requiring reimbursement in the event the trust is terminated during lifetime[10] and placing limitations on the payment of administrative expenses.[11] In this author's experience, which is limited to Arizona, its Medicaid program does not seek to be reimbursed from a special needs trust in the event the trust is terminated during lifetime if the beneficiary is solely

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[6] *See* POMS SI 01120.200.H.1.b. stating that "Medicaid trusts generally have a payback stating that upon termination of the trust, or the death of the beneficiary, the State Medicaid agency will be reimbursed . . ." and POMS SI 01120.199.E.1 that requires an early termination provision to provide for reimbursement to Medicaid.
[7] POMS SI 01120.199.
[8] *See id.*
[9] *See id.*
[10] *See* A.R.S. § 36-2934.01.A.1 which requires the trust to contain "specific language that protects the state's beneficiary interest in the trust and that names the administration or the state medicaid agency as the primary beneficiary of the trust **if the trust is terminated before or on the death of the member**."
[11] *See* A.R.S. § 36-2934.01.B.1 that limits disbursements from a special needs trust to reasonable legal and professional expenses related to the trust not just at time of termination but throughout the entirety of the administration of the trust.

eligible for Medicaid by virtue of being eligible for SSI, i.e., is categorically eligible for Medicaid, but only if the beneficiary is eligible for long-term care Medicaid. The foregoing is ironic, to say the least, given the POMS's requirement to provide for reimbursement to Medicaid on early termination.

B. Termination at Death Provisions

When it comes to termination of a special needs trust upon the death of the beneficiary, no one questions Medicaid's right to reimbursement. Again, though, limitations on payment of administrative expenses prior to such reimbursement exist[12] and, payment of expenses of last illness, funeral and burial may not be made until after Medicaid has been reimbursed.[13] In Arizona, if funeral and burial arrangements have not been made prior to the beneficiary's death, the trustee will be permitted to disburse up to but no more than $1,500 for such expenses with the prior approval of Medicaid (through its recovery agent).

If trust assets then remain, who may be the residual beneficiary? That is a loaded question. From a purely estate planning perspective, whether or not the beneficiary is or may one day be mentally capable of doing their own estate planning, preserving their ability to do so with a limited power of appointment is an option.[14] If this power is not exercised, then, presumably, the laws of intestacy will apply. If SSI eligibility is at issue for the beneficiary, a special needs trust may be presumptively revocable under state law if no residual beneficiary is named, thereby rendering the trust assets countable.[15] So, it may behoove the drafting attorney to name a residual beneficiary of a nominal interest before providing for distribution by intestacy.

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[12] *See* POMS SI 01120.203.E,
[13] *See id.*
[14] A general power of appointment is inadvisable as it may subject it to the claims of creditors of the beneficiary's estate.
[15] *See* POMSSI 01120.200.D.3.

The question of a residual beneficiary for SSI purposes is a non-issue if Medicaid is considered the residual or contingent beneficiary. The POMS assert that, according to the law in most states, the State is not considered a residual or contingent beneficiary but, rather, a creditor and reimbursement to Medicaid is considered the payment of the debt unless the trust reflects a clear intent that the State is a beneficiary rather than a creditor.[16] Who in their right mind would name Medicaid as a beneficiary?! Probably no one except when required to do so by Medicaid, which happens to be the case in Arizona.[17]

C. When All Else Fails. . .the Power to Amend

Even the most artfully crafted termination provision is bound to fail with the SSA or Medicaid eventually given changes in the law, regulation, policy, and the winds. With that in mind, a provision that provides for the power to amend a special needs trust is recommended. To ensure that a special needs trust is not rendered countable for SSI purposes, the power to amend should belong to someone other than the beneficiary and should be limited such that the trust assets are not considered available to the beneficiary for their maintenance and support.[18] The power to amend should not be general or broad in nature, but limited, so as not to jeopardize its status as irrevocable in the eyes of the pertinent governmental assistance programs.[19] For example, a limited power to amend could provide for amendments that ensure that the special needs trust continues to comply with the provisions of 42 U.S.C. § 1396p(d)(4), the POMS, and/or pertinent state Medicaid laws and regulations with the objective of ensuring the beneficiary remains financially eligible for public benefits or governmental assistance programs

[16] POMS SI 01120.200.H.1.b.
[17] *See* A.R.S. § 36-2934.01.A.1.
[18] *See* POMS SI 01120.D.1.a.
[19] Stating a special needs trust is "irrevocable" is not sufficient in and of itself for SSI eligibility purposes. *See* POMS SI 01120.D.e.

that are needs-based.

D. Third Party Special Needs Trusts

Keeping this short n' sweet--unless charitably inclined, do NOT provide for reimbursement to Medicaid as it is NOT required!

IV. The Nuances of Paying the Piper

No ifs, ands or buts, the time has come to pay the piper, so to speak--to at long last pay to "the State all amounts remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the [beneficiary]" of the special needs trust[20] (other than from those amounts retained by a pooled trust). If the beneficiary leaves survivors who were the beneficiary's caregivers and who may not have been compensated or compensated adequately for the care they rendered their loved one, the prospect of inheriting very little or nothing, is a harsh reality. Does no basis exist to deny Medicaid's claim for reimbursement in whole or in part?

A. Medicaid Estate Recovery

Just as OBRA '93 created exceptions for special needs trusts from the transfer penalty rules and their countability for eligibility purposes, this very law also mandated the states to institute an estate recovery program to seek to recover from the estate[21] of a Medicaid enrollee who was 55 years of age or older, at a minimum, payment for nursing facility services, home and community-based services, and related hospital and prescription drug services.[22] States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. States are also required to establish procedures for waiving estate recovery when recovery would cause an undue hardship.[23]

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[20] *See* 42 U.S.C. § 1396p(d)(4)(A)-(C).
[21] *See* 42 U.S.C. § 1396p(b)(1)(A).
[22] *See* 42 U.S.C. § 1396p(b)(1)(B)(i).
[23] *See* 42 U.S.C. § 1396p(b)(2)(A) and (3).

The obvious question is whether the limitations on estate recovery also apply to Medicaid's right to reimbursement from a special needs trust. Unfortunately, case law has arrived at the consensus that the age limitation, survivor exemptions, and undue hardship waiver that apply to estate recovery do not to apply to a special needs trust.[24] The statutory schemes and requirements are distinct primarily in that the special needs trust exceptions allow for individuals to financially qualify for Medicaid who otherwise would not. As such, those who choose to avail themselves of a special needs trust exception are opting for that reimbursement arrangement rather than that of estate recovery.[25]

B. Pre- and Post-Establishment of Special Needs Trust

Logic would have it that the requirement to reimburse Medicaid from a special needs trust would be limited to medical assistance paid from the time the trust was established. But who says logic is at play here? To the contrary, Medicaid's right to reimbursement from a special needs trust is not limited in duration and dates back to when the beneficiary was first eligible for and receiving such medical assistance. Take the POMS, for instance, which leaves no ambiguity on this point: "Medicaid payback . . .cannot be limited to any particular period of time; for example, payback cannot be limited to the period after establishment of the trust."[26] Case law follows suit finding that 42 U.S.C. § 1396p(d)(4) does not limit the payback to a particular period of time[27] and that the State can recover an amount equal to the total medical assistance paid.[28]

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[24] *See* Herting v. California Dept. of Health Care Services, 235 Cal.App.4th 607 (Cal. App. 2015); *see also* Gonzalez v. City National Bank, 36 Cal App.5th 734 (Cal. App. 2019).
[25] *See* Gonzalez, 36 Cal. App. 5th at 782 (*citing* Herting, 235 Cal.App.4th at 609, 614).
[26] POMS SI 01120.203.B.8. It is also in this provision that the POMS make clear that reimbursement cannot be limited to a particular state.
[27] *See* Matter of Abraham XX, 11 N.Y.3d 429 (N.Y. App. 2008); Cockrell v. Comm. of Social Security, Civ. Action 2:18-cv-1124 (S.D. Ohio 2019).
[28] *See* Matter of Abraham XX, 11 N.Y.3d 429 (N.Y. App. 2008).

That being said, in those instances where the special needs trust is funded with a third party recovery, i.e., a personal injury settlement, consider whether a Medicaid lien[29] was paid prior to funding the special needs trust. If so, make sure that Medicaid is not double dipping in seeking to be reimbursed from the special needs trust at the time the trust terminates. In other words, the amount of the lien that was asserted by Medicaid against the third-party recovery and paid should be deducted from Medicaid's claim for reimbursement. An argument can be made that, if the lien was compromised, the amount to be deducted is not limited to what was paid but the total amount of the lien that was fully and finally satisfied by payment of the compromised amount.

C. "Medical Assistance"

So, what is included in the medical assistance for which Medicaid seeks to be reimbursed from a special needs trust at the time of its termination? "Medical assistance" is not amorphous or broadly defined but, rather, is defined as "payment of part or all of the cost of the following care and services," followed by 21 enumerated services.[30] In those states where Medicaid is a fee-for-service system, make sure the claim for reimbursement presented by Medicaid only includes the services specified under federal law. What is not included in the list are capitated payments or payments paid by Medicaid to a managed care organization if Medicaid opts to deliver services in that manner.[31]

However, in 2001, CMS updated the Medicaid Manual regarding its estate recovery provisions as it relates to managed care. Specifically, Transmittal 75 requires Medicaid to seek to recover premium payments in its claim against an estate when the Medicaid beneficiary was

[29] *See* 42 U.S.C. §§ 1396k(a)(1)(A) and 1396a(a)(25)(H).
[30] 42 U.S.C. § 1396d(a).
[31] *See* In re Estate of Ecklund, 991 N. W.2d 232 (Minn. Ct. App. 2025); *see also* Pottsgieser v. Kizer, 906 F.2d 1319 (1990),

enrolled in a managed care organization ("MCO").[32] Transmittal 75 further requires Medicaid to provide a separate notice to the Medicaid beneficiary that explains that the premium payments made to the MCO are included in a claim against the estate.[33] Two takeaways and points of negotiating Medicaid's claim for reimbursement from a special needs trust for a beneficiary who was enrolled in a MCO are that Transmittal 75 is limited in application to estate recovery and, if separate notice of the intent to seek to recover capitated or premium payments was not given, the claim fails.[34]

V. Conclusion: Ending Where One Should Begin

Now that you know all things about termination of a first party special needs trust, which is presumably more than you care to know, let us circle back to the beginning. The beginning is when you are sitting with a client who is confronted with the question, to SNT or not to SNT. Discussion about Medicaid's right to reimbursement from a first party special needs trust is more often than not given de minimus attention. The client does not fully appreciate that termination can occur during lifetime not just at time of death, that a significant claim may already exist at the time the trust is established, what is included in "medical assistance," nor which expenses are disallowed until after Medicaid is reimbursed. With this discussion, the author hopes that the practitioner will have a greater understanding of Medicaid's right to reimbursement from a first party special needs trust, and, as such, devote the time and attention necessary to counseling clients about this oft-overlooked requirement.

[32] State Medicaid Manual, Part 3 – Eligibility, Health Care Financing Administration Pub. No. 45-3, Transmittal 75, § 3810.A.6 (Jan. 11, 2001).
[33] *See id.*
[34] *See* Executive Office of Health and Human Services v. Trocki, 100 Mass. App. Ct. 117 (2021).

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Medicaid's Right to Reimbursement and SNTs

2025 National Conference on Special Needs Planning and Special Needs Trusts

Bridget O'Brien Swartz, J.D., M.P.A.

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Why Begin at the End?

- Most discussions focus on creation and lifetime administration, not termination
- Medicaid reimbursement is central but often not given the attention it's due
- Clients must understand consequences at termination

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Agenda

- Federal Law and regulations
- 1st party SNT termination provisions
- Nuances of Medicaid's right to reimbursement

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Historical Background

- First party SNTs codified > 30 years ago
- Origin: OBRA '93
- Later developments: HCFA Transmittal No. 64, Foster Care Independence Act (1999), POMS

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OBRA '93 Exceptions

- (d)(4)(A) – Disabled Under 65 Trust: Most likely to have "amounts remaining"
- (d)(4)(B) – Income-Only or Miller Trust: Unique to income-cap states and least likely to have "amounts remaining"
- (d)(4)(C) – Pooled Trust: Only to extent amounts are not retained

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Early Termination Provisions

- Federal Medicaid law and regulation limit payback to time of death
- Some states (AZ) require reimbursement on lifetime termination
- SSA (POMS) requires payback if terminated early
- Remaining assets: First Medicaid, then beneficiary

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Termination at Death Provisions: Limitations

- Limited admin expenses prior to reimbursement
- Expenses of last illness, funeral and burial AFTER reimbursement

***Note**:* Important to pre-arrange funeral and burial!

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Termination at Death Provisions: Residual Beneficiary

- Medicaid as creditor v. beneficiary
- Laws of intestacy may render trust revocable, i.e., countable for SSI purposes

***Drafting tip**:* Name residual beneficiary of nominal interest mimicking laws of intestacy!

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Power to Amend… Just in Case

The SNT that passes muster today, will not tomorrow.

- Limited not broad or general power to amend
- Give power to amend to someone other than beneficiary
- Limit power to amend so trust assets not considered available for maintenance and support

***Drafting tip**:* Provide for amendments that ensure the SNT complies with the provisions of 42 U.S.C. § 1396p(d)(4), the POMS, and applicable state laws and regulations.

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Third Party SNT – Short 'n' Sweet

Unless charitably inclined, do NOT provide for reimbursement as it is NOT required!

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Paying the Piper: Medicaid Estate Recovery

OBRA '93 mandated states institute estate recovery program:

- Limited to estates of Medicaid enrollees aged 55 or older
- No recovery if Medicaid enrollee survived by spouse, child < 21, blind or disabled child
- Undue hardship waiver

None of the above limitations or waiver apply to SNTs!

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Paying the Piper: Scope of Payback

- Includes all assistance paid since eligibility, not just post-trust
- Avoid double recovery when liens satisfied prior to trust
- Deduct total (v. compromised) lien amounts from claim for reimbursement

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Paying the Piper: "Medical Assistance"

- Defined set of services (21 categories)
- Excludes capitated payments unless estate recovery rules apply
- Transmittal 75: Premiums recoverable only if notice given

***Practice tip**:* Make sure Medicaid's claim is only for the specific services enumerated and, if reimbursement of premium payments is sought, argue not permissible against SNT and confirm whether separate notice given.

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Conclusion: Counsel your Client!

- Right to reimbursement on termination at death and, possibly, during lifetime
- Dates back to when first eligible not to when the SNT established
- Consider what is included in "medical assistance"
- Confirm proper notice given if reimbursement of premium payments sought
- Consider which expenses are disallowed until after Medicaid is reimbursed

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Practical Answers to Ethical Questions Arising in Elder and Special Needs Law: A Quick Reference Guide

By Gregory S. French, CELA, CAP, Fellow

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Practical Answers to Ethical Questions Arising in Elder and Special Needs Law: A Quick Reference Guide

By Gregory S. French, CELA, CAP, Fellow

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I. Introduction

The commitment of the National Academy of Elder Law Attorneys (NAELA) to the development of Aspirational Standards for the Practice of Elder Law began in September 2003 when the NAELA Board of Directors adopted NAELA's 2004–2007 Long-Range Plan. This plan mandated that NAELA "develop minimum standards of professional conduct consistent with NAELA's mission statement."[1] NAELA's mission statement at that time proclaimed, "The mission of the National Academy of Elder Law Attorneys is to establish NAELA members as the premier providers of legal advocacy, guidance, and services to enhance the lives of people with special needs and people as they age." The NAELA Board subsequently updated NAELA's mission statement as follows: "The mission of the National Academy of Elder Law Attorneys is to educate, inspire, serve, and provide community to attorneys with practices in elder and special needs law."[2]

NAELA's Professionalism and Ethics Committee commenced development of the first edition of the Aspirational Standards in June 2004. Membership comments received at NAELA's May 2004 Symposium and responses to emails of draft Aspirational Standards to all members in April and September 2004 guided the Committee's development of the Aspirational Standards. On October 28, 2004, the NAELA Board of Directors adopted the NAELA Professionalism and Ethics Committee's final draft of the NAELA Aspirational Standards for the Practice of Elder Law.

1 *NAELA's 2004–2007 Long-Range Plan* (NAELA 2003).

2 NAELA, *Mission Statement*, https://www.naela.org/Web/About_Tab/About_Tab_Main_Landing/NAELA%20Mission.aspx (accessed Oct. 28, 2018).

Beginning in November 2004, NAELA's Professionalism and Ethics Committee began development of Commentaries on the Aspirational Standards. The Committee developed these Commentaries to guide attorneys engaged in an elder law practice for a similar reason the American College of Trust and Estate Counsel (ACTEC) developed the ACTEC Commentaries on the American Bar Association (ABA) Model Rules of Professional Conduct. The ACTEC Commentaries note that professional responsibility rules and their comments do not "provide sufficiently explicit guidance regarding the professional responsibilities of lawyers engaged in a trusts and estates practice."[3]

Similarly, NAELA's Professionalism and Ethics Committee developed the Commentaries on the Aspirational Standards to help attorneys understand the Standards. The Commentaries on the first edition of the Standards showed attorneys how to apply NAELA's Aspirational Standards to the practice of elder law and how to handle issues that arise in elder law.

Membership comments received at NAELA's May 2005 Symposium and responses to emails of draft Commentaries to all members in May and August 2005 guided the drafting of the Commentaries. NAELA's Professionalism and Ethics Committee completed and gave final approval of the Commentaries to the Aspirational Standards on November 21, 2005. Along with NAELA's Aspirational Standards, they described best practices which, when applied in conjunction with independent professional judgment and state disciplinary rules, raised the level of professionalism and enhanced the quality of service to clients.

Beginning in June 2013, NAELA's Professionalism and Ethics Committee began to draft the second edition of the Aspirational Standards, the Aspirational Standards for the Practice of Elder and Special Needs Law With Commentaries. The second edition expands the Standards into special needs law. It also begins with a new Standard, Holistic Approach (Standard A). The Standard addresses the holistic approach to legal problems that elder and special needs law attorneys take. The second edition also adds numerous examples throughout the Commentaries on the Aspirational Standards and delves deeper into engagement agreements, document drafting, nonlegal services, client identification, conflicts of interest, confidentiality, and other matters addressed in the first edition.

The NAELA Professionalism and Ethics Committee submitted its draft of the second edition of the Aspirational Standards With Commentaries to NAELA's Board in May 2016. Board members submitted their comments on the draft to the Professionalism and Ethics Committee by August 2016. The Committee carefully considered these comments as it finalized the second edition for Board approval. The NAELA Board unanimously adopted the second edition of the Aspirational Standards for the Practice of Elder and Special Needs Law With Commentaries on April 26, 2017.

At the state level, the Supreme Court of Ohio adopted the Ohio Rules of Professional Conduct effective February 1, 2007. These Rules are based on and similar to the ABA Model Rules of Professional Conduct, which all 50 states and the District of Columbia use as the basis for their professional ethics codes. These Rules replaced

3 Am. College of Trust & Est. Counsel, *ACTEC Commentaries on the Model Rules of Professional Conduct* (5th ed., ACTEC 2016), https://www.actec.org/assets/1/6/ACTEC_Commentaries_5th_rev_06_29.pdf (accessed Oct. 28, 2018).

Ohio's Code of Professional Responsibility, which was adopted in 1970.

The materials that follow answer ethical questions that frequently arise in the practice of elder and special needs law. Correctly answering these questions concerning client identification, confidentiality, potential conflict of interest, client capacity, fiduciary issues, and long-term care planning is critical to an ethical practice.

The answers to the questions are quoted from the Ohio Rules of Professional Conduct, the Comments on those Rules, and the second edition of the Aspirational Standards for the Practice of Elder and Special Needs Law With Commentaries. For a comparison of the ACTEC Commentaries with the NAELA Aspirational Standards, see Professor Mary F. Radford's article in this issue, A Comparison of the 2016 American College of Trust and Estate Counsel Commentaries With the 2017 NAELA Aspirational Standards.

The professional responsibility rules of the state in which an attorney practices determine whether the attorney is subject to discipline and whether the attorney's license is at risk for certain behavior. NAELA's Aspirational Standards build upon and supplement those rules. They do not define a standard of care, establish ethical or disciplinary breaches, or create a cause of action for civil liability or other purposes. Rather, they go beyond what disciplinary rules require or prohibit, articulating what professionalism in elder and special needs law means.

II. Client Identification

A. When Should the Identity of the Client Be Determined?

1. Standard B, Section 1, of the second edition of the Aspirational Standards for the Practice of Elder and Special Needs Law With Commentaries:

   The elder and special needs law attorney: Identifies the client and the individuals who will assist the client at the earliest stage of the representation, obtains the client's agreement on these identifications, and communicates this information to the persons involved.
2. Comment on Aspirational Standard B, Section 1:

   It is the client to whom the attorney owes the professional duties of competence, communication, diligence, loyalty, and confidentiality. … The identity of the client should be resolved at the earliest stage so that the client, the attorney, and other involved persons understand:
   - Whose interests are to be protected in the legal planning and representation process;
   - To whom the attorney owes the professional duties of competence, communication, diligence, loyalty, and confidentiality;
   - The steps that may or may not be taken after the initial consultation if the client or protected individual is not present at that meeting; and
   - That the attorney will arrange at the earliest practicable time to communicate privately with the person who is expected to be the client.

   The attorney should ensure that all involved persons understand which individual is the client and that the others are not clients. The attorney also should determine whether the client authorizes the attorney to communicate with another person, such as a fiduciary or family member, and obtain the client's written consent to such authorized involvement.
3. Ohio Rule 1.18(a):

   A person who consults with a lawyer the possibility of forming a client-law-

yer relationship with respect to a matter is a prospective client.

4. Ohio Rule 1.18, Comment 4:
   In order to avoid acquiring disqualifying information from a prospective client, a lawyer considering whether or not to undertake a new matter should limit the initial interview to only such information as reasonably appears necessary for that purpose. Where the information indicates that a conflict of interest or other reason for nonrepresentation exists, the lawyer should so inform the prospective client or decline the representation.

B. Should Multiple Generations Be Represented Jointly or Severally?

1. Aspirational Standard D, Section 1:
   The elder and special needs law attorney: In the initial meeting when multiple prospective clients are present, ensures that the prospective clients understand whether the representation will be individual, concurrent, or joint.
2. Comment on Aspirational Standard D, Section 1, and Example:
   a. Comment:
   This Standard addresses a common situation when prospective clients ask the attorney to represent multiple family members in either related or distinct matters. Because these situations may easily lead to misunderstandings among family members, the attorney should ensure that prospective clients are educated about the differences among individual, concurrent, and joint representation.
   b. Example:
   The attorney should take reasonable steps to ensure that all the clients understand how different types of representation impose different duties on the attorney with different consequences for the client and confirm this understanding in well-drafted engagement agreements and written waivers.
3. Ohio Rule 1.7(a):
   A lawyer's acceptance or continuation of representation of a client creates a conflict of interest if either of the following applies:
   (1) the representation of that client will be directly adverse to another current client;
   (2) there is a substantial risk that the lawyer's ability to consider, recommend, or carry out an appropriate course of action for that client will be materially limited by the lawyer's responsibilities to another client, a former client, or a third person or by the lawyer's own personal interests.
   "Substantial" when used in reference to degree or extent denotes a matter of real importance or great consequence. Rule 1.0(m).
4. Ohio Rule 1.7, Comment 25:
   In considering whether to represent multiple clients in the same matter, a lawyer should be mindful that if the common representation fails because the potentially adverse interests cannot be reconciled, the result can be additional cost, embarrassment, and recrimination. Ordinarily, the lawyer will be forced to withdraw from representing all of the clients if the common representation fails. Generally, if the relationship between the parties is antagonistic, the possibility that the clients' interests can be adequately served by common representation is low.

C. What Should the Attorney Do Before Undertaking Joint Representation?

1. Aspirational Standard D, Section 2:
   The elder and special needs law attor-

ney: Undertakes joint or concurrent representation, as permitted by relevant state rules of professional conduct and these Aspirational Standards, only after obtaining the consent of the parties and having reviewed with them the advantages and disadvantages of such representation, including the relevant foreseeable conflicts of interest and risks of such representation, in a manner that will be best understood by each person to be represented.

2. Comment on Aspirational Standard D, Section 2:
   In carrying out this responsibility, the attorney should consider private, direct, and personal communications with the prospective clients separately, because this may allow each of them to be more candid and to more freely ask questions of the attorney regarding the implications of joint, concurrent, and individual representation. For example, separate meetings may be advisable in multigenerational representation or with clients who have blended families. In cases of joint or concurrent representation, the consent of the parties should be confirmed in writing with signed waivers.
3. Ohio Rule 1.7(b):
   A lawyer shall not accept or continue the representation of a client if a conflict of interest would be created pursuant to division (a) of this rule, unless all of the following apply:
   (1) the lawyer will be able to provide competent and diligent representation to each affected client;
   (2) each affected client gives *informed consent, confirmed in writing;* ("Informed consent" denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct. Rule 1.0(f). "Confirmed in writing," when used in reference to the informed consent of a person, denotes informed consent that is given in writing by the person or a writing that a lawyer promptly transmits to the person confirming an oral informed consent. If it is not feasible to obtain or transmit the writing at the time the person gives informed consent, then the lawyer must obtain or transmit it within a reasonable time thereafter. Rule 1.0(b)).
   (3) the representation is not precluded by division (c) of this rule.
4. Ohio Rule 1.7, Comment 2:
   In order to analyze and resolve a conflict of interest problem under this rule, a lawyer must:
   (1) clearly identify the client or clients;
   (2) determine whether a conflict of interest exists;
   (3) decide whether the representation is barred by either criteria of division (c);
   (4) evaluate, under division (b)(1), where the lawyer can competently and diligently represent all clients affected by the conflict of interest; and
   (5) if representation is otherwise permissible, consult with the clients affected by the conflict and obtain the informed consent of each of them, confirmed in writing.

III. Attorney Fees and Trust Accounts

A. Should an Engagement Agreement Be Used?

1. Aspirational Standard C, Section 1:
   The elder and special needs law attor-

ney: Uses an engagement agreement, letter, or other writing that will:

(a) Identify the client;
(b) Describe the scope and objectives of the representation;
(c) Disclose potential material conflicts of interest between the attorney and client;
(d) Explain the lawyer's obligation of confidentiality;
(e) Confirm, when there are joint clients, that the lawyer will share information and confidences between them and may withdraw if one client requests that the attorney not disclose a secret to the other client or if the clients cannot agree on how to proceed;
(f) Disclose potential material conflicts between joint clients;
(g) Address (and possibly waive) nonmaterial conflicts of interest between joint clients;
(h) Confirm, when representing a fiduciary, the fiduciary's obligations to the protected individual, clarify whether the attorney may speak directly to the protected individual, and state that the attorney may withdraw if the fiduciary violates a fiduciary or other duty to the protected individual and does not take timely corrective action;
(i) Set out fee arrangements (hourly, fixed fee, or contingent); and
(j) Explain when and how the attorney-client relationship may end.

2. Comment on Aspirational Standard C, Section 1:

The attorney should inform his or her client about confidentiality and other components of the engagement. A clear written engagement agreement is the best way to communicate these matters to the client and others involved. It is imperative that the client and any involved others understand this agreement.

When an attorney represents both spouses or other joint clients, a joint representation letter or agreement should be used. This is especially important if the clients have blended families. Such agreements should provide for the waiver of confidences between the attorney and each jointly represented client, clarify that all information is available to all joint clients, and address actions the attorney should take if a material conflict arises between joint clients.

3. Ohio Rule 1.5(b):

The nature and scope of the representation and the basis or rate of the fee and expenses for which the client will be responsible shall be communicated to the client, preferably in *writing*, before or within a *reasonable* time after commencing the representation, unless the lawyer will charge a client whom the lawyer has regularly represented on the same basis as previously charged. Any change in the basis or rate of the fee or expenses is subject to division (a) of this rule and shall promptly be communicated to the client, preferably in *writing*.

"Writing" or "written" denotes a tangible or electronic record of a communication or representation, including handwriting, typewriting, printing, photostating, photography, audio or videorecording, and electronic communications. A "signed" writing includes an electronic sound, symbol, or process attached to or logically associated with a writing and executed or adopted by a person with the intent to sign the writing. Rule 1.0(p).

4. Ohio Rule 1.5, Comment 2:
   A writing that confirms the nature and scope of the client-lawyer relationship and the fees to be charged is the preferred means of communicating this information to the client and can clarify the relationship and reduce the possibility of a misunderstanding…. In a new client-lawyer relationship, however, an understanding as to fees and expenses must be established promptly. Unless the situation involves a regularly represented client, the lawyer should furnish the client with at least a simple memorandum or copy of the lawyer's customary fee arrangements that states the general nature of the legal services to be provided, the basis, rate or total amount of the fee, and whether and to what extent the client will be responsible for any costs, expenses, or disbursements in the course of the representation.

B. May a Lawyer Limit the Scope of the Representation?

1. Ohio Rule 1.2(c):
   A lawyer may limit the scope of a new or existing representation if the limitation is reasonable under the circumstances and communicated to the client, preferably in writing.
   "Writing" or "written" denotes a tangible or electronic record of a communication or representation, including handwriting, typewriting, printing, photostating, photography, audio or videorecording, and electronic communications. A "signed" writing includes an electronic sound, symbol, or process attached to or logically associated with a writing and executed or adopted by a person with the intent to sign the writing. Rule 1.0(p).
2. Ohio Rule 1.2, Comment 7:
   If, for example, a client's objective is limited to securing general information about the law that the client needs in order to handle a common and typically uncomplicated legal problem, the lawyer and client may agree that the lawyer's services will be limited to a brief telephone consultation. Such a limitation would not be reasonable if the time allotted was not sufficient to yield advice upon which the client could rely. In addition, the terms upon which representation is undertaken may exclude specific means that might otherwise be used to accomplish the client's objectives.
3. Ohio Rule 1.2, Comment 7A:
   Written confirmation of a limitation of a new or existing representation is preferred and may be any writing that is presented to the client that reflects the limitation, such as a letter or electronic transmission addressed to the client or a court order. A lawyer may create a form or checklist that specifies the scope of the client-lawyer relationship and the fees to be charged. An order of a court appointing a lawyer to represent a client is sufficient to confirm the scope of that representation.

C. What Criteria Apply to Determining Whether a Fee Is Excessive?

1. Ohio Rule 1.5(a):
   A lawyer shall not make an agreement for, charge, or collect an *illegal* or clearly excessive fee. A fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence would be left with a definite and firm conviction that the fee is in excess of a *reasonable* fee. The factors to be considered in determining the reasonableness of a fee include the following:
   (1) the time and labor required, the novelty and difficulty of the ques-

tions involved, and the skill requisite to perform the legal service properly;
(2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
(3) the fee customarily charged in the locality for similar legal services;
(4) the amount involved and the results obtained;
(5) the time limitations imposed by the client or by the circumstances;
(6) the nature and length of the professional relationship with the client;
(7) the experience, reputation, and ability of the lawyer or lawyers performing the services;
(8) whether the fee is fixed or contingent.

2. Ohio Rule, Comment 1:
Division (a) requires that lawyers charge fees that are reasonable under the circumstances. The factors specified in divisions (a)(1) through (8) are not exclusive. Nor will each factor be relevant in each instance.

D. What Requirements Apply to "Earned Upon Receipt" Fees?

1. Ohio Rule 1.5(d)(3):
A lawyer shall not enter into an arrangement for, charge, or collect any of the following: (3) A fee denominated as "earned upon receipt," "nonrefundable," or in any similar terms, unless the client is simultaneously advised in *writing* that if the lawyer does not complete the representation for any reason, the client may be entitled to a refund of all or part of the fee based upon the value of the representation pursuant to division (a) of this rule.

2. Ohio Rule 1.5, Comment 6A:
The reasonableness requirement and the application of the factors in division (a) may mean that a client is entitled to a refund of an advance fee payment even though it has been denominated "nonrefundable," "earned upon receipt," or in similar terms that imply the client would never receive a refund…. This does not mean the client will always be entitled to a refund upon early termination of the representation [*e.g.,* factor (a)(2) might justify the entire fee], nor does it determine how any refund should be calculated (*e.g.,* hours worked times a reasonable hourly rate, quantum meruit, percentage of the work completed, etc.), but merely requires that the client be advised of the possibility of a refund based upon application of the factors set forth in division (a). In order to be able to demonstrate the reasonableness of the fee in the event of early termination of the representation, it is advisable that lawyers maintain contemporaneous time records for any representation undertaken on a flat fee basis.

E. What Requirements Apply to Attorney Trust Accounts?

1. Ohio Rule 1.15(a):
A lawyer shall hold property of clients or third persons that is in a lawyer's possession in connection with a representation separate from the lawyer's own property. Funds shall be kept in a separate interest-bearing account in a financial institution authorized to do business in Ohio and maintained in the state where the lawyer's office is situated … . Records of such account funds and other property shall be kept by the lawyer and shall be preserved for a period

of seven years after termination of the representation or the appropriate disbursement of such funds or property, whichever comes first … . For funds, the lawyer shall do all of the following:
(1) maintain a copy of any fee agreement with each client;
(2) maintain a record for each client on whose behalf funds are held that sets forth all of the following:
(i) the name of the client;
(ii) the date, amount, and source of all funds received on behalf of such client;
(iii) the date, amount, payee, and purpose of each disbursement made on behalf of such client;
(iv) the current balance for such client.
(3) maintain a record for each bank account that sets forth all of the following:
(i) the name of such account;
(ii) the date, amount, and client affected by each credit and debit;
(iii) the balance in the account.
(4) maintain all bank statements, deposit slips, and cancelled checks, if provided by the bank, for each bank account;
(5) perform and retain a monthly reconciliation of the items contained in divisions (a)(2), (3), and (4) of this rule.

2. Ohio Rule 1.15, Comment 1:
All property that is the property of clients or third persons, including prospective clients, must be kept separate from the lawyer's business and personal property and, if moneys, in one or more trust accounts. A lawyer should maintain separate trust accounts when administering estate moneys. A lawyer must maintain the records listed in division (a)(1) to (5) of this rule to effectively safeguard client funds and fulfill the role of professional fiduciary.

F. What Must the Attorney Do With Fees Paid in Advance?

1. Ohio Rule 1.15(c):
A lawyer shall deposit into a client trust account legal fees and expenses that have been paid in advance, to be withdrawn by the lawyer only as fees are earned or expenses incurred.
2. Ohio Rule, Comment 3:
The lawyer is not required to remit to the client funds that the lawyer reasonably believes represent fees owed…. The disputed portion of the funds must be kept in a trust account and the lawyer should suggest means for prompt resolution of the dispute, such as arbitration. The undisputed portion of the funds shall be promptly distributed.

G. When May Attorneys in Different Firms Divide Fees?

1. Ohio Rule 1.5(e):
Lawyers who are not in the same *firm* may divide fees only if all of the following apply:
(1) the division of fees is in proportion to the services performed by each lawyer or each lawyer assumes joint responsibility for the representation and agrees to be available for consultation with the client;
(2) the client has given *written* consent after full disclosure of the identity of each lawyer, that the fees will be divided, and that the division of fees will be in proportion to the services to be performed by each lawyer or that each lawyer will assume joint responsibility for the representation;

(3) except where court approval of the fee division is obtained, the *written* closing statement in a case involving a contingent fee shall be signed by the client and each lawyer and shall comply with the terms of division (c)(2) of this rule;
(4) the total fee is *reasonable.*

2. Ohio Rule 1.5, Comment 7:
A division of fee is a single billing to a client covering the fee of two or more lawyers who are not in the same firm. … Within a reasonable time after disclosure of the identity of each lawyer, the client must give written approval that the fee will be divided and that the division of fees is in proportion to the services performed by each lawyer or that each lawyer assumes joint responsibility for the representation. … Joint responsibility for the representation entails financial and ethical responsibility for the representation as if the lawyers were associated in a partnership.

IV. Confidentiality

A. May Secrets Be Kept From Clients Being Jointly Represented?

1. Aspirational Standard E, Section 3:
The elder and special needs law attorney: Establishes as a prerequisite to joint representation a clear understanding and agreement that the attorney will keep no client secrets from any other client in that joint representation.
2. Comment on Aspirational Standard E, Section 3:
Before undertaking joint representation of clients, the attorney should ensure that the clients understand the attorney's ethical obligation to disclose information learned from one joint client to the other joint client and the consequences of such disclosure. The engagement agreement should make clear the attorney's obligation to keep no secrets. If the attorney obtains information from one joint client that is unknown to the other client and the attorney fails to persuade the client to share the information with the other joint client, the attorney should share the information with the joint client and/or withdraw from the representation pursuant to state professional responsibility rules.
3. Ohio Rule 1.8(g):
A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, or in a criminal case an aggregated agreement as to guilty or *nolo contendere* pleas, unless the settlement or agreement is subject to court approval or each client gives *informed consent,* in a *writing* signed by the client. The lawyer's disclosure shall include the existence and nature of all the claims or pleas involved and of the participation of each person in the settlement or agreement.
4. Ohio Rule 1.7, Comment 27:
As to the duty of confidentiality, continued common representation will almost certainly be inadequate if one client asks the lawyer not to disclose to the other client information relevant to the common representation. This is so because the lawyer has an equal duty of loyalty to each client, and each client has the right to be informed of anything bearing on the representation that might affect the client's interests and the right to expect that the lawyer will use that information to that client's benefit. See Rule 1.4. The lawyer should, at the outset of the common representation

and as part of the process of obtaining each client's informed consent, advise each client that information will be shared and that the lawyer will have to withdraw if one client decides that some matter material to the representation should be kept from the other.

B. Does Client Confidentiality Apply to Family Members and Caregivers?

1. Aspirational Standard E, Section 4: The elder and special needs law attorney: Strictly preserves client confidences, especially in situations that involve frequent contacts with family members, caregivers, or other trusted third parties who are not clients.
2. Comment on Aspirational Standard E, Section 4:
   In cases in which an individual needs assistance from others, the individuals providing the assistance may believe that they, too, are clients of the attorney. In some cases, these nonclients will be involved consistently and extensively on a day-to-day basis. … In such cases, there may be an initial expectation that the attorney represents both the client and the others involved. It is the attorney's duty to ensure that individuals who are unrepresented understand that they are not clients of the attorney.

   There may be occasions when the attorney needs to communicate with nonclients who are trusted third parties working closely with the client. In doing so, the attorney must use care in communicating with the unrepresented individuals and may not disclose confidential information without the client's consent.
3. Ohio Rule 1.6(a):
   A lawyer shall not reveal information relating to the representation of a client, including information protected by the attorney-client privilege under applicable law, unless the client gives *informed consent,* the disclosure is impliedly authorized in order to carry out the representation, or the disclosure is permitted by division (b) or required by division (d) of this Rule.
4. Ohio Rule 1.9(c):
   A lawyer who has formerly represented a client in a matter or whose present or former *firm* has formerly represented a client in a matter shall not thereafter do either of the following ("Firm" or "law firm" denotes a lawyer or lawyers in a law partnership, professional corporation, sole proprietorship, or other association authorized to practice law; or lawyers employed in a private or public legal aid or public defender organization, a legal services organization, or the legal department of a corporation or other organization. Rule 1.0(c)):
   (1) use information relating to the representation to the disadvantage of the former client except as these rules would permit or require with respect to a client or when the information has become generally *known* ("Knowingly," "known," or "knows" denotes actual knowledge of the fact in question. A person's knowledge may be inferred from circumstances. Rule 1.0(g));
   (2) reveal information relating to the representation except as these rules would permit or require with respect to a client.

C. When Should the Attorney's Obligation of Confidentiality Be Discussed?

1. Aspirational Standard E, Section 1: The elder and special needs law attor-

ney: Carefully explains to the client and others involved, as early in the representation as possible, the attorney's duty of confidentiality to the client in order to avoid misunderstandings and to ascertain and respect the client's wishes regarding the disclosure of confidential information.

2. Comment on Aspirational Standard E, Section 1:
   The attorney should begin every initial conference with an explanation of the confidentiality rules and, if possible, address confidentiality before the initial meeting so the client can decide who should attend. The explanation should make clear that the client is the only one protected and authorized to waive the protection.
   The confidentiality rules apply not only to matters that the client communicates through the attorney in confidence but also to all information that the attorney acquires through other sources, such as the client's family members, health care providers, tax preparer, or assigned case worker employed by a government agency.
3. Ohio Rule 1.18(b):
   Even when no client-lawyer relationship ensues, a lawyer who has learned information from a prospective client shall not use or reveal that information, except as Rule 1.9 would permit with respect to information of a former client.
4. Ohio Rule 1.18, Comment 3:
   It is often necessary for a prospective client to reveal information to the lawyer during an initial consultation prior to the decision about formation of a client-lawyer relationship. The lawyer often must learn such information to determine whether there is a conflict of interest with an existing client and whether the matter is one that the lawyer is willing to undertake. Division (b) prohibits the lawyer from using or revealing that information, except as permitted by Rule 1.9, even if the client or lawyer decides not to proceed with the representation.

D. Should the Attorney Meet With the Client in Private?

1. Aspirational Standard B, Section 3: The elder and special needs law attorney: Meets with the prospective client in private at the earliest practicable time to help the attorney identify the client and assess the prospective client's capacity and wishes as well as the presence of any undue influence.
2. Comment on Aspirational Standard B, Section 3:
   A private meeting with the prospective client helps the attorney identify the client, assess the prospective client's capacity, and understand his or her wishes, unencumbered and uninfluenced by others. This Standard addresses three common situations confronted by the attorney: (1) the prospective client does not have an involved fiduciary; (2) an agent under a power of attorney assists a principal; and (3) a guardian or conservator assists a ward.
3. Ohio Rule 1.4(a):
   A lawyer shall do all of the following:
   (1) promptly inform the client of any decision or circumstance with respect to which the client's *informed consent* is required by these Rules;
   (2) *reasonably* consult with the client about the means by which the client's objectives are to be accomplished;
   (3) keep the client *reasonably* informed about the status of the matter;
   (4) comply as soon as practicable with *reasonable* requests for information from the client;

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer *knows* that the client expects assistance not permitted by the Ohio Rules of Professional Conduct or other law.

4. Ohio Rule 1.7, Comment 26:
   Particularly important factors in determining the appropriateness of common representation are the effect on client-lawyer confidentiality and the attorney-client privilege. With regard to the attorney-client privilege, the prevailing rule is that, as between commonly represented clients, the privilege does not attach. Hence, it must be assumed that if litigation does later occur between the clients, the privilege will not protect communications made on the subject of the joint representation, while it is in effect, and the clients should be so advised.

E. Should the Attorney Prepare Documents for a Nonclient?

1. Aspirational Standard C, Section 4: The elder and special needs law attorney: Exercises caution when:
   (a) Drafting documents in exigent circumstances for a prospective client before the attorney-client relationship is established;
   (b) Drafting documents for a new client at the request of an existing or former client related to the new client;
   (c) Drafting a special needs trust for a person with special needs; and
   (d) Drafting documents to be signed by nonclients.
2. Comment on Aspirational Standard C, Section 4:
   The attorney will draft documents differently depending on the identity of the client and the circumstances, including challenging situations such as the following:
   (a) Drafting documents in exigent circumstances for a prospective client before the attorney-client relationship is established. …

When drafting documents before establishing an attorney-client relationship, the attorney should consider the following:

- Whether the prospective client has sufficient capacity to understand and execute the documents;
- Whether the prospective client is terminally ill, at risk of an imminent decline in health, or in potential need of protective action due to diminished capacity;
- Whether the prospective client is a possible victim of financial or physical abuse;
- Whether the prospective client is homebound or institutionalized in a hospital or nursing home;
- Whether there are family conflicts that may require urgency;
- Whether the document is a medical directive, living will, or power of attorney, which requires less explanation than a will or living trust; and
- Whether the attorney has the ability to make more than one visit during a short time period.

(b) Drafting documents for a new client at the request of an existing or former client related to the new client.

The attorney may be asked by an existing or former client to draft documents for a family member, a new client. Because of the potential for a conflict of interest, the attorney should proceed with caution. The attorney should meet privately with the new client, assess capacity, establish a client-attorney relationship with the new cli-

ent, confirm that there is no material conflict between the two clients, and inform the referring client that the attorney's relationship with the new client is a separate representation that excludes the referring family member.

(c) Drafting a special needs trust for a person with special needs.

In drafting a special needs trust for a person with special needs, that person may or may not have the capacity to engage the attorney and sign the trust agreement. If the person with special needs lacks capacity to take these actions, the attorney should only draft such a trust at the request of a fiduciary who has the authority to engage the attorney.

(d) Drafting documents to be signed by nonclients.

In elder and special needs law, it sometimes is appropriate to draft documents to be signed by a family member of the client or another third party in order to further the legal representation. An example is an agreement to be signed by the client's agent under power of attorney in which the agent agrees not to act against the client's best interests. Another example is an asset protection trust to be signed by the client's child as trustee. When drafting such documents, the attorney should resolve whether the person being asked to sign the document is the attorney's client and, if not, advise that person to seek independent legal counsel before signing the document.

3. Ohio Rule 1.4(b):
   A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.
4. Ohio Rule 1.4, Comment 2:
   If these rules require that a particular decision about the representation be made by the client, division (a)(1) requires that the lawyer promptly consult with and secure the client's consent prior to taking action unless prior discussions with the client have resolved what action the client wants the lawyer to take. For example, a lawyer who receives from opposing counsel an offer of settlement in a civil controversy or a proffered plea bargain in a criminal case must promptly inform the client of its substance unless the client has previously indicated that the proposal will be acceptable or unacceptable or has authorized the lawyer to accept or to reject the offer. See Rule 1.2(a).

V. Potential Conflict of Interest

A. When Nonclients Are Involved, With Whom Should Communication Occur?

1. Aspirational Standard H, Section 2:
   The elder and special needs law attorney: Maintains direct communication with the client, whether in person, by telephone, or through correspondence, even when the client chooses to involve others (including an agent under a durable power of attorney).
2. Comment on Aspirational Standard H, Section 2:
   Maintaining direct communication with the client is a critical component of effective representation, particularly when the client is making major life decisions that may alter the client's options for long-term services and supports. ... Often the client will direct the attorney to communicate with a third party, either in a formal agency relationship or informally through a family member. Even though the client may have authorized the attorney to communicate directly with the third party, the attorney still should include the client in communications.

3. Ohio Rule 1.4(a):
   A lawyer shall do all of the following:
   (1) promptly inform the client of any decision or circumstance with respect to which the client's *informed consent* is required by these rules;
   (2) *reasonably* consult with the client about the means by which the client's objectives are to be accomplished;
   (3) keep the client *reasonably* informed about the status of the matter;
   (4) comply as soon as practicable with *reasonable* requests for information from the client;
   (5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer *knows* that the client expects assistance not permitted by the Ohio Rules of Professional Conduct or other law.
4. Ohio Rule 1.4, Comment 3:
   Division (a)(2) requires the lawyer to reasonably consult with the client about the means to be used to accomplish the client's objectives.

B. What About Dealing With Family Members Who Are Nonclients?

1. Aspirational Standard D, Section 3:
   The elder and special needs law attorney: Treats family members who are not clients as unrepresented persons and accords them involvement in the client's representation only to the extent that the client consents to their involvement with a signed waiver or, if the client no longer has the capacity to consent, to the extent that their involvement is consistent with the client's wishes and values if known and, if not known, the client's best interests.
2. Comment on Aspirational Standard D, Section 3:
   The attorney should exercise care to observe signs of undue influence. When circumstances suggest undue influence, the attorney should take steps to ensure that the vulnerable person is protected. Meeting alone with the client or prospective client (as discussed in the Comment on Standard B, Client Identification, Section 3) becomes especially important to protect against undue influence.
3. Ohio Rule 4.3:
   In dealing on behalf of a client with a person who is not represented by counsel, a lawyer shall not state or imply that the lawyer is disinterested. When the lawyer *knows* or *reasonably should know* that the unrepresented person misunderstands the lawyer's role in the matter, the lawyer shall make *reasonable* efforts to correct the misunderstanding. The lawyer shall not give legal advice to an unrepresented person, other than the advice to secure counsel, if the lawyer *knows* or *reasonably should know* that the interests of such a person are or have a *reasonable* possibility of being in conflict with the interests of the client.
   "Reasonably should know" when used in reference to a lawyer denotes that a lawyer of reasonable prudence and competence would ascertain the matter in question. Rule 1.0(k).
4. Ohio Rule 1.14, Comment 3:
   The client may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under division (b), must look to the client,

and not family members, to make decisions on the client's behalf.

C. When Can Payment by a Third Party Be Accepted?

1. Aspirational Standard D, Section 4: The elder and special needs law attorney: Accepts payment of client fees by a third party only after:
   (a) Determining that payment by the third party will not influence the attorney's independent professional judgment on behalf of the client;
   (b) Securing the client's informed consent to the payment by the third party in writing; and
   (c) Ensuring that all the parties understand and agree to the ethical ground rules for third-party payment.
2. Comment on Aspirational Standard D, Section 4:
   The attorney must fully communicate to both the client and the third-party payer the requirements of this Standard, which include that the payer will not interfere with the representation of the client and that the payer is not entitled to any confidential information of the client. The attorney should obtain the client's written consent to the third-party payment and confirm in writing with the third-party payer the ground rules relating to confidentiality of information and representation of the client.
   When a party who is paying the fees for client services is actually using the client's own money to pay the fees, the attorney should ensure that the third-party understands the need for lawful authority to use the client's money to do so.
3. Ohio Rule 1.8(f):
   A lawyer shall not accept compensation for representing a client from someone other than the client unless divisions (f)(1) to (3) and, if applicable, division (f)(4) apply:
   (1) the client gives *informed consent;*
   (2) there is no interference with the lawyer's independence or professional judgment or with the client-lawyer relationship;
   (3) information relating to representation of a client is protected as required by Rule 1.6;
   (4) if the lawyer is compensated by an insurer to represent an insured, the lawyer delivers a copy of the following Statement of Insured Client's Rights to the client in person at the first meeting or by mail within ten days after the lawyer receives notice of retention by the insurer.
4. Ohio Rule 1.8, Comment 12:
   Under Rule 1.7(a) a conflict of interest exists if there is substantial risk that the lawyer's representation of the client will be materially limited by the lawyer's own interest in the fee arrangement or by the lawyer's responsibilities to the third-party payer (for example, when the third-party payer is a co-client). Under Rule 1.7(b), the lawyer may accept or continue the representation with the informed consent of each affected client, unless the conflict is nonconsentable under that paragraph. Under Rule 1.7(b), the informed consent must be confirmed in writing.

VI. Client Capacity

A. How Is Client Capacity Assessed and Documented?

1. Aspirational Standard G, Section 2: The elder and special needs law attorney: Develops and uses appropriate skills and processes for making and documenting preliminary assessments of client capacity to undertake the specific legal matters at hand.

2. Example in Comment on Aspirational Standard G, Section 2:
   Although the attorney should consider any medical opinions regarding the client's capacity, the attorney should evaluate client capacity by a legal standard, considering factors such as:
   - The variability of the client's state of mind;
   - The client's ability to appreciate the consequences of his or her decision;
   - The irreversibility of the decision;
   - The substantive fairness of the decision;
   - The consistency of the decision with lifetime commitments of the client;
   - The type of decisions to be made by the client and the applicable legal standard and;
   - The client's ability to articulate reasoning behind his or her decision.

   The attorney also should distinguish between incapacity and the inability to remember. The fact that a client does not remember a decision does not mean that the client did not have the capacity to make the decision at the time it was made.
3. Ohio Rule 1.14(a):
   When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client. "Reasonable" or "reasonably" when used in relation to conduct by a lawyer denotes the conduct of a reasonably prudent and competent lawyer. Rule 1.0(i).
4. Ohio Rule 1.14, Comment 6:
   In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.

B. Under What Circumstances Should the Attorney Take Protective Action?

1. Aspirational Standard G, Section 4: The elder and special needs law attorney: Takes appropriate measures to protect the client when the attorney reasonably believes that the client: (a) has diminished capacity; (b) is at risk of substantial physical, financial, or other harm unless action is taken; and (c) cannot adequately act in his or her own interest.
2. Comment on Aspirational Standard G, Section 4:
   The attorney must determine whether the attorney's ability to continue to advocate for the client and the client's wishes and values has become impossible because of the client's impairment and whether the client is at serious risk of harm. …

   In appropriate situations, and when permitted or mandated by state law, the attorney should take protective action. However, the attorney should carefully consider the impact of protective action on the attorney-client relationship, the client's autonomy and well-being, and the client's relationship with third parties.
3. Ohio Rule 1.14(b):
   When the lawyer *reasonably believes* that the client has diminished capac-

ity, is at risk of *substantial* physical, financial or other harm unless action is taken, and cannot adequately act in the client's own interest, the lawyer may take *reasonably* necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian *ad litem,* conservator, or guardian.

"Reasonable belief" or "reasonably believes" when used in reference to a lawyer denotes that the lawyer believes the matter in question and that the circumstances are such that the belief is reasonable. Rule 1.0(j).

4. Ohio Rule 1.14, Comment 5:
   If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a normal client-lawyer relationship cannot be maintained as provided in division (a) because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation, then division (b) permits the lawyer to take protective measures deemed necessary. Such measures could include: consulting with family members; using a reconsideration period to permit clarification or improvement of circumstances; using voluntary surrogate decision making tools such as durable powers of attorney; or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client.

C. What Determines the Scope of Any Protective Action Undertaken?

1. Aspirational Standard G, Section 5:
   The elder and special needs law attorney: Uses appropriate measures to protect the client, including (a) considering the wishes and values of the client if known or, if not known, the client's best interests; (b) minimizing intrusion into the client's decision-making autonomy; (c) respecting the client's family and social connections; and (d) considering a range of supportive actions other than court proceedings and adult protective services.
2. Comment on Aspirational Standard G, Section 5:
   Attorneys should be aware of the potential conflict between the client's best interests and the attorney's duty to advocate for the client's wishes (e.g., when the client wishes to age in place and it is in the client's best interests to be placed in long-term care). This conflict often occurs when the client has diminished capacity and needs protection, thus requiring the attorney to choose between advocating for the client's wishes or acting against those wishes in order to protect the client. …

   When taking protective action, the attorney should do no more than necessary to protect the client.
3. Ohio Rule 1.14, Comment 5:
   In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests, and the goals of intruding into the client's decision making autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections.
4. Ohio Rule 1.14, Comment 7:
   Thus, if a client with diminished capacity has substantial property that should be sold for the client's benefit, effective completion of the transaction may require appointment of a

legal representative. In addition, rules of procedure in litigation sometimes provide that minors or persons with diminished capacity must be represented by a guardian or next friend if they do not have a general guardian … . In considering alternatives, however, the lawyer should be aware of any law that requires the lawyer to advocate the least restrictive action on behalf of the client.

D. Can Client Confidences Be Disclosed When Taking Protective Action?

1. Aspirational Standard G, Section 6: The elder and special needs law attorney: Preserves client confidences to the extent possible by only divulging that information necessary or appropriate for protective action.
2. Comment on Aspirational Standard G, Section 6:
   Yet if the client suffers from diminished capacity and needs protection, the attorney may need to disclose confidential information to a third party. Many state bar rules provide for limited disclosure; however, such disclosures must be made with care because of the potential of harm to the client. … Even if the attorney is authorized to divulge confidential information to take protective action, the attorney may disclose only that information necessary for the protective action.
3. Ohio Rule 1.14(c):
   Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to division (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.
4. Ohio Rule 1.14, Comment 8:
   When taking protective action pursuant to division (b), the lawyer is impliedly authorized to make the necessary disclosures, even when the client directs the lawyer to the contrary. Nevertheless, given the risks of disclosure, division (c) limits what the lawyer may disclose in consulting with other individuals or entities or seeking the appointment of a legal representative. At the very least, the lawyer should determine whether it is likely that the person or entity consulted with will act adversely to the client's interests before discussing matters related to the client.

E. Can the Attorney Recommend Guardianship Proceedings for the Client?

1. Aspirational Standard G, Section 7: The elder and special needs law attorney: Seeks guardianship or conservatorship only when no other viable alternatives exist.
2. Comment on Aspirational Standard G, Section 7:
   Guardianship and conservatorship are actions of last resort. If guardianship or conservatorship becomes necessary to protect the client's safety, well-being, or finances, the attorney still should pursue the least restrictive alternative within the protective proceedings. Prior to choosing a course of action, consideration should be given to the client's wishes and values to the extent known; the consequences of intruding into the client's decision-making autonomy; and the potential impact on the client's family and social relationships.
3. Ohio Rule 1.14, Comment 7:
   If a legal representative has not been appointed, the lawyer should consider

whether appointment of a guardian *ad litem,* conservator, or guardian is necessary to protect the client's interests … . In many circumstances, however, appointment of a legal representative may be more expensive or traumatic for the client than circumstances in fact require. Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer.

4. Ohio Rule 1.14, Comment 8:
   Disclosure of the client's diminished capacity could adversely affect the client's interests. For example, raising the question of diminished capacity could, in some circumstances, lead to proceedings for involuntary commitment … . Therefore, unless authorized to do so, the lawyer may not disclose such information.

VII. Fiduciary Issues

A. What Governs the Attorney's Responsibilities When Representing a Fiduciary?

1. Aspirational Standard C, Section 3: The elder and special needs law attorney: Recognizes the unique challenges in drafting documents at the request of a fiduciary.
2. Comment on Aspirational Standard C, Section 3:
   Before acting on the fiduciary's request, the attorney should:
   - Confirm that the fiduciary has the authority to act under a valid durable power of attorney, court-ordered letters of authority, or state law.
   - Confirm that the proposed action is consistent with the protected individual's past estate planning documents or, if there are none, with the individual's known goals, wishes, and best interests.
   - Consider meeting privately with the protected individual to ensure that the individual desires the proposed action, especially if the proposed action personally benefits the fiduciary.
   - Refuse to act on the fiduciary's request if the proposed action represents a change in the individual's existing documents that is inconsistent with the individual's best interests.
3. Ohio Rule 1.14, Comment 2:
   The fact that a client suffers a disability does not diminish the lawyer's obligation to treat the client with attention and respect. Even if the person has a legal representative, the lawyer should as far as possible accord the represented person the status of client, particularly in maintaining communication.
4. Ohio Rule 1.14, Comment 4:
   If a legal representative has already been appointed for the client, the lawyer should ordinarily look to the representative for decisions on behalf of the client. In matters involving a minor, whether the lawyer should look to the parents as natural guardians may depend on the type of proceeding or matter in which the lawyer is representing the minor. If the lawyer represents the guardian as distinct from the ward, and is aware that the guardian is acting adversely to the ward's interest, the lawyer may have an obligation to prevent or rectify the guardian's misconduct. See Rule 1.2(d).

B. May the Attorney Disclose Confidences in Fiduciary/Principal Conflicts?

1. Aspirational Standard E, Section 6: The elder and special needs law attorney: Carefully maintains client confidentiality to the extent possible while also meeting the requirements of laws, regulations, or court-orders imposing a duty to disclose.

2. Comment on Aspirational Standard E, Section 6:
   The professional responsibility rules permit an attorney to disclose a client's confidential information without the client's express consent when disclosure is reasonably necessary to comply with a law, court order, or other professional responsibility rule. In making such a disclosure without the client's express consent, the attorney should be cautious to disclose only enough information that is required to comply with the law, court order, or other professional responsibility rule that requires disclosure.

   An example of a state law that may require an attorney or a health care professional employed by the attorney to make disclosures without the client's express consent is a law regarding mandatory reporting of abuse.
3. Ohio Rule 1.6(b):
   A lawyer may reveal information relating to the representation of a client, including information protected by the attorney-client privilege under applicable law, to the extent the lawyer *reasonably believes* necessary for any of the following purposes:
   (1) to prevent reasonably certain death or substantial bodily harm;
   (2) to prevent the commission of a crime by the client or other person;
   (3) to mitigate *substantial* injury to the financial interests or property of another that has resulted from the client's commission of an *illegal* or *fraudulent* act, in furtherance of which the client has used the lawyer's services; ("Illegal" denotes criminal conduct or a violation of an applicable statute or administrative regulation. Rule 1.0(e). "Fraud" or "fraudulent" denotes conduct that has an intent to deceive and is either of the following: (1) an actual or implied misrepresentation of a material fact that is made either with knowledge of its falsity or with such utter disregard and recklessness about its falsity that knowledge may be inferred; (2) a knowing concealment of a material fact where there is a duty to disclose the material fact. Rule 1.0(d)).
   (4) to secure legal advice about the lawyer's compliance with these rules;
   (5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding, including any disciplinary matter, concerning the lawyer's representation of the client;
   (6) to comply with other law or a court order.
4. Ohio Rule 1.6, Comment 6:
   Although the public interest is usually best served by a strict rule requiring lawyers to preserve the confidentiality of information relating to the representation of their clients, the confidentiality rule is subject to limited exceptions. Division (b)(1) recognizes the overriding value of life and physical integrity and permits disclosure reasonably necessary to prevent reasonably certain death or substantial bodily harm. Such harm is reasonably certain to occur if it will be suffered imminently or if there is a present and substantial threat that a person will suffer such harm at a later

date if the lawyer fails to take action necessary to eliminate the threat.

C. May the Attorney Serve as Fiduciary for the Client?

1. Aspirational Standard D, Section 5: The elder and special needs law attorney: Subject to state regulations, may serve as a fiduciary for a client upon the request of a client who has capacity if it is in the client's best interests and if the client gives written informed consent after full disclosure.
2. Comment on Aspirational Standard D, Section 5:
   These requests may raise concerns about undue influence, overreaching, the attorney's financial self-interest, and the best interests of the client. … The attorney must determine that the appointment is in the best interests of the client and justify how his or her appointment furthers the client's best interests. Before obtaining client consent, the attorney should explain to the client the fiduciary role, any conflicts of interest, the options to using the attorney as fiduciary, and the pros and cons of alternatives.
3. Ohio Rule 1.8(c):
   A lawyer shall not solicit any *substantial* gift from a client. A lawyer shall not prepare on behalf of a client an instrument giving the lawyer, the lawyer's partner, associate, paralegal, law clerk, or other employee of the lawyer's *firm,* a lawyer acting "of counsel" in the lawyer's *firm,* or a person related to the lawyer any gift unless the lawyer or other recipient of the gift is related to the client. For purposes of division (c) of this Rule:
   (1) "person related to the lawyer" includes a spouse, child, grandchild, parent, grandparent, sibling, or other relative or individual with whom the lawyer or the client maintains a close, familial relationship;
   (2) "gift" includes a testamentary gift.
   "Partner" denotes a member of a partnership, a shareholder in a law firm organized as a professional corporation, or a member of an association authorized to practice law. Rule 1.0(h).
4. Ohio Rule 1.8, Comment 8:
   This Rule does not prohibit a lawyer from seeking to have the lawyer or a partner or associate of the lawyer named as executor of the client's estate or to another potentially lucrative fiduciary position. Nevertheless, such appointments will be subject to the general conflict of interest provision in Rule 1.7 when there is a significant risk that the lawyer's interest in obtaining the appointment will materially limit the lawyer's independent professional judgment in advising the client concerning the choice of an executor or other fiduciary. In obtaining the client's informed consent to the conflict, the lawyer should advise the client concerning the nature and extent of the lawyer's financial interest in the appointment, as well as the availability of alternative candidates for the position.

VIII. Long-Term Care Planning

A. Should Medicaid Planning Be Undertaken if Long-Term Care Is Foreseeable?

1. Aspirational Standard A, Section 1: The elder and special needs law attorney: In applying a holistic approach to legal problems, works to consider the larger context, both other legal consequences as well as the extra-legal context in which the problems exist and must be solved.

2. Comment on Aspirational Standard A, Section 1, and Example:
   a. Comment:
   [T]he attorney recognizes that the client may not be knowledgeable of the variety of issues the client is facing or will be facing as he or she ages. Therefore, the attorney should be prepared to address with the client issues the client may not even be aware of that are related to the representation.
   b. Example:
   In addition to preparing the legal documents requested by the client, the attorney should offer advice on the issues of how to arrange for home care services, an assisted living facility, or a nursing home. The attorney also should offer advice on how to pay for such services and living arrangements and what measures the client may wish to consider to prevent financial exploitation.
3. Ohio Rule 1.4(b):
   A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.
4. Ohio Rule 1.1, Comment 1:
   In determining whether a lawyer employs the requisite knowledge and skill in a particular matter, relevant factors include the relative complexity and specialized nature of the matter, the lawyer's general experience, the lawyer's training and experience in the field in question, the preparation and study the lawyer is able to give the matter and whether it is feasible to refer the matter to, or associate or consult with, a lawyer of established competence in the field in question. In many instances, the required proficiency is that of a general practitioner. Expertise in a particular field of law may be required in some circumstances.

B. What Should the Attorney Consider When Undertaking Medicaid Planning?

1. Aspirational Standard H, Section 5: The elder and special needs law attorney: When developing a plan to secure and pay for long-term supports and services should:
   (a) Strive to determine the client's wishes and values in order to achieve the client's objectives concerning living options, health care, loved ones, and property;
   (b) Endeavor to preserve and promote the client's dignity, self-determination, and quality of life;
   (c) Counsel the client about the full range of long-term services options, risks, consequences, and relevant costs;
   (d) Counsel the client in light of the client's needs, personal values, wishes, best interests, and the alternatives available; and
   (e) Counsel the client on the estate planning and tax implications of the client's choices for long-term services on his or her property.

2. Comment on Aspirational Standard H, Section 5:
   At all times during the representation, the attorney should be mindful of Model Rule 2.1: Advisor, which states that the "lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation." … The attorney should be mindful that the client's goals should guide the actions of the attorney. Offering a solution to the client's problem is inappropriate when the steps and objectives conflict with the client's values.

3. Ohio Rule 1.4, Comment 5:
   The client should have sufficient information to participate intelligently in decisions concerning the objectives of the representation and the means by which they are to be pursued, to the extent the client is willing and able to do so. Adequacy of communication depends in part on the kind of advice or assistance that is involved … . The guiding principle is that the lawyer should fulfill reasonable client expectations for information consistent with the duty to act in the client's best interests, and the client's overall requirements as to the character of representation.
4. Ohio Rule 1.4, Comment 6:
   Ordinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity. *See* Rule 1.14 … . Where many routine matters are involved, a system of limited or occasional reporting may be arranged with the client.

C. What Responsibilities Does the Attorney Have Concerning Possible Fraudulent Conduct?

1. Ohio Rule 1.2(d)(1):
   A lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer *knows is illegal* or *fraudulent.* A lawyer may discuss the legal consequences of any proposed course of conduct with a client and may counsel or assist a client in making a good faith effort to determine the validity, scope, meaning, or application of the law.
2. Ohio Rule 1.2, Comment 9:
   This prohibition, however, does not preclude the lawyer from giving an honest opinion about the actual consequences that appear likely to result from a client's conduct. Nor does the fact that a client uses advice in a course of action that is illegal or fraudulent of itself make a lawyer a party to the course of action. There is a critical distinction between presenting an analysis of legal aspects of questionable conduct and recommending the means by which an illegal act or fraud might be committed with impunity.
3. Ohio Rule 1.2, Comment 10:
   When the client's course of action has already begun and is continuing, the lawyer's responsibility is especially delicate. The lawyer is required to avoid assisting the client, for example, by drafting or delivering documents that the lawyer knows are fraudulent or by suggesting how the wrongdoing might be concealed. A lawyer may not continue assisting a client in conduct that the lawyer originally supposed was legally permissible but then discovers is improper. *See* Rules 3.3(b) and 4.1(b).
4. Ohio Rule 1.2, Comment 12:
   Division (d)(1) applies whether or not the defrauded party is a party to the transaction. Hence, a lawyer must not participate in a transaction to effectuate illegal or fraudulent avoidance of tax liability … . The last clause of division (d)(1) recognizes that determining the validity or interpretation of a statute or regulation may require a course of action involving disobedience of the statute or regulation or of the interpretation placed upon it by governmental authorities.

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Remote Support: What it Can—and Cannot!—Do

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Legal Issues with Remote Supports for Individuals with Intellectual or Developmental Disabilities

Janet L. Lowder CELA
Jeanne Sydenstricker
Stetson Special Needs Trust Conference
October 23, 2025

I. Introduction

The past decade has seen remarkable growth in the use of remote monitoring and support technologies—ranging from GPS trackers and wearable devices to in-home cameras, smart-home sensors, and mobile applications—to support individuals with intellectual and developmental disabilities (IDD). States were beginning to focus on technology solutions to caregiving when the COVID-19 pandemic, coupled with persistent shortages in direct support professionals, accelerated this shift toward technology-based supervision. Social isolation, already a problem for many folks in the I/DD system before the pandemic, became an enormous issue as day programs shut down and caregivers were lost. States were forced to re-evaluate their approaches to technology solutions for remote monitoring and supervision. For families and service providers, these tools offer the promise of enhanced safety, reduced staffing costs, and reassurance. For individuals with disabilities, they can promote autonomy, reduce the need for constant in-person staff, and allow greater participation in community life.

However, the use of surveillance technologies raises significant legal and ethical concerns. The monitoring of people with disabilities touches on constitutional rights, privacy protections, consent and capacity issues, disability law mandates, tort liability, and regulatory compliance. Without careful safeguards, the very technologies designed to empower people with disabilities risk becoming intrusive, paternalistic, or even discriminatory. This paper explores the legal landscape surrounding remote monitoring in the context of developmental disabilities and outlines best practices for its ethical and lawful implementation.

II. Privacy and Confidentiality

A. Constitutional and Federal Privacy Rights

At the constitutional level, the Fourth Amendment provides protections against unreasonable searches and seizures by government actors. When state-funded programs or publicly operated group homes employ remote monitoring, courts may construe continuous surveillance as a "search," particularly if individuals have not provided valid consent[1]. Landmark cases such as *Katz v. United States,* 389 U.S. 347 and *United States v. Karo*, 468 U.S. 705, established that individuals enjoy a reasonable expectation of privacy in their own homes, a principle that must extend to individuals with disabilities in residential or supported-living settings.

Federal statutory frameworks also apply. The Health Insurance Portability and Accountability Act (HIPAA) governs the collection, use, and disclosure of health-related data. Monitoring systems that record medical information—such as seizure activity, heart rate, or medication adherence—fall squarely within HIPAA's protections. Similarly, the Family Educational Rights and Privacy Act (FERPA) applies when monitoring occurs in educational environments, protecting the confidentiality of student information.

B. State Privacy Statutes and Ethical Dimensions

States vary widely in their treatment of electronic surveillance. Some require explicit written consent before installing cameras in private residences, while others impose heightened restrictions in long-term care facilities. In nearly all states that have adopted remote-support regulations, providers must document the impact of remote monitoring on the individual's privacy, communicate this information in an accessible manner, and obtain written consent from the individual or their legal representative.

Ohio's remote support regulations require that the individual receiving the services and each person who resides with the individual must consent in writing after being informed 1) that the

[1] *See Carpenter v. United States*, (prolonged tracking of a person's movements without a warrant invades a reasonable expectation of privacy, as the data provides a detailed and comprehensive record of a person's movements and associations). *See United States v. Katzin*, (surveillance of a vehicle for 24 hours a day over four weeks was a search. The surveillance revealed patterns of behavior and movement not exposed to the public, thereby invading a reasonable expectation of privacy).

remote support staff will observe their activities and/or listen to their conversations; 2) where in the residence the remote support will take place, and 3) whether or not recordings will be made. The signed consents must be retained with the Individual Service Plan (ISP.) O.A.C. 5123-9-35.

Ethically, providers must strike a delicate balance between safety and dignity. Remote monitoring should never serve as a punitive measure or function as a substitute for human interaction. Instead, it must be deployed in ways that maximize autonomy while minimizing unnecessary intrusion.

III. Consent and Capacity

Consent lies at the heart of lawful remote monitoring. Yet for adults with developmental disabilities, the ability to provide informed consent may be complicated by questions of legal capacity. In cases where guardianship, conservatorship, or powers of attorney are in place, these decision-makers may have authority to consent on behalf of the individual. Even so, best practice and emerging case law emphasize the importance of considering the expressed wishes of the person receiving services, even in circumstances where they lack full legal capacity.

Supported decision-making agreements, now recognized in states such as Texas, Delaware, and Wisconsin[2], provide an alternative framework for ensuring meaningful consent. These agreements allow individuals to choose trusted supporters to help them understand choices without surrendering decision-making authority, offering a promising model for decisions about monitoring.

Conflicts of interest often arise when families prioritize safety while individuals value privacy and independence. Courts or state agencies may be asked to resolve these disputes, applying

[2] *D.C. Code § 7-2133*, (permits adults with disabilities to enter into supported decision-making agreements, authorizing supporters to assist in decision-making, be present during the process, and help obtain and communicate information. Supporters may only act within the authority granted in the agreement); *Tex. Estates Code § 1357.055*, (Texas law requires supported decision-making agreements to be signed voluntarily by the adult with a disability and the supporter in the presence of two witnesses or a notary public); *Utah Code Ann § 75-5-704,* (allows individuals to enter into supported decision-making agreements voluntarily, provided they understand the nature and effect of the agreement. If the individual has a court-appointed guardian or conservator, that person must be notified and given an opportunity to review and participate in discussions about the agreement. In some cases, the guardian or conservator's signature is required for the agreement to be valid); *Rev. Code Wash (ARCW § 11.130.740)*, (requires supported decision-making agreements to be in writing, dated, and signed voluntarily by the adult with a disability and the supporter in the presence of two witnesses or a notary public.)

either a "best interest[3]" standard or, increasingly, a "substituted judgment[4]" approach that honors the individual's own values and preferences.

IV. Disability Rights and Anti-Discrimination

Remote monitoring must be evaluated in light of federal disability rights statutes. The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act prohibit discrimination and require that services be delivered in the most integrated, least restrictive manner possible. Technologies that restrict community access or function as a substitute for needed human supports may violate these laws.

The Supreme Court's decision in *Olmstead v. L.C. by Zimring* affirmed that individuals with disabilities have a right to receive services in the most integrated setting appropriate. Overreliance on surveillance in congregate or institutional settings could undermine this integration mandate by reinforcing segregation rather than promoting community inclusion[5].

Civil rights considerations also arise when monitoring limits freedom of movement or decision-making. In extreme cases, constant electronic surveillance may resemble a restraint[6], raising concerns analogous to seclusion or confinement. Thus, while remote monitoring can support independence, it must never cross the line into technological coercion.

V. Liability and Duty of Care

Once monitoring systems are implemented, providers may assume new legal duties. If an agency installs fall detectors, GPS trackers, or other alert systems, courts may find that the provider has

[3] The best interest standard requires the decision-maker to prioritize the welfare, well-being, and overall benefit of the disabled individual. This is an objective assessment of what would be most beneficial to the individual.
[4] The substituted judgment approach is when the decision-maker makes a determination based on what the individual would have chosen if they were competent. The decision-maker bases decisions on the known preferences, values, and beliefs of the individual.
[5] *See Olmstead v. L.C. by Zimring*, 527 U.S. 581 ("unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II" of the ADA).
[6] The seizure of a person can take the form of physical force or a show of authority that in some way restraints the liberty of the person.

an obligation to respond promptly when those systems detect a risk. Failure to act could give rise to negligence claims. This heightened standard of care mirrors principles developed in custodial contexts, where service providers bear responsibility for responding to foreseeable risks.

Institutional liability is a related concern. Group homes, service agencies, and schools must adopt clear protocols specifying who monitors, how often, and under what circumstances staff must intervene. Vendors providing remote-support services also face obligations to maintain HIPAA compliance, update technology, and safeguard data. Improper maintenance or system failures may expose providers to liability.

Ohio requires remote support be provided in real time, by awake staff with no duties other than remote monitoring. Remote support vendors are required to have a back-up power system in place, and must have an effective system to contacting backup support or emergency personnel as needed.

Product liability law also applies. Device manufacturers and software developers can be held responsible for defective products that cause harm. For example, a malfunctioning GPS tracker that fails to alert caregivers of elopement could expose the manufacturer to claims under theories of design defect, manufacturing defect, or failure to warn.

VI. Regulatory and Funding Considerations

Medicaid remains the dominant public funding source for long-term services and supports for individuals with developmental disabilities. Most states authorize the use of remote supports under Home and Community-Based Services (HCBS) waivers. Federal regulations governing HCBS require that services be person-centered, consent-based, and supportive of community integration. Yet, in practice, many waiver programs impose annual funding caps for technology that are insufficient to cover the cost of effective systems.

The American Rescue Plan Act of 2021 (ARPA) provided significant funds to states to improve their technology solutions. These funds were used for services not covered under other existing policies and programs, including training for providers, consumers and caregivers, smart home technologies, electronic or remote monitoring and supports, broadband or internet fees, digital

health sensors, trackers, video conferencing services and training, and smartphones and tablets. More than half the states used these funds to establish new technology pilot programs for individuals with I/DD. Most states quickly amended their waivers to include training as a waiver service.

States also regulate the use of monitoring through licensing requirements for group homes and residential facilities. These rules may restrict or condition the use of surveillance, particularly where it implicates resident privacy. Emerging state legislation reflects a growing commitment to the "Technology First" movement, which requires service systems to consider technological supports before defaulting to in-person staffing. Ohio and Missouri were early adopters of Technology First statutes[7], and by 2023, nearly half of states had taken steps toward adopting similar frameworks. Still, many jurisdictions lack comprehensive regulation, creating legal uncertainty.

VII. Best Practices for Implementation[8]

Given these legal complexities, best practices emphasize safeguards, transparency, and individual choice. The use of remote supports should be documented in detail in the Individual Service Plan (ISP). The ISP must demonstrate what is important to the individual to ensure the supports and services are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety, and well-being. The ISP should also include documentation of the individual's consent.

States must have detailed licensing requirements for agencies providing remote supports. Agencies should develop written policies addressing consent procedures, data use, and response protocols. Data collected through monitoring must be encrypted, access-controlled, and subject to audit trails to ensure that access to information is limited to authorized persons. Providers should undergo licensing and training to ensure compliance with privacy and security requirements.

[7] The Technology-Related Assistance for Individuals with Disabilities Act of 1988, or the "Tech Act," was amended to the Assistive Technology Act of 2004. Assistive technology devices is any equipment used to increase, maintain, or improve the functional capabilities of individuals with disabilities.
[8] Adoption of uniform terms is important. See Appendix A – Glossary of Terms, from NASDDDS

Monitoring and support arrangements should be revisited periodically to confirm that they remain necessary, effective, and proportionate. Most importantly, the technology should be incorporated into a broader person-centered plan, with meaningful input from the individual being supported. This ensures that technology serves as a tool for empowerment rather than control.

VIII. Conclusion

Remote monitoring and support technologies offer great potential to enhance safety and independence for individuals with developmental disabilities, particularly in the face of staffing shortages and rising demand for community-based services. Yet their use implicates constitutional rights, federal and state privacy laws, disability rights protections, and tort liability. Without careful oversight, these tools risk eroding autonomy, dignity, and civil rights.

Policymakers, providers, and families must therefore approach remote monitoring and supports with caution, ensuring that implementation is rooted in informed consent, respect for privacy, and adherence to disability law mandates. When used appropriately, remote supports can expand independence and promote inclusion. But to achieve this promise, technology must always remain in service of human dignity, not a substitute for it.

GLOSSARY OF TERMS

Adaptive aids or equipment (EAA) - Adaptive aids or equipment are products, sytems, and/or machines used to help people perform activities of daily living (ADLs).

Assistive technology (AT) - Assistive technology is any item, piece of equipment, software program, or product system that is used to increase, maintain, or improve the functional capabilities of persons with disabilities.

Companion care - Companion care provides social and emotional supports to an individual through digital or technology platforms.

Durable medical equipment (DME) - Equipment and supplies ordered by a health care provider for everyday or extended use.

Electronic or remote monitoring/supports - Electronic equipment used to support a person from a distance for residential or in-home supports.

Enabling technology - Equipment and/or methodologies that, alone or in combination with associated technologies, provide the means to support individuals' increased independence in their homes, communities, and/or workplaces.

Environmental accessibility aids (EAA) - EAA are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual.

Personal emergency response system (PERS) - Personal emergency response systems or personal safety monitors directly connect an individual to an emergency responder or organization. These include life alerts, medical alerts, or fall monitors.

Smart home technology - Home equipped with network-connected products for controlling, automating, and optimizing functions such as temperature, lighting, security, etc., either remotely or by a separate system within the home.

Technology solution - Ideas, products, or services that are used to solve a problem or create something new. Advances a goal-oriented and self-directed approach to the development, acquisition, and utilization.

Technology First - Framework for systems change where technology is considered first in the discussion of support available to individuals and families through person-centered approaches to meaningful participation, social inclusion, self-determination, and quality of life.

Telehealth, telemedicine, or telecare - The use of telecommunications and information technology to provide access to health assessment, diagnosis intervention, consultation, supervision, and information across distance.

Video conferencing service or training - May be termed virtual delivery of service or teleservice. Service that provides real-time video communications, including audio, to enable users to share information of the user's choosing.

Wearable technology - Technology devices intended to remain on the user's body.

APPENDIX A

REMOTE SUPPORT
WHAT IT CAN – AND CANNOT!- DO

Janet L. Lowder
Jeanne Sydenstricker
October 23, 2025

1

What is it?

Remote Monitoring	Remote Support (People with IDD)
• Mainly surveillance cameras, video only • Used by many commercial entities (stores, businesses, governments, etc.) • No interaction with people being filmed • Nearly always records and keeps the video for some length of time	• Uses a variety of technologies, including cameras, sensors, etc., in a household • Two-way audio and video • Active unique engagement with support people, who are in a different geographic location • Can be recorded if client agrees • Can be provided 1-on-1 or to a household

2

Why is Remote Support important?

- Helps offset the shortage of Direct Support Providers (DSP) to care for those with IDD
- Encourages and enhances individual independence, self-confidence and promotes self-determination
- Maintains health and safety procedures
- Can combine DSP services and Remote Support if the individual needs both
- Is significantly less expensive than DSP on an hourly basis
  - As available Medicaid dollars are reduced, we must find viable alternatives

3

Ohio Examples

- Ohio is a "Technology First" State and has been a national leader in expanding the use of assistive technology and remote supports.
- It is now required that those authorizing ISP's consider remote support before authorizing on-site personnel.
- Numerous Remote Support companies have started in the past few years
  - Some have very limited individual support—mainly monitoring rather than active engagement
  - Some claim to be statewide—but cannot provide necessary technical support
  - Some are excellent

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Real Life Experiences

- Two men with IDD, ages 42 & 46, live alone in a single family home in their community.
  - Prior to COVID, they had a live-in caregiver.
  - After that, there was a series of drop-in caregivers, with one of the parents sleeping there overnight.
- Nearly 3 years ago, a remote support company called Ohio At Home took over the nights and the morning routines to get the men off to work.

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Real Life Experiences – cont'd

- A bumpy start—lack of clarity on both parts about what was needed and exactly what the remote support personnel would do
- Installation of hardware took a long time and was difficult to hide wires for aesthetic purposes
- Very large house (3 stories) with 8 cameras. Internet capability had to be increased to help insure all stay online. Also have Facebook portals and Alexa which are essential for the residents to see to whom they are talking.
  - (Note: internet costs are not paid for by Medicaid, so each family needs to cover those independently)

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Real Life Experiences – cont'd

- The younger man has IDD, autism and communication disorders.
  - Needs very specific directions at each step for waking up, getting dressed, morning hygiene activities, fixing breakfast, etc.
- Ohio At Home worked long hours with us to learn exactly what to say, how to interpret non-verbal responses, etc.
  - Personnel training and documentation has been excellent
  - Have less turnover than Direct Service Provider agencies, but still a fair amount. Routines and instructions are transferring well.
- Both men take medications using a DOSE medication dispenser.
  - Remote supports is not part of this since it is automated and linked directly to parent's phone.
  - Other families include medication monitoring in remote services as needed.

7

Some of the problems

- On-site Technical Support isn't consistent
  - Ohio At Home is in Columbus; we are in Cleveland
- When internet services goes out, there is no support
  - Can use telephones for backup audio support
- When Remote Support camera goes down, it helps to have a redundant system, e.g. inexpensive Ring cameras in key areas (additional expense to family)
- When power goes out, there is no support unless you have a generator (Ohio At Home has one also)
- Technology changes. Depending on nature of disabilities, it may be advisable to replace some of one's older equipment; there is not always budget for this

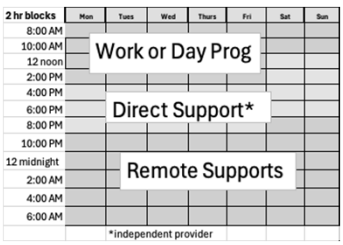
8

Remote Supports are not for Everyone

Good Chance for Success	Not likely to work
• Able to understand verbal directions and engage somewhat with RS personnel • Comfortable being on their own sometimes; RS oversight may be talking to other clients, etc. • Families willing to work with RS to train them on how to best work with their person with disabilities • Generally compliant personality • Comfortable with technology	• Aggressive or angry demeanor • Refuses to engage or respond to RS personnel • Medically very fragile • Poor internet availability • Unwilling to learn about and collaborate on what technology might be useful

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Cost savings can be very significant. Example: a possible average week



	Total Weekly Hours	$ rate per hour	Cost per week with Rem Supts		No remote support
Work	40	0	0		0
Direct Supt	46	30.32	1395		1395
Remote Supt	82	9.48	777		2486
	Total per week		2172		3881
Weekly savings using RS			$1,709		
Annual savings for 1 person			**$88,868**		
Average initial equipment cost (3-5 year life)					
		$5000-$10,000			

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Future Expectations?

- The shortage of qualified Direct Service Providers will continue and is likely to get worse as the population ages.
- People with IDD have increased life spans nearly equal to those without disabilities, and will thus need care for longer periods.
- Technology is making amazing leaps that can help with monitoring both behavior and serious medical issues remotely.
- Medicaid budgets will continue to face downward pressure.
- Solutions like Remote Monitoring will need to be widely expanded to help keep those with IDD safe and healthy.

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Legal Issues with Remote Support

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Introduction

- Tremendous growth in remote monitoring (GPS, wearables, sensors, apps) over last several years
  - COVID-19
  - Staffing shortages
  - Development of technology

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Benefits and Concerns

- Benefits:
  - Increased safety
  - Autonomy
  - Reduced staff reliance resulting in cost savings
- Concerns:
  - Privacy
  - Consent
  - Disability rights
  - Liability

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Privacy and Confidentiality

- Constitutional rights: 4th Amendment, Katz v. US
- HIPAA covers health-related monitoring data
- State laws regarding use of remote monitoring and written consent requirements vary
- Ethics: balance safety vs. dignity, avoid punitive use

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Ohio Consent Requirements

- Ohio: O.A.C. 5123-9-35 outlines requirements for written consent
  - Includes person receiving services and each person residing with them
  - Must be informed
    - That remote staff will observe activities and/or listen to conversations,
    - Where in the residence this will take place, and
    - Whether or not recordings will be made.

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Consent and Capacity

- Informed consent may be limited by capacity.
- Guardians/POAs may consent, but wishes of individual matter.
- Supported decision-making: alternative to guardianship.
- Conflicts: safety vs. privacy and independence.
- Courts will use a best interest vs. substituted judgment standards. Courts are increasingly using substituted judgment.

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Disability Rights and Anti-Discrimination

- ADA and Section 504 prohibit discrimination.
- Services must be least restrictive, integrated.
- Olmstead v. L.C.: integration mandate.
- Risk: surveillance in congregate settings may segregate.
- Excessive monitoring may resemble restraints.

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Liability and Duty of Care

- Providers assume duties once monitoring is implemented
- Negligence risk if alerts ignored
- Agencies need clear protocols for monitoring/response
- Vendors must maintain HIPAA compliance, safeguard data collected and properly maintain the systems
- Ohio: real-time awake staff required, backup systems
- Manufacturers: product liability for device failures

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Regulatory and Funding

- Medicaid HCBS waivers are the primary source of funds for remote supports
- Federal HCBS rules require services, including remote supports, to be person-centered, consent-based, and integrated
- Funding caps often limit technology access, requiring states to use local or state funds to supplement the waiver dollars
- Many states lack comprehensive regulation regarding remote supports

20

"Technology First"

- The Technology First framework started before COVID, with Ohio and Missouri the first adopters
- As of 2023, nearly half the states were on the way to adopting the framework
- Requires consideration of technological supports before defaulting to in-person staffing

21

Best Practices – ISP Documentation

- Use of remote supports must be documented in detail in the ISP, including
  - Evidence that the supports and services are delivered to reflect the individual's preferences, and
  - The supports and services ensure health, safety and wellbeing
  - Written consents should be a part of the ISP

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Best Practices – Licensing Requirements

- States should implement licensing requirements that include:
  - Written policies regarding consent, data use, response protocols
  - Data collected must be secured by encryption, access control, and subject to audit trails
  - Provider training and compliance requirements
  - Regularly review monitoring arrangements
  - Person-centered planning with individual input

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Conclusion

- Remote support enhances safety and independence.
- Also implicates privacy, disability rights, liability.
- Must ensure informed consent and civil rights compliance.
- Technology should empower, not control.
- Always prioritize human dignity.

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Questions??

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STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Thursday
October 23, 2025

First Party Special Needs Trusts-Settlement Consultation: What a Trust Practitioner Should Know, Consider, and Review

STETSON LAW

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Access and Justice For All®

Stetson 2025 National Conference on Special Needs Planning and Special Needs Trusts
October 23, 2025- Main Conference Breakout Session (Thursday)
4:25pm-5:15pm

"First Party Special Needs Trusts-Settlement Consultation, what a Trust Practitioner should know, consider and review"

Ethan J. Ordog, Esquire (Begley Law Group, P.C., Moorestown, New Jersey)

Outline of Topics:

A. Introduction and Settlement Consultation in Your Practice

B. Communications with Personal Injury Counsel/Staff

C. Intake/Confirmation of Benefits/Budget Needs

D. Who is the Client and Issues related to Capacity

E. Court Proceedings and Involvement of Counsel

F. Trust Options and Selection of the Trustee

A. Introduction and Settlement Consultation in Your Practice

Approximately 25 years ago, in a more formal sense, the firm began receiving more and more inquiries related to assistance with the establishment and funding of 1st Party Special Needs Trust, particularly resulting from civil claims of individuals who were receiving and/or could be receiving public benefits. The involvement of our office has continued to develop and take shape with the ever-changing landscape of these matters, as well as the interactions with members of the civil bar who reach out to engage our services either directly and/or through their clients.

To that end, the importance of the development of the relationships with civil Counsel is paramount in being successful in this area of practice, but also to ensure that they are well informed and secure the involvement of Trust Counsel as early in the process as possible to ensure there are no missteps in the process, but perhaps, more importantly, errors in representations made to a client regarding a settlement, the protection of and/or need to preserve eligibility for public benefits and the scope of the process that needs to be undertaken to ensure that all background/biographical information is secured and accurate.

In many instances, there is confusion or and/or lack of formal confirmation of the programs/public benefits that are being received and/or which could be received. Additionally, there is often a need to confirm or review the legal scope of the engagement that has occurred between civil Counsel and a "client" based upon the scope of the retaining party, i.e. agent under power of attorney v. individual and/or some other formal fiduciary appointment which is believed or thought to have existed. Moreover, even in those instances where there is a clearly defined scope of the retention by an agent or otherwise, there is a clear need to ensure further and/or more significant communications between civil Counsel and the injured party, to the extent same is possible or allowable.

It is further recognized that often, a call from civil Counsel may occur after a settlement is reached, at mediation of the matter or even just prior to the expiration of a statute of limitations expiration date. That logistical element is referenced herein because often calls are received in a somewhat panicked state, recognizing the potential claim must be considered in the context of other circumstances related to the client, their public benefits eligibility, ability of an individual to formally retain civil Counsel, etc. Having a system or process for intake and the

coordination of a meeting or call in these instances is extremely important so as to allow the involvement of Trust Counsel to be effectuated in a timely and comprehensive manner.

B. Communications with Personal Injury Counsel/Staff

In developing the relationships with civil Counsel in these matters, it is important to set expectations and the scope of how to begin the communication process so as to be able to timely address both emergent matters and ones that may not be settling or have an anticipated resolution date for some time. Typically, an initial meeting with the civil Counsel occurs upon them contacting the office, often with a preliminary discussion being effectuated in advance of a formal meeting with the attorney and their client or the client's representative. It is important to understand the objectives of civil Counsel and the status of the claims being pursued, as well as initiate a review of important logistics, etc.

It is without fail that many civil practitioners, being focused on the merits of their matter and the pursuit of recovery, etc., may not have been focused on some aspects of the client's benefits, logistics of the scope of any protective arrangement in place, options for planning following recovery and/or the implementation of action items in the event a settlement or recovery is achieved. With that in mind, also recognizing that this matter might be the sole case that civil Counsel is focused on at this time, it is crucial to establish timing for meetings and communications, as well as deadline for the receipt of information and documentation, while establishing attainable goals for the work of Trust Counsel in these matters. While there may be and often are detours that occur in these matters, the focus is on ensuring that all issues and aspects of the matter are considered and communicated, while working to allow resolution based upon the schedule anticipated by civil Counsel.

In advance of a formal meeting, intake information is desirable, which is often secured from civil Counsel, their staff and/or the client/client's representative directly. While the scope of information will be fact sensitive, it is imperative to ensure that appropriate and relevant information is received in order to ensure that Trust Counsel can effectively and adequately provide advice, direction and legal services that are consistent with and in furtherance of the needs of the client. Additionally, it is important to know what other professionals have been involved with and/or engaged in the process/representation to ensure that all of the individuals involved are working in concert with one another. The delineation of the roles of the professionals to be mindful include, but are not limited to the following:

Care Manager/Life Care Planner

Nursing Care Manager

Benefits/Lien Reduction Professional

Financial Advisor

Structure Broker

Corporate/Professional Trustee

Of course, each case is unique and, in certain instances, the civil Counsel will look to Trust Counsel to assist with and/or provide guidance on recommendations on the referral of and/or need for includability of the other professionals who may be needed or necessary to ensure that all aspects of a matter are covered. Civil Counsel will often defer to Trust Counsel on these matters in an effort to ensure that comprehensive services, especially in more complicated matters, have fully been addressed. Moreover, there is often a recognizable need for the education of civil Counsel on these topics and matters because they are outside of the scope

of their area of practice and they simply do not want any mistakes being made which would negatively impact their client and/or potential eligibility for benefits.

Notwithstanding the numerous logistical issues discussed with Counsel in these matters that are preliminary in nature when Trust Counsel is first learning about the scope of the civil claims or the issues involving the client that require attention, there is also a general misconception that EVERY matter requires a special needs trust. Of course, access to other assets, potential less restrictive Trust options and the age of the client will impact the process and recommendations which will be made in a particular matter/set of circumstances. Moreover, communication with the other professionals involved, as well as the client and/or the client's representative are often vital to the formal action plan/ultimate services rendered by Trust Counsel.

C. Intake and Confirmation of Benefits

As indicated above, the scope of this area of practice is typically conditioned upon the belief that, in order to maintain public benefits, that a special needs trust is required because the civil client cannot have *ANY* assets or otherwise risk the loss of public benefits being received. As is explained to civil Counsel, other professionals involved and/or the client/client's representative, the importance of gathering information cannot be understated. Further, it is imperative to understand the scope of what information/direction has been provided to the individual or "client", so as to be able to set expectations and reasonable outcomes for the options that might exist or be recommended. There is typically an initial hurdle to overcome as to what has been said, read online and/or is simply believed to be the manner in which the

recovery of a claim HAS to be dealt with, often without a formal review of the logistics/facts of the matter.

While an individual client believes that income is received from Social Security and/or that their medical insurance is being received from some "governmental" program, including Medicare or Medicaid, until the insurance cards can be reviewed and/or correspondence from Social Security can be secured, it is often speculative at best as to what programs or benefits the individual may receive, had received, or could be receiving. Compounding such issue is the direct request for information on other benefits which may be received, including housing assistance, other sources of income, food/utility assistance, etc.

Although the securing of a full understanding of income, insurance and other public benefits is paramount from the Trust Counsel standpoint, perhaps, as is the case with many of these preliminary communications/request for assistance, the most challenging aspect is the formal willingness of the individual who needs to be protected, in some manner, regardless of the benefits being received, to fully participate in the process or understand the need for such action to be taken at that time. The client may have been advised of the settlement negotiations or recovery amount, without thinking of the associated fees of civil Counsel, recovery which may exist in the form of liens or the countervailing issue of the simple costs associated with aspects of life that will quickly reduce or decrease the amount of a recovery/settlement.

The client often has a plan for the recovery/settlement, regardless of the settlement amount in or the actual funds that will be received, for the purchase assets of a house, car, personal items, entertainment, etc., which far exceeds the value of amount to be received, while also not considering the costs of other associated care costs or life expenses, particularly of the

recovery or anticipated plan of the client now precludes or impacts public benefits being received. Of course, Trust Counsel, given the scope of the involvement, often is presented with the role of engaging in poignant communications to set straight the formal logistics and circumstances surrounding these matters. These communications are of course, not intended to be negative, but must accurately reflect the options and the manner in which a resolution is being coordinated. Also, often these conversations/communications, will assist in the relationship building with the client, particularly as the Trust Counsel may have been brought in at a much later part of the process and the client may not fully understand the scope of the involvement or need for another attorney to be engaged in the process.

Intake and information may and will often come from a number of sources. As Trust Counsel in these matters, it is recognized, in many instances, that important information about the client's income, benefits, assets, debts/obligations, medical condition, etc., is unknown or perhaps not able to be explained or confirmed as requested. In order to provide assistance in the gathering process, it is important to have intake forms which clearly identify information requested.

Intake/Intake Forms (See Attached)

Consistent with the involvement of Trust Counsel, particularly in the assessment of the type or scope of a potential Trust for the client, as well as corresponding issues that may arise regarding protective arrangements, public benefits and the needs of the client, the intake forms seek to understand the general background of the client, establish an understanding of the family dynamic, level of capacity, corresponding medical conditions and public benefits being received. Moreover, the intake forms seeks to ensure that an understanding of assets, debts (particularly

liens) and income attributable to the client is provided so that same can be considered. Further, the intake forms seeks to develop an understanding of the scope of professionals involved, as well as potential recommendations which have been made, i.e. related to the financials (structure, investment, etc.), in addition to potential Trustee(s) who might serve.

Additionally, the intake forms seek to understand what family has been involved, the scope of estate planning and other legal documents which might exist or which may need to be created, while also attempting, at a preliminary level, to understand immediate needs for items/distributions that must or should be considered in the development of recommendations/action items. If there is any present legal relationships that should be known, Guardian, Power of Attorney, Conservator, Personal Representative of an Estate, etc., the intake should seek to secure such information, so any further communications can be had and/or correspondence directed, as may be necessary.

Trust Counsel should also, to the extent same exists or will be created/drafted during the involvement in the matter, secure a copy of any filed Complaint, Life Care Plan, both of the civil Counsel and their adversary, if any, any releases, correspondence related to liens/lien reduction, in addition to any Court Orders or related documents involving the Court which may be important to the client's case. It is imperative that requests be effectuated, in writing, seeking to secure these items, along with an explanation of the need for such documentation in furtherance of the role being played by Trust Counsel.

Budget and Sustainability of the Trust/ Allowable Distributions

From a conceptual understanding of the needs of a client, which may assist with the scope of options/recommendations from Trust Counsel and in furtherance of the intake secured, it is also important to understand the present financial needs/expenses of the client. Trust

Counsel will often engage, quite often with civil Counsel, the client and other professionals involved, in a formal budget meeting, wherein immediate needs of the client are identified, as well as ongoing/continued expenses or what may become expenses, so as to be able to address the scope of any concerns or questions regarding allowable use of settlement proceeds and/or assets which might be directed to a Trust.

While the numbers nearly always change, the underlying premise for such an exercise is to establish a baseline of the expenses of a client, as well as what may or may not become an expense depending on the type of Trust and potential preservation of benefits. This exercise often assists in the assessment of what monthly income needs would be required, particularly if a structure is going to be used/secured, in addition to the need to possible hold a certain amount of corpus, in the event of a large expenditure, like a home for example. An example of a budget intake form/assignment form is attached with the materials.

Discussions on Distributions from a Special Needs Trust

In furtherance of the process, including the budget meeting and intake, as well as communications with civil Counsel and/or the client, it is often requested that a discussion of the potential uses of a Special Needs Trust arise, particularly in consideration of the nature of the conversations related to public benefits eligibility and the direction of funds to a Special Needs Trust to allow same to be used which protecting the client's receipt of Social Security, Medicaid and other programs which provide support to the client.

To that end, for purposes of conversation and/or references, civil Counsel may want to develop a breakdown of items that can be used from the Special Needs Trust, along with

explanation of the interplay between the Trust distributions and income which may be received by the client.

Allowable but In-Kind Support/Maintenance (ISM) Impact for SSI

Mortgage Payment	Rent
Property Insurance (Lender required)	Gas
Property Taxes	Electricity
Water	Sewer
Heating Fuel	Garbage Collection

**** Food as of 9/30/24 no longer considered for ISM calculation purposes****

Other Allowable Distributions from a Special Needs Trust

Purchase of Home	Clothing
Phone/Cable/Internet	Vehicle (Insurance, Gas, Maintenance)
Pre-paid Funeral (With some limits/requirements)	
Tuition/Books/Tutor	Furniture/Tools/Household Supplies
Entertainment	Property Insurance (not lender required)
Television/Computer/Electronics (be mindful of scope and amount)	
Medical Equipment	
Travel (beneficiary and caregiver- be careful)	
Care management/Support (be mindful of state specific limitations and scope of parental support obligation)	
Medical Insurance Premiums/Co-Pays and Deductibles/Non-Covered Medicals	
Commuting/Transport Expenses	

Prescription Drugs (be careful of coverage by other sources)

Personal Needs- hair, cigarettes, alcohol, toiletries, non-prescription drugs

Reading Materials

Legal Fees (depending on scope, may want to get approval)

Distributions Not Allowed

Cash (too hard to track)

Family Travel

Gifts for others

Excessive amounts for allowable distributions

D. Who is the Client and Issues related to Capacity

It is important for the Trust Counsel to understand and identify, as early on in the process as possible who the Client is and if there are any capacity issues which need to be addressed. At a preliminary level, this exercise if easier if you have been referred to a client by civil Counsel who may have concluded a matter and simply wants to make sure that the client takes steps to ensure that eligibility for benefits is secured and your retention and all communications go directly to and from that individual. Slightly more complicated is the similar set of facts described above but those communications come from an individual's relative or some appointed fiduciary, i.e. agent under power of attorney/guardian. Of course, depending on the scope of the client's capacity, it must be determined if your representation, as well as the corresponding scope of allowable involvement centers upon the involvement with the representative, as opposed to the client, in addition to the extent that the individual sought to be protected should still be involved in decisions/discussions to the extent possible or necessary.

That said, often, the initial communications come from civil Counsel and it is important to understand and identify if Trust Counsel is being retained by civil Counsel to become involved in the case and/or if the engagement for services to be rendered is directly connected to the client, who, in turn, would be able to sign a formal engagement agreement. This can also lead to a discussion related to the scope of a matter and how that case came to the civil Counsel, as there may not be a formal connection between the "client" and the party who retained civil Counsel and it is necessary to ensure that the client has capacity and can acknowledge the scope of the civil Counsel involvement and/or it creates the need for a power of attorney or perhaps a Court directed protective arrangement to be pursued to ensure that there is authority to proceed with the litigation and/or ultimately settle a case or received the proceeds of a recovery.

E. Court Proceedings and Involvement of Counsel

a. Preparation of Trust- Special Needs, Settlement Protection, Medicare Set Aside
b. Testimony- Court approval required for settlement and Trust Counsel involved to explain process or suitability of a plan of action for a client
c. Review of Court Order and language approving Trust or terms and conditions related to the appointment of Trustee, etc., as well as the scope of the financials involving the funding of the Trust, i.e. structures, corpus, etc.
d. Preparation of pleadings for approval of settlement or Trust- Civil Court
e. Preparation of pleadings for approval of settlement or Trust- Probate Court (Guardian, Conservator, etc.)

f. Post Approval Court Proceedings- Petitions for allowance or distribution, accounting action for approval, termination of Trust, Trust modification, Transition of Trustee, Action for final distribution, if necessary,

F. Trust Options and Selection of Trustee

1. Special Needs Trust
2. Settlement Protection Trust
3. Settlement Protection Trust with Special Needs Provisions/MSA Provisions
4. Special Needs Trust with MSA Provisions
5. Other Hybrid Version of the foregoing

For Trust Counsel, particularly in these types of matters, there are many factors to be considered when developing a workable and comprehensive plan that is acceptable to those involved but which will also have sustainability and success moving forward. As all of the attorneys and professionals involved in the process work to "complete" (is it ever really done?) their involvement in a matter of this kind, the selection of a Trustee, designated in the Trust document to serve, becomes an extremely important aspect on behalf of the client. First and foremost, it is recognized, depending on the assets being used to funds the Trust and/or the facts of the matter, that there may be limitations on the selection of a Trustee based upon the size of the Trust funding and the location thereof. Moreover, the interplay between the intention of the client/others to have a relative, friend, local banker, etc., serve as Trustee, versus the recognized need, depending on the circumstances to have a more experienced Trustee, i.e. corporate entity, can be a hurdle that needs to be addressed and resolved accordingly.

With further explanation and discussion, most clients/representatives understand the need to engage the services of a corporate Trustee. However, with recent news of issues with certain corporate Trustees, as well as many entities who have "exited" the Special Needs Trust administration market, it is perhaps more prudent than ever to have information and documentation explaining the scope of the involvement of a Trustee and reasons for potential selection. Many corporate Trustees, who often market themselves to civil/Trust Counsel, will have considerable information and documentation on their entity, as well as the stated need to employ the services of a corporate entity.

A Trustee, serving generally in such a role, but specifically in furtherance of the administration of a Special Needs Trust, must be mindful of the following:

1. Mistakes in Administration
    a. Improper distribution
    b. Action/Inaction which results in payment of taxes/failure to properly invest the assets
    c. Action/Inaction which result in a loss of public benefits
    d. Failure to comply with intentions of the Grantor and/or administrative terms that are included in the Trust document
2. Knowledge of Legal Matters
    a. Tax filings- 1041/1040 Income Returns
    b. Protective Arrangements that may be required
    c. Accounting
    d. Tracking of expenditures

e. Communications with Client

f. Process for requests for distribution

g. Fee approval for Trustee

3. Knowledge of Public Benefits

    a. Programs

    b. Eligibility

    c. Changes to the programs or requirements

4. Other Factors to Consider

    a. Access to Investment Advice and Direction

    b. Competent Counsel

    c. Issues arising with beneficiary (work, addiction, etc.)

    d. Family relationships/Influence

    e. Termination of or closing of Administration of the Trust upon passing of Beneficiary

    f. Retention of Care Consultant

Roadmap for Success in Establishing and Funding a Special Needs Trust

A general roadmap, although the estate/trust practitioner will want to cater it to their own practice/process, might look like the following:

1. Intake and Fact Gathering- what is the client's disability, what are the financial circumstances- i.e. inheritance, civil settlement, assets attributable thereto. What is the family dynamic? Does the client have capacity?
2. Estate Planning Documents- Will, Powers of Attorney, Healthcare Directive/Living Will
3. Trust Document- type of Trust- Special Needs Trust, Settlement Trust

4. Public benefits Confirmation (What is the client receiving? Other benefits which could be received?)
5. Liens/Debts
6. Is an MSA required?
7. Who will serve as Trustee?
    a. Process for Requests for Distribution
    b. Access to funds- Card?
8. Budget and allowable distribution confirmation- Life Care Plan?
9. Court Order for Funding and Establishment of Trust
10. What Agencies are required to be noticed of the establishment and funding of the Trust
11. Do they have professionals in place to assist moving forward…
    a. Trust Attorney
    b. Disability Attorney
    c. Financial Advisor
    d. Trustee
    e. Therapist
    f. Physicians
    g. Care Consultant
    h. Lien Resolution Expert
    i. MSA Professional
    j. Others

PERSONAL INJURY & ESTATE PLANNING QUESTIONNAIRE

Date_____ File Number_____

This form is extremely important. The accuracy and completeness in responding will help our firm provide the best representation.

A. **INJURED PERSON**

Full Name:_____

Nickname:_____ Gender: ☐ Male ☐ Female

Street Address _____

City_____ State_____ Zip_____

Home Phone No._____ Fax No._____

E-mail address_____ Cell No._____

Birth Date_____ Social Security No._____

Medicaid No._____

Injured Person is: ☐ Married ☐ Single

Injured Person: ☐ Has Capacity ☐ Is A Minor Expected to Have Capacity
☐ Is Incapacitated ☐ Is A Minor Expected to be Incapacitated

Injured Person is: ☐ A U.S. Citizen ☐ A Qualified Alien ☐ Don't Know

Is Injured Person a Veteran? ☐ Yes ☐ No

If there is a disability, did the disability begin prior to age 22? ☐ Yes ☐ No

If there is a disability, did the disability begin prior to age 26? ☐ Yes ☐ No

Has the Social Security Administration made a Determination of Disability? ☐ Yes ☐ No

Injured Person Suffers from:

☐ Anoxic Brain Injury
☐ Asperger Syndrome
☐ Attention Deficit Disorder (ADD)
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Autism
☐ Bi-Polar Disorder
☐ Blindness
☐ Borderline Personality Disorder
☐ Brain Injury
☐ Cerebral Palsy
☐ Childhood Disintegrative Disorder
☐ Deafness
☐ Depression
☐ Developmentally Delayed
☐ Dissociative Disorder
☐ Down Syndrome
☐ Epilepsy
☐ Fragile X Syndrome
☐ Mental Illness
☐ Mental Retardation
☐ Obsessive Compulsive Disorder
☐ Paraplegia
☐ Quadriplegia
☐ Rett Syndrome
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Spina BiFida
☐ Tourettes Syndrome
☐ Traumatic Brain Injury
☐ Other:_____

B. **SETTLEMENT AMOUNT**

$_____ Gross

$_____ Costs

$_____ Fees

$_____ Liens

$_____ Net

$_____ Allocation to Injured Person

$_____ Anticipated Structure

$_____ Anticipated Lump Sum

$_____ Allocation to Injured Person's Spouse

$_____ Allocation to Others

C. **INJURY/PROGNOSIS**

Date of Accident/Injury_____

Brief Description of Injury_____

How did Injury Occur?_____

D. **PUBLIC BENEFITS/PRIVATE INSURANCE**

1. **Public Benefits.** Is Injured Person receiving or will Injured Person apply for any of the following benefits?

Supplemental Security Income (SSI) ☐ Receives ☐ Applied For ☐ N/A

Amount of SSI: $_____

If receiving, please provide a copy of the Determination of Disability Letter.

Social Security Disability Income (SSDI) ☐ Receives ☐ Applied For ☐ N/A

Amount of SSDI: $_____

If receiving, please provide a copy of the Determination of Disability Letter.

Childhood Disability Benefits (CDB or DAC) ☐ Receives ☐ Applied For ☐ N/A

If receiving, please provide a copy of the Determination of Disability Letter.

Medicaid ☐ Receives ☐ Applied For ☐ N/A

If receiving, please provide copy of Medicaid card.

New Jersey Family Care ☐ Receives ☐ Applied For ☐ N/A

If receiving, please provide copy of NJ Family Care card.

Medicaid Waiver ☐ Receives ☐ Applied For ☐ N/A

Waiver Name: _____

If receiving, please provide copy of Medicaid card.

Katie Beckett Waiver ☐ Receives ☐ Applied For ☐ N/A

Children's Health Insurance Program (CHIP) ☐ Receives ☐ Applied For ☐ N/A

Medicare ☐ Receives ☐ Applied For ☐ N/A

If receiving, please provide copy of Medicare card.

Medicare Buy In ☐ Receives ☐ Applied For ☐ N/A

Does the State pay Medicare Part B Premiums/Deductible? ☐ Yes ☐ No

Federally-Assisted Housing

Section 8 ☐ Receives ☐ Applied For ☐ N/A

Section 202 Multi-Family ☐ Receives ☐ Applied For ☐ N/A

☐ Receives ☐ Applied For ☐ N/A

Monthly Rent: $_____

SNAP (Food Stamps) ☐ Receives ☐ Applied For ☐ N/A

Monthly Amount: $_____

Prescription Drug Assistance ☐ Receives ☐ Applied For ☐ N/A

Low Income Heating & Energy Assistance (LIHEAP) ☐ Receives ☐ Applied For ☐ N/A

Monthly Amount: $_____

Temporary Assistance for Needy Families (TANF) ☐ Receives ☐ Applied For ☐ N/A

Division of Developmental Disabilities (DDD) ☐ Receives ☐ Applied For ☐ N/A

Group Home ☐ Receives ☐ Applied For ☐ N/A

Psychiatric Institutionalization ☐ Receives ☐ Applied For ☐ N/A

Veterans Disability Benefits

Pension	☐ Receives	☐ Applied For	☐ N/A
Housebound	☐ Receives	☐ Applied For	☐ N/A
Aid & Attendance	☐ Receives	☐ Applied For	☐ N/A

Other Public Benefits

Name: _____ ☐ Receives ☐ Applied For ☐ N/A

2. **Private Insurance.** If injured person is covered by private medical insurance:

Name of Insurance Company: _____

Insurance Obtained Through: ☐ Injured Person ☐ Father ☐ Mother ☐ Other - _____

E. PERSONAL INJURY ATTORNEY

1. **Name of Attorney** _____

Name of Law Firm _____

Street Address of Law Firm _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-Mail Address _____ Cell No. _____

2. **Name of Paralegal** _____

Telephone No. _____ Fax No. _____

E-Mail Address _____ Cell No. _____

F. TRUST INFORMATION

Who will establish the Trust?

☐ **Injured Person/Beneficiary**

☐ **Father - Name:** _____ SSN _____

Street Address _____
(if different from injured person)

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

U.S. Citizen? ☐ Yes ☐ No

☐ **Mother - Name:** _____ SSN _____

Street Address _____
(if different from injured person)

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

U.S. Citizen? ☐ Yes ☐ No

Parents are: ☐ Married ☐ Divorced ☐ Separated

If parents are not living together, Injured Person lives with: ☐ Mother ☐ Father

☐ **Court:** **State:** ☐ New Jersey: ☐ Law Division
☐ Chancery Division: ☐ Probate ☐ Equity

☐ Pennsylvania: ☐ Court of Common Pleas ☐ Orphans' Court

County: _____

If trust is going to be established by the court, please attach a copy of the Complaint.

☐ **Grandparent - Name:** _____ SSN _____

Street Address _____
(if different from injured person)

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

☐ **Guardian - Name:** _____ SSN _____

Street Address _____
(if different from injured person)

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

Co-Guardian (if applicable) - Name: _____

Street Address _____ SSN _____
(if different from injured person)

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

G. LIENS

Does this case involve any of the following liens that need to be address?

Medicaid	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
Medicare Advantage	☐ Yes	☐ No
Medicare Part D	☐ Yes	☐ No
ERISA	☐ Yes	☐ No
Federal Employees Health Benefits Act (FEHBA)	☐ Yes	☐ No
Federal Medical Care Recovery Act (FMCRA)	☐ Yes	☐ No
Veterans Administration Claims	☐ Yes	☐ No
TRICARE Claims	☐ Yes	☐ No
Welfare Liens	☐ Yes	☐ No
Violent Crimes Compensation	☐ Yes	☐ No
State Worker's Compensation	☐ Yes	☐ No
Federal Employee Compensation Act (FECA)	☐ Yes	☐ No
Hospital Liens	☐ Yes	☐ No
Child Support	☐ Yes	☐ No
State Division of Mental Health	☐ Yes	☐ No
NJ Division of Developmental Disabilities (DDD)	☐ Yes	☐ No
Other _____		

H. BANKRUPTCY

Has Injured Person ever filed for bankruptcy? ☐ Yes ☐ No

If yes: What was the filing date? _____

What was the discharge date? _____

The undersigned hereby represent to Begley Law Group and each of its attorneys that the information contained in this Questionnaire is accurate and complete, and that the undersigned understand that the law firm and its individual lawyers will rely on this information. The undersigned understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

_____

Signature

PERSONAL INJURY SUPPLEMENTAL QUESTIONNAIRE

Date_____ File Number_____

Name of Injured Person _____

Name(s) of Client _____

This form is extremely important. The accuracy and completeness in responding will help our firm provide the best representation.

A. INJURED PERSON

Injured Person is (*select one*): □ Under age 18 □ Under age 65

B. REFERRAL SOURCE (IF OTHER THAN PERSONAL INJURY ATTORNEY)

Name of Individual or Company_____

Contact Person (*if applicable*) _____

Street Address_____

City_____ State_____ Zip_____

Preferred Telephone No._____ E-mail Address_____

C. STRUCTURED SETTLEMENT BROKER

1. **Name of Company**_____

Street Address _____

City_____ State_____ Zip_____

2. **Name of Contact**_____

Telephone No._____ Fax No._____

E-Mail Address_____ Cell No._____

3. **Name of Assistant**_____

Telephone No._____ E-Mail Address_____

D. FINANCIAL ADVISOR

1. **Name of Company**_____

Street Address _____

City_____ State_____ Zip_____

2. **Name of Contact**_____

Telephone No._____ Fax No._____

E-Mail Address_____ Cell No._____

3. **Name of Assistant**_____

Telephone No._____ E-Mail Address_____

E. TRUST INFORMATION

1. **Trustee**. Who will serve as Trustee?

Name of Initial Trustee _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

Contact Person (*if corporate trustee*) _____

If the trustee is an individual, is he/she bondable? ☐ Yes ☐ No ☐ N/A

F. INCOME

Is the Injured Person employed? ☐ Yes ☐ No

If yes: Name of Employer: _____

Amount of Monthly Income: $ _____

Does Injured Person receive unearned income? ☐ Yes ☐ No

G. ESTATE PLANNING DOCUMENTS

1. **Client**

Document	Has	Needs	Completed
Will			
Living Trust			
Living Will			
Power of Attorney			
Tax Planning			
Other: _____			

2. **Parent(s)**

Document	Has	Needs	Completed
Will			
Living Trust			
Living Will			
Power of Attorney			
Third Party Special Needs Trust			
Tax Planning			
Other: _____			

H. SPECIAL NEEDS TRUST (SNT)

Is an SNT required? ☐ Yes ☐ No

If yes, Trust established by Court Order? ☐ Yes ☐ No

If yes, BLG to file for Court Order? ☐ Yes ☐ No

Identified appropriate Trustee? ☐ Yes ☐ No

If yes, Name of Trustee: _____

I. SETTLEMENT PROTECTION TRUST (SPT)

Is an SPT required? ☐ Yes ☐ No

If yes, Trust established by Court Order? ☐ Yes ☐ No

If yes, BLG to file for Court Order? ☐ Yes ☐ No

Identified appropriate Trustee? ☐ Yes ☐ No

If yes, Name of Trustee: _____

J. MEDICARE SET-ASIDE ARRANGEMENT (MSA)

Is an MSA required? ☐ Yes ☐ No

If yes, type of MSA: ☐ Self-Administered ☐ Custodial ☐ SNT ☐ Pooled Trust

Arrange for MSA calculation? ☐ Yes ☐ No

Arrange for submission of MSA calculation to CMS? ☐ Yes ☐ No

K. GUARDIANSHIP

Has a Guardianship been obtained? ☐ Yes ☐ No

If yes, obtain copy of Court Order.

If no, is BLG to file for Guardianship? ☐ Yes ☐ No

L. PROBATE

Is BLG to represent the Personal Representative in the administration of the estate? ☐ Yes ☐ No

If yes, is there a Will? ☐ Yes ☐ No

If yes, obtain a copy of the Will.

If no, who is the Administrator? _____

Has allocation between WD & SC been determined? ☐ Yes ☐ No

Has Department of Revenue letter been obtained? ☐ Yes ☐ No

Is the proposed Executor/Administrator bondable? ☐ Yes ☐ No

Has Court Order been obtained appointing Executor/Administrator? ☐ Yes ☐ No

Have Letters of Administration/Testamentary been obtained? ☐ Yes ☐ No

If yes, please provide a copy.

Has EIN been obtained? ☐ Yes ☐ No

If yes, EIN # _____

Has previous counsel been involved in the probate? ☐ Yes ☐ No

If yes, Name of Counsel: _____

Has inventory been filed? ☐ Yes ☐ No

Have probate fees been paid? ☐ Yes ☐ No

If yes, amount: $_____

Have Short Certificates been obtained? ☐ Yes ☐ No

If yes, please attach a copy.

Are Death Certificates correct? ☐ Yes ☐ No

If yes, please attach original.

Has an estate account been opened? ☐ Yes ☐ No

If yes, please name bank and give account number:

Bank: _____

Account Number: _____

Have publications been placed in appropriate newspapers? ☐ Yes ☐ No

If yes, please provide name of newspaper _____

Have death taxes been paid? ☐ Yes ☐ No

M. LITIGATION SUPPORT

Check all that apply:

☐ Testify at Friendly Hearing
☐ Mediation
☐ Arbitration
☐ Qualified Settlement Fund (QSF)
☐ Medicaid Lien Reduction
☐ Medicaid Lien Resolution

N. CLIENT

Who is the Client? (*select all that apply*):

☐ Injured Person
☐ Spouse of Injured Person
☐ Father of Injured Person
☐ Mother of Injured Person
☐ Grandmother of Injured Person
☐ Grandfather of Injured Person
☐ Guardian(s) of Injured Person
☐ PI or Family Law Attorney
☐ Trustee

O. EXCEPTIONS FROM CONFIDENTIALITY

Select all that apply:

☐ Attorney
☐ Trustee/Co-Trustees
☐ Structured Settlement Broker
☐ Financial Advisor
☐ Other Family Members:

_____

_____

P. **ADDITIONAL INFORMATION**

Please attach copies of the following, if available:

1. Complaint
2. Pre-Trial Memo
3. Settlement Agreement/Release
4. Life Care Plan
5. Guardianship Order
6. Letter from Social Security Administration Determining Disability
7. Copies of Medical Insurance Cards, including:
   - Private
   - Medicaid
   - Medicare
   - Other _____
8. List of Disabled Person's Assets

Q. **PETITION INFORMATION**

1. Please attach copies of the following, if available:
   - Order Approving Settlement
   - Valuation of Proposed Home
   - Valuation of Proposed Vehicle
   - Proposed Budget Form

2. Narrative to Justify Trust Distribution

   - *Residence.* A residence is needed because: _____
     _____
     _____
     _____
   - *Vehicle.* A vehicle is needed because: _____
     _____
     _____
     _____
   - *Vacation.* A vacation is needed because: _____
     _____
     _____
     _____

Trust Beneficiary is unable to go unaccompanied because:

_____

_____

_____

4. Narrative for Caregiver

A caregiver from an agency is needed because: _____

_____

_____

_____

A caregiver parent is needed because: _____

_____

_____

_____

The undersigned hereby represent to Begley Law Group and each of its attorneys that the information contained in this Questionnaire is accurate and complete, and that the undersigned understand that the law firm and its individual lawyers will rely on this information. The undersigned understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

_____

Signature

_____

Signature

NOTES:

PUBLIC BENEFITS INTAKE

Name_____

SSN_____ DOB_____

1. **SOCIAL SECURITY** - Does the client receive SSI or SSDI? ☐ Yes ☐ No

   If so, please provide monthly amount: Dollar Amount: $_____

   If so, please provide our office with the Social Security Determination Letter.

2. **MEDICAID/MEDICARE** - Does the client receive Medicaid or Medicare? ☐ Yes ☐ No

   If so, please provide our office with a copy of their card(s).

3. **MEDICARE SUPPLEMENT** - Does the client receive any Medicare Supplement Insurance? ☐ Yes ☐ No

   If so, are they paying a premium? Dollar Amount: $_____

   Please provide our office with a copy of their card.

4. **MEDICARE ADVANTAGE** - Does the client receive Medicare Advantage? ☐ Yes ☐ No

   If so, are they paying a premium? Dollar Amount: $_____

   Please provide our office with a copy of their card.

5. **SNAP/FOOD STAMPS** - Does the client receive SNAP? ☐ Yes ☐ No

   If so, please provide our office with a copy of their Snap card.

6. **FEDERAL ASSISTED HOUSING** - Does the client receive Section 8? ☐ Yes ☐ No

   If so, please provide our office with the Housing Authority Letter.

7. **PRIVATE MEDICAL INSURANCE** - Does the client have any private insurance? ☐ Yes ☐ No

   If so, please provide our office with a copy of their card

8. **AFFORDABLE CARE INFORMATION**- Does the client receive insurance under the Affordable Care Act? ☐ Yes ☐ No

   If so, please provide our office with a copy of their card

9. **DISABILITY** - Is the client disabled? ☐ Yes ☐ No

   If yes, what is the disability? _____

10. **FUTURE MEDICAL TREATMENT**- Will ongoing medical treatment be required? ☐ Yes ☐ No

    If yes, please attach a copy of the Life Care plan.

If there is no Life Care plan available, please describe in detail future treatment:

_____

_____

Budget

For: _____ File No. _____

1. **Shelter** - Number of people living in household: _____

Item	**Monthly (pro-rata share)**	**Paid By***
ISM – Should be paid for by SSI to ensure no ISM reduction in SSI.		
Rent		
Mortgage		
Other Mortgage (specify)		
Real Estate Taxes (unless included in mortgage payment)		
Heat		
Electric and Gas		
Water and Sewer		
Homeowner's Insurance Required by Lender		
NON-ISM – Pro-rata share can be paid for by Trust.		
Telephone (landline)		
Cable TV		
Internet		
Cell phone		
Streaming Services (Netflix, Hulu)		
Repairs and Maintenance		
Renter's Insurance		
Homeowner's Insurance Not Required by Lender		
Trash and/or Garbage Removal		
Condominium or Co-op Fees		
Other: _____		
Other: _____		
Other: _____		
Shelter Total		

* T = Trustee, B = Beneficiary, CC = Credit Card, M = Medicaid, P = Private Insurance, O = Other

2. Transportation

Item	Monthly (pro-rata share)	Paid By*
Auto Insurance		
License and Registration		
Gas		
Oil and Maintenance		
Other: _____		
Other: _____		
Other: _____		
Transportation Total		

* T = Trustee, B = Beneficiary, CC = Credit Card, M = Medicaid, P = Private Insurance, O = Other

3. **Personal**

Item	Monthly (pro-rata share)	Paid By*
ISM – Should be paid for by SSI to ensure no ISM reduction in SSI.		
NON-ISM – Pro-rata share can be paid for by Trust.		
Household Supplies		
Clothing and Shoes		
Hair Care		
Vacations		
Entertainment – Specify: _____		
Non-prescription Drugs, Cosmetics, Toiletries and Sundries		
Prescription Drugs not covered by Medicaid		
Unreimbursed Medical		
Unreimbursed Psychiatric/Psychological/Counseling		
Unreimbursed Dental		
Unreimbursed Orthodontic		
Unreimbursed Medical Insurance		
Unreimbursed Caregiver		
Estimated Trustee's Fees		
Other: _____		
Personal Total		

* T = Trustee, B = Beneficiary, CC = Credit Card, M = Medicaid, P = Private Insurance, O = Other

4. **Summary of Monthly Expenses & Income** (computed at 4.3 weeks)

Shelter Total	
Transportation Total	
Personal Total	
Grand Total – Expenses	
Subtract Social Security	
Subtract Other Income	
Grand Total/Net	

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EMILY STARR
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HOT ISSUES IN HOTMA
Trustees (and others) Beware!

By Emily Starr and Stuart Zimring[1]
September 2025

History of Federally Subsidized Housing

The federal government's involvement in subsidized housing began during the Great Depression. In response to the widespread unemployment and housing shortages that were occurring during this time, the Public Works Administration Housing Division was established in 1933. Initially conceived as a job creation program rather than a solution to the housing shortage, it constructed approximately 25,000 housing units around the country. In 1937 Congress created United States Housing Authority, providing federal funding to local housing authorities to develop, own and operate public housing for low-income families. Under this program, for the first time, income limits were established for residents, a feature that would continue throughout all subsidized housing programs that would follow.

The next major expansion of federal housing policy occurred in 1949 with the enactment of the Housing Act of 1949, declaring as public policy a national goal of "a decent home and suitable living environment for every American family." For the first time, public housing was seen as part of urban renewal, providing federal funds for area redevelopment and a goal of constructing 810,000 public housing units over a six-year period. President Lyndon Johnson's Great Society

[1] This article draws heavily from a presentation prepared for the Special Needs Alliance by Patricia Nelson Reade and Emily Starr.

program saw the adoption of the Urban Development Acts of 1965 and 1968 which created the Department of Housing and Urban Development (HUD) and introduced the concept of the rent supplement program providing direct rental assistance to low-income families.

The Housing and Community Development Act of 1974 brought us the Section 8 Program, officially known as the Housing Choice Voucher Program, Multifamily Housing (sometimes referred to as "project based" Section 8) and Public Housing. It also consolidated many of the various programs into Community Development Block Grants. This represented a fundamental shift from the government as the housing provider to the government assisting private markets in developing housing solutions that addressed the specific needs of a given community. Since then, each succeeding administration has modified various aspects of the existing programs to suit particular economic philosophies and theories, sometimes expanding, sometimes contracting, the level of federal support and the types of projects being supported. The definition of "eligibility" and "low Income" has also changed over time. But through it all, the basic Section 8 Program remains the fixture and essential core of rental assistance for low-income individuals in the country. In 2023, of the 5.2 million American households receiving some form of federal rental assistance, 2.3 million receive that assistance through the Housing Choice Voucher Program.[2]

Other than for Multifamily Housing projects (MFH or project-based Section 8), virtually all federally subsidized housing programs are administered at the local level through Public Housing Authorities (PHAs). PHAs are public agencies created by state enabling statutes and can exist at

[2] Center on Budget and Policy Priorities, United States Federal Rental Assistance Fact Sheet

the municipal, county or state level. HUD contracts with the PHAs for public housing and supplies the operating and capital funds. In addition, through contracts with HUD, PHAs usually manage their local Section 8 Programs.

To obtain Section 8 housing assistance, the applicant must meet specific income limitations that generally require that the applicant's income does not exceed 50% of the median income in the applicant's area, adjusted for the size of the family. "Income" includes Social Security, disability benefits, pensions, annuities, alimony, some types of welfare payments and regular contributions from others. Income does not include temporary, infrequent or one-time receipts including gifts, reimbursements for medical expenses, and lump sum distributions such as inheritances, insurance payments or capital gains. Once the applicant is approved, it is up to the applicant to locate a housing unit and a landlord willing to participate in the program. Most if not all PHAs maintain lists of properties and participating landlords. However, the current reality in most cities is that the need far exceeds the demand and waiting lists are long.

In a Multifamily Housing situation, HUD contracts directly with the not- for- profit or for-profit entity owning/operating the units. In Multifamily Housing the subsidized rent stays with the unit rather than being a voucher the family can take with them if they choose to move.

Section 8 Housing Choice Vouchers v. Section 8 Multifamily Housing. The Section 8 Program operates in two different ways. In the Tenant-Based Housing Choice Voucher Program the tenant receives a voucher from the PHA which the Tenant can then take to any qualified property and present it to the landlord. The Voucher is mobile - if the Tenant wants to move, the

Tenant can take the voucher to another property, and the property owner can choose to accept the Section 8 Voucher on a case-by-case basis.

In a Section 8 Multifamily/Project Based program, the property owner contracts directly with HUD or the PHA to, in effect, obtain vouchers on the property owner's units. The subsidy is tied to the unit, not to the tenant, and when a tenant moves out, the unit goes to another qualified tenant. In MFH Project Based programs the property owner generally commits the units to the program for set periods of time.

Section 202 & 811 Programs. The Section 202 Program of Supportive Housing for the Elderly is, as the name implies, a separate program that provides federal funds and project rental assistance for housing projects that serve "elder households." "Elder households" are defined as a household consisting of one or more persons who are at least 62 years old at the time of occupancy. Unlike Section 8, Section 202 housing provides services designed to meet the specific needs of a senior community. Similarly, Section 811, Supportive Services for Persons with Disabilities. Both are types of Project-Based Housing.[3]

HOTMA Background and Compliance Deadlines

On 7/29/2016 President Barack Obama signed the Housing Opportunity Through Modernization Act of 2016 (HOTMA). Sections 102 (income reviews and revised definitions of income and

[3] For a good general discussion of federal subsidized housing programs, see chapter 12 of David English, H. Amos Goodall & Rebecca Morgan, *"Tax, Estate & Financial Planning for the Elderly"* LexisNexis (2024).

assets) and 104 (establishing asset limits) greatly expanded HUD's authority to set standards on how income and resources are treated for eligibility and rental calculations.

HUD issued final regulations relative to HOTMA's income and asset provisions on 2/14/2023. The effective date was initially 1/1/2024 to give Public Housing Agencies (PHAs) and Multifamily Housing (MFH) owners time to develop and implement changes.[4]

HUD subsequently issued notices providing guidance regarding HOTMA's implementation. Issued on 9/29/2023 Notice H 2023-10 PIH 2023-27 extended the final implementation date to January 1, 2025. A revision of that Notice, issued on February 24, 2024, made some changes to the earlier Notice. The revised Notice is found at Exhibit A to this paper and is referred to

[4] HOTMA applies to the following programs:

Public Housing Authorities (PHAs). Sections 102 (income reviews and revised definitions of income and assets) and 104 (establishment of asset limits) apply to all Public Housing Authorities (PHAs) operating Housing Choice Voucher (HCV), Public Housing, Section 8 Moderate Rehabilitation and Section 8 Moderate Rehabilitation Single Room Occupancy.

Multifamily Housing (MFH).

- Section 102 (income reviews and revised definitions of income and assets) applies to the following programs administered by Multifamily Housing (MFH) Owners: Section 8 Project Based Rental Assistance (PBRA); 202/8, 202/162 Project Assistance Contract (202/162 PAC); Section 202/811 Capital Advance with Project Rental Assistance Contract (202/811 PRAC); non-insured 236 projects with Interest Reduction Payments (236 IRP); Section 811 Project Rental Assistance Demonstration (811 PRA); and Senior Preservation Rental Assistance Contracts (SPRAC). These types of projects are delineated by the type of federal funding and tenant population the projects serve.

- Section 104 (asset limitations and exceptions) applies to the following programs administered by Multifamily Housing (MFH) Owners: Section 8 Project Based Rental Assistance (PBRA) and 202/8 (loan funding for projects for elderly and disabled from 1976-1991). Section 104 does not apply to the following programs: Section 202/811 Capital Advance with Project Rental Assistance Contract (202/811 PRAC) (since 1991 capital advances for projects for elderly and disabled persons); non-insured 236 projects with Interest Reduction Payments (236 IRP); Section 811 Project Rental Assistance Demonstration (811 PRA); and Senior Preservation Rental Assistance Contracts (SPRAC). Some or all of these are supportive housing programs for the elderly or persons with disabilities that provide housing and support activities such as cleaning, cooking and transportation.

throughout this paper as the "2/2/24 Notice." There are 10 Attachments to the Notice which provide information somewhat like the Social Security's POMS: detailed instructions for implementing the rules as modified by HOTMA. They will eventually be incorporated into HUD's Occupancy Handbooks.

Compliance deadlines have been extended further. Relative to PHAs, on December 17, 2024, Notice PIH 2024-38 announced a firm deadline of July 1,2025 for PHAs to implement HOTMA income exclusions as well as Section 102/104 definitions and provisions related to de minimis errors but stated that "This compliance deadline does not apply to other provisions." Those deadlines are still to be determined. See Exhibit B to this paper.

Relative to MFHs, on May 29, 2025, HUD published Housing Notice H-2025-03, extending compliance for HOTMA Sections 102 and 104 to January 2026. See Exhibit C to this paper.

Assets

See Exhibit I: Assets, Asset Exclusions, and Limitation on Assets Resource Sheet

When and on whom are asset limits imposed. Until the effective date of HOTMA, there are no restrictions on assets: the income from assets is counted to determine income eligibility and the calculation of rent but there is no asset limit. HOTMA imposes eligibility criteria based not only on income but also on assets. The HOTMA asset rules will be described below. However, it is important to distinguish between the imposition of assets limits on existing tenants and new tenants. Relative to existing tenants, MFH owners have discretion as to whether to impose asset limits and are required to include their policies in their Tenant Selection Plan and policies and

procedures and make them publicly available. PHAs have the same discretion regarding asset limitations and must update their Public Housing Admission and Continued Occupancy Policies (ACOP) and HCV Administrative Plans to reflect HOTMA discretionary decisions.

Their discretion is not all or nothing. Depending on the policies adopted by the respective PHAs and MFH owners, the new asset limits (i) may be disregarded for existing families or may cause families who have resided in subsidized housing for years to lose eligibility and (ii) may or may not be disregarded at the time of recertification. Specifically the options are (1) total non-enforcement during the household's annual and interim reexaminations which must be applied to all households; (2) enforcement requiring the PHA or MFH Owner to initiate termination of housing assistance or initiate eviction within six months of the reexamination that found the family out of compliance with the asset limits; (3) limited enforcement pursuant to a written policy to provide up to six months to cure noncompliance after the effective date of the families' annual or interim recertification; or (4) establishment of exceptions allowing total non-enforcement or limited enforcement for families based on family type, taking into consideration factors such as age, disability, income, the ability of the family to find suitable alternative housing, and whether supportive services are being provided. For PHAs see Exhibit E: Public Housing and Housing Choice Voucher Program, List of Discretionary Policies to Implement HOTMA and for MFH owners, see Exhibit F. See Exhibit G. for a sample of an ACOP election on these issues.

The new asset limitations provide that families (persons residing together) are ineligible for admission to Section 8 housing, voucher and MFH if they own (i) $100,000 (now $103,200

adjusted by inflation for 2025) or more of net family assets; or (ii) real property suitable for occupancy. See Exhibit H to this paper for Inflation-Adjusted values.

In respect to real property suitable for occupancy, 24 CFR 5.618(a)(ii)) provides that a family is ineligible if it has a present ownership interest in, a legal right to reside in, and the effective legal authority to sell, based on state laws, real property that is *suitable for occupancy* by the family as a residence. The family can show that the property is not *suitable for occupancy* because (i) the property does not meet disability related needs for all family members; (ii) is not sufficient in size for the family; (iii) the location is a hardship; (iv) the property is unsafe; or (v) the property cannot be a residence due to local laws. If any of these conditions exist, the family ownership of such property would not pose an eligibility problem for the family: however, the household could nevertheless be out of compliance with any applicable asset limit as its value could be included in the valuation of net family assets which cannot exceed $100,000 (now $103,200 adjusted by inflation). This restriction on real estate suitable for occupancy does not apply to the program for manufactured home and home ownership option (see 24 CFR §982.620); property owned jointly with another owner who is not a member of family who resides in the jointly owned real property; a victim of domestic violence; and a family that is offering the property for sale.

Net family assets are defined as the net cash value of all assets owned by the family (*persons residing together*) after deducting reasonable costs that would be incurred for disposing of real property, savings, stock, bonds and other forms of capital investments. See Exhibit I to this paper, the "2/2/2024 Notice, Attachment F.4.a." A family, for income and asset purposes, is

generally a single person or two or more people living together who are related by blood, marriage, adoption and may include persons who are not related but who reside together and share resources. See “2/2/2024 Notice, Attachment J.”

Net family assets also include the value of any business or family asset disposed of by an applicant or tenant for less than fair market value (including a disposition in trust) during the two years preceding the date of application or reexamination, in excess of the consideration received and costs of disposal. A footnote in “2/2/2024 Notice, Attachment F.4.a.” states “A disposition in trust is when the family creates a trust for the benefit of someone outside of the assisted family. It would not be considered an asset disposed of for less than fair market value if the family establishes a nonrevocable trust for the benefit of someone in the assisted family.” Thus, an important option for a family which has excess assets is to transfer the excess assets to an irrevocable trust with a trustee not within the family assistance unit and to provide that the irrevocable trust cannot be significantly amended by a member of the family assistance unit. (See more on trusts below). This would remove the excess assets entirely: they would not be included for the subsequent two years. Before implementing this planning strategy, the implication of distribution of income from the trust, as discussed below, must be considered as well as other public benefits on which the family may be relying on or may rely on in the future.

The total value of an asset jointly owned by the family and another person(s) outside of the assisted family is included in the net family assets unless the asset is otherwise excluded under the definition of net family assets at 25 CFR §5.603(b), the family can demonstrate that the asset

is inaccessible to it, or the family cannot dispose of any portion of the asset without the consent of a joint owner who refuses to comply. See Exhibit I.

There are many federally mandated asset exclusions (25 CFR 5.603(b)(3) – (b)(4)), "2/2/24 Notice, Attachment F.4.b." Among the items that are excluded from net family assets are

- Retirement accounts recognized by the IRS;
- Assets held in an irrevocable trust not under the control of a member of the family or household;
- Assets held in a revocable trust where a member of the family is the beneficiary, but the grantor/owner and trustee are not members of the family or household;
- Tax refunds or refundable tax credits for 12 months after receipt;
- Real property that family does not have effective legal authority to sell;
- Civil action or settlement proceeds for an incident resulting in disability based on malpractice, negligence or other breach of duty;
- Section 529 education and 529A ABLE accounts and Coverdell education accounts;
- Interests in Indian trust land;
- Family Self-Sufficiency accounts, and
- Value of all *necessary items* of personal property (items essential to the family for maintenance, use and occupancy of the home, or necessary for employment, education, or health & wellness) as well as *non-necessary* items of personal property (all personal property that does not qualify as necessary) with a total combined value of less than $50,000 (now $51,600 as adjusted by inflation). Real estate is never considered personal

property, so its value is always included in net family assets unless it meets a different exclusion. See "2/2/24 Notice, Attachment F.4.c."

Necessary Personal Property	Non-Necessary Personal Property
• Car(s)/vehicle(s) that a family relies on for transportation for personal or business use (e.g., bike, motorcycle, skateboard, scooter) • Furniture, carpets, linens, kitchenware • Common appliances • Common electronics (e.g., radio, television, DVD player, gaming system) • Clothing • Personal effects that are not luxury items (e.g., toys, books) • Wedding and engagement rings • Jewelry used in religious/cultural celebrations and ceremonies • Religious and cultural items • Medical equipment and supplies • Health care–related supplies • Musical instruments used by the family	• Recreational car/vehicle not needed for day-to-day transportation (campers, motorhomes, travel trailers, all-terrain vehicles (ATVs)) • Bank accounts or other financial investments (e.g., checking account, savings account, stocks/bonds) • Recreational boat/watercraft • Expensive jewelry without religious or cultural value, or which does not hold family significance • Collectibles (e.g., coins/stamps) • Equipment/machinery that is not used to generate income for a business • Items such as gems/precious metals, antique cars, artwork, etc.

Self-Certification for Families with Assets of $50,000 (now $51,600 adjusted by inflation) or Less. At admission and at recertifications, PHAs and MFHs may accept a family's self-certification of net family assets if they are equal to or less than $50,000 (now $51,600 adjusted by inflation) and anticipated income earned from assets without taking additional steps to verify accuracy. PHAs and MFHs which choose to accept self-certification of net family assets are required to fully verify net family assets every 3 years. PHAs must include their policy for self-

certification in their ACOPs and Administrative Plans and MFHs must include their policy for self-certification in their Tenant Selection Plans. A Sample Net Family Asset Self-Certification Form is found in Exhibit A, "2/2/2024 Notice, Appendix, pg. 127)."

Income.

See Exhibit J: Income and Income Exclusions Resource Sheet

A**nnual Income:** (24 CFR 5.609)[i] Income is broadly defined and includes:

- all amounts, not specifically excluded by regulations, received from all sources by each member of the family 18 years or older,
- unearned income of dependents under 18 years of age, and
- imputed income on net family assets in excess of $50,000 (now $51,600 adjusted by inflation) when actual income cannot be calculated. Imputed income is based on current passbook savings rate (which will now be adjusted annually) and published in https://www.huduser.gov/portal/datasets/inflationary-adjustments-notifications.html. It is based on the FDIC National Deposit Rate for Savings Accounts.

The income generated by an asset which has been given away during the preceding two years, if it is still counted as an asset for eligibility purposes, is also counted. (See "Net family assets also include the value of any business or family assets disposed of by an applicant or tenant for less than fair market value" above.) Other than for household members under the age of 18, there is no distinction between earned and unearned income. Non-monetary in-kind donations such as

food or clothing received from a food bank or similar organization is not counted but apparently bill payments on behalf of a household member is treated no differently than a gift of cash. See the answer to the following FAQ in Exhibit K (page 4). "Are car payments or car insurance paid by someone outside of the household considered 'in-kind' donations.".

Income exclusions: (24 CFR 5.609(b)(22)), "2/2/24 Notice, Attachment G and Exhibit J.

HOTMA has modified (or more clearly described) the sources of income that are excluded. A comprehensive list of income exclusions can be found on pages 8 and 9 of Exhibit J.

Of greatest interest to most of our clients are

- Non-recurring income (replaces "temporary, nonrecurring or sporadic income") – income that will not be repeated beyond the coming year based on information provided by the family such as gifts for significant life events (birthdays, weddings, anniversaries, tax refunds, non-monetary in-kind donations from a food bank or similar organization);
- Distributions of trust principal from revocable or irrevocable trusts so long as the trust is not considered part of net family assets (see HOTMA's new treatment of trusts below);
- Distributions of trust income for health and medical care of a minor (see HOTMA's new treatment of trusts below);
- Income earned on ABLE accounts and distributions from ABLE accounts for qualified disability expenses (See Exhibit D);

- Imputed income on assets when net family assets are < $50,000 but actual income is included if it can be determined;
- Lump sum additions to net family assets such as lottery winnings, inheritances, insurance settlements for property losses;
- Distributions from retirement plans such as IRA, employer retirement plans and self-employed retirement plans other than periodic payments;
- Lawsuit judgments or settlements based on a claim of malpractice, negligence or other breach of duty that resulted in disability whether received as a lump sum or periodically;
- All earned income by children under age 18;
- Payments received for care of foster children or adults;
- VA Aid and Attendance to the veterans only (payment to veteran's spouse or surviving spouse is not disregarded);
- Loan proceeds received by the family or by a third party on behalf of the family (i.e. car dealership or educational institution);
- Retroactive SSI, Social Security or VA disability benefits;
- Various student financial assistance including distributions from 529 plans.

Of interest is that the earned income disregard has been eliminated for all families other than those participating in the disallowance as of 12/31/2023. (24 CFR 5.611), "2/2/2024 Notice, Attachment G.20."

Income Determinations: (24 CFR 5.609(c)), "2/2/24 Notice, Attachment I."

At the time of application, or during an interim reexamination, income is calculated based on anticipated income. At the time of annual recertifications, unless the PHA/MFH Owner chooses to use a safe harbor income determination, income is calculated based on the income the family received during the preceding 12 months (not the preceding calendar year).

Safe Harbor. 24 CFR 5.609(c)(3), "2/2/2024 Notice, Attachment J.4."

PHA/ MFH owners can chose to use "Safe Harbor" income determinations which are income determinations by other specified means tested programs. PHAs and MFH owners must establish a policy as to whether they are using Safe Harbor income determinations to verify a family's income and, if so, from which programs they will accept income determinations. If they rely on Safe Harbor income determinations, they are not supposed to inquire further about a family's net family assets or the income earned from those assets, except with respect to whether or not the family owns assets that exceed the asset limitations of 24 CFR 5.618. "2/2/24 Notice, Attachment J.4."

Deductions 24 CFR 5.603, 5.611, "2/2/2024 Notice, Attachment C."

There are both mandatory and permissive deductions to be applied to income. They are spelled out in detail in Attachment C. They include a $480 dependent deduction and a $525 elderly/disabled family deduction. Notably, the deduction for excess unreimbursed health and

medical care and reasonable attendant care and auxiliary expenses, which is being phased in over 24 months for families receiving the deduction as of 1/1/2024, is limited to the amount that exceeds 10% of family's income. Previously it was the amount in excess of 3%. "2/2/2024 Notice, Attachment C.4.a."

Hardship Exemptions "2/2/2024 Notice, Attachment C.4. et seq."

Hardship exemptions are established for families unable to pay rent due to loss of childcare expense deductions, families with increased medical/disability expenses or who experience financial hardship due to change in circumstances that would not otherwise trigger interim reexamination.

Verification of Income: "2/2/2024 Notice, Attachment *Table* J.2."

Income can be verified in various ways. There is a hierarchy of verification sources described in "2/2/24 Notice, *Table* J.2." The sources range from utilizing an EIV report (Enterprise Income Verification system) to written third party verification to self-certification. The Enterprise Income Verification System provides a comprehensive on-line system for verification of resident information and income to determine rental subsidies and relies on data sharing agreements with SSA and HHS.

Reporting Obligation: 24 CFR 5.657, "2/2/2024 Notice, Appendix I.5."

Families must report changes in household composition and in income according to policies established by PHAs/MFH Owners describing when and under what conditions families must report changes.

Over-Income Public Housing Families: 24 CFR 960.507(d), 24 CFR 960.102(b), "2/2/2024 Notice, Attachment 1.3."

PHAs may adopt a policy that allows families whose income exceeds the income limit for more than 24 months to pay alternate non-public housing rent. Otherwise, PHAs must terminate the tenancy within six months after the final notification (after the 24-month grace period). See Exhibit L. The policy for over-income families applies to public housing and does not appear to apply to MFH or to the Section 8 voucher program.

HOTMA Treatment Of Trusts

This section will discuss how the drafters and Trustees of SNTs can and should respond to the changes HOTMA has made to the treatment of assets and income to make sure they are taking adequate steps to protect their Beneficiary's status and make sure their documents are drafted and administered in a way that takes the Beneficiary's status into account when making distributions.

Asset Limits & Trusts

As noted above, under the new HOTMA asset limitations, families are ineligible for admission to both the Section 8 Voucher program and the Multifamily Housing program if they own more than $100,000 ($103,200 adjusted by inflation in 2025) in assets that are not excluded from family assets under 25 CFR 5.603(b)(3)-(b)(4) (see Exhibit I).

Among the most important excluded assets for our purposes are:

- Proceeds from civil actions or settlements based on malpractice, negligence or other breach of duty for an incident that results in disability
- 529 Plans and ABLE Accounts;
- Assets held in an irrevocable trust where a family member is the beneficiary, but the grantor and trustee are not members of the family or household, and no family member can have the power to revoke or substantially amend the trust.

Thus, it would seem that most 1st party SNTs funded with litigation proceeds will be considered excluded assets. Further, since the definition of "family" in Section 8 means persons residing together, a 3rd party irrevocable SNT created by other family members that satisfies the requirements noted above should also be excluded from the definition of "assets."

Treatment of "Income" Received by the Trust

As discussed above and as set out in Exhibits G and H, a number of items defined by HOTMA as "income" are excluded in determining the tenant's countable income and therefore, if these **items are** contributed to a SNT, the item becomes an excluded part of the corpus of the Trust.

Among the items that are excluded from the definition of "income" are "non recurring income" such as birthday or wedding presents, inheritances, lottery winnings, tax refunds and proceeds from judgments or settlements from malpractice, negligence or other breach of duty resulting in disability (even if paid in periodic payments) and, therefore, if they are contributed to the SNT by the tenant or contributed directly to the SNT by the donor, they should not constitute countable income (emphasis on "should").

Treatment of Income Distributed from Trusts

As noted above, "income" has a broad definition and there are many, many exclusions from the definition calling to mind Humpty Dumpty's statement in "Alice's Adventures In Wonderland" "When I use a word, it means just what I choose it to mean - neither more nor less." Thus, for our purposes in the HUD-HOTMA-SNT world, the following items are not income:

- Income earned on and distributions made from ABLE Accounts for qualified disability purposes;
- Non-recurring income (formerly called "temporary, non-recurring or sporadic income");

- Distributions of trust principal from revocable or irrevocable trusts so long as the trust is not considered part of family net assets;
- Distributions of trust income to reimburse or pay for health or medical expenses of a minor child;
- Judgements or settlements based on a claim of malpractice, negligence or other breach resulting in disability.

An analysis of what constitutes "countable income" from a trust say and what the HOTMA Notice says leads some to believe that the only distributions of trust income that aren't countable are distributions to pay for health or medical expenses of a minor child. However, it is the opinion of one of the authors that that interpretation is not necessarily correct. A non-recurring distribution from a SNT that contained trust income should (again, note "should") qualify as "not income.". Given the convoluted definitions of "income" and "assets" reasonable minds can and will differ.

Drafting and Administrative Challenges

If the question of whether or not the SNT's beneficiary's family are or may be participants in the Section 8 Voucher Program is not already in your checklist, it should be. If it is, the next question is, which PHA/MFH are they in? As noted above, PHAs and MFHs have latitude in how they administer/enforce various aspects of the new HOTMA Regulations. This information may not change how you, if you're the drafting attorney, draft the SNT, but hopefully it will sensitize you to more carefully review some of your "usual" language in light of your

Beneficiary's status. For example, if you draft a section describing types of discretionary distributions the Trustee may consider making, you may want to include a specific reference to "non-recurring" distributions (either to consider not making them if it would result in countable income), or as a positive suggestion that this is something the Trustee could consider.

If you're the drafting attorney, consider giving adding language directing the Trustee to pay Trust administrative expenses, such as legal and accounting fees and taxes, with income first so that the income is consumed "internally" and only principal is distributed.

As the HOTMA Regulations roll out, try to keep current on what your local PHAs and MFHs are doing.

Know Thy Corpus. The drafting attorney and the Trustee should verify the source of funding of the SNT. There is no question that inheritances, settlements and judgments are not countable, nor are gifts or other "temporary," "one-time" or "infrequent" income. Both the drafting attorney and the Trustee should obtain enough information regarding the source of a contribution to a SNT to satisfy any inquiries from a PHA or MFH regarding the source of the funds.

Consider Segregating Income. As noted above, the income generated by a SNT and distributed to the Beneficiary is includable in calculating the tenant/beneficiary's annual income. Therefore, in order to avoid questions about what IS a distribution of income (countable) and what is a distribution of principal (not countable), Trustees should consider keeping earned income separate from principal and maintain records that clearly identify the income and for what

purpose it was distributed. Remember that some expenditures such as reimbursement for medical expenses of a minor are excluded from income. So if it can be shown that the income from the SNT Sub-Account was used for a purpose that is excluded from income, the income will not be counted.

Be Careful of Recurring Periodic Distributions. Remember that regular recurring periodic distributions are treated as income. While it is true that no distribution of principal from a SNT should be considered income, a PHA or MFH could take the position that regular periodic distributions are counted as income even if they are principal. This does not mean Trustees shouldn't make regular, periodic distributions where appropriate. The Trustee simply needs to be aware of the issue and be prepared to deal with it if it comes up. Unfortunately, historically, the definition of "non-recurring" seems to vary from region to region and PHA/MFH to PHA/MFH, so again, know your PHAs and MFHs.

The "In-Kind/Recurring Distribution Conundrum

Under HOTMA non-monetary in-kind donations such as food, clothing or personal items received from a foodbank or a non-profit are not counted as income even if they occur regularly. However, as indicated in the FAQ on page 4 of Exhibit K, if an outsider is making car payments or paying for car insurance, that is considered "bill paying" and is considered income. But what if these items are being paid for out of the principal of the SNT? Does that convert the principal distribution which is not countable as income into countable income? Do the attorneys representing the Trustees need to advise them that it's "probably" OK to buy the cell phone, but

not pay the cell phone bill? Can the Trustee give the Beneficiary a Truelink card properly coded so that it can be used for food, clothing, "personal item" but not to pay bills? At this point, I do not believe we have answers and again, a lot will depend on how each PHA/MFH applies the rules.

Don't Be Afraid to Advocate. All politics is local (as someone once said), and there is nothing more "local" than the way individual PHAs and MFHs interpret and apply the rules. Don't hesitate to advocate on behalf of your beneficiaries and your Trustees whenever appropriate.

Conclusion

HOTMA will impact clients relying on federally subsidized housing once they are implemented though the new asset regulations may be applied to existing tenants differently than to new applicants for housing. Rent may increase due to new income definitions. Existing trusts and trusts to be drafted for a beneficiary who may rely on HUD subsidized housing may need to be modified. There will likely be significant confusion by PHAs and MFH owners and possibly incorrect or incomplete notices issued to tenants. As there is so much discretion given to PHAs and MFH owners, it is critical to consult the ACOPs and Tenant Selection Plans of the applicable PHA or MFH to determine the actual rules that will be applied to any tenant once HOTMA is implemented.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Housing
Office of Public and Indian Housing

Special Attention of:

Multifamily Asset Management Division Directors
Multifamily Contract Administrators
Multifamily Project Owners
Multifamily Regional Center Directors
Public Housing Agencies
Public Housing Hub Office Directors
Public Housing Program Center Directors
Regional Directors
Field Office Directors
Resident Management Corporations

Notice H 2023–10

Notice PIH 2023–27

Issued: February 2, 2024
Originally issued September 29, 2023

Expires: This Notice remains in effect until amended, superseded, or rescinded.

Cross References:

Regulations: 24 CFR Parts 5, 882, 891, 960, 966, 982

Office of Housing Notices: H 2020–06; H 2019–06; H 2016–01; H 2015–12

Office of Public and Indian Housing Notices: PIH 2019–09; PIH 2017–05 (HA); PIH 2016–05; PIH 2015–21; PIH 2013–04 (HA); PIH 2012–29; PIH 2012–03; PIH 2012–1 (HA)

Implementation Guidance: Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA)

1. PURPOSE

The purpose of this notice is to provide guidance to Public Housing Agencies (PHAs) and Multifamily Housing (MFH) Owners on the implementation of the many program changes brought about by the Housing Opportunity Through Modernization Act of 2016 (HOTMA) sections 102 and 104 and detailed in the final rule published in *Federal Register* Notice 88 FR 9600 on February 14, 2023. Although the final rule addresses sections 102, 103, and 104, this notice addresses guidance for sections 102 and 104 only.[1]

Through this notice, HUD is also modernizing its documentation requirements to reduce the burden on families accessing housing assistance in support of Office of Management and Budget (OMB) Memo M-22-10, *Improving Access to Public Benefits Programs Through the Paperwork Reduction Act.*

[1] The Office of Public and Indian Housing (PIH) published a separate notice on section 103 of HOTMA. See *Supplemental Guidance for Implementation of Section 103; Limitation on Public Housing Tenancy for Over-Income Families under the Housing Opportunity Through Modernization Act of 2016 (HOTMA)* (Notice PIH 2023–03 (HA)).

2. BACKGROUND

HOTMA was signed into law on July 29, 2016 (Public Law 114–201, 130 Stat. 782). The HOTMA statute consists of 14 sections of law that affect the Public Housing and Section 8 rental assistance programs. On September 17, 2019, HUD issued a proposed rule to update its regulations according to HOTMA's statutory mandate. The proposed rule may be found at 84 FR 48820 (September 17, 2019).

Sections 102 and 104 of HOTMA make sweeping changes to the United States Housing Act of 1937 (1937 Act), particularly those affecting income calculations and reviews. **Section 102** changes requirements related to income reviews for Public Housing and Section 8 programs. **Section 104** sets maximum asset limits for Public Housing and Section 8 applicants and participants.

Section 102 of HOTMA applies to all PHAs operating a Housing Choice Voucher (HCV) (including Project-Based Vouchers), Public Housing; Section 8 Moderate Rehabilitation, or Section 8 Moderate Rehabilitation Single Room Occupancy (SRO), including Moving to Work (MTW) Agencies (see Section 4 (Notice Applicability) of this notice). Section 102 also applies to the following programs administered by MFH: Section 8 Project-Based Rental Assistance (PBRA), 202/8, 202/162 Project Assistance Contract (202/162 PAC), Section 202/811 Capital Advance with Project Rental Assistance Contract (202/811 PRAC), non-insured 236 projects with Interest Reduction Payments (236 IRP), Section 811 Project Rental Assistance Demonstration (811 PRA), and Senior Preservation Rental Assistance Contracts (SPRAC).[2] Section 102 is effective on January 1, 2024.

Section 104 of HOTMA applies to all PHAs operating an HCV, Public Housing, Section 8 Moderate Rehabilitation, or Section 8 Moderate Rehabilitation SRO program, including MTW Agencies (see Section 4 (Notice Applicability) of this notice). Section 104 also applies to the following programs: Section 8 PBRA and 202/8. Section 104 does not apply to following programs: 202/811 PRAC, 236 IRP, 811 PRA, 202/162 PAC, and SPRAC. Section 104 is effective on January 1, 2024.

HUD, through rulemaking,[3] implemented sections 102 and 104 through several changes to the following Public Housing and Section 8 regulations:

- 24 CFR Part 5: General HUD Program Requirements; Waivers
- 24 CFR Part 882: Section 8 Moderate Rehabilitation Programs
- 24 CFR Part 960: Admission to, and Occupancy of, Public Housing
- 24 CFR Part 982: Section 8 Tenant-Based Assistance: Housing Choice Voucher Program

[2]HUD administratively extended the applicability of Section 102 of HOTMA to the following programs: 202/162, 202/811 PRAC, 811 PRA, and SPRAC.

[3] *Federal Register*: Housing Opportunity Through Modernization Act of 2016: Implementation of Sections 102, 103, and 104.

HUD also made conforming changes to its regulations found in 24 CFR Part 891, which govern the Section 202 and 811 Capital Advance programs and the Section 202 Direct Loan program (202/8). These programs are affected by various changes to the income regulatory provisions in 24 CFR Part 5. HUD, in error, did not make conforming changes to certain Section 202 Direct Loan regulations, consistent with the HOTMA final rule, in 24 CFR Part 891, Subpart E, including 891.655, 891.740, and 891.750, which govern 202/162 PAC projects. HUD published conforming changes to the Section 202/162 PAC program regulations as a technical correction that will become effective on January 1, 2024.[4] The revised Section 202 Direct Loan regulatory references in this notice will become effective with the effective date of the forthcoming technical correction.

Note: The final rule does not otherwise revise or modify any other federal laws or regulations. PHAs/MFH Owners must continue to follow all laws and regulations as codified in statute and in the Code of Federal Regulations.

2.1 Technical Corrections and Clarifications

HUD has updated Attachment A to address the asset limitation found in Section 104 of HOTMA and replaced the previous Attachment A that included placeholder language. In addition, HUD has made several technical corrections and added clarifying language throughout the notice, based on feedback from stakeholders and further analysis of the HOTMA Income and Assets Final Rule and related laws and regulations. These changes from the previous version of the notice published on September 29, 2023, are listed here as follows:

- Throughout the notice, HUD has added both the references to the 202/162 PAC program and the program's regulations as the conforming changes to the program were issued through the following *Federal Register* notice: https://www.federalregister.gov/documents/2023/11/02/2023-24236/section-202-direct-loan-technical-amendments.
- In Section 6.1, HUD removed a sentence that incorrectly stated that PHAs must pick a compliance date that falls before the deadline for their PHA Plan submission. HUD also added MTW Plans to the list of documents requiring updates due to HOTMA.
- In Attachment B, subtopic B.2, HUD added clarifying language on the three-step process for calculating income, specifically for Step 2, adding that the PHA/MFH Owner may use the verification obtained during an interim reexamination for an annual reexamination if there have been no other changes to annual income since the interim reexamination. In Step 3, HUD replaced the word "paycheck" with "pay stub." In the example B1, HUD changed the SSA COLA amount to the actual 2024 COLA amount of 3.2 percent. In the example B3, HUD changed "four current and consecutive paystubs" to "two current and consecutive paystubs." In example B4, HUD changed the COLA amount to 3.2 percent and adjusted the calculations.
- In Attachment C, subtopic C.2, HUD clarified that while the elderly/disabled family deduction is effective on January 1, 2024, PHAs/MFH Owners will apply the new deduction amount to a family's next annual or interim reexamination, whichever is

[4] Federal Register :: Public Inspection: Direct Loan Technical Amendments.

sooner, following the date on which the PHA/MFH Owner implements the new elderly/disabled family deduction.

- In Attachment C, subtopic C.4.a, HUD clarified that the phased-in relief for the health and medical care expenses deduction will not start until after the PHA/MFH Owner implements the phased-in relief. Likewise, in the Phased-in Relief Timing Table (Table C1), HUD replaced the date of January 1, 2024, with the date on which the PHA/MFH Owner implements the phased-in relief.
- In Attachment C, subtopic C.5, HUD edited the phrase "age 12 and younger" to "under 13 years of age," to align with HUD's definition of "child-care expenses" in 24 CFR 5.603. HUD also clarified in this subsection that the amount of child-care expenses (not the expenses incurred to enable a family member to work) deducted from annual income must not exceed the amount of employment income that is included in annual income.
- In Attachment C, subtopic C.6.b, HUD edited the date by which PHAs/MFH Owners are encouraged to communicate the new hardship exemptions to applicants and families, replacing January 1, 2024, with the date on which the PHA/MFH Owner begins to comply with HOTMA.
- In Attachment C, subtopic C.7, HUD added another example of a permissive deduction that PHAs may choose to establish, which is the amount paid from a family's annual income, and not another source such as Medicaid or a child welfare agency, for unreimbursed health or medical expenses of a foster child or a foster adult. In Attachment E, subtopic E.2, HUD clarified that PHAs may establish a permissive deduction to allow the unreimbursed health and medical expenses paid by the family on behalf of foster children and adults to be deducted from annual income.
- In Attachment F, subtopic F.1, HUD added clarifying language to address how PHAs/MFH owners must consider garnished, levied, or withheld wages or benefits.
- In Attachment F, subtopic F.4.e, HUD updated the method for subtracting federal tax refunds and refundable tax credits from assets to accurately reflect the statutory and regulatory requirements of HOTMA. Previously, the notice stated that the tax refund was to be subtracted from the asset account into which the tax refund amount was deposited. To align with HOTMA, the tax refund must instead be subtracted from the total value of net family assets. HUD deleted the reference to a tax refund or refundable tax credit that is deposited into an excluded asset, as this is incorrect. The tax refund/credit amount must be subtracted from total net family assets, regardless of where the amount is deposited. In example F2, HUD clarified that the Rodriguez family owns a total of $10,000 of net family assets.
- In Attachment F, subtopic F.5, with regard to the start date for using the HUD-published passbook rate, HUD updated the date of January 1, 2024, with the date on which the PHA/MFH Owner implements the new passbook rate, and added clarifying language on PHA flexibility around passbook rates up until they implement the new passbook rate.

- In Attachment F, subtopic F.6.b, HUD added clarifying language on how PHAs/MFH Owners are to impute asset income using the HUD-published passbook rate.
- In Attachment G, subtopic G.1.f, HUD clarified that non-recurring, non-monetary in-kind donations from friends and family may be excluded as non-recurring income.
- In Attachment G, subtopic G.6, HUD clarified that workers' compensation payments, regardless of the length or frequency of the payments, are always excluded from annual income. HUD updated example G6 to reflect this clarification.
- In Attachment G, subtopic G.16.d, HUD corrected the example reference to example G13, and reversed the wording on the process for calculating the excess amount of student financial assistance to include in annual income. The previous one-step process, as described, was incorrect. This error was also corrected in Chart G2.
- In Attachment I, subtopic I.2, HUD clarified in the PHA/MFH Owner discretion section that PHAs/MFH Owners have discretion on whether to process earned income increases only if there has been a previous interim decrease since the last annual reexamination.
- In Attachment J, subtopic J.1, HUD added a clarifying footnote (J1) to reduce confusion about the Form HUD–9886/HUD–9887 requirements for family members who become a head of household, co-head, or spouse.
- In Attachment J, Table J1, HUD added instructions on the use of EIV for new admissions in the row on Income Information for PIH Programs and Income Report for MFH Programs. HUD also added a footnote reminding PHAs/MFH Owners that they must rely on other documents to verify families' reported income before admission.
- In Attachment J, Table J2, Level 6, HUD clarified that PHAs/MFH Owners must pull the EIV Income Report for each family at every Annual Reexamination, unless using Safe Harbor documentation to verify the family's income. HUD also added to the Level 1 row that self-certification may be used as the highest form of verification when the family reports zero income.
- In Attachment J, subtopic J.5.a, HUD clarified that PHAs/MFH Owners are required to obtain a minimum of two current and consecutive pay stubs for determining projected annual income from wages when they are relying on pay stubs for Level 4 documentation.
- HUD renamed subtopic J.8 in Attachment J to "Zero Income Procedures" and updated this section to include guidance to PHAs/MFH Owners on accepting families' self-certifications of zero income at admission and reexamination without taking further steps to verify the zero reported income.
- HUD added the Appendix: Sample Net Family Assets Self-Certification Form.

3. BURDEN REDUCTION AND PROGRAM ALIGNMENT

OMB Memo M-22-10, *Improving Access to Public Benefits Programs Through the Paperwork Reduction Act*, challenges federal agencies to review documentation

requirements for those accessing public benefits programs like HUD's rental assistance programs. Through the process of implementing HOTMA, HUD has reviewed its verification and documentation requirements for admission and continued occupancy, including the use of HUD's Enterprise Income Verification (EIV) system in the Public Housing, Housing Choice Voucher, and the Multifamily Housing programs listed above. These programs share regulatory language around the requirement to obtain third-party verification of family annual income, the value of assets, expenses related to deductions from annual income and other factors that affect the determination of adjusted income (§§ 5.659(d), 960.259(c), 982.516(a)(2)).

Through this notice, HUD is aligning the timeframes within which documentation must be dated and the breadth of documentation required to verify tenant bank accounts and employment income across PIH and MFH programs. Consistency among HUD's programs will reduce burden among tenants who move from one program to another and among entities that administer multiple HUD programs.

4. NOTICE APPLICABILITY

HOTMA updates and creates new rules for programs administered by the Office of Public and Indian Housing (PIH) (HCV [including Project-Based Vouchers], Moderate Rehabilitation, Moderate Rehabilitation SRO, Public Housing), and programs administered by the Office of Multifamily Housing (MFH) (Section 8 PBRA, 202/8, 202/162 PAC, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC). HUD's revisions to the Part 5 income regulations also affect certain programs administered by the Office of Community Planning and Development (CPD).[5] HUD reminds PHAs/MFH Owners that they are required to meet all program requirements on rental units assisted and/or developed by multiple HUD programs.

This notice applies only to the following programs:

- Housing Choice Voucher (HCV);
- Public Housing;
- Section 8 Moderate Rehabilitation (Mod Rehab);
- Section 8 Moderate Rehabilitation Single Room Occupancy (SRO);
- Section 8 Project-Based Rental Assistance (PBRA);
- Section 202/8 (202/8);
- Section 202/162 Project Assistance Contract (202/162 PAC);
- Section 202/811 Capital Advance with Project Rental Assistance Contracts (202/811 PRAC);
- Non-insured 236 projects with Interest Reduction Payments (236 IRP);
- Section 811 Project Rental Assistance (811 PRA); and

[5] CPD will issue separate guidance on how HOTMA impacts its programs.

- Senior Preservation Rental Assistance Contracts (SPRAC).

The contents of this notice apply to PHAs participating in the MTW program except where an approved MTW waiver is in place. For example, MTW PHAs that have previously developed a different method of measuring prior-year income as part of the Rent Reform Demonstration or Stepped and Tiered Rent Demonstration may continue to use those methods after this notice takes effect. References to form HUD–50058 in this notice take on the meaning of form HUD–50058 MTW for MTW PHAs and form HUD–50058 MTW Expansion for MTW Expansion PHAs.

5. STRUCTURE OF THIS PUBLICATION

This notice is organized by distinct topic areas to assist PHAs/MFH Owners in identifying programmatic changes that affect their operations. Each topic area is presented as an attachment to the notice. Each attachment follows a uniform structure:

- Regulation(s)
- Affected Program(s)
- Summary of Change(s)
- Subtopics

Within each topic area, and in some cases within subtopic areas, the notice indicates whether PHAs/MFH Owners have discretion in establishing policies within their individual programs.

6. EFFECTIVE DATE, COMPLIANCE, AND UPDATES TO PHA/MFH OWNER POLICIES

The final rule's effective date is January 1, 2024. HUD recognizes, however, that HOTMA includes significant program and systems changes and that PHAs/MFH Owners and families need time to understand the changes and implement them. HUD understands that the system development timeframes for the Housing Information Portal (HIP) and Tenant Rental Assistance Certification System (TRACS) make full implementation and compliance with the final rule by the January 1, 2024, deadline unlikely. Additionally, because these HOTMA changes apply to all current participants and new admissions, implementation of the HOTMA final rule cannot be achieved immediately on a universal basis but rather is an ongoing process that will happen over the course of a year as routine program activities occur. Subparagraphs 6.1 and 6.2 describe HUD's implementation requirements by program office.

6.1 Compliance Date and Required Actions for PHAs (Office of Public and Indian Housing)

To comply with HOTMA, PHAs must be able to submit transactions to the Housing Information Portal (HIP). This requires the PHA's software vendor to make system updates and fully convert to making all submissions to HIP. Each PHA will set its own compliance date as early as January 1, 2024, but no later than January 1, 2025. "Compliance" means, in this instance, utilizing the HOTMA rules as it applies to the affected programs and corresponding reporting in HIP. The Real Estate Assessment Center (REAC) will issue a separate HIP transition notice later this year.

Requirements for Updating PHA Annual Plans or Annual MTW Plans:

- The deadline to submit the updated PHA Annual Plan or Annual MTW Plan to HUD will depend on the PHA's fiscal year start date. However, the PHA's chosen compliance date should also be considered.
- The regulations (24 CFR § 903.5(b)(3)) require that a PHA submit its PHA Annual Plan 75 days prior to the beginning of its fiscal year. To best utilize the required PHA Plan process for review and discussion of the ACOP and HCV Administrative Plan at the public hearing, PHAs must also submit their PHA Annual Plan to HUD at least 75 days before their compliance date or their Fiscal Year start date, whichever is sooner. See Table 1, below, to determine the due date of your PHA's Annual Plan or Annual MTW Plan based on your fiscal year start date and compliance date.
- PHAs must update their Public Housing Admissions and Continued Occupancy Policies (ACOP) and HCV Administrative Plans to reflect HOTMA rules and discretionary decisions, including the required public notification and review.
- The plans will indicate that policies are not effective until the PHA's compliance date.

Note: PHAs must continue to follow their existing ACOPs and Administrative Plans until the PHA's software is compliant with HIP.

What PHAs must do once their software is HOTMA compliant:

- Each PHA will establish a compliance date based on when the PHA's software is able to submit to HIP. All transactions **effective** on the PHA's compliance date or later will be processed using HOTMA policies. In setting a compliance date the PHA must consider when its software will be ready to submit to HIP and the time needed to ensure that all transactions effective on that day are processed using HOTMA rules. For example, a PHA with a May 1, 2024, compliance date will need to send Annual Reexamination packets reflecting the HOTMA changes in January 2024. The PHA must inform the family as to whether their income determination is being conducted under the pre-HOTMA regulations or in accordance with the HOTMA final rule.
- PHAs must implement their revised ACOP and Administrative Plans.

PHA Annual Plan Due Date Based on PHA's Fiscal Year Start Date and Compliance Date:

The 4 columns on the right represent Fiscal Year Start Dates and the rows represent possible Compliance Dates. When a PHA determines its Compliance Date, it can use this table to determine the Annual Plan due date by locating the appropriate Compliance Date row and then finding the column with its Fiscal Year Start Date.

Table 1: Recommended Annual Plan Due Date

Compliance Date	FY Start: July 1, 2024	FY Start: October 1, 2024	FY Start: January 1, 2025	FY Start: April 1, 2025

January 1, 2024	October 18, 2023	October 18, 2023	Oct 18, 2024	October 18, 2023
February 1, 2024	November 18, 2023	November 18, 2023	November 18, 2023	November 18, 2023
March 1, 2024	December 17, 2023	December 17, 2023	December 17, 2023	December 17, 2023
April 1, 2024	January 16, 2024	January 16, 2024	January 16, 2024	January 16, 2024
May 1, 2024	February 16, 2024	February 16, 2024	February 16, 2024	February 16, 2024
June 1, 2024	March 18, 2024	March 18, 2024	March 18, 2024	March 18, 2024
July 1, 2024	April 17, 2024	April 17, 2024	April 17, 2024	April 17, 2024
August 1, 2024	April 17, 2024	May 18, 2024	May 18, 2024	May 18, 2024
September 1, 2024	April 17, 2024	June 18, 2024	June 18, 2024	June 18, 2024
October 1, 2024	April 17, 2024	July 18, 2024	July 18, 2024	July 18, 2024
November 1, 2024	April 17, 2024	July 18, 2024	August 18, 2024	August 18, 2024
December 1, 2024	April 17, 2024	July 18, 2024	September 17, 2024	September 17, 2024
January 1, 2025	April 17, 2024	July 18, 2024	October 18, 2024	October 18, 2024
Latest Submission Deadline	April 17, 2024	July 18, 2024	October 18, 2024	October 18, 2024

By January 1, 2025:

Full compliance with the HOTMA final rule is mandatory effective January 1, 2025.

Compliance Example:

In March 2024, the PHA's software vendor says they will be ready to submit to HIP in June 2024. The PHA sets their compliance date as August 1, 2024, to allow for enough time to send out recert packets that reflect HOTMA changes in April 2024 for families with an August 1, 2024, annual reexamination effective date. The PHA's fiscal year start date is October 1, 2024. Based on the compliance date table above, the PHA determines that they must submit their updated Annual Plan to HUD by May 18, 2024. The PHA posts on their Web site that they will be applying the new HOTMA changes to all

transactions effective August 1, 2024. They also send notifications to participants, so they understand the new rules for reporting interim changes.

6.2 Compliance Date and Required Actions for MFH Owners (Office of Multifamily Housing)

By March 31, 2024:

- By March 31, 2024, MFH Owners must update their Tenant Selection Plans and EIV policies and procedures to reflect HOTMA rules and discretionary policies.
- MFH Owners must make the revised Tenant Selection Plan publicly available.

Note: MFH Owners must continue to follow their existing Tenant Selection Plans and EIV policies & procedures until the MFH Owner's software is compliant with TRACS 203A.

What MFH Owners must do once their software is HOTMA compliant:

Once a MFH Owner's software is HOTMA compliant (i.e., TRACS 203A system requirements have been fully implemented), the following things must happen:

- MFH Owners must provide tenants at least 60 days' notice that their lease will be modified at the end of the lease term after the expiration of the 60 days' notice. Once proper notice is given, MFH Owners must begin using the revised Model Leases at the expiration of a family's lease term.
- MFH Owners must implement their revised Tenant Selection Plans and EIV policies and procedures.
- All tenant data submissions must comply with the HOTMA regulations. Prior to their first reexaminations under HOTMA, MFH Owners must inform families that their income determinations will be conducted in accordance with the HOTMA final rule. As a best practice, HUD recommends that MFH Owners describe to families how their income determinations will change with the implementation of the final rule.
- MFH Owners must use the revised Tenant Consent form (form HUD–9887/9887A) and Fact Sheets ("How Your Rent is Determined").

How HUD will monitor MFH Owner compliance prior to January 1, 2025:

Prior to January 1, 2025, MFH Owners will not be penalized for HOTMA-related tenant file errors during Management and Occupancy Reviews (MORs). Instead, the Contract Administrator will issue observations with corrective actions.

By January 1, 2025:

Full compliance with the HOTMA final rule is mandatory effective January 1, 2025.

How HUD will monitor owner compliance on or after January 1, 2025:

- Contractor Administrators will issue HOTMA-related findings during MORs.
- MFH Owners must correct all HOTMA-related observations that were issued by Contract Administrators during 2024.

- MFH Owners who fail to implement HOTMA may be found in default of their business agreements with HUD.

Questions about compliance should be directed to MFH_HOTMA@hud.gov.

MFH Model Leases

MFH is updating the five program Model Leases to conform to the requirements in the HOTMA final rule. MFH Owners must begin using the new HUD-approved leases once HOTMA is fully implemented at the property.

The following information outlines the process that MFH Owners must follow to renew families under the applicable revised Model Lease:

- **Any modification to the lease may be effective only at the end of a lease term for all MFH programs.** Lease terms are listed in paragraph 2 in form HUD–90105–A (Section 8 Model Lease); paragraphs 1 and 9 in form HUD–90105–B (202/8 Model Lease); paragraphs 1 and 8 in form HUD–90105–C (202 PRAC Model Lease); paragraphs 1 and 8 in form HUD–90105–D (811 PRAC Model Lease); and paragraphs 1 and 8 in form HUD–92236 (811 PRA Model Lease).
- MFH Owners must provide families with copies of the HUD-approved lease at least 60 days prior to the end of a family's lease term.
- MFH Owners must include a letter clearly stating that the family can either accept the modification or move, but that a response is due from the family within 30 days.
- Families must either accept the modification by signing both copies of the modification and returning one to the MFH Owner[6] or refuse the modification and give the owner a 30-day notice of intent to vacate.
- If, within 30 days, the family indicates that the modification is unacceptable or does not respond, the MFH Owner may begin the procedures for terminating tenancy.

The lease modification notice must be served to families in the following manner[7]:

1) The MFH Owner must send a letter by first-class mail, properly stamped, and addressed and including a return address, to the family at the unit address; **and**
2) The MFH Owner must deliver a copy of the notice to any adult person answering the door at the unit. If no adult answers the door, the person serving the notice may place it under or through the door or affix it to the door.

The date on which the notice is deemed received by the family is the later of:

1) The date the first-class letter is mailed; or
2) The date the notice is properly given.

[6] Electronic signature is acceptable pursuant to Notice H 2020–10, except where not permitted by state and/or local laws.

[7] 24 CFR § 247.4(b), as applicable to 24 §§ CFR 891.430(b), 891.630(b), and 891.770(b).

Service of the notice is deemed effective once the notice has been both mailed and hand-delivered. **MFH Owners are not permitted to deliver lease modification notices to families electronically.**

Families who are under old leases after the MFH Owner becomes compliant with HOTMA must continue to report income and household composition changes between annual reexaminations in accordance with their existing leases until they sign a revised lease. MFH Owners will be required to determine whether changes reported by families under the old lease will require an interim reexamination consistent with HOTMA's requirements. Since the remaining provisions reflect changes to existing regulatory provisions during the period of an existing lease, all other HOTMA final rule provisions can be implemented without the family's execution of a revised lease.

No other modifications may be made to the Model Leases without HUD's approval. MFH Owners may incorporate existing HUD-approved lease addenda into the revised Model Leases if the addenda do not conflict with the requirements of the final rule.

7. SUPERSEDED AND RESCINDED NOTICES

7.1 Guidebooks and Handbooks

This notice supersedes relevant portions of HUD's guidance as provided in the HCV Guidebook, the Public Housing Occupancy Program Guidebook, and the HUD Handbook 4350.3: Occupancy Requirements of Subsidized Multifamily Housing Programs. HUD will update and replace all the sections and chapters listed below. Before consulting one of these resources, please ensure you are using a version dated after the publication date of this notice. Questions regarding the relevancy of existing handbook/guidebook guidance should be directed to the HOTMA mailbox maintained by each program office.

HCV Guidebook chapters to be updated:

- Eligibility Determination and Denial of Assistance
- Reexaminations

Public Housing Occupancy Guidebook chapters to be updated:

- Eligibility Determination and Denial of Assistance
- Income Determination
- Reexaminations

HUD Handbook 4350.3: Occupancy Requirements of Subsidized Multifamily Housing Programs chapters to be updated:

- Chapter 3. Eligibility for Assistance and Occupancy
- Chapter 4. Waiting List and Tenant Selection
- Chapter 5. Determining Income and Calculating Rent
- Chapter 7. Recertification, Unit Transfers, and Gross Rent Changes
- Chapter 9: Enterprise Income Verification (EIV)

- Glossary

7.2 Housing and PIH Notices

This notice supersedes and replaces the guidance provided in the following program notices:

- Exclusion from Annual Income of Temporary Employment from the U.S. Census Bureau (H 2020–06)
- Verification of Social Security Numbers (SSNs), Social Security (SS) and Supplemental Security Income (SSI) Benefits; and Effective Use of the Enterprise Income Verification (EIV) System's Identity Verification Report (PIH 2018–24)
- Administrative Guidance for Effective and Mandated Use of the Enterprise Income Verification (EIV) System (PIH 2018–18)
- Income Exclusion Under Temporary Census Employment and Census Access (PIH 2017–05)
- Passbook Savings Rate Effective February 1, 2016 (H 2016–01)
- Amendment to the Definition of Tuition (PIH 2015–21/H 2015–12)
- Guidance on Verification of Excluded Income (PIH 2013–04 (HA))
- Establishing the Passbook Savings Rate (PIH 2012–29)
- Housing Choice Voucher – Homeownership Option 10 Year Asset Exclusion (PIH 2012–03)
- Income Exclusion of Kinship, Kin-GAP and Other Guardianship Care Payments (PIH 2012–01 (HA))

Streamlining Administrative Practices in the Housing Choice Voucher program (Notice PIH 2012–15) is still useful for PHAs who are streamlining their programs. Numerous provisions in that notice are no longer applicable or additional flexibilities have been offered through more recent PIH notices. As it relates to the HOTMA final rule, however, the notice includes numerous recommendations surrounding interim reexaminations and annual reexaminations that are no longer applicable. Therefore, HUD is rescinding PIH Notice 2012–15.

The following sections of Streamlining Program Regulations for Programs Administered by Public Housing Agencies (Notice PIH 2016–05) are rescinded:

C: "Exclusion of mandatory education fees from income"

E: "Earned income disregard"

F: "Family declaration of assets under $5,000"

N: "Family income and composition: regular and interim examinations"

The following Housing notices are partially rescinded by this notice:

- *Streamlining Administrative Regulations for Multifamily Housing Programs* (H 2016–09)
  - "24 CFR 5.216 – Verification of Social Security Numbers" (Section IV). This section of the notice states that an interim reexamination is required to add or update a household member's Social Security Number (SSN).
  - "24 CFR 5.609 – Definition Change – Exclusion of mandatory education fees from income" (Section VI). This section of the notice references the outdated income exclusion in 24 CFR § 5.609(b)(9).
- *Section 811 Project Rental Assistance (PRA) Occupancy Interim Notice* (H 2013–24)
  - "Annual Recertification" (Section IV.F). This section of the notice states that MFH Owners must conduct interim reexaminations as described in HUD Handbook 4350.3 REV-1, Chapter 7.
- *Enterprise Income Verification (EIV) System* (H 2013–06)
  - "Using EIV Reports" (Section VII). This section of the notice states that MFH Owners are required to use EIV Income Reports as a third-party source to verify a tenant's employment and income information during interim reexaminations.
  - "Use of EIV Reports" (Attachment 6). This attachment to the notice states that the use of EIV Reports (Income Report, Income Discrepancy Report, and Summary Report) is mandatory at interim reexaminations.

8. PAPERWORK REDUCTION ACT

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520), an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number. The information collection requirements of this notice were assigned OMB Control Numbers 2577–0169, 2577–0295, 2577–0083, 2502–0204, 2577–0226, 2577–0282.

For questions regarding this notice please contact MFH_HOTMA@hud.gov for Multifamily Housing program questions or HOTMAQuestions@hud.gov for PIH program questions.

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ATTACHMENT A: TOPIC: ASSET LIMITATION

Regulations

24 CFR §§ 5.100 (real property); 5.603; and 5.618

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance), Section 202/8	Section 202/162 PAC, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	No	Yes

Summary

For the Public Housing and Section 8 programs (including PBRA and HCV), PHAs/MFH Owners must deny admission of an applicant if they are determined to not meet the requirements of the asset limitation (see paragraph A.1 and A.2 below).

PHAs/MFH Owners have discretion with respect to application of the asset limitation at annual and interim reexamination, as discussed in paragraph A.3 below. For the purpose of reexaminations, paragraph A.1 does not apply to PHAs/MFH Owners who establish total non-enforcement policies as described in paragraph A.3.a of this attachment.

Subtopics

A.1 Asset Limitation

This section describes the asset limitation. The enforcement options are described in subsequent paragraphs A.2. and A.3. A family is out of compliance with the asset limitation if they have either of the following:

- **Net family assets that exceed $100,000, as adjusted annually for inflation.** See Attachment F (paragraph F.4.a) (Determining Net Family Assets) of this notice for the definition of net family assets. HUD will adjust this amount annually in accordance with the Consumer Price Index–Urban Wage Earners and Clerical Workers (CPI–W). See Attachment H (Inflationary Adjustments) of this notice for more information on inflationary adjustments. In determining whether the net family assets for a family exceed $100,000 (as adjusted for inflation), a PHA/MFH Owner may accept a declaration from the family that their net assets do not exceed $50,000 (as adjusted for inflation), without needing to further verify that declaration. See Attachment F (paragraph F.7) (Self-Certification of Net Family Assets Equal to or Less Than $50,000 (as adjusted by inflation)) of this notice. For assets disposed of for less than fair market value during the two years preceding the date of application for the program or reexamination, as applicable, the difference in value between the consideration received and the fair market value must be included in net family assets.

- **Real property that is suitable for occupancy.** Real property means "real property as provided under the State law in which the property is located."[A1] Families are out of compliance if they have a present ownership interest in, a legal right to reside in, and the effective legal authority to sell a property (based on laws of the state or locality in which the property is located) that is suitable for occupancy by the family as a residence. However, there are several exemptions to the real property restriction, discussed below in paragraph A.4.a (Exemptions to the Real Property Restriction in the Asset Limitation). In determining whether the family owns real property that would make them out of compliance, a PHA/MFH Owner may rely upon a self-certification, both at the time of admission and at reexamination, from the family stating that they do not have any present ownership interest in any real property. A PHA/MFH Owner could use a form that requests certification of the family's present ownership interest in the property, and also inquire about the family's legal right to reside in, and the effective legal authority to sell any real property that is suitable for occupancy by the family. If the family certifies that they do not have any present ownership interest in real property, the PHA/MFH Owner may take that as sufficient to determine the family is not out of compliance with the real property restriction. However, if the family owns real property, the PHA/MFH Owner must seek third-party verification of the family's legal right to reside in the property, the effective legal authority to sell the property, and whether the property is suitable for occupancy by the family as a residence.

Note: Ownership of real property is relevant to the asset limitation in two distinct ways: 1) if the family has an ownership interest in real property, that interest may cause the family's net family assets to exceed $100,000 (adjusted for inflation), in which case the family is out of compliance; and 2) if the family has a present ownership interest in, a legal right to reside in, and the effective legal authority to sell a property that is suitable for occupancy by the family as a residence, then the family is out of compliance. There are several exemptions to the real property restriction at § 5.618(a)(1)(ii), discussed in paragraph A.4.a, which identify when a real property ownership interest does not by itself render the family out of compliance with the asset limitation. However, those exemptions do not indicate that such real property is excluded from the calculation of net family assets. Unless the real property is specifically excluded from net family assets in the definition under § 5.603, it may be included in net family assets. If the value of that real property brings the net family assets above $100,000 (as adjusted for inflation), the family will be out of compliance.

A.2 Compliance at Admission

At admission, ownership of net family assets that exceed $100,000 (as adjusted) or ownership of disqualifying real property require denial of assistance. PHAs/MFH Owners do not have the discretion to not enforce or provide limited enforcement of the asset limitation at admission.

With respect to MFH programs only, MFH Owners must enforce the asset limitation at initial certification for families who lost their assistance because they failed to recertify

[A1] Real Property as defined in 24 CFR § 5.100.

timely or began to pay market rent, remained in the unit, and then lost income, once again requiring assistance.

Note: Families residing in units converting to Section 8 PBRA or PBV through the Rental Assistance Demonstration (RAD) may not be rescreened upon conversion pursuant to the RAD statute; therefore, RAD families converting to PBRA or PBV are not subject to the asset limitation provision **at conversion.** Instead, families residing in units converting under the First or Second Component of RAD to PBRA (including units originally assisted under the Section 202/811 PRAC program) or PBV will be subject to the PHA/MFH Owner's discretionary asset limitation policies at their next annual or interim reexamination after conversion, whichever is sooner.

A.3 PHA/MFH Owner Discretion at Annual and Interim Reexamination

PHAs/MFH Owners have discretion with respect to the application of the asset limitation at annual and interim reexamination. PHAs/MFH Owners may adopt a written policy of total non-enforcement, enforcement, or limited enforcement, as described below. They may also adopt exception policies as described in A.3.d.

Regardless of the policy they adopt, PHAs/MFH Owners must comply with federal fair housing and civil rights requirements, including reasonable accommodation requirements. This obligation applies regardless of whether PHAs/MFH Owners establish enforcement, limited enforcement, or exception policies to the asset limitation at reexamination. This may mean, for example, that a PHA/MFH Owner would be required to allow someone to cure their noncompliance or provide more time to demonstrate they have cured their noncompliance before terminating assistance if there was a nexus between the person's disability and their need to cure or their need for additional time to demonstrate they have cured their noncompliance. A reasonable accommodation could require delaying the initiation of termination or eviction proceedings for more than six months.

A.3.a Total Non-Enforcement

At annual and interim reexamination, PHAs/MFH Owners may choose not to enforce the asset limitation, if they establish a written non-enforcement policy. PHAs/MFH Owners may establish a total non-enforcement policy for all families at reexaminations, which would mean that they will not initiate termination or eviction proceedings for a family for non-compliance with the asset limitation. Where the PHA/MFH Owner exercises this discretion to allow families who would otherwise fail to comply with the asset limitation to continue renting their units, the families will continue to receive assistance. If they adopt a total non-enforcement policy, PHAs/MFH Owners must apply the non-enforcement policy the same for all families within a program (e.g., if adopted in a PHA's Admissions and Continued Occupancy Policy, it must apply to all Public Housing families). Any non-enforcement policy must be included in the PHA's Administrative Plan or ACOP or a MFH Owner's Tenant Selection Plan.

Note: PHAs/MFH Owners who adopt a total non-enforcement policy are still required to calculate net family assets in the manner required by § 5.603, as part of the process of calculating annual income in accordance with § 5.609. In the

course of calculating net family assets, PHAs/MFH Owners thus still need to determine whether the family owns real property that must be included in net family assets. However, if they adopt a total non-enforcement policy, they are not required to obtain and verify additional information about owned real property strictly to determine whether it qualifies for an exemption under § 5.618 (e.g., whether owned real property is suitable for occupancy). For example, if a PHA/MFH Owner finds a family owns real property, that real property would need to be included in the calculation of net family assets unless it is specifically excluded by § 5.603, but the PHA/MFH Owner would not need to inquire whether it was suitable for occupancy.

A.3.b Enforcement

PHAs/MFH Owners may choose to enforce the asset limitation at reexamination. PHAs/MFH Owners with an enforcement policy at reexamination must initiate termination or eviction proceedings within six months of the income examination that determined the family was out of compliance. They may delay the initiation of termination or eviction proceedings for noncompliant families for up to but no longer than six months. See paragraph A.4 on the features that determine whether owned real property renders the family out of compliance with the asset limitation. See paragraph A.5 on how requirements to initiate termination or eviction proceedings vary by program.

Any enforcement policy, including the amount of time that a PHA/MFH Owner will delay the initiation of termination or eviction proceedings for noncompliant families, must be included in the PHA's Administrative Plan or ACOP or a MFH Owner's Tenant Selection Plan.

A.3.c Limited Enforcement: Option to Cure

PHA/MFH Owners may alternatively adopt a written policy of limited enforcement, which would differ from total enforcement of the asset limitation at reexamination in only one regard: all families who are found to be out of compliance at reexamination would be provided the same opportunity to come back into compliance. Families would have up to but no longer than six months, depending on the limited enforcement policy that the PHA/MFH Owner adopts, to demonstrate that they have come back into compliance. If the family does demonstrate they have come back into compliance within that period, the PHA/MFH Owner would not initiate termination or eviction proceedings.

Limited enforcement policies cannot provide families more than six months to come back into compliance and do not extend the period of time the PHA/MFH Owner may delay initiation of termination or eviction proceedings; the PHA/MFH Owner may still only delay initiation of termination or eviction proceedings for the family for a period of not more than six months. (In the case of a reasonable accommodation, a family may be afforded more than six months to comply.) See paragraph A.4 on the features that determine whether owned real property renders the family out of compliance with the asset limitation.

If the PHA/MFH Owner has adopted a limited enforcement policy, that policy must address the timeframe for curing non-compliance (e.g., families will have six months to demonstrate they have cured non-compliance with the asset limitation). In establishing a limited enforcement policy, PHAs/MFH Owners may choose to allow an opportunity to cure non-compliance that is less than six months. Any limited enforcement policy, including the amount of time that a PHA/MFH Owner will delay the initiation of termination or eviction proceedings for families who do not demonstrate compliance, must be included in the PHA's Administrative Plan or ACOP or a MFH Owner's Tenant Selection Plan.

What families must do to cure non-compliance depends on why they were identified as out of compliance. Families could cure non-compliance by removing prohibited assets — for example, by selling real property or bringing net family assets below $100,000 (as adjusted for inflation). However, the value of assets disposed of for less than fair market value would still be counted in the family's net family asset total in the two years preceding the date of application for the program or reexamination. See Attachment F (paragraph F.4.a) for a discussion of what constitutes a disposition of assets for less than fair market value.

If the family is non-compliant with the asset limitation because of a present ownership interest in real property, but their net family assets do not exceed $100,000 (adjusted for inflation), they can cure non-compliance by demonstrating that either they no longer own the prohibited asset or that it now qualifies for an exemption (e.g., because the family is now offering it for sale), so long as the family's net family assets do not exceed $100,000 (adjusted for inflation) after such action is taken. (Note, however, that offering real property for sale does not thereby exclude the real property from the calculation of net family assets.)

A family with more than $100,000 (as adjusted annually for inflation) in net family assets may bring their assets below the threshold in several ways. The family could purchase something that is not counted among net family assets, such as necessary personal property (e.g., a car used for everyday transportation). Alternatively, the family may cure non-compliance by moving assets such that they are no longer counted among net family assets, so long as doing so is not counted as disposing of assets for less than fair market value. In some circumstances, the family may transfer funds into a retirement plan recognized as such by the Internal Revenue Service (e.g., an individual retirement arrangement, employer retirement plan, or retirement plan for self-employed individuals), if the account is held by a member of the family. An asset moved to a retirement account held by a member of the family is not considered an asset disposed of for less than fair market value. Likewise, the family may be able to move funds into an irrevocable trust for the benefit of someone in the assisted family.

When PHAs/MFH Owners have a limited enforcement policy and the family demonstrates they have cured non-compliance, PHAs/MFH Owners must record the curing of a family's ineligibility in the family's file and permit families to remain in the program. The related updates to the family's income and assets would be processed at the next reexamination, which may be an interim if the family's circumstances meet the threshold for processing such a reexamination, or

it may be the next annual reexamination. See Attachment I (Interim Reexaminations) of this notice.

A.3.d Exception Policies

At annual and interim reexamination, PHAs/MFH Owners may also establish exceptions to the asset limitation (not at admission or initial certification where the family is being rescreened for assistance). If the PHA/MFH Owner has adopted a written exception policy for reexaminations, then families in the specified exception categories will receive either total non-enforcement or limited enforcement, depending on the exception policy the PHA/MFH Owner has adopted. Families in the specified exception categories would either (a) not be subject to termination or eviction proceedings due to non-compliance with the asset limitation at a reexamination, or (b) they would be provided an opportunity, up to but no longer than six months, to come back into compliance, after which point the asset limitation would be enforced. An exception policy may be combined with a limited enforcement policy for all other families not in the exception categories, as described below.

PHAs/MFH Owners are permitted to include more than one exception as part of any exception policy. Exception policies may be based on family type and may take into consideration such factors as age, disability, income, the ability of the family to find suitable alternative housing, and whether supportive services are being provided[A2]. All exception policies must comply with civil rights and fair housing statutes and requirements, including but not limited to requirements identified in 24 CFR § 5.105(a).

Limited exception policies, which establish an opportunity to cure non-compliance, cannot provide families more than six months to cure these conditions. (In the case of a reasonable accommodation, a family may be afforded more than six months to comply.) If they have adopted such a policy, PHAs/MFH Owners must initiate termination or eviction proceedings for families who remain in non-compliance with the asset limitation within six months of the reexamination at which the non-compliance was determined. In establishing a limited exception policy, PHAs/MFH Owners may choose a period of delay that is less than six months.

PHAs/MFH Owners may choose to combine a limited enforcement policy (which applies to all families) with an exception policy for families in the specified exception categories. For example, they may adopt a limited enforcement policy that provides all families a window of six months to cure non-compliance with the asset limitation, and they may simultaneously adopt an exception policy that provides that the asset limitation will not be enforced at all at annual and interim reexaminations for families in the exception categories. PHAs/MFH Owners could alternatively adopt a limited enforcement policy for all families that provides a window of less than six months to cure non-compliance, alongside a

[A2] Sec. 104(e)(5) of P.L.114-201 (HOTMA).

limited exception policy that allows families in the exception categories a longer period of time (up to but no longer than six months) to cure non-compliance.

Any exception policy must be included in the PHA's Administrative Plan or ACOP or a MFH Owner's Tenant Selection Plan. The exception policy must describe whether excepted families are subject to total non-enforcement or limited enforcement.

Example A1: Asset Limitation Exception Policies

Sample Policy A: For all families that meet the definition of extremely low income at reexamination and are found to be non-compliant with the asset limitation, the PHA/MFH Owner will not enforce the asset limitation at reexamination. Such families will not be subject to termination or eviction proceedings due to non-compliance with the asset limitation at reexamination. All other families will be subject to a limited enforcement policy and provided six months to cure noncompliance.

Sample Policy B: For all families that meet the definition of extremely low income at reexamination and are found to be non-compliant with the asset limitation, the PHA/MFH Owner will not enforce the asset limitation at reexamination. Such families will not be subject to termination or eviction proceedings due to non-compliance with the asset limitation at reexamination. All other families will be subject to the enforcement policy.

Sample Policy C: Families with an elderly family member or a member with a disability will be given six months to cure their non-compliance with the asset limitation, as stated in the PHA/MFH Owner's policies. All other families will be subject to a limited enforcement policy and provided four months to cure noncompliance.

Sample Policy D: Families with an elderly family member or a member with a disability will be given six months to cure their non-compliance with the asset limitation, as stated in the PHA/MFH Owner's policies. All other families will be subject to the enforcement policy.

A.4 Real Property Determination

At admission and at reexamination, if the PHA/MFH Owner is enforcing the asset limitation, including limited enforcement, and a family declares that they have a present ownership interest in real property, then the PHA/MFH Owner must determine whether the property qualifies for an exemption as described in paragraph A.4.a (Exemptions to the Real Property Restriction in the Asset Limitation), whether the family lacks a legal right to reside in the real property as described in paragraph A.4.b (Legal Right to Reside in the Real Property), whether they lack the effective legal authority to sell the real property as described in paragraph A.4.c (Effective Legal Authority to Sell the Real Property), or whether the real property is unsuitable for occupancy as described in paragraph A.4.d (Suitability of Real Property for Occupancy). If the PHA/MFH Owner finds that any of these four things are true, then the family's present ownership interest in real property does not itself mean the family is out of compliance with the asset limitation. The type of third-party documentation that will be used to verify the disposition of a family's real property may vary by a family's circumstances and the locality in which the real property is located.

A.4.a Exemptions to the Real Property Restriction in the Asset Limitation

The real property restriction does not apply to the following:

- Any property for which the family is receiving assistance under 24 CFR § 982.620 (i.e., a manufactured home owned by a family who receives assistance to lease the space or lot in which it is located). Likewise, any property for which the family is receiving assistance under the Homeownership Option in 24 CFR Part 982. See 24 CFR § 5.618(a)(1)(ii)(A).
- Any property jointly owned by a family member and another individual who does not live with the family but who resides at the jointly owned property. See 24 CFR § 5.618(a)(1)(ii)(B).
- Any property owned by a family that includes a person who is a victim of domestic violence, dating violence, sexual assault, or stalking, as those terms are defined in 24 CFR Part 5 (Subpart L). For example, if the victim is a minor, the real property limitation does not apply to any property owned by the victim's parent or guardian. When a family requests an exemption from the real property limitation on this basis, the PHA/MFH Owner must accept self-certification and follow the confidentiality and documentation-request requirements established at 24 CFR § 5.2007. See 24 CFR § 5.618(a)(1)(ii)(C).
- Any property that the family is offering for sale. Documentary evidence of the sales process could include, for example, a contract with a real estate agent or a current real estate listing. See 24 CFR § 5.618(a)(1)(ii)(D).

A.4.b Legal Right to Reside in the Real Property

The real property restriction applies only when the family has the legal right to reside in the real property. Whether a family has the legal right to reside in a property may be dependent on state and local law. The family may own real property that legally they may not reside in. For example, the family may own a commercial property, such as a convenience store or other retail establishment, which cannot be occupied as a place of residence by the family. Families who claim they lack the legal right to reside in the real property must provide evidence to support their claim(s). What constitutes sufficient evidence will vary by circumstance.

A.4.c Effective Legal Authority to Sell the Real Property

The real property restriction applies only when the family has the effective legal authority to sell the real property, based on the laws of the state or locality in which the property is located. There may be multiple reasons why a family does not have such legal authority. For example, when families are contesting ownership of a property in court, or an individual is in divorce proceedings, they may be unable to sell the property until the completion of those proceedings. Someone who owns heirs' property may not have the authority to sell until others' claims to fractional ownership have been settled. Families who claim they lack the legal authority to sell the real property must provide evidence to support their claim(s). What constitutes sufficient evidence will vary by circumstance. For example, a divorce pleading or complaint may demonstrate that there are actual divorce proceedings occurring.

A.4.d Suitability of Real Property for Occupancy

A property will be considered suitable for occupancy unless the family demonstrates that the real property meets one of the following five conditions (24 CFR § 5.618(a)(2)):

- The property is not capable of meeting the disability-related needs of all members of the family (e.g., does not meet physical accessibility requirements, family has disability-related need for additional bedrooms, family needs proximity to accessible transportation). Documentary requirements to establish disability-related needs must comply with applicable fair housing and civil rights requirements.
- The property is not sufficient for the size of the family. A PHA/MFH Owner's occupancy standards may be used for such a determination.
- The property is geographically located so that it creates a hardship for the family (e.g., the distance or commuting time between the property and the family's place of work or school would place a hardship on the family, as determined by the PHA/MFH Owner. Distance or commute time to school/work are illustrative, but not exhaustive, examples of geographic hardships). Through written policies, PHAs/MFH Owners may set parameters on what constitutes such a hardship, but they must consider the specific circumstances of the family, including information provided by the family, in making a determination.
- The property is not safe to reside in because of its physical condition (e.g., the property's physical condition poses a risk to the family's health and safety and the condition of the property cannot be easily remedied). Unsafe property conditions could include external circumstances or environmental factors outside the control of the family. The property may be deemed not suitable for occupancy if the alterations that would be needed to make it safe to live in are cost prohibitive.
- The family does not have the legal right to reside in the property.

A.5 Special Considerations for Terminating Assistance or Evicting Families for Non-Compliance with the Asset Limitation

Even if PHAs/MFH Owners do not adopt a non-enforcement or limited enforcement policy and/or exception policy, they may delay for a period of up to six months the initiation of termination or eviction of assistance proceedings. They are not required to initiate termination or eviction of assistance proceedings immediately upon determining the family is out of compliance with the asset limitation, nor are they required to begin the proceedings during the six-month period in order to have a termination of assistance or eviction completed at the six-month mark. PHAs/MFH Owners are encouraged to set policies for the initiation of termination or eviction of assistance proceedings that provide families adequate opportunity to find new housing.

What it means to initiate termination or eviction of assistance proceedings due to non-compliance with the asset limitation will vary by program:

- In the Section 8 Project-Based Rental Assistance program, including the Section 202/8 program, participants who are not compliant with the asset limitation must either pay the contract rent for the unit or vacate the unit after termination of assistance.
- In the Housing Choice Voucher program, participants who are not compliant with the asset limitation are subject to termination of assistance, but there is no requirement that the unit owner initiate eviction because of non-compliance with the asset limitation.
- In the Public Housing program, participants who are not compliant with the asset limitation are subject to termination of assistance and eviction from the unit, if they fail to vacate the unit voluntarily. There is no general provision that allows such families to remain and pay an alternative rent.
- In the Section 8 Project-Based Voucher program, participants who are not compliant with the asset limitation are subject to termination of assistance. The PHA and owner may agree to remove the unit from the HAP contract, at which point the unit becomes an unassisted unit, and the owner may choose to allow the family to stay and pay the market rent. (The owner may charge the family a rent that is below-market rate, in which case it would be considered a landlord-assisted unit for rent reasonableness purposes.) When the family subsequently vacates the unit, the unit may be added back to the HAP contract. If the project is partially assisted, the PHA and owner may substitute a different unit for the unit removed due to the ineligibility of the tenant, consistent with the requirements for adding units to the HAP contract. Alternatively, if the owner refuses to agree to remove the unit from the HAP contract, the owner must evict the family, if they fail to vacate the unit voluntarily. In this case, the owner may not enter into a new lease with the now-ineligible family for that PBV-assisted unit, and the PBV unit must be leased to an eligible family.
- In the Section 8 Moderate Rehabilitation program, participants who are not compliant with the asset limitation are no longer eligible for assistance. 24 CFR § 882.512 expressly allows that families who were eligible at admission but subsequently become ineligible may remain in HAP contract units. However, if the owner fails to have at least 90 percent of the assisted units leased or available for leasing by eligible families, the PHA may reduce the number of units covered by the HAP contract. The PHA will agree to an amendment of the HAP contract to provide for subsequent restoration of any reduction in units if the PHA determines that the restoration is justified by demand, the owner otherwise has a record of compliance with obligations under the HAP contract, and contract authority is available.

PHAs/MFH Owners must follow program procedures for terminating assistance or tenancy. For example, for Public Housing families, when the PHA initiates the eviction and termination process, the PHA must provide a lease termination notice of 30 days unless a state or local law requires a longer notice period, and the family must be provided an opportunity for a hearing under the PHA administrative grievance procedure.

A.6 Required Policy Updates to Administrative Plans, ACOPs, and Tenant Selection Plans

A.6.a Admission Policies

PHAs/MFH Owners must establish written screening criteria in their Administrative Plans, ACOPs, or Tenant Selection Plans, as applicable, to prohibit the admission of applicants who own net family assets that exceed $100,000 (as adjusted for inflation) and/or real property that is suitable for occupancy. Policies should indicate the general parameters PHAs/MFH Owners will use when determining whether the location of real property constitutes a geographic hardship.

A.6.b Reexamination Policies

Whether a PHA/MFH Owner chooses to adopt a total non-enforcement, enforcement, limited enforcement, and/or exception policy for reexaminations, that policy and accompanying details must be set forth in the PHA's ACOP or Administrative Plan or in a MFH Owner's Tenant Selection Plan, as applicable.

PHAs/MFH Owners must also update their Administrative Plans, ACOPs, or Tenant Selection Plans, as applicable, to indicate when they will initiate termination or eviction proceedings after participant families are determined to be out of compliance with the asset limitation, when the PHA/MFH Owner has established either an enforcement policy or policies to permit families to cure their noncompliance. PHAs/MFH Owners must initiate termination or eviction proceedings for families who remain out of compliance with the asset limitation within six months of the reexamination at which the non-compliance was determined. Policies should indicate the general parameters PHAs/MFH Owners will use when determining whether the location of real property constitutes a geographic hardship.

ATTACHMENT B: TOPIC: CALCULATING INCOME

Regulations

24 CFR §§ 5.609(c)(1); 5.609(c)(2); 5.609(c)(4); 5.657(f); 882.515; 882.515(f); 882.808; 882.808(i)(5); 891.105; 891.410(c); 891.410(g)(1); 891.410(g)(2); 891.610(c); 891.610(g)(1); 891.610(g)(2); 891.750(c); 960.257; 982.516; and 982.516(f)

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

See each subtopic.

Subtopics

B.1 New Admissions and Interim Reexaminations

Regulations: 24 CFR §§ 5.609(c)(1); 882.515; 891.410(c) and (g)(2); 891.610(c) and (g)(2); 960.257; and 982.516

Summary: When calculating a household's income, including asset income, at the time of admission to the program or during interim reexaminations, PHAs/MFH Owners must use anticipated income (current income) (i.e., the family's estimated income for the upcoming 12-month period). This requirement is consistent with the pre-HOTMA process for conducting income examinations at admission and for interim reexaminations.

B.2 Annual Reexaminations

Regulations: 24 CFR §§ 5.609(c)(2); 882.808; 891.410(g)(1); and 891.610(g)(1) 960.257; and 982.516

Summary: The final rule revises the standards for income calculation during annual reexamination.

PHAs/MFH Owners have the option of using a "safe harbor" income verification from another federal means-tested program to verify gross annual income. See Attachment J (paragraph J.4) (Determination of Income Using Other Means Tested Public Assistance (i.e., "Safe Harbor")) of this notice for an example of how to calculate annual income using the safe harbor method.

During annual reexaminations, except where the PHA/MFH Owner uses a streamlined income determination under 24 CFR §§ 5.657(d), 960.257(c), or 982.516(b) (see Attachment I (paragraph I.8) (Streamlined Income Determination)), PHAs/MFH Owners must first determine the family's income for the previous 12-month period and use this

amount as the family income for annual reexaminations; however, adjustments to reflect current income must be made. Any change of income since the family's last annual reexamination, including those that did not meet the threshold to process an interim reexamination of family income in accordance with the PHA/MFH Owner's policies and 24 CFR §§ 5.657(c), 960.257(b), or 982.516(c), must be considered. Income from assets is always anticipated, irrespective of the income examination type.

A change in income, for example, may be a loss of income or the addition of a new source of income. Changing to a different employer in the prior year does not necessarily constitute a change if the income earned from either employer is substantially the same. PHA/MFH Owners will look at the entirety of the family's unearned income and earned income from the prior year, in which earned income may have been one constant job or many different jobs that start and stop. Cost of Living Adjustments (COLA) to Social Security income and Social Security disability income are always considered changes to income because the COLA is an adjustment that automatically occurs annually by law.[B1] See Attachment B (paragraph B.3) of this notice for more information on the COLA. The three steps outlined below apply for both earned and unearned income.

Overview of Calculating Annual Income at Annual Reexamination

Step 1: Determine the annual income for the previous 12-month period as defined at 24 CFR § 5.609(a) and (b). If there have been no changes to income beyond this calculation, then this is the amount that will be used to determine the family's rental assistance.

The PHA/MFH Owner reviews the following information to determine prior-year income:

- The EIV Income Report (must be pulled within 120 days of the effective date of the annual reexamination to be considered current);
- The income reported on the most recent reexamination HUD–50058/HUD–50059; and
- What the family certified to on the PHA/MFH Owner's current annual reexamination paperwork for prior-year income, if available.

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination.

- If an interim reexamination was performed within the reexamination cycle and there are no additional changes, the PHA/MFH Owner must use the annual income from the interim reexamination to determine the family's rental assistance. The PHA/MFH Owner may use the verification obtained from the interim reexamination for this step.
- If the PHA/MFH Owner did not perform an interim reexamination or if the family reports that there have been changes since the last reexamination, move to Step 3.

[B1] P.L. 92–336: https://www.govinfo.gov/content/pkg/STATUTE-86/pdf/STATUTE-86-Pg406.pdf#page=16.

Step 3: If there were changes in annual income not processed by the PHA/MFH Owner since the last reexamination, use current income.

- Family reports their income for the prior year and whether there have been permanent changes.

If there are no reported changes to an income source, the PHA/MFH Owner may use documentation of prior-year income to calculate the annual income used for the current annual reexamination HUD–50058/HUD–50059. For example, the PHA/MFH Owner could use the following documentation :

- EIV + self-certification (wages, Supplemental Security Income (SSI), Social Security, and unemployment)
- Current level 4[B2] documents verifying prior-year income that are dated within the required timeframe (120 days of receipt by the PHA/MFH Owner), for example:
  - Year-end statement
  - Pay stub with year-to-date amount
  - Tax forms (Form 1040, W2, 1099, etc.)

If there are reported changes by the family or the PHA/MFH Owner notes discrepancies between EIV and what the family reports, follow the verification hierarchy to document and verify income. See Attachment J (paragraph J.5) (Verification Hierarchy) of this notice for information about verification.

Example B1: Calculating Annual Income at Annual Reexamination Using EIV

Background: Staff are processing the 3/1/2024 annual reexamination for Ruby Myers and her minor daughter, Georgia. No interim reexaminations have been processed, and Ruby has not reported any changes to annual income to the PHA/MFH Owner since the 3/1/2023 annual reexamination. The SSA published 2024 COLA is 3.2 percent.
Last reexamination – 3/1/2023 Annual Reexamination Ruby: Georgia: Wages: $30,000 SSI: $10,980 ($915 monthly)
The EIV report pulled on 12/15/2023 Ruby: Georgia: Wages Total: $33,651 SSI Total: $10,980 Quarter 3 of 2023: $8,859 (City Public School) 2023 benefit $915 monthly Quarter 2 of 2023: $8,616 (City Public School) Quarter 1 of 2023: $8,823 (County Public School) Quarter 4 of 2022: $7,353 (County Public School)

[B2] See Table J2.

Income Reported on Reexamination Application	
Ruby: Wages at City Public School: $32,000 (switched jobs but no permanent change to amount)	Georgia: SSI benefits: $10,980 (no changes in income)
Calculating Ruby's wages: Step 1: Determine prior annual income from EIV (i.e., Q4 2022 through Q3 of 2023: $33,651). Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination (in this case, there have been no interim reexaminations processed since the last annual reexamination). Step 3: Ruby certifies that the $33,651 of wages in EIV is accurate and reflects her current annual income, so the PHA/MFH Owner will use $33,651 for annual wages for the 3/1/2024 annual reexamination given there have been no additional changes to annual income.	Calculating Georgia's SSI benefit: Step 1: Determine the prior annual income from EIV (i.e., $915 x 12 months: $10,980). Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination (in this case, there have been no interim reexaminations processed since the last annual reexamination). Step 3: Ruby certifies the SSI income in EIV is accurate and reflects Georgia's current annual income. The PHA/MFH Owner must adjust the prior-year income (2023 SSI benefit) by the 3.2-percent COLA and will use this amount to calculate annual SSI income for the 3/1/2024 annual reexamination: COLA: $29.28 ($915 x 0.032 New gross SSI benefit: $11,331.36 ($944.28 x 12 months)
If Ruby did not agree with the annual wages reported in EIV, the PHA/MFH Owner would be required to verify her current income in accordance with HUD's verification hierarchy in Attachment J (paragraph J.5) (Verification Hierarchy) of this notice.	
Summary of Annual Income (as reported on the HUD–50058/HUD–50059)	
Ruby (Head of Household): Other Wage: $33,651	Georgia (Other Youth Under 18): SSI: $11,748
Myers Family Total Annual Income: $45,399	

Example B2: Calculating Annual Income at Annual Reexamination Using EIV: Family Disagrees with EIV

Background: Staff are processing Paul Hewson's 5/1/2024 annual reexamination. Since the last annual reexamination, Paul reported a decrease in annual income that exceeded 10 percent. Last year, Paul reported a decrease in earned income because he transferred from a full-time job at Sasha's Sweets to a part-time job at Viking Bakery. Following HUD's EIV verification hierarchy, staff confirmed Paul was no longer employed at Sasha's Sweets and decreased his anticipated annual income from $28,000 to $7,500 resulting from his new part-time employment at Viking Bakery; an interim reexamination was processed effective 7/1/2023. After the 7/1/2023 interim, Paul worked briefly at two different jobs, but he says he is no longer working and is not planning to work.
5/1/2023 Annual Reexamination

Wages: $28,000

Last Reexamination: 7/1/2023 Interim Reexamination

Wages: $7,500

The EIV report pulled on 1/15/2024

Wages Total: $18,271

Quarter 3 of 2023: $2,500 (Viking Bakery)

Quarter 3 of 2023: $796 (Sweet Tooth Candy Bar)

Quarter 2 of 2023: $1,300 (Sasha's Sweets)

Quarter 2 of 2023: $584 (Larry's Concessions)

Quarter 2 of 2023: $2,401 (Viking Bakery)

Quarter 1 of 2023: $6,500 (Sasha's Sweets)

Quarter 4 of 2022: $600 (Sasha's Sweets)

SS/SSI: No history of benefits.

Income Reported on Reexamination Application

Wages: $0 (permanent change; no longer receiving)

Social Security: $14,400 ($1,200 monthly)

Paul certified on the PHA's annual reexamination paperwork that he does **not** agree with the annual wages of $18,271 reported in EIV and it is not reflective of his current anticipated annual income. He reported he is currently unemployed, and provided a copy of an award letter from the Social Security Administration to document that he will begin receiving a monthly disability benefit of $1,200 effective 3/1/2024.

Calculating Wages and SS Benefit

Step 1: Determine prior annual income taking into consideration the 8/1/2023 interim reexamination (i.e., EIV wages reflected Q4 2022 through Q3 2023: $18,271)

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there was a 7/1/2023 interim that reduced wages to $7,500.

Step 3: Obtain documentation to verify current income and confirm Paul is no longer employed at Viking Bakery or The Sweet Tooth Candy Bar (the employers reported in the most recent quarter of EIV). This step is necessary, because Paul did not agree with the EIV income report or income reported on the last interim reexamination. Paul reported that he is no longer working at all.

Process the annual reexamination effective 5/1/2024 using annual SS income of $14,400 and $0 wages.

Summary of Annual Income (as reported on the HUD–50058/HUD–50059)
Paul (Head of Household): $14,400 (SS)
Hewson Family Total Annual Income: $14,400

Example B3: Calculating Annual Income at Annual Reexamination

Background: Staff are processing the 11/1/2024 annual reexamination for Samantha and Fergus Poole, head of household and spouse. On 2/14/2024 Samantha reported her monthly child support payment was reduced from $200 to $100 per month, but an interim reexamination was **not** processed, because the reduction in child support income for Samantha's daughter, Hailey, did not result in a decrease of 10 percent or more in annual adjusted income, and the PHA/MFH Owner did not establish a lower threshold (see Attachment I, paragraph I.1). Samantha did not report any additional changes to the PHA/MFH Owner.	
Last reexamination – 11/1/2023 Annual Reexamination	
Samantha: Business income: $28,000 VA disability pension: $12,000 Child support: $2,400	Fergus: Wages: $8,250 Other non-wage income: $3,000 (Go Fund Me online fundraiser)
The EIV report pulled on 9/16/2024	
Samantha: Wages Total: $0 (no wage data reported since Q1 2023)	Fergus: Wages Total: $8,600 Quarter 1 of 2024: $2,100 (Ian's Fish 'n' Chips) Quarter 1 of 2024: $500 (Claire's Healthcare Supplies) Quarter 4 of 2023: $1,000 (Claire's Healthcare Supplies) Quarter 3 of 2023: $1,800 (The Onion Garden Shop) Quarter 2 of 2023: $3,200 (Ivar's Fish Haus)

Current Family Circumstances: Income Reported on Reexamination Application

Samantha and Fergus reported how much income was earned/received in the previous 12-month period and noted permanent changes, where applicable, for each source of their income on PHA/MFH Owner's annual reexamination form. However, no information was reported by the family concerning other non-wage income. Fergus reported **only** wages and his current employment at Ian's Fish 'n' Chips for the annual reexamination. The family supplied the supporting documentation noted below to the PHA/MFH Owner for the 11/1/2024 annual reexamination.

Samantha:

Business income: $28,750 (last year); has decreased to $18,000 (permanent change)

VA disability benefit: $12,000 (last year); has increased to $12,300 (permanent change)

Child support: $2,400 (last year); has decreased to $1,200 (permanent change)

Fergus:

Wages: $6,000

Calculating Samantha's Net Business Income

Step 1: Determine prior annual *net business income* (i.e., $28,000 on last HUD–50058/HUD–50059).

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there have been no interim reexaminations processed since the last annual reexamination.

Step 3: Adjust to reflect current **net business income**. Samantha reported on the annual reexamination application that business income permanently decreased to $18,000. The PHA/MFH Owner must obtain supporting documentation from Samantha that demonstrates current net business income. Samantha provided documentation that supported the current annual net business income is $18,000. Process the annual reexamination effective 11/1/2024 using annual **net business income** determined in Step 3.

Calculating Samantha's VA Pension Income

Step 1: Determine prior annual **VA pension income** (i.e., $12,000 supported by a VA award letter Samantha supplied that documents the prior year monthly VA pension was $1,000).

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there have been no interim reexaminations processed since the last annual reexamination.

Step 3: The PHA/MFH Owner needs to adjust to reflect current **VA pension income**. Samantha supplies a VA award letter showing the COLA adjusted monthly pension of $1,025, or $12,300 annually. Process the annual reexamination effective 11/1/2024 using annual **VA pension income** determined in Step 3 ($12,300 in this example).

Calculating Samantha's Child Support Income

Step 1: Determine prior annual **child support income** (i.e., $2,400 on the last HUD–50058/HUD–50059).

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there have been no interim reexaminations processed since the last annual reexamination. The family reported a decrease from $200 to $100 monthly, but the change was not processed because it did not meet the threshold.

Step 3: The family reported changes, so the PHA/MFH Owner must adjust to reflect current **child support income**. In this example, the family submitted a child support history report from the local child support office that documents regular $100 monthly child supports payments beginning 3/1/2024 through the current month. Process the annual reexamination effective 11/1/2024 using current annual **child support income** determined in Step 3 ($1,200 in this example).

Calculating Fergus's Wages

Step 1: Determine prior annual income from **wages** in EIV (i.e., Q2 2023 through Q1 of 2024: $8,600).

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there have been no interim reexaminations processed since the last annual reexamination.

Step 3: There is a discrepancy between what the family reported and EIV, so the PHA/MFH Owner must verify and adjust to reflect current annual income from **wages**. Fergus reported $6,000 in annual income from wages on the annual reexamination from a single employer, Ian's Fish 'n' Chips. The PHA/MFH Owner projected annual income of $7,800 based on the two paystubs for this employer, and EIV shows $8,600 earned in the most recent four quarters in EIV. To complete Step 3, the PHA/MFH Owner must do the following: resolve the discrepancy between EIV wages, the $6,000 annual income Fergus reported, and the $7,800 projected based on the paystubs he provided, and verify he is no longer employed at Claire's Healthcare Supplies in accordance with HUD's verification hierarchy and local policies. The PHA/MFH Owner determined that Fergus reported his net vs. gross annual income from **wages,** which he corrected on the annual reexamination form to reflect his current gross annual income of $9,000. The PHA/MFH Owner verified Fergus was no longer employed at Claire's Healthcare Supplies and obtained two additional paystubs. Based on two current and consecutive paystubs, Fergus is now projected to earn $9,360 annually. Process the annual reexamination effective 11/1/2024 using income from **wages** determined in Step 3 ($9,360 in this example).

Calculating Fergus's Other Non-Wage Income

Step 1: Determine prior annual income from other **non-wage income** (i.e., $3,000 on the last HUD–50058/HUD–50059).

Step 2: Take into consideration any interim reexamination of family income completed since the last annual reexamination. In this case, there have been no interim reexaminations processed since the last annual reexamination.

Step 3: The family did not report any non-wage income on the annual reexamination form, but it was included on the last HUD–50058/HUD–50059. The PHA/MFH Owner must verify and adjust to reflect current **non-wage income**. The PHA/MFH Owner must verify no income was received through a "Go Fund Me" online fundraiser so that it may be excluded. Fergus provided a self-certification that he hasn't solicited funds online and doesn't plan to in the following year; he also provided records from the account that documented no fundraising activity in the prior 12-month period. Process the annual reexamination effective 11/1/2024 using annual **non-wage income** of $0 determined in Step 3.

Summary of Annual Income (as reported on the HUD–50058/HUD–50059)	
Samantha (Head of Household):	Fergus (Co-head):
Own business: $18,000	Wages: $9,360
Pension: $12,300	
Child support: $1,200	
Poole Family Total Annual Income: $40,860	

B.3 Applying the Current SSA COLA at Next Annual and Interim Reexamination

Regulations: 24 CFR §§ 5.609(c)(2); 960.257; 982.516; and 891.105

Summary: Annually in October, the Social Security Administration (SSA) announces the cost-of-living adjustment (COLA) by which federal SS and SSI benefits are adjusted to reflect the increase, if any, in the cost of living as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers prepared by the Bureau of Labor Statistics. The purpose of the COLA is to ensure that the purchasing power of SS and SSI benefits are not eroded by inflation. The federal COLA does not apply to state-paid disability benefits. Additional information regarding the SSA COLA is available online at www.socialsecurity.gov.

Effective the day after SSA has announced the COLA, PHAs/MFH Owners are required to factor in the COLA when determining SS and SSI annual income for all annual reexaminations and interim reexaminations of family income that have not yet been completed and will be effective January 1 or later of the upcoming year.

Example B4: Adjusting the SS Benefit by the COLA

Elizabeth Peterson receives $500 a month (SS benefit). The PHA/MFH Owner is processing her annual reexam (in November 2023), which is effective 1/1/2024. The PHA/MFH Owner must determine annual SS income as follows:

- Current benefit amount: $500
- COLA: $16.00 ($500 x 3.2 percent [or 0.032])
- New gross SS benefit effective 01/01/2024: $516.00 ($500 current benefit + $16 COLA)
- Annual SS income effective 1/1/2024: $6,192 ($516 x 12)

B.4 De Minimis Errors

Regulations: 24 CFR §§ 5.609(c)(4); 5.657(f); 960.257(f); 982.516(f); 882.515(f); 882.808(i)(5); 891.105; and 891.655

Summary: PHAs/MFH Owners will not be considered out of compliance solely due to de minimis errors in calculating family income. De minimis errors occur when a PHA/MFH Owner's determination of a family's income deviates from the correct income determination by no more than $30 per month in monthly adjusted income (or $360 in annual adjusted income). HUD may revise the threshold amount that constitutes a "de minimis error" through rulemaking. PHAs/MFH Owners will not be issued a finding by

HUD or the Contract Administrator (MFH only) for de minimis errors in income calculation.

As PHAs/MFH Owners become aware of the existence of an income calculation error, they are obligated to correct the error(s) retroactive to the effective date of the action the error was made regardless of the dollar amount associated with the error. PHAs/MFH Owners must take corrective action to credit or repay a family if the family was overcharged tenant rent, including when PHAs/MFH Owners make de minimis errors in the income determination. Families will not be required to repay the PHA/MFH Owner in instances where the PHA/MFH Owner miscalculated income resulting in a family being undercharged for rent.

PHAs/MFH Owners must revise their Administrative Plans, ACOPs, and Tenant Selection Plans, as applicable, to reflect how they will repay or credit a family the amount they were overcharged as a result of the PHA/MFH Owner's de minimis error in income determination.

PHA/MFH Owner Discretion: None.

ATTACHMENT C: TOPIC: DEDUCTIONS AND EXPENSES

Regulations

24 CFR §§ 5.603; 5.611(a)(1); 5.611(a)(2); 5.611(a)(3); 5.611(a)(3)(ii); 5.611(b)(1); 5.611(b)(1)(i); 5.611(b)(1)(ii); 5.611(c)(1); 5.611(c)(1)(D); 5.611(c)(2); 5.611(d); 5.611(e); 5.611(e)(2); and 891.105

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

PHAs/MFH Owners must consider mandatory deductions when determining a family's annual adjusted income. PHAs may also consider additional (permissive) deductions to a family's annual income if established by a written policy in the PHA's ACOP or Administrative Plan.

Subtopics

C.1 Dependent Deduction

Regulation: 24 CFR § 5.611(a)(1)

Summary: Effective January 1, 2024, the dependent deduction amount is $480. This amount will be adjusted annually (see Attachment H) and applies to a family's next annual or interim reexamination after the annual adjustment, whichever is sooner. Not later than September 1 annually, HUD will publish the CPI–W adjusted dependent deduction to the HUDUser Web site.[C1] PHAs/MFH Owners must implement the adjusted dependent deduction for all income examinations that are effective on January 1 or later.

PHA/MFH Owner Discretion: None.

C.2 Elderly/Disabled Family Deduction

Regulation: 24 CFR § 5.611(a)(2)

Summary: Effective January 1, 2024, the elderly/disabled family deduction increases from $400 to $525 and applies to a family's next interim or annual reexamination, whichever is sooner, after the date on which the PHA/MFH Owner implements the new elderly/disabled family deduction. The amount of the deduction will be adjusted annually (see Attachment H). Not later than September 1 annually, HUD will publish the CPI–W adjusted elderly/disabled family deduction to the HUDUser Web site.

[C1] https://www.huduser.gov/portal/pdrdatas_landing.html.

PHA/MFH Owner Discretion: None.

C.3 Unreimbursed Health and Medical Care Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expenses Deduction

C.3.a New Higher Threshold for Deducting Health and Medical Care Expenses and Unreimbursed Reasonable Attendant Care and Auxiliary Apparatus Expenses

Regulation: 24 CFR § 5.611(a)(3)

Summary: The final rule establishes that the sum of unreimbursed health and medical care and reasonable attendant care and auxiliary expenses that exceed 10 percent of the family's annual income can be deducted from annual income. Prior to January 1, 2024, the threshold was 3 percent of the family's annual income.

C.3.b New Definition of Unreimbursed Health and Medical Care Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expenses Deduction

Regulation: 24 CFR § 5.603

Summary: Health and medical care expenses, as defined in 24 CFR § 5.603, include costs incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease or payments for treatments affecting any structure or function of the body. Health and medical care expenses include medical insurance premiums and long-term care premiums that are paid or anticipated during the period for which annual income is computed. Medical insurance premiums continue to be eligible health and medical care expenses. However, health and medical care expenses may be deducted from annual income only if they are eligible and not otherwise reimbursed and may only be deducted for elderly or disabled families.

Although HUD revised the definition of health and medical care expenses to reflect the Internal Revenue Service (IRS) general definition of medical expenses, HUD is not permitting PHAs/MFH Owners to specifically align their policies with IRS Publication 502[C2] for determining which expenses are included in HUD's mandatory deduction for health and medical care expenses. IRS Publication 502, in some instances, may instruct that certain expenses are not to be considered medical expenses that would otherwise be allowed under HUD's definition of health and medical care expenses. PHAs/MFH Owners must review each expense to determine whether it is eligible in accordance with HUD's definition of health and medical care expenses.

PHA/MFH Owner Discretion: None.

C.3.c Unreimbursed Reasonable Attendant Care and Auxiliary Apparatus Expenses

Regulation: 24 CFR § 5.611(a)(3)(ii)

[C2] Publication 502 explains the itemized deduction for medical and dental expenses used for tax purposes, including what expenses, and whose expenses, can and cannot be included in figuring the deduction.

Summary: Auxiliary apparatus items can include, for example, expenses for wheelchairs, ramps, adaptations to vehicles, guide dogs, assistance animals, or special equipment to enable a person who is blind or has low vision to read, or type or special equipment to assist a person who is deaf or hard of hearing. Some examples of attendant care expenses can include teaching a person with disabilities how to perform day-to-day tasks independently like cleaning, bathing, doing laundry, and cooking. Attendant care can be 24-hour care, or care during sporadic periods throughout the day.

In order to claim the deduction for the cost of unreimbursed reasonable attendant care and auxiliary apparatus expenses, the family must include a person with a disability, and the expenses must enable any member of the family (including the member who is a person with a disability) to be employed. If the unreimbursed reasonable attendant care and auxiliary apparatus expense exceeds the amount earned by the person who was enabled to work, the deduction will be capped at the amount earned by that individual.

PHA/MFH Owner Discretion: None.

C.4 Hardship Exemptions for Health and Medical Care Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expenses

Regulations: 24 CFR §§ 5.611(c)(1); 5.611(c)(1)(D); and 5.611(c)(2)

Summary: As stated in C.3.a, the threshold to deduct health and medical care expenses and reasonable attendant care and auxiliary apparatus expenses has been increased from an excess of 3 to an excess of 10 percent of annual income. Concurrently with this increase, the regulations provide financial hardship exemptions for unreimbursed health and medical care expenses, and for reasonable attendant care and auxiliary apparatus expenses for eligible families. A family will benefit from this hardship exemption only if the family has eligible expenses that can be deducted in excess of 5 percent of annual income. In order to claim **unreimbursed health and medical care expenses**, the family must have a head, co-head, or spouse that is elderly or a person with a disability. In order to claim **unreimbursed reasonable attendant care and auxiliary apparatus expenses**, the family must include a person with a disability, and the expenses must enable any member of the family (including the member who is a person with a disability) to be employed.

To initiate, extend,[C3] or conclude a hardship exemption only, PHAs/MFH Owners will process and submit a non-interim reexamination transaction as described in Attachment I (paragraph I.4) (Non-Interim Reexamination Transactions) of this notice.

Families may be eligible for relief under one of two categories; phased-in relief or general relief, as defined below.

Note: A family receiving phased-in relief may request to receive general hardship relief instead; **once a family chooses to obtain general relief, a family may no longer receive the phased-in relief.**

[C3] See paragraph C.6.e, below.

C.4.a Phased-In Relief

This section describes the phased-in relief for families affected by the statutory increase in the threshold to receive unreimbursed health and medical care and reasonable attendant care and auxiliary apparatus expense deductions from annual income.

All families who received a deduction for unreimbursed health and medical care and/or reasonable attendant care or auxiliary apparatus expenses based on their most recent income review prior to January 1, 2024, will begin receiving the 24-month phased-in relief at their next annual reexamination or interim reexamination, whichever occurs first after the date on which the PHA/MFH Owner implements the phased-in relief. Families who receive phased-in relief will have eligible expenses deducted that exceed 5 percent of annual income for 12 months. Twelve months after the 5 percent phase-in began, families will have eligible expenses deducted that exceed 7.5 percent of annual income for the immediately following 12 months. After the family has completed the 24 months phase-in at the lower thresholds, as described above, the family will remain at the 10 percent threshold, unless the family qualifies for relief under the general hardship relief provision.

When an eligible family's phased-in relief begins at an interim reexamination, the PHA/MFH Owner will need to process another transaction one year later to move the family along to the next phase. The transaction can be either an interim reexamination if triggered, or a non-interim reexamination transaction.

The following table demonstrates when the phased-in relief will begin and increase every 12 months during the 24-month phase-in period.

Table C1: Phased-in Relief Timing

Phased-in Relief Timing	In Excess Threshold Percentage for Families Receiving the Health and Medical Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expense Deduction as of January 1, 2024	Reexamination Type
First annual reexamination or interim reexamination, whichever occurs first on or after the date on which the PHA/MFH Owner implements the phased-in relief.	5 percent	Annual or Interim Reexamination
Twelve months after the 5-percent phase-in began	7.5 percent	Annual Reexamination or Interim Reexamination If no Interim Reexamination is triggered, then the PHA/MFH Owner processes with a non-interim transaction.
Twelve months after the 7.5-percent phase-in began	10 percent	Annual Reexamination or Interim Reexamination If no Interim Reexamination is triggered, then the PHA/MFH Owner processes with a non-interim reexamination transaction.

Example C1: Phased-In Relief (Health and Medical Care Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expenses)

Ms. Bell's annual reexamination is due on June 1, 2024. Her last annual reexamination was effective June 1, 2023, and she received a deduction for unreimbursed health and medical expenses. She did not have any interim reexaminations after her annual reexamination was completed. Ms. Bell's unreimbursed health and medical expenses were 8 percent of her annual income. For her annual reexamination effective June 1, 2024, the PHA determines that Ms. Bell's annual income is $10,000 and her unreimbursed health and medical expenses are $800 (8 percent of her annual income).

Although Ms. Bell's unreimbursed health and medical care expenses are not in excess of the new 10-percent threshold to receive the deduction, since she was receiving a deduction for unreimbursed health and medical expenses on January 1, 2024, Ms. Bell is automatically eligible for the deduction pursuant to the phased-in hardship exemption. The PHA/MFH Owner will apply the phased-in relief threshold to deduct the expenses that exceed 5 percent of her annual income which is $300 ($800 - $500) for this reexamination.

Since her expenses are more than 7.5 percent of her annual income, Ms. Bell will receive the benefit of the unreimbursed health and medical expense deduction until her next annual reexamination on June 1, 2025, or interim reexamination (whichever occurs first), when the threshold will be increased to 7.5 percent. Assuming her medical expenses are still $800, she will be able to deduct $50 ($800 - $750).

PHAs/MFH Owners **must** track the 24-month phase-period for each eligible family, even if a family's expenses go below the appropriate phase-in percentage, during the first or second 12-month phase-in period. The phase-in must continue for families who move with continued assistance in the HCV program or port to

another PHA. The phase-in must also continue for families who move to another Public Housing unit at the same PHA, or who transfer internally to another unit within the same MFH property. The family must receive phased-in relief if they are determined to be eligible as of January 1, 2024.

The table below describes the potential phased-in relief outcomes based on a family's status in PIH and MFH programs:

Table C2: Phased-in Relief Outcomes According to Family's Status in Program for Multifamily Housing Program

Family's Status in Program	Is Family Receiving Phased-in Relief?	Outcome of Phased-in Relief	Required Documentation
Family's assistance is terminated in any program.	Yes	Phased-in relief ends upon termination. When readmitted, family's expense deduction will be calculated using the 10-percent threshold unless request for general relief is approved by the PHA/MFH Owner.	N/A. No documentation of phased-in relief is needed.
Public Housing: Family transfers PH units within the same PHA. Housing Choice Voucher: Family moves with continued assistance in the HCV program with the same PHA or ports to a new PHA. MFH: Family transfers units within the same MFH property and are not treated as a new admission.	Yes	Families must continue to receive the phased-in relief. The family will receive the remaining calendar months of the percentage phase-in in their new unit.	The PHA or MFH Owner will use the existing phase-in documentation to determine the remaining calendar months of the percentage phase-in.
Family is treated as a new admission under a different property/program (e.g., family moves from one MFH property to another MFH property, the family moves from Public Housing to the HCV program, etc.).	Yes	Unless the PHA/MFH has a written policy to continue the phased-in relief upon admission, the family's expense deduction will be calculated using the 10-percent threshold unless request for general relief is approved by PHA/MFH Owner.	If the PHA/MFH Owner elects to continue the phased-in hardship relief, then the following documentation is required: Copy of forms HUD–50058 or 50059 from the family showing phased-in relief. If the forms are unavailable, then the PHA/MFH Owner may

			obtain self-certification from family declaring effective date of 5-percent or 7.5-percent phase-in. The PHA/MFH Owner must document in the file the reason that the forms HUD-50058 or 50059 were unavailable.
Unit in which family resides converts to PBV or PBRA funding under the Rental Assistance Demonstration.	Yes	Families must continue to receive the phased-in relief. The family will receive the remaining calendar months of the percentage phase-in in their new unit.	Copy of forms HUD–50058 or 50059 from the family showing phased-in relief. If the forms are unavailable, then the PHA/MFH Owner may obtain self-certification from family declaring effective date of 5-percent or 7.5-percent phase-in. The PHA/MFH Owner must document in the file the reason that the forms HUD-50058 or 50059 were unavailable.

PHA/MFH Owner Discretion: PHAs/MFH Owners may establish a policy to continue the phased-in hardship relief for families who were eligible for relief as of January 1, 2024, and who are treated as new admissions under a different program.

C.4.b General Relief

This section describes when a family is eligible for general relief related to the health and medical care expense and reasonable attendant care and auxiliary apparatus expense deduction.

To receive general relief, a family must demonstrate that the family's unreimbursed health and medical care expenses or unreimbursed reasonable attendant care and auxiliary apparatus expenses increased, or the family's financial hardship is a result of a change in circumstances that would not otherwise trigger an interim reexamination.

Relief is available regardless of whether the family previously received an unreimbursed health and medical care expense deduction, unreimbursed reasonable attendant care and auxiliary apparatus expense deduction, are currently receiving phased-in hardship relief, or were previously eligible for either this general relief or the phased-in relief.

If a PHA/MFH Owner determines that a family is eligible for general relief, the family will receive a deduction for the sum of the eligible expenses that exceed 5 percent of annual income. The family's hardship relief ends when the

circumstances that made the family eligible for the relief are no longer applicable or after 90 days, whichever comes earlier. However, PHAs/MFH Owners may, pursuant to their own discretionary policy, extend the relief for one or more additional 90-day periods while the family's hardship condition continues.

Example C2: General Relief (Health and Medical Care Expenses and Reasonable Attendant Care and Auxiliary Apparatus Expenses)

Mr. Beck's annual reexamination is due on August 1, 2024. In his last reexamination, he did not have any unreimbursed health and medical expenses and/or auxiliary and attendant care expenses. However, Mr. Beck has since been in a car accident, and he has increased eligible health and medical expenses equal to 6 percent of his annual income. On February 15, 2024, Mr. Beck asks the PHA/MFH Owner for a hardship exemption to allow him to receive a health and medical care expense deduction, which will help him cover his rent.

The PHA/MFH Owner determines that the family Is eligible for general relief and an interim reexamination would not have otherwise been triggered. The PHA/MFH Owners processes a non-interim change that applies a health and medical expense deduction for the eligible expenses that exceed 5 percent of annual income for 90 days. The PHA/MFH Owner may extend the relief for one or more additional 90-day periods while Mr. Beck's hardship condition continues and may extend the exemption beyond 90 days if a policy for extending hardship relief is included in the written policy for the PHA/MFH Owner.

PHA/MFH Owner Discretion: PHAs/MFH Owners must establish written policies regarding the types of circumstances that will allow a family to qualify for a financial hardship and when such deductions may be eligible for additional 90-day extensions. PHAs/MFH Owners must develop policies requiring families to report if the circumstances that made the family eligible for the hardship exemption are no longer applicable.

Examples of circumstances constituting a financial hardship may include the following situations:

- The family is awaiting an eligibility determination for a federal, state, or local assistance program, such as a determination for unemployment compensation or disability benefits;
- The family's income decreased because of a loss of employment, death of a family member, or due to a natural or federal/state declared disaster; or
- Other circumstances as determined by the PHA/MFH Owner.

PHAs/MFH Owners must not conduct an interim reexamination to add, remove, or to extend a hardship exemption, unless another change experienced by the family triggers an interim reexamination under the applicable regulation or in accordance with the PHA/MFH Owner's discretionary policies on conducting interim reexaminations for adjusted income decreases that are less than ten percent. Instead, the PHA/MFH Owner will process and submit a non-interim reexamination transaction as described in Section 16.4 (Non-Interim Reexamination Transactions) of this notice.

C.5 Child-Care Expenses Deduction and Hardship Exemption to Continue Child-Care Expenses Deduction

Regulation: 24 CFR §§ 5.603 Child-Care Expenses and 5.611(d)

See also Attachment I (paragraph I.4) (Non-Interim Reexamination Transactions).

Summary: Under 24 CFR § 5.611(d), any reasonable child-care expenses necessary to enable a member of the family to be employed or to further their education are deducted from income. Reasonable child-care expenses are defined in 24 CFR § 5.603(a) and are expenses for the care of children (including foster children if the unreimbursed child-care expenses are paid from the family's annual income and not from another source, such as a stipend from the child welfare agency), under 13 years of age, when all the following statements are true:

- The care is necessary to enable a family member to be employed or to further his or her education (e.g., work, look for work, or further their education (academic or vocational)); and
- The expense is not reimbursed by an agency or individual outside the household.

The amount deducted must not exceed the amount of employment income that is included in annual income.

A family whose eligibility for the child-care expense deduction **is ending** may receive a hardship exemption to continue receiving a child-care expense deduction in certain circumstances when the family no longer has a member that is working, looking for work, or seeking to further their education, and the deduction is necessary because the family is unable to pay their rent.

When a family requests a hardship exemption to continue receiving a child-care expense deduction that is ending, the PHA/MFH Owner must recalculate the family's adjusted income and continue the child-care deduction if the family demonstrates to the PHA's/MFH Owner's satisfaction that the family is unable to pay their rent (see Attachment C (paragraph C.6.a) (Policy for Determination of the Family's Inability to Pay Rent)) because of loss of the child-care expense deduction and the child-care expense is still necessary even though the family member is no longer working, looking for work, or furthering their education. The hardship exemption and the resulting alternative adjusted income calculation must remain in place for a period of up to 90 days. The PHA/MFH Owner, at their discretion, may extend such hardship exemptions for additional 90-day periods based on family circumstances.

To initiate, extend or conclude a hardship exemption, PHAs/MFH Owners will submit a non-interim transaction code on form HUD–50058/HUD–50059, unless there is an accompanying event that triggers an interim reexamination.

Example C3: Hardship Exemption to Continue Child-Care Expense Deduction

Ms. Branch had been paying $250 per week for her child, Violet, to attend child care, while she was employed at a local coffee shop. Ms. Branch became unemployed when the coffee shop permanently closed. Ms. Branch has plans to enroll in college in two months. Although Ms. Branch has the availability to watch Violet, the child-care center has a long waiting list, and if Ms. Branch pulls Violet out temporarily, she would likely be without reliable child care when she starts college. Continuing to pay child-care expenses while not receiving earned income has made the family unable to pay their rent portion.

The PHA/MFH Owner determined that Ms. Branch met the hardship exemption criteria, as established in the MFH Owner's written policies, and is unable to pay rent. The PHA/MFH Owner will allow Ms. Branch to

continue to receive the child-care expense deduction for 60 days as Ms. Branch is anticipated to enroll in college in the next two months.

PHA/MFH Owner Discretion: PHAs/MFH Owners must develop policies requiring families to report if the circumstances that made the family eligible for the hardship exemption are no longer applicable. PHAs/MFH Owners may extend hardship exemptions for additional 90-day periods based on family circumstances as stated in their written policies.

C.6 Hardship Policy Requirements

C.6.a Policy for Determination of the Family's Inability to Pay Rent

Regulation: 24 CFR § 5.611(e)

Summary: PHAs/MFH Owners must establish policies on how they define what constitutes a hardship (i.e., when a family is unable to pay rent, triggering eligibility for a hardship exemption).

PHA/MFH Owner Discretion: PHAs/MFH Owners have discretion to establish policies for the purpose of determining eligibility for general hardship relief for the health and medical care expense deduction and for the child-care expense hardship exemption. PHAs/MFH Owners must describe these policies in their ACOPs, Administrative Plans, or Tenant Selection Plans, as applicable.

Some factors to consider when determining if the family is unable to pay rent may include determining that the rent, utility payment, and applicable expenses (child-care expenses or health and medical expenses) is more than 45 percent (for example) of the family's adjusted income, or verifying whether the family has experienced unanticipated expenses, such as large medical bills, that have affected their ability to pay their rent. PHA/MFH Owners may use different percentage thresholds or methods for determining a family's inability to pay rent; the examples provided in this paragraph are for consideration purposes.

C.6.b Family Notification of Hardship Exemption

Regulation: 24 CFR § 5.611(e)(2)

Summary: PHAs/MFH Owners must promptly notify families in writing of the change in the determination of adjusted income and the family's rent resulting from the application of the hardship exemption. The written notice must also inform the family of the dates that the hardship exemption will begin and expire and the requirement for the family to report to the PHA/MFH Owner if the circumstances that made the family eligible for relief are no longer applicable. The notice must also state that the family's adjusted income and tenant rent will be recalculated upon expiration of the hardship exemption. PHAs/MFH Owners must provide families 30 days' notice of any increase in rent.

PHAs/MFH Owners are encouraged to communicate the availability of hardship exemptions and how to request a hardship to all applicants and families prior to beginning to comply with HOTMA.

PHA/MFH Owner Discretion: None.

C.6.c Family Notification of Hardship Exemption Denial

PHAs/MFH Owners must promptly notify families in writing if they are denied either an initial hardship exemption or an additional 90-day extension of the exemption. The notification must specifically state the reason for the denial.

C.6.d Family Notification of Hardship Exemption Termination

PHAs/MFH Owners must notify the family if the hardship exemption is no longer necessary and will be terminated because the circumstances that made the family eligible for the exemption are no longer applicable. The notice must state the termination date and provide 30 days' notice of rent increase, if applicable.

Example C4: Termination of Hardship Exemption

The Olivera family is currently receiving a hardship exemption for child-care expenses. The family received an interim reexamination to decrease their earned income when an adult family member went on unpaid medical leave. The family is unable to pay rent during this time but still needs child care while the adult family member is receiving physical therapy. The family subsequently reports to the PHA/MFH Owner that the adult family member will resume employment in 3 weeks on March 23, at which point the family will no longer need the child-care hardship exemption. When the hardship exemption ends, the PHA/MFH Owner will process an interim reexamination to add the family's earned income and restart the non-hardship child-care expense deduction. The PHA/MFH Owner has a policy to consider earned income increases following an interim reexamination due to a decrease in income (see Attachment I (paragraph I.2)).

The PHA/MFH Owner must notify the family in writing that the hardship exemption will be terminated effective March 23 and provide the family with 30 days' notice of any rent increase. The family's rent increase will be effective on May 1.

C.6.e Extension of Hardship Exemption for Additional 90-Day Period(s)

PHAs/MFH Owners may at their discretion extend hardship exemptions for additional 90-day periods if the hardship continues pursuant to the PHA/MFH Owner's hardship policies. This provision applies to families receiving hardship exemptions for the child-care expenses deduction and general hardship relief for health and medical care expenses and reasonable attendant care and auxiliary apparatus expenses.

PHA/MFH Owners may extend the hardship relief for as many 90-day periods as the hardship continues to affect the family. Policies for extending hardship relief for additional 90-day periods must be established in PHAs' Administrative Plans or ACOPs, and in MFH Owners' Tenant Selection Plans.

PHAs/MFH Owners must obtain third-party verification of the family's inability to pay rent or must document in the file the reason that third-party verification was not available. PHAs/MFH Owners must attempt to obtain third-party verification prior to the end of the 90-day period.

C.7 Additional (Permissive) Deductions

Regulation: 24 CFR § 5.611(b)(1)

Summary: A PHA may, but is not required to, establish an additional deduction or deductions from a family's annual income. These deductions are also known as "permissive deductions." Note that the public housing Operating Fund formula is not

revised to account for any decrease in PHA revenue attributable to implementing permissive deductions. Likewise, the subsidy costs attributable to implementing permissive deductions will not be taken into consideration in determining the PHA's HCV renewal funding or moderate rehabilitation funding. PHAs that adopt permissive deductions are required to incorporate these policies as part of the Administrative Plan or ACOP, as applicable.

MFH Owners are not permitted to adopt permissive deductions.

PHAs can respond to community needs by establishing a wide range of permissive deductions, including permissive deductions to provide incentives for families to work. Program regulations do not specify what types of permissive deductions are allowable. PHAs operating the Public Housing program have previously adopted permissive deductions that incentivize or encourage self-sufficiency and economic mobility.

As examples, a PHA may adopt an income deduction based on the following:

- The amount earned by certain members of the family (e.g., all income earned by elderly family members, etc.);
- The amount earned by families having certain characteristics (e.g., all income earned by family members employed by nonprofit organizations, etc.);
- the amount received by families or members from guaranteed income programs offered by select states and local governments;
- The amount earned by families or members during a certain time period or from certain sources (e.g., all income earned by full-time dependent students between June-August, all income earned by family members employed by nonprofit organizations, etc.)
- The amount paid from the family's annual income, and not another source such as Medicaid or a child welfare agency, for unreimbursed health or medical expenses of a foster child or foster adult.

PHAs are still subject to federal nondiscrimination requirements, including the obligation to provide reasonable accommodations that may be necessary for households with family members with disabilities.

C.7.a. Additional (Permissive) Deductions: Public Housing Only

Regulation: 24 CFR § 5.611(b)(1)(i)

Summary: PHAs may continue to adopt additional deductions from annual income in the Public Housing program. Permissive deductions may be used to incentivize or encourage self-sufficiency and economic mobility. **A PHA that adopts such deductions will not be eligible for an increase in Capital Fund and Operating Fund formula grants based on the application of such deductions**, so the financial impact of implementing permissive deductions must be carefully evaluated. PHAs may adopt permissive deductions for Public Housing only if they have established a written policy for such deductions.

PHAs must put the total dollar amounts of any permissible deductions in column 8d and line 8e of the form HUD-50058.

PHA/MFH Owner Discretion: PHAs are not required to adopt permissive deductions, but any PHA establishing permissive deductions in the Public Housing program must create written policies in the PHA's ACOP. MFH Owners are not permitted to adopt permissive deductions.

C.7.b Additional (Permissive) Deductions: HCV and Moderate Rehabilitation Only

Regulation: 24 CFR § 5.611(b)(1)(ii)

Summary: When deciding whether to adopt a permissive deduction for the HCV program, the PHA will need to review its Housing Assistance Payments (HAP) funds utilization and projected leasing closely to ensure that enough HAP is available to support the number of families currently or planned to be leased. The costs attributable to permissive deductions will not be taken into consideration in determining the PHA's HCV renewal funding or Moderate Rehabilitation/SRO funding. A PHA must have sufficient funding to cover the increased HAP cost of the deductions.

For the HCV program, PHAs will be required to report any HAP spent on permissive deductions into VMS monthly. Additional guidance for reporting HAP spent on permissive deductions in VMS will be provided in the VMS Manual.

For Moderate Rehabilitation programs, PHAs will be required to report the additional subsidy cost as part of the Moderate Rehabilitation Year End Settlement they are currently required to submit to HUD.

Since permissive deductions will be excluded from the renewal calculation, PHAs may use outside funding to cover the cost. For example, the PHA may receive non-federal funding to cover the cost of a particular permissive deduction. This could also apply for research studies where the research director asks the PHA to exclude stipends or basic/guaranteed income amounts received during the study period, and the research study provides funding to the PHA to cover the cost.

PHA/MFH Owner Discretion: PHAs are not required to adopt permissive deductions, but any PHA establishing permissive deductions in the HCV or Moderate Rehabilitation/SRO programs must create written policies in the PHA's HCV Administrative Plans.

MFH Owners are not permitted to adopt permissive deductions.

ATTACHMENT D: TOPIC: APPLICABLE FAIR HOUSING AND CIVIL RIGHTS REQUIREMENTS

Regulations

24 CFR §§ 5.105(a), 8.6, 982.53; 28 CFR §§ 35.160 and 36.303

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

While HOTMA did not revise existing Fair Housing or Civil Rights requirements, PHAs/MFH Owners are reminded to follow all applicable nondiscrimination and equal opportunity requirements at 24 CFR § 5.105(a) and 24 CFR § 982.53, including but not limited to:

- the Fair Housing Act;
- Section 504 of the Rehabilitation Act of 1973;
- Title VI of the Civil Rights Act of 1964;
- the Age Discrimination Act;
- HUD's Equal Access Rule; and
- Title II of the Americans with Disabilities Act of 1990.

These requirements prohibit discrimination on the basis of race, color, religion, sex (including gender identity and sexual orientation), familial status, national origin, disability, age, and marital status. PHAs/MFH Owners must also comply with Title III of the Americans with Disabilities Act of 1990, as applicable (see 28 CFR part 36).

When an assisted household includes a person with disabilities, a reasonable accommodation may be necessary. A reasonable accommodation is a change, exception, or adjustment to rules, policies, practices, or services that may be necessary in order to enable an applicant or resident with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common areas, or to participate in or access programs and activities. Under Section 504, reasonable accommodations may also include a structural change to a unit, or to a public or common use area. In addition, the PHAs/MFH Owners must provide effective communication to persons with disabilities, including those with vision, hearing, and other communication-related disabilities, which includes ensuring that information is provided in appropriate accessible formats as needed (e.g., Braille, audio, large type, assistive listening devices, sign language interpreters, accessible Web sites; and other accessible electronic communications). See 24 CFR § 8.6.

PHAs/MFH Owners must also take reasonable steps to ensure meaningful access for persons with limited English proficiency (LEP). LEP guidance and LEP information is available here: https://www.federalregister.gov/documents/2007/01/22/07-217/final-guidance-tofederalfinancial-assistance-recipients-regarding-title-vi-prohibition-against.

In addition, PHAs/MFH Owners must comply with the Violence Against Women Act (VAWA), HUD's implementing VAWA regulation at 24 CFR part 5 – subpart L, and applicable program regulations.

ATTACHMENT E: TOPIC: HOUSEHOLD COMPOSITION

Regulations

24 CFR §§ 5.403; 5.603; 5.609; 891.105; and 891.520

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance), Section 202/8	Section 202/162 PAC, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes[E1]	Yes

Summary

See subtopics.

Subtopics

E.1 Definition of Family

Regulation: 24 CFR § 5.403

Summary: The final rule revises the definition of family to also include a single person who:

- Is an otherwise eligible youth who has attained at least 18 years of age and not more than 24 years of age;
- Has left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)); and
- Is homeless or is at risk of becoming homeless at age 16 or older.

The definition of "family" in the final rule incorporates revisions made to the 1937 Act by the Fostering Stable Housing Opportunities provisions of the Consolidated Appropriations Act, 2021, which expands the definition of "single persons." Due to the modification of the statute prior to this final rule, HUD is making a conforming change to 24 CFR § 5.403 to align with the new statutory language.

PHA/MFH Owner Discretion: None.

E.2 New Definitions of Foster Adult and Foster Child

Regulation: 24 CFR § 5.603

Summary: The final rule establishes definitions for "foster adult" and "foster child." A foster adult is defined as a member of the household who is 18 years or older and meets

[E1] SPRACs have a program-specific definition of Family found in paragraph 2.3 (Families to be Housed) of the SPRAC II (form HUD−93742a).

the definition of a foster adult under state law. State-level agencies define who is considered a foster adult/child, so the classification may vary from state to state.

In general, a foster adult is unable to live independently due to a debilitating physical or mental condition and is placed with the family by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

A foster child is defined as a member of the household who meets the definition of a foster child under state law. In general, a foster child is placed with the family by an authorized placement agency (e.g., public child welfare agency) or by judgment, decree, or other order of any court of competent jurisdiction.

Foster adults/children are not considered **family members** and must not be included in calculations of income for eligibility and rent determination purposes. However, foster adults/children are considered **household members** and must be included when determining unit size or subsidy standards based on established policies.

The definition of "dependent" under § 5.603 was revised to explicitly **exclude** foster children and foster adults. PHAs/MFH Owners may not provide a dependent deduction under § 5.611(a) for a foster child or foster adult. Consistent with the determination that foster adults/children are not family members, income earned by foster adults/children, payments received for the care of foster adults/children, and expenses incurred related to foster adults/children are not considered to be family income or family expenses used in the determination of annual income. Reasonable unreimbursed child-care expenses (as defined in § 5.603) for foster children under 13 years of age may be deducted from annual income if those expenses are necessary to enable a member of the family to work, look for work, or to further their education, but only if the unreimbursed child-care expense for the care of the foster child is paid from the family's annual income (and not another source, such as a stipend from a child welfare agency). PHAs may use their discretion to establish permissive deductions pursuant to 24 CFR 5.611(b) related to foster children and foster adults – for example, to allow unreimbursed health and medical expenses (defined in § 5.603) of an elderly or disabled family related to their foster child or foster adult to be deducted from annual income, so long as the expenses are paid from the elderly or disabled family's annual income (and not another source, such as a stipend from a child welfare agency). MFH Owners are not permitted to adopt permissive deductions (see section C.7 for information on permissive deductions).

Families may be eligible to continue to receive the child-care expense deduction, pursuant to a hardship exemption, when the unreimbursed child-care expense is for the care of a foster child under the age of 13, but only if the unreimbursed child-care expense for the care of the foster child is paid from the family's annual income (and not another source, such as a stipend from a child welfare agency). See Attachment C (paragraph C.5) (Child-Care Expenses Deduction and Hardship Exemption to Continue Child-Care Expenses Deduction) of this notice.

When a member of an assisted family is temporarily placed in foster care (as confirmed by the state child welfare agency), the member is still counted as a family member in the unit from which they were removed. This means that a foster child or foster adult could be considered an assisted family member in one household while also being a foster child

or adult in another household and receiving consideration in both families' voucher size and/or unit size.

PHA/MFH Owner Discretion: None.

E.3 Alignment of Family Member Definition Across Programs

Regulations: 24 CFR §§ 5.403; 5.603; and 5.609

Summary: Since approximately 2008, MFH programs have treated foster children and foster adults as family members. Effective with the final rule, foster children and foster adults will be treated as household members in MFH programs. This policy alignment is not a direct result of HOTMA but serves rather to conform MFH programs with the existing treatment of foster children/adults across other HUD programs.

HUD reminds PHAs and MFH Owners that the income and net family assets of household members are excluded when determining initial eligibility or eligibility for continued assistance; however, household members are considered for purposes of unit size and subsidy standards. For example, a live-in aide must be considered for bedroom size requirements for a unit, but their income and expenses would not be included for the purposes of income eligibility and assistance levels. Household members do not qualify for expenses or deductions, except that reasonable unreimbursed child-care expenses may be deducted for foster children under the age of 13 if it enables a member of the family to work, look for work, or go to school, and only if the unreimbursed child-care expense for the care of the foster child is paid from the family's annual income (and not another source, such as a stipend from a child welfare agency).

PHA/MFH Owner Discretion: None.

ATTACHMENT F: TOPIC: INCOME

Regulations

24 CFR §§ 5.100; 5.603; 5.603(b); 5.603(b)(3) – (b)(4); 5.609; 5.609(a)(1) – (a)(2); 5.618; 882.515(a); 882.808(i)(1); 891.105; 891.655; 960.259(c)(2); and 982.516(a)(3)

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

See subtopics.

Subtopics

F.1 Annual Income

Regulations: 24 CFR §§ 5.609(a)(1)–(a)(2); and 891.105

Summary: Annual income includes all amounts received from all sources by each member of the family who is 18 years of age or older, the head of household, or spouse of the head of household, in addition to unearned income received by or on behalf of each dependent who is under 18 years of age. Annual income does not include amounts specifically excluded in paragraph (b) of 24 CFR § 5.609. See Attachment G (Income Exclusions). All amounts received by the head of household, co-head, or spouse, including the income of a day laborer, independent contractor, and seasonal worker (see paragraphs F.2.a, F.2.b, and F.2.c, below) are included in annual income regardless of age, unless otherwise excluded in paragraph (b) of 24 CFR § 5.609.

Note: Annual income includes "all amounts received," not the amount that a family **may be** legally entitled to receive but **did not** . For example, a family's child-support or alimony income must be based on payments received, not the amounts the family is entitled to receive based on any court or agency order. A copy of a court order or other written payment agreement alone may not be sufficient verification of amounts received by a family. However, when a family member's wages or benefits are garnished, levied, or withheld[F1] to pay restitution, child support, tax debt, student loan debt, or other applicable debts, PHAs/MFH Owners must use the gross amount of the income, prior to the reduction, to determine a family's annual income.

[F1] See: https://www.dol.gov/general/topic/wages/garnishments and https://faq.ssa.gov/en-us/Topic/article/KA-01873.

Annual income also includes all actual anticipated income from assets even if the asset is excluded from net family assets but the income from the asset is not otherwise excluded. Imputed returns on net family assets are included in annual income only when net family assets exceed $50,000 (a figure that is annually adjusted for inflation) and actual asset income cannot be calculated for all assets (see F.6.b, below, for a discussion of scenarios where income can be calculated for some but not all assets). PHAs/MFH Owners will not impute income from assets if the total value of net family assets is equal to or less than $50,000 (as adjusted by inflation). See paragraph F.4.a (Determining Net Family Assets), below, for the definition of net family assets and paragraph F.6 (Actual and Imputed Income from Assets).

PHA/MFH Owner Discretion: None.

F.2 Earned Income

Regulation: 24 CFR § 5.100

Summary: Earned Income is defined as income or earnings from wages, tips, salaries, other employee compensation, and net income from self-employment. Earned income does not include any pension or annuity, transfer payments (meaning payments made or income received in which no goods or services are being paid for, such as welfare assistance, Social Security, and other governmental subsidies/benefits), or any cash or in-kind benefits.

PHA/MFH Owner Discretion: None.

F.2.a Definition of Day Laborer

Regulation: 24 CFR § 5.603(b)

Summary: A day laborer is defined as an individual hired and paid one day at a time without an agreement that the individual will be hired or work again in the future.

Income earned as a day laborer is not considered nonrecurring income under 24 CFR § 5.609(b)(24) (see Attachment G (paragraph G.1) (Nonrecurring Income) of this notice) and must be included, unless specifically excluded in 24 CFR § 5.609(b) (e.g., earnings of full-time students in excess of the dependent deduction (24 CFR §§ 5.609(b)(3), (b)(14), etc.).

PHA/MFH Owner Discretion: None.

F.2.b Definition of Independent Contractor

Regulation: 24 CFR § 5.603(b)

Summary: An independent contractor is an individual who qualifies as an independent contractor instead of an employee in accordance with the Internal Revenue Code federal income tax requirements and whose earnings are consequently subject to the self-employment tax.

In general, an individual is an independent contractor if they have the right to control or direct only the conduct of the work. For example, while instructions and route information are generally provided, third-party delivery and

transportation service providers are considered independent contractors unless state law dictates otherwise. In addition, individuals considered "gig workers," such as babysitters, landscapers, rideshare drivers, and house cleaners, typically fall into the category of independent contractor.

Income earned as an independent contractor is not considered nonrecurring income (see Attachment G (paragraph G.1) (Nonrecurring Income)) and must be included unless specifically excluded in 24 CFR § 5.609(b) (e.g., 24 CFR §§ 5.609(b)(3), (b)(14), etc.).

PHA/MFH Owner Discretion: None.

F.2.c Definition of Seasonal Worker

Regulation: 24 CFR § 5.603(b)

Summary: A seasonal worker is defined as an individual who is: 1) hired into a short-term position (e.g., for which the customary employment period for the position is 6 months or fewer); and 2) the employment begins about the same time each year (such as summer or winter). Typically, the individual is hired to address seasonal demands that arise for the employer or industry.

Some examples of seasonal work include employment limited to holidays or agricultural seasons. Seasonal work may include but is not limited to employment as a lifeguard, ballpark vendor, or snowplow driver.

Income earned as a seasonal worker is not considered nonrecurring income (see Attachment G (paragraph G.1) (Nonrecurring Income)) and must be included unless specifically excluded in 24 CFR § 5.609(b) (e.g., § 5.609(b)(14), etc.).

PHA/MFH Owner Discretion: None.

F.3 Definition of Unearned Income

Regulation: 24 CFR § 5.100

Summary: Unearned income means any annual income, as calculated under 24 CFR § 5.609, that is not earned income.

PHA/MFH Owner Discretion: None.

F.4 Assets

Asset requirements in 24 CFR §§ 5.603 and 5.609 apply to HCV (including Project-Based Vouchers and all special purpose vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO, and MFH programs.

F.4.a Determining Net Family Assets

Regulations: 24 CFR §§ 5.100 and 5.603

Summary: Net family assets are defined as the net cash value of **all assets owned by the family**, after deducting reasonable costs that would be incurred in disposing of real property, savings, stocks, bonds, and other forms of investment, except as excluded (see Attachment F (paragraph F.4.b) (Exclusions from Net Family Assets) of this notice).

Assets with negative equity. The cash value of real property[F2] or other assets with negative equity would be considered $0 for the purposes of calculating net family assets. Negative equity in real property or other investments does not prohibit the family from selling the property or other investments, so negative equity alone would not justify excluding the property or other investments from family assets.

Assets disposed of for less than fair market value. In determining the value of net family assets, PHAs/MFH Owners must include the value of any business or family assets disposed of by an applicant or tenant for less than fair market value (including a disposition in trust,[F3] but not in a foreclosure or bankruptcy sale) during the two years preceding the date of application for the program or reexamination, as applicable, in excess of the consideration received.

For example, if a family gave away a home with a net value of $80,000, the value of the home must be included in the calculation of net family assets for two years following the transfer of property. If a family sold a home for less than fair market value, the difference between the value and the amount for which they sold it would be included in net family assets for two years following the transfer of property. For example, if a family sold a property with a fair market value of $80,000 to a friend for $20,000, then the difference in value ($60,000) minus the cost to dispose of the property ($10,000), which is in this example totals $50,000, would be counted in net family assets for two years from the date of the property's transfer to the other party.

An asset moved to a retirement account held by a member of the family is not considered to be an asset disposed of for less than fair market value. In the case of a disposition as part of a separation or divorce settlement, the disposition will not be considered less than fair market value if the applicant or tenant receives consideration not measurable in dollar terms.

Asset owned by business entity. If a business entity (e.g., limited liability company or limited partnership) owns the asset, then the family's asset is their ownership stake in the business, not some portion of the business's assets. However, if the family holds the assets in their own name (e.g., they own one-third of a restaurant) rather than in the name of a business entity, then the percentage value of the asset owned by the family is what is counted toward net family assets (e.g., one-third of the value of the restaurant).

Jointly owned assets. For assets jointly owned by the family and one or more individuals outside of the assisted family, PHAs/MFH Owners must include the total value of the asset in the calculation of net family assets, unless the asset is otherwise excluded (see F.4.b of this notice), or unless the assisted family can demonstrate that the asset is inaccessible to them, or that they cannot dispose of

[F2] Real property, as used in 24 CFR Part 5, has the same meaning as that provided under the state law in which the real property is located.

[F3] A disposition in trust is when the family creates a trust for the benefit of someone outside of the assisted family. It would not be considered an asset disposed of for less than fair market value if the family establishes a nonrevocable trust for the benefit of someone in the assisted family.

any portion of the asset without the consent of another owner who refuses to comply. If the family demonstrates that they can only access a portion of an asset, then only that portion's value shall be included in the calculation of net family assets for the family. Likewise, any income from a jointly owned asset must be included in annual income, unless that income is specifically excluded (see Attachment G), or unless the family demonstrates that they do not have access to the income from that asset, or that they only have access to a portion of the income from that asset.

If an individual is a beneficiary who is entitled to access the account's funds only upon the death of the account's owner, and may not otherwise withdraw funds from an account, then the account is not an asset to the assisted family, and the family should provide proper documentation demonstrating that they are only a beneficiary on the account.

PHA/MFH Owner Discretion: None.

F.4.b Exclusions from Net Family Assets

Regulations: 24 CFR § 5.603(b)(3)–(b)(4)

Required exclusions from net family assets include the following:

- The value of necessary items of personal property. (See paragraph F.4.c (Necessary and Non-Necessary Personal Property) of this notice.)
- The value of all non-necessary items of personal property with a total combined value of $50,000 or less, annually adjusted for inflation. (See paragraph F.4.c (Necessary and Non-Necessary Personal Property) of this notice.)
- The value of any account under a retirement plan recognized as such by the Internal Revenue Service, including Individual Retirement Accounts (IRAs), employer retirement plans (e.g., 401(k), 403(b)), and retirement plans for self-employed individuals.
- The value of real property that the family does not have the effective legal authority to sell in the jurisdiction in which the property is located. Examples of this include but are not limited to: co-ownership situations (including situations where one owner is a victim of domestic violence), where one party cannot unilaterally sell the real property; property that is tied up in litigation; inherited property in dispute.
- Any amounts recovered in any civil action or settlement based on a claim of malpractice, negligence, or other breach of duty owed to a family member arising out of law that resulted in a member of the family being a person with disabilities.
- The value of any Coverdell education savings account under section 530 of the Internal Revenue Code of 1986; the value of any qualified tuition program under section 529 of such Code; and the amounts in, contributions to, and

distributions from any Achieving a Better Life Experience (ABLE) account authorized under section 529A of such code.

- The value of any "baby bond" account created, authorized, or funded by the federal, state, or local government (money held in trust by the government for children until they are adults).
- Interests in Indian trust land.
- Equity in a manufactured home where the family receives assistance under 24 CFR Part 982.
- Equity in property under the Homeownership Option for which a family receives assistance under 24 CFR Part 982.
- Family Self-Sufficiency accounts.
- Federal tax refunds or refundable tax credits for a period of 12 months after receipt by the family.
- The full amount of assets held in an irrevocable trust. (See paragraph F.4.d (Trusts) of this notice.)
- The full amount of assets held in a revocable trust where a member of the family is the beneficiary, but the grantor/owner and trustee of the trust is not a member of the participant family or household. (See paragraph F.4.d (Trusts) of this notice)

PHA/MFH Owner Discretion: PHAs/MFH Owners may need to revise application forms, interview guides and individual verification forms to ensure that they are gathering adequate information to make appropriate asset exclusion determinations.

F.4.c Necessary and Non-Necessary Personal Property

Regulation: 24 CFR § 5.603

Summary: Necessary personal property is excluded from net family assets. Non-necessary personal property with a combined value greater than $50,000, as adjusted by inflation, is considered part of net family assets. When the combined value of all non-necessary personal property does not exceed $50,000, as adjusted by inflation, all non-necessary personal property is excluded from net family assets.

All assets are categorized as either real property (e.g., land, a home) or personal property. Personal property includes tangible items, like boats, as well as intangible items, like bank accounts. For example, a family could have non-necessary personal property with a combined value that does not exceed $50,000 but also own real property such as a parcel of land. Even though the non-necessary personal property would be excluded from net family assets, the real property would be included in net family assets regardless of its value unless the real property meets a different exclusion under 24 CFR § 5.603.

Necessary personal property are items essential to the family for the maintenance, use, and occupancy of the premises as a home; or they are necessary for employment, education, or health and wellness. Necessary personal property includes more than merely items that are indispensable to the bare existence of the family. It may include personal effects (such as items that are ordinarily worn or utilized by the individual), items that are convenient or useful to a reasonable existence, and items that support and facilitate daily life within the family's home. Necessary personal property also includes items that assist a household member with a disability, including any items related to disability-related needs, or that may be required for a reasonable accommodation for a person with a disability. Necessary personal property does not include bank accounts, other financial investments, or luxury items.

Determining what is a necessary item of personal property is a highly fact-specific determination, and therefore it is incumbent on PHAs/MFH Owners to gather enough facts to qualify whether an asset is necessary or non-necessary personal property.

Items of personal property that do not qualify as necessary personal property will be classified as non-necessary personal property.

The following table lists examples of necessary and non-necessary personal property. **This is not an exhaustive list.**

Table F1: Examples of Necessary and Non-Necessary Personal Property

Necessary Personal Property	Non-Necessary Personal Property
• Car(s)/vehicle(s) that a family relies on for transportation for personal or business use (e.g., bike, motorcycle, skateboard, scooter) • Furniture, carpets, linens, kitchenware • Common appliances • Common electronics (e.g., radio, television, DVD player, gaming system) • Clothing • Personal effects that are not luxury items (e.g., toys, books) • Wedding and engagement rings • Jewelry used in religious/cultural celebrations and ceremonies • Religious and cultural items • Medical equipment and supplies • Health care–related supplies • Musical instruments used by the family	• Recreational car/vehicle not needed for day-to-day transportation (campers, motorhomes, travel trailers, all-terrain vehicles (ATVs)) • Bank accounts or other financial investments (e.g., checking account, savings account, stocks/bonds) • Recreational boat/watercraft • Expensive jewelry without religious or cultural value, or which does not hold family significance • Collectibles (e.g., coins/stamps) • Equipment/machinery that is not used to generate income for a business • Items such as gems/precious metals, antique cars, artwork, etc.

• Personal computers, phones, tablets, and related equipment • Professional tools of trade of the family, for example professional books • Educational materials and equipment used by the family, including equipment to accommodate persons with disabilities • Equipment used for exercising (e.g., treadmill, stationary bike, kayak, paddleboard, ski equipment)	

Example F1: Necessary and Non-Necessary Personal Property

The Cross family owns three items of personal property. The family has a checking account valued at $5,000, a $15,000 recreational boat, and Ms. Cross's $3,000 engagement ring.

The checking account and recreational boat are both considered non-necessary personal property. They are worth a combined $20,000. The engagement ring is considered necessary personal property, because it is jewelry used in a religious/cultural celebration or ceremony. Since the total value of non-necessary personal property is less than $50,000, the family's non-necessary personal property will not be considered when calculating the Cross family's net family assets.

Cross Family's Personal Property

Item	Estimated Value	Type	Amount to be considered as non-necessary personal property
Checking account	$5,000	Non-necessary Personal Property	$5,000
Ring (engagement ring)	$3,000	Necessary Personal Property	$0
Recreational boat	$15,000	Non-necessary Personal Property	$15,000
		Total Non-necessary Personal Property:	$20,000

Calculation of Cross Family's Total Net Assets

Asset	Total to be Considered in Net Family Assets
Non-necessary Personal Property	$0
Real Property	$0
Total:	$0

The Cross family's total net family assets are $0.

PHA/MFH Owner Discretion: None.

F.4.d Trusts

Regulations: 24 CFR §§ 5.603 and 5.609

Summary: Whether the value of a trust counts as a net family asset and whether distributions from the trust count as annual income to the family depends on the following three factors:

- Whether the trust is under the control of the family;
- Whether distributions are made from the trust's principal; and

- The purpose of the distribution, if the distribution is made from income earned on the trust's principal.

F.4.d.i Trusts as Net Family Assets

The value of irrevocable trusts and revocable trusts that are not under the control of the family are both excluded from net family assets.

The distinguishing feature of a revocable trust is that the grantor can terminate and/or amend the trust at any time for any reason before his or her death. In circumstances when a member of the assisted family is the beneficiary of a revocable trust, but the grantor is not a member of the assisted family, the beneficiary does not "own" the revocable trust, and the value of the trust is excluded from net family assets. For the revocable trust to be considered excluded from net family assets, no family or household member may be the account's trustee.

A revocable trust that is under the control of the family or household (e.g., the grantor is a member of the assisted family or household) **is** included in net family assets, and, therefore, income earned on the trust is included in the family's income from assets. This also means that PHAs/MFH Owners will calculate imputed income on the revocable trust if net family assets are more than $50,000, as adjusted by inflation, and actual income from the trust cannot be calculated (e.g., if the trust is comprised of farmland that is not in use).

F.4.d.ii Actual Income from a Trust

If the PHA/MFH Owner determines that the revocable trust is included in the calculation of net family assets, then the actual income earned by the revocable trust is also included in the family's income.

Where an irrevocable trust is excluded from net family assets, the PHA/MFH Owner must not consider actual income earned by the trust (e.g., interest earned, rental income if property is held in the trust) for so long as the income from the trust is not distributed.

F.4.d.iii Trust Distributions and Annual Income

- **Revocable trust considered part of net family assets:** If the value of the trust is considered part of the family's net assets, then distributions from the trust are not considered income to the family.
- **Revocable or irrevocable trust not considered part of net family assets:** If the value of the trust is not considered part of the family's net assets, then distributions from the trust are treated as follows:
  - All distributions from the trust's principal are excluded from income.
  - Distributions of income earned by the trust (i.e., interest, dividends, realized gains, or other earnings on the trust's

principal), are included as income unless the distribution is used to pay for the health and medical expenses for a minor.

Table F2 below is a tool to assist PHAs/MFH Owners in determining whether a trust should be considered a net family asset and/or whether a trust's earned interest or distributions are considered income to the family.

Table F2: Annual Income/Net Family Assets Scenarios based on Trust Type

Trust Type	Is the trust considered a net family asset?	Is the actual interest earned by the trust considered family income?	Are distributions of trust principal considered family income?	Are distributions of interest earned on the trust principal considered family income?
Revocable Grantor is not part of the assisted family or household (and the family or household is not otherwise in control of the trust)	No	No	No	Yes, unless the distributions are used to pay for the health and medical expenses for a minor
Revocable Grantor is part of the assisted family or household (or the trust is otherwise under the control of the family or household)	Yes	Yes	No	No
Irrevocable (Typically, Special Needs Trusts are irrevocable.)	No	No	No	Yes, unless the distributions are used to pay for the health and medical expenses for a minor

PHAs/MFH Owners must be careful to distinguish between distributions of principal and distributions of earnings on a trust's principal when verifying family income from irrevocable trusts and revocable trusts where the grantor is not part of the assisted family or household, so as not to unintentionally include distributions of principal that are not considered income.

Note: The policy implemented under HOTMA is a change from the previous policies of both PIH and MFH. Previously, PIH considered all distributions of principal or income earned on the principal as income unless the distribution qualified as an income exclusion. In determining whether a distribution from a trust should be counted as income to the beneficiary, MFH considered how the

trust was funded, whether the distribution was from trust income or principal, and whether any distribution from trust income met an existing income exclusion. The policy under HOTMA aligns the policies of MFH and PIH and clarifies that the term "income" means "trust income" and not **any** distribution from the trust to the beneficiary.

PHA/MFH Owner Discretion: None.

F.4.e Federal Tax Refunds or Refundable Tax Credits

Regulation: 24 CFR § 5.603

Summary: All amounts received by a family in the form of federal tax refunds or refundable tax credits are excluded from a family's net family assets for a period of 12 months after receipt by the family.

Taxpayers have several options for receiving their tax refunds: via paper check or direct deposit into a checking or savings account; via TreasuryDirect to buy savings bonds; via direct deposit into a Traditional, Roth, or Simplified Employee Pension Plan-IRA; or via purchase of savings bonds, a Health Savings Account, an Archer Medical Savings Account, or a Coverdell Education Savings Account. Refundable tax credits, such as the Earned Income Tax Credit (EITC), are determined as part of an overall tax return submission to the Internal Revenue Service (IRS). Taxpayers receive one federal tax refund reflecting the taxpayer's tax liability, if negative, including any applicable refundable tax credits.

At the time of an annual or interim reexamination of income, if the federal tax refund was received during the 12 months preceding the effective date of the reexamination, then the amount of the refund that was received by the family is subtracted from the total value of net family assets. When the subtraction results in a negative number, then net family assets are considered $0.

Note: Only the amount that the family receives is excluded from net family assets. For example, if a family anticipates a $500 federal tax refund but only receives $250, then only $250 will be excluded from the net family assets because that is the amount that the family received.

PHAs/MFH Owners are not required to verify the amount of the family's federal tax refund or refundable tax credit(s) if the family's net assets are equal to or below $50,000 (adjusted annually for inflation), even in years when full verification of assets is required or if the PHA/MFH owner does not accept self-certification of assets. PHAs/MFH Owner must verify the amount of the family's federal tax refund or refundable tax credits if the family's net assets are greater than $50,000.

The anticipated income earned by the assets in which a family has deposited their federal tax refund or refundable tax credits must be included in the family's annual income unless the income is specifically excluded under 24 CFR § 5.609(b).

Example F2: Federal Tax Refund Excluded from Net Family Assets

The Rodriguez family received a $4,500 federal tax refund on 3/1/2024 and deposited the refund into their checking account. At their next annual reexamination with an effective date of 8/1/2024, the PHA/MFH Owner asks the family about any assets they own, the anticipated income from the assets, and if they received a federal tax refund or refundable tax credits in the past 12 months and where they deposited the refund/refundable tax credits or if they purchased savings bonds with the refund.

The Rodriguez family explain that they received a $4,500 refund and that they deposited the refund into their checking account, which has a balance of $10,000. The Rodriguez family reports that they have actual income of $100 from the checking account this year. The family owns no other assets. Therefore, the family's total calculation of net family assets is $10,000. In determining the total value of net family assets, the PHA/MFH Owner subtracts $4,500 from the total of $10,000 of net family assets, for a total countable asset of $5,500. The full value of actual income is included as income, because actual income is always included even on excluded assets.

F.4.f Net Family Assets Examples

In some cases, amounts that are excluded from net family assets may be included as annual income when disbursements are made to a family from an asset. In other cases, amounts are excluded from annual income as a lump-sum addition to net family assets, but those funds are then considered a net family asset if held in an account or other investment that is considered part of net family assets. These concepts are illustrated in the three examples below.

Example F3: Retirement Accounts

Background: The value of any account under a retirement plan recognized by the Internal Revenue Service, including IRAs, employer retirement plans, and retirement plans for self-employed individuals, is not considered in determining net family assets. Any income earned on the funds while stored in such a retirement account is not considered actual income from assets. However, any distribution of periodic payments from the retirement account is considered income at the time it is received by the family (§ 5.609(b)(26)).

Scenario

Prior quarter ending balance of 401(k) account: $157,500

Prior quarter yield: 5 percent ($7,500)

Distributions made to family: $12,000 in prior year, same amount is anticipated to be received this year.

Result: In this example, the family's income reexamination will not include the 401(k), because the value of the 401(k) and the earnings will be considered neither net family assets nor income to the family; however, the family's income reexamination will include the $12,000 in distributions (unearned income) which has been paid from the retirement account in increments of $1,000 monthly to the family.

Example F4: Civil Rights Settlements

Background: A civil rights settlement, regardless of how the settlement is paid (lump sum or several distributions), is excluded from annual income; however, the amounts would be considered part of net family assets, if held in a savings account, revocable trust, or in some other asset that is not excluded from the definition of net family assets.

Scenario

Jessica receives a civil rights settlement in the amount of $20,000, because she was not provided a reasonable accommodation. Jessica deposits the $20,000 into her savings account, which already contains $5,000, and earns 0.5 percent interest annually.

Total civil rights settlement received: $20,000 (excluded from income under § 5.609(b)(25))

Value of savings account: $25,000 (which includes the $20,000 settlement)

Actual income earned from savings account: $25,000 x 0.005 = $125 included in annual income

Result: In this example, the family's income reexamination will not include the amount received from the civil rights settlement, because the funds are not considered income under § 5.609(b)(25). However, the value of the savings account where the settlement was deposited will be used in the calculation of net family assets, and the actual income earned from interest accrual (as self-certified by the family) will be included in the family's annual income.

Example F5: Life Insurance

Background: The cash value of life insurance policies that are available to the participant before death are included in net family assets (e.g., the surrender value of a whole life policy or a universal life policy). Net family assets will not include the value of term life insurance, which has no cash value to the individual before death.

Scenario A: The Johnson family has a whole life insurance policy with a face value of $100,000 and a surrender value of $30,000. Net family assets will include $30,000 for the life insurance policy. The Johnson's family policy also pays an annual dividend of $100. This will be included as actual income.

Scenario B: The Dexter family has a term life insurance policy with a face value of $100,000 payable upon death. The total amount included in the family's net family assets for this insurance policy will be $0.

F.5 Passbook Rate

Regulation: 24 CFR § 5.609(a)(2)

Summary: HUD will annually publish a passbook rate based on the Federal Deposit Insurance Corporation (FDIC) National Deposit Rate for savings accounts, which is an average of national savings rates published on a monthly basis. PHAs/MFH Owners must use the HUD-published passbook rate when calculating imputed asset income for net family assets that exceed $50,000 (a figure that is annually adjusted for inflation). The HUD-published passbook rate will be posted to a dataset on the HUD User Web site, alongside annual inflationary adjustments (see Attachment H).

To determine the passbook rate for the next calendar year, HUD will average the most recent three months of FDIC updates to the National Deposit Rate for savings accounts, rounded to the nearest hundredth of 1 percent. In order to ensure updated passbook rates may be used for reexaminations with an effective date of January 1, HUD will calculate the update in July each year, using FDIC data from April, May, and June for publication on HUD User not later than September 1.

For 2024, the passbook rate will be 0.40 percent. Below is an explanation of how the passbook rate was calculated for 2024. For reexaminations that occur after January 1, 2024, but before the date on which the PHA/MFH Owner implements the new passbook rate, PHAs may continue to set their own passbook rates, and MFH Owners must continue to use the 0.06 percent passbook rate. PHAs may also choose to implement the 2024 HUD passbook rate before complying with HOTMA as they have the flexibility to set their own passbook rate.

Table F3: Calculation of Passbook Rate for 2024

FDIC Monthly Update, Date of Publication	National Deposit Rate, Savings Accounts
4/17/2023	0.39 percent
5/15/2023	0.40 percent
6/20/2023	0.42 percent
HUD Passbook Rate (average of 3 months of FDIC National Deposit Rates)	**0.40 percent**

PHA/MFH Owner Discretion: None. PHAs were previously permitted to set their own passbook rates within a HUD-published range; effective with the final rule, PHAs/MFH Owners will be required to use the HUD-published passbook rate. The final rule supersedes Notice H 2016–01 (Passbook Saving Rate Effective February 1, 2016).

F.6 Actual and Imputed Income from Assets

Regulation: 24 CFR § 5.609(a)(2)

Summary: Actual income and imputed income are treated as described below.

F.6.a Actual Income

Actual income from assets is always included in a family's annual income, regardless of the total value of net family assets or whether the asset itself is included or excluded from net family assets, unless that income is specifically excluded by 24 CFR § 5.609(b).

Income or returns from assets are generally considered to be interest, dividend payments, and other actual income earned on the asset, and not the increase in market value of the asset. The increase in market value is relevant to the cash value of the asset for the purpose of determining total net family assets and imputing income.

The following examples illustrate how to calculate actual income from assets.

Example F6: Actual Asset Income from an Asset Excluded from Net Family Assets

Background: Eugene Park owns a checking account with $3,500 that earns 0 percent interest. He also has a savings account with a balance of $10,000 for which he expects to earn $300 in annual interest. Mr. Park has no other assets. Because those assets are classified as non-necessary personal property, and their combined value of $13,500 does not exceed $50,000, the combined value of all non-necessary personal property is excluded from the calculation of net family assets (see paragraph F.4.c (Necessary and Non-Necessary Personal Property) of this notice). The total value of Eugene Park's net family assets is $0, and $300 is included in annual income.

Scenario

Total value of assets: $3,500 + $10,000 = $13,500

Net family assets: $0.00 (total value of assets is less than $50,000, therefore the value is excluded from net family assets)

Result: Actual income from assets (must be included in the calculation of annual income for Eugene Park): $300 ($0 from checking account + $300 from savings account)

Example F7: Calculating Net Family Assets and Actual Asset Income when Net Family Assets Exceed $50,000 (As Adjusted)

Background: Sherry McNeil received a federal tax refund of $1,200 and deposited the refund into her checking account. At the time of her annual reexamination six months later, the account had a balance of $10,000 and earns 0-percent interest. Sherry also owns a stock portfolio with a verified value of $45,000. The stocks earned $405 in cash dividends last year, which Sherry expects to earn again in the coming year.
Scenario Total value of assets: $55,000 ($10,000 + $45,000) Net family assets: $53,800 ($55,000 – $1200) (tax refund received in the last 12 months is excluded from net family assets under § 5.603(b)(3)(xi).) Because the total value of Sherry's non-excluded assets exceeds $50,000, this value ($53,800) is included as net family assets and must be confirmed via third-party verification. Actual Income from Checking Account: $0 earned ($10,000 x 0 percent) Actual Income from Stock Portfolio: $405 earned in dividends last year on $45,000
Result: Total actual income from assets (must be included in the calculation of annual income for Sherry McNeil): $405 ($0 + $405)

F.6.b Imputed Income

Imputed income from assets is no longer determined based on the greater of actual or imputed income from the assets. Instead, imputed asset income must be calculated for specific assets when three conditions are met:

- The value of net family assets exceeds $50,000 (as adjusted for inflation);
- The specific asset is included in net family assets; and
- Actual asset income cannot be calculated for the specific asset.

Imputed asset income is calculated by multiplying the net cash value of the asset, after deducting reasonable costs that would be incurred in disposing of the asset, by the HUD-published passbook rate (see Table F3 above). If the actual income from assets can be computed for some assets but not all assets, then PHAs/MFH Owners must add up the actual income from the assets, where actual income can be calculated, then calculate the imputed income for the assets where actual income could not be calculated. After the PHA/MFH owner has calculated both the actual income and imputed income, the housing provider must combine both amounts to account for income on net family assets with a combined value of over $50,000.

When the family's net family assets do not exceed $50,000 (as adjusted for inflation), imputed income is not calculated. Imputed asset income is never calculated on assets that are excluded from net family assets. When actual income for an asset — which can equal $0 — can be calculated, imputed income is not calculated for that asset.

Example F8: Combining Actual and Imputed Asset Income

Background: The Jorgensen family owns a small piece of vacant land with a cash value of $25,000. The family also owns a savings account with a verified balance of $55,000, with an interest rate of 0 percent. The family's total net assets are $80,000. The PHA/MFH Owner can calculate the actual income of the savings account as $0, as seen below. The PHA/MFH Owner is unable to calculate the actual income earned for the property owned by the family, because the property neither generates any income for them nor could an income amount be computed as a matter of interest or dividend earnings. Therefore, imputed asset income for the real property must be calculated. The passbook savings rate in effect is 0.10 percent.
Scenario Actual Income from savings account: $55,000 x 0 percent = $0 actual income of savings account Imputed income from family's property: $25,000 x 0.001= $25 imputed income
Result: Total asset income (must be included in the calculation of annual income for the Jorgensen family): $25 ($0 + $25)

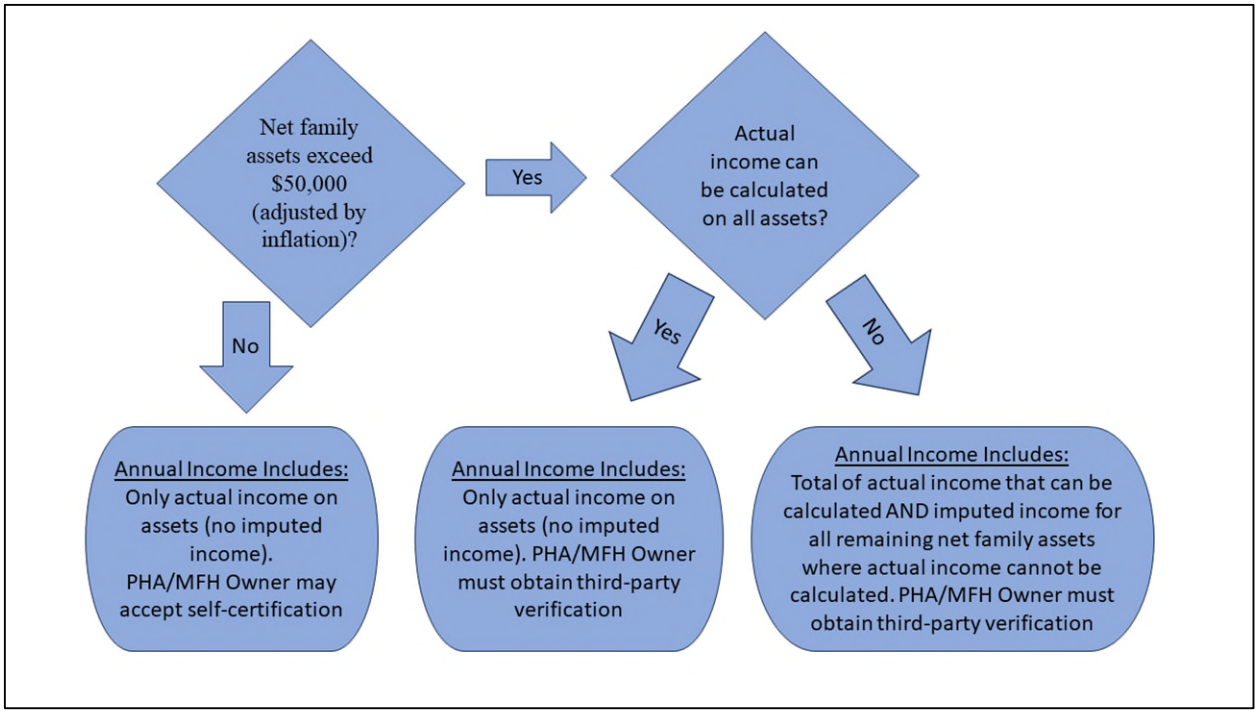
PHAs/MFH Owners should not conflate an asset with an actual return of $0 (as in the example above), with an asset for which an actual return cannot be computed, such as could be the case for some non-financial assets that are items of non-necessary personal property. If the asset is a financial asset and there is no income generated (for example, a bank account with a 0 percent interest rate or a stock that does not issue cash dividends), then the asset generates zero actual asset income, and imputed income is not calculated. When a stock issues dividends in some years but not others (e.g., due to market performance), the dividend is counted as the actual return when it is issued, and when no dividend is issued, the actual return is $0. When the stock never issues dividends, the actual return is consistently $0.

Example F9: Imputing Income when Actual Income Cannot Be Calculated

Background: The Conrad family owns a recreational boat with a Kelley Blue Book value of $15,000. They also own a checking account with $10,000 that earns 0 percent interest and a savings account with $30,000 that earns 3 percent interest, putting their net family assets value at $55,000. No actual returns on the boat can be computed, however actual income can be calculated for the savings account. The passbook savings rate in effect is 0.10 percent.
Scenario Actual income from assets: $900 (($10,000 x 0 percent) + ($30,000 x 0.03)) Imputed income from assets: $15 ($15,000 x 0.001)
Result: Total income from assets (must be included in the calculation of annual income for the Conrad family): $915 ($900 + $15)

The following chart illustrates different net family asset scenarios and whether to include actual and/or imputed assets in the family's annual income determination.

Chart F1: Decision Chart for Determining Income from Assets



PHA/MFH Owner Discretion: None.

F.7 Self-Certification of Net Family Assets Equal to or Less Than $50,000 (as adjusted for inflation)

Regulations: 24 CFR §§ 5.603; 5.609; 5.618; 5.659(e); 882.515(a); 882.808(i)(1); 891.105; 891.655; 960.259(c)(2); and 982.516(a)(3)

Summary: PHAs/MFH Owners may determine net family assets based on a self-certification by the family that the family's total assets are equal to or less than $50,000, adjusted annually for inflation, without taking additional steps to verify the accuracy of the declaration at admission and/or reexamination. PHAs/MFH Owners are not required to obtain third-party verification of assets if they accept the family's self-certification of net family assets. When PHAs/MFH Owners accept self-certification of net family assets at reexamination[F4], the PHA/MFH Owner must fully verify the family's assets every three years.

PHAs/MFH Owners may follow a pattern of relying on self-certification for two years in a row and fully verifying assets in the third year.

The family's self-certification must state the amount of income the family anticipates receiving from such assets. The actual income declared by the family must be included in the family's income, unless specifically excluded from income under 24 CFR § 5.609(b). PHAs/MFH Owners must clarify, during the self-certification process, which assets are included/excluded from net family assets.

[F4] See 24 CFR § 5.659(e); 960.259(c)(2); 982.516(a)(3).

PHAs/MFH Owners may combine the self-certification of net family assets and questions inquiring about a family's present ownership interest in any real property into one form.

Example F10: Self-Certification of Net Family Assets

We know from Example F1 that the Cross family's net family assets are $0. In this case, the checking account earns 0.07 percent interest annually.

Cross Family's Personal Property

Item	Estimated Value	Type	Amount to be Considered as Non-Necessary Personal Property
Checking account	$5,000	Non-necessary personal property	$5,000
Ring (engagement ring)	$3,000	Necessary personal property	$0
Recreational boat	$15,000	Non-necessary personal property	$15,000
		Total Non-necessary personal property	$20,000

Calculation of Cross Family's Total Net Assets

Asset	Total to be considered in Net Family Assets	Anticipated Income
Non-necessary Personal Property (Checking Account)	$0	$3.50
Real Property	N/A	N/A
Total:	**$0**	**$3.50**

The PHA/MFH Owner may accept a self-certification of assets from the Cross family if the PHA/MFH Owner has a policy to do so (see paragraph below this example for PHA/MFH Owner Discretion on accepting self-certification). The self-certification must include any anticipated income from assets. In this example, if the PHA/MFH Owner is accepting a self-certification of assets, then the calculations above would not need to be included on the self-certification form. Only the total anticipated income from assets must be included on the form.

Note that in this instance, even though the checking account is excluded from the calculation of net family assets (because the combined value of non-necessary personal property does not exceed $50,000), the family must report actual asset income from the checking account (in this case, $3.50).

PHA/MFH Owner Discretion: PHAs/MFH Owners are not required to adopt a policy to allow for self-certification of net family assets for families with net family assets that are equal to or below $50,000, adjusted annually for inflation. PHAs/MFH Owners who choose not to accept self-certifications of assets must verify all families' assets on an

annual basis. Third-party verification of assets is required when net family assets exceed $50,000, adjusted annually by HUD.

Accepting a family's self-certification at admission may reduce the initial burden on applicants and speed up the lease-up process. In deciding whether to accept a self-certification of assets at admission, PHAs/MFH Owners are encouraged to consider the local needs and priorities in their communities along with the potential risks of accepting self-certification of net family assets, including the requirement to repay funds for participants/tenants who are later found to be ineligible for assistance.

PHAs/MFH Owners must include in their ACOPs, Administrative Plans, or Tenant Selection Plans, as applicable, whether and when they accept a self-certification of assets equal to or less than $50,000, which amount will be adjusted annually by HUD. See Attachment H (Inflationary Adjustments) of this notice for more information.

ATTACHMENT G: TOPIC: INCOME EXCLUSIONS

Regulations

24 CFR §§ 5.609(b)(4)–(5); 5.609(b)(7)–(10); 5.609(b)(14)–(15); 5.609(b)(17); 5.609(b)(19)–(24); 5.609(b)(24)(i)–(vii); 5.609(b)(25); 5.609(b)(27)–(28); 5.611; 891.105 and 891.655

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

The section below provides descriptions and clarifying information for new and updated income exclusions referenced in 24 CFR § 5.609(b). Please note that this section does not address all income exclusions listed in 24 CFR § 5.609(b) but only those that are newly added or updated by the final rule.

PHAs/MFH Owners must revise their interview guides and individual verification forms to ensure that adequate information will be collected to make appropriate income exclusion determinations.

Subtopics

G.1 Nonrecurring Income

Regulation: 24 CFR §§ 5.609(b)(24) and CFR 891.105

Summary: The nonrecurring income exclusion replaces the former exclusion for temporary, nonrecurring, and sporadic income (including gifts), but it provides a narrower definition of excluded income in contrast to the former broad exclusion of temporary, nonrecurring, or sporadic income.

Income that will not be repeated beyond the coming year (i.e., the 12 months following the effective date of the certification), based on information provided by the family, is considered nonrecurring income and is excluded from annual income. However, income received as an independent contractor, day laborer, or seasonal worker is not excluded from income under § 5.609(b)(24), even if the source, date, or amount of the income varies.

Income that has a discrete end date and will not be repeated beyond the coming year during the family's upcoming annual reexamination period will be excluded from a family's annual income as nonrecurring income. This does not include unemployment income and other types of periodic payments that are received at regular intervals (such as weekly, monthly, or yearly) for a period of greater than one year that can be extended. For example, an increasing number of cities and states are piloting guaranteed income

programs that have discrete beginning and end dates. This income can be excluded as nonrecurring in the final year of the pilot program. For example, for an annual reexamination effective 2/1/2024, guaranteed income that will be repeated in the coming year but will end before the next reexamination on 2/1/2025 will be fully excluded from annual income.

Income amounts excluded under this category may include, but are not limited to, nonrecurring payments made to the family or to a third party on behalf of the family to assist with utilities, eviction prevention, security deposits to secure housing, payments for participation in research studies depending on the duration, and general one-time payments received by or on behalf of the family.

The following list of exclusions is codified at 24 CFR § 5.609(b)(24) as nonrecurring income. Please note that the list is not exhaustive:

- Payments from the U.S. Census Bureau for employment lasting no longer than 180 days and not culminating in permanent employment;
- Direct federal or state economic stimulus payments;
- Amounts directly received by the family as a result of state refundable tax credits or state tax refunds at the time they are received;
- Amounts directly received by the family as a result of federal refundable tax credits or federal tax refunds at the time they are received;
- Gifts for holidays, birthdays, or other significant life events or milestones (e.g., wedding, baby shower, or anniversary gifts);
- In-kind donations (e.g., food, clothing, or toiletries received from a food bank or similar organization); and
- Lump-sum additions to net family assets (e.g., lottery winnings, contest winnings, etc.).

PHAs/MFH Owners may accept a self-certification from the family stating that the income will not be repeated in the coming year.

Example G1: Recurring and Nonrecurring Income

Scenario A: Non-recurring earned income excluded from annual income: Justin Clark worked for four months over the past year for a company that has since gone out of business. During the Clark family's reexamination interview, the PHA/MFH Owner asks Justin whether he expects to work for the company again in the coming year. Justin provides proof that the company went out of business. The PHA/MFH Owner must exclude Justin's earned income received from the company that went out of business from the family's annual income.

Scenario B: Recurring earned income included in annual income: Ana Johnson works as an independent information technology (IT) contractor during various times of the year, when her clients require additional IT contract support. Ana reasonably believes that she will be contracted again the following year based on discussions with her clients. The PHA/MFH Owner must include the income that Ana earns as an IT contractor in the family's annual income.

Scenario C: Guaranteed Basic Income (GBI) excluded from annual income: Lucretia Jones reports at her upcoming annual reexamination effective on 5/1/24 that her GBI program will be ending on 1/31/25. The

PHA/MFH Owner excludes this income because the programs will stop before the next annual reexamination on 5/1/25. This income must be excluded, because there is a set term for the program, and the payments will not be repeated beyond the coming year, which is the final year of a GBI program.

Scenario D: Research stipend included as annual income: Lillian Gonzalez reports at the annual reexamination that will be effective on 5/1/24 that she receives monthly payments for participation in a research project that is expected to last for 18 months and will end on 9/30/25. The PHA/MFH Owner includes this as income because the amounts will be received through the next annual reexamination on 5/1/25. For the 5/1/25 annual reexamination, the family provides a letter stating that the income will end on 9/30/25, so the PHA/MFH Owner will exclude the income received after the 5/1/25 annual reexamination.

PHA/MFH Owner Discretion: None.

G.1.a Nonrecurring Income: Temporary U.S. Census Bureau Employment

Regulation: 24 CFR § 5.609(b)(24)(i)

Summary: Payments from the U.S. Census Bureau for employment relating to the decennial census or the American Community Survey lasting no longer than 180 days and not culminating in permanent employment are excluded from annual income. However, it should be noted that any permanent employment with the U.S. Census Bureau should be considered in the annual income calculation.

PHA/MFH Owner Discretion: None.

G.1.b Nonrecurring Income: Economic Stimulus or Recovery Payments

Regulation: 24 CFR § 5.609(b)(24)(ii)

Summary: Direct federal or state payments intended for economic stimulus or recovery are excluded from annual income.

HUD will continue to advise PHAs/MFH Owners of which payments are considered economic stimulus or recovery payments for the purposes of income calculation.

PHA/MFH Owner Discretion: None.

G.1.c Nonrecurring Income: State Tax Refunds

Regulation: 24 CFR § 5.609(b)(24)(iii)

Summary: Amounts directly received by the family as a result of state refundable tax credits or state tax refunds at the time they are received are excluded from annual income.

PHA/MFH Owner Discretion: None.

G.1.d Nonrecurring Income: Federal Tax Refunds

Regulation: 24 CFR § 5.609(b)(24)(iv)

Summary: Amounts directly received by the family as a result of federal refundable tax credits and federal tax refunds at the time they are received are excluded from annual income.

PHA/MFH Owner Discretion: None.

G.1.e Nonrecurring Income: Gifts

Regulation: 24 CFR § 5.609(b)(24)(v)

Summary: Gifts for holidays, birthdays, or other significant life events or milestones (e.g., weddings, baby showers, anniversaries) are excluded from annual income.

Example G2: Gifts for Holidays, Birthdays, or Other Significant Life Events or Milestones

Mariah Smith received a check for $250 on her 25th birthday from her favorite aunt and $30 from her cousin. These gifts are excluded from annual income.

PHA/MFH Owner Discretion: None.

G.1.f Nonrecurring Income: In-Kind Donations

Regulation: 24 CFR § 5.609(b)(24)(vi)

Summary: Non-monetary in-kind donations, such as food or toiletries, received from a food bank or similar organization are excluded from annual income. When calculating annual income, PHAs/MFH Owners are prohibited from assigning monetary value to non-monetary in-kind donations received by the family from a food bank or similar organization.

Non-recurring, non-monetary in-kind donations from friends and family may be excluded as non-recurring income. See (24 CFR § 5.609(b)(24)).

Example G3: In-Kind Donations

Jonas Crandall receives a basket weekly from the local food bank that includes both food and toiletries. Because this is an in-kind donation from the local food bank, the PHA/MFH Owner must not include the basket items in the calculation of annual income.

PHA/MFH Owner Discretion: None.

G.2 Lump-Sum Additions to Net Family Assets

Regulation: 24 CFR § 5.609(b)(24)(vii)

Summary: Lump-sum additions to net family assets, including but not limited to lottery or other contest winnings, are excluded from annual income. These amounts may count toward net family assets in accordance with 24 CFR § 5.603.

Example G4: Lump-Sum Additions to Net Family Assets

Scenario A: Trevor Lucky bought 10 lottery tickets and discovered that one of the tickets won Trevor $1,000. Trevor reported his winnings as part of an interim reexamination. The PHA/MFH Owner determined that the lottery winnings are a one-time, lump-sum addition to net family assets and should not be included in the annual income calculation.

Scenario B: Logan fundraises $5,000 online to help pay for personal expenses (e.g., "Go Fund Me"). The PHA/MFH Owner verified with Logan that this was a one-time solicitation for donations of cash and that Logan

does not intend for this to be a recurring source of income. The $5,000 is a one-time, lump-sum addition to net family assets and should not be included in the annual income calculation.

Scenario C: At the next annual reexamination, the PHA/MFH Owner determines that Logan solicited for donations online a second time and raised an additional $4,500. Again, Logan certified that he does not intend for this to be a recurring source of income, but, because the PHA/MFH Owner can establish a pattern, the $4,500 is **not** considered a lump-sum addition to net family assets and **should** be included in the annual income calculation.

PHA/MFH Owner Discretion: None.

G.3 Income Earned on Amounts Placed in a Family's Family Self Sufficiency (FSS) Account

Regulation: 24 CFR § 5.609(b)(27)

Summary: Income earned on amounts placed in a family's FSS account is excluded from the family's calculation of annual income.

PHA/MFH Owner Discretion: None.

G.4 Income of Live-in Aides, Foster Children, and Foster Adults

Regulation: 24 CFR § 5.609(b)(8)

Summary: Income of a live-in aide, foster child, or foster adult as defined in 24 CFR §§ 5.403 and 5.603 is excluded from the family's calculation of annual income.

PHA/MFH Owner Discretion: None.

G.5 Payments Received for the Care of Foster Children or Foster Adults or State or Tribal Kinship or Guardianship Care Payments

Regulation: 24 CFR § 5.609(b)(4)

Summary: Payments received for the care of foster children or foster adults, or state or Tribal kinship or guardianship care payments, are excluded from annual income.

This income exclusion also applies to Kinship Guardian Assistance Payments (Kin-GAP), kinship care payments, and other state-based kinship or guardianship payments that are alternatives to traditional foster care programs.

PHA/MFH Owner Discretion: None.

G.6 Insurance Payments or Settlements

Regulation: 24 CFR § 5.609(b)(5)

Summary: Insurance payments and settlements for personal or property losses, including but not limited to payments under health insurance, motor vehicle insurance, and workers' compensation, are excluded from annual income. Any workers' compensation is always excluded from annual income, regardless of the frequency or length of the payments.

Example G5: Insurance Payments or Settlements

Bethanne Williams received a settlement from her insurance company in the amount of $2,500 because of a car accident. Bethanne's car accident settlement payment is excluded from annual income.

Example G6: Workers' Compensation Received In Lieu of Wages

Tobias Reynolds was injured in a work accident. He is receiving bi-weekly workers' compensation payments. These amounts are excluded from annual income.

PHA/MFH Owner Discretion: None.

G.7 Civil Action Recoveries or Settlements

Regulation: 24 CFR § 5.609(b)(7)

Summary: Any amounts recovered in any civil action or settlement based on a claim of malpractice, negligence, or other breach of duty owed to a family member arising out of law that resulted in a member of the family becoming a person with disabilities are excluded from annual income. Any amounts recovered are excluded irrespective of whether they are received periodically or in a lump sum payment.

Example G7: Civil Action Recoveries or Settlements

Jacob Mitchell became a person with disabilities due to a construction site accident. He received $60,000 from a civil negligence case. The $60,000 received by Jacob is excluded from annual income.

PHA/MFH Owner Discretion: None.

G.8 Earned Income of Dependent Full-Time students

Regulation: 24 CFR § 5.609(b)(14)

Summary: Earned income of dependent full-time students in excess of the amount of the deduction for a dependent in § 5.611 is excluded from annual income. Full-time students must be dependent family members for this exclusion to apply. This exclusion does not apply to the head of household, spouse, or co-head. This means that the first $480 of the income earned by dependent full-time students will be included in the family's calculation of annual income.

The dependent deduction will be adjusted annually in accordance with the (CPI–W). See Attachment H. Full-time dependent students are eligible to receive both the $480 (as adjusted for inflation) dependent deduction and the exclusion described in this paragraph.

PHA/MFH Owner Discretion: None.

G.9 Adoption Assistance Payments

Regulation: 24 CFR § 5.609(b)(15)

Summary: Adoption assistance payments in excess of $480 per adopted child are excluded from the family's calculation of annual income. This amount will be adjusted annually in accordance with the CPI–W. See Attachment H.

All dependents, including adopted family members, are eligible to receive the $480 (as adjusted for inflation) dependent deduction and the exclusion described in this paragraph.

PHA/MFH Owner Discretion: None.

G.10 Veterans Regular Aid and Attendance

Regulation: 24 CFR § 5.609(b)(17)

Summary: Payments to veterans in need of regular aid and attendance are excluded from annual income under 38 U.S.C. 1521. This income exclusion applies only to veterans in need of regular aid and attendance and not to other beneficiaries of the payments, such as a surviving spouse.

Certain veterans are eligible for "aid and attendance" payments from the Veterans Affairs (VA) Administration. These payments are distinct from payments made to veterans under other VA programs, including the Veterans Pension program. PHAs/MFH Owners should carefully review any income documentation provided by the family, because many types of VA income, including the Veterans Pension and the VA Survivors Pension, are included in annual income.

PHA/MFH Owner Discretion: None.

G.11 Home-Based Care Payments for a Family Member(s) with a Disability(ies)

Regulation: 24 CFR § 5.609(b)(19)

Summary: Payments made by or authorized by a state Medicaid agency (including through a managed-care entity) or other state or federal agency to a family to enable a family member who has a disability to reside in the family's assisted unit are excluded from the calculation of the family's annual income. Authorized payments may include payments to a member of the assisted family through the state Medicaid agency (including through a managed-care entity) or other state or federal agency for caregiving services the family member provides to enable a family member who has a disability to reside in the family's assisted unit.

A family member with a disability qualifies for this income exclusion. Amounts received may be intended for items such as services, equipment, and compensation provided to a family member. The payments are excluded from income as long as the amounts are provided to enable a family member with a disability to remain in the family's assisted unit. Both the person providing the care and the person who has the disability must be family members (not household members) and must live in the same assisted household. The exclusion does not apply to income earned by the family for other caregiving services provided to individuals outside of the assisted household.

PHA/MFH Owner Discretion: None.

G.12 Loan Proceeds

Regulation: 24 CFR § 5.609(b)(20)

Summary: Loan proceeds (the net amount disbursed by a lender to a borrower under the terms of a loan agreement) received by the family or a third party (e.g., proceeds received by the family to finance the purchase of a car) are excluded from annual income. The

loan borrower or co-borrower must be a member of the family for this income exclusion to be applicable.

Loan proceeds may include, but are not limited to, personal loans (with a loan agreement) and student loans, regardless of whether the proceeds are received in the form of a refund to the student.

PHA/MFH Owner Discretion: None.

G.13 Certain Payments Received by Tribal Members

Regulation: 24 CFR § 5.609(b)(21)

Summary: Payments received by Tribal members as a result of claims relating to the mismanagement of assets held in trust by the United States, to the extent such payments are also excluded from gross income under the Internal Revenue Code (IRC) or other federal law, are excluded from annual income.

Generally, payments received by tribal members in excess of the first $2,000 of per-capita shares are included in a family's annual income for purposes of determining eligibility. However, as explained below, payments made under the Cobell Settlement, and certain per-capita payments under the recent Tribal Trust Settlements, must be excluded from annual income in HUD programs that adopt the definitions of annual income in 24 CFR 5.609, the Census Long Form, and the IRS Form 1040, including the programs affected by this notice.[G1]

The following two subsections describe the circumstances when settlement payments paid to Tribal members are excluded from annual income through federal law or as required under the IRC.

G.13.a Cobell Settlement

In *Elouise Cobell et al. v. Ken Salazar et al.*,[G2] a class of individual members of Indian tribes filed suit against the United States for its failure to adequately manage certain trust assets. The settlement was authorized pursuant to the Claims Resolution Act of 2010 (Pub. L. 111–291). In accordance with the Act, lump-sum or periodic payments received by an individual Indian under the Cobell Settlement are statutorily excluded from counting toward a family's annual income, or as a resource, for purposes of determining initial eligibility or level of HUD assistance, for a period of one year from the time of receipt of that payment. This exclusion from income applies to all HUD programs and is included in the

[G1] A payment received by a tribal member from the tribe for distribution of Indian gaming profits is not a per-capita payment within the meaning of the Per Capita Distribution Act and does not qualify for income exclusion. If a family member who is a tribal member receives the Internal Revenue Service (IRS) Form 1099–MISC, Miscellaneous Income, from the tribe for reporting Indian gaming profits, then this payment must be counted toward the family's annual income.

[G2] https://naturalresources.house.gov/uploadedfiles/cobellsettlementagreement_120709.pdf.

list of federally mandated exclusions from annual income that HUD periodically publishes in the *Federal Register*.[G3]

G.13.b Tribal Trust Settlements

The United States has entered into settlements with a number of federally recognized Indian tribes, settling litigation in which the tribes alleged that the Department of the Interior and the Department of the Treasury mismanaged monetary assets and natural resources the United States holds in trust for the benefit of the tribes. In some circumstances, proceeds from these settlements have resulted in, or will result in, per-capita payments to Indian families by Indian tribes. To date, at least 70 Indian tribes have settled Tribal Trust cases.

24 CFR 5.609(b)(21) requires that certain payments received by Tribal members, to the extent that such payments are excluded from gross income under the IRC, must be excluded from family income. The Internal Revenue Service (IRS) issued guidance in IRS Notice 2013–1, "Per Capita Payments from Proceeds of Settlements of Indian Tribal Trust Cases," advising that per-capita payments made from the proceeds of the enumerated Tribal Trust Settlements are excluded from the gross income of the members of the tribe receiving the per-capita payments under 25 USC 117b(a) and 25 USC 1407.

IRS Notice 2013–1 also clarifies, however, that per-capita payments that exceed the amount of the Tribal Trust Settlement proceeds and that are made from an Indian tribe's private bank account in which the tribe has deposited the settlement proceeds are included in the gross income of the members of the tribe receiving the per-capita payments. For example, if an Indian tribe receives proceeds under a settlement agreement, invests the proceeds in a private bank account that earns interest, and subsequently distributes the entire amount of the bank account as per-capita payments, then a member of the tribe excludes from gross income that portion of the member's per-capita payment attributable to the settlement proceeds under 25 USC 117b(a) and 25 USC 1407 and must include the remaining portion of the per-capita payment in gross income in accordance with the guidance provided in IRS Notice 2013-1. Per-capita payments not excluded from gross income in accordance with the IRC should be reviewed for potential exclusion as "nonrecurring income" (24 CFR § 5.609(b)(24)) or as "lump sum additions to net family assets" (24 CFR § 5.609(b)(24)(vii)).

The IRS last updated the list of Indian tribes who have entered into Tribal Trust Settlements with the United States in 2013,[G4] and for whom per-capita Tribal Trust payments are excluded from gross income. PHAs/MFH Owners should ensure they are reviewing the current list of Tribal Trust Settlements when determining whether a family's per-capita proceeds should be excluded from annual income.

[G3] Last published on 5/20/2014: https://www.federalregister.gov/documents/2014/05/20/2014-11688/federally-mandated-exclusions-from-income-updated-listing.

[G4] See IRS Notice 2013-55, available at: http://www.irs.gov/pub/irs-drop/n-13-55.pdf.

Example G8: Tribal Trust Settlements

Scenario A: An Indian tribe received $1.2 million from a Tribal Trust Settlement. The Indian tribe immediately distributed per-capita payments to its members. The Tribal Trust Settlement is treated in accordance with the guidance in IRS Notice 2013–1 and excluded from adjusted gross income under 25 USC 117b(a) and 25 USC 1407. Therefore, the per-capita payments to members are excluded from annual income.

Scenario B: An Indian tribe received $10 million from a Tribal Trust Settlement. The Indian tribe invested the settlement funds at a private institution. After a year, the Indian tribe distributed the settlement funds plus earned interest to its members. IRS Notice 2013–1 provides guidance that per capita payments that exceed the amount of the Tribal Trust case settlement proceeds and that are made from an Indian tribe's private bank account in which the tribe has deposited the settlement proceeds are not excluded from adjusted income under 25 USC 117b(a) and 25 USC 1407, so the interest payments to members are not excludable from annual income under 24 CFR 5.609(b)(21). The PHA/MFH Owner must determine whether the per-capita interest payments to members should be included in the family's income or excluded from income under a different regulatory provision such as 24 CFR 5.609(b)(24).

Please note that the first $2,000 of per capita payments are also excluded from assets, except when these per capita payments are in excess of the settlement amount and are included (IRS Notice 2013-1, 25 USC 117b(a), and 25 USC 1407).

PHA/MFH Owner Discretion: None.

G.14 Exclusions from Other Federal Statutes

Regulation: 24 CFR § 5.609(b)(22)

Summary: This exclusion applies to all amounts that HUD is required by federal statute to exclude from annual income. HUD will publish a notice in the *Federal Register* to identify the benefits that qualify for this exclusion. Updates will be published when necessary.

PHA/MFH Owner Discretion: None.

G.15 Replacement Housing Gap Payments

Regulation: 24 CFR § 5.609(b)(23)

Summary: Replacement housing "gap" payments made in accordance with the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 ("URA"), as implemented by 49 CFR Part 24, are excluded from annual income. "Gap" payments offset the increased out-pocket costs of displaced persons who move from one federally subsidized housing unit to another federally subsidized housing unit.

However, replacement housing "gap" payments are not excluded from annual income if the increased cost of rent and utilities is reduced or eliminated, and the displaced person retains or continues to receive the replacement housing "gap" payments.

Replacement housing "gap" payments should cover a minimum of 42 months of tenancy at the new unit.

Example G9: Replacement Housing Gap Payments

The Patel family was displaced from their Project-Based Voucher unit as the result of a HUD-funded acquisition and rehabilitation of the property that will last longer than one year. The family subsequently obtained a Housing Choice Voucher (HCV) and moved into a home where the owner accepts HCVs. The Patels' rent and utility expenses are $100 higher in their new unit. The Patels receive replacement housing "gap" payments of $100 intended to cover the difference between the Patels' former rent and utility expenses in their Project-Based Voucher unit and their current rent and expenses under their HCV assistance. The "gap" payments must be excluded from the family's annual income for the period during which gap payments are provided under the URA (42 months) or the increased cost of rent and utilities is reduced or eliminated, whichever is shorter.

PHA/MFH Owner Discretion: None.

G.16 Student Financial Assistance

Regulation: 24 CFR § 5.609(b)(9)

Summary: The treatment of student financial assistance depends on the HUD program, student/household characteristics, and the type of financial assistance received by the student. The student financial assistance rules apply to both full-time and part-time students.

The two types of student financial assistance applicable to MFH and PIH programs are described below.

G.16.a Amounts Received Under Section 479B of the Higher Education Act (HEA) of 1965, as amended (20 U.S.C. 1087uu)

Section 479B provides that certain types of student financial assistance are to be excluded in determining eligibility for benefits made available through federal, state, or local programs financed with federal funds. The types of financial assistance listed below are considered 479B student financial assistance programs; however, this list is not exhaustive, and 479B will be updated as of July 1, 2024.

- Federal Pell Grants;
- Teach Grants;
- Federal Work Study Programs;
- Federal Perkins Loans;
- Student financial assistance received under the Bureau of Indian Education;
- Higher Education Tribal Grant;
- Tribally Controlled Colleges or Universities Grant Program;
- Employment training program under section 134 of the Workforce Innovation and Opportunity Act (WIOA).

G.16.b Other Student Financial Assistance

Other student financial assistance includes grants or scholarships received from the following sources:

- The Federal government;
- A state (including U.S. territories), Tribe, or local government;
- A private foundation registered as a nonprofit under 26 U.S.C. 501(c)(3);
- A business entity (such as a corporation, general partnership, limited liability company, limited partnership, joint venture, business trust, public benefit corporation, or nonprofit entity); or
- An institution of higher education.

Other student financial assistance does not include:

- Financial support provided to the student in the form of a fee for services performed (e.g., a work study or teaching fellowship that is not excluded under section 479B of the Higher Education Act HEA); or
- Gifts, including gifts from family or friends.

Note: Other student financial assistance may be paid directly to the student or to the educational institution on the student's behalf. The PHA/MFH Owner must verify that the other student financial assistance is for the student's actual covered costs.

The following sections describe the treatment of the two above-described types of student financial assistance by program type.

G.16.c Non–Section 8 Programs Subject to this Notice

All assistance received under 479B of the HEA by students participating in the Public Housing or non–Section 8 programs administered by MFH is excluded from income. Other student financial assistance received by the student that, either by itself or in combination with HEA assistance, exceeds the actual covered costs is not excluded from income. Prior to the final rule, the full amount of student financial assistance paid directly to the student or to the educational institution was excluded.

Actual covered costs include: tuition, books, supplies (including supplies and equipment to support students with learning disabilities or other disabilities), room and board, and fees required and charged to a student by an institution of higher education (as defined under section 102 of the Higher Education Act of 1965 (20 U.S.C. 1087uu)). For a student who is not the head of household, co-head, or spouse, actual covered costs also include the reasonable and actual costs of housing while attending the institution of higher education and not residing in an assisted unit.

The formula for calculating the amount of other student financial assistance that is excluded from income always begins with deducting the assistance received under 479B of the HEA from the total actual covered costs, because the 479B assistance is intended to pay the student's actual covered costs. This formula is illustrated in chart 2, below.

Chart G1: Steps in Calculating Amount of Other Student Financial Assistance

Step 1: Subtract the **amount received under section 479B of the HEA** from the **actual covered costs** to arrive at the **amount of actual covered costs exceeding section 479B assistance**.

If the amount of assistance received under section 479B of the HEA exceeds the actual covered costs and the student did not receive any other student financial assistance, then step 2 is not necessary; none of the student financial assistance will be included in income, because the assistance received under section 479B of the HEA is excluded from income for students participating in the Public Housing and non–Section 8 programs administered by MFH.

Step 2: Subtract the **actual covered costs exceeding section 479B assistance** from the amount of **other student financial assistance** to arrive at the amount of **student financial assistance included in income**.

Step 2 requires the amount of other student financial assistance received by the student to be subtracted from the amount of actual covered costs paid by other means. If the resulting number in Step 2 is a positive amount, then that is the amount that should be included in the family's income. If the resulting number in Step 2 is zero or a negative amount, then there will be no student financial assistance included in income (i.e., all student financial assistance is excluded from annual income).

The following examples illustrate the treatment of student financial assistance for Public Housing and non–Section 8 programs:

Example G10: Treatment of Student Financial Assistance in Non–Section 8 Programs

<table>
<tr><td colspan="2">Juan is a full-time student, and he received the following grants and scholarships to cover his first year of college: Federal Pell Grant: $25,000; University Scholarship: $15,000; Rotary Club Scholarship: $3,000.</td></tr>
<tr><td>Total assistance received under 479B of HEA: $25,000 (Federal Pell Grant)

Total other student financial assistance received: $18,000</td><td>Juan's actual covered costs: $28,000</td></tr>
<tr><td>Step 1: Determine amount of actual covered costs exceeding section 479B assistance.

$28,000 (actual covered costs) minus $25,000 (total assistance received under 479B of HEA) equals $3,000</td><td>Step 2: Determine amount of student financial assistance to include in income.

$18,000 (other student financial assistance received) minus $3,000 (actual covered costs exceeding section 479B assistance) equals $15,000 (if negative, then use $0)</td></tr>
<tr><td colspan="2">Amount of student financial assistance included in Juan's income: $15,000</td></tr>
</table>

Example G11: Treatment of Student Financial Assistance in Non–Section 8 Programs

Sarah is a part-time student, and she received the following amounts to cover her first year of college: Federal Perkins Loan: $2,000; Scholarship from Local Car Dealership: $500; Gift from Aunt Lois: $1,000. The $1,000 is a gift from Aunt Lois, so it is not considered student financial assistance, and it is not considered in this calculation. Note: If Aunt Lois gives Sarah the $1,000 gift as a one-time, lump-sum payment, it would be excluded from income under 24 CFR § 5.609(b)(24)(vii).	
Total assistance received under 479B of HEA: $2,000 (Federal Perkins Loan) Total other student financial assistance received: $500 Total non-student financial assistance: $1,000 Total student financial assistance: $2,500	Sarah's actual covered costs: $3,000
Step 1: Determine amount of actual covered costs exceeding section 479B assistance. $3,000 (actual covered costs) **minus** $2,000 (total assistance received under 479B of HEA) **equals** $1,000	Step 2: Determine amount of student financial assistance to include in income. $500 (other student financial assistance received) **minus** $1,000 (amount of actual covered costs exceeding section 479B assistance) **equals** –$500 (if negative, then use $0)
The amount of student financial assistance received by Sarah is less than her actual covered costs after deducting assistance received under 479B of the HEA and other student financial assistance received, therefore there is no student financial assistance to include in income. Amount of student financial assistance included in Sarah's income: $0	

Example G12: Treatment of Student Financial Assistance in Non–Section 8 Programs

Dante is a full-time student, and he received the following amounts to cover his first year of college: Federal Pell Grant: $9,000; Federal Perkins Loan: $13,000; Local Library Scholarship: $1,000.	
Total assistance received under 479B of HEA: $22,000 (Federal Pell Grant plus Federal Perkins Loan) Total other student financial assistance received: $1,000	Dante's actual covered costs: $16,000
Step 1: Determine amount of actual covered costs exceeding section 479B assistance. $16,000 (actual covered costs) **minus** $22,000 (total assistance received under 479B of HEA) **equals** $–6,000	Step 2: Determine amount of student financial assistance to include in income. Not necessary because Step 1 resulted in a negative amount, so all other student financial assistance would be included in Dante's income
Amount of student financial assistance included in Dante's income: $1,000	

G.16.d Section 8 (Including HCV and 202/8)

There are distinct differences in the treatment of student financial assistance between the Section 8 program and the Public Housing and non–Section 8

programs administered by MFH due to language in the annual appropriations acts. Section 210(b) of the Consolidated Appropriations Act, 2023,[G5] requires that, "for purposes of determining the eligibility of a person to receive assistance under section 8 of the United States Housing Act of 1937 (42 U.S.C. 1437f), any financial assistance (in excess of amounts received for tuition and any other required fees and charges) that an individual receives under the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), from private sources, or from an institution of higher education (as defined under section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)), shall be considered income to that individual, except for a person over the age of 23 with dependent children." HUD interprets that "a person over the age of 23" is 24 years old.

While the Consolidated Appropriations Act, 2023, language is limited to federal fiscal year 2023, this does not rule out the possibility that similar language will be included in future years' appropriations bills. For any funds from a year where HUD's appropriations include this Section 8 student financial assistance limitation, if the student is the head of household, co-head, or spouse and is under the age of 23 or without dependent children, then both the assistance received under 479B of the HEA and other student financial assistance received by the student will be counted as income to the extent that it exceeds the total of tuition and any other required fees and charges.[G6] In contrast, the student financial assistance received by a Section 8 student who is the head of household, spouse, or co-head of household and is over the age of 23 with dependent children will be treated in a manner identical to the student financial aid received by students who participate in the Public Housing and non–Section 8 programs administered by MFH.

During years in which an appropriations act does not contain this Section 8 student financial assistance limitation (or any other such limitation), then the determination of student financial assistance as included/excluded income for all Section 8 students defaults to the methodology described above for the Public Housing and non–Section 8 programs administered by MFH.

There are two steps required as part of the calculation for Section 8 students, the first of which is to determine the student's relationship to the household, age, and whether they have dependent children; based on the result of the first step, the second step is to calculate whether any excess student financial assistance should be included in the family's income. If the student is the head of household, co-head, or spouse and is 23 or younger or does not have dependent children, then 479B assistance **will** be part of the total equation (see example G13, below). If the

[G5] https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.

[G6] The definition of tuition and other required fees and charges for Section 8 students is synonymous with the definition of "actual covered costs" described in the previous section for the Public Housing and non–Section 8 programs administered by MFH. For Section 8 students, HUD uses the term "tuition and other required fees" solely to reflect the language in the appropriations bill.

student is over 23 with dependent children, then the calculation will be identical for Public Housing and non–Section 8 MFH students, as described above.

The formula for calculating the excess amounts of financial assistance included in annual income is a one-step process of subtracting the total tuition plus required fees and charges from the total student financial assistance from all sources The one-step calculation is illustrated in chart 3, below.

Chart G2: Formula for Calculating Excess Amounts of Financial Assistance

Subtract total tuition plus required fees and charges from the total student financial assistance from all sources to arrive at excess amount of student financial assistance.
If the excess amount of student financial assistance is a positive number, then include that amount in annual income. If the excess amount of student financial assistance is zero or negative, then do not include that amount in annual income.
If the total tuition plus required fees and charges is zero or exceeds the amount of total financial assistance from all sources, then no excess amounts of student financial assistance will be included in annual income. Any amount of student financial assistance that exceeds the total tuition plus required fees and charges must be included in annual income.

Example G13: Treatment of Student Financial Assistance in Section 8 Programs

<table>
<tr><td colspan="2">Roberto is a 22-year-old full-time student without dependent children. Since Roberto is a Section 8 participant head of household who is not over 23 with dependent children, the PHA/MFH Owner follows the Appropriations Act policy to determine if Roberto receives student financial assistance in excess of tuition from both HEA and other sources. Roberto received the following amounts to cover his first year of college: Federal Pell Grant: $12,000; University Scholarship: $22,000; City Scholarship: $3,000.</td></tr>
<tr><td>Total assistance received under 479B of HEA: $12,000 (Federal Pell Grant)
Total other student financial assistance received: $25,000
Total student financial assistance from all sources: $37,000</td><td>Total tuition + required fees and charges: $27,000</td></tr>
<tr><td colspan="2">Subtract the total cost of tuition + required fees and charges from the total amount of student financial assistance: $37,000 – $27,000 = $10,000</td></tr>
<tr><td colspan="2">The total amount of student financial assistance from all sources received by Roberto exceeds the total amount of tuition and required fees and charges.</td></tr>
<tr><td colspan="2">Excess student financial assistance: $10,000</td></tr>
<tr><td colspan="2">Amount of student financial assistance included in Roberto’s income: $10,000</td></tr>
</table>

Example G14: Treatment of Student Financial Assistance in Section 8 Programs

<table>
<tr><td colspan="2">Cedric is a 28-year-old head of household and a full-time student with a 5-year-old daughter and a 9-year-old son who are his dependents. The PHA/MFH Owner will follow the rules under § 5.609(b)(9) (the same as for non–Section 8 programs) as described in the previous section. Cedric received the following amounts to cover his first year of college: Teach Grant: $8,000; Federal Pell Grant: $3,000; College Scholarship: $6,000.</td></tr>
<tr><td>Total assistance received under 479B of HEA: $11,000 (Teach Grant plus Federal Pell Grant)

Total other student financial assistance received: $6,000</td><td>Total tuition + required fees and charges: $26,000</td></tr>
<tr><td>Step 1: Determine amount of tuition plus required fees exceeding 479B assistance.

$26,000 (total tuition + required fees and charges) minus $11,000 (total assistance received under 479B of HEA) equals $15,000</td><td>Step 2: Determine amount of student financial assistance to include in income.

$6,000 (other student financial assistance received) minus $15,000 (amount of tuition + required fees and charges exceeding 479B assistance) equals –$9,000 (if negative, then use $0)</td></tr>
<tr><td colspan="2">The amount of other student financial assistance received by Cedric does not exceed the total amount of tuition and required fees and charges.</td></tr>
<tr><td colspan="2">Excess student financial assistance: $0</td></tr>
<tr><td colspan="2">Amount of student financial assistance included in Cedric’s income: $0</td></tr>
</table>

Example G15: Treatment of Student Financial Assistance in Section 8 Programs

<table>
<tr><td colspan="2">Angel is a 38-year-old full time student, head of household, without dependent children. Since Angel does not have dependent children, the Appropriations Act policy does not apply, and the PHA/MFH Owner must include assistance received under 479B of the HEA as part of the excess student financial aid calculation. Angel received the following amounts to cover her first year of college: Perkins Loan: $8,000.</td></tr>
<tr><td>Total assistance received under 479B of HEA: $8,000 (Perkins Loan)</td><td>Total tuition + other fees and charges: $6,200</td></tr>
<tr><td colspan="2">Determine whether the amount of student financial assistance, including 479B assistance, exceeds the total of tuition + required fees and charges: $8,000 – $6,200 = $1,800</td></tr>
<tr><td colspan="2">Excess student financial assistance: $1,800</td></tr>
<tr><td colspan="2">Amount of student financial assistance included in Angel’s income: $1,800</td></tr>
</table>

PHA/MFH Owner Discretion: None.

G.17 Achieving a Better Life Experience (ABLE) Accounts

Regulation: 24 CFR § 5.609(b)(22)

Summary: ABLE accounts are excluded from the definition of net family assets, and therefore income generated from such accounts is not considered when calculating income from assets. Distributions from these accounts are also excluded from income.

HUD developed specific guidance on ABLE accounts based on language included in the ABLE Act of 2014. Certain contributions deposited into ABLE accounts are excluded in addition to the above-mentioned exclusions. See *Treatment of ABLE Accounts in HUD-Assisted Programs* (Notice H 2019–06/PIH 2019–09).

PHA/MFH Owner Discretion: None.

G.18 Income and Distributions from Coverdell Education Savings Accounts, 529 Accounts and "Baby Bond" Accounts

Regulation: 24 CFR § 5.609(b)(10)

Summary: Income and distributions from any Coverdell education savings account under section 530 of the Internal Revenue Code of 1986 or any qualified tuition program under section 529 of such Code; and income earned by government contributions to, and distributions from, "baby bond" accounts created, authorized, or funded by Federal, State, or local government are excluded from income and net family assets.

PHA/MFH Owner Discretion: None.

G.19 Gross Income from Self-Employment or Operation of a Business

Regulation: 24 CFR §§ 5.609(b)(24) and 5.609(b)(28)

Summary: The gross income received by a family through self-employment, or the operation of a business is excluded from income. Gross income is all income amounts received into the business, prior to the deduction of business expenses. To determine the amount of business or self-employment income included in a family's annual income, the net income of the business must first be determined.

Net income is the "gross income amount minus business expenses" that allows the business to operate.

The net income from self-employment or the operation of a business is considered income. Expenditures for business expansion or amortization of capital indebtedness are not deductible when determining the income from a business. An allowance for the depreciation of assets used in a business or profession may be deducted, based on a straight-line depreciation, as provided in IRS's regulations.[G7] Any withdrawal of cash or assets from the operation of a business is income except to the extent that such withdrawal is to reimburse the family member for cash or assets that the family has invested in the operation of the business.

[G7] 26 CFR § 1.167(b)-1 Straight line method: https://www.ecfr.gov/current/title-26/chapter-I/subchapter-A/part-1/subject-group-ECFRc4930337f38ecfd/section-1.167(b)-1.

Example G16: Exclusion of Gross Income from Self-Employment or Operation of a Business

Bill Conrad is the sole owner of BC Lawn Service. BC Lawn Service grossed $75,000 annually in 2024. BC Lawn Service also incurred a total of $35,000 in business expenses, including lawn equipment, rakes, insurance, depreciation of a tractor, and wage payments. After subtracting the $35,000 in business expenses from the $75,000 gross income, the net income is $40,000, which will be included in Bill's calculation of annual income.

PHA/MFH Owner Discretion: None.

G.20 Elimination of the Earned Income Disregard (EID)

Regulation: 24 CFR § 5.611

Summary: The Earned Income Disregard (EID) will not apply to any family who is not eligible for **and already participating in** the disallowance as of December 31, 2023.

The EID allowed eligible families to have a portion of their earned income excluded from annual income for a maximum period of 24 consecutive months.

Although HOTMA eliminates the EID from HUD regulations, families who were receiving the EID benefit as of December 31, 2023, may continue to receive the full benefit until the remaining timeframe for an individual family's EID expires. Because the EID lasts up to 24 consecutive months, no family will still be receiving the EID benefit after December 31, 2025.

Note: The EID policies described above are distinct from similar policies in the Jobs Plus program. Families eligible to receive the Jobs Plus program rent incentive (Jobs Plus Earned Income Disregard (JPEID)) pursuant to the FY2023 Notice of Funding Opportunity (NOFO) or earlier appropriation distributed through prior Jobs Plus NOFOs may continue to receive JPEID under the terms of the NOFO. The JPEID was established by HUD as an alternative requirement to EID for Jobs Plus grantees by waiving section 3(d) of the U.S. Housing Act of 1937 (42 U.S.C. 1437a(d)) and § 960.255(b) and (d). For more information about JPEID waivers and alternative requirements, please review the following *Federal Register* notices: 80 FR 13415 (March 13, 2015) and 83 FR 13506 (March 29, 2018).

PHA/MFH Owner Discretion: None.

G.21 Civil Rights Settlements or Judgments

Regulation: 24 CFR § 5.609(b)(25)

Summary: Civil rights settlements or judgments, including settlements or judgments for back pay, are excluded from the calculation of annual income.

Historically HUD has followed a practice of excluding from income civil rights settlements and judgments as lump-sum additions to assets, which would include amounts received as a result of litigation or other actions, such as conciliation agreements, voluntary compliance agreements, consent orders, other forms of settlement agreements, or administrative or judicial orders under nondiscrimination laws. However, this new exclusion clarifies that even where such payments are not lump-sum payments but instead may have a payment schedule, such payments are excluded. Additionally, this

exclusion applies to back pay received by the family pursuant to a civil rights settlement or judgment.

PHA/MFH Owner Discretion: None.

ATTACHMENT H: TOPIC: INFLATIONARY ADJUSTMENTS

Regulations

See table H1, below.

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

HUD will annually publish the eight inflation-adjusted items in the table below no later than September 1, and the updated values will be shared online at the HUD User website. The publication will apply to both MFH and PIH programs. The revised amounts will be effective on January 1 of the following year. The first set of adjustments for inflation will be made effective January 1, 2025.

HUD plans to publish in the *Federal Register* a notice soliciting the public's comment on HUD's methodology for recalculating inflationary adjusted items.

Table H1: Inflationary Adjustment Items

Adjusted Item	Regulatory Reference	Notice Section	Amount Effective on 1/1/2024 (subject to Annual Adjustment)	Rounding Methodology	Applicable Programs
Eligibility restriction on net family assets	24 CFR § 5.618(a)(1)(i)	Attachment A	$100,000	Nearest dollar	Section 8 PBRA, 202/8, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO
Threshold above which imputed returns must be calculated on net family assets	24 CFR §§ 5.609(a)(2) and (b)(1)	Attachment F	$50,000	Nearest dollar	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod

					Rehab, Section 8 Mod Rehab SRO
Threshold above which the total value of non-necessary personal property is included in net family assets	24 CFR § 5.603(b) *Net family assets*	Attachment F	$50,000	Nearest dollar	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO
The amount of net assets for which the PHA/MFH Owner may accept self-certification by the family	24 CFR § 5.618(b)(1) 24 CFR § 5.659(e) 24 CFR § 92.203(e)(1) 24 CFR § 93.151(e)(1) 24 CFR § 882.515(a) 24 CFR § 882.808(i)(1) 24 CFR § 960.259(c)(2) 24 CFR § 982.516(a)(3)	Attachment F	$50,000	Nearest dollar	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO
Mandatory deduction for elderly and disabled families	24 CFR § 5.611(a)(2)	Attachment C	$525	Next lowest multiple of $25	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO
Mandatory deduction for a dependent	24 CFR § 5.611(a)(1)	Attachment C	$480	Next lowest multiple of $25	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing,

					Section 8 Mod Rehab, Section 8 Mod Rehab SRO
Income exclusion for earned income of dependent full-time students	24 CFR § 5.609(b)(14)	Attachment G	$480	Next lowest multiple of $25	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO
Income exclusion for adoption assistance payments	24 CFR § 5.609(b)(15)	Attachment G	$480	Next lowest multiple of $25	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO

HUD will annually publish the recalculated inflationary-adjusted items to HUD's Policy Development and Research Web site, HUD User. The new amounts will become effective January 1 of the following year.

PHAs/MFH Owners must use the adjusted levels post to HUD User for income and asset calculations effective on or after January 1 of the following year. Note that it will be particularly important for PHAs/MFH Owners who begin reexaminations 90 to 120 days in advance of the effective date of the reexamination to update their documents in a timely manner, because several of these figures must be known from the outset of the reexamination. For example, when a PHA/MFH Owner issues a reexamination notice and requests documents from a family, they must be able to provide a form for the self-certification of assets that includes the updated threshold value of net family assets above which the family may not self-certify.

ATTACHMENT I: TOPIC: INTERIM REEXAMINATIONS

Regulations

24 CFR §§ 5.567(c)(1); 882.515(b)(1); 960.257(b)(1); 982.516(c)(1); 891.105; 891.410(g); 891.610(g); and 891.750

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA[I1], SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

A family may request an interim determination of family income or composition because of any changes since the last determination. The PHA/MFH Owner must conduct any interim reexamination within a reasonable period of time after the family request or when the PHA/MFH Owner becomes aware of a change in the family's adjusted income that must be processed in accordance with the final rule. What qualifies as a "reasonable time" may vary based on the amount of time it takes to verify information, but the PHA/MFH Owner generally should conduct the interim reexamination not longer than 30 days after the PHA/MFH Owner becomes aware of changes in income.

The following subsection focuses on HOTMA's revisions to income reexamination requirements. The final rule changes the conditions under which interim reexaminations must be conducted, codifies when interim reexaminations should be processed and made effective, and requires related changes for annual reexaminations and streamlined income determinations. When the PHA/MFH Owner determines that an interim reexamination of income is necessary, they must ask the family to report changes in all aspects of adjusted income. For example, if the family is reporting a decrease in annual adjusted income that is more than 10 percent, but the family also had a change in assets that would result in a change in income, the change in assets must also be reviewed. HUD recommends as a best practice that PHAs/MFH Owners maintain documentation of all reported decreases in annual adjusted income in the family's file, including those that did not result in an interim reexamination. HUD also recommends reviewing the applicable regulations to ensure that any program-specific reexamination requirements are addressed[I2].

[I1] HUD is applying 24 CFR § 5.657 to 811 PRA families pursuant to Section 2.4(a)(1) of the Rental Assistance Contract (RAC) Part II.

[I2] For example, see 24 CFR § 891.410(g) and § 891.610(g)(3).

I.1 Decreases in Adjusted Income

Regulations: 24 CFR §§ 5.657(c)(2); 882.515(b)(2); 891.105; 891.410(g)(2); 891.610(g)(2); 960.257(b)(2); and 982.516(c)(2)

Summary: A family may request an interim determination of family income for **any** change since the last determination. However, the PHA/MFH Owner may decline to conduct an interim reexamination of family income if the PHA/MFH Owner estimates that the family's adjusted income will decrease by an amount that is less than 10 percent of the family's annual adjusted income. PHAs/MFH Owners have the discretion to set a lower percentage threshold, in which case that lower percentage threshold must be included in the ACOP, Administrative Plan, or Tenant Selection Plan, as applicable.

PHAs/MFH Owners must conduct an interim reexamination of family income when the PHA/MFH Owner becomes aware that a family's annual adjusted income has changed by an amount that the PHA/MFH Owner estimates will result in a decrease of 10 percent or more in annual adjusted income or a lower threshold set by HUD or by a PHA/MFH Owner in their ACOP, Administrative Plan, or Tenant Selection Plan, as applicable. In addition to decreases in family income, increases in deductions may produce a sufficient decrease in adjusted income to support an interim reexamination effective January 1, 2024, or later.

HUD is using its discretion, as authorized by HOTMA, to establish a lower threshold through notice to process interim reexaminations under certain circumstances. Specifically, HUD is requiring PHAs/MFH Owners to apply a 0-percent threshold and to process an interim reexamination when there is a decrease in family size attributed to the death or permanent move-out from the assisted unit of a family member during the period since the family's last reexamination that results in a decrease in adjusted income of any amount. If there is no change/decrease in adjusted income as a result of the decrease in family size, then a non-interim transaction is processed instead of an interim reexamination. This 0-percent threshold for interim reexamination applies only to decreases in family size that result in a **decrease** in adjusted income. If the net effect of the changes in annual adjusted income due to a decrease in family size results in an **increase** in annual adjusted income, then PHA/MFH Owner will process the removal of the household member(s) as a non-interim reexamination transaction **without** making changes to the family's annual adjusted income.

Example I1: Interim Reexaminations / Decreases in Annual Adjusted Income

Scenario A: A family with an annual adjusted income of $9,600 experiences a change in household composition and becomes eligible for two dependent deductions totaling $960, resulting in a 10-percent decrease in the family's adjusted income. The $960 decrease in the family's adjusted income would require an interim reexamination, because the income decrease meets the 10-percent threshold for an interim reexamination.

Scenario B: A family experiences an increase in deductible child-care expenses from $0 to $12,000 annually. Before the change, their annual adjusted income was $40,000. Since the child-care expense deduction results in a greater than 10-percent reduction in annual adjusted income, an interim reexamination is required.

Scenario C: A family with an adjusted income of $9,600 adds a dependent family member with no income. This would result in an adjusted income decrease of $480 due to the dependent deduction. The decrease does not meet the 10-percent threshold of the family's adjusted income, and because this is a family member joining the assisted

unit (as opposed to a decrease a family size), the PHA/MFH Owner is not required to conduct an interim reexamination. However, the PHA/MFH Owner has adopted a policy that has decreased the threshold from a 10-percent change to a 5-percent change, therefore the decrease would meet the threshold, triggering an interim reexamination.

Scenario D: A family member moved out of the assisted unit. The family's adjusted income prior to the change in household composition was $20,000, but that number decreased to $18,000 when the family member moved out. Since HUD requires PHAs/MFH Owners to process decreases in adjusted income greater than 0 percent due to decreases in family size, the PHA/MFH Owner must process an interim reexamination.

Scenario E: A family member moves into the assisted unit who receives $20,000 in pension income (which is more than 10% of the household's adjusted income). At the same time, the head of household got a new job that increases the household's income by $15,000 per year. The PHA/MFH Owner will process the increase in pension income due to the new household member but will not include the head of household increase in earned income until the next annual reexamination.

PHA/MFH Owner Discretion: PHAs/MFH Owners may establish a percentage threshold lower than 10 percent of annual adjusted income for processing interim reexaminations due to decreases in a family's annual adjusted income. PHAs/MFH Owners must identify in their ACOPs, Administrative Plans, and Tenant Selection Plans, as applicable, the percentage threshold they will use for conducting interim reexamination decreases of a family's annual adjusted income.

PHAs/MFH Owners **are not permitted** to establish a dollar-figure threshold amount instead of a percentage threshold. PHAs/MFH Owners may establish policies to round calculated percentage decreases up or down to the nearest unit (e.g., a calculated decrease of 9.5 percent may be rounded up to 10 percent).

I.2 Increases in Adjusted Income

Regulations: 24 CFR §§ 5.657(c)(3); 882.515(b)(3); 960.257(b)(3); and 982.516(c)(3); 891.105; 891.410(g)(2); and 891.610(g)(2)

Summary: PHAs/MFH Owners must conduct an interim reexamination of family income when the PHA/MFH Owner becomes aware that the family's adjusted income has changed by an amount that the PHA/MFH Owner estimates will result in an increase of 10 percent or more in annual adjusted income or another amount established through a HUD notice, with the following exceptions:

- PHAs/MFH Owners **may not** consider any increases in **earned income** when estimating or calculating whether the family's adjusted income has increased, unless the family has previously received an interim reduction during the same reexamination cycle; and
- PHAs/MFH Owners may choose not to conduct an interim reexamination during the last three months of a certification period if a family reports an increase in income within three months of the next annual reexamination effective date.

Note: Families who delay reporting income increases until the last three months of their certification period may be subject to retroactive rent increases in accordance with the PHA/MFH Owner's policies.

PHAs/MFH Owners **must not** process interim reexaminations for income increases that result in less than a 10-percent increase in annual adjusted income. When the family

previously received an interim reexamination for a decrease to annual adjusted income during the same annual cycle, a PHA/MFH Owner has the discretion to consider or ignore a subsequent increase in **earned** income for the purposes of conducting an interim reexamination. PHAs/MFH Owners must identify in their ACOPs, Administrative Plans, and Tenant Selection Plans, as applicable, if they perform interim reexaminations for **earned** income increases that result in a 10-percent increase in annual adjusted income. If a PHA/MFH Owner has a policy of considering increases in earned income after an interim conducted for a decrease in income, and the family's adjusted income has increased by 10 percent or more, the PHA/MFH Owner must conduct an interim reexamination in accordance with local policies. Conversely, PHAs/MFH Owners that adopt local policies to never consider increases in **earned** income must not perform an interim reexamination.

A series of smaller reported increases in adjusted income may cumulatively meet or exceed the 10-percent increase threshold, at which point the PHA/MFH Owner must conduct an interim reexamination. When an increase of any size is reported by a family, it is a recommended best practice for the PHA/MFH Owner to note the reported increase in the tenant file.

Example I2: Interim Reexaminations / Increases in Annual Adjusted Income

Scenario A: The Martinez family's annual reexamination is due on 11/1/2024. The family no longer has child-care expenses for their three children. The family stopped paying for daycare as of 8/31/2024 and reported the change (and certified no other changes to annual household income or expenses) to the PHA/MFH Owner on 9/7/2024, resulting in an estimated 15-percent increase in the family's annual adjusted income. Although 15 percent is well above the 10-percent threshold, the PHA/MFH Owner does not process an interim reexamination, because they have a policy to not process changes reported within three months of the next annual reexamination.

Scenario B: The Allen family had an annual adjusted income of $29,000 as of their last annual reexamination effective 5/1/2024. The family experienced the following changes to income and household composition since 5/1/2024:

- In July, the Allen family's eldest child, Kristina Allen (age 20), starts going to college full-time on a Pell Grant. Kristina is not employed, nor does she receive any other type of student financial assistance. The family now qualifies for a $480 dependent deduction, because full-time students are considered dependents.
- The family reports Kristina's student status to the PHA/MFH Owner, which noted the change in the family's file. The PHA/MFH Owner is not allowed to perform an interim reexamination, because the dependent deduction represents a 1.7-percent decrease in the family's annual adjusted income, and the PHA/MFH Owner did not establish a threshold lower than 10 percent for interim decreases in income.
- In October, the family added an adult family member, Tom Smith, to the household. The new adult family member receives a pension of $275 monthly, or $3,300 annually.

The PHA/MFH Owner determined that the Allen family's new annual adjusted income is $31,820, accounting for both the addition of Tom's pension income and the deduction of the full-time student dependent allowance for Kristina. The Allen family's annual adjusted income increased a total of $2,820, or only 9.7 percent. Since this decrease is below the 10-percent threshold, the PHA/MFH Owner will not conduct an interim reexamination. Instead, they will process a non-interim transaction to add Tom to the family without changing the family's annual adjusted income effective 10/1/2024.

Scenario C: The Nguyen family's last annual reexamination was 4/1/2024. In June 2024, Patrick Nguyen lost his job, and the family's adjusted income fell from $25,000 to $13,000. The PHA/MFH Owner conducted an interim reexamination for the decrease in income. In November 2024, Kelly Nguyen finds a job, and the family's adjusted income rises to $18,000. The PHA/MFH Owner has a policy of considering increases in earned income

when an interim reexamination has been performed for a decrease in income. Since the family's adjusted income has increased by more than 10 percent when including earned income, and the family previously received an interim reduction during the same reexamination cycle, the PHA/MFH Owner will conduct an interim reexamination for the increase.

Scenario D: The Mosberg family had an annual adjusted income of $35,909 based on earned income (and two dependent deductions) as of the last annual reexamination effective 6/1/2024. The family experienced the following changes to income since 6/1/2024:

- In August, Libby reported she received a raise at work, increasing her annual earned income by $2,650. She also recently started receiving monthly child support payments of $150, or $1,800 annually. She reported no other changes to the PHA/MFH Owner. While the **combined** increase of earned income (wages) and unearned income (child support) is a 12.3-percent increase in annual adjusted income since the 6/1/2024 annual reexamination, the PHA/MFH Owner must look at the earned and unearned income changes independently to determine if an interim reexamination should be performed. The earned income is about 7 percent of the increase, and the unearned income is approximately 5 percent of the total 12.3-percent increase.

The PHA/MFH Owner documented in the tenant file that the family reported the change, but an interim reexamination was **not** performed, because the 5-percent increase in annual adjusted income based on **unearned** income does not meet the 10-percent threshold. Further, the PHA/MFH Owner may not perform an interim reexamination for Libby's 7-percent increase in annual adjusted income based on **earned** income, because an interim reexamination for an income decrease during the reexamination cycle was not completed **and** it does not meet the 10-percent threshold to perform an interim. Note: Even if Libby's change in earned income had exceeded 10 percent of her annual income, the PHA/MFH Owner may not perform an interim reexamination, because there was no prior interim reexamination for a decrease in income.

In November, Libby reported that her monthly child support payments increased again, from $150 to $325. She certified no other changes to income or deductions. Libby's annual **unearned** income from child support of $3,900 is now a 10.8-percent increase in annual adjusted income (based on the effective 6/1/2024 annual reexamination), so the PHA/MFH Owner **must** perform an interim reexamination, but only for the **unearned** child support income. The PHA/MFH Owner will continue to disregard the increased **earned** income reported by the family until the Mosberg's next annual reexamination.

PHA/MFH Owner Discretion: PHAs/MFH Owners have discretion on the following policies:

- Whether the PHA/MFH Owner will conduct interim reexaminations for income increases reported by families within the last three months of a family's reexamination period; and
- Whether the PHA/MFH Owner will count increases in earned income when estimating or calculating whether the family's adjusted income has increased when the family previously received an interim reduction during the same reexamination cycle and whether they will conduct interim reexaminations when families previously underwent interim reexaminations for decreases in income (both earned and unearned income).

PHAs/MFH Owners must establish policies for the above-discretionary items in their ACOPs, Administrative Plans, and Tenant Selection Plans, as applicable.

PHA/MFH Owner Discretion: None.

I.3 Interim Reexaminations to Determine Public Housing Over-Income Status

Regulations: 24 CFR § 960.507

Summary: Regardless of changes in adjusted annual income, in some circumstances PHAs are required to conduct interim reexaminations of Public Housing families to determine whether they continue to exceed the income limit. When a PHA makes an initial determination that a Public Housing family is over-income during an interim reexamination, the PHA must conduct a second interim reexamination 12 months after the over-income determination, and then again 12 months after the second over-income determination, unless the family's income falls below the over-income limit during the 24-month period.

Per 24 CFR 960.507(c), PHAs are required to conduct income examinations of Public Housing families who have been determined to exceed the over-income limit at specific intervals. This continued evaluation of the family's over-income status requires the PHA to notify any family that exceeds the over-income limit that they remain over the income limit, even if the family is paying the flat rent. (24 CFR 960.253). The PHA must conduct an income examination 12 months after the initial over-income determination to determine and provide notification if the family remains over-income, unless the PHA determined the family's income fell below the over-income limit since the initial over-income determination. The PHA must again conduct an income examination and provide notification 24 months after the initial over-income determination, unless the PHA determined the family's income fell below the over-income limit since the second over-income determination. An interim income reexamination to determine if a Public Housing family remains over-income does not reset the family's normal annual reexamination date.

See Notice PIH 2023–03 (HA) for additional guidance on the required reexaminations and notice for over-income Public Housing families.

Example I3: Interim Reexamination to Public Housing Over-Income Status

Scenario A: Uninterrupted Grace Period: The Blayney Family

In June 2024, the PHA processed an interim reexamination for the Blayney family effective 7/1/2024 due to an increase in the family's annual adjusted income of 10 percent or more. The PHA sent written notification of its initial determination that the family's income exceeds the applicable over-income limit. The 24-month grace period starts.

The PHA must conduct an interim reexamination 12 months later, or by 7/1/2025, to determine if the Blayney family remains over-income, even if the family is paying a flat rent. The PHA must notify the Blayney family that their income has exceeded the over-income limit for 12 consecutive months.

After completion of the 7/1/2025 interim reexamination, the Blayney family's income continued to exceed the applicable over-income limit for an additional 12 consecutive months. The PHA must conduct a second interim reexamination, even if the family is paying flat rent, 24 months from the initial determination, or by 7/1/2026, to determine if the family remains over-income.

At the 7/1/2026 interim reexamination, the Blayney family's income continued to exceed the applicable over-income limit. The PHA must either terminate their tenancy in no more than six months from the end of the 24-consecutive-month grace period, by 1/1/2027, or charge them the alternative non–public housing rent (at the next lease renewal or in no more than 60 days after the final notice, whichever is sooner), depending on the PHA's continued occupancy policies.

Scenario B: Interrupted Grace Period: The Morrison Family

The Morrison family experienced an income increase that resulted in an interim reexamination effective 2/1/2024. The family was sent the required written notification no later than 30 days after the PHA's initial determination of the family's over-income status. The 24-month grace period starts.

The PHA must conduct an interim reexamination 12 months later, or by 2/1/2025, to determine if the family remains over-income, even if the family is paying a flat rent.

After completion of the interim reexamination effective 2/1/2025, the Morrison family remained over the applicable over-income limit. The PHA must conduct a second interim reexamination, even if the family is paying a flat rent, 24 months from the initial determination, or by 2/1/2026, to determine if the family remains over-income. However, at a regularly scheduled annual reexamination effective 5/1/2025, the family is determined to no longer be over-income. This is prior to the expiration of the 24-month grace period on 2/1/2026. Thus, the grace period no longer applies, and the family remains an income-eligible PH program participant.

If the family is determined to be over-income again in the future, they would be entitled to a new 24-consecutive-month grace period.

PHA Discretion: None.

I.4 Non-Interim Reexamination Transactions

Regulations: 24 CFR §§ 5.657(c)(2) 891.105; 891.410(g)(2); and 891.610(g)(2)

Summary: Families may experience changes within the household that do not trigger an interim reexamination under HOTMA but still need to be reported in a non-interim reexamination submission to HUD. In these cases, PHAs/MFH Owners will submit a separate, new action code on form HUD–50058/HUD–50059. Further instructions on the use of this action code will be provided along with supplemental guidance on other revisions to forms HUD–50058/HUD–50059. The code will be used for the following transaction types when an interim reexamination is not triggered under the final rule:

- Adding or removing a hardship exemption for the child-care expense deduction;
- Updating or removing the phased-in hardship relief for the health and medical care expense deduction and/or reasonable attendant care and auxiliary apparatus expense deduction (the phased-in relief will begin at an eligible family's first annual or interim reexamination, whichever is sooner, after January 1, 2024);
- Adding or removing general hardship relief for the health and medical care expense deduction and/or reasonable attendant care and auxiliary apparatus expense deduction;
- Adding or removing a minimum rent hardship;
- Adding or removing a non-family member (i.e., live-in aide, foster child, foster adult);
- Ending a family's EID or excluding 50 percent (decreased from 100%) of a family member's increase in employment income at the start of the second 12-month EID period.
- Adding a family member and the **increase in adjusted income** does not trigger an interim reexamination under the final rule;
- Removing a family member and the **increase in adjusted income** does not trigger an interim reexamination under the final rule;

- Adding/updating a family or household member's Social Security number; and
- Updating a family member's citizenship status from eligible to ineligible or vice versa, resulting in a change to the family's rent and/or utility reimbursement, if applicable (i.e., family begins receiving prorated assistance or previously prorated assistance becomes full assistance), or updating the prorated rent calculation due to the addition or removal of family members in household with an ineligible noncitizen(s).

HCV Program Only:

- Processing contract rent changes that do not correspond with an interim or annual reexamination (including PBV rent increases);
- Implementing an update to the payment standard that does not correspond with an interim or annual reexamination.

Note: PHAs/MFH Owners will make all other changes to assets, income, and deductions at the next annual or interim reexamination of income, whichever is sooner.

I.5 Policies for Families to Report Changes to Annual Adjusted Income or Household Composition

Regulations: 24 CFR §§ 5.657(c)(4); 882.515(b)(1)–(4); 882.808(i)(4); 891.105; 891.410(g)(2); 891.610(g)(2); 960.257(b)(4); and 982.516(d)

Summary: PHAs/MFH Owners must require families to report **household composition changes**; however, PHAs/MFH Owners determine the timeframe in which reporting happens. PHAs/MFH Owners must develop policies that describe when and under what conditions families must report **changes in annual adjusted income** consistent with the new requirements for processing interim reexaminations. PHAs/MFH Owners are responsible for educating families on the requirements for reporting changes. Families are responsible for reporting these changes to the PHA/MFH Owner. It is the PHA's/MFH Owner's responsibility to track all reported changes to a family's annual adjusted income to ensure that the PHA/MFH Owner is correctly processing interim reexaminations in accordance with HUD's requirements.

A PHA's/MFH Owner's policies may require families to report only changes that the family estimates meet the threshold for an interim reexamination, and the PHA/MFH Owner must determine if an interim reexamination is necessary. Alternatively, PHAs/MFH Owners may establish policies requiring that families report all changes in income and household composition, and the PHA/MFH Owner will subsequently determine if the change requires an interim reexamination.

PHA/MFH Owner Discretion: PHAs/MFH Owners have the discretion to develop specific reporting policies that describe which changes must be reported to the PHA/MFH Owner and the timeline for reporting the change. For example, PHAs/MFH Owners may develop policies stipulating that families are not required to report **any** income increases that become effective within the last three months of the family's certification period, or PHAs/MFH Owners may develop policies requiring families to report all changes to household composition, income, and deductions within 10 days of the change.

I.6 Processing Time Period for Interim Reexaminations

Regulations: 24 CFR §§ 5.657(c)(1); 882.515(b)(1); 891.105; 891.410(g)(2); 891.610(g)(2); 960.257(b)(1); and 982.516(c)(1)

Summary: The updated regulations codified long-standing guidance on how long PHAs/MFH Owners should take to process an interim reexamination.

Families may request an interim determination of income or household composition because of any changes since the last determination. While the PHA/MFH Owner may decline to conduct an interim reexamination of family income if they estimate the family's annual adjusted income will change by less than 10 percent, when the PHA/MFH Owner conducts an interim reexamination, it must be conducted within a reasonable period after the family's request or after the PHA/MFH Owner becomes aware of an increase in the family's adjusted income. What qualifies as a "reasonable time" may vary based on the amount of time it takes to verify information, but the PHA/MFH Owner generally should conduct the interim reexamination not longer than 30 days after the PHA/MFH Owner becomes aware of changes in income.

PHA/MFH Owner Discretion: None.

I.7 Effective Date of Interim Rent Changes

Regulations: 24 CFR §§ 5.657(c)(5); 882.515(b)(4)–(b)(5); 891.105; 891.410(g)(2); 891.610(g)(2); 960.257(b)(6); and 982.516(c)(4)

Summary: The updated regulation codified long-standing guidance on when interim reexaminations are made effective.

- **Changes Reported Timely:** If the family has reported a change in family income or composition in a timely manner according to the PHA/MFH Owner's policies, then the PHA/MFH Owner must provide the family with a 30-day advance notice of any rent increases, and such rent increases will be effective the first day of the month beginning after the end of that 30-day period.

  If the tenant has complied with the interim reporting requirement and the tenant's rent is anticipated to decrease, rent decreases will be effective on the first day of the month after the date of the actual change leading to the interim reexamination of family income. This means the decrease will be applied retroactively.

- **Changes Not Reported Timely:** If the family has failed to report a change in family income or composition in a timely manner according to the PHA/MFH Owner's policies, PHAs/MFH Owners must implement any resulting rent increases retroactively to the first day of the month following the date of the change leading to the interim reexamination of family income.

  Any resulting rent decrease must be implemented no later than the first rent period following completion of the reexamination. The PHA/MFH Owner may choose to adopt a policy that would make the effective date of an interim reexamination retroactive to the first of the month following the date of the actual decrease in income as opposed to the first of the month following completion of the reexamination. PHAs/MFH Owners may also choose to establish conditions or requirements for when such a retroactive application would apply (e.g., where a

family's ability to report a change in income promptly may have been hampered due to extenuating circumstances such as a natural disaster or disruptions to the PHA/MFH Owner management operations).

PHAs/MFH Owners that choose to adopt such policies must ensure the earliest date that the retroactive decrease is applied is the later of the first of the month following the date of the change that led to the interim reexamination, or the first of the month following the most recent previous income examination (i.e., most recent interim or annual reexamination or the family's initial examination if that was the family's only income examination before the interim reexamination in question).

In applying a retroactive change in rent or family share as the result of an interim reexamination, the PHA/MFH Owner must clearly communicate the effect of the retroactive adjustment to the family so that there is no confusion over the amount of the rent that is the family's responsibility. In the HCV and Moderate Rehabilitation/SRO programs, the PHA must also clearly communicate the effect of the retroactive adjustment to the owner as well. These policies may reduce the potential hardship on families and eliminate or significantly reduce the amount a family may owe the PHA for back rent if the family has had difficulty in making timely rent payments during the time between the loss of income and the interim reexamination.

An exception to the requirement that a PHA/MFH Owner implement resulting rent increases retroactively to the first of the month following the date of the change leading to the interim reexamination exist if a PHA/MFH Owner failed to process a family's interim reexamination because the family did not timely report an income decrease, as illustrated in example I4, scenario D, below.

Example I4: Effective Date of Interim Rent Changes

Scenario A: The Miller family had a decrease in family income that met the threshold due to the loss of a job on 6/2/2024. They reported the decrease to the PHA/MFH Owner in accordance with the PHA/MFH Owner's policies on 6/15/2024. The interim reexamination must be effective 7/1/2024, regardless of when the PHA/MFH Owner processes the interim reexamination.

Scenario B: The Leon family had an increase of 10 percent or more in annual adjusted income on 6/1/2024 due to receiving a new type of benefit income. The increased income meets the threshold to require an interim. They reported the increase to the PHA/MFH Owner in accordance with local policies on 6/20/2024. The PHA/MFH Owner did not process the interim reexamination until 7/11/2024, so the effective date of the interim reexamination is 9/1/2024 to give the family the required 30-day notice of the increase in total tenant portion.

Scenario C: The Nguyen family had a family member join the household, thereby increasing the annual adjusted income by 10 percent or more due to the new member's Social Security income starting on 8/1/2024. The increased income meets the threshold to require an interim. However, the change in income was not reported to the PHA/MFH Owner until 9/15/2024. The PHA/MFH Owner has a policy requiring a family to report changes in family income within 30 days. Because the family failed to alert the PHA/MFH Owner of the increase in income in accordance with the PHA/MFH Owner's policy, the increased income is effective retroactive to 9/1/2024, the first of the month following the date of the income change.

Scenario D: The Housseini family's current annual reexamination is effective on 2/1/2024. A member of the Housseini family lost their job on 1/2/2024, but the family failed to report the change until 4/5/2024. If the PHA/MFH Owner has a written policy allowing for retroactive rent decreases even when the family does not

report changes timely, the retroactive rent decrease could be applied on 3/1/2024 (the first of the month following the family's most recent previous income examination).

PHA/MFH Owner Discretion: PHAs/MFH Owners must establish policies describing when and under what conditions a family is required to report changes in family income or composition in order to meet the "timely manner" requirement. PHAs/MFH Owners must update their Administrative Plans, ACOPs, or Tenant Selection Plans, as applicable, to include these policies and must communicate them clearly to participating families.

PHAs/MFH Owners may adopt a policy to apply rent decreases retroactively for circumstances in which families fail to report changes in a timely manner. A retroactive rent decrease may not be applied prior to the later of either the first of the month following the date of the actual decrease in income, or the first of the month following the most recent previous income examination. PHAs/MFH Owners may establish additional criteria to describe the conditions under which retroactive decreases will be applied (e.g., the kinds of extenuating circumstances that may inhibit timely reporting). In all cases of retroactive application, the PHA/MFH Owner must clearly communicate to the family how the retroactive adjustment will affect their responsibility for rent. In the HCV and Moderate Rehabilitation programs, the PHA must also clearly communicate the impact of the retroactive adjustment to the owner.

I.8 Streamlined Income Determination

Regulation: 24 CFR §§ 5.609(c)(2)(i); 5.657(d); 891.105; 891.410(g)(4); 891.610(g)(4); 960.257(c); and 982.516(b)

Summary: HOTMA did not update or otherwise change the streamlined income determination provision codified in the FAST Act[I3] and in HUD's regulations found in 24 CFR §§ 5.657(d), 960.257(c), and 982.516(b); however, PHAs/MFH Owners should be aware that the adjustments of non-fixed income sources at annual reexamination using third-party verification must follow the HOTMA income calculation rules outlined in Attachment B (Calculating Income) of this notice.

Under current program regulations, PHAs/MFH Owners may elect to apply a streamlined income determination for families receiving fixed income[I4]using the methodology below. For any income determined pursuant to a streamlined income determination, a PHA/MFH Owner must obtain third-party verification of all income amounts every 3 years.

When **90 percent or more** of a family's unadjusted income consists of fixed income, owners using streamlined income determinations must apply a COLA or COLAs to the family's fixed-income sources, provided that the family certifies both that 90 percent or more of their unadjusted income is fixed income and that their sources of fixed income have not changed from the previous year. Sources of non-fixed income need not be adjusted and must not be adjusted by a COLA, but PHAs/MFH Owners may choose to adjust sources of non-fixed income by the amount determined on the basis of third-party verification. PHAs/MFH Owners have the discretion to either adjust the non-fixed

[I3] P.L. 114–94.

[I4]24 CFR §§ 5.657(d)(2); 960.257(c)(2); and 982.516(b)(2); 891.410(g)(4); and 891.610(g)(4).

income or carry over the calculation of non-fixed income from the first year to years 2 and 3. Adjustments to non-fixed income must be calculated in accordance with section 14.2 (Annual Reexamination) of this notice.

When **less than 90 percent** of a family's unadjusted income consists of fixed income, owners using streamlined income determinations must apply a COLA to each of the family's sources of fixed income. Owners must determine all other income pursuant to section 14.2 (Annual Reexaminations) of this notice.

The table below explains the applicable PHA/MFH Owner action at each point in time in the streamlining cycle.

Table I1: PHA/MFH Owner Action at Point in Time in Streamlining Cycle

Point in Time in Streamlining Cycle	PHA/MFH Owner Action
Year 1	PHA/MFH Owner completes a Move in, Initial Certification (MFH Only) or Annual Reexamination consistent with the regulations on reexaminations.
Years 2 and 3	PHA/MFH Owner completes an Annual Reexamination with the following streamlined income determination for each type of source: • **Fixed Income:** Apply inflation adjustment factor; PHA/MFH Owner does not collect third-party verification. • **Non-fixed income when fixed income is more than 90 percent of unadjusted income:** PHA/MFH Owner has discretion to either adjust the income using third-party verification or use the previous year's calculation. • **Non-fixed income when fixed income is less than 90 percent of unadjusted income:** PHA/MFH Owner must adjust the income using third-party verification. • **Assets and Deductions:** PHA/MFH Owner completes verification and calculation of assets and deductions.
Year 4	Three-year cycle starts over.

PHA/MFH Owner Discretion: PHAs/MFH Owners have the discretion to implement streamlined income determinations under current program regulations.

I.9 Impact of Interim Reexamination Requirements on Family Self-Sufficiency (FSS) Programs

Summary: PHAs/MFH Owners who operate FSS programs should note two effects that the new interim reexamination regulations will have on families participating in their FSS programs.

First, HOTMA requires that interim reexaminations must be conducted: (1) when a family's income decreases by at least 10 percent of their annual adjusted income, or such lower threshold established by a PHA/MFH Owner or by HUD through notice; or (2) when a family's income increases by at least 10 percent of their annual adjusted income or such other amount established by HUD through notice, except in certain circumstances as described earlier in paragraph I.2 (Increases in Adjusted Income) of this notice.

PHAs/MFH Owners may not consider any increases in **earned income** when estimating or calculating whether the family's adjusted income has increased unless the family has previously received an interim reduction during the same reexamination cycle. Families participating in the FSS program are subject to these interim requirements, therefore their escrow accounts may not grow as their earnings increase throughout the year.

Second, the "Streamlining and Implementation of Economic Growth, Regulatory Relief, and Consumer Protection Act Changes to Family Self-Sufficiency Program" final rule states that the FSS contract of participation (COP) will generally expire 5 years **from the date of the family's first re-certification of income after** the effective date of the FSS COP. The PHA/MFH Owner may not perform an interim reexamination of annual income when enrolling a family in the FSS program unless the family experienced a change in annual adjusted income that meets the threshold for conducting an interim reexamination under the HOTMA final rule. Families for whom their first reexamination of income does not occur until their regularly scheduled annual reexamination will not have the opportunity to begin escrowing their increased earnings until that time and may have fewer escrow increases over the life of the 5-year contract.

Although families participating in FSS may experience fewer escrow increases under the HOTMA final rule, the revised interim reexamination regulations may provide these families the opportunity to use their increased earnings to realize other short- or long-term goals outside of the scope of the FSS program, such as investing in a hobby, going on a vacation with family, purchasing a car, etc.

PHA/MFH Owner Discretion: None.

ATTACHMENT J: TOPIC: VERIFICATION

Regulations

24 CFR §§ 5.216(g)(1); 5.230; 5.230(c)(5)(iii); 5.232; 24 CFR 5.232(c); 5.233; 5.240(c); 5.609(c)(3); 5.659(d); 891.105; 891.410(b)-(c) and (g); 891.610(b)-(c) and (g); 891.750; 960.259(c); and 982.516(a)(2)

Applicable Programs

HUD Multifamily Housing	HUD Multifamily Housing	Public and Indian Housing
Section 8 (Project Based Rental Assistance)	Section 202/162 PAC, Section 202/8, Section 202/811 PRAC, Section 236 IRP, Section 811 PRA, SPRAC	HCV (including Project-Based vouchers), Public Housing, Section 8 Moderate Rehabilitation, Section 8 Moderate Rehabilitation SRO
Yes	Yes	Yes

Summary

The final rule updated verification of income requirements in 24 CFR §§ 5.230; 5.232; 5.233; 5.609; and 5.659.

Subtopics

J.1 Authorization for the Release of Information (Forms HUD–9886/HUD–9887)

Regulations: 24 CFR §§ 5.230; 5.232; 891.105; 891.410(b)-(c); and 891.610(b)-(c)

Summary: In accordance with the final rule, all applicants must sign the consent form at admission, and participants must sign the consent form no later than their next interim or regularly scheduled income reexamination. After an applicant or participant has signed and submitted a consent form either on or after January 1, 2024 (regardless of the PHA/MFH Owner's compliance date), they do not need to sign and submit subsequent consent forms at the next interim or regularly scheduled income examination except under the following circumstances[J1]:

- When any person 18 years or older becomes a member of the family;
- When a member of the family turns 18 years of age; and
- As required by HUD or the PHA in administrative instructions.

These consent forms contain provisions authorizing HUD and the PHA/MFH Owner to obtain necessary information for verification of an application or to maintain a family's assistance, including income information and tax return information. The executed consent forms will remain effective until the family is denied assistance, the assistance is terminated, or if the family provides written notification to the PHA/MFH Owner to

[J1] Any person, regardless of age, who subsequently becomes a family member as the head of household, co-head of household, or spouse, must sign the consent form, in accordance with 24 CFR § 5.230(a).

revoke consent. If a family voluntarily leaves a HUD program, the family's assistance is considered to be terminated and the signed consent forms will no longer be in effect.

HUD will publish a new form HUD–9886–A and is updating forms HUD–9887 and HUD–9887–A (Fact Sheet) to conform with the final rule. HUD will include language in the forms allowing PHAs/MFH Owners to obtain financial records from financial institutions whenever the PHA/MFH Owner determines that such a record is needed to determine an applicant's or participant's eligibility for assistance or level of benefits.

PHA/MFH Owner Discretion: PHAs/MFH Owners have the discretion to establish policies around when family members must sign the consent forms when they turn 18 between reexaminations. PHAs/MFH Owners must establish these policies in their ACOPs, Administrative Plans, and Tenant Selection Plans, if requiring family members to sign consent forms at intervals other than at reexamination.

J.2 Revocation of Consent

Regulations: 24 CFR §§ 5.230(c)(5)(iii); 24 CFR 5.232(c); 891.105; 891.410(g)(3)(ii); and 891.610(g)(3)(ii)

Summary: The executed consent forms will remain effective until the family is denied assistance, the assistance is terminated, or if the family provides written notification to the PHA/MFH Owner to revoke consent. Revocation of consent or refusal to sign the consent forms prohibits the PHA/MFH Owner from requesting and accessing income information and financial records, including pulling EIV reports and using the EIV data to verify income (although the data matches between HUD and other agencies will continue to occur automatically if the family is not terminated from the program). PHAs/MFH Owners will not be able to process interim or annual reexaminations of income, including when a family's income decreases and the family requests an interim reexamination to decrease tenant rent, without the family's executed consent form(s).

Families have the right to revoke consent by providing written notice to the PHA/MFH Owner; however, revoking consent may result in termination of assistance or denial of admission, if the PHA/MFH Owner has a policy that the revocation of consent will result in termination of assistance or denial of admission. When PHAs/MFH Owners do not establish such a policy, the family is required to sign a new consent form by the next reexamination, whichever occurs first, in order to avoid termination of assistance or be reviewed for eligibility for admission. PHAs/MFH Owners must explain to families the consequences, if any, of revoking their consent.

PHAs/MFH Owners must notify their local HUD office of a family's revocation of consent.

PHA/MFH Owner Discretion: PHAs/MFH Owners may decide whether revocation of a family's consent will result in termination of assistance or denial of admission. Such a policy must be included in the PHA/MFH Owner's Administrative Plan, ACOP, or Tenant Selection Plan, as applicable.

J.3 Mandated and Discretionary use of HUD's Enterprise Income Verification (EIV) System

Regulation: 24 CFR § 5.233

Summary: The regulation clarifies that PHAs/MFH Owners must use EIV to verify tenant employment and income information at annual and streamlined reexaminations of family composition and income. However, PHAs/MFH Owners are no longer required to use EIV to verify tenant employment and income information during an interim reexamination of family composition and income.

PHAs/MFH Owners are still required to use EIV in its entirety, including using all of the required reports, such as the Existing Tenant Search and Income Reports, to verify tenant employment and income information at all other times.

Note: HUD intends to update the discrepancy logic for the MFH and Public Housing Income Discrepancy Reports and the Income Verification Tools (IVTs) to conform to the requirements of the final rule. PHAs/MFH Owners are not required to investigate discrepancies resulting from the MFH and Public Housing Income Discrepancy Reports and the IVT Tools until HUD updates the discrepancy logic. HUD will notify PHAs/MFH Owners when the new reports are ready for use.

Table J1 provides guidance on the frequency with which individual EIV reports must be utilized by a PHA/MFH Owner.

Table J1: Mandatory and Discretionary Use of EIV by PHAs/MFH Owners

Report Title	Report Description	Frequency of Use	PHAs/MFH Owners
Debts Owed to PHAs & Terminations	Allows users to access information concerning former tenants who left owing a debt to a PHA or who had their voucher terminated for cause.	At the time of processing an applicant family for admission, and to enter debt information or terminations for families who have ended program participation.	PHAs only Report does not exist in MFH EIV.
Deceased Tenants Report	Identifies tenants reported by Social Security Administration (SSA) as being deceased.	At least quarterly	PHAs/MFH Owners
Existing Tenant Search	Identifies applicants who may be receiving assistance at another Multifamily project or PIH location.	At the time of processing an applicant family for admission	PHAs/MFH Owners
Failed EIV Prescreening Report	Identifies tenants who have missing or invalid personal identifiers (last name, date of birth, SSN) in HIP/TRACS. These tenants will not be sent to SSA from EIV for the SSA identity test.	Monthly	PHAs/MFH Owners
Failed Verification Report (Failed	Identifies tenants whose personal identifiers (last name, date of birth, SSN) do not match the SSA database.	Monthly	PHAs/MFH Owners

SSA Identity Test)	*PHAs/MFH Owners that admit families using a self-certification of SSN must review the Failed SSN Verification Report monthly to identify and follow up on new issues.		
Identity Verification Report	Identifies tenants that, failed SSA verification, and failed EIV pre-screening.	Monthly	PHAs/MFH Owners
Income Discrepancy Report for MFH Programs	Identifies households where there is an income discrepancy in the wage, unemployment, and SSA benefit information reported in EIV and wage, unemployment, and SSA benefit information reported in TRACS for the period of income used for discrepancy analysis. The report serves as a tool to alert MFH Owners that there may be a discrepancy in the income reported by the tenant during the period of income used for the discrepancy analysis.	Must be used at annual reexamination. MFH Owners may use the report at other intervals, in accordance with the MFH Owner's written EIV policies and procedures. MFH Owners **are not** required to use the report at annual reexamination if they used Safe Harbor verification to determine the family's income at the last reexamination. *See note under Summary above about updates to the MFH Income Discrepancy Report.	MFH Owners

Income Information for PIH Programs Income Report for MFH Programs	Provides employment and income reported by HHS and SSA for each household member that passes the SSA identity test. Identifies tenants who: • May not have reported complete and accurate income information; and/or • May be receiving multiple subsidies.	Must be used at annual reexamination; not required at interim reexaminations. PHAs/Owners may use, if desired. PHAs/MFH Owners **are not** required to use at annual reexamination if they use Safe Harbor verification to determine the family's income. **New Admissions:** Review new admissions within 120 days after the move-in information is transmitted to HUD to confirm/validate the income reported by the household.[J2]	PHAs/MFH Owners
Income Validation Tool Report for PIH Programs	Provides projections of discrepant income for wages, unemployment compensation, and SSA benefits pursuant to HUD's data sharing agreements with the Department of Health and Human Services (HHS) using the National Directory of New Hires (NDNH) database, and the SSA.	PHAs are required to obtain an EIV Income and Income Validation Tool Report for each family any time the PHA conducts an annual reexamination of family income and composition. PHAs may use the report at other intervals, in accordance with the PHA's ACOP or Administrative Plan. PHAs **are not** required to use the report at annual reexamination if they used Safe Harbor verification to determine the family's income at the last reexamination. *See note under Summary above about updates to the MFH and Public Housing Income Discrepancy Reports.	PHAs

[J2] PHAs/MFH Owners must rely on other documents (e.g., pay stubs, benefit award letters, etc.) to verify families' income eligibility before admission.

Multiple Subsidy Report	Identifies tenants who may be receiving rental assistance at more than one location.	At least quarterly	PHAs/MFH Owners
New Hires Report	Identifies tenants who have new employment within the last six months. Report is updated monthly.	PHAs/MFH Owners must review this information at annual reexamination except when the PHA/MFH Owner uses Safe Harbor verification to determine the family's income. PHAs/MFH Owners that do not require families to undergo interim reexaminations (IRs) for income increases after an IR decrease do not need to review this report at all between a family's annual reexamination. If the PHA/MFH Owner's policy is to require an IR for increases in income after an IR decrease, then the PHA/MFH Owner must review the report quarterly after the family's IR decrease.	PHAs/MFH Owners
No Income Reported by HHS or SSA	Identifies tenants who passed the SSA identity test but where no income was reported by HHS or SSA. This scenario does not mean that the tenant does not have any income. PHAs/MFH Owners must obtain written, third-party verification of any income reported by the tenant.	As identified in a PHA's ACOP or Administrative Plan or a MFH Owner's written EIV policies and procedures.	PHAs/MFH Owners
No Income Reported on 50059	Identifies households where there is no income listed on the HUD–50059.	As identified in MFH Owner's written EIV policies and procedures.	MFH Owners

Summary Report	Summary of household information from the current, active certification in the TRACS file at the time of the income match.	Must be used at annual reexamination; not required at interim reexaminations. MFH Owners may use the report at other intervals, if desired, as described in the MFH Owner's written EIV policies and procedures.	MFH Owners

PHA/MFH Owner Discretion: PHAs/MFH Owners may choose to use EIV to verify tenant employment and income information at interim reexaminations of family composition and income. PHAs that choose to use EIV to verify income information at interim reexaminations must include this information in the PHA's ACOP and/or Administrative Plan. MFH Owners who choose to use EIV to verify tenant employment and income information at interim reexaminations must establish this policy in their written EIV policies and procedures. Any policy adopted by a PHA/MFH Owner must be applied consistently for all households.

J.4 Determination of Income Using Other Means Tested Public Assistance (i.e., "Safe Harbor")

Regulation: 24 CFR §§ 5.609(c)(3) and 891.105; 891.410(b)-(c) and (g); and 891.610(b)-(c) and (g)

Summary: PHAs/MFH Owners may determine a family's annual income, including income from assets, prior to the application of any deductions based on income determinations made within the previous 12-month period, using income determinations from the following types of means-tested federal public assistance programs:

- The Temporary Assistance for Needy Families block grant (42 U.S.C. 601, et seq.).
- Medicaid (42 U.S.C. 1396 et seq.).
- The Supplemental Nutrition Assistance Program (42 U.S.C. 2011 et seq.).
- The Earned Income Tax Credit (26 U.S.C. 32).
- The Low Income Housing Tax Credit (26 U.S.C. 42).
- The Special Supplemental Nutrition Program for Woman, Infants, and Children (42 U.S.C. 1786).
- Supplemental Security Income (42 U.S.C. 1381 et seq.).
- Other programs administered by the Secretary.
- Other means-tested forms of federal public assistance for which HUD has established a memorandum of understanding.
- Other federal benefit determinations made by other means-tested federal programs that the Secretary determines to have comparable reliability and announces through a *Federal Register* notice.

If a PHA/MFH Owner elects to use the annual income determination from one of the above-listed forms of means-tested federal public assistance, then they must obtain the

income information by means of a third-party verification. The third-party verification must state the family size, must be for the entire family (i.e., the family members listed in the documentation must match the family's composition in the assisted unit, except for household members), and must state the amount of the family's annual income. The annual income need not be broken down by family member or income type. Annual income includes income earned from assets, therefore when using Safe Harbor to verify a family's income, PHAs/MFH Owners will neither further inquire about a family's net family assets, nor about the income earned from those assets, except with respect to whether or not the family owns assets that exceed the asset limitation in 24 CFR § 5.618.

The Safe Harbor verification may be in the form of an award letter from the relevant federal program and must show that the family's income determination was made in the previous 12 months. **HUD clarifies in this notice that the verification will be considered acceptable if the documentation meets the criteria that the income determination was made within the 12 months prior to the receipt of the verification by the PHA/MFH Owner. This satisfies all verification date requirements for Safe Harbor income determinations.**

The Safe Harbor documentation will be considered acceptable if any of the following dates fall into the 12-month period prior to the receipt of the documentation by the PHA/MFH Owner:

- Income determination effective date;
- Program administrator's signature date;
- Family's signature date;
- Report effective date; or
- Other report-specific dates that verify the income determination date.

The only information that PHA/MFH Owners are permitted to use to determine income under this Safe Harbor is the total income determination made by the federal means-test program administrator. Other federal programs may provide additional information about income inclusions and exclusions in their award letters; however, these determinations and any other information **must not** be considered by the PHA/MFH Owner for purposes of the HOTMA Safe Harbor provision. PHAs/MFH Owners are not permitted to mix and match Safe Harbor income determinations and other income verifications.

The amounts of unreimbursed reasonable attendant care expenses and child-care expenses deducted from a family's annual income, except for when a family is approved for a child-care expense hardship exemption, must still be capped by the amount earned by any family member who is enabled to work as a result of the expense. PHAs/MFH Owners are therefore required to obtain third-party verification of the applicable employment income and cap the respective expense deductions accordingly.

It is anticipated that in many cases tenants will provide the PHA/MFH Owner with the Safe Harbor third-party verification for the purpose of reexamination, rather than the PHA/MFH Owner mailing a verification form to the third party to complete. If the PHA/MFH Owner does not accept Safe Harbor documentation, is unable to obtain Safe Harbor documentation, or if the family disputes the other program's income

determination, the PHA/MFH Owner must calculate the family's annual income using the methods established in § 5.609(c)(1) and (2).

If the PHA/MFH Owner uses a Safe Harbor determination to determine the family's income for an income examination (New Admission/Move Ins, Initial Certification for MFH programs only, Interim Reexamination, or Annual Reexamination), then the family is obligated to report changes in income that meet the reporting requirement and occur after the effective date of the PHA/MFH Owner's transaction. This might mean that a certain source of income was not considered in the family's income, because the other program does not consider the source to be income. For example, if the family begins receiving a new source of income on 2/1/2024 and the PHA/MFH Owner completed an annual reexamination effective 3/1/2024 using a Safe Harbor income determination, then the family does not need to report that change in income. If the family has a change in adjusted income in accordance with HUD's rules that occurs after 3/1/2024, when the Annual Reexamination was effective, then the family must report the change to the PHA/MFH Owner.

Example J1: Acceptable Verification of Safe Harbor

Background: A PHA/MFH Owner decides to implement the Safe Harbor provision, and their policy states that they will accept income determinations from the Supplemental Nutrition Assistance Program (SNAP). At the Smith family's annual reexamination interview, the Smiths provide the reexamination specialist an original print-out from the agency that administers SNAP benefits. The printout reflects the Smith's correct family size of 4, and current household composition, and it states the total amount of the family's earned income. The annual income is $19,500 ($812.50 x 24 semi-monthly pay periods). The print-out was dated 30 days prior to the PHA/MFH Owner's request, and the income was determined six months ago.

SNAP Budget Calculation (from State Department of Social Services)

Report Date: 05/17/2024

Head of Household: Smith, Hunter

Home Address: 123 Main Street, USA

Household members:

Last Name	First Name	Date of Birth	Relationship
Smith	Hunter	01/01/1974	Head of Household
Smith	Annabelle	06/18/1976	Spouse
Smith	Lola	05/17/2019	Daughter
Smith	Eric	05/17/2019	Son

Budget Calculation

Monthly Earned Income: $1,625

Total Unearned Income: $0

Standard Deduction: $112.50

Monthly child care/dependent care: $50

Allowable medical deductions: $0

Result: The PHA/MFH Owner may use this printout to determine the Smith's annual income for their annual reexamination. The PHA/MFH Owner lists $19,500 as the annual income for the family's reexamination ($1,625 monthly earned income + $0 unearned income x 12 months). The PHA/MFH Owner **does not** need to take any additional steps to verify or calculate gross annual income, including comparing the income determination to EIV data. The PHA would then verify and apply applicable deductions to calculate the family's annual adjusted income.

PHA/MFH Owner Discretion: PHAs/MFH Owners are not required to accept or use determinations of income from other federal means-tested forms of assistance.

PHAs/MFH Owners must establish in policy whether and when they will accept Safe Harbor income determinations (e.g., at reexamination only or at admission and reexamination), including which programs from which they will accept income determinations. PHAs/MFH Owners must also create policies that outline the course of action when families present multiple verifications from the same or different acceptable Safe Harbor programs (e.g., to accept the most recent income determination). These policies must be included in the PHA's/MFH Owner's ACOP, Administrative Plan, or Tenant Selection Plan, as applicable.

J.5 Verification Hierarchy

Regulation: 24 CFR §§ 5.240(c); 5.659(d); 891.105; 891.410(b)-(c) and (g); 891.610(b)-(c) and (g); 960.259(c); 982.201(e); and 982.516(a)(2)

Summary: PHAs/MFH Owners are responsible for obtaining third-party verification of reported family annual income, the value of assets, expenses related to deductions from annual income, and other factors that affect the determination of adjusted income. Third-party verification is a process by which PHAs/MFH Owners gather information (e.g., about the family's annual income, value of assets, etc.) independently from the source of the income, assets, expenses, or other factors that affect the determination of adjusted income. Third-party verification may be obtained directly from the third party or through the family. PHAs/MFH Owners must document in the tenant file the reason why third-party verification was not available unless HUD's regulations specifically permit families to self-certify a particular component of adjusted income.

HUD developed a hierarchy (see table J2, below) that describes verification documentation from most acceptable to least acceptable. The PHA/MFH Owner must demonstrate efforts to obtain third party verification prior to accepting self-certification except instances when self-certification is explicitly allowed (e.g., net family assets that do not exceed $50,000).

A description of each verification technique and additional guidance follows Table J2.

Table J2: Verification Hierarchy

Level	Verification Technique	Ranking/Order of Acceptability
6	Upfront Income Verification (UIV), using HUD's Enterprise Income Verification (EIV) system	Highest PHAs/MFH Owners must pull the EIV Income Report for each family at every Annual Reexamination, unless using Safe Harbor documentation to verify the family's income

		EIV may be used as the sole verification of Social Security income. EIV income information may be used to calculate other types of annual income when family agrees. See Level 4 for more information.
5	Upfront Income Verification (UIV) using non-EIV system (e.g., The Work Number, web-based state benefits systems, etc.)	Highest
4	Written, third-party verification from the source, also known as "tenant-provided verification" OR EIV + Self-Certification PHAs/MFH Owners can choose either option when both are available to verify income. PHAs/MFH Owners must use written, third-party verification when the income type is not available in EIV (e.g., self-employment, Go Fund Me accounts, general public assistance, Veterans Administration benefits, etc.)	High • Written, third-party verification is used when tenant disputes EIV-reported employment and income information. • The EIV Income Report may be used to verify and calculate income if the family self-certifies that the amount is accurate and representative of current income. The family must be provided with the information from EIV.
3	Written, Third-Party Verification Form	Medium • Use if Level 5 or Level 4 verification is not available or is rejected by the PHA/MFH Owner and when the applicant or tenant is unable to provide acceptable documentation. • May substitute Level 2 for written, third-party verification form, only completing one of the two forms of verification before moving to self-certification.
2	Oral Third-Party Verification	Medium
1	Self-Certification (not third-party verification)	Low • Use as a last resort when unable to obtain any type of third-party verification or if specifically permitted, such as to determine actual income from assets when the family certifies that net family assets do not exceed $50,000. • May be used as highest form of verification when the family reports zero income.

J.5.a Third-Party Verification Descriptions and Guidance

- **Upfront Income Verification (UIV) (Level 6/5):** The verification of income before or during a family reexamination, through an independent source that systematically and uniformly maintains income information in computerized form for a number of individuals. It should be noted that the EIV system is available to all PHAs/MFH Owners as a UIV technique and that all

PHAs/MFH Owners are required to use EIV in its entirety (see paragraph J.3 on Mandated and Discretionary Use of EIV). PHAs/MFH Owners are encouraged to continue using other non-HUD UIV tools, such as The Work Number (an automated verification system) and state government databases, to verify tenant-reported income.

- **Written, Third-Party Verification (Level 4):** An original or authentic document generated by a third-party source dated within 120 days of the date received by the PHA/MFH Owner. For fixed-income sources, a statement dated within the appropriate benefit year is acceptable documentation.

  Such documentation may be in the possession of the tenant (or applicant) and is commonly referred to as tenant-provided documents. PHAs/MFH Owners may obtain any tenant-provided documents and follow up directly with the third-party source to obtain necessary verification of information, when necessary.

  Examples of acceptable tenant-provided documentation (generated by a third-party source) include but are not limited to the following: pay stubs, payroll summary report, employer notice/letter of hire/termination, SSA benefit verification letter, bank statements, child support payment stubs, welfare benefit letters and/or printouts, and unemployment monetary benefit notices.

  PHAs/MFH Owners are required to obtain a minimum of two current and consecutive pay stubs for determining projected annual income from wages when they are relying on pay stubs for Level 4 documentation. MFH Owners were previously required to collect the most recent four to six weeks of pay stubs to verify employment income. For new income sources or when two pay stubs are not available, the PHA/MFH Owner should determine income based on the information from a traditional written, third-party verification form or the best available information.

  Income tax returns with corresponding official tax forms and schedules attached and including third-party receipt of transmission for income tax return filed (i.e., tax preparer's transmittal receipt, summary of transmittal from online source, etc.) are an acceptable form of written, third-party verification.

  When verification of assets is required, PHAs/MFH Owners are required to obtain a minimum of one statement that reflects the current balance of banking/financial accounts. MFH Owners were previously required to average the balance of six checking account statements to determine the cash value of a checking account.

  EIV may be used as Level 4 verification and may be used to calculate income as long as the family agrees with the information in EIV; this practice is known as "EIV + Self-Certification." The PHA/MFH Owner may use their discretion to determine which method of calculation is reasonable: the last 4 quarters combined or an average of any number of quarters. The EIV Income

report must be pulled within 120 days prior to the reexamination effective date.

- **Written, Third-Party Verification Form (Level 3):** This practice is also known as "traditional third-party verification." This type of verification is a form developed by the PHA/MFH Owner and used uniformly for all families when needed to collect information from a third-party source. The form is completed by the third party by hand (in writing or typeset). PHAs/MFH Owners send the form directly to the third-party source by mail, fax, or email.

  The PHA/MFH Owner may skip this level of verification before attempting Level 2, which means they will have only completed Level 3 or Level 2 verification before moving to Self-Certification.

- **Oral Third-Party Verification (Level 2):** Independent verification of information by contacting the individual income/expense source(s), as identified through the UIV technique, or identified by the family, via telephone or in-person visit. PHA/MFH Owner staff must document in the tenant file the date and time of the telephone call (or visit to the third party) and the name of the person contacted and their telephone number, along with the confirmed information.

  This verification method is commonly used when the independent source does not respond to the PHA/MFH Owner's faxed, mailed, or e-mailed request for information in a reasonable time frame (e.g., 10 business days).

  The PHA/MFH Owner may skip this level of verification if they attempted Level 3, which means they will have only completed Level 3 or Level 2 verification before moving to Self-Certification.

- **Non-Third-Party Verification Technique: Self-Certification (Level 1):** The tenant submits a signed statement of reported income and/or expenses to the PHA/MFH Owner. This verification method should be used as a last resort when the PHA/MFH Owner has not been successful in obtaining information via all other required verification techniques. When the PHA/MFH Owner relies on self-certification to verify income or expenses, the PHA/MFH Owner must document in the tenant file why third-party verification was not available.

  HUD does not require that a self-certification be notarized; however, HUD recommends including language on any self-certification to ensure the certifier understands the consequences of knowingly providing false information.

  Sample language to use in a self-certification: "I/We, the undersigned, certify under penalty of perjury that the information provided here is true and correct, to the best of my knowledge and recollection. WARNING: Anyone who knowingly submits a false claim or knowingly makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties. (18 U.S.C. 287, 1001, 1010, 1012; 31 U.S.C. 3279, 3802)"

J.6 Verification of Social Security Number (SSN)

Regulation: 24 CFR § 5.216(g)(1) 891.105; 891.410(b)-(c) and (g); 891.610(b)-(c) and (g)

Summary: It has become increasingly difficult for applicants to meet HUD's SSN disclosure requirements, particularly for those individuals experiencing homelessness. To help protect individuals' privacy, many federal, state, and local agencies no longer print an individual's SSN on official documentation. Individuals may be required to visit their local Social Security office and provide original identity documentation in order to obtain a replacement Social Security card.

HUD is adjusting what the Department considers acceptable documentation of SSN under 24 CFR § 5.216(g)(1) to make it easier for applicants to access programs even if they do not have access to their Social Security card or other documentation acceptable to HUD. PHAs/MFH Owners must still attempt to gather third-party verification of SSN prior to admission; however, they will also have the option of accepting a self-certification and a third-party document with the applicant's name printed on it to satisfy the SSN disclosure requirement if the PHA/MFH has exhausted all other attempts to obtain the required documentation. HUD has provided similar flexibility to PHAs through the CARES Act waivers and for Emergency Housing Vouchers.

HUD prescribes, through this notice and in accordance with 24 CFR 5.216(g)(1)(iii), that the following evidence of SSN is acceptable only after the PHA/MFH Owner has attempted to first obtain a valid SSN card issued by the SSA or an original document issued by a federal or state government agency that contains the name of the individual and the SSN of the individual, along with other identifying information of the individual:

Self-certification of SSN *and* at least one third-party document, such as a bank statement, utility or cell phone bill, benefit letter, etc., that contains the name of the individual.

If verifying an individual's SSN using this method, the PHA/MFH Owner must document why the other SSN documentation was not available.

If the tenant's SSN becomes verified in EIV, then no further verification is required. If the tenant's SSN fails the SSA identity match, then the PHA/MFH Owner must obtain a valid SSN card issued by the SSA or an original document issued by a federal or state government agency that contains the name of the individual and the SSN of the individual, along with other identifying information of the individual. The tenant's assistance must be terminated if they fail to provide the required documentation.

J.7 Verification of Excluded Income

To reduce administrative burdens on PHAs/MFH Owners, HUD is providing guidance and clarification on the requirements for verifying excluded income.

For income sources where the entire amount qualifies to be excluded from the annual income determination in accordance with 24 CFR § 5.609(b) and any *Federal Register* notice on mandatory exclusions issued by HUD, the PHA/MFH Owner **is not** required to:

- Verify the income using third-party verification;

- Document in the tenant file as to why the third-party verification was not available as required by 24 CFR §§ 5.659(d), 960.259(c)(i), and 24 CFR 982.516(a)(2); 891.105; 891.410(b)-(c) and (g); 891.610(b)-(c) and (g); or
- Report the income on forms HUD–50058/HUD–50059.

PHAs/MFH Owners may accept an applicant or participant's self-certification as verification of excluded income. The PHA/MFH Owner's application and reexamination questionnaire documentation may serve as the self-certification of excluded income. PHAs/MFH Owners have the option of verifying the income using third-party verification, if necessary, to determine if a source of income qualifies for exclusion.

Examples of excluded income categories that are verifiable through applicant or participant self-certification include:

- Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as food stamps.
- Income of a live-in aide. For a complete list of income exclusions, see 24 CFR § 5.609(b).

An income source that is partially excluded, for example, earnings in excess of $480 for full-time students 18 years of age or older (24 CFR § 5.609(b)(14)), must be third-party verified and reported on forms HUD–50058/HUD–50059.

J.8 Zero Income Procedures

PHAs/MFH Owners may accept a self-certification of zero income from the family at admission and at reexamination without taking any additional steps to verify zero reported income. HUD does not require that such self-certification be notarized. PHAs/MFH Owners are reminded that they must verify families' income in EIV within 120 days after admission, except where the PHA/MFH Owner used Safe Harbor documentation to verify a family's income.

PHAs/MFH Owners have discretion to establish reasonable procedures to manage the risk of unreported income, such as asking families to complete a zero income worksheet at admission or periodically after admission to determine if they have any sources of unreported income, or searching an upfront income verification source (see Level 5) for unreported income, such as a public benefits database to which the PHA/MFH Owner has access. These procedures are meant to avoid improper payments and the need for repayment agreements.

In calculating annual income from a zero income worksheet, PHAs/MFH Owners must not assign monetary value to non-monetary in-kind donations from a food bank or similar organization received by the family (24 CFR § 5.609(b)(24)(vi)). PHAs/MFH Owners perform an interim reexamination only due to an increase in the family's adjusted income (24 CFR §§ 5.657(c)(3); 882.515(b)(3); 891.410(g)(2); 891.610(g)(2); 960.257(b)(3); and 982.516(c)(3)).

PHAs/MFH Owners that establish zero income procedures must update their local discretionary policies, procedures, and forms to comply with the final rule requirements. For example, families who begin receiving income which does not trigger an interim

reexamination should no longer be considered zero income even though the family's income is not reflected on the form HUD–50058/HUD–50059.

APPENDIX: SAMPLE NET FAMILY ASSET SELF-CERTIFICATION FORM

Self-Certification of Net Family Assets and Real Property

This form will help determine your eligibility for the program under the asset limitation. Your housing provider may also use this form to help determine your income from assets if your total net family assets do not exceed $50,000 (adjusted annually for inflation). Third-party verification is required when net family assets exceed $50,000, and every three years.

Real Property (for example: land, house, condominium, commercial building, etc.).

1. Do you or any member of your assisted family have an ownership interest in any real property?

   ☐ Yes ☐ No

   If the answer to question #1 is No, skip to question #6.

2. If yes, please check off if any of the following statements are true about the property:

   ____ The property does not meet the disability-related needs for all members of the family (for example, physical accessibility requirements, accessible common areas, disability-related need for additional bedrooms, or closeness to accessible transportation/medical facilities/other supportive services, etc.);
   ____ The property is not sufficient for the size of the family;
   ____ The property is located in an area that is a hardship (for instance, far from a family member's place of work or school);
   ____ The property is not safe to live in because of physical condition; or
   ____ The property is not a property where a family can live based on the State or local laws where the property is located.

   If you checked off any of the above statements, you will need to provide additional documentation to demonstrate that the statement is true.

3. If you did not check off any of the statements in question 2, do you or any member of your assisted family have the legal authority to sell the property?

   ☐ Yes ☐ No

4. There is an exemption from the limitation on assistance for families that have an ownership interest in real property for victims of domestic violence, dating violence, sexual assault, and stalking. If you or any member of the assisted family is a victim, you can claim

this exemption from the real property limitation. Please check this box if you think you may be eligible for this exemption.

☐ I believe I may be eligible for this exemption, and I would like more information from the PHA's VAWA Coordinator or Executive Director, or the MFH property's Owner/Agent. (If you do not understand this exemption or how to exercise your rights, you can speak to these individuals for more information.)

5. What is the estimated cash value of the property (market value minus mortgage/other loans and costs to sell. Enter $0 if market value of property is less than outstanding debt (i.e., mortgage is upside down/underwater)?

$

Other Assets (for example: accounts, luxury items that are not necessary)

6. How much income do you expect your family to earn from your total family assets in the next year? This includes interest, dividends, and other earnings, e.g., anything for which you receive Form 1099 tax documents. Actual income (interest, dividends, etc.) from excluded assets is included as income.

$

7. Do you or any member of your assisted family have other assets (including checking accounts, savings accounts, certificates of deposits (CDs), stocks, bonds, luxury items, recreational vehicles, etc.) that total more than $50,000 (adjusted annually for inflation)?

☐ Yes ☐ No

Assets to consider	Assets always excluded
• Checking and savings accounts • Stocks, bonds, mutual funds • Luxury items or items that are not necessary, e.g., recreational boat, vehicles not used for regular transportation • Assets disposed of for less than fair market value; for example, if you gave away a house to someone out outside of the assisted family within the past two years, the value of the house would be considered an asset (except as determined by certain divorce or separation settlements)	• Retirement accounts (e.g., IRAs, 401k, 403b) • Educational savings accounts (Section 529, Section 530, Coverdell ESA, etc.) • ABLE accounts • Non-revocable trusts • Necessary items of personal property (items essential for the maintenance, use, and occupancy of a home or necessary for employment, education, cultural expression, or health and wellness) • Federal tax refunds (must be subtracted from total net family assets)

I/We, the undersigned, certify that the information provided here is true and correct to the best of my knowledge and recollection. Anyone who knowingly submits a false claim or knowingly makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties. (18 U.S.C. 287, 1001, 1010, 1012; 31 U.S.C. 3279, 3802)

Head of Household Signature

Date

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-5000

OFFICE OF PUBLIC AND INDIAN HOUSING

SPECIAL ATTENTION OF:
Office Directors of Public Housing; Regional Directors; Public Housing Agencies

NOTICE PIH 2024-38
Issued: December 17, 2024

Expires: This notice remains in effect until amended, superseded or rescinded.

Cross References: Notice PIH 2023-27, Notice H 2024-09

Subject: Housing Opportunity Through Modernization Act (HOTMA) Sections 102 and 104: Updated Guidance to Public Housing Agencies (PHAs) on Compliance

I. Purpose

The purpose of this Notice is to identify which income and assets provisions from Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA) that Public Housing Agencies (PHAs) must comply with no later than July 1, 2025.[1]

Section 6.1 of Notice PIH 2023-27 previously established a compliance deadline of January 1, 2025, by which PHAs had to fully comply with the HOTMA final rule.[2] This Notice supersedes, in part, Section 6.1 of Notice PIH 2023-27. This Notice indicates that for the specific HOTMA provisions identified below, the new deadline for PHA compliance is July 1, 2025. For all other provisions that are not identified in this Notice, HUD will not enforce PHA compliance by January 1, 2025.

II. Background

HOTMA was signed into law on July 29, 2016 (Pub. L. 114-201). The final rule implementing Sections 102 and 104 of HOTMA (88 FR 9600) became effective January 1, 2024. HUD initially provided, in the HOTMA Section 102 and 104 Implementation

[1] References to form HUD–50058 in this notice take on the meaning of form HUD–50058 MTW for MTW PHAs and form HUD–50058 MTW Expansion for MTW Expansion PHAs.
[2] *Housing Opportunity Through Modernization Act of 2016; Implementation of Sections 102, 103, and 104*. 88 Fed. Reg., 9,600. February 14, 2023.

Guidance (Notice PIH 2023-27),[3] that PHAs could set a compliance date between January 1, 2024, and January 1, 2025, based on when the PHA's software could submit to HIP.

Due to further IT system development delays, HUD will not enforce compliance with all Section 102 and 104 income and assets provisions by January 1, 2025.[4] PHAs will not have software capable of submitting HOTMA-compliant forms to HIP by January 1, 2025, because HIP development has not been completed. The IMS/PIC legacy system reflects pre-HOTMA requirements in many places. When the timeline for completion of HIP development and PHA migration is known, HUD will issue further guidance on the deadline to comply with any outstanding provisions of Sections 102 and 104. HUD will provide regular updates on the progress of systems development.

III. Applicability

This notice applies to PHAs administering Office of Public and Indian Housing (PIH) programs (HCV [including Project-Based Vouchers], Moderate Rehabilitation, Moderate Rehabilitation SRO, Public Housing), including PHAs that participate in the Moving to Work (MTW) Demonstration.[5]

IV. PHA Compliance with HOTMA Sections 102 and 104

A. HUD Enforcement Prior to July 1, 2025

1. Earned Income Disregard

Regulation: 24 CFR 5.611

PHAs must have ceased enrolling families into the Earned Income Disregard (EID) as of December 31, 2023. EID will not apply to any family that was not eligible for and already participating in the disregard as of December 31, 2023. Please refer to Notice PIH 2023-27, Attachment G, Section G.20, for guidance on the end of EID.[6]

2. Form HUD-9886-A

Regulation: 24 CFR 5.230, 5.232

PIH communicated by letter on February 23, 2024, that PHAs may begin having families sign the new Form HUD-9886-A (Authorization for the Release of Information/Privacy Act Notice) on January 1, 2024. The Form HUD-9886-A instructs readers to use the HUD-9886-A for reexaminations effective on or after January 1, 2024, and to use Form HUD-9886 for reexaminations effective prior to January 1,

[3] Notice PIH 2023-27, *Implementation Guidance: Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA)*. Re-issued February 2, 2024.
[4] PIH Message to Public Housing Agencies. "HOTMA 102/104 Income and Assets Rule Compliance." September 18, 2024.
[5] The contents of this notice apply to PHAs participating in the MTW program except where an approved MTW waiver is in place. For example, MTW PHAs that have previously developed a different method of measuring prior-year income as part of the Rent Reform Demonstration or Stepped and Tiered Rent Demonstration may continue to use those methods after this notice takes effect.
[6] PIH Message to Public Housing Agencies. "Updates on HIP and HOTMA Implementation." February 23, 2024.

2024. Please refer to Notice PIH 2023-27, Attachment J, Section J.1 for guidance on the authorization for release of information form. Form HUD-9886 expires on January 31, 2025, at which point the Form HUD-9886-A will be the only approved version of the authorization for release of information form. PHAs must transition to using the Form HUD-9886-A by February 1, 2025.

PHAs that have begun use of the Form HUD-9886-A must also start implementing policies related to the revocation of consent. Please refer to Notice PIH 2023-27, Attachment J for guidance on the new authorization for the release of information form (HUD-9886-A) and the family's ability to revoke consent. Section J.1 provides guidance on the use of the Form HUD-9886-A. Notice PIH 2023-27, Attachment J, Section J.2 provides guidance on revocation of consent.

B. HUD Enforcement Beginning July 1, 2025

This Notice identifies additional provisions in Sections 102 and 104 of HOTMA that PHAs must comply with no later than July 1, 2025. HUD has determined that PHAs can comply with these specific provisions while they remain in IMS/PIC, prior to the availability of HOTMA-compliant HUD-50058 forms in HIP. All transactions with an effective date on or after July 1, 2025, must be processed using these HOTMA policies. Since the reexamination process typically starts 90-120 days prior to the effective date of the transaction, this means that PHAs may need to utilize such policies in reexaminations as soon as March 3, 2025.

This compliance deadline does not apply to other provisions, which require systems development. For provisions not on this list, HUD either identified technical obstacles in IMS/PIC that PHAs would encounter when trying to report HUD-50058 transactions that used such provisions, or the provision is closely linked to other HOTMA provisions that have similar obstacles. For example, HOTMA raised the Elderly/Disabled Family deduction to $525 effective January 1, 2024, but PHAs in IMS/PIC are unable to comply with this change, because they are unable to submit transactions at the higher amount.

PHAs may immediately begin complying with HOTMA provisions identified below, once they have made any necessary updates to their materials and processes. HUD encourages PHAs to consult with their software vendors prior to beginning to implement these provisions, to ensure HUD-50058 transactions are submitted successfully.

1. Income Exclusions

Regulation: 24 CFR 5.609(b)

PHAs may immediately begin to implement income exclusions in 24 CFR 5.609(b), on all income examinations including at new admissions, annual, or interim reexaminations. For all income examinations with an effective date on or after July 1, 2025, PHAs must utilize the list of income exclusions. Please note that Notice PIH 2023-27 does not reference all income exclusions, but rather provides guidance on

new or revised income exclusions. For the full list of income exclusions, please refer to the regulations at 24 CFR 5.609(b).

Please refer to Notice PIH 2023-27, Attachment G, for guidance on the following new and revised exclusions:

- Nonrecurring Income (24 CFR 5.609(b)(24))
- Lump-Sum Additions to Net Family Assets (24 CFR 5.609(b)(24)(vii)
- Income Earned on Amounts Placed in a Family's Family Self Sufficiency (FSS) Account (24 CFR 5.609(b)(27))
- Income of Live-in Aides, Foster Children, and Foster Adults (24 CFR 5.609(b)(8))
- Payments Received for the Care of Foster Children or Foster Adults or State or Tribal Kinship or Guardianship Care Payments (24 CFR 5.609(b)(4))
- Insurance Payments or Settlements (24 CFR 5.609(b)(5))
- Civil Action Recoveries or Settlements (24 CFR 5.609(b)(7))
- Earned Income of Dependent Full-Time Students (24 CFR 5.609(b)(14))
- Adoption Assistance Payments (24 CFR 5.609(b)(15)
- Veterans Regular Aid and Attendance (24 CFR 5.609(b)(17))
- Home-Based Care Payments for a Family Member(s) with one or more Disabilities (24 CFR 5.609(b)(19))
- Loan Proceeds (24 CFR 5.609(b)(20))
- Certain Payments Received by Tribal Members (24 CFR 5.609(b)(21))
- Exclusions from Other Federal Statutes (24 CFR 5.609(b)(22))
- Replacement Housing Gap Payments (24 CFR 5.609(b)(23))
- Student Financial Assistance (24 CFR 5.609(b)(9))
- Achieving a Better Life Experience (ABLE) Accounts (24 CFR 5.609(b)(22))
- Income and Distributions from Coverdell Education Savings Accounts, 529 Accounts, and "Baby Bond" Accounts (24 CFR 5.609(b)(10))
- Gross Income from Self-Employment or Operation of a Business (24 CFR 5.609(b)(24) and 5.609(b)(28))
- Civil Rights Settlements or Judgments (24 CFR 5.609(b)(25))

Please refer to Notice PIH 2023-27, Attachment F, Section F.4.d.iii for guidance on the income exclusion at 24 CFR 5.609(b)(2):

- Certain distributions of irrevocable trusts or revocable trusts outside the control of the family or household (including most Special Needs Trusts) (24 CFR 5.609(b)(2))

Note that adoption of some new or revised definitions below may affect the calculation for certain income exclusions. For example, the revised definition of the term "health and medical care expenses" may affect the income exclusion at 24 CFR 5.609(b)(6):

- Amounts for or in reimbursement of the cost of health and medical care expenses (24 CFR 5.609(b)(6))

2. Definitions

Regulation: 24 CFR 5.100, 5.403, 5.603

PHAs may immediately begin to use the following definitions. For all transactions with an effective date on or after July 1, 2025, PHAs must use these definitions.

- "Earned income" and "unearned income" (24 CFR 5.100). Please refer to Notice PIH 2023-27, Attachment F, Sections F.2 and F.3 for guidance on these definitions.
- "Family" (24 CFR 5.403). Please refer to Notice PIH 2023-27, Attachment E, Section E.1 for guidance on the definition of family.
- "Day laborer," "independent contractor," and "seasonal worker" (24 CFR 5.603). Please refer to Notice PIH 2023-27, Attachment F, Sections F.2.a, F.2.b, and F.2.c for guidance on these definitions.
- "Dependent" (24 CFR 5.603). Please refer to Notice PIH 2023-27, Attachment E, Section E.2 for guidance on the revision to this definition.
- "Foster child" and "foster adult" (24 CFR 5.603). Please refer to Notice PIH 2023-27, Attachment E, Section E.2 for guidance on these definitions. **Note:** The definitions of "foster child" and "foster adult" were added to 24 CFR 982.4 as part of a final rule published on May 7, 2024 ("Housing Opportunity Through Modernization Act of 2016-Housing Choice Voucher (HCV) and Project-Based Voucher Implementation; Additional Streamlining Changes," 89 FR 38224), and this rule did not have a delayed compliance date.[7] For the Housing Choice Voucher program [including Project-Based Vouchers], PHAs must already be implementing the definition of "foster child" and "foster adult".
- "Health and medical care expenses" (24 CFR 5.603). Please refer to Notice PIH 2023-27, Attachment C, Section C.3.b for guidance on this definition.
- "Minor" (24 CFR 5.603).

3. De Minimis Errors

Regulation: 24 CFR 5.609(c)(4); 882.515(f); 882.808(i)(5); 960.257(f); and 982.516(f)

Please refer to Notice PIH 2023-27, Attachment B, Section B.4 for guidance on de minimis errors, which includes guidance on when PHAs must take corrective action to credit or repay a family.

[7] *Housing Opportunity Through Modernization Act of 2016 – Housing Choice Voucher (HCV) and Project-Based Voucher Implementation; Additional Streamlining Changes*. 89 Fed. Reg., 38,224. May 7, 2024.

C. Summary of Compliance Requirements

The table below summarizes the provisions of Sections 102 and 104 of HOTMA identified in this Notice and their respective compliance deadlines.

Provisions	Required Compliance Date
Ceasing Enrollment into Earned Income Disregard (EID)	January 1, 2024
Use of HUD-9886-A	No later than February 1, 2025
Income Exclusions	No later than July 1, 2025
Definitions	No later than July 1, 2025
De Minimis Errors	No later than July 1, 2025

HUD will not be enforcing compliance with any other provision by January 1, 2025.[8] HUD will issue further guidance on the compliance deadline for all other provisions, when there is more information about when PHAs will be able to submit HOTMA-compliant HUD-50058 forms in HIP.

V. Further Information

Questions concerning this notice should be submitted by email to the following Office of Public Housing and Voucher Programs mailbox: HOTMAQuestions@hud.gov.

Richard J. Monocchio
Principal Deputy Assistant Secretary
Public and Indian Housing

[8] HUD has also determined that PHAs can implement two discretionary provisions of Sections 102 and 104 of HOTMA while they remain in IMS/PIC, prior to the HOTMA-compliant HUD-50058 forms becoming available in HIP. As previously noted, PHAs may start implementing the "Safe Harbor" income verification option of the HOTMA final rule. Please refer to Notice PIH 2023-27, Attachment J, Section J.4 for guidance on Safe Harbor income verification. If a PHA chooses to adopt this policy while in IMS/PIC, they must list the annual income from the other program's determination in Section 7 of the HUD-50058 for the Head of Household using the "Other Non-Wage Sources" income code. Additionally, PHAs may choose not to use the Enterprise Income Verification (EIV) system to verify tenant employment and income information during an interim reexamination of family composition and income. Please refer to Notice PIH 2023-27, Attachment J, Section J.3, for guidance on mandated and discretionary use of the EIV system. PHAs may choose to continue to use EIV to verify tenant employment and income information at interim reexaminations of family composition and income.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-8000

ASSISTANT SECRETARY FOR HOUSING–
FEDERAL HOUSING COMMISSIONER

Special Attention of:

All Multifamily Regional Center Directors
All Multifamily Satellite Office Directors
All Multifamily Asset Management Division Directors
All Multifamily Operations Officers
All Multifamily Field Counsel
All Contract Administrators
All Multifamily Project Owners

Notice H–2025–03
Issued: 5/29/2025

Expires: This Notice remains in effect until amended, superseded, or rescinded

SUBJECT: Extension of Mandatory Compliance Date: Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA)

I. Purpose

The purpose of this Notice is to extend the HOTMA final rule compliance date to January 1, 2026. This Notice supersedes Notice H 2024–09, which extended the date by which Owners must comply fully with Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA) final rule until July 1, 2025.

II. Background

Section 6.2 of Notice H 2023–10 requires Multifamily Housing Owners to be in full compliance with the HOTMA final rule and HUD's updated income and asset documentation requirements for income certifications having an effective date on or after January 1, 2025. Thereafter, HUD published Notice H 2024–09 that extended the January 1, 2025 deadline to July 1, 2025. This Notice however extends the compliance date to January 1, 2026. The requirement applies to Owners participating in the programs listed in section 4 (Applicability) of Notice H 2023–10.

III. Revision of Date

The compliance dates stated in section 6.2 of Notice H 2023–10 and Notice H 2024–09 are extended to January 1, 2026.

IV. Further Information

If you have questions about this Notice, please send them to MFH_HOTMA@hud.gov.

Frank Cassidy
Principal Deputy Assistant Secretary for Housing

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-5000

OFFICE OF PUBLIC AND INDIAN HOUSING

Special Attention of:

Public Housing Field Office Directors
Public Housing Agency Directors
Public Housing Hub Office Directors
Multifamily Regional Center Directors
Rural Services (RHS) Directors
Supervisory Housing Project Managers
Housing Project Managers
Contract Administrators
Multifamily Owners and Management Agents

NOTICE PIH 2019-09
NOTICE H-2019-06

Issued: April 26, 2019

This notice remains in effect until amended, superseded or rescinded.

Cross Reference: 24 CFR 5.609; ABLE Act of 2014

Title: Treatment of ABLE Accounts in HUD-Assisted Programs

Purpose: This notice provides guidance regarding the federally mandated exclusion of ABLE accounts from the calculation of income and assets, as required under the Achieving a Better Life Experience Act of 2014 (ABLE Act). Per the mandate of the ABLE Act, for the purpose of determining eligibility and continued occupancy, HUD will disregard amounts in the designated beneficiary's/individual's ABLE account.

Background: The Achieving Better Life Experience (ABLE) Act (P.L. 113-295.) was signed into law on December 19, 2014. The ABLE Act allows States to establish and maintain a program under which contributions may be made to a tax-advantaged ABLE savings account to provide for the qualified disability expenses of the designated beneficiary of the account. The designated beneficiary must be a person with disabilities, whose disability began prior to his or her 26th birthday and who meets the statutory eligibility requirements.

Applicability: This notice applies to the following programs:

1. Housing Choice Voucher Program, including all special voucher types
2. Public Housing
3. Project-based Section 8
    - New Construction
    - State Agency Financed
    - Substantial Rehabilitation
    - Section 202/8
    - Rural Housing Services (RHS) Section 515/8
    - Loan Management Set-Aside (LMSA)
    - Property Disposition Set-Aside (PDSA)
    - Rental Assistance Demonstration Project Based Rental Assistance (RAD/PBRA)
4. Section 202/162 Project Assistance Contract (PAC)
5. Section 202 Project Rental Assistance Contract (PRAC)
6. Section 202 Senior Preservation Rental Assistance Contracts (SPRAC)
7. Section 811 PRAC

8. Section 811 Project Rental Assistance (PRA)
9. Section 236 (including RAP)
10. Section 221(d)(3)/(d)(5) Below Market Interest Rate (BMIR)

Definition of Terms: This Section includes definitions of terms referred to in this notice.

A. *ABLE account* means an account established for the benefit of an eligible individual, maintained under a qualified ABLE program.
B. *Contribution* is the deposit of funds into an ABLE account.
C. *Designated beneficiary* is the eligible individual who established and owns the ABLE account.
D. *Distribution* is the withdrawal or issuance of funds from an ABLE account.

Treatment of ABLE account in HUD programs: Section 103 of the ABLE Act mandates that an individual's ABLE account (specifically, its account balance, contributions to the account, and distributions from the account) is excluded/disregarded when determining the designated beneficiary's eligibility and continued occupancy under certain federal means-tested programs.

Individuals have to be income eligible to receive assistance under HUD programs. Per 24 CFR 5.609, annual income is defined as the anticipated total income from all sources received by every family member which are not specifically excluded in 24 CFR 5.609(c). The exclusion found at 24 CFR 5.609(c)(17) instructs PHAs and owners to exclude from income all amounts that are specifically excluded by other Federal statute when the statute is applicable to HUD programs. Given that the ABLE Act creates a federally mandated exclusion for ABLE accounts applicable to HUD programs, in determining a family's income, HUD will exclude amounts in the individual's ABLE account pursuant to 24 CFR 5.609(c)(17). The entire value of the individual's ABLE account will be excluded from the household's assets. This means actual or imputed interest on the ABLE account balance will not be counted as income. Distributions from the ABLE account are also not considered income. All wage income received, regardless of which account the money is paid to, is included as income.

For example:

1. Contributions made by the designated beneficiary

Pursuant to 24 CFR 5.609(a), all amounts received by the designated beneficiary are counted as income, unless they fall under one of the enumerated exclusions under 5.609(c) or are federally mandated, as with distributions from ABLE accounts.

If the beneficiary has a portion of his/her wages directly deposited into his/her ABLE account, then all wage income received, regardless of which account the money is paid to, is included as income. *Pre-tax employer contributions to an ABLE account (that are not deducted from wages) are excluded.* If the designated beneficiary subsequently deposits any amount previously included as income into his/her ABLE account, that deposited amount must not be included in the household's asset calculation or counted as income again when the beneficiary receives a distribution from the account.

2. **Contributions made by others directly into the ABLE account**

If someone other than the designated beneficiary contributes directly to the ABLE account, that contribution will not be counted as income to the designated beneficiary.

If a relative provides a recurring gift of $100 per month directly to the beneficiary, the recurring gift would be counted as income. If a relative deposits the $100 recurring monthly gift directly into the

ABLE account, then it will not be counted as income. Note: Any person can contribute to an ABLE account. However, the Internal Revenue Service (IRS) limits the total annual contributions that any ABLE account can receive from all sources for a given calendar year.

3. Rollovers from existing ABLE accounts

Rollovers from existing ABLE accounts to the designated beneficiary's ABLE account are not counted as income to the designated beneficiary.

Verification: In accordance with program requirements at 24 CFR 5.240(c), PHAs and owners should verify the amount held in the ABLE account. PHAs and owners should develop a policy and procedure for verifying ABLE accounts that obtains the following information:

- the name of the designated beneficiary; and
- the State ABLE program administering the account to verify that the account qualifies as an ABLE account.

Contact Information: If you have any questions regarding this notice, please contact Annecia Durr (Office of Housing) at Annecia.Durr@hud.gov or 202-402-2618, or Becky Primeaux (Office of Public and Indian Housing) at Becky.L.Primeaux@hud.gov or 202-402-6050.

Paperwork Reduction Act: The information collection requirements referred to in this notice have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3520) and assigned OMB control numbers 2577-0169 and 2502-0204.

/s/
R. Hunter Kurtz
Principal Deputy Assistant Secretary
for Public and Indian Housing

/s/
Brian D. Montgomery
Assistant Secretary for Housing –
Federal Housing Commissioner

Public Housing and Housing Choice Voucher Program
List of Discretionary Policies to Implement HOTMA

This chart is meant to help PHAs think about the policies they need to set in their Admissions and Continued Occupancy Plans (ACOP) and/or Administrative Plans (Admin Plan). The information provided here is subject to change, pending the final PIH Notice implementing HOTMA 102 and 104.

Topic	Related HOTMA Policy Background	HOTMA Discretionary Policies These are policy choices that PHAs need to make and include in their ACOPs or Admin Plans.
Asset Limitation for New Admissions (24 CFR § 5.618)	• PHAs must deny admission of an applicant family for the following: 1. Net family assets that exceed $100,000 (adjusted annually for inflation); and/or 2. The family has a present ownership interest in, a legal right to reside in, and the effective legal authority to sell the real property (based on laws of the state or locality in which the property is located) that is suitable for occupancy by the family as a residence. • PHAs must include this admission and termination/eviction policy in their ACOPs or Admin Plans.	No discretion.

Asset Limitation for Interim and Annual Reexaminations (24 CFR § 5.618)	• PHAs must initiate eviction (Public Housing) or termination (Section 8 HCV) of a family's assistance no later than six months after the effective date of an annual or interim reexamination for the following: 1. Net family assets that exceed $100,000 (adjusted annually for inflation); and/or 2. The family has a present ownership interest in, a legal right to reside in, and the effective legal authority to sell the real property (based on laws of the state or locality in which the property is located) that is suitable for occupancy by the family as a residence.	**Non-enforcement policy & cure period:** • PHAs may choose to establish a written policy to not enforce the asset limitation for all families, for up to six months after the effective date of a family's annual or interim reexamination. Families are given the opportunity to cure noncompliance with the asset limitation during this period. • Non-enforcement policies must address the timeframe for curing non-compliance (e.g., PHA may choose to adopt local policies to allow any number of months, up to six months, to cure). **Asset limitation exception policy & cure period (interim/annual reexamination only):** • PHAs may also establish in written policy exceptions to the asset limitation based on family type and may take into consideration such factors as age, disability, income, the ability of the family to find suitable alternative housing, and whether supportive services are being provided. • Excepted families are given the opportunity to cure noncompliance with the asset limitation during this period (e.g., PHA may choose to adopt local policies to allow any number of months, up to six months, to cure).

		• Exception policies **must** conform with applicable fair housing statues and regulations. Exception policies must address which families are excepted and the timeframe for curing compliance. ***Note:*** PHAs may establish **both** non-enforcement and exception policies. PHAs must include this termination/eviction policy in their ACOP or Admin Plans. This policy must indicate when the PHA will initiate termination or eviction proceedings after participant families are determined to be out of compliance. The above discretion is **not** applicable to eligibility determinations for new admissions.

Self-Certification – Real Property Ownership (24 CFR § 5.618(b)(2))	• PHAs must determine whether a family has present ownership in real property for the purposes of determining whether the family is compliant with the asset limitation provision. • If a family declares present ownership in real property, PHAs must seek third-party verification of the following, as applicable: ○ Whether or not the family has the legal right to reside in the property; and ○ Whether or not the family has the effective legal authority to sell the property; and ○ Whether or not the property is suitable for occupancy by the family as a residence.	• PHAs may rely upon a self-certification from the family at both admission and reexamination stating that they do not have any present ownership interest in any real property. • PHAs must include in their ACOPs or Admin Plans whether they will accept a family's self-certification of present ownership of real property. In the case of a family member who is a victim of domestic violence, dating violence, sexual assault, or stalking, the PHA must comply with the confidentiality requirements under 5.2007. The PHA must accept a self-certification from the family member, and the restrictions on requesting documentation under § 5.2007 apply.
Self-Certification of Net Family Assets Equal to or Less Than $50,000 (adjusted annually for inflation) (24 CFR §§ 5.603; 5.609; 5.618; 882.515(a); 882.808(i)(1);	• PHAs must determine if the family's total net family assets are equal to or less than $50,000, and they must determine the actual income earned from the asset(s).	• PHAs may accept a family's self-certification of net family assets equal to or less than $50,000 (adjusted annually for inflation) and anticipated income earned from assets without taking additional steps to verify accuracy, at admission and at reexamination. • Accepting a family's self-certification at admission may reduce the initial burden on applicants and speed up the lease-up process. In deciding whether to accept a self-certification of assets at

960.259(c)(2); 982.516(a)(3))		admission, PHAs are encouraged to consider the local needs and priorities in their communities along with the potential risks of accepting self-certification of net family assets, including the requirement to repay funds for participants/tenants who are later found to be ineligible for assistance. • PHAs who choose to accept self-certification of net family assets equal to or less than $50,000 (adjusted annually for inflation) at reexamination are required to fully verify net family assets every three years (882.515(a); 882,808(i)(1); 960.259(c)(2); 982.516(a)(3)). • PHAs who choose not to accept a family's self-certification must verify a family's net assets. • PHAs must include in their ACOPs or Admin Plans whether they will accept a family's self-certification of net family assets equal to or less than $50,000 at admission (only for new admissions effective on or after 1/1/2024) and at reexamination.
Hardship Exemptions for Health/Medical Care Expenses & Reasonable Attendant Care &	N/A	• PHAs must develop written policies in their ACOPs or Admin Plans defining what constitutes a hardship for the purposes of the general relief hardship exemption for health and medical care expenses and reasonable attendant care & auxiliary apparatus expenses.

Auxiliary Apparatus Expenses – <u>General Relief</u> (24 CFR § 5.611(c)(2))		• PHAs may, pursuant to their own discretionary policy, extend the hardship relief for one or more additional 90-day periods while the family's hardship condition continues. • PHAs must state whether they will allow extensions of the 90-day hardship period and the maximum number of 90-day extension periods (if establishing a maximum policy) that a family may receive. ***Note***: PHAs are not limited by HUD to a maximum number of 90-day extensions. PHAs must obtain third-party verification of the hardship or must document in the file the reason that third-party verification was not available. PHAs must attempt to obtain third-party verification prior to the end of the 90-day hardship period.
Hardship Exemptions for Health/Medical Care Expenses & Reasonable Attendant Care & Auxiliary Apparatus Expenses – <u>Phased-</u>	• All families who received a deduction for unreimbursed health and medical care and/or reasonable attendant care or auxiliary apparatus expenses based on their most recent income review prior to January 1, 2024, will begin receiving the 24-month phased-in relief at their next annual or interim reexamination, whichever occurs first after January 1, 2024.	N/A

In Relief (24 CFR § 5.611(c)(1))	• Families who receive phased-in relief will have eligible expenses deducted as follows: ○ 1st twelve months – in excess of 5% of annual income. ○ 2nd twelve months – in excess of 7.5%. of annual income. ○ After 24 months – in excess of 10% threshold will phase in and remain in effect unless the family qualifies for General Hardship relief. • Once a family chooses to obtain general relief, a family may no longer receive the phased-in relief.	
Hardship Exemption to Continue Child Care Expense Deduction (24 CFR § 5.611(d))	• PHAs must develop written policies to define what constitutes a hardship, which includes the family's inability to pay rent, for the purposes of the childcare expense hardship exemption. • PHAs must include this policy in their ACOPs or Admin Plans. • PHAs must obtain third-party verification of the family's inability to pay rent or must document in the file with the reason third-party verification was not available. PHAs must attempt to obtain third-party	• PHAs must develop written policies to define what constitutes a hardship, which includes the family's inability to pay rent, for the purposes of the childcare expense hardship exemption. • PHAs must include this policy in their ACOPs or Admin Plans. • PHAs may, pursuant to their own discretionary policy, extend the relief for one or more additional 90-day periods while the family's hardship condition continues. • PHAs must include in their ACOPs or Admin Plans whether they will allow extensions of the 90-day

	verification prior to the end of the 90-day period.	hardship period and the maximum number of 90-day extension periods (if establishing a maximum policy) that a family may receive. ***Note:*** PHAs are not limited by HUD to a maximum number of 90-day extensions

Additional (Permissive) Deductions – Public Housing, Housing Choice Voucher, and Moderate Rehabilitation/SRO Only (24 CFR § 5.611(b)(1))	N/A	• Program regulations do not specify which types of permissive deductions are allowable in the HCV, Public Housing, or Moderate Rehabilitation/SRO programs. • A PHA that chooses to adopt an additional permissive deduction(s) from annual income for the HCV and/or Moderate Rehabilitation/SRO, or Public Housing programs must include written policies in their ACOPs or Admin Plans. ***Note:*** A PHA that adopts such deductions for the Public Housing program will not be eligible for an increase in Capital Fund and Operating Fund formula grants based on the application of such deductions. For the HCV and Moderate Rehabilitation/SRO programs, a PHA must have sufficient funding to cover the increased housing assistance payments cost of the deductions because permissive deductions will be excluded from the renewal calculation.

De Minimis Errors in Income Determinations (24 CFR §§ 5.609(c)(4); 960.257(f); 982.516(f); 882.515(f); 882.808(i)(5))	• PHAs must take corrective action to credit or repay a family if the family was overcharged tenant rent because of de minimis errors in calculating family income. • PHAs may not implement local policies to require families to repay in instances resulting in a family being undercharged for rent where the PHA miscalculated the family's income.	• PHAs must include in their ACOPs or Admin Plans how they will repay or credit a family the amount that the family was overcharged retroactive to the effective date of the action the error was made, regardless of the dollar amount associated with the error, because of the PHA's de minimis error in income determination.
Interim Reexaminations - Decreases in Adjusted Income (24 CFR §§ 960.257(b)(2); 982.516(c)(2); 882.515(b)(2); 891.410)	• PHAs are required by HUD to process interim reexaminations for *all* decreases in adjusted income when a family member permanently moves out of the unit. • PHAs **<u>are not permitted</u>** to establish a dollar figure threshold amount instead of a percentage threshold less than ten percent.	• PHAs may decline to conduct an interim reexamination of family income if the PHA estimates that the family's annual adjusted income will decrease by an amount that is less than ten percent of the family's annual adjusted income, or such lower threshold established by the PHA. • PHAs must identify in their ACOPS or Admin Plans the percentage threshold they will use for conducting interim reexamination for decreases in a family's adjusted income. • PHAs may establish policies to round calculated percentage decreases up or down to the nearest unit (e.g., a calculated decrease of 9.5% may be rounded up to 10%).

Interim Reexaminations - Increases in Adjusted Income (24 CFR §§ 960.257(b)(3); 982.516(c)(3); 882.515(b)(3))	• PHAs must conduct an interim reexamination of family income when the they become aware that the family's annual adjusted income has changed by an amount that would result in an estimated increase of ten percent or more in annual adjusted income or another amount established through a HUD notice, except PHAs may not consider any increases in *earned* income when estimating or calculating whether the family's adjusted income has increased, unless the family has previously received an interim reduction during the same reexamination cycle. • PHAs **<u>may not</u>** establish a different threshold to conduct interim reexaminations for increases in adjusted income.	• PHAs may choose not to conduct an interim reexamination if a family reports an increase in income within three months of their next annual reexamination effective date. • PHAs may choose not to include *earned* income increases in determining whether the 10% threshold is met for increases in adjusted income when the family previously had an interim reexamination performed for a decrease in annual adjusted income (earned, unearned, or combined) since the last annual reexamination. • PHAs must describe these policies in their ACOPs or Admin Plans.
Interim Reexaminations - Reporting Changes & Effective Date (24 CFR §§ 960.257(b)(4); 982.516(d);	• Families must report household composition changes and changes to adjusted income consistent with HOTMA requirements; however, PHAs determine the timeframe in which reporting must occur to be considered "timely."	• PHAs must develop policies that describe when and under what conditions families must report changes in household composition and adjusted income consistent with HUD's requirements for processing an interim reexamination or other non-interim reexamination transaction. • PHAs have the discretion to develop specific reporting policies that describe which changes

882.515(b)(1) - (4); 882.808(i)(4); 891.410)	• If the PHA has adopted a retroactive rent decrease policy, it may not be applied prior to the later of: ○ The 1st of the month following the date of the actual decrease in income; or ○ The 1st of the month following the most recent previous income examination. ***Note:*** The PHA must clearly communicate to the family and owner, if applicable, how a retroactive adjustment will affect the family's responsibility for rent.	must be reported and the timeline for reporting the change to be considered timely. • PHAs may adopt a policy to apply rent decreases retroactively and establish additional criteria to describe the conditions under which retroactive decreases will be applied e.g., extenuating circumstances that may inhibit timely reporting. • PHAs must describe these policies in their ACOPs or Admin Plans.
Revocation of Consent Form (Form HUD-9886)[1] (24 CFR §§ 5.230(c)(5)(iii) and 24 CFR 5.232(c))	• The executed consent form will remain effective until the family is denied assistance, the assistance is terminated, or the family provides written notification to the PHA to revoke consent. • Families have the right to revoke consent by notice to the PHA; however, revoking consent can result in termination or denial of assistance if the PHA has established an admission and occupancy policy that the	• PHAs may establish in written policy that revocation of consent will result in termination of assistance or denial of admission. • When PHAs do not establish a policy such that revoking consent will result in termination of assistance, participant families will be required to sign a new consent form by the next regularly scheduled reexamination or interim reexamination, whichever occurs first.

[1] Revocation of consent or refusal to sign the consent form prohibits the PHA from requesting and accessing income information and financial records, including pulling any EIV reports and using EIV data to verify income.

	revocation of consent will result in termination of assistance or denial of admission. • PHAs may not process interim or annual reexaminations of income, including when a family's income decreases and the family requests an interim reexamination to decrease tenant rent, without the family's executed consent form(s). • PHAs must explain to families the consequences, if any, of revoking their consent. • PHAs **must** notify their local HUD office when an applicant or participant family member revokes their consent. ***Note:*** Data matches between HUD and other agencies will continue to automatically occur, when consent is revoked, if the family is not terminated from the program.	• PHAs may establish policies to deny admission but allow existing participant families to continue to receive assistance after revoking their consent until the next interim or annual reexamination, whichever is sooner.

Determination of Family Income Using Other Means Tested Public Assistance, i.e., "Safe Harbor" (24 CFR §§ 5.609(c)(3) and 891.105)	• PHAs may determine the family's income prior to the application of any deductions based on income determinations made within the previous 12-month period for purposes of the following means-tested forms of Federal public assistance: ○ The Temporary Assistance for Needy Families block grant (42 U.S.C. 601, et seq.). ○ Medicaid (42 U.S.C. 1396 et seq.). ○ The Supplemental Nutrition Assistance Program (42 U.S.C. 2011 et seq.). ○ The Earned Income Tax Credit (26 U.S.C. 32). ○ The Low-Income Housing Tax Credit (26 U.S.C. 42). ○ The Special Supplemental Nutrition for Woman, Infants, and Children (42 U.S.C. 1786). ○ Other programs administered by the Secretary. ○ Other means-tested forms of Federal public assistance for which HUD has established a memorandum of understanding.	• PHAs that choose to implement Safe Harbor income determinations must: ○ Establish in policy when they will accept Safe Harbor income determinations (e.g., at reexamination only or at admission and reexamination), including which programs from which they will accept income determinations; and ○ Create policies that outline the course of action when families present multiple verifications from the same or different acceptable Safe Harbor programs (e.g., PHAs could establish policies to accept the most recent income determination). • PHAs must include in their ACOPs or Admin Plans whether they will accept Safe Harbor income determinations, along with the accompanying policies described above, if applicable.

	○ Other Federal benefit determinations made by other means-tested Federal programs that the Secretary determines to have comparable reliability and announces through a Federal Register notice. • PHAs are not required to accept or use determinations of income from other Federal means-tested forms of assistance. • Safe Harbor verification must be obtained by means of third-party verification and must state the family size, must be for the entire family (i.e., the family members listed in the documenting must match the family's composition in the assisted unit, except for household members) and must state the amount of the family's annual income.	

Enterprise Income Verification (EIV) Usage (24 CFR § 5.233)	• PHAs must use HUD's EIV system in its entirety, in accordance with 24 CFR 5.233. • PHAs must update their EIV policies and procedures to reflect their discretionary use of EIV reports (e.g., Income Report, zero income reports, New Hires Report, IVT) under HOTMA.	• PHAs are not required to use EIV during interim reexaminations. • PHAs who adopt local policies to not include *earned* income increases in determining whether the 10% threshold is met for increases in adjusted income when the family previously had an interim reexamination performed for a decrease in annual adjusted income (earned, unearned, or combined) since the last annual reexamination, are not required to use the EIV New Hires report between annual reexaminations. • PHAs who have a policy to consider *earned* income increases in calculating whether the 10% threshold has been met for an interim reexamination are required to review the EIV New Hires report at least quarterly, for the remainder of the reexamination period **after** the interim reexamination to decrease rent occurs.

Preparing for HOTMA

Topic	Information/Guidance
PHA forms	• PHAs must update any form referencing eligibility or admission annual and interim reexamination, etc. to comply with the HOTMA final rule. • For example: ○ The PHA's local interim reexamination form must provide families a place to report all changes that impact annual adjusted income including: ***all*** changes in income, assets, expenses, and household composition. ○ A self-certification form to determine present ownership interest in any real property. If applicable i.e., the family has ownership in real property, the form can also include questions regarding the legal right to reside in, and the effective legal authority to sell a property (based on laws of the state or locality in which the property is located) that is suitable for occupancy by the family as a residence. ○ A self-certification form to declare net family assets are $50,000 or less. This form must allow families to report anticipated asset income earned.
Impact of HOTMA on Family Self-Sufficiency (FSS) Programs	PHAs who operate FSS programs should note that families participating in the FSS program are subject to all HOTMA interim reexamination regulations. PHAs cannot implement local policy to perform an interim reexamination for increases in adjusted income below the 10% threshold for FSS participants. Although families participating in FSS may experience fewer escrow increases under the HOTMA final rule, the revised IR regulations may provide these families the opportunity to use their increased earnings to realize other short or long-term goals outside of the scope of the FSS program. The HOTMA interim reexamination regulations impact administration of the FSS program in the following ways:

	1. FSS participants are subject to *all* requirements of the HOTMA interim reexamination regulations; and 2. At enrollment, PHAs may not perform an interim reexamination of annual income *unless* the family experienced a change in adjusted annual income that meets the threshold to perform an interim reexamination under the HOTMA final rule. 3. Families for whom their first reexamination of income does not occur until their regularly scheduled annual reexamination will not have the opportunity to begin escrowing their increased earnings until that time and may have fewer escrow increases over the life of the 5-year contract[2].
HOTMA Resources	**HOTMA Resources Page (Public Housing and HCV):** HOTMA Resources | HUD.gov / U.S. Department of Housing and Urban Development (HUD) **HUD Exchange (Public Housing and HCV only):** Materials Posted: HOTMA Income and Assets Training Series - HUD Exchange

https://www.hud.gov/sites/dfiles/PIH/documents/PH_HCV_Discretionary_Policie_Implement_HOTMA-Revised_2-29-24.pdf

[2]See the Streamlining and Implementation of Economic Growth, Regulatory Relief, and Consumer Protection Act Changes to Family Self-Sufficiency Program final rule for more information on requirements related to the term of the FSS contract of participation (COP) i.e., it generally expires 5 years *from the date of the family's first re-certification of income after* the effective date of the FSS COP.

Multifamily Housing Programs
List of Discretionary Policies to Implement HOTMA

This chart is intended to make MFH Owners aware of the policies they must set in their respective Tenant Selection Plan (TSP) and EIV policies and procedures by March 31, 2024.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
Asset Limitation for New Admissions (24 CFR § 5.618) Section 8 and 202/8 programs only. Reference: Notice H 2023-10 / Attachment A	• MFH Owners must deny admission of an applicant family for the following: 1. Net family assets that exceed $100,000 (adjusted annually for inflation); and/or 2. The family has a present ownership interest in, a legal right to reside in, and the effective legal authority to sell the real property (based on laws of the state or locality in which the property is located) that is suitable for occupancy by the family as a residence. • MFH Owners must include this admissions policy in their TSP.	No discretion.
Asset Limitation at Annual and Interim Reexaminations (24 CFR § 5.618) Section 8 and 202/8 programs only. Reference: Notice H 2023-10 / Attachment A		MFH Owners have the following policy options at annual and interim reexaminations: **1.** Total Enforcement • MFH Owners may choose to fully enforce the asset limitation exactly as

[1] All discretionary policies must be clearly stated in an owner's Tenant Selection Plan and EIV policies and procedures. Additionally, all discretionary policies must be applied equally to each family pursuant to 24 CFR § 5.105(a).

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		written in the statute[2] (i.e., the real property requirement and the $100,000 net family assets requirement). Nothing in paragraphs (4), (5), or (6) of Section 104 of HOTMA compels MFH Owners to exercise the discretion provided by the statute. **2.** Total Non-Enforcement • MFH Owners may choose to establish a written policy to not enforce the asset limitation for all families at annual and interim reexamination. **3.** Limited Enforcement • MFH Owners may choose to establish a written policy to not enforce the asset limitation for all families, for up to six months after the effective date of a family's annual or interim reexamination. Families are given the opportunity to cure noncompliance with the asset limitation during this period. • Limited non-enforcement policies must address the timeframe for curing

[2] Pub. L. 114-201.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		non-compliance (e.g., MFH Owners may choose to adopt policies to allow any number of months, up to six months, to cure noncompliance with the asset limitation). • MFH Owners who establish limited enforcement policies may not delay initiation of termination of assistance beyond six months after the effective date of the annual or interim reexamination. **4.** Exception Policies • MFH Owners may establish in written policy exceptions to the asset limitation based on family type and may take into consideration such factors as age, disability, income, the ability of the family to find suitable alternative housing, and whether supportive services are being provided. • MFH Owners may establish total non-enforcement for excepted families, or they may establish limited enforcement for excepted families to give those families the opportunity to cure noncompliance with the asset

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		limitation for a period up to six months. • Exception policies must conform with applicable fair housing statues and regulations. • Exception policies must describe the families who are excepted, and the policies must describe whether excepted families are subject to total nonenforcement or limited nonenforcement of the asset limitation. If excepted families are subject to limited nonenforcement, then the exception policy must address the timeframe for curing non-compliance (e.g., MFH Owners may choose to adopt policies to allow any number of months, up to six months, to cure noncompliance with the asset limitation). • MFH Owners who establish exception policies with a limited enforcement period may not delay initiation of termination of assistance beyond six months after the effective date of the annual or interim reexamination.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		Note: MFH Owners may establish <u>both</u> limited non-enforcement and exception policies. The above discretion is <u>not</u> applicable to eligibility determinations for new admissions or initial certifications (IC) of assistance. MFH Owners must include their asset limitation policy at annual and interim reexamination in their TSP.
De Minimis Errors in Income Determinations (24 CFR §§ 5.609(c)(4); 5.657(f); 891.105; 891.410(g); and 891.610(g)) Reference: Notice H 2023-10 / Attachment B	• MFH Owners must take corrective action to credit or repay a family if the family was overcharged tenant rent because of de minimis errors in calculating family income. • MFH Owners may not implement policies to require families to repay in instances resulting in a family being undercharged for rent where the MFH Owner miscalculated the family's income.	• MFH Owners must include in their TSP how they will repay or credit a family the amount that the family was overcharged retroactive to the effective date of the action the error was made, regardless of the dollar amount associated with the error, because of the MFH Owner's de minimis error in income determination.
Hardship Exemptions for Health/Medical Care Expenses & Reasonable Attendant Care & Auxiliary Apparatus Expenses — General Relief (24 CFR § 5.611(c)(2)) Reference:	• MFH Owners must provide hardship relief to a family that demonstrates its eligible health and medical care expenses, or reasonable attendant care and auxiliary apparatus expenses exceed 5 percent of the family's annual income.	• Generally, MFH Owners must develop written policies in their TSP defining what changes in circumstances are required for the family to be eligible for the health and medical care expenses and reasonable attendant care & auxiliary apparatus general hardship exemption, that would

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
Notice H 2023-10 / Attachment C	• An increase in health and medical care, reasonable attendant care, and auxiliary apparatus expenses constitutes a qualifying eligibility factor under 24 CFR 5.611(c)(2)(i), so long as it exceeds 5% of the family's annual income (24 CFR 5.611(c)(2)(ii)). • To meet the requirements for the health and medical care expense hardship exemption, the family must have expenses that meet the definition of health and medical care expenses as provided by 24 CFR 5.603(b). • To meet the requirements for the reasonable attendant care and auxiliary apparatus expenses hardship exemption, the family must have expenses that meet the definition of reasonable attendant care and auxiliary apparatus expenses at 24 CFR 5.603(b).	not otherwise trigger an interim reexamination. • MFH Owners may, pursuant to their own discretionary policies, extend the hardship relief for one or more 90-day intervals, while the family's hardship condition exists. • MFH Owners must state in their TSP whether extensions of the 90-day hardship period are allowable, and the maximum number of 90-day extensions (if establishing a maximum policy) families may receive. Note: MFH Owners are not limited by HUD to a maximum number of 90-day extensions. • MFH Owners must obtain third-party verification of the hardship or must document in the file the reason that third-party verification was not available. MFH Owners must attempt to obtain third-party verification prior to the end of the 90-day hardship period.
Hardship Exemptions for Health/Medical Care Expenses & Reasonable Attendant	• All families who received a deduction for unreimbursed health and medical care and/or reasonable attendant care or auxiliary apparatus expenses based on	• MFH Owners may continue the phased-in relief for a new admission who was receiving the phased-in relief at their prior assisted housing at the time that the

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
Care & Auxiliary Apparatus Expenses — Phased-In Relief (24 CFR § 5.611(c)(1)) Reference: Notice H 2023-10 / Attachment C	their most recent income review prior to January 1, 2024, will begin receiving the 24-month phased-in relief at their next annual or interim reexamination, whichever occurs first on or after the date the MFH Owner complies with HOTMA. • Families who receive phased-in relief will have eligible expenses deducted as follows: o 1st 12 months – in excess of 5% of annual income. o 2nd 12 months – in excess of 7.5%. of annual income. o After 24 months – in excess of 10% threshold will phase in and remain in effect unless the family qualifies for General Relief. • Once a family chooses to obtain general relief, a family may no longer receive the phased-in relief.	family is admitted to their current unit. This discretion should be stated in the TSP. For example, a family is admitted to a new MFH property, but they would have still been receiving the 24-month phased-in hardship exemption had they continued to reside in their previous unit at a different MFH property. MFH Owners may establish a policy to continue the phased-in hardship exemption for the family's remaining months in the 24-month phase-in period.
Hardship Exemption to Continue Child-Care Expense Hardship (24 CFR § 5.611(d)) Reference:	• MFH Owners must develop written policies to define what constitutes a hardship, which includes the family's inability to pay rent, for the purposes of	• MFH Owners may, pursuant to their own discretionary policies, extend the hardship relief for one or more additional 90-day periods while the family's hardship condition continues.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
Notice H 2023-10 / Attachment C	the childcare expense hardship exemption. • MFH Owners must include this policy in their TSP. • MFH Owners must obtain third-party verification of the family's inability to pay rent or must document in the file with the reason third-party verification was not available. MFH Owners must attempt to obtain third-party verification prior to the end of the 90-day period.	• MFH Owners must include in their TSP whether they will allow extensions of the 90-day hardship period and the maximum number of 90-day extension periods (if establishing a maximum policy) that a family may receive. Note: MFH Owners are not limited by HUD to a maximum number of 90-day extensions.
Self-Certification of Net Family Assets Equal to or Less Than $50,000 (adjusted annually for inflation) (24 CFR §§ 5.603; 5.609; 5.618; 5.659; 891.105; and 891.415(a)(2)) Reference: Notice H 2023-10 / Attachment F; Appendix: Sample Net Family Assets Self-Certification Form	MFH Owners must determine if the family's total net family assets are equal to or less than $50,000, and they must determine the actual income earned from the asset(s).	• MFH Owners may accept a family's self-certification of net family assets equal to or less than $50,000 (adjusted annually for inflation) and anticipated income earned from assets without taking additional steps to verify accuracy, at admission and at reexamination. • Accepting a family's self-certification at admission may reduce the initial burden on applicants and speed up the lease-up process. In deciding whether to accept a self-certification of assets at admission, MFH Owners are encouraged to consider the local needs and priorities in their communities along with the potential

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		risks of accepting self-certification of net family assets, including the requirement to repay funds for participants/tenants who are later found to be ineligible for assistance. • MFH Owners who choose to accept self-certification of net family assets equal to or less than $50,000 (adjusted annually for inflation) at reexamination are required to fully verify net family assets every three years (5.659(e)). • MFH Owners who choose not to accept self-certification must verify net family assets every year. • MFH Owners must include in their TSP whether they will accept a family's self-certification of net family assets equal to or less than $50,000 at admission (only for new admissions effective on or after 1/1/2024) and/or at reexamination.
Interim Reexaminations — Decreases in Adjusted Income (24 CFR §§ 5.657(c)(2); 891.105; 891.410(g); and 891.610(g) **Reference:** Notice H 2023-10 / Attachment I	• MFH Owners are required by HUD to process interim reexaminations for *all* decreases in adjusted income when a family member permanently moves out of the unit.	• MFH Owners may decline to conduct an interim reexamination of family income if the MFH Owner estimates that the family's annual adjusted income will decrease by an amount that is less than ten percent of the family's annual

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
	• MFH Owners <u>are not permitted</u> to establish a dollar figure threshold amount instead of a percentage threshold less than 10%.	adjusted income, or such lower threshold established by the MFH Owner. • MFH Owners must identify in their TSP the percentage threshold they will use for conducting interim reexamination for decreases in a family's adjusted income. • MFH Owners may establish policies to round calculated percentage decreases up or down to the nearest unit (e.g., a calculated decrease of 9.5% may be rounded up to 10%).
Interim Reexaminations — Increases in Adjusted Income (24 CFR §§ 5.657(c)(3); 891.105; 891.410(g)(2); and 891.610(g)(2) Reference: Notice H 2023-10 / Attachment I	• MFH Owners must conduct an interim reexamination of family income when they become aware that the family's annual adjusted income has changed by an amount that would result in an estimated increase of ten percent or more in annual adjusted income or another amount established through a HUD notice, except MFH Owners may not consider any increases in *earned* income when estimating or calculating whether the family's adjusted income has increased, unless the family has previously received an interim reduction during the same reexamination cycle.	• MFH Owners may choose not to conduct an interim reexamination if a family reports an increase in income within three months of their next annual reexamination effective date. • MFH Owners may choose not to include <u>earned</u> income increases in determining whether the 10% threshold is met for increases in adjusted income when the family previously had an interim reexamination performed for a decrease in annual adjusted income (earned, unearned, or combined) since the last annual reexamination.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
	• MFH Owners may not establish a different threshold to conduct interim reexaminations for increases in adjusted income.	• MFH Owners must describe these policies in their TSP.
Interim Reexaminations — Reporting Changes & Effective Date (24 CFR §§ 5.657(c)(4); 891.410(g)(2); and 891.610(g)(2) Reference: Notice H 2023-10 / Attachment I	• Families must report household composition changes and changes to adjusted income consistent with HOTMA's requirements; however, MFH Owners determine the timeframe in which reporting must occur to be considered "timely." • If the MFH Owner has adopted a retroactive rent decrease policy, it may not be applied prior to the later of: o The 1st of the month following the date of the actual decrease in income; or o The 1st of the month following the most recent previous income examination. Note: MFH Owners must clearly communicate to the family how a retroactive adjustment will affect the family's responsibility for rent.	• MFH Owners must develop policies that describe when and under what conditions families must report changes in household composition and adjusted income consistent with HUD's requirements for processing an interim reexamination or other non-interim reexamination transaction. • MFH Owners have the discretion to develop specific reporting policies that describe which changes must be reported and the timeline for reporting the change to be considered timely. • MFH Owners may adopt a policy to apply rent decreases retroactively and establish additional criteria to describe the conditions under which retroactive decreases will be applied. • MFH Owners must describe these policies in their TSP.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
Revocation of Consent Form (Form HUD–9887)[3] (24 CFR §§ 5.230(c)(5)(iii); 24 CFR 5.232(c)); 891.105; 891.410(g)(3)(ii); and 891.610(g)(3)(ii) Reference: Notice H 2023-10 / Attachment J	• The executed consent form will remain effective until the family is denied assistance, the assistance is terminated, or the family provides written notification to the MFH Owner to revoke consent. • Families have the right to revoke consent by notice to the MFH Owner; however, revoking consent can result in termination or denial of assistance if the MFH Owner has established an admission and occupancy policy that the revocation of consent will result in termination of assistance or denial of admission. • MFH Owners may not process interim or annual reexaminations of income, including when a family's income decreases and the family requests an interim reexamination to decrease tenant rent, without the family's executed consent form(s). • MFH Owners must explain to families the consequences, if any, of revoking their consent.	• MFH Owners may establish in written policy that revocation of consent will result in termination of assistance or denial of admission. • When MFH Owners do not establish a policy such that revoking consent will result in termination of assistance, participant families will be required to sign a new consent form by the next regularly scheduled reexamination or interim reexamination, whichever occurs first. • MFH Owners may establish policies to deny admission but allow existing participant families to continue to receive assistance after revoking their consent until the next interim or annual reexamination, whichever is sooner. • MFH Owners must describe these policies in their TSP.

[3] Revocation of consent or refusal to sign the consent form prohibits the MFH Owner from requesting and accessing income information and financial records, including pulling any EIV reports and using EIV data to verify income.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
	• MFH Owners must notify their local HUD office when an applicant or participant family member revokes their consent. Note: Data matches between HUD and other agencies will continue to automatically occur, when consent is revoked, if the family is not terminated from the program.	
Determination of Family Income Using Other Means Tested Public Assistance, i.e., "Safe Harbor" (24 CFR §§ 5.609(c)(3); 891.105; 891.410(b)-(c) and (g); and 891.610(b)-(c) and (g) Reference: Notice H 2023-10 / Attachment J	• MFH Owners may determine the family's income prior to the application of any deductions based on income determinations made within the previous 12-month period for purposes of the following means-tested forms of Federal public assistance: o The Temporary Assistance for Needy Families block grant (42 U.S.C. 601, et seq.). o Medicaid (42 U.S.C. 1396 et seq.). o The Supplemental Nutrition Assistance Program (42 U.S.C. 2011 et seq.). o The Earned Income Tax Credit (26 U.S.C. 32). o The Low Income Housing Tax Credit (26 U.S.C. 42).	• MFH Owners that choose to implement Safe Harbor income determinations must: o Establish in policy when they will accept Safe Harbor income determinations (e.g., at reexamination only or at admission and reexamination), including which programs from which they will accept income determinations; and o Create policies that outline the course of action when families present multiple verifications from the same or different acceptable Safe Harbor programs (e.g., MFH Owners could establish policies to accept the most recent income determination). • MFH Owners must describe these policies in their TSP.

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
	○ The Special Supplemental Nutrition for Woman, Infants, and Children (42 U.S.C. 1786). ○ Other programs administered by the Secretary. ○ Other means-tested forms of Federal public assistance for which HUD has established a memorandum of understanding. ○ Other Federal benefit determinations made by other means-tested Federal programs that the Secretary determines to have comparable reliability and announces through a Federal Register notice. • MFH Owners are not required to accept or use determinations of income from other Federal means-tested forms of assistance. • Safe Harbor verification must be obtained by means of third-party verification and must state the family size, must be for the entire family (i.e., the family members listed in the documenting must match the family's composition in the assisted unit, except for household members) and must	

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
	state the amount of the family's annual income. • Safe Harbor verification must not be mixed and matched with other income verifications, including other Safe Harbor income determinations.	
Enterprise Income Verification (EIV) Usage (24 CFR § 5.233) Reference: Notice H 2023-10 / Attachment J	• MFH Owners must use HUD's EIV system in its entirety, in accordance with 24 CFR 5.233. • MFH Owners must update their EIV policies and procedures to reflect their discretionary use of EIV reports (e.g., Income Report, zero income reports, New Hires Report, etc.) under HOTMA.	• MFH Owners are not required to use EIV during interim reexaminations. • MFH Owners who adopt policies to not include earned income increases in determining whether the ten percent threshold is met for increases in adjusted income when the family previously had an interim reexamination performed for a decrease in annual adjusted income (earned, unearned, or combined) since the last annual reexamination, are not required to use the EIV New Hires report between annual reexaminations. • MFH Owners who have a policy to consider earned income increases in calculating whether the ten percent threshold has been met for an interim reexamination are required to review the EIV New Hires report at least quarterly, for the remainder of the reexamination

HOTMA Provision / Regulation / H 2023–10 Reference	Required HOTMA Policy	MFH Owner's Discretionary Policies[1]
		period after the interim reexamination to decrease rent occurs. • MFH Owners are not required to use the EIV Income Report or New Hires Report at annual reexamination if they use Safe Harbor verification to determine the family's income. • MFH Owners are not required to use the EIV Income Discrepancy Report at annual reexamination if they used Safe Harbor verification to determine the family's income at the last reexamination. • MFH Owners must describe these policies in their EIV policies and procedures.

https://www.hud.gov/sites/dfiles/Housing/documents/MFH_List_Discretionary_Policies_Implement_HOTMA-Updated02012024.pdf

ADMISSIONS AND CONTINUED OCCUPANCY POLICY

FOR THE

PUBLIC HOUSING PROGRAM

Product # 301-001

May 1, 2005

Revision Date	
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October 1, 2006	March 1, 2017
June 1, 2007	July 1, 2017
September 1, 2008	July 1, 2018
September 1, 2009	June 1, 2019
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ADMISSIONS AND CONTINUED OCCUPANCY POLICY (ACOP)

EFFECTIVE JULY 1, 2025

Portland Housing Authority

Nan McKay
AND ASSOCIATES, INC.

Admissions and Continued Occupancy Policy (ACOP)

PORTLAND HOUSING AUTHORITY

Approved by the HA Board of Commissioners:

Date: April 3, 2025

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Upon the PHA's HOTMA 102/104 compliance date, the below section on the asset limitation is added:

Asset Limitation [24 CFR 5.618; Notice PIH 2023-27]

The PHA has discretion with respect to the application of the asset limitation at annual and interim reexamination. The PHA may adopt a written policy of total nonenforcement, enforcement, or limited enforcement as well as adopting exception policies.

PHA Policy

The PHA has adopted a policy of total nonenforcement of the asset limitation for all program participants. The asset limitation only applies to initial eligibility determinations for new admissions to the PHA's public housing program.

New admissions moving with continued housing assistance from one of PHA's HUD funded housing programs i.e. Public Housing, Housing Choice Vouchers, or Section 8 Multifamily will not be subject to termination due to asset limitation.

13-III.D. ALTERNATIVES TO TERMINATION OF TENANCY

Exclusion of Culpable Household Member [24 CFR 966.4(l)(5)(vii)(C)]

As an alternative to termination of the lease for criminal activity or alcohol abuse HUD provides that the PHA may consider exclusion of the culpable household member. Such an alternative can be used for any other reason where such a solution appears viable in accordance with PHA policy.

Additionally, under the Violence against Women Act, the PHA may bifurcate a lease in order to terminate the tenancy of an individual who is a tenant or lawful occupant of a unit and engages in criminal activity directly related to domestic violence, dating violence, sexual assault, stalking, or human trafficking.

PHA Policy

The PHA will consider requiring the tenant to exclude a household member in order to continue to reside in the assisted unit, where that household member has participated in or been culpable for action or failure to act that warrants termination.

As a condition of the family's continued occupancy, the head of household must certify that the culpable household member has vacated the unit and will not be permitted to visit or to stay as a guest in the assisted unit. The family must present evidence of the former household member's current address upon PHA request.

Repayment of Family Debts

PHA Policy

If a family owes amounts to the PHA, as a condition of continued occupancy, the PHA will require the family to repay the full amount or to enter into a repayment agreement, within 30 days of receiving notice from the PHA of the amount owed. See Chapter 16 for policies on repayment agreements.

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2025 HUD Inflation-Adjusted Values (Table 1): Effective January 1, 2025

Note: If your agency/property/program administrator is not yet complying with Sections 102 and 104 of HOTMA, you will not utilize this table. Annual inflationary adjustments, the new thresholds (e.g., asset limitation), and the requirement to use this passbook rate are among the provisions of Sections 102 and 104 of HOTMA.

Calculation Component	Adjusted Item	Regulatory Reference	Amount	Applicable Programs[1]
Asset Limitation	Eligibility restriction on net family assets	24 CFR § 5.618(a)(1)(i)	$103,200	Section 8 PBRA, 202/8, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA
Annual Income	Threshold above which imputed returns must be calculated on net family assets	24 CFR §§ 5.609(a)(2) and (b)(1)	$51,600	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF
	Threshold above which the total value of non-necessary personal property is included in net family assets	24 CFR § 5.603(b) Definition *Net family assets*	$51,600	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF
	The amount of net assets for which the PHA/MFH Owner/Grantee may accept self-certification by the family	24 CFR § 5.618(b)(1) 24 CFR § 5.659(e) 24 CFR § 92.203(e)(1) 24 CFR § 93.151(e)(1) 24 CFR § 882.515(a) 24 CFR § 882.808(i)(1) 24 CFR § 960.259(c)(2) 24 CFR § 982.516(a)(3)	$51,600	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF

[1] Some components in Tables 1 & 2 may also apply to other HUD programs not listed here that use the definitions of annual income and adjusted income in 24 CFR Part 5, subpart F to determine eligibility or assistance levels.

Calculation Component	Adjusted Item	Regulatory Reference	Amount	Applicable Programs[1]
Annual Income	Income exclusion for earned income of dependent full-time students	24 CFR § 5.609(b)(14)	$480	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF
	Income exclusion for adoption assistance payments	24 CFR § 5.609(b)(15)	$480	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF
Adjusted Income	Mandatory deduction for elderly and disabled families	24 CFR § 5.611(a)(2)	$525	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME
	Mandatory deduction for a dependent	24 CFR § 5.611(a)(1)	$480	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME

2025 HUD Passbook Savings Rate (Table 2): Effective January 1, 2025

Adjusted Item	Regulatory Reference	Rate	Applicable Programs
Passbook Savings Rate	24 CFR 5.609(a)	0.45%	Section 8 PBRA, 202/8, 202/811 PRAC, 236 IRP, 811 PRA, SPRAC, HCV, Public Housing, Section 8 Mod Rehab, Section 8 Mod Rehab SRO, HOPWA, HOME, HTF

https://www.huduser.gov/portal/datasets/inflationary-adjustments-notifications.html

Assets, Asset Exclusions, and Limitation on Assets Resource Sheet

For more information refer to the full HOTMA Income and Assets Training Series, including the Income Fact Sheet.

Definition of Assets 24 CFR 5.603(b) "Net Family Assets" Para. (1)

Net family assets: the net cash value of all assets owned by the family, after deducting reasonable costs that would be incurred in disposing of real property, savings, stocks, bonds, and other forms of capital investment.

This new definition includes the cash value of all family assets with the exception of the expanded and enumerated exclusions.

Eligibility Restrictions Due to Family Assets 24 CFR 5.618(a)

HOTMA restricts families from receiving assistance in the public housing or housing choice voucher program if their net family assets exceed $100,000* or if the family owns real property suitable for the family to live in. There are qualifications and exemptions from both requirements.

PHAs cannot waive the asset requirements but can delay enforcement for current participants up to 6 months based on PHA policy.

Determining net family assets 24 CFR 5.603(b) "Net Family Assets" Para. (2)

- PHAs must include the value of any business or family assets disposed of by an applicant or tenant for less than fair market value (including a disposition in trust, but not in a foreclosure or bankruptcy sale) during the two years preceding the date of application or reexamination, in excess of the consideration received.
- In the case of a disposition as part of a separation or divorce settlement, the disposition will not be considered to be for less than fair market value if the applicant or tenant receives consideration not measurable in dollar terms.
- Negative equity in real property or other investments does not prohibit the owner from selling the property or other investments, so negative equity alone would not justify an exclusion from family assets.

** 2024 amount. After 2024, HUD will adjust the amount annually based on CPI-W.*

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Assets, Asset Exclusions, and Limitation on Assets Resource Sheet

Income from Assets 24 CFR 5.609(a)

In general, income from assets is considered income. If it is possible to calculate actual returns from an asset, the PHA should use that amount.

If it is not possible to calculate an actual return on an asset, and:

- The net family assets are $50,000* or less, the imputed income from that asset is excluded
- The net family assets are over $50,000,* the PHA must impute income for the asset based on the current passbook savings rate, as determined by HUD

Net Family Assets Scenario	Actual Income	Imputed Returns	Amount Included in Income
Assets of $50,000 or less	Included	Not calculated	Actual income only
Exceeds $50,000 and actual income can be computed for ALL assets	Included	Not calculated	Actual income only
Exceeds $50,000 and NO actual income can be computed	N/A	Calculated using HUD passbook rate for all assets	Imputed returns for all assets
Exceeds $50,000, but actual income can only be computed for some assets	Included for assets that can be computed	Calculated for any remaining assets where actual income cannot be computed	Actual income that can be computed AND imputed returns for all remaining assets that cannot be computed

Restriction on Owning Real Property Suitable for Occupancy

24 CFR 5.618(a)(ii)

A family cannot receive benefits if they have "present ownership interest in, a legal right to reside in, and the effective legal authority to sell, based on state or local laws of the jurisdiction where the property is located, real property that is suitable for occupancy by the family as a residence."

The restriction on owning real property does not apply to:

- A family that receives assistance for the property under the Housing Choice Voucher Program for:
  - Manufactured home (24 CFR 982.620)
  - Homeownership Option
- Property jointly owned with someone else, and occupied by the other owner who is not a member of the household receiving benefits.
- A victim of domestic violence, dating violence, sexual assault, or stalking.
- A family that is offering the property for sale.

Assets, Asset Exclusions, and Limitation on Assets Resource Sheet

A family that owns a property may show it is not "suitable for occupancy" if it:

- Does not meet the disability-related needs for all members of the family.
  - » Examples: Physical needs, proximity to transit, need for additional bedrooms or space, etc.
- Is not sufficient for the size of the family.
- Is located so as to be a hardship for the family.
  - » Example: the location would be a hardship for the family's commute to work or school
- Is unsafe because of physical condition.
  - » Unless issues can be "easily remedied"
- Cannot be a residence per local or state laws.
  - » Example: a storefront zoned for commercial use only

Documentation of Assets 24 CFR 5.618(b)

For documentation of net family assets under $50,000*, the PHA may accept self-certification from the family that the assets are under that amount.

- Certification must include any expected income from the assets (actual returns only).
- No further documentation is required by the PHA for the net family asset restriction.
- Assets must be verified every 3 years.

Property ownership: the PHA may accept self-certification that the "family does not have any present ownership interest in any real property."

- The statutory self-certification *only* asks about ownership, and does not address the other elements of the restriction (such as a legal right to reside in, and the effective legal authority to sell the property).
- PHAs can use a form with the statutory self-certification question as well as follow-up questions related to other elements.

If family declares a property and asks for an exemption because a family member is a victim of domestic violence, dating violence, sexual assault, or stalking:

- The PHA must accept self-certification of the family member
- **24 CFR 5.2007** applies
  - » Confidentiality rules
  - » Restrictions on document requests
- HUD expects to update VAWA-related forms at a later date
  - » Form HUD **5380** Notice of Occupancy Rights under VAWA
  - » Form HUD **5382** Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking, and Alternate Documentation

Assets, Asset Exclusions, and Limitation on Assets Resource Sheet

Excluded assets 25 CFR 5.603(b) "Net Family Assets" Para. (3) and (4)

The following assets are excluded under HOTMA. If the family owns an excluded asset, its value does not count toward the restriction due to net family assets. Most of these exclusions are new.

Category	Excluded Asset	Example(s)	Notes
Personal property	Necessary items of personal property	Medical devices, vehicle for commute	Determining what is a "necessary item" for personal property is a highly fact-specific determination. Additional guidance is forthcoming from HUD.
Personal property	Non-necessary items of personal property if the combined total value does not exceed $50,000*	Vintage baseball cards, recreational boat, coin collection, art so long as the *total* value is under the limit	This matches the value of assets that can be self-certified by the family.
Savings account	Retirement account recognized by IRS	IRA, 401(k), 401(b) and retirement plans for self-employed individuals	
Real property	Real property that the family does not have the effective legal authority to sell in the jurisdiction in which the property is located	Property subject to a lawsuit may be legally restricted from sale.	Such property does not count against the dollar amount limit or the real property limitation
Cash	Any amounts recovered in any civil action or settlement based on a claim of malpractice, negligence, or other breach of duty owed to a family member, for an incident resulting in a disability	A drunk driver injures a family member, who then has a disability. The family sues, and the driver's insurance pays the family.	
Savings account	The value of certain education or disability support savings accounts	Under Internal Revenue Code sections 529, 529A, 530, "baby bond" accounts	Coverdell accounts, tuition programs, any "baby bond" account created, authorized, or funded by Federal, state, or local government
Real property	Interest in Indian trust land	Family has interest in land held in trust by Bureau of Indian Affairs	Existing exclusion
Real property	Equity in a manufactured home where the family receives assistance under 24 CFR 982	HCV Manufactured Home Space Rental participants	
Real property	Equity in property where the family receives assistance under 24 CFR 982	HCV homeownership participant	For real property other than manufactured homes
Savings account	Family Self-Sufficiency (FSS) accounts		The family does not have access to FSS funds during their participation in the program. Also excluded from income.
Cash	Federal tax refunds or refundable tax credits for a period of 12 months after receipt by the family	Earned Income Tax Credits (EITC)	
Trust Funds	Trust that is not revocable by, or under the control of, any member of the family or household	Non-revocable trust fund; trust fund revocable once minor child reaches age 21	As long as a trust meets this definition, it is not an asset of the family

https://files.hudexchange.info/resources/documents/Assets-Asset-Exclusions-and-Limitation-on-Assets-Resource-Sheet.pdf

Income and Income Exclusions Resource Sheet

For more information refer to the full HOTMA Income and Assets Training Series, including the Income Fact Sheet.

Annual Income 24 CFR 5.609(a)

Annual income includes, with respect to the family:

- All amounts, not specifically excluded below, received from all sources by each member of the family 18 years or older or is the head of household or spouse of the head of household, plus
- Unearned income by or on behalf of each dependent who is under 18 years of age, and
- Imputed returns on net family assets exceeding $50,000 (adjusted annually using the CPI-W) when the value of the actual returns from a given asset cannot be calculated. Imputed returns are based on the current passbook savings rate, as determined by HUD. (***Note:*** *if it is possible to calculate actual returns from an asset, the PHA should use that amount as income).*

EXCLUSIONS

Federally Mandated Income Exclusions 24 CFR 5.609(b)(22)

Amounts that HUD is required by federal statute to exclude as income for determining eligibility or benefits. HUD will publish an updated notice in the Federal Register to identify the benefits that qualify for this exclusion. Updates will be published when necessary.

- Mandatory Income exclusions related to ABLE accounts will be detailed here. PHAs can refer to Notice PIH 2019-09/H-2019-06, or any subsequent notice on the subject, for details on when ABLE account income is excluded.

Assets 24 CFR 5.609(b)(1)

Imputed returns: Any imputed return on an asset when net family assets total $50,000 or less (adjusted by HUD annually per CPI-W) and no actual income from the net family assets can be determined. *(**Note that:** Actual returns from assets are included in income.)*

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Income and Income Exclusions Resource Sheet

Non-recurring income 24 CFR 5.609(b)(24)

Income that will not be repeated in the coming year based on information provided by the family. Some examples of non-recurring income include:

- U.S. Census Bureau for employment income (relating to decennial census or the American Community Survey) lasting no longer than 180 days and not resulting in permanent employment.
- Direct federal or state payments for economic stimulus or recovery.
- State or federal refundable tax credits or state or federal tax refunds received directly at the time they are received directly by the family.
- Gifts for significant life events or milestones (e.g., holidays, birthdays, wedding gifts, baby showers, anniversaries).
- Non-monetary, in-kind donations, such as food, clothing, or toiletries, received from a food bank or similar organization.
- Lump-sum additions to net family assets, including but not limited to **lottery** or other contest winnings.

Note that: *Income received as an independent contractor, day laborer, or seasonal worker is not excluded from income, even if the source, date, or amount of the income varies.*

Self-employment Income 24 CFR 5.609(b)(28)

Gross income received through self-employment or operation of a business; with the exception of the following which **shall be considered income**:

- Net income from the operation of a business or profession. Expenditures for business expansion or amortization of capital indebtedness shall not be used as deductions in determining net income. An allowance for depreciation of assets used in a business or profession may be deducted, based on straight line depreciation, as provided in IRS regulations; and
- Any withdrawal of cash or assets from the operation of a business or profession will be included in income, except to the extent the withdrawal is reimbursement of cash or assets invested in the operation by the family.



Note: *gross income is the total income that a business brings in and is not reflective of the costs of operating a business or of being self-employed*

Minors Earned Income 24 CFR 5.609(b)(3)

All earned income of all children under the age of 18, including foster children.

Income and Income Exclusions Resource Sheet

Adoption assistance payments 24 CFR 5.609(b)(15)

Earned income in excess of the amount of the deduction for a dependent in § 5.611.

- Deduction is currently $480* per child. The end result is that all adoption assistance payments will be excluded.

Earned Income of Dependent Students

24 CFR 5.609(b)(14)

Earned income of dependent full-time students in excess of the amount of the deduction for a dependent.

- Deduction is currently $480* per dependent. The end result is that these payments will not be counted.



See the **Student Aid and Financial Assistance Resource Sheet** for more information on how to calculate the exclusion, particularly when the student receives funds from both types of sources.

Title IV HEA Assistance 24 CFR 5.609(9)(i)

Any assistance that section **479B of the Higher Education Act of 1965**, as amended (20 U.S.C. 1087uu), requires to be excluded from a family's income including Bureau of Indian Affairs or Department of Education student assistance programs. These amounts are only excluded up to the cost that covers tuition and other required fees in Section 8 households if the student is the head of household or that person's spouse.

Other Student Financial Assistance 24 CFR 5.609(9)(ii)

Student financial assistance, not excluded under the HEA for "actual covered costs" of higher education paid directly to the student or to the educational institution on the student's behalf.

Educational Savings Account 24 CFR 5.609(b)(10)

Income and distributions from any Coverdell educational savings account of or any qualified tuition program under IRS sections 529 and 530.

Baby bonds 24 CFR 5.609(b)(10)

Income earned by government contributions to, or distributions from, 'baby bond' accounts created, authorized, or funded by federal, state, or local government.

Foster Children / Adults Payments 24 CFR 5.609(b)(4)

Payments received for the care of foster children or adults, including state kinship, guardianship care payments, or tribal kinship payments.

** As adjusted annually by CPI-W and rounded to the next lowest multiple of $25.*

Income and Income Exclusions Resource Sheet

Foster Children/ Adults Income 24 CFR 5.609(b)(8)

Income of foster child or adult (as defined in 24 CFR 5.403 and 5.603).

Live-in Aide 24 CFR 5.609(b)(8)

Income of a live-in aide.

Note on Foster Children/Adults and Live-in Aides: *Foster adults and foster children are members of the household and therefore considered when determining appropriate unit size and utility allowance. However, they are not considered members of the "assisted family" in determining annual and adjusted income or net family assets; nor are the assets of foster adults or children taken into consideration for purposes of asset limitations. A live-in aide is treated similarly for purposes of income and assets.*

State Payments to Allow Individuals with Disabilities to Live at Home 24 CFR 5.609(b)(19)

These payments must be made:

- by or authorized by a state Medicaid managed care system or other state agency
  - » Includes: state Medicaid-managed care system, other state agency, or authorized entity
- to a family to enable a family member who has a disability to reside in the family's assisted unit.

Note on HOTMA changes to State Payments to Allow Individuals with Disabilities to Live at Home:

- HOTMA expands the exclusion to cover all payments by the state Medicaid-managed care system, other state agency, or authorized entity, for caregiving services to enable a family member with a disability to live in the assisted unit.
- No change if the family already received such payment that was excluded from income
- Previous requirement that these payments offset the cost of services or equipment has been eliminated.

Plan to Attain Self-Sufficiency (PASS) 24 CFR 5.609(b)(12)(i)

Amounts received by a person with a disability that are disregarded for a limited time for purposes of Supplemental Security Income eligibility and benefits because they are set aside for use under a Plan to Attain Self-Sufficiency (PASS).

Income and Income Exclusions Resource Sheet

Trust distributions 24 CFR 5.609(b)(2)

Irrevocable trust or revocable trust outside of family or household control, excluded from the definition of net family assets under § 5.603(b),

- Distributions of the principal, or corpus, of the trust, and
- Distributions of income from the trust used to pay the costs of health and medical care expenses for a minor.

Revocable trust or a trust under the control of the family or household: any distributions from the trust are excluded from income.

- Except that any actual income earned by the trust, regardless of whether it is distributed, shall be considered income to the family at the time it is received by the trust.



Note: *given that the corpus (or principal) of a trust is not new money coming in for the family, any distributions of a trust's principal, regardless of the form of the trust, are excluded. As a general rule, PHAs and owners must count any distributions of income from an irrevocable trust or a trust not under the control of the family (e.g., distributions of earned interest) as income to the family with the exception of distributions used to pay the health and medical care expenses of a minor.*

Reimbursements for Health and Medical Care Expenses 24 CFR 5.609(b)(6)

Amounts received by the family that are specifically for, or in reimbursement of, the cost of health and medical care expenses for any family member.

Insurance payments and settlements for personal or property loss 24 CFR 5.609(b)(5)

Including, but not limited to: payments through health insurance, motor vehicle insurance, and workers' compensation.

Retirement plan 24 CFR 5.609(b)(26)

Income received from any account under an IRS-recognized retirement plan. However, any distribution of **periodic payments** from these accounts shall be income at the time they are received by the family. Retirement accounts include:

- Individual retirement arrangements (IRAs)
- Employer retirement plans, and
- Retirement plans for self-employed individual

Military 24 CFR 5.609(b)(11)

The special pay to a family member serving in the Armed Forces who is exposed to hostile fire.

Income and Income Exclusions Resource Sheet

Veterans 24 CFR 5.609(b)(17)

Payments related to aid and attendance for veterans under 38 U.S.C. 1521.

Lawsuit Settlements 24 CFR 5.609(b)(7)

Any amounts recovered in any civil action or settlement based on a claim of malpractice, negligence, or other breach of duty owed to a family member arising out of law, that resulted in a member of the family having a **disability**.

Reparations for Persecution 24 CFR 5.609(b)(13)

Reparation payments paid by a foreign government for claims by people persecuted during the Nazi era.

Tribal Claims Payments 24 CFR 5.609(b)(21)

Payments received by tribal members as a result of claims relating to the mismanagement of assets held in trust by the United States. This includes payments from tribal trust settlements. Payments must be excluded from gross income under the Internal Revenue Code or other federal law.

Civil Rights Settlements and Judgements 24 CFR 5.609(b)(25)

Civil rights settlements or judgments, including settlements or judgments for back pay.

Reimbursements from other publicly assisted programs 24 CFR 5.609(b)(12)(ii)

Amounts received by a participant in other publicly assisted programs which are specifically for or in reimbursement of out-of-pocket expenses incurred (e.g., special equipment, clothing, transportation, child care, etc.) to allow participation in a specific program.

Resident Services Stipend 24 CFR 5.609(b)(12)(iii)

Resident service stipends not to exceed $200 per month. This is a modest amount provided to a resident for performing a service for the PHA, on a part-time basis, that enhances the quality of life in the development.

Employment training programs 24 CFR 5.609(b)(12)(iv)

Incremental earnings and benefits from training programs funded by HUD or qualifying federal, state, tribal, or local employment training programs (including training programs not affiliated with a local government) and training of a family member as resident management staff.

- Excluded amounts must be received under employment training programs with clearly defined goals and objectives and only excluded during participation in the program unless the amounts are excluded as Federal Financial Aid (§ 5.609(b)(9)(i)).

Income and Income Exclusions Resource Sheet

Family Self Sufficiency Account 24 CFR 5.609(b)(27)

Income earned on amounts placed in a family's FSS.

Housing "gap" payments 24 CFR 5.609(b)(23)

Replacement housing "gap" payments that offset increased rent and utility costs to families that are displaced from one federally subsidized housing unit and move into another federally subsidized housing unit (49 CFR part 24).

If the gap is reduced or eliminated because of a subsequent move by the tenant or change in the subsidy, and the tenant continues to receive the payment, the payment that is no longer needed to close the gap should be counted as income.

Deferred Supplemental Security Income, Social Security benefits, or Department of Veterans Affairs disability benefits 24 CFR 5.609(b)(16)

Deferred periodic amounts from:

- Supplemental Security Income and Social Security benefits that are received as a lump sum or in prospective monthly amounts, or
- Department of Veterans Affairs disability benefits that are received in a lump sum amount or in prospective monthly amounts.

Property Tax Rebates 24 CFR 5.609(b)(18)

Refunds or rebates under state or local law for property taxes paid on the dwelling unit.

Loan Proceeds 24 CFR 5.609(b)(20)

The net amount disbursed by a lender to a borrower, under the loan terms. Funds may be received by the family or a third party (e.g., educational institution or car dealership).

Income and Income Exclusions Resource Sheet

Annual Income Exclusions 24 CFR 5.609(b)

Income Exclusions Table

Category	Exclusion	CFR	Description
Other	Federally Mandated Income Exclusions	24 CFR 5.609(b)(22)	Amounts that must be excluded by federal statute. HUD will publish a Federal Register notice that includes the qualifying benefits.
Assets	Imputed Income from Assets	24 CFR 5.609(b)(1)	Any imputed return on an asset when net family assets total $50,000 (adjusted annually) or less and no actual income from the net family assets can be determined.
Non-recurring income	Non-recurring income	24 CFR 5.609(b)(24)	Income that will not be repeated in the coming year based on information provided by the family.
Self-employment	Gross Self-employment Income	24 CFR 5.609(b)(28)	Gross income received through self-employment or operation of a business
Dependents	Minors (children under the age of 18 years)	24 CFR 5.609(b)(3)	All earned income of all children under the age of 18, including foster children.
Dependents	Adoption assistance payments	24 CFR 5.609(b)(15)	Adoption assistance payments for a child in excess of the amount of the dependent deduction.
Students	Earned Income of Dependent Students	24 CFR 5.609(b)(14)	Earned income of dependent full-time students in excess of the amount of the dependent deduction.
Students	Title IV HEA Assistance	24 CFR 5.609(b)(9)(i)	Any assistance that Section 479B of the Higher Education Act (HEA) of 1965, as amended, requires to be excluded from a family's income.
Students	Other Student Financial Assistance	24 CFR 5.609(b)(9)(ii)	Student financial assistance, not excluded under the HEA, for actual covered costs of higher education.
Students	Educational Savings Account	24 CFR 5.609(b)(10)	Income and distributions from any Coverdell educational savings account of or any qualified tuition program under IRS section 530 or any qualified tuition program under section 529.
Baby bonds	Baby bonds	24 CFR 5.609(b)(10)	Income earned by government contributions to, or distributions from, 'baby bond' accounts created, authorized or funded by federal, state or local government.
Foster children / adults	Payments for Foster Children / Adults	24 CFR 5.609(b)(4)	Payments received for the care of foster children or adults, including State kinship, guardianship care payments, or tribal kinship payments.
Foster children / adults	Income of foster children / adults	24 CFR 5.609(b)(8)	Income of a live-in aide, foster child, or foster adult as defined in 24 CFR 5.403 and 5.603.
Live-in Aide	Income of a Live-in Aide	24 CFR 5.609(b)(8)	Income of a live-in aide, foster child, or foster adult.
People with Disabilities	ABLE accounts	24 CFR 5.609(b)(22)	Will be included in federally mandated excluded amounts. Notice PIH 2019-09/H-2019-06 details when ABLE account income is excluded.
People with Disabilities	State Payments to Allow Individuals with Disabilities to Live at Home	24 CFR 5.609(b)(19)	Payment made by an authorized by a state Medicaid managed care system or other state agency to a family to enable a family member to live in the family's assisted unit.
People with Disabilities	Plan to Attain Self-Sufficiency (PASS)	24 CFR 5.609(b)(12)(i)	Amounts set aside for use under a Plan to Attain Self-Sufficiency (PASS).
People with Disabilities	Reimbursements for Health and Medical Care Expenses	24 CFR 5.609(b)(6)	Amounts for, or in reimbursement of, health and medical care expenses for any family member.

(continued)

Income and Income Exclusions Resource Sheet

Category	Exclusion	CFR	Description
Trusts	Trust distributions	24 CFR 5.609(b)(2)	Any distributions of a trust's principal are excluded. PHAs and owners must count any distributions of income from an irrevocable trust or a trust not under the control of the family (e.g., distributions of earned interest) as income to the family with the expectation of distributions used to pay the health and medical care expenses of a minor.
Insurance	Insurance payments and settlements for personal or property loss	24 CFR 5.609(b)(5)	Insurance payments and settlements for personal or property loss including, but not limited to: payments through health insurance, motor vehicle insurance, and workers' compensation.
Retirement	Retirement plan	24 CFR 5.609(b)(26)	Income received from any account under an IRS-recognized retirement plan. However, periodic payments are income at the time of receipt.
Military	Hostile fire special payment	24 CFR 5.609(b)(11)	The special pay to a family member serving in the Armed Forces who is exposed to hostile fire.
Veterans	Veterans aid and attendance payments	24 CFR 5.609(b)(17)	Payments related to aid and attendance for veterans under 38 U.S.C. 1521.
Lawsuits	Lawsuit Settlements	24 CFR 5.609(b)(7)	Amounts recovered in a civil action or settlement based on malpractice, negligence and other breach of duty claim resulting in a family member becoming disabled.
Lawsuits	Reparations for Persecution	24 CFR 5.609(b)(13)	Reparation payments paid by a foreign government for claims by people persecuted during the Nazi era.
Lawsuits	Tribal Claims Payments	24 CFR 5.609(b)(21)	Payments received by tribal members from claims relating to the mismanagement of assets held in trust by the United States.
Lawsuits	Lawsuits related to civil rights	24 CFR 5.609(b)(25)	Civil rights settlements or judgments, including settlements or judgments for back pay.
Reimbursements	Reimbursements from publicly assisted programs	24 CFR 5.609(b)(12)(ii)	Amounts received by a participant in other publicly assisted programs for or in reimbursement of expenses to allow program participation (e.g., special equipment, clothing, transportation, child care, etc.).
Resident Services Stipend	Resident Services Stipend	24 CFR 5.609(b)(12)(iii)	Resident service stipends of $200 or less per month for performing a part-time service for the PHA that enhances the quality of life in the development.
Employment training programs	Employment training programs	24 CFR 5.609(b)(12)(iv)	Incremental earnings and benefits from training programs HUD and qualifying employment training programs and training of a family member as resident management staff.
FSS	Family Self Sufficiency Account	24 CFR 5.609(b)(27)	Income earned on amounts placed in a family's FSS account.
Housing gap payments	Housing "gap" payments	24 CFR 5.609(b)(23)	Replacement housing "gap" payments to offset increased rent and utility costs to families displaced from one federally subsidized housing unit and another.
Benefits	Deferred Supplemental Security Income, SS income and benefits, or VA disability benefits	24 CFR 5.609(b)(16)	Deferred periodic amounts from: SSI, Supplemental Security Income and benefits or VA disability benefits that are received in a lump sum or prospective monthly amounts.
Property tax rebates	Property Tax Rebates	24 CFR 5.609(b)(18)	Refunds or rebates under state or local law for property taxes paid on the dwelling unit.
Loans	Loan Proceeds	24 CFR 5.609(b)(20)	The net amount disbursed by a lender to a borrower or a third party (e.g., educational institution or car dealership).

https://files.hudexchange.info/resources/documents/Income-and-Exclusions-Resource-Sheet.pdf

HOTMA FAQ

These are the most frequently asked questions from our HOTMA Compliance training program. This page is updated frequently, so check back often to see the latest questions and answers.

Last Updated: May 29, 2025

RETURN TO HOTMA HQ

Presentation Changelog

Question: As HUD issues further guidance, is NCHM going to be updating the course presentation?

Answer: Yes, NCHM is dedicated to providing our participants with the most up-to-date and reliable information available, especially during the lead-up to HOTMA going into effect. HUD will likely clarify some lingering questions and issue guidance, and NCHM is ready to modify our materials to reflect this new information. NCHM has launched the HOTMA Compliance Changelog, tracking all important changes to the HOTMA Compliance presentation.

Question: I see the newest changes, and they impacted a session I attended. Can I get an updated presentation for future reference?

Answer: NCHM will provide past participants with updated presentations as they are completed. These will be disseminated via email, so please be on the lookout for HOTMA update emails containing these updated files.

HUD Guidance and Notices

Document: Implementation Guidance: Sections 102 and 104 of the Housing Opportunity Through Modernization Act of 2016 (HOTMA)

PDF Download Link

Implementation Deadlines

Question: When is the compliance deadline for HOTMA?

Answer: The deadline is currently a moving target. For Public and Indian Housing programs, the deadline to comply with income and asset provisions is not yet set. The initial deadline was 1/1/2025, but HIP will not be ready in time to accommodate this.

Multifamily Programs have a compliance date of 1/1/2026.

HOME, HTF, and HOPWA Programs have a compliance date of 1/1/2026.

Question: If we have already processed ARs effective in 2024 and 2025, and we have not yet implemented HOTMA, will we have to correct them?

Answer: HUD will not penalize sites for HOTMA-related discrepancies from 1/1/2024 through 7/1/2025.

Family Composition

Question: Are foster children and foster adults listed on the certification?

Answer: Yes. Foster adults and foster children are members of the household. They will be considered when determining appropriate unit size and utility allowance. Under HOTMA, HUD clarifies that foster adults

and foster children are no longer considered members of the assisted family and as such, their income and assets are excluded.

Income

Question: Is it true that HUD now requires only 2 paystubs to calculate annual income from employment?

Answer: Yes, but if 2 paystubs do not reflect an accurate accounting of the member's annual income, you may request more.

Question: Are car payments or car insurance paid by someone outside of the household considered "in-kind" donations?

Answer: No, those are examples of bills paid on behalf of a family member and would continue to be counted as income. In-kind donations are things like personal items, toiletries, clothing, etc. The value of these recurring contributions will be excluded from income if the items were donated by food banks or similar organizations.

Question: Our property is layered with HUD Section 8 and LIHTC. If the way we determine income changes due to Section 8 allowing a "look-back" at the previous year, would that change also apply to LIHTC?

Answer: Not necessarily; it is important to know how your state housing finance agency is implementing HOTMA for LIHTC. Keep in mind that

looking back at last year's income is only as good as the current circumstances. If something has changed or there is a known anticipated change, you must take that into consideration.

Question: How should income be calculated for someone that works for the school system and then gets unemployment in the summertime? Should we process IRs?

Answer: The correct approach is to pro-rate the income. Include the employment income for the school year and unemployment for the summer in one certification. This is also the correct approach for other forms of known seasonal employment.

Question: HOTMA's new Safe Harbor provision allows for the use of "means-tested verifications." Are we required to accept these, or can we continue to obtain traditional third-party verifications?

Answer: The language used is that sites "may" accept means-tested verifications (LIHTC, WIC, SNAP, etc.). Sites are allowed to continue verifying using traditional third-party verifications. NCHM recommends that you do your own work and include acceptable forms and methods of verification in written policies and procedures.

Question: When is the last day a HOME or Public Housing participant can begin utilizing the Earned Income Disregard (EID)?

Answer: The last day participants were eligible to begin an EID was 12/31/2023. They are still entitled to receive 24 months of the benefit; that is why the EID program officially sunsets on 1/1/2026.

Assets

Question: Is it true that we must evict households that have assets worth more than $103,200 upon Annual Recertification?

Answer: No. O/A's have the discretion to choose whether or how to implement the new asset limitations upon Annual Recertification.

Question: My software will not allow me to use the new Passbook Savings Rate at this time. What are my options?

You only need to use the new Passbook Savings Rate if your site has implemented HOTMA. Until then, continue to use 0.06% as the Passbook Savings Rate until you have become HOTMA-compliant. You will not be penalized for this.

Question: Is it true that we will not be required to obtain a six-month average balance for each checking account on a certification?

Answer: Yes, the cash value of a checking account will now be its current balance.

Question: What is the Passbook Rate for 2024?

Answer: It has been revised from 0.06% to 0.40%.

Question: What is the Passbook Rate for 2025?

Answer: It will be increased to 0.45%.

Question: If a Section 8 applicant household has assets that amount to $51,600 or less in total cash value, do we allow a self-certification of assets for the move-in certification?

Answer: In subsidized programs, assets must be verified at least every three years. You may allow self-certifications in the intervening years when the total cash value is $51,600 or less. NCHM recommends obtaining verifications at move-in to establish a baseline.

Question: Do sites have to allow self-certification of assets, or can they continue to require third-party verification?

Answer: The language says tenants "may" self-certify. If a site wants to continue to conduct third-part verification of all assets, it is important to treat everyone the same way. The verification procedures should be addressed in the written policies and procedures.

Question: Does the $51,600 asset self-certification threshold apply to the LIHTC program?

Answer: The IRS considers the HOTMA final rule to supersede Rev Proc 94-65 and will allow for self-certification of assets when the cash value does not exceed $50,000. NCHM recommends consulting with the applicable State Housing Finance Agency, as they may have more restrictive requirements in place.

Question: If someone owns real property that is physically unsafe and is cost-prohibitive to render safe, what kind of verification should we use to prove this?

Answer: There are many options to verify such information, and HUD requires O/As and PHAs to determine what would be sufficient verification of such circumstances, and to outline this in their policies.

Question: If a household's assets exceed $51,600 in cash value, for which of those assets must we impute asset income?

Answer: Calculate imputed asset income for each asset that has an undeterminable amount of asset income (e.g.: homes, land, collections, recreational vehicles).

Question: What exactly do we need to verify to determine whether someone owns real property?

Answer: Ultimately, sites will need to determine a) whether the family has any interest in real property, as defined by state/local law; b) whether the family may legally occupy the real property, per state/local law; and c) whether the family has the legal authority to sell the real property under their state/local laws. You may also need to verify whether the property falls under one of HUD's or the site's own exceptions to these ownership rules when it comes to eligibility for assistance.

$103,200 Asset Threshold/Disposed Assets

Question: Are we still required only to count disposed assets when the amount disposed exceeds $1,000?

Answer: No. HOTMA eliminates any threshold to counting disposed assets. All amounts disposed will be reflected on the certification for two years from the date of disposal.

Question: What programs are subject to the $103,200 asset cap?

Answer: The new rule is specific to HUD Section 8 PBRA and programs administered by PHAs, such as Housing Choice Vouchers. This includes Section 202/8 programs, and excludes PRAC programs.

Question: Are there restrictions on how a household may get rid of their assets in excess of $103,200 in order to qualify for subsidy?

Answer: No, but keep in mind that applicants and tenants are still subject to the existing guidance regarding disposing assets for less than their fair market value. HUD offers ideas such as purchasing a piece of necessary property (such as a vehicle to be used for everyday transport), or placing it into an excluded asset under the household's control (such as an IRS-regulated retirement savings plan or an irrevocable trust).

Question: When a household has assets that exceed the $103,200 threshold, can we allow them to self-certify that assets have dropped

below $103,200, or do we need to third-party verify?

Answer: HUD allows families to self-certify this, however, NCHM recommends third-party verification to certify that a household's assets now total $103,200 or less.

Question: If a tenant spends down their assets on something like an elaborate vacation, what documentation does the file need to verify it was spent?

Answer: HUD does not require verification of purchases made from assets. Your policies and procedures may include verification standards that are stricter than HUD's.

Question: Our site is Section 8 PBRA layered with LIHTC. Does the $103,200 threshold apply to LIHTC?

Answer: Section 42 regulations have not been updated with regard to asset caps. When a site is layered, you must follow the most restrictive guidance; your site's Section 8 PBRA layer would be subject to the cap. Please consult your state housing finance agency for LIHTC guidance.

Question: Our site is electing to implement limited enforcement of the asset limitations upon recertification; we will grant affected households six months to cure their ineligibility. Will TRACS 203A have a method of monitoring these households so we can keep track of how far they are into their six-month period?

Answer: TRACS 203A updates are still in the works. For now, it will be your responsibility to track it.

Question: If we opt to delay termination of subsidy for six months for a household whose assets exceed the $103,200 cap upon Annual Recertification, how much rent does that household pay during that time?

Answer: They continue to receive subsidy for the 6-month period.

Certifications, Leases, and Forms

Question: With the changes under HOTMA, sites will need new forms and leases. When will these be available?

Answer: We are patiently awaiting updated forms and leases from HUD. At this point in time, the only forms that have been updated for HOTMA are the HUD-50058 and the 9886 for PIH programs. All remaining forms are still awaiting approval from the OMB.

Question: Is it true that the HUD forms 9887 and 9886 will only need to be signed once after HOTMA is effective?

Answer: Yes, starting in 2025 with the new version of the forms, tenants will only be required to sign once per issuance of subsidy instead of annually.

Question: Will all tenants need to sign the new HOTMA-compliant lease, or is their original lease still valid?

Answer: All tenants will need to sign a HOTMA-compliant lease. Once the model leases have been finalized and released, NCHM will update this page.

Question: Do we still need to have a 9887 signed when a dependent turns 18 years old?

Answer: Yes.

Question: If a change triggers an IR under the new rules, must we continue to verify and incorporate ALL changes that have occurred since the last certification?

Answer: You must still VERIFY all changes whenever an IR is executed. Only incorporate the changes that warrant an IR in the new certification. For example, if a household experiences a 10% increase in earned income AND a 10% increase in unearned income, verify both changes, but only adjust the unearned income source.

Deductions

Question: Is there a cut-off on how many times a family can receive the 90-day hardship exemption for the child care deduction?

Answer: There is no HUD-imposed limitation on how many times a family may benefit from this hardship exemption, but sites should address how they evaluate whether hardships exist in their written policies and procedures.

Question: Since the definition of the health and medical care deduction has expanded, would things like vitamins be deductible?

Answer: The new language states it includes any costs incurred in the diagnosis, cure, mitigation, treatment, or prevention of disease or payments for treatments affecting any structure or function of the body. NCHM recommends verifying with a doctor that items like vitamins are necessary to mitigate, treat, or prevent a condition. HUD has clarified that Exhibit 5-3 of the Handbook 4350.3 REV-1 is out-of-date and that they will be updating it.

Question: Who qualifies to have their disability and health and medical care expense threshold phased-in to 10% over three years?

Answer: The phase-in is only for existing tenants who are currently receiving assistance and taking the deduction(s) under the current 3% threshold. It does not apply to new move-ins, or to households who are not benefiting from the deduction as of 12/31/2023.

EIV

Question: How do the new rules impact the use of the Income Discrepancy Report in EIV?

Answer: HUD intends to update the discrepancy logic within EIV to conform to the requirements of the final rule. Owners are still required to generate the reports but are not required to investigate discrepancies resulting from the Income Discrepancy Reports until HUD updates the discrepancy logic.

Question: Does HOTMA change how we should be running our master EIV reports?

Answer: Please see Table J1 on pages 114-118 of Notice H 2023-10 (Rev. 2/2/2024) for revised guidance on EIV master reports.

Question: HOTMA indicates we do not need to run the EIV Income Report during IRs. Do we still need to run it after a household begins receiving subsidy through a MI or IC?

Answer: Yes. HOTMA only removes the obligation to run EIV during IRs. Going forward, all programs must run the EIV Income Report no later than 120 days after the date of MI or IC.

General Questions

Question: How will HUD communicate new limitations, restrictions, and deduction amounts that are subject to annual inflationary adjustments?

Answer: They will be posted to HUDUser.gov by no later than September 1 of the year prior to their effective date. HUD has already released the adjustments for 2025.

Question: What programs does HOTMA impact?

Answer: HOTMA impacts the following:

- Public Housing programs, including the Housing Choice Voucher (HCV) Program
- Moving to Work (MTW) Agencies
- Section 8 Project-Based Rental Assistance (PBRA) programs
- Rental Assistance Demonstration programs (RAD)
- Section 202/811 Project Rental Assistance Contracts (PRACs)
- Section 202/162 Project Assistance Contracts (PACs)
- Senior Preservation Rental Assistance Contracts (SPRACs)
- Section 811 Project Rental Assistance programs (PRAs)
- HOME Investment Partnerships programs
- Housing Trust Fund programs (HTF)
- Housing Opportunities for Persons With AIDS programs (HOPWA)
- Section 8 SRO Moderate Rehabilitation programs (Mod Rehab)
- Rural Housing Services*
- The Low Income Housing Tax Credit (LIHTC) program*

**To the extent that the respective governing agency uses the Section 8 definition of income.*

Question: How does HOTMA impact LIHTC?

Answer: Since the LIHTC program borrows from HUD guidance, the IRS has confirmed that HOTMA will impact the LIHTC program. We anticipate

that further guidance from the IRS in the coming months will provide some clarity to those impacts.

Question: So HOTMA's Final Rule is final...right?

Answer: Since the publication of the Final Rule, we have received additional guidance pertaining to implementation during this transition period. We anticipate further changes, guidance, and more in the coming months from HUD. As more information is released, we will be your partner in understanding how these changes impact your organization.

Question: Will NCHM be offering HOTMA-specific training?

Answer: Yes, our first HOTMA training session ran on August 17-18, 2023 and we plan to have sessions at least monthly in 2025.

Additionally, NCHM will provide updates on HOTMA news via blog posts, FAQ entries, and generally updating the HOTMA HQ page, so check in frequently.

Question: How do we handle applicants on our waiting list who will be ineligible due to new asset restrictions?

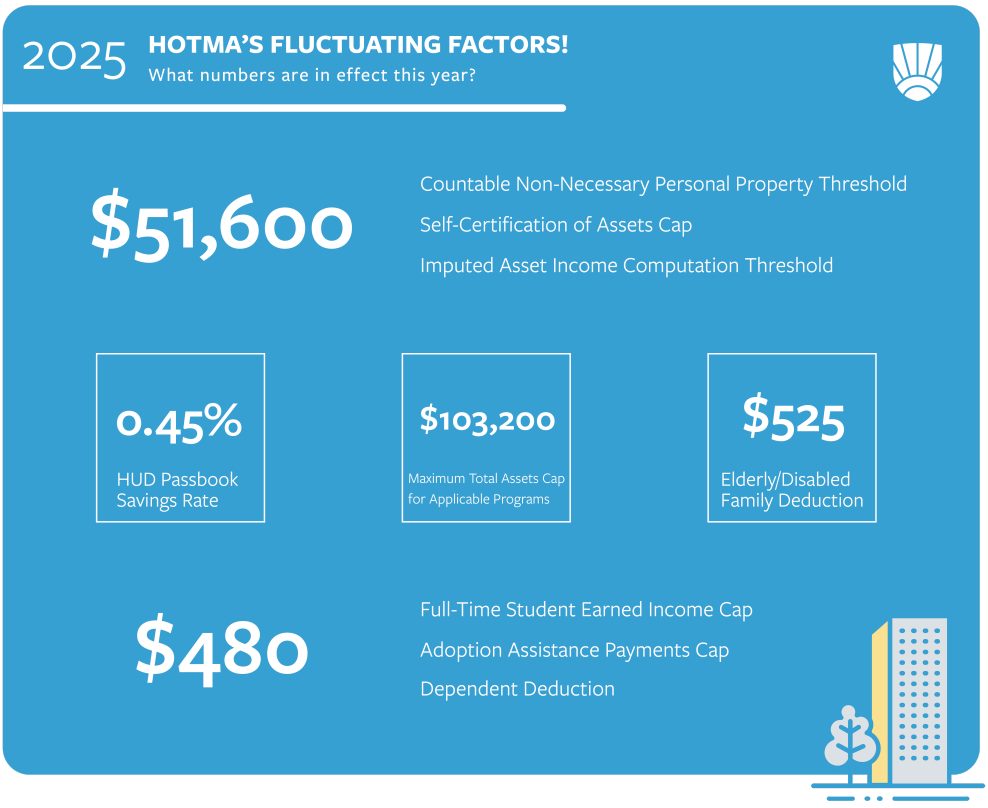
Answer: The O/A or PHA must decide how to communicate the new asset restrictions to applicants on the waiting list. There is no option to grandfather in these applicants.

Question: Will HOTMA changes be included in the next revision of the HUD Handbook 4350.3?

Answer: For now, changes under HOTMA are will be communicated through HUD and PIH Notices. The HUD Handbook 4350.3 will be undergoing extensive revision to incorporate all changes that have happened since 2013 – this will take some time.

Supporting Documents

HOTMA's Fluctuating Factors



FAQ CATEGORIES

Presentation Changelogs

HUD Guidance and Notices

Implementation Deadlines

Family Composition

Income

Assets

$100,000 Asset Threshold/Disposed Assets

Certifications, Leases, and Forms

Deductions

EIV

General Questions

Supporting Documents

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Section 103: Over-Income Limits for Public Housing Families Fact Sheet

Section 103 creates new limitations on program participation for families residing in public housing that remain over-income (OI) for 24 consecutive months. After a 24 month grace period, PHA policy may allow OI families to continue to live in a public housing unit paying an alternative rent. If the PHA does not adopt such a policy, the PHA must terminate tenancy of the OI family within six months of the final notification.

The new rules are implemented through two new sections in the public housing regulations: 24 CFR 960.507 ***Families exceeding the income limit***, and 24 CFR 960.509 ***Lease requirements for non-public housing over-income families***. Related definitions can be found in 24 CFR 960.102(b).

The provisions implementing section 103 will be effective March 16, 2023. All PHAs must fully implement OI policies no later than June 14, 2023. There are **no exceptions** to the income limitation on public housing program participation.

Over-income (OI) limit: set by multiplying the very low-income level for the applicable area by a factor of 2.4, a limit equal to approximately 120% of the AMI. OI procedures are triggered by ***annual or interim reexaminations***. During the reexamination, if the family is determined to be OI, the OI notification process begins.

Over-income (OI) family: families whose income exceeds the OI limit, including families during the grace period or before program termination or execution of a non-public housing over-income lease. These families retain all of their rights and obligations as public housing program participants.

Non-public housing over-income (NPHOI) family: a family whose income exceeds the OI limit for 24 consecutive months and remains in the unit paying the alternative non-public housing rent.

These families must have signed an NPHOI lease and are no longer public housing program participants. NPHOI families may not participate in public housing resident councils or programs for low-income or public housing participants. NPHOI families cannot receive a utility allowance from the PHA, be subject to income reexaminations, or be required to comply with Community Service and Self-Sufficiency Requirements.

Alternative Non-Public Housing Rent: A remaining NPHOI family must be charged a monthly rent equal to the higher of: the applicable fair market rent (24 CFR 888(A)), or the amount of the monthly subsidy provided for the unit (HUD will publish annually).

This material is based upon work supported, in whole or in part, by Federal award number NAL-C-17-094-05 awarded to NALCAB by the U.S. Department of Housing and Urban Development. The substance and findings of the work are dedicated to the public. Neither the United States Government, nor any of its employees, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product, or process disclosed, or represents that its use would not infringe privately-owned rights. Reference herein to any individuals, agencies, companies, products, process, services, service by trade name, trademark, manufacturer, or otherwise does not constitute or imply an endorsement, recommendation, or favoring by the author(s), contributor(s),the U.S. Government or any agency thereof. Opinions contained herein are those of the author(s) and do not necessarily reflect the official position of, or a position that is endorsed by, HUD or any Federal agency.

Section 103: Over-Income Limits for Public Housing Families Fact Sheet

Falling below OI limit: If the PHA determines (in an interim or regular reexamination) that a family's income has fallen below the OI limit at any time during the 24-month grace period the family will remain public housing program participants and return to regular income reexamination periods. If the family becomes OI again, the PHA begins a new 24-month grace period.

Notices: PHAs must give OI families 3 notices, each within 30 days of the income examination that determines the family is, or remains, OI: at the initial determination of OI status, following the reexamination at the conclusion of the 1st 12 months of the grace period, and at the conclusion of the 24 month grace period.

All notices must be provided in writing and state what actions will be taken as required under the PHA's OI policy in the Admissions and Continued Occupancy Policy (ACOP). If applicable, the notice must include the alternative rent amount. All notices must provide information on the family's right to a grievance hearing.

Policies: PHAs must have a continued occupancy policy detailed in its ACOP to either:

- Require OI families to execute a new NPHOI lease within 60 days of notification and charge the family the alternative non-public housing rent, or
- Terminate the tenancy of the family no more than 6 months after the notification.

PHAs may choose to adopt a waitlist preference for NPHOI families who again become income-eligible for readmission to the public housing program. These families would then reapply. OI families who have vacated public housing are not eligible for this preference.

Reporting: The PHA must submit a report annually that specifies:

- The number of OI families residing in a PHA's public housing as of the end of the calendar year. This report will be pulled by HUD via the form HUD-50058.
- The number of families on the waiting lists for admission to public housing. This information will be submitted through the Operating Fund Web Portal beginning January 1, 2024.

Related Resources:

- **Supplemental Guidance for Implementation of Section 103; Limitation on Public Housing Tenancy for Over-Income Families under the Housing Opportunity Through Modernization Act of 2016 (HOTMA)**
  - » See Appendix for directions on calculating the OI limit.
- **Implementation of Section 103: Over-Income Limits for Public Housing Families recorded training, presentation, and transcript**
- **Sample NPHOI lease**
- **Sample OI Notices**

Re: [redacted]st Party Pooled Trust for the benefit of
[redacted]

Dear Sir or Madam,

I am writing regarding [redacted], a Metro Housing Section 8 Voucher recipient who recently received a Recertification Packet. I am counsel for PLAN [redacted] which is trustee of the [redacted]cial Needs Pooled Trust, an irrevocable special needs trust which holds an account for [redacted] benefit.

In October 2023, [redacted] established an irrevocable pooled trust account with the [redacted] Special Needs Pooled Trust. The [redacted] Special Needs Pooled Trust is a totally discretionary, qualifying Medicaid pooled trust, as permitted under SSI regulations. Further, under federal housing regulations, such trusts are not considered countable assets and disbursements of principal are not considered countable income.

Irrevocable discretionary trusts are excluded from net family assets pursuant to HUD regulation 24 CFR s. 5.603(b), which states:

> *In cases where a trust fund has been established and the trust is not revocable by, or under the control of, any member of the family or household, the value of the trust fund will not be considered an asset as long as the fund continues to be held in trust. 24 CFR s. 5.603(b)*

Undistributed income from irrevocable discretionary trusts are also excluded from countable annual income at 24 CFR s. 5.609(b)(2), which states that annual income **does not include**:

> *For an irrevocable trust...outside the control of the family or household...distributions of the principal or corpus of the trust. 24 CFR s. 5.609(b)(2)*

[redacted] trust account is irrevocable and is not under the control of [redacted] or any other member of her family and therefore, meets the asset exemption above. In addition, under no circumstances does PLAN make any distributions of income to or for the benefit of [redacted] All distributions are from principal and therefore, do not constitute countable income under the HUD regulations.

HOT ISSUES IN HOTMA

Trustees (and others) Beware!

Emily Starr
Stuart Zimring
September 26, 2025

1

A Brief History of Subsidized Housing

- 1933 – The Great Depression
  - Public Works Administration Housing Division Created
    - Focused on jobs, not housing
  - 1937 – US Housing Authority Created
    - First Agency focused on low-income housing
- 1949 – Housing Act of 1949
  - Declaring a national goal of "a decent home and suitable living environment for every American family."

2

A Brief History of Subsidized Housing (cont'd)

- 1965 & 1968 – Urban Development Acts
  - Lyndon Johnson's Great Society creates the Department of Housing and Urban Development
  - Concept of direct rental assistance to low-income families is created
- 1974 – Housing and Community Development Act
  - Housing Choice Voucher Program (aka Section 8 Program) is created
  - Tenant-Based Housing Choice Voucher Program
  - Section 8 Multifamily/Project Based Program
- 2023 – 5.2 million American households receive some form of federal rental assistance; 2.3 through Housing Choice Voucher Program

3

HOTMA History

- Housing Opportunity Through Modernization Act (HOTMA) signed by Barack Obama in 2016
- Among the provisions are updated eligibility rules for federally subsidized housing including:
  - Traditional public housing (PHAs)
  - Section 8 vouchers (issued by PHAs)
  - Project based Section 8 (Multi Family Housing: MFHs)

4

Implementation

- Regulations issued in February of 2023 (date of implementation was to be 1/1/2024)
- Notice issued by HUD on 9/29/2023 postponed implementation to 1/1/2025
- Further notices have extended those deadlines
  - PHAs were to implement income exclusions by 7/1/2025. New deadlines for implementing other sections of HOTMA, most significantly the asset provisions, have not been published.
  - The deadlines for MFHs to implement all income and asset deadlines is 1/1/2026.

5

Eligibility until HOTMA is Implemented (Old Rules)

- Based on income only
- Income is imputed from assets
- Income is also imputed from assets transferred within the past two years
- Principal distributed from (d)(4)(A) trusts is not income. DeCambre v Brookline Housing Authority

6

Eligibility once HOTMA is Implemented (New Rules) : Assets

- Eligibility may be precluded if the family owns
  - non-excluded assets valued in excess of $100,000 (adjusted for inflation – currently $103,200) including assets disposed of during the prior 2 years for less than FMV
  - real property suitable for occupancy

7

"Family"

- For Section 8 purposes a family includes, but is not limited to,
  - A single person or group of persons
  - Regardless of whether they are related
  - Who live together and meet the eligibility requirements
  - Includes live-in aides and foster children

8

Whose Assets Count?

- Included: Assets of all adult and minor family members
- Excluded:
  - Assets owned by live-in aides
  - Assets owned by foster children and foster adults
- Jointly owned assets
  - The portion owned or controlled by family members

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Assets Excluded from Net Family Assets

- Retirement accounts recognized by the IRS
- Assets held in an irrevocable trust not under the control of a member of the family or household
- Real property that family does not have effective legal authority to sell
- Trusts
  - Assets held in an **irrevocable** trust not under control of a member of the family
  - Assets held in a **revocable** trust where the grantor/owner and trustee are not members of the family

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Assets Excluded from Net Family Assets
continued

- Civil action or settlement proceeds for an incident resulting in disability based on malpractice, negligence or other breach of duty
- Tax refunds or refundable tax credits for 12 months after receipt
- Section 529 education and 529A ABLE accounts and Coverdell education accounts
- Non-necessary items of personal property with a total value at more than $50,000
- And many more.

11

Asset Rules: Options

- PHA and MFH Owners are given discretion with regard to imposing asset limits on existing tenants, penalties for exceeding asset limits, and verification of income
- Policy choices of PHAs and MFH owners are required to be in writing and publicly available
  - Admissions and Continued Occupancy Policy (ACOPS) for PHAs
  - Tenant Selection Plans for MFHs

12

Enforcement of Asset Limits on Existing Tenants

- PHAs and MFH administrators have discretion relative to imposing asset limits on existing tenants
  - Enforce all asset limits
  - Written policy not to enforce asset limits for all families
  - Limited enforcement to give tenants up to six months to cure
  - Establish written policy against certain families considering age, disability income ability of family to find suitable housing
- A PHA/MFH owner that does not adopt no enforcement or limited enforcement policies can nevertheless delay termination or eviction for 6 months

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Eligibility once HOTMA is Implemented: Income

- Unless specifically excluded, income is
  - All amounts received by adult household members
  - Unearned income of household members less than18 years
  - Income generated by assets
    - Actual income
    - Imputed income on net family assets in excess of $50,000 (now $51,600 adjusted for inflation) when the actual income cannot be calculated
      - Based on passbook savings rate
      - Includes income imputed on assets given away during the preceding 2 years

14

Eligibility once HOTMA is Implemented: Income, continued

- No distinction between earned and unearned income other than for household members under 18
- In-kind income is included unless it is non-recurring
- Income eligibility is based on area median income

15

Income Exclusions

- Non-recurring income
  - Income received in one year not expected in next year
- Distributions to family members from
  - retirement accounts that are not periodic
  - ABLE accounts
  - 529 Plans
- Distribution from Trusts
  - Principal distributions are excluded
  - Income distributions for health and medical expenses of a minor are excluded.

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Income Exclusions, continued

- Lump sum additions to net family assets
  - Lottery winnings
  - Inheritances
    - Be sure distribution happens all in one year to avoid treatment as recurring income
- VA Aid and Attendance
- Worker's Compensation
- Insurance payments and settlement for personal or property losses regardless of frequency of payments
- Claims based on negligence resulting in disability regardless of whether received periodically or as a lump sum

17

Safe Harbor Income Calculation

- PHAs\MFH owners can adopt a policy to use income determinations from other programs
  - TANF
  - MassHealth
  - SNAP
  - SSI.

18

Enforcement of Income Limits

- 24 month grace period for tenants of PHAs whose income exceeds the limit, then
  - PHA may allow household to stay and pay alternative rent (FMV) or
  - PHA may terminate tenancy within 6 months

19

HOTMA Treatment of Trusts – Assets & Income Received

- A SNT should be funded with "excluded assets"
  - Proceeds from civil actions based on malpractice, negligence or other breach of duty for an incident resulting in a disability'
  - Assets held in an Irrevocable Trust where a family member is the beneficiary but the Grantor & Trustee are not members of the family or household and no family member has a power of revocation or amendment.
  - NOTE – the definition of "family" means persons residing together

20

HOTMA Treatment of Trusts – Assets & Income Received

- Items that are considered "excluded income" and therefor not countable can be contributed to the SNT, becoming an excluded part of the corpus.
  - "non-recurring income"
    - Birthday or wedding presents
    - Inheritances
    - Lottery winnings
    - Tax refunds
    - Proceeds from judgments or settlements from malpractice, negligence or other breach of duty resulting in disability (even if received in periodic payments! – structured settlements)

21

Drafting & Administrative Challenges

- In the Beginning…
  - Ask questions:
  - "Are You Now or Have You Ever Been…?"
  - Voucher or MFH?
  - Which PHA or MFH?
- Know Thy Corpus
- Drafters – Review your "usual" distribution clauses
- Consider segregating income
  - Maintain careful records

22

Drafting and Administrative Challenges

- Give Trustee discretion to distribute income to other beneficiaries
- Give Trustee express discretion to retain income and distribute principal
- Include provision allowing Trustee to distribute income to ABLE account

23

Beware of Recurring Periodic Distributions

- Regular Recurring periodic distributions are treated as income.
- Distributions of principal from a SNT are not income.
- Do regular distributions of principal from a SNT become "income" because they occur regularly?
- What is an "irregular periodic distribution?"

24

The "In-Kind/Recurring Distribution Conundrum

- Under HOTMA, non-monetary in-kind donations, *i.e.* food, clothing, personal items from a foodbank or other non-profit aren't income, even if occurring regularly.
- But, car payments, car insurance, *i.e.* "bill paying" is considered income.
- But are they "income" if they're paid from principal of the SNT?
- And what about our BFF – the Truelink Card?
- INQUIRING MINDS WANT TO KNOW!!

25

Advocate

- Like politics, the interpretation of many of the HOTMA Rules is local. PHAs and MFHs will interpret and apply the rules differently.
- Don't hesitate to advocate on behalf of your beneficiaries and Trustees!

26

STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Thursday
October 23, 2025

Proposed Changes to Model Rule 1.14: How They Will Affect Practice

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Center for Professional Responsibility

MEMORANDUM

To: **ABA Entities, Courts, Bar Associations (state, local, specialty, and international), Individuals, and Entities**
From: **Working Group on Model Rule of Professional Conduct 1.14**
Date: **July 21, 2025**
Re: **Seeking Comment on Second Discussion Draft of Possible Amendments to ABA Model Rule of Professional Conduct 1.14**

I. INTRODUCTION

ABA Model Rule of Professional Conduct 1.14 (MRPC 1.14) provides guidance to lawyers working with people who have cognitive limitations that affect their ability to make decisions, including decisions related to a representation. It has not been revised in more than two decades.

Experience with MRPC 1.14, and changes in the law and understanding of the rights and abilities of people with cognitive and intellectual limitations over the past two decades, have revealed a need for amendments to the Rule. Ambiguities in MRPC 1.14, as well as seemingly inconsistent guidance, have created inadvertent confusion for lawyers. In addition, it appears language in MRPC 1.14 has unintentionally encouraged and normalized the use of guardianship and conservatorship when less restrictive protective actions could meet client needs.

Inspired in part by changes made by the Maryland Supreme Court, a working group of eight ABA entities[1] recommended that the Center for Professional Responsibility consider revisions to MRPC 1.14. Since then, representatives from a number of ABA entities have worked together to study MRPC 1.14 and whether and how it might be best amended.[2] In April 2025, the group released Discussion Draft 1 of possible amendments to Rule 1.14, representing the joint work of members of the Standing Committee on Ethics and Professional Responsibility, the Standing Committee on Professional Regulation, and representatives of the ABA entities that originally came together to recommend revision.

[1] ABA Section of Civil Rights and Social Justice; Commission on Disability Rights; Commission on Law and Aging; Judicial Division; National Conference of State Trial Judges; Real Property, Trust and Estate Law; Senior Lawyers Division; Section of Family Law.

[2] Entities that have had representatives engaged in this work include the Civil Rights and Social Justice (led by Section's Elder Affairs Committee); Commission on Disability Rights; Commission on Aging; Judicial Division; National Conference of State Trial Judges; Real Property, Trust and Estate Law Section; Senior Law Division; the Section of Family Law; Solo, Small Firm and general Practice Division; Standing Committee on Ethics and Professional Responsibility; and Standing Committee on Professional Regulation.

Today, the group releases for review and comment Discussion Draft 2. This new draft includes change based on comments received concerning Discussion Draft 1. We are grateful for the comments received regarding Discussion Draft 1. Changes have been made to Comments 3, 6, 10, and 16. New Comment 11 was taken from Comment 10 and revised. And new Comment 14 was added. No amendments were made to the black letter presented in Discussion Draft 1.

This Memorandum summarizes the key suggested changes, the rationale behind them, and seeks comment. Appendix A is a redline of the changes made between Discussion Draft 1 and Discussion Draft 2. Appendix B provides a redline of Discussion Draft 2 to current Model Rule of Professional Conduct 1.14.

II. THE NEED FOR AMENDMENT

A detailed explanation of the need for updating MRPC 1.14 and possible amendments to the black letter and Comments to MRPC 1.14 are provided in the memo accompanying the first discussion draft, located at this link. This memorandum explains possible, further amendments to the official Comments as discussed below.

III. CHANGES NEW TO DISCUSSION DRAFT 2

A. **Comment 3**. *Comment 3* addresses the ordinary client-lawyer relationship and provides guidance on how decision-making limitations may, or may not, impact it. For example, it explains that decision-making limitations may affect some aspects of decision-making but not others. It also recognizes that individuals with substantial decision-making limitations may nevertheless provide guidance with respect to values and preferences relevant to reaching a decision. It incorporates and modifies much of what exists in current Comment 1. In the Discussion Draft 2, the word "some" was changed to "legal" in the next to last sentence to avoid suggesting that all people with disabilities can only make "some" legal decisions.

B. **Comments 10 and 11.** *Comments 10 and 11* incorporate core guidance from current Comment 6 on factors to consider in determining the extent of a client's decision-making limitations and substantially expands that guidance. It cautions against over-reliance on diagnosis, emphasizes the importance of accommodations and supports, and recognizes the responsibility of the lawyer to make a decision based on the lawyer's reasonable belief. The Comments also recognizes, as does current Comment 6, that a lawyer may seek guidance from a healthcare professional (not simply a "diagnostician"). The Comment guides lawyers to look for healthcare professionals with knowledge and experience in the kind of limitations specific to the client's situation. It also explains that unless such consultation is permitted as a reasonably necessary protective action, it will require the client's informed consent if the lawyer will reveal confidential information about the client. Thus, consultations that can be accomplished without such revelation may be done without client consent even if grounds for taking protective action are not satisfied.

The change to Comment 10 proposed in Discussion Draft 2 was added to provide clarity on an issue that commenters flagged as a source of confusion for some lawyers: what significance lawyers should attach to a medical evaluation of capacity. In response to comments received,

language was also added to encourage lawyers to consider whether supports or accommodations could alleviate factors contributing to decision-making limitations.

The Comment was also broken into two parts, resulting in new Comment 11, in the interest of readability. Minor changes in wording were made for the same reason.

C. **Comment 14:** *Comment 14* is new to Discussion Draft 2. It addresses an issue that commenters flagged as a source of confusion: whether taking protective action requires a lawyer to withdraw from further representation of the client. The new Comment explains that the mere fact that a lawyer takes protective action does not mean that the lawyer must terminate the representation, but that in some cases withdrawal may be needed (e.g., because the protective action creates a conflict of interest). It explains that the lawyer who takes protective action must inform the client of the protective action.

D. **Comment 16:** *Comment 16* addresses emergency legal assistance. Discussion Draft 2 removes a clause that one commenter flagged as potentially encouraging lawyers to action on behalf of a person with whom they had no prior relationship. As such encouragement was not intended, and the clause was not necessary, it was excised.

IV. OPPORTUNITY FOR FURTHER INPUT

Please send any comments to Discussion Draft 2 to modelruleamend@americanbar.org by August 30, 2025. Please note that comments may be posted on the ABA's website.

RULE 1.14: CLIENT WITH DECISION-MAKING LIMITATIONS

(a) A lawyer shall, as far as reasonably possible, maintain an ordinary client-lawyer relationship with a client with decision-making limitations, including when the client's decision-making limitations impact the client's ability to provide direction to the lawyer or make reasoned, informed choices.

(b) A person has decision-making limitations if the person has substantial difficulty receiving and understanding information, evaluating information, or making or communicating decisions even with appropriate supports or accommodations.

(c) When the lawyer reasonably believes that the client: (1) has decision-making limitations, (2) is at risk of substantial physical, financial or other harm unless action is taken, and (3) cannot adequately act in the client's own interest to address the risk, the lawyer may take reasonably necessary protective action to address the risk.

(d) Information relating to the representation of a client with decision-making limitations is protected by Rule 1.6. However, when taking protective action pursuant to paragraph (c), the lawyer may reveal information related to the representation, to the extent the lawyer reasonably believes necessary to protect the client's interests.

Comment

Client Abilities and Limitations

[1] A client's decision-making limitations do not diminish the lawyer's obligations under the Rules and the importance of treating the client with attention and respect. Except as provided in this Rule, a client with decision-making limitations is owed all the protections under the Rules ordinarily afforded by the client-lawyer relationship.

[2] A client may have decision-making limitations with regard to certain issues and not others. Lawyers are required to maintain, as far as reasonably possible, an ordinary client-lawyer relationship with clients with decision-making limitations. Decision-making limitations can be situational in nature and vary in degree. A client's decision-making limitations may be affected by multiple factors.

Sometimes decision-making limitations can be alleviated or eliminated by using supports or making accommodations to enhance the client's decision-making abilities, and such use can assist the lawyer in maintaining an ordinary client-lawyer relationship. Examples of supports and accommodations include communication devices or services, assistance of appropriate third parties or supported decision-making, environmental changes (e.g., conducting client meetings in a familiar setting), and using plain language or otherwise modifying the lawyer's communication and counseling techniques for the client.

Ordinary Client-Lawyer Relationship

[3] An ordinary client-lawyer relationship is based, in part, on the assumption that the client, when properly advised and assisted, can make and communicate reasoned, informed decisions about important matters. When the client has decision-making limitations, however, maintaining an ordinary client-lawyer relationship may not be possible in all respects. In particular,

a client with decision-making limitations may have limited ability to make or communicate legally binding decisions. Nevertheless, a client with decision-making limitations often can understand, deliberate upon and reach conclusions about matters affecting the client's own well-being. For example, some adults with substantial decision-making limitations, including those due to intellectual, developmental or cognitive disabilities, mental health conditions or substance abuse disorder, can make ~~some~~legal decisions. In addition, even if not able to make decisions, persons with decision-making limitations, including minors, may have preferences and values that can guide the lawyer's representation.

[4] The client may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons may not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (c), must look to the client, and not family members or other persons, to make decisions on the client's behalf. Whenever possible, the lawyer should afford the client the opportunity to communicate privately with the lawyer without the presence or influence of others.

[5] When the client has granted an agent authority to make decisions, including an agent acting under a power of attorney, the lawyer nevertheless should take direction from the client and maintain communication with the client to the extent feasible unless the client has otherwise directed or is unable to provide direction. In addition, a lawyer may consult with and represent a person who seeks to challenge the actions of an agent or terminate or modify the agent's appointment. When representing a client in such situations, the lawyer must take direction from the client and advocate for the client's objectives.

When a court has appointed a guardian, conservator or other appointee to act on behalf of a client or prospective client, a lawyer should ordinarily look to the court appointee for those decisions on behalf of the client or prospective client over which the appointee has authority. However, a lawyer may consult with and represent a person subject to guardianship or conservatorship who seeks representation to challenge or modify the terms of that arrangement, or who seeks representation with regard to any other matter over which the person retains decision-making authority. When representing a client in such situations, the lawyer must take direction from the client and advocate for the client's objectives.

In matters involving a minor, whether the lawyer should look to the parents as natural guardians may depend on the type of proceeding or matter in which the lawyer is representing the minor.

If the lawyer represents the guardian, conservator, or agent of a person with decision-making limitations, and is aware that the guardian, conservator or agent is acting adversely to the person's interest, the lawyer may have an obligation to prevent or rectify the misconduct.

[6] When a client in a criminal matter appears to have decision-making limitations, the lawyer's ethical duty to render competent representation and to protect~~ion of~~ the client's constitutional rights may require the lawyer to seek a competency evaluation or other mental health evaluation to determine whether the client is capable of deciding whether to testify or to plead guilty or to determine whether the client can meaningfully participate in preparation for trial, sentencing or another adjudicatory process. Because a client's liberty may be at stake, these questions are uniquely difficult. Judicial decisions vary regarding whether, without the client's informed consent, a lawyer for the accused may or must raise doubts with the court about the competency of the accused. In such situations, lawyers should inform themselves of relevant judicial decisions and other authority in the jurisdiction and are encouraged to seek guidance from

other organizations and resources, such as the ABA Defense Function Standard on Establishing and Maintaining an Effective Client Relationship and the ABA Criminal Justice Standards on Mental Health.

[7] A lawyer representing a minor should be mindful that the minor may have decision-making limitations due to age and stage of development. As with adult clients with decision-making limitations, the lawyer for a minor with decision-making limitations should, as far as reasonable, maintain an ordinary client-lawyer relationship. A lawyer for a minor capable of providing direction should advocate for the minor's objectives of the representation. See Rule 1.2(a).

[8] A lawyer acting as guardian ad litem for a person is typically tasked with advocating for the best interest of that person. Because a person's best interest may diverge from the person's objectives, lawyers who simultaneously act as a guardian ad litem for a person and provide direct legal representation of that person may find themselves in an ethically untenable position.

Taking Protective Action

[9] If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that an ordinary client-lawyer relationship cannot be maintained as provided in paragraph (a), paragraph (c) permits the lawyer to take protective measures the lawyer deems necessary. Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decision-making tools such as durable powers of attorney or consulting with support groups, healthcare professionals or other professional services, adult-protective agencies or other persons or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests, and the goals of intruding into the client's decision-making autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections. In litigation involving the capacity of the client, such as a guardianship or conservatorship proceeding, the lawyer should advocate for the client's expressed position regarding what, if any, protective action should be taken.

[10] In determining the extent of the client's decision-making limitations, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision; variability of state of mind and ability to understand consequences of a decision; the substantive fairness of a decision, ~~and~~ the consistency of a decision with the known long-term commitments and values of the client, and whether ~~.~~ supports or accommodations could alleviate factors contributing to decision-making limitations. A lawyer's reasonable belief that the client cannot make and communicate reasoned, informed decisions may be based on the lawyer's own observations. In forming a reasonable belief, a lawyer should ordinarily not rely exclusively on a medical diagnosis, but rather should consider the client's functional abilities and whether the limitations in the client's abilities could be alleviated by the use of accommodations or supports. In forming a reasonable belief, a lawyer who is aware that a healthcare professional's evaluation of the client's current abilities and limitations should take such evaluation into consideration. However, the lawyer should recognize that the evaluation may have been done for a different purpose and under different circumstances, and that the evaluator may have evaluated the client based on standards that differ from the relevant legal standard.

[11] A determination of decisional incapacity need not have been made by a healthcare professional or court for a lawyer to form a reasonable belief that a client cannot make and

communicate decisions. Nevertheless, in appropriate circumstances, the lawyer may seek guidance from a healthcare professional with relevant expertise or with knowledge of the client's abilities or limitations. If obtaining such guidance requires revealsing confidential information about the client and is not done with the client's client does not or cannot give informed consent, it falls outside the ordinary client-lawyer relationship and is permissible only if it is a reasonably necessary protective action under Rule 1.14(c).

[12~~1~~] If a lawyer reasonably believes that the client meets the criteria set forth in subsection (b) of this Rule, the lawyer may consider whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests. For example, if the client has substantial property that should be sold for the client's benefit, effective completion of the transaction may require appointment of a guardian or conservator, which may be temporary or limited in nature, or a court order in lieu of such an appointment. In addition, rules of procedure in litigation sometimes provide that minors or persons with decision-making limitations must be represented by a guardian or next friend if they do not have a general guardian. In many circumstances, however, appointment of such a legal representative may be more intrusive, expensive or traumatic for the client than circumstances in fact require. Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer. In considering alternatives, however, the lawyer should generally advocate the least restrictive action on behalf of the client, and be aware of any law that so requires. The lawyer should also communicate with the client regarding such protective action to the extent feasible unless doing so is not necessary for the client to make informed choices about the representation and would be detrimental to the client or the lawyer's ability to protect the client's interests. See Rule 1.4.

[13~~2~~] If another person has petitioned a court for an appointment of a conservator or a guardian or another restriction on the client's legal capacity, the lawyer may not advocate for such an appointment or restriction if the client opposes it. If the lawyer represents a client who is a respondent in a proceeding for guardianship or conservatorship, the lawyer must advocate for the client's objectives if known or ascertainable.

[14] Taking protective action under subsection (c) of this Rule does not, without more, require the lawyer to terminate the representation. However, the lawyer must inform the client of the protective action and should consider whether withdrawing from the representation has become necessary under Rule 1.16(a). For example, the lawyer may have a conflict of interest necessitating withdrawal in light of the particular protective action, the subject of the representation, the nature of the client-lawyer relationship, and other relevant considerations. See, e.g., Rule 1.7.

Disclosure of Information When Taking Protective Action

[15~~3~~] Disclosure of the client's decision-making limitations could adversely affect the client's interests, including constitutional or other legal rights. For example, raising the question of decision-making limitations could, in some circumstances, lead to proceedings for involuntary civil commitment. Information relating to the representation is protected by Rule 1.6. Therefore, unless authorized to do so, the lawyer may not disclose such information. When taking protective action pursuant to paragraph (c), the lawyer may reveal information about the representation, but only to the extent reasonably necessary to protect the client's interests. Nevertheless, given the risks of disclosure, paragraph (d) limits what the lawyer may disclose in consulting with other persons or entities or seeking the appointment of a legal representative. At the very least, the lawyer

should determine whether it is likely that the person or entity consulted with will act adversely to the client's interests before discussing matters related to the client.

Emergency Legal Assistance

[164] In an emergency where the health, safety or a financial interest of a person with decision-making limitations is threatened with imminent and irreparable harm, a lawyer may take legal action on behalf of such a person even though the person is unable to establish a client-lawyer relationship or to make or communicate reasoned, informed judgments about the matter such as when the person ~~or another acting in good faith on that person's behalf~~ has consulted with the lawyer. Even in such an emergency, however, the lawyer should not act unless the lawyer reasonably believes that the person with decision-making limitations has no other lawyer, agent or other representative available. The lawyer should take legal action on behalf of the person with decision-making limitations only to the extent reasonably necessary to maintain the status quo or otherwise avoid imminent and irreparable harm. A lawyer who undertakes to represent a person with decision-making limitations in such an exigent situation has the same duties under these Rules as the lawyer would with respect to a client.

[175] A lawyer who in an emergency acts on behalf of a person with decision-making limitations who is unable to establish a client-lawyer relationship should keep the confidences of the person with decision-making limitations as if dealing with a client, disclosing them only to the extent necessary to accomplish the intended protective action. The lawyer should disclose to any tribunal involved and to any other counsel involved the nature of the lawyer's relationship with the person with decision-making limitations. The lawyer should take steps to regularize the relationship or implement other protective solutions as soon as possible. Ordinarily, a lawyer would not seek compensation for such emergency actions taken.

RULE 1.14: CLIENT WITH DECISION-MAKING LIMITATIONS~~DIMINISHED CAPACITY~~

(a) ~~When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the~~A lawyer shall, as far as reasonably possible, maintain an ordinary~~normal~~ client-lawyer relationship with a~~the~~ client with decision-making limitations, including when the client's decision-making limitations impact the client's ability to provide direction to the lawyer or make reasoned, informed choices.

(b) A person has decision-making limitations if the person has substantial difficulty receiving and understanding information, evaluating information, or making or communicating decisions even with appropriate supports or accommodations.

(c~~b~~) When the lawyer reasonably believes that the client (1) has decision-making limitations~~diminished capacity~~, (2) is at risk of substantial physical, financial or other harm unless action is taken, and (3) cannot adequately act in the client's own interest to address the risk, the lawyer may take reasonably necessary protective action to address the risk~~, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian~~.

(d~~c~~) Information relating to the representation of a client with decision-making limitations~~diminished capacity~~ is protected by Rule 1.6. However, w~~W~~hen taking protective action pursuant to paragraph (c~~b~~), the lawyer ~~is impliedly authorized under Rule 1.6(a) to~~ may reveal information related to the representation ~~about the client~~, ~~but only~~ to the extent the lawyer reasonably believes necessary to protect the client's interests.

Comment

Client Abilities and Limitations

~~[1] The normal client-lawyer relationship is based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters. When the client is a minor or suffers from a diminished mental capacity, however, maintaining the ordinary client-lawyer relationship may not be possible in all respects. In particular, a severely incapacitated person may have no power to make legally binding decisions. Nevertheless, a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. For example, children as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody. So also, it is recognized that some persons of advanced age can be quite capable of handling routine financial matters while needing special legal protection concerning major transactions.~~

[1~~2~~] ~~The fact that a~~A client's decision-making limitations ~~suffers a disability~~ do~~es~~ not diminish the lawyer's obligations under the Rules and the importance of ~~to~~ treating the client with

attention and respect. Except as provided in this Rule, a client with decision-making limitations is owed all the protections under the Rules ordinarily afforded by the client-lawyer relationship~~Even if the person has a legal representative, the lawyer should as far as possible accord the represented person the status of client, particularly in maintaining communication~~.

[2] A client may have decision-making limitations with regard to certain issues and not others. Lawyers are required to maintain, as far as reasonably possible, an ordinary client-lawyer relationship with clients with decision-making limitations. Decision-making limitations can be situational in nature and vary in degree. A client's decision-making limitations may be affected by multiple factors. Sometimes decision-making limitations can be alleviated or eliminated by using supports or making accommodations to enhance the client's decision-making abilities, and such use can assist the lawyer in maintaining an ordinary client-lawyer relationship. Examples of supports and accommodations include communication devices or services, assistance of appropriate third parties or supported decision-making, environmental changes (e.g., conducting client meetings in a familiar setting), and using plain language or otherwise modifying the lawyer's communication and counseling techniques for the client.

Ordinary Client-Lawyer Relationship

[3~~1~~] An ordinary~~The normal~~ client-lawyer relationship is based, in part, on the assumption that the client, when properly advised and assisted, ~~is capable of making~~can make and communicate reasoned, informed decisions about important matters. When the client has decision-making limitations~~is a minor or suffers from a diminished mental capacity~~, however, maintaining an~~the~~ ordinary client-lawyer relationship may not be possible in all respects. In particular, a client with decision-making limitations ~~severely incapacitated person~~ may have limited ability ~~no power~~ to make or communicate legally binding decisions. Nevertheless, a client with decision-making limitations ~~diminished capacity~~ often ~~has the ability to~~can understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. For example, some adults with substantial decision-making limitations including those due to intellectual, developmental or cognitive disabilities, mental health conditions, or substance abuse disorder can make some decisions. In addition, even if not able to make legal decisions, persons with decision-making limitations, including minors, may have preferences and values that can guide the lawyer's representation.

~~children as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody. So also, it is recognized that some persons of advanced age can be quite capable of handling routine financial matters while needing special legal protection concerning major transactions.~~

[4~~3~~] The client may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons ~~generally does~~may not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (~~b~~c), must look to the client, and not family members or other persons, to make decisions on the client's behalf. Whenever possible, the lawyer should afford the client the opportunity to communicate privately with the lawyer without the presence or influence of others.

[54]

When the client has granted an agent authority to make decisions, including an agent acting under a power of attorney, the lawyer nevertheless should take direction from the client and maintain communication with the client to the extent feasible unless the client has otherwise directed or is unable to provide direction. In addition, a lawyer may consult with and represent a person who seeks to challenge the actions of an agent or terminate or modify the agent's appointment. When representing a client in such situations, the lawyer must take direction from the client and advocate for the client's objectives.

When a court has appointed a guardian, conservator, or other appointee to act on behalf of a client or prospective client, a lawyer should ordinarily look to the court appointee for those decisions on behalf of the client or prospective client over which the appointee has authority. However, a lawyer may consult with and represent a person subject to guardianship or conservatorship who seeks representation to challenge or modify the terms of that arrangement, or who seeks representation with regard to any other matter over which the person retains decision-making authority. When representing a client in such situations, the lawyer must take direction from the client and advocate for the client's objectives.

~~If a legal representative has already been appointed for the client, the lawyer should ordinarily look to the representative for decisions on behalf of the client.~~ In matters involving a minor, whether the lawyer should look to the parents as natural guardians may depend on the type of proceeding or matter in which the lawyer is representing the minor.

If the lawyer represents the guardian, conservator, or agent of a person with decision-making limitations~~as distinct from the ward~~, and is aware that the guardian, conservator, or agent is acting adversely to the person's~~ward's~~ interest, the lawyer may have an obligation to prevent or rectify the ~~guardian's~~ misconduct. ~~See Rule 1.2(d).~~

[6] When a client in a criminal matter appears to have decision-making limitations, the lawyer's ethical duty to render competent representation and to protect the client's constitutional rights may require the lawyer to seek a competency evaluation or other mental health evaluation to determine whether the client is capable of deciding whether to testify or to plead guilty or to determine whether the client can meaningfully participate in preparation for trial, sentencing or another adjudicatory process. Because a client's liberty may be at stake, these questions are uniquely difficult. Judicial decisions vary regarding whether, without the client's informed consent, a lawyer for the accused may or must raise doubts with the court about the competency of the accused. In such situations, lawyers should inform themselves of relevant judicial decisions and other authority in the jurisdiction and are encouraged to seek guidance from other organizations and resources, such as the ABA Defense Function Standard on Establishing and Maintaining an Effective Client Relationship and the ABA Criminal Justice Standards on Mental Health.

[7] A lawyer representing a minor should be mindful that the minor may have decision-making limitations due to age and stage of development. As with adult clients with decision-making limitations, the lawyer for a minor with decision-making limitations should, as far as reasonable, maintain an ordinary client-lawyer relationship. A lawyer for a minor capable of providing direction should advocate for the minor's objectives. See Rule 1.2(a)

[8] A lawyer acting as guardian ad litem for a person is typically tasked with advocating for the best interest of that person. Because a person's best interest may diverge from the person's

objectives, lawyers who simultaneously act as a guardian ad litem for a person and provide direct legal representation of that person may find themselves in an ethically untenable position.

Taking Protective Action

[95] If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a ~~normal~~n ordinary client-lawyer relationship cannot be maintained as provided in paragraph (a) ~~because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation~~, ~~then~~ paragraph (c~~b~~) permits the lawyer to take protective measures the lawyer deem~~ed~~s necessary. Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decision-making tools such as durable powers of attorney or consulting with support groups, healthcare professionals or other professional services, adult-protective agencies or other ~~individuals~~ persons or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decision-making autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections. In litigation involving the capacity of the client, such as a guardianship or conservatorship proceeding, the lawyer should advocate for the client's expressed position regarding what, if any, protective action should be taken.

[106] In determining the extent of the client's ~~diminished capacity~~decision-making limitations, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision~~,~~; variability of state of mind and ability to ~~appreciate~~ understand consequences of a decision; the substantive fairness of a decision; ~~and~~ the consistency of a decision with the known long-term commitments and values of the client; and whether supports or accommodations could alleviate factors contributing to decision-making limitations. A lawyer's reasonable belief that the client cannot make and communicate reasoned, informed decisions may be based on the lawyer's own observations. In forming a reasonable belief, a lawyer should ordinarily not rely exclusively on a medical diagnosis, but rather should consider the client's functional abilities and whether the limitations in the client's abilities could be alleviated by the use of accommodations or supports. In forming a reasonable belief, a lawyer who is aware that a healthcare professional's evaluation of the client's current abilities and limitations should take such evaluation into consideration. However, the lawyer should recognize that the evaluation may have been done for a different purpose and under different circumstances, and that the evaluator may have evaluated the client based on standards that differ from the relevant legal standard.

[11] A determination of decisional incapacity need not have been made by a healthcare professional or court for a lawyer to form a reasonable belief that a client cannot make and communicate decisions. Nevertheless, i~~I~~n appropriate circumstances, the lawyer may seek guidance from a healthcare professional with relevant expertise or with knowledge of the client's abilities or limitations. If obtaining such guidance requires revealing confidential information about the client and the client does not or cannot give informed consent, it is permissible only if it is a reasonably necessary protective action under Rule 1.14(c) ~~an appropriate diagnostician~~.

[12] [~~117~~] If a lawyer reasonably believes that the client meets the criteria set forth in subsection (b) of this Rule, the lawyer may consider ~~a legal representative has not been appointed,~~

~~the lawyer should consider~~ whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests. For example~~Thus~~, if the~~a~~ client~~ with diminished capacity~~ has substantial property that should be sold for the client's benefit, effective completion of the transaction may require appointment of a guardian or conservator, which may be temporary or limited in nature, or a court order in lieu of such an appointment~~legal representative~~. In addition, rules of procedure in litigation sometimes provide that minors or persons with decision-making limitations~~diminished capacity~~ must be represented by a guardian or next friend if they do not have a general guardian. In many circumstances, however, appointment of such a legal representative may be more intrusive, expensive or traumatic for the client than circumstances in fact require. Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer. In considering alternatives, however, the lawyer should generally ~~be aware of any law that requires the lawyer to~~ advocate the least restrictive action on behalf of the client, and be aware of any law that so requires. The lawyer should also communicate with the client regarding such protective action to the extent feasible unless doing so is not necessary for the client to make informed choices about the representation and would be detrimental to the client or the lawyer's ability to protect the client's interests. See Rule 1.4.

[13] ~~[12]~~ If another person has petitioned a court for an appointment of a conservator or a guardian, or another restriction on the client's legal capacity, the lawyer may not advocate for such an appointment or restriction if the client opposes it. If the lawyer represents a client who is a respondent in a proceeding for guardianship or conservatorship, the lawyer must advocate for the client's objectives if known or ascertainable.

[14] Taking protective action under subsection (c) of this Rule does not, without more, require the lawyer to terminate the representation. However, the lawyer must inform the client of the protective action and should consider whether withdrawing from the representation has become necessary under Rule 1.16(a). For example, the lawyer may have a conflict of interest necessitating withdrawal in light of the particular protective action, the subject of the representation, the nature of the client-lawyer relationship, and other relevant considerations. See, e.g., Rule 1.7.

Disclosure of Information When Taking Protective Action~~the Client's Condition~~

[15] ~~[13]~~ Disclosure of the client's ~~diminished capacity~~ decision-making limitations could adversely affect the client's interests, including constitutional or other legal rights. For example, raising the question of decision-making limitations~~diminished capacity~~ could, in some circumstances, lead to proceedings for involuntary civil commitment. Information relating to the representation is protected by Rule 1.6. Therefore, unless authorized to do so, the lawyer may not disclose such information. When taking protective action pursuant to paragraph (c~~b~~), the lawyer may reveal information about the representation~~is impliedly authorized to make the necessary disclosures~~, but only to the extent reasonably necessary to protect the client's interests~~ even when the client directs the lawyer to the contrary~~. Nevertheless, given the risks of disclosure, paragraph (d~~c~~) limits what the lawyer may disclose in consulting with other ~~individuals~~ persons or entities or seeking the appointment of a legal representative. At the very least, the lawyer should determine whether it is likely that the person or entity consulted with will act adversely to the client's interests before discussing matters related to the client.~~ The lawyer's position in such cases is an unavoidably difficult one.~~

Emergency Legal Assistance

[16] [14~~9~~] In an emergency where the health, safety or a financial interest of a person with ~~seriously diminished capacity~~decision-making limitations is threatened with imminent and irreparable harm, a lawyer may take legal action on behalf of such a person even though the person is unable to establish a client-lawyer relationship or to make or communicate reasoned, informed ~~express considered~~ judgments about the matter, such as when the person ~~or another acting in good faith on that person's behalf~~ has consulted with the lawyer. Even in such an emergency, however, the lawyer should not act unless the lawyer reasonably believes that the person with decision-making limitations has no other lawyer, agent or other representative available. The lawyer should take legal action on behalf of the person with decision-making limitations only to the extent reasonably necessary to maintain the status quo or otherwise avoid imminent and irreparable harm. A lawyer who undertakes to represent a person with decision-making limitations in such an exigent situation has the same duties under these Rules as the lawyer would with respect to a client.

[17] [15~~10~~] A lawyer who in an emergency acts on behalf of a person with decision-making limitations who is unable to establish a client-lawyer relationship~~seriously diminished capacity in an emergency~~ should keep the confidences of the person with decision-making limitations as if dealing with a client, disclosing them only to the extent necessary to accomplish the intended protective action. The lawyer should disclose to any tribunal involved and to any other counsel involved the nature of ~~his or her~~the lawyer's relationship with the person with decision-making limitations. The lawyer should take steps to regularize the relationship or implement other protective solutions as soon as possible. Ordinarily~~Normally~~, a lawyer would not seek compensation for such emergency actions taken.

Current Rule October 2025

Rule 1.14: Client with Diminished Capacity

Client-Lawyer Relationship

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

COMMENTS

Client-Lawyer Relationship

[1] The normal client-lawyer relationship is based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters. When the client is a minor or suffers from a diminished mental capacity, however, maintaining the ordinary client-lawyer relationship may not be possible in all respects. In particular, a severely incapacitated person may have no power to make legally binding decisions. Nevertheless, a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. For example, children as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody. So also, it is recognized that some persons of advanced age can be quite capable of handling routine financial matters while needing special legal protection concerning major transactions.

[2] The fact that a client suffers a disability does not diminish the lawyer's obligation to treat the client with attention and respect. Even if the person has a legal representative, the lawyer

should as far as possible accord the represented person the status of client, particularly in maintaining communication.

[3] The client may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (b), must look to the client, and not family members, to make decisions on the client's behalf.

[4] If a legal representative has already been appointed for the client, the lawyer should ordinarily look to the representative for decisions on behalf of the client. In matters involving a minor, whether the lawyer should look to the parents as natural guardians may depend on the type of proceeding or matter in which the lawyer is representing the minor. If the lawyer represents the guardian as distinct from the ward, and is aware that the guardian is acting adversely to the ward's interest, the lawyer may have an obligation to prevent or rectify the guardian's misconduct. See Rule 1.2(d).

Taking Protective Action

[5] If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a normal client-lawyer relationship cannot be maintained as provided in paragraph (a) because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation, then paragraph (b) permits the lawyer to take protective measures deemed necessary. Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decisionmaking tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decisionmaking autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections.

[6] In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.

[7] If a legal representative has not been appointed, the lawyer should consider whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests. Thus, if a client with diminished capacity has substantial property that should be sold for the client's benefit, effective completion of the transaction may require

appointment of a legal representative. In addition, rules of procedure in litigation sometimes provide that minors or persons with diminished capacity must be represented by a guardian or next friend if they do not have a general guardian. In many circumstances, however, appointment of a legal representative may be more expensive or traumatic for the client than circumstances in fact require. Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer. In considering alternatives, however, the lawyer should be aware of any law that requires the lawyer to advocate the least restrictive action on behalf of the client.

Disclosure of the Client's Condition

[8] Disclosure of the client's diminished capacity could adversely affect the client's interests. For example, raising the question of diminished capacity could, in some circumstances, lead to proceedings for involuntary commitment. Information relating to the representation is protected by Rule 1.6. Therefore, unless authorized to do so, the lawyer may not disclose such information. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized to make the necessary disclosures, even when the client directs the lawyer to the contrary. Nevertheless, given the risks of disclosure, paragraph (c) limits what the lawyer may disclose in consulting with other individuals or entities or seeking the appointment of a legal representative. At the very least, the lawyer should determine whether it is likely that the person or entity consulted with will act adversely to the client's interests before discussing matters related to the client. The lawyer's position in such cases is an unavoidably difficult one.

Emergency Legal Assistance

[9] In an emergency where the health, safety or a financial interest of a person with seriously diminished capacity is threatened with imminent and irreparable harm, a lawyer may take legal action on behalf of such a person even though the person is unable to establish a client-lawyer relationship or to make or express considered judgments about the matter, when the person or another acting in good faith on that person's behalf has consulted with the lawyer. Even in such an emergency, however, the lawyer should not act unless the lawyer reasonably believes that the person has no other lawyer, agent or other representative available. The lawyer should take legal action on behalf of the person only to the extent reasonably necessary to maintain the status quo or otherwise avoid imminent and irreparable harm. A lawyer who undertakes to represent a person in such an exigent situation has the same duties under these Rules as the lawyer would with respect to a client.

[10] A lawyer who acts on behalf of a person with seriously diminished capacity in an emergency should keep the confidences of the person as if dealing with a client, disclosing them only to the extent necessary to accomplish the intended protective action. The lawyer should disclose to any tribunal involved and to any other counsel involved the nature of his or her relationship with the person. The lawyer should take steps to regularize the relationship or implement other protective solutions as soon as possible. Normally, a lawyer would not seek compensation for such emergency actions taken.

Proposed Changes to Model Rule 1.14: How They Will Affect Practice

Charles P. Sabatino

2025 National Conference on Special Needs Planning and Special Needs Trusts

October 23, 2025

1

Proposed Changes to Model Rule 1.14: How They Will Affect Practice

Keep in mind:

1. Final version will be different than that in your materials.
2. Final not available until formally added to the agenda of ABA Midyear Meeting, February 2026.
3. Comment numbers I refer to are those in your materials.
4. What you have reflects about 90% of the final version.
5. Everything is proposed and can change, but not much.
6. I'm hitting highlights, not every jot and tittle.

2

Five Quandaries we will cover

(but not all the possible issues)



- Diminished Capacity?



- Protective Action Guidance?



- 3rd Parties–Supporter/Exploiter?



- How Much Can I Disclose in and out of Litigation?



- Meaningful Access to Counsel when a surrogate is in place

3

3

- New Comment on representing clients in criminal matters, new Cmt. 6
- New Comment on representing Minors, new Cmt. 7
- Change "normal client-lawyer relationship" to "ordinary client-lawyer relationship
- There will be another new comment on skills needed for competent representation of client with d-m limitatons.

4

4

1.14(a) Says Act Normal…
…as far as reasonably possible, maintain a normal client-lawyer relationship….

1.14(b) Except when you can't…
Lawyer may take reasonably necessary protective action, ….
But only if the "lawyer reasonably believes

- **the client has diminished capacity,**
- **is at risk of substantial physical, financial or other harm unless action is taken and**
- **the client cannot adequately act in the client's own interest.**

More Guidance than Rule

5

5

Rule 1.14(c) – impliedly authorized disclosure

When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

6



- Lives alone in an apartment she has rented for years. Neighbor refers her.
- She has gotten eviction notice due to 3 months past due rent and inability to maintain her apartment in safe condition.
- Comes in using a walker, disheveled, and malodorous.
- Almost no understanding of problems with her apartment or her person. Does not remember exactly when she last paid rent.
- She's only here because neighbor insisted she needed to see you.

7

7

Does she have the capacity to hire you?

Yes?

No?

I need more info?

8

Quandary 1

What is "Diminished Capacity"?

The Rule and Comments refer to Diminished Capacity several times but <u>do not define it</u>, although Comment 6 provides some factors to consider:

- **Ability to articulate reasoning leading to decision,**
- **Variability of state of mind & ability to appreciate consequences;**
- **Substantive fairness of decision; &**
- **Consistency of decision with known long-term commitments & values.**

9

9

Does the person possess sufficient mind to understand, in a reasonable manner, the nature, extent, character, and effect of the act or transaction in which the person is engaged.

17 C.J.S. *Contracts* 45 (2000)

Compare:

Contract to buy a multi-state business ⇧ **vs.** **Contract to buy a cup of coffee** ⇩

Consider: **Accommodations needed to ensure access to justice.**

10

10

Response to Quandary 1:

- **Substitute "Decision-making Limitations" for "diminished capacity" throughout.**
- **New 1.14(b): "A person has decision-making limitations if the person has substantial difficulty receiving and understanding information, evaluating information, or making or communicating decisions even with appropriate supports or accommodations."**

11

11

- **Further elaboration of decision-making abilities and limitations in:**
  - **Cmt. 1 (Lawyers duties)**
  - **Cmt. 2 and 3 (eg's of abilities and Supported Decision-Making)**

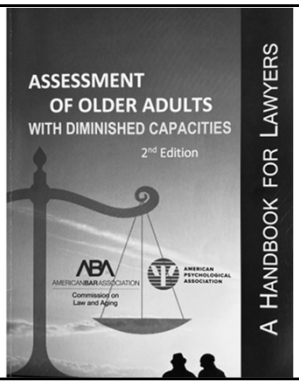
"Examples of supports and accommodations include communication devices or services, assistance of appropriate third parties or supported decision-making, environmental changes (e.g., conducting client meetings in a familiar setting), and using plain language or otherwise modifying the lawyer's communication and counseling techniques for the client."

12

12

Resource

www.americanbar.org/groups/law_aging/resources



13



- **You agree to assist and learn Ms. M actually has funds to pay the back rent which you pay. You connect her to a local money management service to help manage her bills. Eviction withdrawn - for time being.**
- **Shortly later, landlord informs you that she has twice left her stove's gas burner on heating a pan of food to cinders, setting off building smoke alarms. She says she forgot she was cooking something.**

14

14

Is Protective Action Justified?

Yes, only with Consent?
Yes, even if she does not consent?
No?
Wven if yes, what can I do?

15

15

Quandary 2

How to understand & apply Protective Action?

MRPC 1.14(b) says:

…the lawyer **may** take reasonably necessary protective action, **including** consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, **seeking the appointment of a guardian ad litem, conservator or guardian.**

The Rule may create a slippery slope towards guardianship.

16

16

Quandary 2 Response

Unintended encouragement of Guardianship as a Protective Action

Revisions:

1. **Eliminate examples of protective action (especially guardianship) from the Rule and address in Comments.**
2. **Express emphasis on "supports and accommodations"**
   - **Rule 1.14(b) - in definition of d-m limitations**
   - **Cmt. 2 (under Client Abilities and Limitations) – several eg's**
   - **Cmt. 10 (under Protective Action)**

17

17

Quandary 2 Response

Unintended encouragement of Guardianship as a Protective Action

Revisions:

3. **No substantive change to Protective Action examples in current Cmt. 5 (now 12) and factors for guiding lawyer's actions.**

18

18

Protective Action Guidance in Current Cmt. 5 (now 12) unchanged

Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decision-making tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client.

19

19

Protective Action Guidance in Current Cmt. 5 (now 12) unchanged

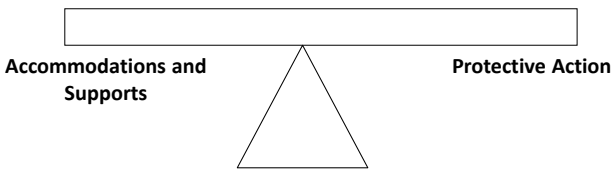
"… the lawyer should be guided by such factors as

- the wishes and values of the client to the extent known,
- the client's best interests and
- the goals of minimizing intrusion into the client's decision-making autonomy to the least extent feasible,
- maximizing client capacities and
- respecting the client's family and social connections."

20

20

Is this a Protective Action Problem or an Accommodation Challenge?



21

Supports and Accommodations: The Most Creative Part of Your Work

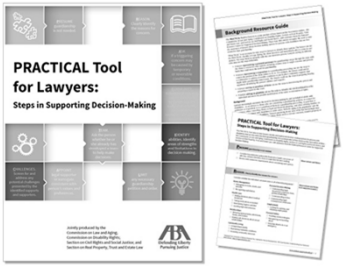
Will appropriate supports and accommodations improve situation?

- E.g. communication devices, health alerts, plain language instructions, alarms, timers, & other tools.
- Is there available family, friends, and supporters (including from civic, religious, or social communities) who can help address the concerns.

- **Is client amenable to referrals to available services. e.g.:**
  - Talk lines/Senior Call Check
  - Friendly outreach programs
  - Case managers
  - Delivery services
  - Visiting nurses
  - Senior centers
  - Credit monitoring/freeze
  - Direct deposit/automatic bill payment

22

ABA Supported Decision-Making Tool



www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/supported-decision-making/

23



- **Two months later, Ms. M asks to see you. She comes in with her son, who moved in with Ms. M from out-of-state after losing his job.**
- **Son says Mom is increasingly frail and confused and needs him to manage things for her under a POA.**
- **Ms. M appears distraught and somewhat confused but tells you to do what her son thinks is best.**

24

24

Yes?
No?
Depends?

25

25

Quandary 3

How Helpful is Current Cmt. [3] which says:

- The client may wish to have family members or other persons participate in discussions with the lawyer.
- When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege.
- Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (b), must look to the client, and not family members, to make decisions on the client's behalf.

Also see, ***Rule 4.3 Dealing with Unrepresented Person***

26

26

Quandary 3 Response

Revisions: Additional guidance added to: Cmt. 3 (now 5) re family participation

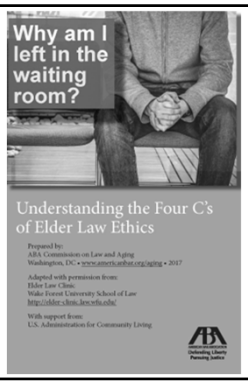
- "The lawyer should seek the client's informed consent to the presence of such persons"
- "Whenever possible, the lawyer should afford the client the opportunity to communicate <u>privately</u> with the attorney without the presence and influence of others."
- (There will likely be a new Comment on importance of Client Identification)

27

27

Resource

www.americanbar.org/groups/law_aging/resources/ethics_and_counseling_older_clients/



28

The 4 C's explained to those in the waiting room

1. **Client Identification**
2. **Conflicts of Interest**
3. **Confidentiality**
4. **Capacity**

29



- **Weeks later, Son contacts you. Mom received notice of termination of her Medicaid. You agree to help.**
- **Termination based on failure to provide financial records. Probing, you discover Son is bilking Mom's bank account. He admits using "some" of it for gambling. Poor explanations for the rest. Unrepentant.**
- **Ms. M now unable to understand at all what's going on financially, but says: "I don't want you to get him in trouble, so please don't tell anyone!"**

30

30

Tell him you will report him to APS, unless he seeks gambling addiction counseling and pays Mom back?

Tell him you will report him to APS, unless he resigns as Mom's agent?

File a petition for an accounting and removal of Son as agent?

File petition for guardianship?

Something else?

31

Quandary 4

Current Rule 1.14(c) states:

When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

32

32

How helpful is Comment 8 re Disclosures?

Current Cmt. 8 Excerpt:

When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized to make the necessary disclosures, *even when the client directs the lawyer to the contrary*.

33

Quandary 4 Response

Revision: Rule 1.14(d) will eliminate implied consent

(d~~e~~) Information relating to the representation of a client with decision-making limitations ~~diminished capacity~~ is protected by Rule 1.6. However, w~~W~~hen taking protective action pursuant to paragraph (c~~b~~), the lawyer ~~is impliedly authorized under Rule 1.6(a) to~~ may reveal information related to the representation ~~about the client, but only~~ to the extent the lawyer reasonably believes necessary to protect the client's interests.

34

34

Quandary 4 Response

Revision:

Additional guidance added to Cmt. 8, now 18 (re disclosure of client's condition)

"Disclosure of the client's diminished capacity could adversely affect the client's interests, which may include constitutional and legal rights."

35

35



- **Lo and behold! A formerly estranged daughter of Ms. M shows up and tells you her brother is a scum bag and she is going to file for guardianship over Mom.**
- **Court appoints you to represent Ms. M who insists she does not need or want a guardian.**
- **A couple weeks before hearing, she tells you that she has very good news – she has won a Publishers Clearinghouse lottery for $2 million, which she will get soon because she just paid $10,000 to cover taxes and fees. You quickly confirm it's a scam, but she insists it's real.**

What do you do?

36

36

What would you do?

Quandary 4a

- **Since the 1.14(c) criteria are met, disclose to the petitioner, Court, GAL, or visitor?**
- **Don't disclose. Your representation is directed by her goal of preventing guardianship?**
- **Something else?**

37

37

Revision:

Quandary 4a Response

Additional guidance added to Cmt. 5, now 9 (re protective actions):

"In litigation involving the capacity of the client, such as a guardianship proceeding, the attorney should advocate for the client's expressed position when deciding what, if any, protective action should be taken."

38

38

Revision: New Cmt. 13

Quandary 4a Response

If another person has petitioned a court for an appointment of a conservator or a guardian or another restriction on the client's legal capacity, the lawyer may not advocate for such an appointment or restriction if the client opposes it. If the lawyer represents a client who is a respondent in a proceeding for guardianship or conservatorship, the lawyer must advocate for the client's objectives if known or ascertainable.

39

39



Suppose Ms. M <u>already</u> had a guardian,

and

You first meet her when she calls you to ask your help to terminate the guardianship. She had been having serious health problems but is now better. She informs you that the guardian will absolutely oppose ending the guardianship.

Can you represent her? 40

40

Can you agree to represent her?

Yes?

No?

Only if guardian consents?

Approval of court required?

41

Quandary 5

Current Cmt. 4 to Rule 1.14 states:

If a legal representative has already been appointed for the client, the attorney should ordinarily look to the representative for decision on behalf of the client.

<u>But</u> Current Cmt. 2 states:

Even if the person has a legal representative, the lawyer should as far as possible accord the represented person the status of client, particularly in maintaining communication." 42

42

Nina A. Kohn & Catheryn Koss, 91 Wash. L. Rev. 581 (June, 2016)

(1) agency principles do not bar such representation;
(2) contract principles do not bar such representation; and
(3) even if such representation were inconsistent with state law …, constitutional due process protections would require that exceptions be made to permit representation of persons subject to guardianship, at the very minimum to challenge the terms or existence of their guardianships….

43

43

Quandary 5 Response

Revision:

Cmt. 4, now 7, re Guardianship:

…a lawyer may consult with and represent a person subject to guardianship or conservatorship who seeks representation to challenge or modify the terms of that arrangement, or who seeks representation with regard to any other matter over which the person retains decision-making authority. When representing a client in such situations, the lawyer must take direction from the client and advocate for the client's objectives.

44

Quandary 5 Response

Revision: Cmt. 4, now 7, re Agent:

When the client has granted an agent authority to make decisions, including an agent acting under a power of attorney, the lawyer nevertheless should take direction from the client and maintain communication with the client to the extent feasible unless the client has otherwise directed or is unable to provide direction. In addition, a lawyer may consult with and represent a person who seeks to challenge the actions of an agent or terminate or modify the agent's appointment.

45

Five Quandaries Recap of Rule 1.14

- What is Diminished Capacity?
- Protective Action Guidance
- 3rd Parties–Supporter/Exploiter?
- How Much Can I Disclose in and out of Litigation?
- Meaningful Access to Counsel when a surrogate is in place?

46

46



It was dawning on Ed that maybe his conscience wasn't such a good guide after all

47

STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Friday
October 24, 2025

Medicaid Update

STETSON LAW

Center for Elder Justice

Access and Justice For All®

Upcoming Medicaid Changes: Eligibility and Service Implications

Alice Burns
Associate Director, KFF's Program on Medicaid and the Uninsured

September 18, 2025

KFF
The independent source for health policy research, polling, and news.

1

Contents

1. What is KFF?
2. What is Medicaid
3. How has optional coverage changed the long-term care landscape?
4. What changes did the reconciliation law make to Medicaid?
5. What other policy changes may exacerbate the effects of federal Medicaid cuts?
6. When will these changes happen and what to watch?

KFF

2

What is KFF?

A leader in health policy analysis, polling, and health journalism, KFF is dedicated to filling the need for trusted information on national health issues.

- KFF is a non-profit organization focusing on national health issues, as well as the U.S. role in global health policy
- Unlike grant-making foundations, KFF develops and runs its own policy analysis, journalism and communications programs, sometimes in partnership with major news organizations.
- We serve as a non-partisan source of facts, analysis and journalism for policymakers, the media, the health policy community and the public.
- Our product is information (policy research, facts, numbers, news coverage)
- Always provided free of charge
- The modern day KFF was established in the early 1990s with its current mission
- KFF is NOT associated with Kaiser Permanente

3

KFF's Surveys of State Medicaid Programs

KFF surveys all 50 states and DC 3 times each year.

Budget Survey

- Annual survey of Medicaid directors and their staff
- Written survey and structured follow-up interviews
- Focus on spending and enrollment trends
- Conducted by KFF and Health Management Associates in partnership with the National Associate of Medicaid Directors
- https://www.kff.org/medicaid/50-state-medicaid-budget-survey-archives/

Eligibility and Enrollment Survey

- Annual survey of Medicaid officials
- Written survey
- Focus on Medicaid and CHIP eligibility, enrollment, and renewal policies for children and adults ("MAGI") populations
- Conduced by KFF and Georgetown's Center for Children and Families
- Now incudes a second survey about eligibility for people with disabilities and older adults ("non-MAGI")
- Conduced by KFF and Watts Health Policy Consulting
- https://www.kff.org/series/medicaid-eligibility-and-enrollment-survey/

Home Care Survey

- Annual survey of Medicaid officials who administer home care (also "home and community-based services or HCBS)
- One survey is sent to each home health, personal care, and waiver program
- Focus is on home care services, benefits, and availability
- https://www.kff.org/medicaid/50-state-survey-archives-medicaid-hcbs-and-eligibility-based-on-disability-or-age-65/

KFF 4

4

KFF's Medicaid Data Resources: Finding State-Level Data

Issue briefs and reports: Home page

Overview of Medicaid, designed for college student curricula: Medicaid 101

Snapshots of key data Medicaid for each state: Medicaid State Fact Sheets

Compendium of KFF data on people enrolled in Medicare and Medicaid: State Profiles for Dual-Eligible Individuals

State-level data on Medicaid (but also health and health coverage of the entire population): State Health Facts

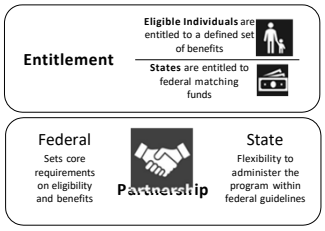
KFF 5

5

What is Medicaid?

6

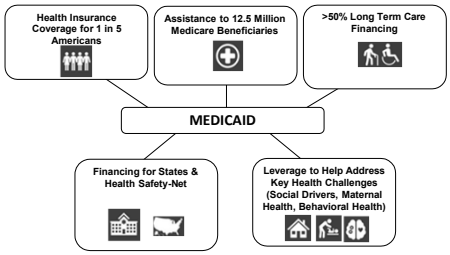
Medicaid is an entitlement health program that is jointly financed by the federal and state governments.



KFF 7

7

Medicaid plays a central role in the US health care system.

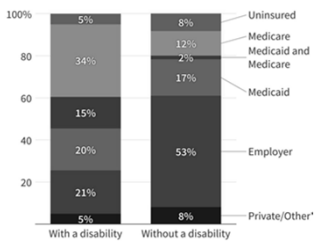


KFF 8

8

Over 1 in 3 people with disabilities have Medicaid.

Percentage of individuals by insurance coverage and disability status, 2023



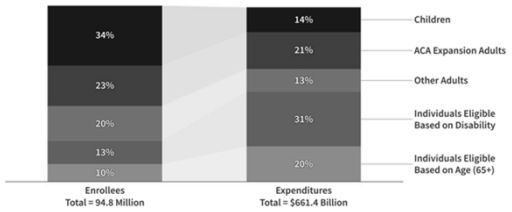
Note: The American Community Survey (ACS) includes a 1% sample of the US population and allows for precise state-level estimates. The questions on disability asks respondents whether they have a hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty (defined as difficulty with bathing or dressing), or an independent living difficulty. Respondents who report any one of the size difficulties are considered to have a disability. *Includes coverage through an employer, privately purchased health insurance, and all other coverage types.

Source: KFF's 5 Key Facts About Medicaid Coverage For People with Disabilities

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9

Over half of Medicaid spending is for people who qualify based on being ages 65 and older or having a disability.



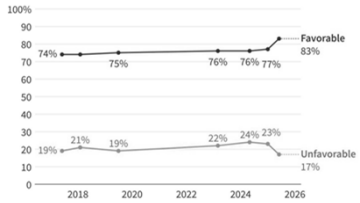
Note: Includes full and partial benefit enrollees enrolled in at least one month of Medicaid during 2021. Total may not sum to 100% due to rounding.
Source: KFF's 10 Things to Know About Medicaid

KFF 10

10

Medicaid continues to be viewed favorably by the public.

In general, do you have a favorable or unfavorable opinion of Medicaid, the federal-state government health insurance for certain low-income adults and children and long-term care program for adults 65 and older and younger adults with disabilities?



Note: See topline for full question wording.
Source: KFF's Health Tracking Polls

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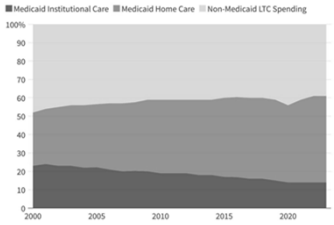
11

How has optional coverage changed the long-term care landscape?

12

Optional Medicaid eligibility and services have supported the increased use of LTC in people's homes and the community.

Share of annual national spending on long-term care from Medicaid by location of care



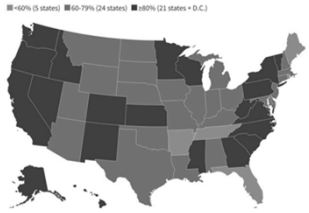
Source: KFF's 5 Key Facts about Medicaid's Share of National Health Spending

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13

In nearly all states, most people who use Medicaid long-term care, receive services at home.

Share of Medicaid enrollees who used any home care among those who used any LTSS in 2021



Note: 5,653,500 Medicaid enrollees in the US used any LTSS in 2021. 75% of whom used only HCBS, 21% of whom used only institutional LTSS, and 4% of whom used both. The extremely small number of people using HCBS in Rhode Island suggests a potential data quality issue. 2021 data in Mississippi was not usable, so 2020 data was used instead.

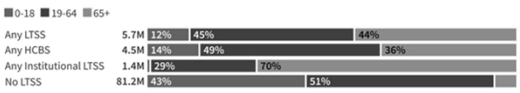
Source: KFF's 10 Things About Long-Term Services and Supports (LTSS)

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14

Over half of Medicaid enrollees who use long-term care are under age 65.

Distribution of full-benefit Medicaid enrollees, by LTSS use and age



Note: LTSS = Long-term services and supports. HCBS = home- and community-based services.
Source: KFF's 10 Things About Long-Term Services and Supports (LTSS)

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Optional and Mandatory Medicaid Eligibility for Older Adults and People With Disabilities

Children, parents, and most other adults under age 65 qualify for Medicaid based on their Modified Adjusted Gross Income "MAGI." Older adults and people eligible for Medicaid on the basis of disabilities must meet eligibility criteria beyond only income – these eligibility groups are often referred to as "non-MAGI."

Mandatory non-MAGI Eligibility Groups

- People who receive Supplemental Security Income (SSI)
  - 2025 income limit: $967/ month for an individual
  - Asset limit: $2,000 individual
- Medicare beneficiaries through the Medicare Savings Programs (MSP)
  - Multiple programs that cover Medicare premiums and in most cases, cost sharing
  - 2025 income limit: $1,781/ month for an individual
  - 2025 asset limit: $9,660

Optional MAGI Eligibility

- States may increase income or asset eligibility limits for the mandatory groups
- Optional eligibility groups for low-income older adults and people with disabilities
  - Medicaid buy-in (47 states), Family Opportunity Act (9 states)
  - Medically needy coverage (34 states)
  - Poverty level coverage (28 states)
- Optional eligibility groups for people who use long-term care; several options offered by all states except for Montana

KFF 16

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Most states have higher income or asset limits for older adults and people with disabilities.

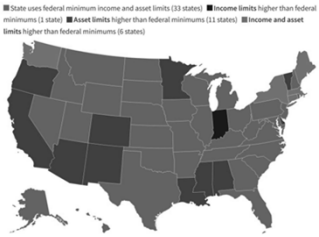


Source: KFF's Survey of Medicaid Financial Eligibility & Enrollment Policies for Older Adults & People with Disabilities, 2025 (Appendix Table 5)

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17

Many states have higher income or asset limits for the Medicare Savings Programs (MSP).



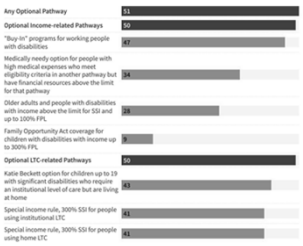
Source: KFF's Survey of Medicaid Financial Eligibility & Enrollment Policies for Older Adults & People with Disabilities, 2025 (Appendix Table 2)

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In 2025, all States use optional eligibility groups to cover older adults and people with disabilities ("non-MAGI" enrollees).

Number of states adopting each Medicaid eligibility pathway in 2025



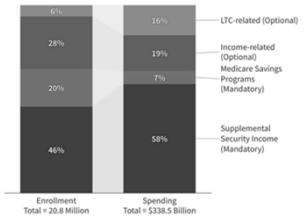
Note: Alabama is the only state that does not offer any optional income-related pathways and Montana is the only state that does not offer any long-term care-related pathways. Home care is also known as home- and community-based services or HCBS. States electing the medically needy pathway must cover pregnant people and children and may cover older adults, people with disabilities, and/or low-income parents. The Katie Beckett option for children and Family Opportunity Act for children with disabilities up to 300% FPL pathways include states electing a state plan option and/or comparable waiver. Florida data reflect the state's responses to KFF's 2022 survey and supplemental research.
Source: KFF's Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025

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Among non-MAGI enrollees, most people are eligible for Medicaid through the mandatory eligibility groups.

Percent of enrollment and spending by type of eligibility pathway



Note: LTC = Long-term care. Spending and enrollment data does not include Mississippi and West Virginia due to data quality concerns in 2021.
Source: KFF's 5 Key Facts About Medicaid Eligibility for Seniors and People with Disabilities

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Optional and Mandatory Long-Term Care Benefits in Medicaid

States are required to cover nursing facility care under Medicaid, but nearly all benefits provided in the home are optional for states to provide. Most Medicaid LTC is being provided through those optional services.

Mandatory Covered Services

- Institutional Care
  - Nursing facility care
- Home care or home and community-based services (HCBS)
  - Home health

Optional Covered Services

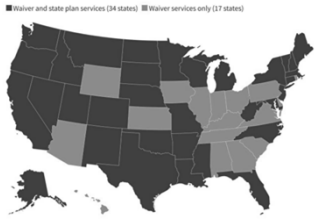
- Institutional Care
  - Intermediate facility care
- Home care or home and community-based services (HCBS)
  - State plan benefits: generally available statewide
    - Personal care state plan
    - 1915i: for people at risk of institutional care*
    - 1915j: allows self-direction of HCBS
    - 1915k/ community-first choice: expanded personal care benefit
  - Waiver benefits: cost neutrality required, may have enrollment caps/ waiting lists
    - 1915c: population-specific HCBS for people needing institutional care
    - 1115: general Medicaid demonstration

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All states offer optional home care benefits, most of which are available through waiver programs.

States offering optional home care benefits by program type, 2024



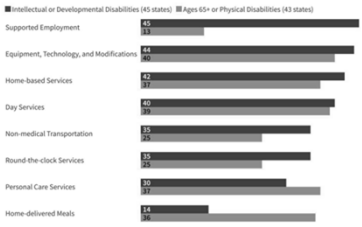
Note: State plan services include those offered under the Personal Care State Plan and Community First Choice. Waivers include 1915(c) and 1115 waivers.
Source: KFF's Medicaid HCBS Survey 2024 (Appendix Table 1)

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22

States use waiver services to create home care programs that are tailored to the unique needs of different target populations.

Number of states covering specific home care services by target population among states that responded to the survey and have a waiver for that population



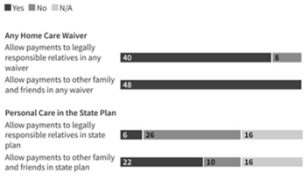
Note: The total number of states with a waiver for each target population only includes states that responded to the survey. Florida, Indiana, and Utah did not respond to the 2024 survey.
Source: KFF's What is Medicaid Home Care (HCBS)?

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23

States support family caregivers through optional Medicaid home care programs.

Number of states that allow payments for family caregivers by type of home care program and type of caregiver (n = 48)



Note: Legally responsible relatives include spouses, parents of minor children, and other caregivers. HCBS waivers include 1915(c) and 1115 program. If states allow payments for family caregivers under any waiver, they are counted as allowing such payments. Payments may not be available for all waivers within a state. N/A = not applicable because the state does not offer personal care in the state plan. All states except for Florida, Indiana, and Utah responded.
Source: KFF's How do Medicaid Home Care Programs Support Family Caregivers?

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24

There are over 700,000 people on waiting lists for home care, most of whom have intellectual or developmental disabilities.

Number of people (1000s) on waiting lists or interest lists by target population and whether or not state screens people on waitlists for eligibility, 2024



Note: KFF started asking about interest lists for the first time in 2023. States were asked to report the total number of people who were on a "waiting list referral list, interest list, or another term." States that screen for eligibility on 1 or more list might not screen people for eligibility on all lists. Other populations include children who are medically fragile or technology dependent, people with HIV/AIDS, people with mental health needs, and people wit traumatic brain or spinal cord injuries. Data include Section 1915 (c) and Section 1115 HCBS waiver waiting lists.
Source: KFF's A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024

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What Changes did the Reconciliation Law Make to Medicaid?

26

CBO estimates H.R. 1 will reduce federal Medicaid spending by $911 billion over 10 years.

CBO's estimated 10-year federal spending cuts, by policy



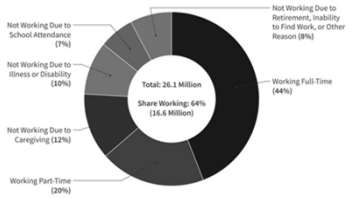
Note: Over the 10-year period, the Medicaid spending reductions total $911B, including $79B in estimated Medicaid spending interactions. Without accounting for interactions, the total is $990B.
Source: KFF's Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package

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Work requirements are estimated to reduce Medicaid spending by $326 billion, but data show most Medicaid adults <65 are working.

Work status and barriers to work among Medicaid adults ages 19-64 who do not receive SSI/SSDI and who are not also enrolled in Medicare, 2023:



Note: Total may not sum to 100% due to rounding. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one job. Medicaid adults include both parents of dependent children and adults without dependent children.
Source: KFF's Understanding the Intersection of Medicaid and Work: An Update

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Reconciliation package requires states to implement work requirements for the expansion group by December 2026.

States would be required to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group on meeting qualifying activities or exemption criteria:

Qualifying Activities	Mandatory Exemptions	Optional Hardship Exceptions
• 80 hours of work, community service, and/or "work program" participation • Enrolled in education at least half time • Any combination of the above totaling 80 hours • Monthly income of minimum wage multiplied by 80 hours • Seasonal workers with an average monthly income over 6 months of minimum wage multiplied by 80 hours	• Parent/guardian/caretakers of dependent children under age 14 or disabled individuals • Pregnant or postpartum • Foster youth/former foster youth under age 26 • Medically frail • Participating in SUD program • Meeting SNAP/TANF work requirements • Inmate of public institution or recently released from incarceration • Entitled to Medicare Part A/enrolled in Medicare Part B • America Indians and Alaska Natives • Disabled veterans	State option to allow short-term hardship exceptions, if *requested* by an individual who… • was in an inpatient hospital, nursing facility, intermediate care facility, or inpatient psychiatric hospital • resided in a county with a federally-declared emergency or disaster • resided in a county with a high unemployment rate (above 8% or 1.5x the national unemployment rate), subject to a request from the state to the Secretary • traveled outside of the individual's community for an extended period for medical care for themselves or for their dependent

Source: KFF's A Closer Look at the Work Requirement Provisions in the "Big Beautiful Bill"

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Experience in Arkansas and Georgia highlight implementation challenges with work requirements.



- **Enrollee awareness / outreach**: complex policies caused "confusion and uncertainty."
- **Exemptions:** enrollees struggled to access safeguards for people with disabilities and had trouble navigating the process to qualify for exemptions.
- **Data matching:** about 2/3 of enrollees successfully data matched and exempted from reporting. Among those who had to actively report, about 70% did not obtain an exemption or report compliance, resulting in over 18,000 people losing coverage.



- **Verification at application:** over 18 months since launch of "Pathways" program, GA has only enrolled 7,000 individuals—far short of the state's own estimated enrollment of 25,000 adults in the first year and 64,000 over 5 years.
- **Administrative costs:** recent investigative reporting found "Pathways" program has cost the federal and state government more than $86 million (as of the end of 2024), with three-quarters spent on consulting fees.

Source: KFF's A Closer Look at the Work Requirement Provisions in the "Big Beautiful Bill" and KFF's Implementing Work Requirements on a National Scale: What We Know from State Waiver Experience

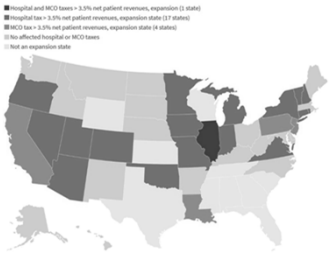
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30

Provider tax changes are estimated to cut Medicaid spending by $191 billion.

All states will be prohibited from enacting new provider taxes, and ACA expansion states will have to reduce existing taxes.

22 states have provider taxes on hospitals or MCOs that will be reduced starting in October 2027.



Note: Includes Medicaid provider taxes as reported by states. FL did not respond to the 2024 survey.
Source: KFF's Which States Might Have to Reduce Provider Taxes Under the Senate Reconciliation Bill

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New state-directed payment limits estimated to cut Medicaid spending by $149 billion.

States with state-directed payments for hospitals or nursing facilities that would have to be reduced because of the reconciliation law's new limits

New payments will also be subject to the lower standards

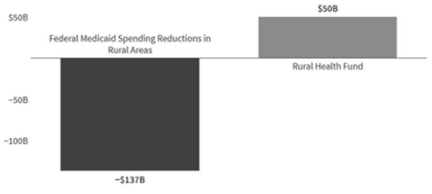


Note: North Carolina and Wisconsin do not provide enough information to understand how their payment rates would compare to the proposed caps and so are considered "possibly affected." Vermont does not have MCOs but has SDPs as part of their multipayer initiative.
Source: KFF's Reconciliation Language Could Lead to Cuts in Medicaid State Directed Payments to Hospitals and Nursing Facilities

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KFF estimates that $137 billion of Medicaid would be in rural areas, far more than the $50 billion in the rural health fund.



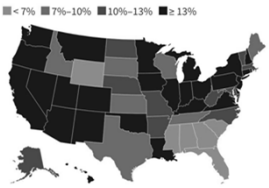
Note: The analysis uses T-MSIS data to estimate the percentage of Medicaid spending that paid for services used by rural enrollees. Those percentages were then applied to national estimated reductions in federal Medicaid spending from KFF's broader analysis of federal Medicaid spending reductions.
Source: KFF's How Might Federal Medicaid Cuts in the Senate-Passed Reconciliation Bill Affect Rural Areas?

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Medicaid cuts in the reconciliation law are a big reduction in federal funding for states.

Federal Medicaid Cuts in the Senate Reconciliation Bill as a % of 10-Year Baseline Federal Spending (2025-2034)



- Federal cuts to states of $911 billion over 10 years represents 14% of federal spending on Medicaid over the period.
  - States with the largest cuts to federal Medicaid spending (≥ 19%) include LA, IL, NV, OR
- Federal spending cuts of $100 billion per year represent:
  - 10% of all federal revenue to states
  - 36% of state spending on Medicaid
  - 24% of state spending on elementary and secondary education
  - 46% of state spending on higher education
  - 74% of state spending on transportation
  - 138% of state spending on corrections
  - Based on FY 2023 federal and state spending by budget category from NASBO

Source: KFF's Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package

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The reconciliation package would have impacts on people using long-term care & long-term care providers.

- **Over half the savings in the bill come from reducing Medicaid enrollment, some of which is enrollment is among older adults and people with disabilities.**
  - The bill delays implementation of two Biden-era rules that would have streamlined Medicaid eligibility and renewal for people eligible on the basis of disability or age - groups who are most likely to use long-term care.
  - CBO estimated that one million or more Medicare beneficiaries could lose Medicaid.
- **Places a moratorium on implementing new staffing requirements for nursing facilities**
- **Reduces the maximum home equity limit to $1 million, regardless of inflation**
- **The bill provides additional funding to ICE to expand detention and deportation operations of immigrants in the U.S.**
  - Immigrants make up 28% of all direct care workers, a greater share of whom are naturalized citizens than noncitizens.
- **Although provisions in the final reconciliation package do not directly limit or reduce long-term care, history shows that during the last major reduction in federal spending, all states reduced spending on home care.**
  - Home care is particularly vulnerable to cuts because it is a significant source of optional state Medicaid spending.

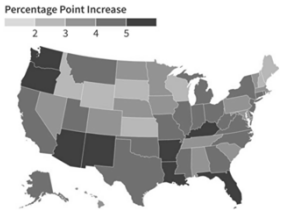
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What other policy changes could exacerbate the effects of Medicaid cuts?

36

Between H.R. 1 and the expiration of enhanced ACA tax credits, an additional 14.2 million people may be uninsured in 2034.



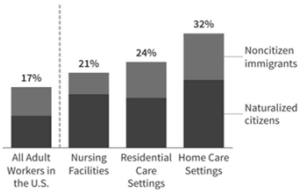
Note: CMS also estimates that the finalized Marketplace Integrity and Affordability rule will increase the number of uninsured (its impact will be greatest in 2026, before many of its rules sunset).
Source: How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?

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Changes to immigration policy will exacerbate challenges for the long-term care workforce.

Share of direct care workers providing LTC services who are immigrants, by setting and citizenship status



Note: All adult workers include all individuals 18 and older who earned at least $1,000 during the year. Direct care workers are a subset of all long-term care workers. Nursing facilities are residential settings that provide round-the-clock nursing and personal care to residents who need short-term or long-term care. Residential care facilities include a variety of settings such as assisted living facilities, continuing care retirement communities, and group homes. Home care settings include home health and nonresidential services for older adults and younger adults with disabilities.
Source: KFF's What Role Do Immigrants Play in The Direct Long-Term Care Workforce?

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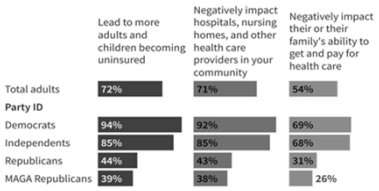
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When will these changes start to happen and what to watch as they do?

39

People are worried that cuts to Medicaid will have negative effects on their communities.

Percent who say that, if the federal government significantly reduces its spending on Medicaid, they are **very** or **somewhat worried** that this would...



Note: Partisans include independents who lean to either party. Independents are pure independents. MAGA supporters are Republicans and Republican-leaning independents who support the Make America Great Again movement. See topline for full question wording.
Source: KFF's Health Tracking Poll: The Public's Views of Funding Reductions to Medicaid

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When do the new changes take effect and what to watch for?

July 2025	Moratoriums on new provider taxes, eligibility rules, and nursing facility staffing rule
	Lower limits for all new state-directed payments
January 2026	Expiration of enhanced premium tax credits
	Other ACA marketplace changes take effect, including new limits on coverage for immigrants
October 2026	Reduced Medicaid FMAP for emergency Medicaid for immigrants
	Restrictions on immigrant eligibility for Medicaid
December 2026	More frequent renewals for Medicaid expansion enrollees
January 2027	Medicaid work requirements for expansion enrollees
	New restrictions on ACA coverage for legal immigrants
October 2027	Reductions in existing provider taxes start to phase in for Medicaid expansion states
January 2028	Reductions in existing state-directed payments start to phase in for Medicaid expansion states
	Cost sharing requirements for Medicaid expansion enrollees with incomes 100% - 138% FPL
	Pre-enrollment verification required for ACA Premium Tax Credits
	Lower home equity limits for Medicaid

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KFF Resources

Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package
How Might Federal Medicaid Cuts in the Enacted Reconciliation Package Affect Rural Areas?
How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?
Implementation Dates for 2025 Budget Reconciliation Law
KFF Health Tracking Poll: The Public's Views on Funding Reductions to Medicaid
KFF Health Tracking Poll: The Public's Views on Potential Changes to Medicaid
Reconciliation Language Could Lead To Cuts in Medicaid State-Directed Payments to Hospitals and Nursing Facilities
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10 Things About Long-Term Services and Supports (LTSS)
Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025

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KFF Resources

5 Key Facts About Medicaid Eligibility for Seniors and People with Disabilities
What is Medicaid Home Care (HCBS)?
How do Medicaid Home Care Programs Support Family Caregivers?
Payment Rates for Medicaid Home Care: States' Responses to Workforce Challenges
A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024
Understanding the Intersection of Medicaid and Work: An Update
A Closer Look at the Work Requirement Provisions in the "Big Beautiful Bill"
Implementing Work Requirements on a National Scale: What We Know from State Waiver Experience
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What Role Do Immigrants Play in the Direct Long-Term Care Workforce?
Health Tracking Poll: The Public's Views of Funding Reductions to Medicaid
Health Tracking Poll: Views of the One Big Beautiful Bill

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October 24, 2025

MEDICARE UPDATES

David A. Lipschutz

Co-Director/Attorney, Center for Medicare Advocacy

I. Federal Update

A. Reconciliation Bill

On July 4, 2025, President Trump signed into law H.R. 1 – One Big Beautiful Bill Act (OBBB).[1] Narrowly passing Congress using the reconciliation process in the Senate (which requires a simple majority rather than 60 votes), the bill extends the 2017 tax cuts and funds other administration priorities. In order to offset some of the costs of these policies, the bill makes unprecedented and wide-ranging cuts to a number of safety-net programs, including over $1 trillion in cuts to health programs, which will result in an estimated 10 million people losing insurance coverage, along with cuts to food assistance provided to low-income individuals through the federal SNAP program, among other changes.[2] With respect to health care, the bulk of cuts, which will be implemented over a number of years, are directed at the Medicaid program and aimed at reducing the number people covered. These changes include: new "community engagement" (work requirements) for certain individuals to maintain coverage; more frequent eligibility redeterminations; rescission of eligibility for certain groups of lawfully present immigrants (similar to the Medicare-specific provision described below); and reduced ability for states to raise additional Medicaid funds through provider taxes. There are also significant changes for Affordable Care Act marketplace enrollees, including non-renewal of financial assistance for qualifying individuals.

[1] Pub. Law No: 119-21.

[2] Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.

Many of the cuts to Medicaid will impact people who have both Medicare and Medicaid (dual eligibles). As outlined in joint publications by the Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst,[3]

- One in five Medicare enrollees relies on Medicaid to help pay Medicare premiums and cost sharing
- Nearly 30% of Medicaid funding goes to people with Medicare
- Medicaid is the primary payer for 63% of nursing facility residents
- Without Medicaid, over 12 million Medicare enrollees would experience gaps in care that jeopardize their health and well-being.

There are also provisions of the OBBB that will directly impact Medicare beneficiaries, including:

- *Limiting eligibility and terminating coverage of certain lawfully present non-citizens* – Upon enactment, §71201 restricts Medicare eligibility to citizens or nationals of the U.S., lawful permanent residents (green card holders), certain Cuban/Haitian entrants and Compacts of Free Association (COFA) migrants (rescinding eligibility for all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and individuals granted humanitarian parole for a period of at least 1 year). Not later than one year after enactment (July 4, 2026), the Commissioner of the Social Security Administration is directed to identify individuals with Medicare coverage who do not meet the new criteria,

[3] Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst, "A Cut to Medicaid is a Cut to Medicare" (March 2025) – Fact Sheet: https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-fact-sheet.pdf; Issue Brief: https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-Issue-Brief.pdf.

and notify such individuals "as soon as practicable after such identification and in a manner designed to ensure such individual's comprehension of such notification" that their coverage will be terminated as of 18 months after enactment (approximately January 2027). Note: Undocumented individuals have never been eligible for Medicare coverage, but, until enactment of the OBBB, lawfully present individuals who meet the requisite work history requirements through SSA have been eligible for Medicare coverage.

- *Ending implementation of a rule streamlining eligibility and enrollment in Medicare Savings Programs (MSPs)* – §71101 prohibits the Secretary of Health & Human Services from implementing (for 9 years) certain provisions of the final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230), which was aimed at making it easier for Medicare beneficiaries to enroll in and qualify for MSPs, which can cover some Medicare premiums and costs for lower income beneficiaries. The Congressional Budget Office (CBO) estimates that this will save over $66 billion over 10 years due to fewer people enrolling in MSPs; more than 1.3 million dually eligible individuals are expected to lose assistance through MSPs.

- *Prohibiting implementation of a final staffing rule for nursing facilities* - §71111 prohibits CMS from implementing a final rule issued in 2024 (89 Fed Reg 408706) which established national minimum staffing requirements for nursing facilities to promote quality care (note that provisions of this rule were vacated by a federal court, but the Trump Administration continues to defend the rule). Researchers at the University of

Pennsylvania have estimated that the staffing rule would save 13,000 residents' lives each year.[4]

- *Restricting the Medicare program's ability to negotiate the price of certain drugs* – the Inflation Reduction Act of 2022 (Pub. Law No: 117-169) gave the Secretary authority to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, with negotiated prices first effective in 2026. Section 71203 of the OBBB carves out certain "orphan drugs" (medications developed to treat rare diseases) from Medicare drug price negotiation.

Finally, unless Congress acts, the bill threatens Medicare's sustainability by triggering massive future cuts to the program. Nearly $500 billion in Medicare cuts would be required,[5] with an estimated $45 billion occurring as soon as fiscal year 2026.

B. Federal Agency Cuts & Reorganization

Since January 2025, there have been significant changes, including workforce reductions, at several agencies that could impact access to services for Medicare beneficiaries (and those approaching eligibility).[6]

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[4]Letter (Jul. 8, 2024) from Rachel M. Werner, Professor, Health Care Management and Economics, Professor, Medicine, University of Pennsylvania, Norma B. Code, Director of Research, LDI, Professor, Medical Ethics and Health Policy, University of Pennsylvania, to Senator Elizabeth Warren, available at: https://www.warren.senate.gov/imo/media/doc/letter_from_researchers_to_sen_warren_070824.pdf. Also see, e.g., Center for Medicare Advocacy, *CMA Alert*: "Reconciliation Bill will Cause Nursing Home Residents to Suffer" (June 5, 2025), available at: https://medicareadvocacy.org/bill-will-cause-nursing-home-residents-to-suffer/.

[5] See, e.g., Congressional Budget Office (CBO) "Potential Statutory Pay-As-You-Go Effects of a Bill to Provide Reconciliation Pursuant to H. Con. Res. 14, the One Big Beautiful Bill Act" (May 20, 2025), available at: https://www.cbo.gov/publication/61423.

[6] See, e.g., KFF, "Which Federal Agencies Make Medicare Work and How Were They Affected by Recent Changes Made by the Trump Administration?" by Nancy Ochieng, Juliette Cubanski, and Tricia Neuman (June 4, 2025),

The **Social Security Administration** (SSA) handles eligibility, enrollment and premium payment for certain parts of Medicare, along with assistance with programs for low-income beneficiaries. Already at a 50-year staffing low, SSA has faced mass workforce reductions, policy changes that have led to overwhelmed field offices and telephone lines, crashing of SSA's website, and the dissolution of the agency's Office of Civil Rights and Equal Opportunity.[7]

The **Department of Health & Human Service** (HHS), which houses the **Centers for Medicare & Medicaid Services** (CMS) has terminated staff and announced a major reorganization, including the dismantling of the Administration of Community Living (ACL). HHS has eliminated half of its 10 regional offices, including those in Boston, Chicago, New York City, San Francisco, and Seattle. Staff cuts at HHS, when combined with recent staff departures, will lead to an estimated 25% reduction in the HHS workforce. According to *Politico*, staff cuts at CMS include 200 people from the Office of Program Operations and Local Engagement which "ensures Medicare health plans and providers are in compliance with CMS requirements and helps manage case work for Medicare Advantage and Affordable Care Act marketplace patients."[8]

According to an HHS statement,[9] the reorganization includes the following change: "HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental

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available at: https://www.kff.org/medicare/issue-brief/which-federal-agencies-make-medicare-work-and-how-were-they-affected-by-recent-changes-made-by-the-trump-administration/.

[7] See, e.g., Center for Medicare Advocacy, *CMA Alert* "CMA Urges Court to Stop DOGE's Dismantling of Social Security" (April 10, 2025), available at: https://medicareadvocacy.org/cma-urges-court-to-stop-doges-dismantling-of-social-security/; also see, e.g., SSA, "Social Security Announces Workforce and Organization Plans" (Feb. 28, 2025), *available at*: https://blog.ssa.gov/social-security-announces-workforce-and-organization-plans/#:~:text=Last%20Updated:%20April%2018%2C%202025,the%20agency%20by%20specific%20dates.

[8] *Politico*, "HHS Aftershocks" by Kelly Hooper and Chelsea Cirruzzo (March 28, 2025), available at: https://www.politico.com/newsletters/politico-pulse/2025/03/28/hhs-aftershocks-00255723.

[9] HHS, "Fact Sheet: HHS' Transformation to Make America Health Again" (March 27, 2025), available at: https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html.

Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse." It is unclear what impact this reorganization might have on the independence and decision-making of these agencies.

II. Medicare Advantage Updates

The Medicare Advantage program (MA, also known as "Part C") – the private plan option in Medicare in addition to traditional Medicare (sometimes called "Original" or Fee-for-Service) – now covers more than half of all Medicare beneficiaries, and is growing. According to KFF, MA enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2025 to 64% by 2034.[10]

It is well established that MA plans are significantly overpaid relative to what traditional Medicare spends on a given beneficiary due to a variety of factors, including manipulation of the risk-adjusted payment system. According to the Medicare Payment Advisory Commission (MedPAC), "Medicare spends approximately 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in [traditional] Medicare, a difference that translates into a projected $84 billion in 2025."[11] MedPAC notes: "the benefits from MA's higher cost relative to [traditional Medicare] are subsidized by the taxpayers and beneficiaries who fund Medicare, increasing fiscal strain on the program. The Commission estimates that Part B

[10] KFF, "Medicare Advantage in 2025: Enrollment Update and Key Trends" (July 2025), available at: https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/.
[11] Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy" (March 13, 2025), available at: https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/; also see accompanying Press Release at: https://www.medpac.gov/wp-content/uploads/2025/03/March_2025_MedPAC_Report_Press_Release_SEC.pdf.

premiums, paid by all Medicare beneficiaries, will be about $13 billion higher in 2025 because of higher MA spending."[12]

As outlined in a Center for Medicare Advocacy issue brief, during the Biden Administration modest, but important, progress was made in improving access to care for MA enrollees in areas such as oversight of prior authorization, network adequacy, marketing misconduct, and supplemental benefits.[13] During the first Trump Administration, the Medicare Advantage program was favored over traditional Medicare, both in Medicare's own materials and in policy.[14] While the second Trump Administration is less than a year old, its approach to Medicare and Medicare Advantage is still taking shape. On the one hand, in its first significant MA policy updates, it increased MA payment without taking measures to account for rampant upcoding and failed to finalize some key consumer protections and plan oversight provisions in the final CY2026 Part C & D rule. On the other hand, there appears to be increased scrutiny of Medicare Advantage by the new administration. For example, CMS announced that it will be expanding its audit efforts regarding MA plan payment, and the Department of Justice (DOJ) has both maintained involvement in pre-existing MA-related suits and taken new actions against MA plans.

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[12] *Id*.

[13] Center for Medicare Advocacy, "Issue Brief: Medicare Advantage Oversight and Consumer Protections" (April 1, 2025), available at: https://medicareadvocacy.org/issue-brief-medicare-advantage-oversight-and-consumer-protections/.

[14] See, e.g., Center for Medicare Advocacy "Special Report: MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage" (September 20, 2021), available at: Medicare's own materials; also see Center for Medicare Advocacy, *CMA Alert* "Center for Medicare Advocacy Analysis of President's Medicare Executive Order" (October 19, 2019), available at: https://medicareadvocacy.org/alert-analysis-of-presidents-medicare-executive-order/.

A. New Rules for 2026

On April 15, 2025, CMS issued a final rule: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.[15] The final rule included, among other provisions, certain improvements to MA appeals in the hospital setting and other protections surrounding MA appeals, including:

- Ensuring that MA appeal rules apply to adverse decisions, regardless of whether the decision is made before, after, or during the receipt of services;
- Codifying requirements that plans give providers notice of a coverage decision and enrollees are notified when providers submit requests on behalf of beneficiaries; and
- Clarifying that an enrollee's liability to pay for services cannot be determined until an MA organization issues a decision, ensuring that an enrollee has the right to appeal MA plan coverage denials that affect their ongoing course of treatment.

The final rule also establishes guardrails for Medicare Advantage Special Supplemental Benefits for the Chronically Ill (SSBCI) by codifying a list of non-allowable examples (e.g., non-healthy food, alcohol, tobacco and life insurance).

Pursuant to a rule issued in 2024, starting in 2026, MA plans are required to issue a "Mid-Year Enrollee Notification of Unused Supplemental Benefits" annually, between June 30 and July 1 of the plan year, personalized to each enrollee including a list of any supplemental benefits not accessed by the individual during the first six months of the year.[16] In a memo dated September

[15] Contract Year 2026 Policy and Technical Changes, 90 Fed. Reg. 15792 (Apr. 15, 2025).
[16] 89 Fed. Reg. 30448 (April 23, 2024), amending 42 C.F.R. §§422.111(l) and .2267(e)(42).

8, 2025, CMS announced that it is suspending enforcement of this rule for contract year 2026 "and beyond" while the agency "reconsiders regulatory requirements."[17]

Note that a rule finalized in February 2024 aimed at improving the electronic exchange of information and prior authorization processes related to MA plans, Medicaid managed care plans, and plans offered through the federal exchanges included MA-related provisions that are first effective in 2026.[18] Such provision require MA plans to:

- Issue organization determinations for items and services subject to prior authorization within 7 days of a request and within 14 days for items and services not subject to prior authorization (until 2026, the timeframe for all standard organization determinations was 14 days);
- Include a specific reason for denying a prior authorization request in notices sent to providers; and
- Publicly report prior authorization metrics, similar to the metrics that traditional Medicare already makes available.

In anticipation of the upcoming annual enrollment period (AEP), CMS made a number of changes to the **Medicare Plan Finder (MPF)**, the primary online tool that Medicare beneficiaries use to compare Medicare Advantage and Part D plans. These changes include a new filter that allows users to screen out MA Special Needs Plans (SNPs) from other types of MA plans,[19] an expanded display of MA supplemental benefits,[20] and the posting of MA

[17] CMS Memo: "Mid-Year Notice of Unused Supplemental Benefits; Delayed Enforcement of Requirements under 42 CFR §§ 422.111(l), and 422.2267(e)(42)" (Sept. 8, 2025).
[18] Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8758 (Feb. 8, 2024).
[19] See CMS Memo: "Medicare Plan Finder Enhancements for Contract Year 2026" (May 27, 2025), available at: https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://granepbm.com/wp-

provider directory information for 2026.[21] Note that for the MA provider directory information, CMS is using a third-party vendor for 2026 plan information, and has announced that there will be a Special Enrollment Period (SEP) for individuals who relied on inaccurate provider directory information when signing up for a plan through the Medicare Plan Finder.[22] This SEP is applies to enrollments effective in 2026 only. CMS also issued a final rule relating to MA provider directories that outline MA plan obligations which are generally applicable for the 2027 plan year.[23]

B. Federal Oversight

i. CMS Action

As part of the annual process for determining payment rates to Medicare Advantage and Part D plans in the next calendar year, in January 2025 the outgoing Biden Administration issued an Advance Notice proposing MA payment rates for 2026.[24] On April 7, 2025, CMS issued the final Rate Announcement for CY2026[25] which, on the one hand, retained a phase-in of updates to the risk adjustment payment model that will make payments to MA plans more accurate, but, on the

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content/uploads/2025/05/CY2026_MPF_HPMS_updates_05272025_final.pdf&ved=2ahUKEwjchqzv-caPAxUFFFkFHZs3AqUQ-NANegQIKhAC&usg=AOvVaw2hZzEZqE09r5fT0YEPnOJo.

[20] See CMS Memo: "Updates to the Contract Year 2026 Medicare Plan Finder and Medicare.gov" (Aug. 25, 2025), available at: https://www.cms.gov/files/document/cy2026mpfenhancements08252025finalpdf.pdf.

[21] Id.

[22] CMS Memo: "Special Election Period for Incorrect Medicare Plan Finder Medicare Advantage (MA) Provider Directory Information" (Sept. 12, 2025), available at: https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://portal.kingdomins.com/wp-content/uploads/2025/09/HPMS_MPF_Provider_Directory_SEP.pdf&ved=2ahUKEwjaxef35vGPAxU9E1kFHWODDk8Q-NANegQIJBAC&usg=AOvVaw1lihhZt6MiVvXsj6yLQCVp.

[23] 90 Fed. Reg. 45140 (Sept. 19, 2025).

[24]Centers for Medicare & Medicaid Services (CMS), "Calendar Year (CY) 2026 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the CY 2026 Advance Notice)" – see Press Release (Jan. 10, 2025): https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-2026-payment-policy-updates-medicare-advantage-and-part-d-programs.

[25] CMS, CY2026 Rate Announcement – see Press Release (April 7, 2025) at: https://www.cms.gov/newsroom/press-releases/cms-finalizes-2026-payment-policy-updates-medicare-advantage-and-part-d-programs.

other hand, increased payment by 5.06% from the proposed rate and did not use other means at CMS' disposal to rein in overpayments to MA plans.

On May 21, 2025, CMS announced that it will be expanding its audit efforts for MA plans. In a press release, CMS stated that "Beginning immediately, CMS will audit all eligible MA contracts for each payment year in all newly initiated audits and invest additional resources to expedite the completion of audits for payment years 2018 through 2024." [26] This effort builds on a Biden Administration rule from 2023 that finalized the structure of risk adjustment data validation, or RADV audits. Such audits are aimed at recouping improper payments to MA plans by, among other things, confirming diagnoses used for risk-adjusted payment are supported by medical records. Note that on September 25, 2025, Judge O'Connor of the Northern District of Texas vacated the 2023 CMS rule re: RADV audits on which CMS' effort were based.[27]

ii. DOJ Action

Over the course of the new Administration, the federal Department of Justice (DOJ) has both maintained involvement in pre-existing Medicare Advantage-related suits and taken new actions against MA plans. For example, DOJ continues to: defend a challenge to the RADV auditing rule (described above, but recently vacated by the court);[28] defend a CMS rule aimed at making

[26] CMS, Press Release: "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits" (May 21, 2025), available at: https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits.
[27] See Order Granting Plaintiff's Motion to Dismiss, U.S. District Court, Northern District of Texas., Case 4:23-cv-00909-O (Sept. 25, 2025), available at: https://storage.courtlistener.com/recap/gov.uscourts.txnd.380836/gov.uscourts.txnd.380836.76.0_2.pdf.
[28] See, e.g., *STAT News,* "Trump, building on Biden policy, to speed up audits of Medicare Advantage insurers" by Bob Herman (May 21, 2025), available at: https://www.statnews.com/2025/05/21/cms-expands-medicare-advantage-radv-audits-used-to-spot-potential-fraud/?utm_source=topic_author_alerts&utm_medium=email&utm_campaign=alert_author-bob-herman.

agent/broker commissions and incentives more in line with beneficiary interests;[29] and maintain involvement in a suit that alleges UnitedHealth Group committed MA fraud by not eliminating unnecessary diagnosis codes of its members.[30] According to the *Wall Street Journal*, DOJ is also now investigating UnitedHealth Group for possible criminal Medicare fraud.[31]

In addition to these actions, on May 1, 2025 DOJ filed another Medicare Advantage-related suit, this time against several plan sponsors other than UnitedHealth. As described by *KFF Health News*:

> Now a blockbuster lawsuit filed May 1 by the federal Department of Justice alleges that insurers Aetna, Elevance Health (formerly Anthem), and Humana paid "hundreds of millions of dollars in kickbacks" to large insurance brokerages — eHealth, GoHealth, and SelectQuote. The payments, made from 2016 to at least 2021, were incentives to steer patients into the insurer's Medicare Advantage plans, the lawsuit alleges, while also discouraging enrollment of potentially more costly disabled beneficiaries.[32]

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[29] See, e.g., Center for Medicare Advocacy, "Issue Brief: Marketing Medicare Advantage and Part D Plans: Regulation and Recent Legal Challenges" (March 27, 2025), available at: https://medicareadvocacy.org/cma-issue-brief-marketing-medicare-advantage-and-part-d-plans-regulation-and-recent-legal-challenges/.

[30] See, e.g., *STAT News*, "House Democrats urge judge to advance UnitedHealth Medicare fraud case to trial" by Bob Herman (May 16, 2025), available at: https://www.statnews.com/2025/05/16/unitedhealth-house-democrats-urge-judge-to-advance-medicare-fraud-case/?utm_campaign=stat_plus_today&utm_medium=email&_hsenc=p2ANqtz-_4TrUJi8G3I8k6diQlnGBPWLwf5aWVz6U5pmkh1JoJhlIun8ip_D9MNNpbb1my9Q6Zr5VD7r02NDCOOpreMHHgNbw9DEnzgPRST9HgTRQMPHmXN3A&_hsmi=361902073&utm_content=361902073&utm_source=hs_email.

[31] *Wall Street Journal*, "UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud" by Christopher Weaver and Anna Wilde Mathews (May 15, 2025), available at: https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f.

[32] *KFF Health News*, "Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' for Primo Customers" by Julie Appleby (May 19, 2025) available at: https://kffhealthnews.org/news/article/the-week-in-brief-medicare-advantage-insurance-trump-doj-insurance-brokers/.

III. Part D Updates

A. Inflation Reduction Act (IRA) Provisions

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 (IRA).[33] Among other things, the IRA makes a number of changes to the Part D prescription drug benefit that will be phased in over several years, including.

- Caps beneficiary out-of-pocket costs in 2024 (at around $3,500), and lowers that cap to $2,000 in 2025 ($2,100 in 2026); also allows spreading of costs over the course of the year (2025);
- Eliminated cost-sharing for vaccines covered under Part D (effective 2023);
- Imposed a $35 cap on covered insulin (2023);
- Expands eligibility for the Part D Low-Income Subsidy (LIS, or "Extra Help") (2024) – those currently eligible for the partial subsidy are now eligible for the full subsidy (full LIS up to 150% of the Federal Poverty Level (FPL) with higher resource limits);
- For the first time, the Secretary of Health & Human Services (HHS) will be able to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, effective 2026; and
- Other measures that limit the growth in the cost of drugs and Part D premiums.[34]

Starting in 2025, a provision of the IRA gives Medicare beneficiaries the option to pay out-of-pocket costs in monthly payments spread out over the year instead of having to pay high upfront

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[33] Public Law 117-169 (Aug. 16, 2022).
[34] See, generally, KKF (formerly Kaiser Family Foundation) website at: https://www.kff.org/medicare/, including this summary document of the relevant IRA provisions: https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/; also see Department of Health & Human Services website at: https://www.hhs.gov/inflation-reduction-act/index.html.

costs at once or over a short period of time. This option is called the Medicare Prescription Payment Plan (aka "M3P" or "smoothing").[35] See, generally, CMS webpage on the Medicare Prescription Payment Plan.

B. Premium Stabilization Demonstration

Among other things, the IRA made significant changes to Part D's standard benefit design, which shift additional costs to Part D plan sponsors while reducing beneficiary out-of-pocket expenses. Out of concern about how these shifting costs could impact plan sponsors' offerings, including premiums that they charge, in July 2024 CMS announced a voluntary Part D Premium Stabilization Demonstration "designed to test whether additional policy changes stabilize year-over-year changes in premiums for participating standalone PDPs, leading to more predictable options for beneficiaries during the initial implementation of the Inflation Reduction Act of 2022's (IRA's) benefit improvements […]."[36] This demonstration limited premium increases for participating Part D plan sponsors to no more than $35 a month for 2025.

On July 28, 2025, CMS issued a memorandum[37] announcing that the Part D Premium Stabilization Demonstration will continue for another year for CY 2026, but will be scaled back. The monthly premium subsidy to plan sponsors will be reduced from $15 to $10, and the limit on the monthly PDP premium increase will increase from $35 in 2025 up to $50 in

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[35] See, generally, CMS webpage at: https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan.

[36] CMS, Memorandum: "Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information" (July 29, 2024), available at: https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf.

[37] CMS Memo:
"Annual Release of Part D National Average Bid Monthly Bid Amount and Other Part C & D Bid Information" (July 28, 2025), available at: http://www.cms.gov/files/document/july-28-2025-parts-c-d-announcement.pdf.

2026. The component of the demonstration that further mitigated costs to plan sponsors relating to risk corridors is being eliminated.

As noted by KFF[38] after CMS' announcement about a scaled back demo for 2026, "In announcing these changes, CMS states that it is 'facilitating the [Part D] program's return to operating under regular market conditions.' Increasingly, however, these regular conditions appear unfavorable to the ongoing stability of the stand-alone prescription drug plan market, further tilting the playing field for coverage towards Medicare Advantage."

C. Miscellaneous Updates

Note that most regulatory efforts and legislative proposals to streamline prior authorization tend to exclude prescription drugs. On September 2, 2025, HHS announced that it had issued a final rule[39] that "ensures that health care providers using certified health IT systems are able to submit prior authorizations electronically, select drugs consistent with a patient's insurance coverage, and exchange electronic prescription information with pharmacies and insurance plans" effective Oct. 1, 2025.

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[38] KFF *Quick Take:* "The Trump Administration is Reducing Enhanced Support for the Part D Stand-Alone Drug Plan Market" by Juliette Cubanski (July 28, 2025), available at: https://www.kff.org/quick-take/the-trump-administration-is-reducing-enhanced-support-for-the-part-d-stand-alone-drug-plan-market/.

[39] See Dept Health & Human Services (HHS) Press Release: "Americans to Gain New Access to Real-Time Prescription Drug Price Information" (Sept. 2, 2025), available at: https://www.hhs.gov/press-room/hhs-prescription-drug-price-transparency-rule.html. The final rule is at 90 Fed. Reg. 36536 (Aug. 4, 2025).

IV. New Observation Status Appeals Process

A. Overview

On October 4, 2024, CMS issued a rule implementing the Court's order in the nationwide class action, *Alexander v. Azar,* 613 F. Supp. 3d 339 (D. Conn. 2020)*, aff'd sub nom. Barrows v. Becerra,* 24 F.4th 116 (2d Cir. 2022).[40] In March 2020, the U.S. District Court in Hartford, Connecticut issued a decision concluding that Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation services have the right to appeal that decision to Medicare and a chance to receive certain types of coverage, or to receive reimbursement for certain noncovered services resulting from that change. Although the actual hospital services received are typically indistinguishable to beneficiaries under either classification, the distinction between designation as an inpatient (Part A coverage) versus outpatient (Part B coverage) can and has resulted in devastating financial consequences for Medicare beneficiaries. For example, many Medicare beneficiaries who were reclassified as outpatient have had to either pay thousands of dollars out of pocket for required skilled nursing facility (SNF) care or forgo it altogether.

The Center for Medicare Advocacy, Justice in Aging, and *pro bono* partner Wilson Sonsini Goodrich & Rosati represented the plaintiffs in this lengthy litigation. See the Center for Medicare Advocacy's Frequently Asked Questions webpage for more information about the case and outpatient observation status.[41]

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[40] 89 Fed. Reg. 83240 (Oct. 4, 2024).

[41] Center for Medicare Advocacy website at: https://link.edgepilot.com/s/092767ca/Jwg95muhu0qkp9o7qV9smQ?u=https://medicareadvocacy.org/frequently-asked-questions-about-the-observation-status-court-decision/

As discussed below, the regulations address two types of appeals: retrospective and prospective. The retrospective appeals are for class members who were denied the right to appeal in the past. Prospective appeals are available on an ongoing basis for eligible beneficiaries who are still in the hospital.

B. Retrospective Appeals (42 C.F.R. §§405.931 – .938)

Retrospective appeals have been operational since January 1, 2025. Retrospective appeals are for class members who did not have an appeals process available at the time of their hospitalizations, covering hospitalizations that occurred between January 1, 2009 and February 13, 2025.

As outlined in the our Retrospective Appeals Flowchart, to file a retrospective appeal, you must be a Medicare enrollee who:

- Was admitted as a hospital inpatient on or after January 1, 2009.
- Was enrolled in Original Medicare at the time of the hospital stay.
- While in the hospital, was changed from inpatient to outpatient receiving observation services.
- Received either a Medicare Summary Notice and/or a Medicare Outpatient Observation Notice (MOON) showing that the observation services were not covered under Medicare Part A; and **EITHER:**
    - Was not enrolled in Medicare Part B at the time of the hospitalization; **OR**
    - Stayed at the hospital for 3 or more consecutive days but was designated as an inpatient for less than 3 days. You also need to have been admitted to a nursing facility within 30 days of discharge from the hospital.

See the Flowchart and other resources linked below for additional information.

C. Prospective Appeals (42 C.F.R. §§405.1210 – .1212)

Prospective appeals became operational on February 14, 2025. Covering hospitalizations starting on or after February 14, 2025, prospective appeals are for individuals who are in the hospital and wish to appeal their reclassification from inpatient to observation. Such appeals are available on an expedited basis as well as under the standard appeals timeframe for those who do not appeal before leaving the hospital.

As outlined in our Prospective Appeals Flowchart, to file a prospective appeal, you must be a:

- A person enrolled in Traditional Medicare (not Medicare Advantage) who is admitted as an inpatient, but later reclassified as an "outpatient receiving observation services"; and was EITHER:
    - Not enrolled in Part B coverage at the time of hospitalization; OR
    - In the hospital for 3 or more consecutive days (not including the date of discharge) but classified as an inpatient for fewer than 3 days.

D. Resources

See Center for Medicare Advocacy website at: https://medicareadvocacy.org/observation-status-appeal-resources/ which includes the following resources:

- Frequently Asked Questions about the "Observation Status" Court Decision
- Recorded Webinar (Jan. 22, 2025) on Observation Status Appeals
- Retrospective Appeals Flowchart
- Prospective Appeals Flowchart

- Request for Retrospective Appeal of Medicare Part A Coverage – to request a retrospective appeal.
- Medicare Change of Status Notice – to be issued by hospitals to patients eligible to submit prospective appeals.
- Instructions from the Centers for Medicare & Medicaid Services (CMS) on Patient Status Appeals.
- Appointment of Representative form – to appoint someone to act on your behalf for a Medicare appeal.
- CMS booklet on Medicare Appeals.
- NAELA News Article on Observation Status Appeals

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Medicare Updates

2025 National Conference on Special Needs Planning and Special Needs Trusts

Stetson Law

October 24, 2025

Presented by
David Lipschutz, Co-Director, Law & Policy
Center for Medicare Advocacy

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About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a non-profit, non-partisan law organization founded in 1986 that works to advance health equity, access to comprehensive Medicare, and quality health care. Based in Connecticut and Washington DC with additional attorneys in California, Maryland, Massachusetts, and Wisconsin.

- Attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic Change - Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

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Agenda

I. Federal Updates
- H.R.1 – Reconciliation Bill
- Agency Cuts/Reorganization

II. Medicare Advantage Updates
- New Rules for 2026
- Federal Oversight

III. Part D Updates
- Inflation Reduction Act of 2022
- Part D Premium Stabilization Demonstration

IV. New Observation Status Appeals

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Federal Updates

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H.R. 1 – "One Big Beautiful Bill" Act (OBBB)

- Cuts over $1 trillion from health programs (over 10 years), resulting in estimated 10 million people losing health insurance coverage (+ 4 million if ACA subsidies are not renewed by the end of this year)
- **Medicaid** (including more than 12 million dual eligibles)
  - Work requirements (Jan. 2027) - Adults 19 to 64
  - More frequent eligibility checks (Jan. 2027) – every 6 months
  - Immigration restrictions (eligibility for many lawfully-present immigrants ends Oct. 2026)
  - Reduced state funding options – limitations on provider taxes
  - States will have to make tough choices re: reduced Medicaid spending

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H.R. 1 and Medicare

- **New Restrictions on Lawfully Present Immigrants**
  - Starting immediately, **only** the following groups can newly enroll in Medicare:
    - U.S. citizens,
    - Lawful permanent residents (green card holders),
    - Cuban and Haitian family reunification program entrants, and,
    - individuals from certain Pacific Island nations with special agreements with the U.S. ("COFA" migrants).
  - Medicare eligibility is **eliminated** for all other lawfully present immigrants, regardless of how long they have worked or paid into the system. Including:
    - Refugees and people granted asylum,
    - People with Temporary Protected Status,
    - Survivors of human trafficking,
    - Survivors of domestic violence, and,
    - Individuals granted humanitarian parole.

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H.R. 1 and Medicare (cont'd)

- **Eligibility Restrictions** (cont'd)
  - By July 2026, SSA is directed to identify individuals who do not meet the new criteria and notify such individuals "as soon as practicable after such identification and in a manner designed to ensure such individual's comprehension of such notification" that their coverage will be terminated as of 18 months after enactment (January 2027)
- **Blocking Improvements to Medicare Savings Programs** (MSPs)
  - Prohibits implementation (for 9 years) a 2023 final rule aimed at streamlining MSP enrollment (see next slide)
- **Blocking Nursing Home Staffing Standards**
  - Prohibits implementation of a 2024 rule establishing minimum staffing ratios
- **Limiting Drug Price Negotiation**
  - Expands carve-outs for certain orphan drugs from negotiation

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Medicare Savings Programs (MSPs)

- **Medicare Savings Programs** (MSPs) are Medicaid programs that assist low-income Medicare beneficiaries with Medicare costs, administered by state Medicaid agencies:
  - **Qualified Medicare Beneficiary** (QMB) covers Part A premiums for individuals without free Part A; Part B premiums; and cost-sharing including co-payments, co-insurance, and deductibles
  - **Specified Low-Income Medicare Beneficiary** (SLMB) covers Part B premiums
  - **Qualified Individual** (QI) covers Part B premiums
- Barriers to enrollment: previously no link between enrollment in other federal programs with the MSPs, even though high likelihood individuals in those programs would be eligible for MSPs; burdensome documentation requirements for enrollment;
- CMS finalized a rule (Sept. 21, 2023) that targeted barriers to enrollment and designed to increase enrollment in MSPs for eligible beneficiaries
- **H.R. 1 stops implementation of improvements to MSPs** (not already implemented) in the final rule

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Agency Cuts and Reorganization

- **HHS** Fact Sheet (3/27): agency reorganization includes: "HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse."
- KFF (June 2025) cuts include eliminating half of 10 Regional Offices, cuts to Office of Program Operations and Local Engagement (helps with casework); Administration for Community Living (ACL) dissolved
- **Social Security** – plans to reduce workforce by 12%, eliminate 6 of 10 Regional Offices
  - See *CMA Alert* (9/11/25) re: recent changes re: SSA procedures

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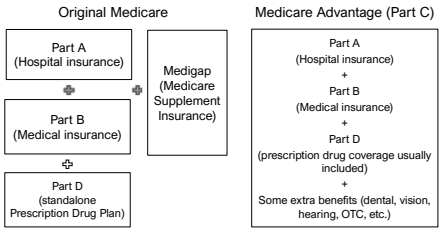
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Medicare Advantage Updates

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Reminder: Two Paths to Medicare



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Potential Medicare Advantage Tradeoffs for Beneficiaries

Source: KFF

Potential Advantages

- One stop shopping – no need for Medigap or separate Part D plan
- Lower premiums than Medigap; most pay no premium other than Part B
- Plans typically offer additional benefits (like dental)
- Plans have an out-of-pocket limit for benefits covered under Parts A and B
- Potential for better coordinated care

Potential Disadvantages

- Limited provider network
- Potential for higher out-of-pocket costs for certain services
- More utilization review than traditional Medicare
- No choice of separate drug plan to reduce drug costs
- Limited ability to switch back to traditional Medicare with Medigap

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Final Rules for 2026

- CMS Final Rule for CY 2026 90 Fed Reg 15792 (April 15, 2025) included some **MA appeal changes**, including:
  - Ensuring that MA appeal rules apply to adverse decisions, regardless of whether the decision is made before, after, or during the receipt of services;
  - Codifying requirements that plans give providers notice of a coverage decision and enrollees are notified when providers submit requests on behalf of beneficiaries; and
  - Clarifying that an enrollee's liability to pay for services cannot be determined until an MA organization issues a decision, ensuring that an enrollee has the right to appeal MA plan coverage denials that affect their ongoing course of treatment.

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Final Rules for 2026

- **MA Supplemental Benefits for the Chronically Ill (SSBCI)**
  - A final rule issued in 2025 establishes guardrails for SSBCI benefits by codifying a list of non-allowable examples (e.g., non-healthy food, alcohol, tobacco and life insurance). 90 Fed. Reg.15,792 (April 15, 2025).
  - Pursuant to a rule issued in 2024, starting in 2026, MA plans are required to issue a "Mid-Year Enrollee Notification of Unused Supplemental Benefits" annually, between June 30 and July 1 of the plan year, personalized to each enrollee including a list of any supplemental benefits not accessed by the individual during the first six months of the year. 89 Fed. Reg. 30448 (April 23, 2024), amending 42 C.F.R. §§422.111(l) and .2267(e)(42).
    - **NOTE:** CMS has delayed implementation of this rule re: mid-year notices for 2026 "and beyond"

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Final Rules for 2026

- **CMS Final Rule re: Interoperability** (MA, Medicaid, ACA) 89 Fed Reg 8758 (Feb. 8, 2024) included MA-related provisions first effective in 2026, including:
  - For items and services subject to prior authorization, MA plans must issue an organization determination (coverage decision) within 7 days (currently 14 days; expedited decisions remain 72 hours)
  - Include specific reasons for denying a prior authorization request in notices sent to providers
  - Publicly report certain prior authorization metrics
  - By January 2027, MA plans will be required to have "application programming interface" (API) in place for prior authorizations, separate patient and provider API

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Regulatory Action

- CMS **increased payment to MA plans** for CY 2026 by 5.06% from proposal issued by outgoing Biden Administration
- In May 2025, CMS announced **expanded audit efforts for MA plans** re: collecting past overpayments (note: on Sept. 25, 2025, a federal judge in Texas vacated the 2023 rule that served as basis for these increased audits – will HHS appeal this ruling?)
- **Department of Justice** – has maintained involvement in suits against MA plans re: collecting overpayments and defending audits, and brought new suit against several MA plan sponsors alleging illegal kickbacks to insurance brokerages to steer individuals towards MA plans
- On Aug. 18, 2025, a federal judge in Texas vacated key provisions of rule designed to align agent/broker compensation with beneficiary needs – will HHS appeal this ruling?

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Part D Updates

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Inflation Reduction Act of 2022 (IRA)

- Allows Medicare to **negotiate with drug manufacturers** for the price of some Part D and Part B drugs (starting in 2026)
- **Caps beneficiary out-of-pocket Part D drugs costs at $2,000** per year (starting in 2025 – also allows spreading of costs over course of the year); in 2024, the 5% coinsurance for Part D catastrophic coverage was eliminated) – cap will be $2,100 in 2026
- Imposes **checks on the annual rise in costs of drugs and Part D premiums** (limitations on drug prices starting in 2023, and limitations on Part D premiums starting in 2024)
- **Limits monthly out-of-pocket copays for insulin to $35** (starting in 2023)
- **Eliminates cost-sharing for adult vaccines** covered under Part D (2023)
- **Expands access to the Part D low-income subsidy** ("Extra Help") (starting in 2024) – full LIS up to 150% FPL with higher resource limits

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Standard Part D Benefit - 2026

Coverage Phase	Beneficiary Costs
Annual Deductible	$615
Initial Coverage Limit	25% of costs up to $2,100 (including deductible)
Catastrophic Coverage	$0

- Note that non-standard plans (enhanced plans) can reduce or eliminate the deductible and/or cost-sharing for covered Part D drugs

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Part D Premium Stabilization Demo

- IRA of 2022 included out-of-pocket cap for Part D drugs and other consumer protections, also shifted additional costs to Part D plans
  - Part D Premium Stabilization Demo, introduced in 2024 for the 2025 plan year, is being scaled back for 2026
    - Monthly premium subsidy to plan sponsors will be reduced from $15 to $10, and the limit on the monthly PDP premium increase will increase from $35 in 2025 up to $50 in 2026.
    - The component of the demonstration that further mitigated costs to plan sponsors relating to risk corridors is being eliminated.

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Observation Status Appeals

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New Observation Status Appeals Process

- Hospital observation status can impact eligibility for SNF care, can impact people with no Part B coverage
  - Medicare requires a 3-day inpatient hospital stay as a prerequisite for SNF coverage – observation ≠ inpatient
- CMS issued a final rule in Oct. 2024 implementing court's decision in *Alexander v. Azar*
- Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation status have a right to appeal that decision
- Retrospective and Prospective appeals available

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Observation Status Appeals (cont'd)

- **Retrospective Appeals** – effective Jan. 1, 2025
  - For class members with hospitalizations between Jan. 1, 2009 and Feb. 13, 2025
- **Prospective Appeals** – effective Feb. 14, 2025
  - For individuals who wish to appeal their reclassification from inpatient to observation
  - Expedited appeals; also standard appeals available for those who don't appeal before leaving the hospital
  - For information on who qualifies as class members, FAQs and more, visit CMA's Observation Appeals Resource Page; Final Rule, October 15, 2024: 89 Fed. Reg. 83240 (Oct. 15, 2024).

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Questions and Discussion

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The Update

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Special Needs Trust Update

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October 24, 2025

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Cases

Matter of H., ____ A.D.3d ____ (2nd Dep't 2025), ____ N.Y.S.3d ____, 2025 N.Y. Slip Op. 03190 (NY Supreme Ct., App. Div., 2nd Dep't, May 28, 2025). Father transferred life estate in his home to daughter. Later, father/guardian petitioned to transfer that life estate back to himself and transfer a 52% remainder interest into an SNT for daughter and the other 48% remainder interest to himself. Probate court denied petition stating father had provided no authority for the relief requested. Appellate Court reversed and remanded for a determination of the merits of the petition and whether it was in daughter's best interests.

In 2009, father was appointed as the guardian of the person and property of daughter. In 2015, father, in his individual capacity, executed a deed transferring to daughter a life estate in the property where they both resided (the "subject property").

In 2022, father, in his role as daughter's guardian, filed a petition to create an SNT for daughter and to execute, in both his individual capacity and as guardian, a deed whereby he would transfer to himself a life estate in the subject property , transfer 52% of the remainder interest to himself as trustee of the SNT, and transfer 48% of the remainder interest to himself. The petition alleged, among other things, that the transfers were in daughter's best interests because, as a result of daughter's life estate in the subject property, father could not secure certain real estate tax benefits that would make the subject property more affordable. The petition also requested that the court authorize father to use the subject property to secure a mortgage loan of up to $100,000. There was no opposition to the petition. In an order dated January 10, 2023, the court denied the

petition and, in effect, dismissed the proceeding, stating that father had provided no authority for the relief requested.

On appeal, the New York Supreme Court, Appellate Division, determined that the letters of guardianship clearly contemplated that father had the ability to petition the probate court to collect or dispose of any property belonging to daughter, and, therefore, that the probate court erred in determining that father did not provide authority for the relief requested. Since the relevant statute requires the court to employ a "best interests" analysis and the probate court denied the petition solely on the ground that father did not provide authority for the relief requested, the probate court never determined what was in daughter's best interests.

Accordingly, The Court of Appeals reversed the order, reinstated the petition, and remanded the matter to the probate court for a determination of the petition on its merits.

In re Hector M. Hernandez Supplemental Needs Trust, _____ Mich. App. _____, _____ N.W.2d _____ (Mich. Ct. App., October 14, 2024). 2024 WL 4486764. Michigan Court of Appeals affirmed probate court's modification of its own order that had allowed the guardian to designate the residual beneficiaries of an SNT.

Hector M. Hernandez, Sr. suffered a stroke in 2014, resulting in quadriplegia. Hector was legally incapacitated and his sister, Luisa, was appointed his guardian. Hector received a $2 million settlement from a medical malpractice lawsuit. The probate court required Luisa to create a special needs trust (SNT) for Hector's benefit. The petition for authorization and approval of the trust was a protected proceeding and the probate court's authorization of the establishment of the trust was a protective order.

With the oversight of the Court, the funds from the lawsuit were placed in a SNT special needs trust for Hector's benefit. Hector's children never received notice of the proceedings to establish or fund the trust.

The trust included a residuary clause that directed any remaining assets to Luisa – *unless* – Hector exercised his power of appointment through a valid Last Will and Testament or "other estate plan."

After Hector died in 2021, the probate court approved distribution of trust funds to Luisa. However, Hector's children (the heirs of his Estate) were never provided notice of the petition to establish or fund the trust, nor were they provided notice of the petition to distribute funds to Louisa. Hector's children learned of the Court's order to distribute all trust funds to Luisa and petitioned to vacate the order approving the distribution of trust assets to Luisa, arguing they were entitled to notice as presumptive heirs. The probate court granted the children's motion and ruled that the court improperly authorized the

trust because neither the Trustee nor the Guardian notified Hector's adult children of the proceedings. The Court then altered the residuary clause of the trust and replaced Luisa with Hector's estate as the remainder beneficiary. The Court also modified its order allowing a final account and directed all remaining assets to the personal representative of the Estate.

In her appeal Luisa argued that the probate court erred that Hector's children were entitled to notice of the petition because at the time of the trust funding Hector was not a "protected individual" and for this reason notice was never required. The Appeals Court disagreed and found that the probate court's authorization of the special needs trust was a "protective order," and thus Hector's adult children were entitled to notice of the proceedings. In addition, the Court of Appeals ruled that Luisa failed to show by clear and convincing evidence that Hector intended the residuary clause to allocate his property upon his death. The probate court's modification of the residuary clause to direct the trust's remaining assets to Hector's Estate was warranted, because the trust's purpose became impossible to achieve upon Hector's death.

The Court of Appeals affirmed the probate court's decision to grant summary disposition in favor of Hector's adult children and to modify the trust's residuary clause.

In the Interest of Joanne Black, 2025 WL 1466913 (Unreported, Colo. Ct. App., May 22, 2025). Colorado Court of Appeals affirmed decision of the Probate Court to deny brother's motion to terminate sister's conservatorship retroactively, just as the court was about to allow sister to recoup the funds stolen from her by brother.

Bernard Black was removed as the conservator for his sister, Joanne Black, in 2015, after the probate court discovered that he had stolen more than $1 million from her (he placed the money in an SNT for Joanne and an "Issue Trust" for himself and his children). The damages were trebled and Black was surcharged in the amount of $4.6 million. Rather than repay the stolen money, as ordered by the court, Black embarked on a campaign of scorched earth multi-jurisdictional litigation against Joanne that has persisted for a decade.

Some examples follow. In 2016, Black sued Joanne in federal district court in Illinois, seeking a declaration that he controlled the assets he had stolen, even though the Colorado probate court had by then frozen all of Joanne's assets. When Joanne asked the Colorado probate court to disburse funds from the SNT so she could hire a lawyer to defend her in the Illinois lawsuit, Black objected by challenging the probate court's jurisdiction over the SNT. In 2017, Black's wife brought an action in Illinois state court, asserting that the Issue trust owed her nearly half a million dollars. Within weeks, Black, as trustee, consented to the court's entry of judgment, but the Illinois Appellate Court later vacated the consent

judgment, concluding that it was the "product of fraud or collusion." In 2018, after Black funneled more than $250,000 out of the SNT in violation of the Colorado probate court's order, the court suspended Black as trustee of all trusts benefiting Joanne. In other cases, Black's behavior was described as "in bad faith, vexatious, and without reasonable basis," "frivolous and baseless," and "shocking." One court declared that Black is the antithesis of a person interested in Joanne's welfare. Joanne is not the beneficiary of her brother's concern and care; she is his "victim."

In the present case in 2023, as the probate court was fashioning a remedy that would finally allow Joanne to recoup some of the stolen funds, Black moved to terminate Joanne's conservatorship, retroactively, based on a New York order issued in 2016. The probate court denied the motion and Black appealed.

The Court of Appeals held that, according to state law, termination of a conservatorship may only be sought by the protected person, the conservator, or a "person interested in a protected person's welfare." Because "Black is none of those," the court concluded that he lacked standing to move for termination of Joanne's conservatorship. Accordingly, the court affirmed the probate court's order

Matter of Black, ____ A.D.3d ____ (2nd Dep't 2025), ____ N.Y.S.3d ____, 2025 N.Y. Slip Op. 04174 (NY Supreme Ct., App. Div., 2nd Dep't, July 16, 2025). In a disciplinary proceeding begun in 2020, a New York Appellate Court sustained a Special Referee Report and disbarred Bernard Black.

In 2020, the Grievance Committee for the Ninth Judicial District in New York commenced a formal disciplinary proceeding against Bernard Black. The petition contained six charges against Black and stated that the Grievance Committee intended to move for an order to apply the doctrine of collateral estoppel to bar Black from relitigating the issues from an order of the Colorado Probate Court that was affirmed by the Colorado Court of Appeals. Following numerous motions and cross-motion, the New York Appellate Court granted the request of the Grievance Committee and applied the doctrine of collateral estoppel.

In 2022, the court referred the matter to a Special Referee to hear and report. A hearing was conducted. Following the hearing, the Grievance Committee withdrew charge five of its petition. In a report dated July 20, 2023, the Special Referee sustained charges one through four and charge six of the petition and found that "[t]here was no showing that [the respondent] acted with venal intent." The Grievance Committee moved the court to confirm the Special Referee's report as to the charges, disaffirm the report insofar as it determined that the respondent acted without venal intent, and impose such discipline

upon Black as the court deemed just and proper. Black cross-moved to confirm the report as to charge six and the finding of substantial evidence in mitigation, including the lack of venal intent, disaffirm the report as to charges one through four, and to impose various forms of discipline short of disbarment.

There was mitigating evidence produced, including testimony regarding Black's honesty and integrity provided by several highly regarded law professors. But, as we have seen over the last eight years or so, there was also plenty of damning evidence that was produced.

In view of the evidence adduced at the hearing, the court found that the Special Referee properly sustained charges two through four and charge six of the petition, but that charge one was not properly sustained. Based on the record, the court sustained charges two through four and charge six and determined that the proper sanction was disbarment. Black disbarred!

In re Center for Special Needs Trust Administration, 2025 WL 1293218 (Bankr. M.D. Fla., May 9, 2025). United States Bankruptcy Court in Florida finds Govoni and Boston Finance Group LLC in contempt and grants bankruptcy trustee's emergency motion for sanctions.

The Center for Special Needs Trust Administration, Inc. ("The Center") served as a trustee of special needs trusts for over 2,000 beneficiaries. The Center loaned more than $100M to Boston Finance Group, LLC (BFG), a company controlled by The Center's founder, Leo Govoni. The loan was in default. The Center filed for Chapter 11 bankruptcy in February of 2024 and Michael Goldberg was appointed as the Chapter 11 Trustee. The Trustee filed an adversary proceeding against BFG and Govoni for breach of the loan documents.

The court granted summary judgment against BFG and Govoni, finding them liable for $120,324,391.07 in damages. The Trustee sought a temporary restraining order to prevent the dissipation of assets, which was later converted into a preliminary injunction. Despite court orders, BFG and Govoni failed to produce required documents and comply with discovery orders. Govoni's actions, including dissolving sixteen Alter Ego Entities, violated the court's preliminary injunction.

On May 2, 2025, the court found Govoni and BFG in contempt for failing to comply with court orders and granted the Trustee's Emergency Motion for Sanctions. Govoni was ordered to pay $5,000 per day until compliance and to cover attorneys' fees and costs incurred by the Trustee and the Unsecured Creditors' Committee.

Chamberlin et al v. Goldberg, 2025 WL 545958 (M.D. Fla. February 21, 2025). United States District Court in Florida affirmed bankruptcy court's order on appeal.

This is another case concerning The Center for Special Needs Trust Administration, Inc. ("The Center"). The appellants in this case have a son who is a beneficiary of one of the special needs trusts mismanaged by The Center. The parents filed a class action lawsuit against Boston Finance Group, LLC (BFG), a company controlled by The Center's founder, Leo Govoni (and involved in the Bankruptcy proceedings). The bankruptcy court granted the Chapter 11 Trustee's motion to enforce the automatic stay.

The District Court affirmed the bankruptcy court's order enforcing the automatic stay because the complaint violated the automatic stay because it sought to exercise control over the property of the estate and interfered with the Trustee's administration of the case. Automatic stay under 11 U.S.C. § 362 prevents actions that seek to control property of the bankruptcy estate. Commingled funds are considered property of the bankruptcy estate unless they can be traced. The claims in the Appellants' complaint were deemed to be intertwined with those against The Center.

Order affirming bankruptcy court's order on appeal.

United States v. Leo Joseph Govoni, 2025 WL 1997709 (M.D. Fla., July 18, 2025). United States District Court in Florida denied Govoni's motion to revoke the order of detention that was issued due to his repeated flaunting of court orders and ongoing attempts to hide his assets from the bankruptcy court.

After May 2025 when the Florida Bankruptcy Court found Leo Govoni in contempt and ordered him to pay $5,000 per day until he complied with the Bankruptcy Court's orders, he was indicted on 15 counts in a separate court case. The inditement by the Federal District Court included conspiracy to commit mail fraud, wire fraud, bank fraud and illegal monetary transactions among other crimes. Govoni was accused of embezzling more than $100M from beneficiaries of the special needs trusts that were managed by The Center for Special Needs Trust Administration, Inc., a company he owned.

Govoni argued that he should not be detained because he was in poor health. He also tried to argue that his alleged crimes were only economic in nature and for this reason, he was not a danger to others and should be released on bond. The United States argued that Govoni posed a substantial risk of flight and obstruction of justice, citing his access to financial means and potential access to a private plane. The Court reviewed Govoni's actions after the ruling of the Bankruptcy Court, which included refusing to allow chief restructuring officers to enter his building in violation of the Court's order and, on the same day that the Bankruptcy Court ordered sanctions based on Govoni's actions, he was caught inside the Govoni headquarters removing valuable commercial-grade coffee machines and

barrels of rum (preventing the chief restructuring officer from taking it), in violation of the Court's order. In addition to other evidence, the United States presented evidence of Govoni's attempts to obstruct justice, including transferring funds to his wife's accounts. Despite the Bankruptcy Court finding Govoni in contempt and imposing a $5,000 daily fine, Govoni refused to pay the contempt fine (which reached $200,000 before the Bankruptcy Court stopped the daily fine). The Magistrate Judge ordered Govoni's detention, concluding that no conditions of release would ensure his appearance in court.

Govoni filed a motion to revoke the detention order, arguing that the government failed to prove he was a danger to the community or a flight risk. Upon de novo review, the District Court agreed with the Magistrate Judge's decision, emphasizing Govoni's history of obstructive conduct and the risk of flight due to the potential lengthy prison sentence he faced. The motion for revocation of the detention order was denied.

In the Matter of G. W., _____ A.2d _____ (N.J. Super. Ct. App. Div., June 18, 2025). New Jersey Court of Appeals enforced a state agency's present lien prior to the funding of a pooled SNT.

Gabrielle is an adult who resides in a group home operated by the Arc of Bergen and Passaic Counties (Arc), where she receives day and residential services paid for through the Division of Developmental Disabilities (DDD), which is a division of New Jersey's Department of Human Services, and New Jersey's Medicaid program, which is implemented through the Division of Medical Assistance and Health Services (DMAHS). These two programs have separate and different state lien statutes.

On December 11, 2019, Gabrielle's sister died intestate, leaving Gabrielle to inherit approximately $600,000 from her estate. Arc petitioned for guardianship and transfer of the inheritance to a pooled SNT so Gabrielle could continue to be eligible for Medicaid. In response, DDD notified the court that it had a lien pursuant to the state statute in the amount of a little more than $1 million. DDD and DMAHS, both represented by the state Attorney General, filed a joint response to Arc petition. DMAHS took no position regarding Arc's requested relief, but DDD argued that it held a present lien against Gabrielle's property that must be addressed before any trust could be established for Gabrielle. Arc filed a reply arguing DMAHS's future Medicaid lien would take priority over the existing DDD lien.

The probate court accepted Arc's arguments and granted the petition, finding that it did "not make sense" that the monies paid by DDD should have to be repaid because of the inheritance and "the monies due to Medicaid, which Gabrielle was required to be eligible for in order to get those DDD benefits [would] take a back seat," not to mention that it

would be in Gabrielle's best interest for the DDD lien not to be recognized and thereby allow the pooled SNT to be funded.

The Court of Appeals reversed the trial court's order, holding that it was contrary to the plain language of both statutes. A DDD lien attaches to a living person's assets or a decedent's estate, while a Medicaid lien attaches only to a decedent's estate. In the event both DMAHS and DDD have liens against a decedent's estate, it is only then that a DDD lien is subordinate to a Medicaid lien.

Tami Corrello v. Douglas Corrello, No. A-2592-23 Unpublished (N.J. Super. Ct. App. Div., August 6, 2025). Appeals Court upholds lower Court's orders and sanctions ex-husband after he fails to follow Court order to pay alimony and alleges that the assets in the special needs trust funded for the benefit of his ex-wife are resources attributable to her.

Tami and Doug Corrello divorced and the Judge required Doug to pay his ex-wife, Tami, alimony of $352 per week. In subsequent years the Court addressed Doug's requested modifications to alimony. Doug alleged (among other things) that Tami failed to disclose assets, which consisted of a special needs trust established by her mother and funded for her benefit. The lower court ruled that the trust was not to be treated as a regular income source, and Doug's challenge to that was barred by res judicata. When Doug did not pay alimony, Tami had to borrow a significant sum from her mother's estate to compensate for the unpaid alimony. The court found Tami did disclose loans from her mother's estate and addressed the existence of the special needs trust in her earlier filings.

Divorce court denied Doug's motion to terminate or modify alimony based on Tami's past representations. The court granted most of Tami's cross-motion to enforce prior orders and to sanction Doug. Appeals Court affirmed.

Conservatorship of the Person and Estate of Mercado, No. D084147 Unpublished (Cal. Ct. App., May 28, 2025). California Court of Appeals affirmed a decision of the probate court to deny a petition to establish a special needs trust but to invite a petition to fund a pooled SNT based on the small size of the proposed trust fund.

In 2015, Julia Hernandez petitioned for a limited conservatorship of the person of her son, Martin Mercado, and the probate court eventually named Hernandez, as well as Alicia Mercado ("Mercado") and Roxana Hernandez as co-limited conservators of the person. In December 2022, the court appointed Mercado as the limited conservator of the

conservatee's estate. In March of 2023, Mercado dismissed her counsel and began representing herself. At the same time, the court appointed counsel for the conservatee.

In September 2023, Mercado filed a petition to create and fund an SNT. At some point thereafter, the court appointed a guardian ad litem for the conservatee. In December 2023, Mercado filed an amended petition to create an SNT. The court set a March 6, 2024, hearing on Mercado's amended petition. In advance of the hearing, both the conservatee's guardian ad litem and court-appointed counsel, respectively, filed reports with the court.

Observing that the conservatee's estate contained approximately $90,000, the conservatee's attorney recommended it was in the conservatee's best interest to establish an SNT. The two petitions had each included a different proposed SNT, and the conservatee's counsel recommended that the first SNT be approved. The guardian ad litem also recommended that an SNT be established, but stated that she felt a pooled SNT was a more appropriate and cost-effective option.

On March 6, 2024, the probate court denied Mercado's amended petition. It ordered payment of the conservatee's counsel's requested fees, but ordered that the guardian ad litem's fees be deferred until a petition was filed by Mercado regarding the establishment of a pooled SNT account for the conservatee. Mercado appealed this order.

Remember that Mercado is unrepresented. Even so, she managed to file an opening brief with the appellate court in which she contended that she as conservator had the authority to create an SNT, that her amended petition was compliant with the rules of court and Social Security Administration requirements, and that the probate court failed to consider certain factors under the California Probate Code and "under undue influence" erred by misinterpreting or misapplying the law when it denied her amended petition. The problem for Mercado was that the hearing at which the probate court made the order was not reported and Mercado was not able to get a reporter's transcript of the hearing or copies of the petitions and proposed trust documents into the appellate record.

The Court of Appeals affirmed the probate court's order, stating that, having no evidence to support Mercado's claims, they presumed the probate court did not abuse its discretion.

STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts

Friday
October 24, 2025

IEPs and Transition Plans: Present Levels for Future Planning

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Center for Elder Justice

Access and Justice For All®

FLORIDA DEPARTMENT OF EDUCATION
BUREAU OF EXCEPTIONAL EDUCATION AND STUDENT SERVICES
SUMMARY OF PERFORMANCE TEMPLATE

Part 1: Background Information

Student Name: _____ **Date of Birth:** _____ **Year of Graduation/Exit:** _____

Address: _____
(Street) (Town, state) (Zip code)

Telephone Number:_____ **Primary Language:** _____

Current School: _____ **City:** _____

Student's primary exceptionality: _____

Other exceptionality(ies), if applicable: _____

When was the student determined eligible for exceptional student education? _____

If English is not the student's primary language, what services were provided for this student as an English language learner?

_____

Date of most recent IEP or most recent 504 plan: _____**Date this Summary was completed:** _____

This form was completed by: Name: _____ **Title:** _____

School: _____ **E-mail:** _____ **Telephone Number:** _____

Please check and include the most recent copy of assessment reports you are attaching which clearly identify the student's disability or functional limitations and/or will assist in postsecondary planning:

- □ Psychological/cognitive
- □ Neuropsychological
- □ Medical/physical
- □ Achievement/academics
- □ Adaptive behavior
- □ Social/interpersonal skills
- □ Community-based assessment
- □ Self-determination
- □ Response to Intervention (RTI)
- □ Language proficiency assessments
- □ Reading assessments
- □ Communication
- □ Behavioral analysis
- □ Classroom observations (or in other settings)
- □ Career/vocational or transition assessment
- □ Assistive technology
- □ Informal assessment: _____
- □ Informal assessment: _____
- □ Other: _____

Part 2 – Student's Postsecondary Goal(s)

1.

2.

3.

Part 3 – Student Input (Highly Recommended)

SUMMARY OF PERFORMANCE: STUDENT PERSPECTIVE

A. How does your disability affect your schoolwork and school activities (such as grades, relationships, assignments, projects, communication, time on tests, mobility, extra-curricular activities)?

B. In the past, what supports have been tried by teachers or by you to help you succeed in school (aids, adaptive equipment, physical accommodations, other services)?

C. Which of these accommodations and supports has worked best for you? Why do you think they worked best?

D. Which of these accommodations and supports have not worked? Why do you think they did not work?

E. What strengths and needs should professionals know about you as you enter the postsecondary education or work environment?

F. What areas do you think you need to improve upon (communication, self-advocacy, study skills, etc.)?

Part 4 – Summary of Performance (Complete all that are relevant to the student.)

ACADEMIC CONTENT AREA	**Present Level of Performance** (grade level, standard scores, strengths, needs)	**<u>Essential</u> accommodations or modifications, and/or assistive technology utilized in high school, and why needed.**
Reading (Basic reading/decoding; reading comprehension; reading speed)		
Math (Calculation skills, algebraic problem solving; quantitative reasoning)		
Written Language (written expression, spelling)		
Learning Skills (class participation, note taking, keyboarding, organization, homework management, time management, study skills, test-taking skills)		

FUNCTIONAL AREAS	**Present Level of Performance** (strengths and needs)	**<u>Essential</u> accommodations or modifications and/or assistive technology utilized in high school and why needed.**
Social Skills and Behavior (Interactions with teachers/peers, level of initiation in asking for assistance, responsiveness to services and accommodations, degree of involvement in extracurricular activities, confidence and persistence as a learner, emotional or behavioral issues related to learning and/or attention)		
Independent Living Skills (Self-care, leisure skills, personal safety, transportation, banking, budgeting)		
Environmental Access/Mobility (assistive technology, mobility, transportation)		

FUNCTIONAL AREAS (continued)	**Present Level of Performance** (strengths and needs)	**Essential accommodations or modifications and/or assistive technology utilized in high school and why needed**
Self-Determination Self-Advocacy Skills (Ability to identify and articulate postsecondary goals, learning strengths and needs; independence and ability to ask for assistance with learning)		
Career-Vocational/Transition/ Employment (Career interests, career exploration, job training, employment experiences and supports)		
Additional considerations that can assist in making decisions about disability determination and needed accommodations (e.g., medical problems, family concerns, sleep disturbance)		

Part 5 – Recommendations to assist the student in meeting postsecondary goals

Suggestions for accommodations, adaptive devices, assistive services, compensatory strategies, and/or collateral support services to enhance access in the following **post-high school** environments (only complete those relevant to the student's postsecondary goals).

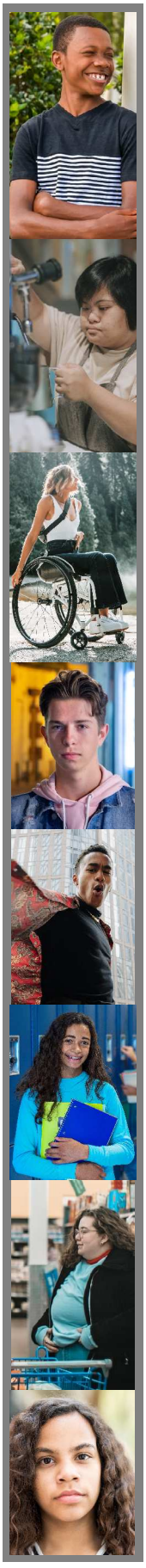
Education and Training	
Employment	
Independent living	

I have reviewed and agree with the content of this Summary of Performance.

Student Signature: _____ Date: _____

This template was adapted from the template developed by the National Transition Documentation Summit © 2005 including representation from the Association on Higher Education and Disability (AHEAD), the Council for Exceptional Children's Division on Career Development and Transition (DCDT), and Division on Learning Disabilities (DLD), the National Joint Committee on Learning Disabilities (NJCLD), the Learning Disability Association (LDA) and the National Center on Learning Disabilities (NCLD). It was based on the initial work of Stan Shaw, Carol Kochhar-Bryant, Margo Izzo, Ken Benedict, and David Parker. It reflects the contributions and suggestions of numerous stakeholders in professional organizations, school districts and universities particularly the Connecticut Interagency Transition Task Force. It is available to be freely copied or adapted for educational purposes.

Considering Age of Majority, Transfer of Rights and Decision-Making Options



Age of Majority and Transfer of Rights

According to the Individuals with Disabilities Education Act (IDEA), the transfer of parental rights can take place "when a child with a disability reaches the age of majority under State law which applies to all children (except for a child with a disability who has been determined to be incompetent under State law)." In Florida, individuals reach the age of majority and receive the transfer of their rights at age 18 (Section 743.07, Florida Statutes (F.S.)).

Students Turning 18 - What to Expect

Preparing students for decision-making about their lives is a powerfully important process. Federal and state requirements include the following:

1. At the age of 18, students will have the right to make educational decisions.
    - At least one year prior to a student turning 18, the student and parents must be notified that the transfer of rights to the student will occur at age 18. This must be done no later than the student's 17th birthday and must be documented in the individual education plan (IEP).
    - A separate notice will be provided to the parents and student closer to, but still prior to, the student's 18th birthday.
    - Additionally, House Bill (HB) 19 (2023) amends S. 1003.5716, F.S. to indicate the school district will provide "information and instruction to the student and his or her parent on self-determination and the legal rights and responsibilities regarding the educational decisions that transfer to the student upon attaining the age of 18. The information must include the ways in which the student may provide informed consent to allow his or her parent to continue to participate in educational decisions, including:
        - Informed consent to grant permission to access confidential records protected under the Family Educational Rights and Privacy Act (FERPA) as provided in s. 1002.22.
        - Powers of attorney as provided in Chapter 709, F.S.;
        - Guardian advocacy as provided in s. 393.12, F.S; and
        - Guardianship as provided in Chapter 744, F.S." (HB 19 (2023) Individual Education Plans).

2. Eligibility for Supplemental Security Income (SSI) benefits will be re-determined using an adult disability standard (usually in the month before the 18th birthday).
3. "Health insurance may change. Florida law requires dependent coverage to be offered until the dependent is age 30. Adults whose health insurance covers youth should check their policies" (Disability Rights Florida, n.d.).
4. Students receive the right to vote and must register by mail or online with the state. One must turn 18 by election day to be eligible to vote in that election, but registration can be completed at age 16 and after (Disability Rights Florida).
5. All males are required to register for military service within 30 days of turning 18. There is not a general exemption from registration based on mental or physical condition, but there are certain criteria that can provide exemption. Find out more - Exemption from Selective Service Registration at https://www.sss.gov/faq/.

Decision-Making Alternatives: Choosing the Best Option with My Child

Florida legislation provides a system that permits persons with disabilities to participate in decision-making to the fullest extent possible.

Least Restrictive Choice ← **Mid-Range Choices** →

Supported Decision-Making

Supported decision-making (SDM) is making one's own decisions with the option to get support from a group of trusted family members, friends and/or professionals. With this model, an individual can choose to make the decisions he/she wishes to make and choose to access assistance where needed. Francisco and Martinis explain, "[Supported decision-making] is just a fancy way of describing how we all make choices. We all need help making decisions, every single day." https://supportmydecision.org/assets/tools/Supported-Decision-Making-Teams-Setting-the-Wheels-in-Motion.pdf SDM pilot projects are being conducted in multiple states, including Florida.

Banking Services

A power of attorney that specifies the agent has the authority to conduct **banking transactions** on behalf of the person includes the following: establish, continue, modify, or terminate a banking account; contract for services available from a financial institution; withdraw money or property of the principal deposited with or left in the custody of a financial institution. (Section 709.2208, F.S.)

Power of Attorney

A **Power of Attorney** is a legal document through which a person gives someone (agent) the authority to act on his/her behalf, and the individual maintains the right to act on behalf of himself/herself. A **Durable Power of Attorney** is when the authority to act on the person's behalf does not end if the person suffers mental incapacity at some point in the future. (Section 709.2102, F.S.)



Advance Directives

Advance Directives are witnessed, written documents or oral statements that express a person's desires concerning health care. A **Living Will** is an advanced directive that expresses a person's instructions regarding life-prolonging procedures. **A Health Care Surrogate** is an advanced directive in which a person designates someone to make health care decisions and apply for health care benefits. (Section 744.3115, F.S.)

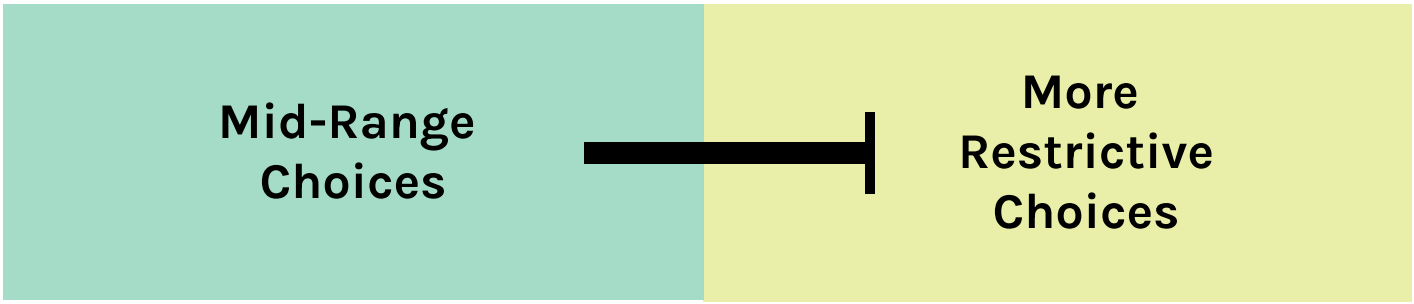
Trusts

A legal document called a **Trust** can be used to give someone the authority to manage the property of a person who needs or wants assistance. A **Special Needs Trust** assists a person with a disability to maintain needs-based benefits, such as medicaid health insurance by excluding certain assets and income. See Florida Medicaid.com for more information.

project10 transition education network

State Secondary Transition Interagency Committee, Florida Department of Education, Bureau of Exceptional Student Education

When selecting a decision-making alternative with your child, it is suggested that the best option is the one that will give the child who is becoming an adult the maximum amount of decision-making ability while also safeguarding his/her health and general welfare. Some of the options listed below can be combined in a way that matches the level of assistance that your young adult needs. Finding the right balance between assistance and autonomy is the key to ensuring your child has the opportunity to lead the most self-determined life possible.



Medical Proxy

A **Medical Proxy** is used when a person is or has become unable to make health care decisions and an advance directive has not been established. The patient's legal guardian could be assigned as the medical proxy by a judge or others could serve as the medical proxy, such as the patient's spouse, adult child, parent or adult sibling. (Section 765.401, F.S.)

Representative Payee

A **Representative Payee** is an entity selected by the Social Security Administration (SSA) (preferably family or friends, but could be an organization) to manage an individual's SSA benefits. This means the beneficiary's benefits will go to the Representative Payee for appropriate use. The Social Security Administration (SSA) benefits must be used to provide food, clothing, shelter, medical care and personal comfort items for the SSA beneficiary. All remaining funds must be saved in an interest-bearing account or savings bonds to be used for the SSA beneficiary's future needs. (Section 402.33, F.S.)

Guardian Advocacy

Guardian Advocacy is available for persons with a developmental disability (DD). Individuals cannot be determined as in need of a guardian based only on the fact that they have a DD. However, if a person with a DD lacks the capacity to make some (not all) decisions related to care for person or property, a Guardian Advocate may be appointed by a circuit court to assist with decision-making in the areas of the person's needs. (Section 393.12, F.S.)

Guardianship

Full Guardianship is used when a person has been found to lack all capacities to care for self and property. The court (circuit court) will appoint a guardian to exercise all of a person's rights and powers that can be legally delegated.
Limited Guardianship is used when a person has been found to lack capacities to exercise some, but not all, of their rights. The court will appoint a guardian to exercise rights that can legally be delegated. (Section 744.2102, F.S.)

Resources for the content of this chart include the following:
American Civil Liberties Union
https://www.aclu.org/sites/default/files/field_document/faq_about_supported_decision_making.pdf
Disability Rights Florida: What Are the Alternatives to Guardianship?
https://disabilityrightsflorida.org/disability-topics/disability_topic_info/what_are_the_alternatives_to_guardianship
Florida Developmental Disabilities Council - Developing Abilities and Restoring Rights: A Guide for Supporting Persons with Disabilities
https://fddc.org/wp-content/uploads/2020/08/Developing-Abilities-Restoring-Rights-Guide.pdf
The Florida Bar - Guidance Offered for Parents of Teens with Special Needs
https://www.floridabar.org/the-florida-bar-news/guidance-offered-for-parents-of-teens-with-special-needs/
Florida Statutes
http://www.leg.state.fl.us/Statutes/index.cfm?Mode=Search%20Statutes&Submenu=2&Tab=statutes
The National Resource Center for Supported Decision-Making - http://supporteddecisionmaking.org/

Resources

Access the Vote - Inclusive Elections for ALL - Provides instructions to ensure voters with a disability have access to voting. https://www.accessthevote.org/

Brink - A nonpartisan, non-profit 501(c)(3) seeking to make the democratic process more accessible to people with disabilities using technology, design, and behavioral science. https://www.brinkapp.co/

Center for Parent Information and Resources - Getting Ready for When Your Teen Reaches the Age of Majority - A Parent's Guide - This online tip sheet covers many relevant topics related to the transfer of parental rights to the student. https://www.parentcenterhub.org/age-of-majority-parentguide/#defs

Cost for Guardianship - An infographic that explains the cost of establishing guardianship for a child with a developmental disability in Florida using the expedited guardian advocate application process. https://www.guardianproject.us/what-does-getting-guardianship-cost-infographic/

Disability Rights Florida - Turning 18 & Other Options - Explains things that change when youth turn 18. https://disabilityrightsflorida.org/disability-topics/disability_topic_info/turning_18_guardianship_other_options

Florida Developmental Disabilities Council - Developing Abilities and Restoring Rights - A Guide for Persons with Disabilities: This guide provides educational materials in the area of legal rights. There is also an accompanying workbook. https://fddc.org/wp-content/uploads/2020/08/Developing-Abilities-Restoring-Rights-Guide.pdf

Florida Developmental Disabilities Council - Lighting the Way to Guardianship and Other Decision-Making Alternatives - A Manual for Individuals and Families: This resource provides information in English and Spanish. Additional FDDC Lighting the Way resources are available, including: fact sheets, an online training and a booklet on making life decisions designed for individuals with disabilities. https://www.fddc.org/publications/

Exemption from Selective Service Registration - Explains registration requirements for men with a disability turning 18. https://www.sss.gov/faq/

Exploring My Decision-Making Options - See the checklist on pages 7-8 that assists a person with a disability to determine the types of support needed for decision-making. http://flfcic.fmhi.usf.edu/docs/Florida_WINGS_DecisionMaking_FINAL_Digital.pdf

Family Network on Disabilities (FND) - Planning is Crucial: Guardianship and Alternatives: This webinar provides a deeper dive into the issues surrounding guardianship and decision-making alternatives. https://www.youtube.com/watch?v=ZjgNgLoof0Y

The Florida Bar and GAPS Legal, PLLC - Turning 18 - This website walks families through a step-by-step process about decision-making options with opportunities to choose specific paths that are of special interest. https://www.turning18.org/getting-started.html

The Florida Bar, #Just Adulting - This relevant legal information for young adults is easily accessible through the app or a pdf. https://www.floridabar.org/the-florida-bar-news/young-adults-have-easier-access-to-the-bars-justadulting-app/

The Florida Bar, Pro Bono & Legal Aid - This web page provides information about legal services at reduced rates. https://www.floridabar.org/public/probono/

Guardianship Glossary - In addition to providing a definition for more than 40 terms, this resource also provides links to the 20 circuit court locations that serve Floridians. https://www.guardianproject.us/florida-guardianship-glossary-list

PACER Center, Prepare Your Child for Age of Majority and Transfer of Rights - This resource explains how parents can prepare their child with a disability to prepare for the transfer of rights. https://www.pacer.org/parent/php/PHP-c63.pdf

Supported Decision-Making: Frequently Asked Questions - This resource explains the difference between guardianship and supported decision-making. https://www.aclu.org/sites/default/files/field_document/faq_about_supported_decision_making.pdf

We greatly value your input.
Please share via QR code.

Getting Ready for Educational Opportunities After High School: Families Supporting Students for Success



Families can help their students prepare for postsecondary education (PSE) opportunities while they are in middle and high school. Are you ready?

Families can help their students with disabilities prepare for postsecondary educational opportunities through collaborative transition planning. Secondary transition, the stage that includes students from age 14 through 21, is a crucial time of planning and preparation for students' lives after high school. Studies have shown that family involvement in this planning and preparation period will increase the likelihood of success of the student. See the Predictors of Post-School Outcomes handout to read about family activities that support positive post-school outcomes for their youth.

Student engagement in school is important for post-school success. The table below shows that students with disabilities who complete high school are more highly engaged in postsecondary education, job training and employment than students with disabilities who did not complete high school. Parents can provide support that helps their students to remain engaged and complete high school. Transition planning is a key strategy that helps students, families, educators, agencies and communities to help students move from high school to post-school life. Transition planning "provides the basic structure for preparing an individual to live, work and play in the community as fully and independently as possible" (Parent Tips for Transition Planning, 2007).

Levels of Student Engagement - Information Source (NLTS2, 2011)	High School Completers with No Engagement in PSE, Training or Employment	High School Non-Completers with No Engagement in PSE, Training or Employment
Percentage of Students with Disabilities	12.6%	35.5%

Postsecondary education prepares students for employment. Students in middle and high school can also develop job skills at home. Students, are you ready for some tips?

Transition Innovations published tips on practicing job skills at home. Some of their suggestions are adapted as follows:

- Show initiative: You don't have to wait to be told to do something. When you see something that needs to be done, take action.
- Set goals: Create a goal, plan how you will reach it and follow through.
- Improve communication skills: Practice conversations in which you may need to advocate for yourself, such as with a teacher, a co-worker, or a supervisor. Practice with your family.

Self-Determination Skills Help Students in All Phases of life.

Core components of self-determination include:

- Choice-Making
- Decision-Making
- Problem-Solving
- Goal-Setting & Attainment
- Self-Regulation
- Self-Instruction
- Self-Advocacy
- Internal Locus of Control
- Self-Efficacy
- Efficacy Expectations
- Self-Awareness
- Self-Knowledge

Check it out!

Self-Determination Parent Checklist, Appendix O in the Family Guide to Secondary Transition Planning for Students with Disabilities Comprehensive Toolkit

1. Have you and your student researched potential PSE programs?

Strategic planning for postsecondary education begins in middle and high school with the IEP and measurable postsecondary goals. All of the elements of the IEP will prepare your student for moving into life after high school. The postsecondary goals will reflect your student's preferences and will indicate what type of post-school activities your student wants to pursue. Whether choosing a training program, CTE center, college or university, there is much to learn in order to select the best option for your student. In addition to identifying the career focus for postsecondary education, students and families will need to consider the following:

Which options are available to your student?

- Review the chart under question 3 for information about postsecondary institution entrance requirements.
- Refer to FairTest, the National Center for Fair and Open Testing, to find colleges and universities that limit the use of exam scores, such as ACT/SAT scores, for college admissions.
- Refer to the *Florida Postsecondary Education Guide* and/or the Florida Consortium on Inclusive Higher Education website for information on inclusive higher education opportunities for people with intellectual disabilities

Which options will help your student achieve his/her postsecondary education goal?

- Vocational training program
- Certificate program at a CTE center or college
- Two-year degree program at a CTE center or college
- Four-year degree program at a college or university
- Inclusive postsecondary programs for students with an intellectual disability which lead to meaningful credentials

Will your student live at home, with other family or friends, on campus or in an apartment?

- Identify the available postsecondary education options that accommodate this preference or need.
- Identify availability of needed community resources, such as transportation and health services.

Which options will best accommodate your student's learning needs?

- Identify the services and supports available to all students.
- Meet with the Disability Services Office to learn about available accommodations and disability documentation requirements.

What are some opportunities for social integration?

- Identify available activities that interest your student and provide opportunities for social connection.
- Some PSE institutions are primarily attended by commuters which can affect the social activity options.

Financial Planning for Postsecondary Education

How will PSE be funded for your student?

- Research financial aid and scholarships on the Department of Education website
- Research scholarships on the Project 10 website
- Refer to the PAY FOR COLLEGE webpage at FloridaShines

Key Resource for Career and Postsecondary Education Planning

FloridaShines works witih Florida's K-20 educational community to provide services to Florida residents. FloridaShines helps students to accomplish the following:

- Go to College
- Succeed in College
- Find a Career

* These questions and answers are adapted from PACER's ***Transition to Postsecondary Education or Training: What Parents Can Do Now***

2. Is your student taking an appropriate course of study?

All students planning to attend college, university or a career and technical education (CTE) program, including students with disabilities, need to take a high school curriculum or course of study that will prepare them to meet the standards expected by those institutions. In Florida, all students, including students with disabilities, are expected to graduate with a standard diploma. Use the **Graduation Options Chart** on the Project 10 website to review graduation options for students with disabilities. Also check out the **Academic Advisement Flyer** from the Florida Department of Education for information about diploma designations, as well as, the State University System, the Florida College System and Career and Technical Colleges. If students with disabilities plan to attend a postsecondary institution that has high expectations, students will need to make high school curriculum choices that support that goal. The requirements of postsecondary education institutions vary and it is important for students to understand those differences. The table below provides some general information.

Factors to Compare	Florida University System	Florida College System	Florida Postsecondary CTE Programs	Inclusive Postsecondary Education Programs (IPSEs)
Admissions	Very competitive for all high school graduates	Open to everyone	Open to everyone	Open to students with cognitive disabilities
GPA	Grade point average (GPA) influences acceptance	Requires HS diploma; no minimum GPA requirement; entry into specific programs may be more competitive	Requires HS completion; No minimum GPA requirement; entry into specific programs may be more competitive	No minimum GPA is required
Test Requirements	College entrance exams influence acceptance	Assessments may be required for specific programs	Assessments may be required for specific programs	Program requirements vary from program to program
Course of Study	College prep course of study may be required	College prep course of study may be helpful to the student, but is not required.	College prep course of study is not required, but may be helpful to the student	College prep course of study is not required

Age-appropriate assessments determine the accommodations and modifications that may be necessary for your student to be successful and form a clear picture of your student's strengths, needs, interests and preferences. With the information gathered from transition assessments, the student, with the assistance of the IEP team, will begin to set goals for life after high school. These goals are called measurable postsecondary goals and they must be in place by the student's 16th birthday.

Measurable Postsecondary Goals

Measureable postsecondary goals describe what your student wants to do after graduating from high school. These goals are important because they provide a vision and a framework for IEP teams to plan transition services that support your student as he/she makes a successful move into adult life after high school.

Measurable postsecondary goals (MPGs) are written in the areas of education, training, employment and independent living, when appropriate.

***Important Information about the TABE Tests**

The Tests of Adult Basic Education (TABE) are commonly given to students who are entering a Florida College or postsecondary CTE program as a means to identify areas in which students may need extra help. However, a minimum TABE score may not be used as an entrance requirement.

3. Does your student understand his/her disability?

Students with disabilities benefit from understanding the nature of their disability and how their disabilities impact learning and living. The development of self-awareness and self-knowledge is a core component of self-determination and can be learned throughout the student's K-12 experience. When a student describes his or her disability, including strengths and needs, the IEP team is given direction about how to best nurture the student's interests and abilities while also providing needed supports. These skills help students to advocate for themselves as they transition to life after high school.

4. Has your student developed effective communication and social skills with adults and peers?

The first year of college can be very challenging, especially if your student will be living far from home. New student or freshman orientations are a great place to begin learning about the campus, making friends and finding activities of interest.

According to the Do2Learn website, "Communication is key to human interaction. Children and adults with communication issues often lack the information and/or skills to communicate effectively which can lead to a variety of social and behavioral difficulties." Prepare your student early for making the most out of his/her postsecondary education experience by helping him/her to communicate well with adults and peers in a variety of settings.

5. Does your student have computer skills or use other assistive technologies to complete computer-based tasks?

Many postsecondary tasks are expected to be completed using a computer. It is beneficial for students with disabilities to strengthen their computer skills during high school. Assistive technology and/or accommodations can promote accessibility for students who have visual, hearing, physical or other disabilities. Developing computer skills and/or assistive technologies during the K-12 experience will help prepare students for postsecondary education and assist them to advocate with the college's Disability Services Office, as well as with computer lab and library staff, to coordinate technology tools that facilitate learning and academic success.

You can assist your student to develop computer skills in the following areas:

- Keyboarding
- Email
- Accessing Internet Browsers and Internet Safety
- Microsoft Word, Excel and PowerPoint

If your student needs assistance performing these skills, find support through the Florida Alliance for Assistive Services and Technologies (FAAST) or Florida Diagnostic Learning Resources System (FDLRS) Centers. These organizations are supported through the Florida Department of Education (FDOE), Bureau of Exceptional Education and Student Services (BEESS). The school district's ESE office can also help with assistive technology.

Developing Communication Skills for Life

- Appropriate Topics of Conversation
- Tone of Voice and Volume Control
- Starting a Conversation
- Participating in Reciprocal Conversation
- Paying Attention and Listening to Others
- Responding to Questions
- Waiting Your Turn to Speak
- Staying on Topic
- Ending a Conversation



6. Has your student learned skills to assist with organizing, planning and prioritizing?

Students with disabilities typically receive guidance and direction during high school about how to follow schedules; how to behave in a classroom setting; how to plan for homework and class project completion; where and when to go to classes; and what to bring to class. These skills fall into the category of executive functioning (EF). **EF can be described as the set of skills that enable individuals to remember details, organize tasks, manage time and solve problems. These skills are necessary for setting and achieving goals.**

This level of monitoring and support for EF is not usually provided in the postsecondary setting. Students will be responsible for managing their own time, schedules and assignments. It is essential for students with disabilities to be prepared to act as independently as possible. Families, school personnel and others who support students with disabilities can prepare students to take on these responsibilities by assisting them to assemble resources that will help them perform the tasks necessary to be successful in life after high school.

The three dimensions of EF include the following:

- **Working Memory** - The ability to hold information in our minds for the purpose of using in everyday life.
  For example - Remember a phone number long enough to dial it.
- **Inhibitory Control** - The ability to manage thoughts and impulses in a way that provides time to think before acting.
  For example - Refrain from making rude remarks to a teacher or to a fellow student.
- **Cognitive/Mental Flexibility** - The ability to respond to changing demands in a variety of settings with agility.
  For example - Use appropriate tone of voice and physical actions in the classroom and at a soccer game.

Executive function skills are sort of like a 911 dispatch system. The 911 dispatcher determines which services are needed and alerts emergency medical technicians, firemen and policemen according to the needs of each call. In the same way, executive functioning accesses the various skills and abilities a person needs to perform tasks and solve problems. *How Children and Adults Can Build Core Capabilities for Life* is a video from Harvard University's Center on the Developing Child that explains how children, youth and adults develop and improve EF.

In addition to developing and strengthening their EF skills, students can also seek assistance from individuals in their circle of support and access tools, including smartphone apps that can help students assume responsibility for self-management. By using these tools, students can strengthen their executive functioning skills and efficiently accomplish the tasks needed on the pathway to education after high school. See the menu on the right for information on apps in the **Executive Functioning App Matrix.**

Top Executive Functioning Tips for Parents and Students

Top Tip for Parents:
Avoid directive prompting language, such as "Go upstairs and get your backpack." Instead use a 'visualization' question, "If you were standing at the door, ready to go to school, what items would you have with you?" This helps engage students in planning and taking responsible action.

Top Tip for Students:
Help students to see life-management tools in a positive light. These tools can be a key to freedom. When tasks are completed efficiently, more time is free for activities of the student's choice.

Executive Functioning App Matrix
This matrix highlights more than 40 apps that can be used to address a variety of needs that fall under the umbrella of executive function.

7. Does your student accept responsibility for his/her success?

The IEP meeting is an important place for students to practice and demonstrate their ability to assume responsibility for their progress towards achieving their goals. Families can support students in this process through regular IEP meeting attendance and participation. It is imperative that students with disabilities learn responsibility for their success because the need for self-direction and self-advocacy becomes much greater at the postsecondary education level and in all of life after high school.

The Individuals with Disabilities Education Act (IDEA) and Subpart D of Section 504 of the Rehabilitation Act of 1973 (504 Plan) are federal laws that govern the education of students with disabilities ages 3-21 (or until receipt of a standard high school diploma). Federal laws that govern individuals with disabilities beyond high school include Subpart E of Section 504 of the Rehabilitiation Act of 1973 (504 Plan) and the Americans with Disabilities Act (ADA) of 1990. See the table below for a comparison of how services are accessed.

Students with disabilities who want to get further education after high school will move from a school system in which the emphasis is on **success** and adults advocated for and directed their learning (IDEA) to a postsecondary education system in which the emphasis is on **access** and they will be required to advocate for themselves (504 Plan and ADA) . These are the central differences between the educational experiences before and after high school. It is also important to remember that accommodations may be provided at the postsecondary education level in order to ensure equity in access to learning and the campus experience, but curriculum or course requirements cannot be modified.

IDEA	504 Subpart E and ADA
Secondary Education (Middle School and High School)	Postsecondary Education (Universities, Colleges and Career and Technical Colleges)
Services are provided through Exceptional Student Education (ESE), School District	Advocate for services through the Disability Services Office/campus administration and with professors/instructors
Emphasis on success: Modifying standards is a possibility for students with the most significant cognitive disabilities.	Emphasis on equal access: Standards, course objectives and the curriculum cannot be modified; however, accommodations may be accessed.
Appropriate accommodations, as indicated on the student's IEP, can be provided. Schools arrange evaluations.	Appropriate accommodations may be accessed through disability disclosure and documentation of the disability.

Disability Disclosure in Postsecondary Education

At the postsecondary level, services for students with disabilities begin with a visit to the Office of Disability Services. A student may consider disclosing a disability when accommodations/supports are needed to be successful.

Disclosure of a disability provides advantages such as access to accommodations and legal protection against discrimination. However, disclosure may not always produce positive results.

Refer to *The 411 on Disability Disclosure: A Workbook for Youth with Disabilities* for more details.



Resources by Question

Question 1:

Florida Center for Students with Unique Abilities
https://fcsua.org/

Florida Consortium on Inclusive Higher Education
https://fcihe.com/

Florida Department of Education: Scholarships webpage
http://www.fldoe.org/contact-us/search.stml?q=Scholarships

Florida Developmental Disabilities Council: Florida Postsecondary Education Guide
https://www.fddc.org/publications

FloridaShines
https://www.floridashines.org/

Transition to Postsecondary Education or Training: What Parents Can Do Now
https://www.pacer.org/transition/resource-library/publications/NPC-15.pdf

Question 2:

Academic Advisement Flyer - FDOE
http://www.fldoe.org/core/fileparse.php/7764/urlt/StandardDiplomaRequirements.pdf

Florida College System Admissions
http://www.fldoe.org/schools/higher-ed/fl-college-system/academic-student-affairs/admissions.stml

Graduation Options Chart
http://project10.info/Documents/24-Credit_and_18-Credit_Grad_Options_Chart_03.30.2020.FINAL.pdf

Transition Services Checklist, Appendix N in the Family Guide to Secondary Transition Planning Comprehensive Toolkit
https://padlet.com/aschoenb/cbxve4zdy1e4



Question 3:

Core Components of Self-Determination from I'm Determined, Virginia Department of Education's Self-Determination Project
http://www.imdetermined.org/files_resources/131/core_components_of_self-determination.pdf

Parent Tips for Transition Planning
https://www.pacer.org/publications/pdfs/ALL14.pdf

Self-Determination Parent Checklist, Appendix O in the Family Guide to Secondary Transition Planning Comprehensive Toolkit
https://padlet.com/aschoenb/cbxve4zdy1e4

Post-High School Outcomes of Young Adults with Disabilities Up to 6 Years After High School: Key Findings from the National Longitudinal Transition Study-2 (NLTS2)
https://ies.ed.gov/ncser/pubs/20113004/

Transition of Students with Disabilities to Postsecondary Education: A Guide for High School Educators
https://www2.ed.gov/about/offices/list/ocr/transitionguide.html

Question 4:

8 Tips to Teach Effective Communication Skills
https://stanfield.com/8-tips-teach-effective-communication-skills/

Question 4: (Continued)

10 Ways to Improve Your High-Schooler's Communication Skills

https://www.understood.org/en/learning-attention-issues/child-learning-disabilities/communication-disorders/10-ways-to-improve-your-high-schoolers-communication-skills?view=slideview

Do2Learn Social Skills Toolbox

http://do2learn.com/organizationtools/SocialSkillsToolbox/AppropriateTopicsOfConverstion.htm

Practicing Social Skills: How to Teach Your Student Social Interactions

http://www.ldonline.org/article/21025/

Question 5:

Florida Diagnostic & Learning Resources System (FDLRS) Centers

http://www.fdlrs.org/departments/technology

Florida Alliance for Assistive Services and Technology (FAAST) - Apps as Assistive Technology - Affordable, available and Accessible

https://faast.org/apps-as-assistive-technology-affordable-available-and-accessible/

Speech to Text in Google Docs

https://www.youtube.com/watch?v=j8ike1_wXGk

Ways to Help Your HS Student with Executive Functioning

https://www.understood.org/en/learning-attention-issues/child-learning-disabilities/executive-functioning-issues/executive-functioning-issues-and-learning-6-ways-to-help-your-high-schooler

Question 6:

Executive Functioning App Matrix

http://online.anyflip.com/xbjb/eppj/mobile/index.html#p=3

Executive Functioning Description

https://www.merriam-webster.com/dictionary/executive%20function

Family Network on Disabilities - The Insider's Guide to Apps for Organizations

https://fndusa.org/apps/

FairTEST: The National Center for Fair and Open Testing

https://www.fairtest.org/

How Children and Adults Can Build Core Capabilities for Life - Center on the Developing Child at Harvard University

https://developingchild.harvard.edu/innovation-application/key-concepts/adult-capabilities/



Question 7:

At a Glance: Which Laws Do What

https://www.understood.org/en/school-learning/your-childs-rights/basics-about-childs-rights/at-a-glance-which-laws-do-what

Family Guide to Secondary Transition Planning, p. 74

http://project10.info/DPage.php?ID=322#NS142

The 411 on Disability Disclosure: A Workbook for Youth with Disabilities

http://www.ncwd-youth.info/wp-content/uploads/2016/10/411_Disability_Disclosure_complete.pdf

We value your input.
Please share via QR code.



Transition Continuum

Post-Secondary Education and Career Opportunities for Students with Disabilities seeking a Standard Diploma via Access Points

Beginning in 9th-grade students seeking Standard Diploma via Access Points will have the opportunity to enroll in Career Preparation and Self-Determination courses. Students may also enroll in Career Experience for additional work experience opportunities. In high school, this would be an introduction class, if a student defers their diploma this course becomes a full-day course in the Structured Work-Study Program. Students who defer their diploma and obtain paid employment would enroll in the Career Placement. Below is a brief overview of each of the courses.

Career Courses for Students:

Career Preparation	Self-Determination	Career Experience	Career Placement
•9th-10th grade •Self–determination and self –advocacy •Career Planning, Career Exploration •Students will explore careers and occupations •Students will learn about community and agency resources •Students will learn about effective work habits •CBI Opportunities	•9th-10th grade •Self-Determination and Self-Advocacy •Choice Making and Motivation •Decision Making and Problem Solving •Personal and Social Relationships •Personal and Career Planning •Leadership	•10th–12th grades intro program •Students on deferral full-time program •Specific to Career Experiences •Unpaid job exploration and work experience •Promotes general work skills and habits •Increase competency and fluency •Focus on 22 general work skills outlined by the U.S. Dept. of Labor •Typically 1 to 2 hours 5 x weekly for High School students, Structured Work Study full day program •CBVE opportunities	• Students participate in paid work experience with appropriate supports •Transportation NOT provided by SCS students are transportation trained to job sites once placed •Students monitored by ESE teacher and Transition Employment Trainer (Job Coach) •CBVE opportunities

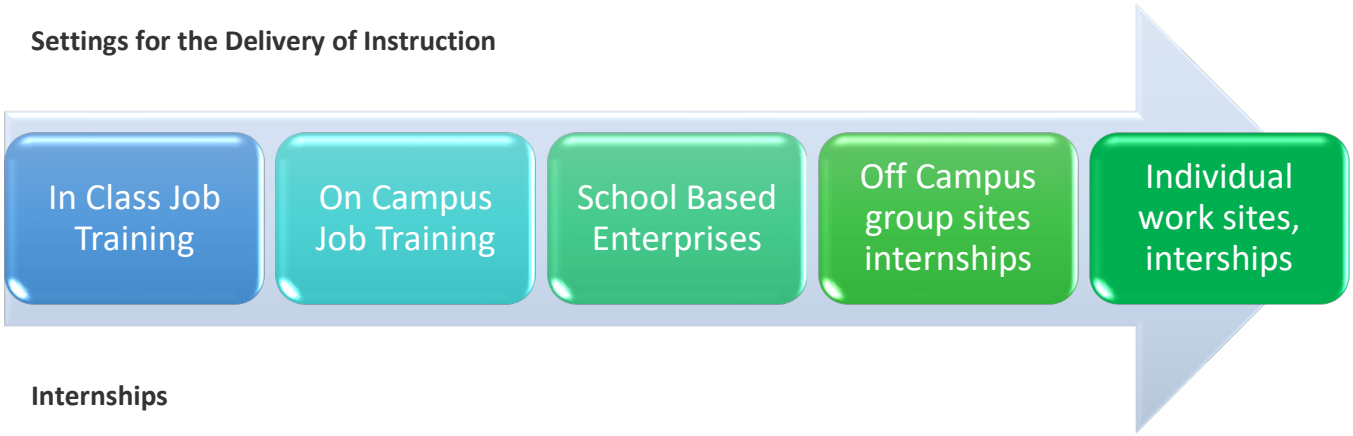
Community-Based Instruction (CBI)

Schools provide Community-Based Instruction opportunities to promote the transferring of functional skills into the community. Functional skills refer to those skills that a student needs to increase independence and to enhance the quality of life.

Career-Based Vocational Education (CBVE)

CBVE is vocational education and training provided by high school instructors to students with disabilities in community work settings. This training is non-paid vocational exploration and assessment. The goal of the CBVE program is to help students identify career interests and develop the skills and attitudes necessary for paid employment.

Settings for the Delivery of Instruction



Internships

Providing real work settings for students is an important component of job training. Community partnerships are continually developed to support students with internships and job training locations. The following businesses have worked with students in Sarasota County Schools:

- All Faiths Food Bank
- Boys and Girls Club
- Bright Beginnings Preschool
- Buff City Soaps
- Burlington
- Chick-Fil-a Pelican Point
- Detwiler's Farm Market
- G2 Secure
- Goodwill Manasota
- Hampton by Hilton
- Honey Baked Ham
- Original Egg
- Peachs Restaurant
- Pet Supplies Plus
- Pines of Sarasota
- Publix Supermarket
- Rise and Nyes
- Salvation Army
- Sarasota County Humane Society
- Sarasota County Schools Athletic Department
- Sarasota County Schools Custodial Department
- Sarasota County Schools Food and Nutrition
- Sarasota Memorial Health Care
- Sharkey's on the Pier
- Southgate Animal Hospital
- St. Francis Animal Rescue
- Suncoast Humane Society
- Tasty Home Cookin'
- Teen Court
- The Bazaar at Apricot and Lime
- Wildlife Center of SWFL
- Winsor of Venice

CTE Program at Suncoast Technical College for students on Access Points

In Culinary Arts to Careers (CA2C) students have the opportunity to train for a variety of careers in the field of food service and preparation emphasizing and building proficiency in food production and cooking, cost control, nutrition, sanitation, and workplace safety. Practical work experience stresses sanitation and safety and includes food preparation. Applications for students on Access Points are available during their junior year and may also apply as part of the deferral process.

Post-High School Transition Programs

Florida Center for Students with Unique Abilities

The purpose of the Florida Center for Students with Unique Abilities is to provide support to students, families, and institutions of higher education so that students with intellectual disabilities have opportunities for on-campus college experiences that lead to employment opportunities. A variety of programs are available for students with intellectual disabilities at college campuses across the state. Find a Post-Secondary Education Program and learn more about programs and steps to apply click HERE

Structure Work-Study Program and Deferral of Diploma

During the students' annual Individual Education Plan (IEP) meeting, the team will share information regarding the deferral process. Additional information regarding deferral is located at https://www.sarasotacountyschools.net/Page/4689

The legislation allows certain students with disabilities to defer receiving the diploma and continue to receive educational services from the school district.

> *Only a student whose IEP requires special education, transition planning, transition services, or related services through the age of 21 may defer receipt of their standard diploma. In addition, once a student defers, the student must be enrolled in accelerated college credit instruction, industry certification courses that lead to college credit, a collegiate high school program, courses necessary to satisfy the Scholar designation requirements, or a structured work-study, internship or pre-apprenticeship program in order to continue to receive FAPE (s. 1003.4282 (10)(c), F.S.).*

Structured Work Study Program

The Post-High School Transition Program provides students with disabilities employment opportunities on and off campus. This program serves students with disabilities who are 18 through 21 years of age with an IEP and have met high school graduation requirements and deferred receipt of their diploma Sarasota County School District offers a Structured Work Study Program with a specialized curriculum in job training skills for students with disabilities who have meet criteria for a Standard Diploma via Access Points and are determined eligible for a deferred diploma.



Sarasota County School's Transition teachers and job coaches provide this post-high school instruction to promote employability and independence through work experience. Students develop marketable and transferable job skills as well as confidence in their own abilities. Sarasota County currently has post-high school structured work-study sites at locations throughout the county.

Criteria for the Structured Work Study Program

- Students must be between the ages of 18-21, have an IEP, meet all the requirements for graduation, and defer receipt of their diploma by May 15 of their senior year.
- Students must have some successful Community-Based Instruction (CBI), Career-Based Vocational Education (CBVE), and/or volunteer experience during 9-12 grades.
- Students who have demonstrated successful off-campus work experiences are encouraged to apply.
- Student/parent/guardian must have a goal for employment or independence that is reflected in the Transition IEP.
- Student attendance and behavior records are considered a factor for eligibility and placement.
- Students must have sufficient emotional and behavioral stability to participate in all aspects of the program.
- Students must accept and follow reasonable rules and behave respectfully towards others.
- Parents/guardians are requested to visit the Post-High School Transition site before a student is selected.
- Student should be in the process of becoming a client of Vocational Rehabilitation or a related agency
- Students will participate in non-paid work-based experience to continue to improve employability skills. All coursework will focus on facilitating vocations and employability skills which may include the following:
    - work-based learning experiences in the community
    - community-based instruction
    - school-based enterprises
    - self-determination and self-advocacy training
    - communication and social skills training
    - transportation training on public transportation

Students must complete an application process. Once accepted, students will defer their diploma by May 15 of their 12th-grade year. Students will enroll in the Structured Work Study Program for the next school year.

Exiting the Structured Work Study Program

- Students who have successfully demonstrated the employment competencies for one semester, will continue working with their connected agencies and exit the program
- Students who are aging out of the program will continue working with their connected agencies and exit the program when they have reached exit age (21).
- Students may end a deferral at any time upon request and be transitioned to the connected outside agencies
- If a student is not enrolled or attending the Structured Work Study program, a meeting will be held with the student and family to transition to outside agencies and end deferral.

Agency Collaboration

A variety of agencies can play a role in providing services to students and families. Programs may offer services, funding, programs or supports that can be very valuable in assisting in the transition process. See https://www.sarasotacountyschools.net/Page/4701 for additional information on these agencies and others.











Florida Association of
Centers for Independent Living



The 411 on the Big 5: Sharing Transition-Related Information with Students with Disabilities and Their Families

(Required by Section 1003.5716, Florida Statutes)

Agency for Persons with Disabilities (APD)	Resources
How does APD support transition-aged youth (14-21) with disabilities?	**Agency Mission:** APD supports individuals with unique abilities and their families in living, learning and working within their communities by creating multiple pathways to possibilities. Find APD's Mission and Guiding Principles by using the link below. https://apd.myflorida.com/about/mission **Services**: APD offers a wide range of social, medical, residential, and behavioral services. The following is a list of services offered. Services provided are based on need and coverage criteria, so not all individuals receive all services. See the list of services by using the link below. https://apd.myflorida.com/customers/services/
How can students apply for services and at what age? 	**Apply for Services:** In order to be eligible for services from the Agency for Persons with Disabilities (APD), an individual must have a developmental disability (as defined in section 393.063(12), Florida Statutes), which occurs prior to age 18 and constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Disabilities served by APD include: • Intellectual disabilities (Full Scale IQ of 70 or below) • Severe forms of autism • Spina bifida cystica or myelomeningocele • Cerebral palsy • Prader-Willi syndrome • Down syndrome • Phelan-McDermid syndrome or • Individuals between the ages of 3-5 at high risk for a developmental disability https://apd.myflorida.com/customers/application/
What is the key understanding families and school districts should have about APD?	**Frequently Asked Questions (FAQs):** APD has an extremely helpful array of topics included in the FAQs. Check them out using the link below. https://apd.myflorida.com/about/faqs.htm APD Events Calendar: Use the Events Calendar to find APD activities in the county where you live by using the link below. https://resourcedirectory.apd.myflorida.com/EventCalendar.aspx
APD Landing Page - https://apd.myflorida.com/	apdCares CONNECTING YOU TO THE COMMUNITY

Division of Blind Services (DBS)	Resources
How does DBS support transition-aged youth (14-21) with disabilities? 	**Transition Services - General Description:** The DBS website states that transition activities are coordinated among a team that consists of the student, parent(s) or caregiver(s), educators, service providers, and friends. The transition must promote movement from school to post-school activities. The activities can include instruction, related services, community experiences, the development of employment and other post-school, adult-living objectives, functional vocational evaluation, and the acquisition of daily living skills when needed. **School-to-Work Services**: The School-to-Work Transition Program consists of a group of services that are provided by DBS and local partners on an individualized basis for students eligible to receive services under an individual education plan (IEP). Services are determined based on each individual client's needs. Types of services that may be provided are: • **Assessment** - Includes a comprehensive evaluation in orientation and mobility, adaptive daily living skills, assistive technology, low vision needs, functional assessments, vocational evaluation, and job readiness. • **Information and Referral** - Provides specific information to an individual or group which aids them in securing assistance and collateral services which they are entitled to and from which they may benefit. • **Assistive Technology** - Trains an individual or group to use adaptive devices and technology for communications and daily living needs including computer, keyboarding, access software, screen readers, note takers, closed circuit televisions, accessible cell phones and other devices. • **Counseling Services** - Provides counseling to address psychological and social issues related to vision loss. • **Job Readiness** - Includes resume preparation, interview training, appropriate hygiene and grooming training, accessing transportation, and time management training. Services also include simulated job tasks to enable the individual to adjust to work or provide a work experience. • **Job Coaching** - Provides on-site instruction to enable a participant to perform the assigned job related activities.
How can students apply for services and at what age?	**Apply for Services:** The DBS Application for Services form is available online or for download in both English and Spanish. You can find the link to the online application and a PDF application using the link below. https://dbs.fldoe.org/Information/Apply/index.html
What is the key understanding families and school districts should have about DBS?	**Inquire about Available Services:** Find Statewide offices as well as local offices near you using the link below. https://dbs.fldoe.org/Information/contact.html#county
Division of Blind Services - https://dbs.fldoe.org/	DIVISION OF BLIND SERVICES Florida Department of Education | dbs.fldoe.org

Florida Association of Centers for Independent Living (FACIL)	Resources
How does FACIL support transition-aged youth (14-21) with disabilities? 	**The Mission of FACIL:** The Florida Association of Centers for Independent Living (FACIL) is a statewide membership organization whose mission is to strengthen the capacity of Centers for Independent Living (CILs) to support community living and independence for Floridians with disabilities. **FACIL Carries Out Its Mission By:** • Providing a statewide voice in support of Independent Living to the Florida Legislature, state and local governmental agencies and other human service organizations. • Enhancing the public's understanding of the vital role CILs play in the lives of Floridians with disabilities. • Leveraging a diverse array of resources for FACIL members to expand their positive impact for Floridians with disabilities. Read more about how FACIL supports Centers for Independent Living (CIL) by using the link below. https://floridacils.org/about-facil/
How can students apply for services and at what age?	**Apply for Services:** Find contact information for the CIL nearest you. Use the link below to click on your county to learn more about the services that are available to you. https://floridacils.org/find-a-cil/ Also, find addresses and phone numbers using the link below. https://floridasilc.org/cil-directory-2/
What is the key understanding families and school districts should have about FACIL?	**Information about Centers for Independent Living (CILs):** CILs are consumer-driven, non-profit organizations who support community living and independence for people with disabilities based on the belief that all people can live with dignity, make their own choices and participate fully in society. CILs provide tools and supports for integrating people with disabilities fully into their communities. CILs serve all disabilities and all ages in every county in Florida. Using the link below, learn more about CILs. https://floridacils.org/
FACIL Landing Page - https://floridacils.org/	FACIL Florida Association of Centers for Independent Living

Florida Center for Students with Unique Abilities (FCSUA)	Resources
How does FCSUA support transition-aged youth (14-21) with disabilities? 	**The Purpose of FCSUA:** The Florida Center for Students with Unique Abilities at the University of Central Florida was established in 2016 through the Florida Postsecondary Comprehensive Transition Program Act (FPCTP Act), Section 1004.6495, Florida Statutes. FCSUA was charged with managing the Florida Postsecondary Comprehensive Transition Program (FPCTP) application and approval process. **FCSUA Carries Out Its Purpose through the Following Objectives:** • Support the development and approval of Florida Postsecondary Comprehensive Transition Programs (FPCTPs). • Provide FPCTP initial and continuing grants to universities, state colleges, and technical colleges. • Disseminate information to students with disabilities and their families on programs, services, and support across the state. • Administer student scholarships to attend FPCTPs. See the FCSUA brochure using the link below. https://fcsua.net/docs/FCSUA%20Brochure.pdf FCSUA Supports Florida College and Career Transition (CCT) Clubs that will help students with intellectual disabilities prepare for and access Florida Postsecondary Comprehensive Transition Programs across Florida. Use the link below to find out more. https://fcsua.org/K_clubs.php
How can colleges, universities, and students apply for support from FCSUA?	**Apply to Become an Approved FPCTP:** (1) The application must be submitted by your institutional leader. (2) Include key elements, such as experiential inclusive opportunities, access to courses, and the opportunity for students to earn a meaningful credential. Find out more about applying for program funding using the link below. https://fcsua.org/I_application.php **Apply for Student Scholarships:** The Florida Postsecondary Comprehensive Transition Program Scholarship for eligible students to attend approved Florida Postsecondary Comprehensive Transition Programs (FPCTPs). Annual scholarships of $7,000 are available. Find out more about this opportunity using the link below. https://fcsua.org/I_scholarships.php
What is the key understanding school districts, families and students should have about FCSUA?	**How to Find a Florida Postsecondary Comprehensive Transition Program:** Use this map to find postsecondary education programs that serve students with intellectual disabilities. Review programs and watch videos that describe each program using the link below. https://fcsua.org/Find_FPCTP.php
FCSUA Landing Page - https://fcsua.org/index.php	Florida Center for Students with UNIQUE ABILITIES

Vocational Rehabilitation (VR)	Resources
How does VR support transition-aged youth (14-21) with disabilities?	**VR's Primary Purpose:** VR helps people who have disabilities get or keep a job. VR is committed to helping people with disabilities find meaningful careers. **VR Provides Transition Youth Services:** Beginning at age 14, students with disabilities can connect with VR for Pre-Employment Transition Services (Pre-ETS) through the school transition staff, guidance counselor, or self-referral. Every student (ages 14-21) with a disability has the opportunity to participate in Pre-ETS. This includes: • Job exploration counseling • Postsecondary educational counseling • Self-advocacy training and peer mentoring • Work readiness training • Work-based learning experience
How can students apply for VR services and at what age? 	**Steps to Get Started:** To access Pre-ETS, students (ages 14-21) can follow a series of steps that will help them explore career paths, train for a job, and continue their education based on their interests and abilities. Use the link below to follow the steps to access Pre-ETS. https://www.rehabworks.org/student-youth/student-steps.html Use the link below to access the Pre-ETS Flyer. https://www.rehabworks.org/_resources/docs/flyers/pre-employment-transition-services.pdf **Accessing VR traditional services includes the following steps:** 1. Be Referred for Services 2. Apply for Services - Use the link below to access the Referral Form https://www.rehabworks.org/_resources/docs/customers/vocational-rehabilitation-referral-form.docx 3. Eligibility Decision 4. Possible Wait List Category 5. Write Your Individualized Plan for Employment 6. Participate in Services to Get Ready for Work 7. Become Employed! 8. Case Closure https://www.rehabworks.org/customers/vr-steps.html
What is the key understanding families and students should have about VR?	**Contact Transition Youth Services:** Find contact information at the link below. https://www.rehabworks.org/student-youth/student-contact.html **Find Answers to Frequently Asked Questions** using the link below. https://www.rehabworks.org/student-youth/student-faq.html
VR Landing page - https://www.rehabworks.org/	FLORIDA DEPARTMENT OF EDUCATION fldoe.org | VR Vocational Rehabilitation

SARASOTA COUNTY SCHOOLS – TRANSITION RESOURCES FOR FAMILIES

Agency for Persons with Disabilities

Address: 2295 Victoria Ave. # 221A, Ft. Myers, FL 33901
Phone Number: (239) 338-1372
Website: apd.myflorida.com/
Contact: APD.info@apdcares.org
APD supports persons with developmental disabilities in living, learning, and working in their communities. Individuals must have a primary diagnosis of: autism, cerebral palsy, spina bifida, intellectual disabilities, Prader-Willi Syndrome, Phelan McDermid Syndrome or Downs syndrome, and functional limitations in major life activities.

DOE - Division of Blind Services

Address: 600 8th Avenue W., Suite 302, Palmetto, FL 34221
Phone Number: (941) 721-2914
Website: dbs.myflorida.com/
Contact: dbs.myflorida.com/Information/contact-palmetto.html
DOE - Division of Blind Services assists blind individuals as well as those with useable but diminished vision. Their programs include: blind babies, children and family (school age), VR transition program for high school students, Vocational Rehabilitation program for those entering the workforce, and independent living program for seniors.

Florida Association of Centers for Independent Living (CIL)

Address: 325 John Knox Road, Building C, Suite 132, Tallahassee, FL 32303
Phone Number: (850) 575-6004
Website: www.floridacils.org
CILs are consumer-driven, non-profit organizations whose mission is to support community living and independence for people with disabilities based on the belief that all people can live with dignity, make their own choices and participate fully in society. CILs provide tools, resources and supports for integrating people with disabilities fully into their communities to promote equal opportunities, self-determination and respect.

Florida Center for Students with Unique Abilities

Address: University of Central Florida - Teaching Academy, 4000 Central Florida Blvd., P.O. Box 161250 Orlando, FL 32816
Phone Number: (407) 823-5225
Website: www.fcsua.org
Contact: fcsua@ucf.edu
The Florida Center for Students with Unique Abilities mission is to provide support to students, families, and institutions of higher education so that students with intellectual disabilities have opportunities for on-campus college experiences that lead to employment opportunities.

Vocational Rehabilitation (DOE - Division of Vocational Rehabilitation)

Address: 3660 N. Washington Blvd., Sarasota, FL 34234
Phone Number: (941) 359-5670
Website: www.RehabWorks.org
Contact: www.rehabworks.org/contact.shtml
Vocational Rehabilitation (VR) provides services to eligible individuals with physical and/or mental impairments that will enable an individual to achieve an employment goal and/or enhance their independence. Clients must have a documented disability, require VR services to become employed, and will benefit in terms of an employment outcome with VR services.

Suncoast Center for Independent Living, Inc.

Address: 3281 17th Street, Sarasota, FL 34235
Phone Number: (941) 351-9545
Website: www.scil4u.org
Contact: ilspecialist@scil4u.org
Suncoast Center for Independent Living serves anyone with a disability. Their program offers youth transition, advocacy, independent living skills, peer mentoring, information and referral, medical equipment loan program, computer loan program, and a home modification program. To help with these challenges, SCIL offers several basic and advance courses in Health and Wellness, Life Math and Budgeting, Household Skills and Computer Skills Class. SCIL also offers a specialized program for youth aged 16-22.

Center for Autism and Related Disabilities (CARD)

Address: 13301 Bruce B. Downs Blvd., MHC 2113A, Tampa, FL 33612
Phone Number: (800) 333-4530
Website: www.card-usf.fmhi.usf.edu
Contact: card-usf@usf.edu
Center for Autism and Related Disabilities (CARD) at the University of South Florida is a community based project that provides information and consultation to individuals diagnosed with autism spectrum disorders and related disabilities. CARD-USF offers instruction and coaching to families and professionals through a training and assistance model.

Centerstone

Address: 391 6th Avenue W., Bradenton, FL 34205
Phone Number: (941) 782-4236
Website: www.centerstoneflorida.org
Contact: centerstone.org/connect-with-us/
Centerstone offers community based behavioral health care including mental health and addiction services for children and adults. Centerstone offers short term hospitalization, treatment, psychological testing, and behavioral health services.

Academy at Glengary

Address: 910 Glengary St., Sarasota, FL 34312
Phone Number: (941) 894-8039
Website: www.academysrq.org
Contact: www.academysrq.org/contact
The Academy at Glengary offers vocational training for adults with a mental health diagnosis. Training opportunities are offered in culinary arts, hospitality, phone reception, business, maintenance, janitorial, customer service, accounting/banking, videography, and graphic design.

United Way 2-1-1- of Manasota, Inc.

Address: 1800 2nd St., Suite 102
Sarasota, FL 34236
Phone Number: (941) 366-2686
Website: www.unitedwaysuncoast.org https://211.gs-humanservices.org/
211 provides unmatched, critical services- Free and confidential assistance. No matter the situation, 211 Specialists listen, identify underlying problems, tackle root causes, and connect people to community resources and services. You can access 2-1-1 by phone, email, chat or text (just text your zip code to 898-211). Reaching out will get you connected to a multilingual 2-1-1 specialist in your area who can put you in touch with local organizations providing critical services to improve and save lives.

Jewish Family & Children's Services of Suncoast

Address: 2688 Fruitville Rd. Sarasota, FL 34237
Phone Number: (941) 366-2224
Website: www.jfcs-cares.org/families/
JFCS offers supportive case management connection to public benefits and mainstream, community resources, SOAR Certified case managers, relationship and adult education classes, and addiction prevention and mentoring program for children impacted by a family members substance use.

Family Network on Disabilities Statewide

Address: 26750 U.S. Highway 19 N., Suite 410, Clearwater, FL 33761
Phone Number: (800) 825-5736
Website: www.fndusa.org
Contact: fnd@fndusa.org
The Family Network on Disabilities Statewide is the state of Florida's Parent Training and Information Center. The mission of FND is to strive for the complete integration and equality of persons with disabilities in a society without barriers and to serve families of children with disabilities, ages birth through 26, who have a full range of disabilities.

First Step of Sarasota Inc.

Address: 1451 10th Street, Sarasota, FL 34236
Phone Number: (941) 552-1950
Website: www.fsos.org
Contact: www.fsos.org/contact-us

First Step of Sarasota offers innovative and comprehensive mental health and substance abuse programs for adults and children including inpatient, outpatient, and telehealth services. First Step offers treatment programs for both children and adults to help them transform their lives and conquer their challenges.

Bayside Center for Behavioral Health

Address: 1650 South Osprey Ave., Sarasota, FL 34239
Phone Number: (941) 917-7760

Sarasota Memorial Hospital's Bayside Center for Behavioral Health offers timely, accessible mental health assessments, as well as referrals to the most appropriate level of care, so you or your loved one can get back to living a full life. They offer free, confidential mental health assessments and free assessments for families in need, given by licensed child and adolescent therapists who are on call 24 hours a day. They also offer comprehensive, inpatient programs for short-term, intensive psychiatric treatment for adults, adolescents and children.

Project 10: Transition Education Network, USF, St. Petersburg

Address: 140 7th Avenue S., SVB112, St. Petersburg, FL 33701
Phone Number: (727) 873-4370
Website: www.project10.info
Contact: usfsp-project10@usf.edu

Project 10: Transition Education Network is Florida's statewide discretionary project supporting the secondary transition of youth with disabilities. Project 10 assists school districts in providing appropriate planning and timely transition services and programs to assist youth with disabilities in their transition to adulthood. Project 10 also serves as a collaborative resource for other state agencies, discretionary projects, non-profit organizations and families in the provision of transition services for students.

CareerSource Suncoast

Address: 1112 Manatee Ave. E., Bradenton, FL 34208
Phone Number: (941) 358-4200
Website: www.careersourcesuncoast.com
Contact: www.careersourcesuncoast.com/contact

CareerSource Suncoast is the leading provider of workforce services in the Manatee and Sarasota counties. CareerSource Suncoast employs Career Coaches who not only help career seekers find job leads, but prepare them for a lasting career. They help enhance clients' essential skills, resumes, interview skills, offer personalized job referrals, and free employability skills workshops.

The Haven

Address: 4405 DeSoto Rd., Sarasota, FL 34235
Phone Number: (941) 355-8808
Website: www.thehavensrq.org
Contact: Info@TheHavenSRQ.org

The Haven is empowering the lives of children, teens, and adults with disabilities, one person at a time. Specialized services and programs include: employment, transition, community living, Haven Industries, vocational, and social training.

Family Care Council Florida

Address: P.O. Box 300100, Ferk Pak, FL 32730
Phone Number: (800) 470-8101
Website: www.fccflorida.org

The mission of the Family Care Councils of Florida (FCCF) is to educate and empower individuals with developmental disabilities and their families, partnering with the Agency for Persons with Disabilities, to bring quality services to individuals with dignity and choice.

Lighthouse of Manasota

Address: 7318 N. Tamiami Trl., Sarasota, FL 34243
Phone Number: (941) 359-1404
Website: www.lighthouseofmanasota.org
Contact: info@LighthouseEducationCenter.org
The Lighthouse of Manasota is a non-profit for individuals with low vision or blindness. Their no cost services are for all ages in Sarasota, Manatee, Desoto, Highlands and Charlotte Counties. They also offer vision rehabilitation training and support for visually-impaired persons throughout their life span.

Loveland Center

Address: 157 S. Havana Rd., Venice, FL 34292
Phone Number: (941) 493-0016
Website: www.lovelandcenter.org
Contact: info@lovelandcenter.org
Loveland Center offers individuals with intellectual and developmental disabilities a variety of classes and activities through the Adult Day Training program. The goal of the Adult Day Training program is to provide an educational environment that will teach students important life skills designed to improve decision-making, self-sufficiency, self-advocacy, and interaction within the community.

Palm Shores Behavioral Health Center

Address: 1324 37th Avenue E., Bradenton, FL 34208
Phone Number: (941) 586-9175
Website: www.palmshoresbhc.com
Contact: https://palmshoresbhc.com/contact-us
Palm Shores Behavioral Health Center provides a clinical program and services for children and adolescents. Their services include intensive, residential inpatient treatment for children and adolescents ages 5-17 years old experiencing behavioral, emotional, education, family and social challenges.

UMatter Inclusive Postsecondary Education Program at USF St. Petersburg Campus

Address: 4202 E. Fowler Ave. EDU 105, Tampa, FL 33620
Phone Number: (727) 873-4654
Website: www.usf.edu/education/umatter/index.aspx
Contact: www.usf.edu/education/umatter/contact-us.aspx
UMatter is an innovative inclusive postsecondary education (IPSE) program created to provide young people with intellectual disabilities the opportunity to experience higher education and campus life. The UMatter program is hosted at USF's St. Petersburg campus to provide young people with intellectual disabilities the learning, social skills, and career training needed to set them up to be competitively employed and live independently.

Easterseals of Southwest Florida

Address: 350 Braden Ave., Sarasota FL, 3242
Phone Number: (941) 355-7637 x425
Website: www.easterseals-swfl.org
Contact: dherndon@easterseals-swfl.org
Easterseals Employment Services is committed to helping people with disabilities find meaningful careers. In conjunction with Florida Division of Vocational Rehabilitation, Easterseals provides career exploration, job coaching, and supported employment services to high school students attending Easterseals Academy, adults attending Life Skills Development, and community members with physical and/or intellectual disabilities.

State College of Florida-Disability Resource Center

Address: 5840 26th Street W., Bradenton, FL 34207
Phone Number: (941) 752-5295
Website: scf.edu/StudentServices/DisabilityResourceCenter
Contact: drc@scf.edu
The Disability Resource Center (DRC) is committed to ensuring equal access to college programs, services, and activities for qualified students with disabilities. The DRC assists students with disabilities through the provision of reasonable accommodations, information, resources services and skill development.

CASL (Community Assisted and Supported Living)

Address: 157 S. Havana Rd., Venice, FL 34292
Phone Number: (941) 807-5402
Website: www.caslinc.org
Contact: www.caslinc.org/contact-us

CASL (Community Assisted and Supported Living) provides various levels of care to suit the diverse needs of residents. The levels of care include an assisted living facility, independent housing, family style homes, and live-in support.

Social Security Administration

Address: 2001 Siesta Dr., Suite 301, Sarasota, FL 34239
Phone Number: (877) 490-9532
Website: www.ssa.gov
Contact: www.ssa.gov/agency/contact

The Supplemental Security Income (SSI) program pays benefits to eligible disabled adults and children who have limited income and resources.



1

Session Description

This session will discuss the history and purpose of IEPs and Transition Plans under the Individuals with Education Act (IDEA). Through IEPs and Transition Plans, specially designed instruction is utilized to meet students with disabilities' unique needs and prepare them for further education, employment, and independent living. *See* 20 U.S.C. § 1400(d)(1)(A).

Each IEP and Transition Plan contains present levels of academic achievement and functional performance which highlight the student's current disability related needs but can be used in planning for meeting future needs.

2

The History of the Individuals with Disabilities Education Act (IDEA)

THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) WAS THE CULMINATION OF A SERIES OF CASES BROUGHT IN THE 1970'S BY DISABILITY RIGHTS FAMILIES AND ADVOCATES TO MOVE AWAY FROM THE SEGREGATION OF STUDENTS WITH PHYSICAL, INTELLECTUAL, AND EMOTIONAL DISABILITIES IN INSTITUTIONALIZED SETTINGS.

- Two significant cases extended the Brown v. Board of Education decision by using the due process clause of the 14th Amendment to provide parents of children with disabilities specific rights to challenge and strike down state law that denied their child from the right to a public education. 347 U.S. 483 (1954). See P.A.R.C v. Pennsylvania, 343 F. Supp. 279 (E.D. Pa. 1972); Mills v. Board of Education of the District of Columbia, 358 F. Supp. 866 (D.D.C. 1972).
- The federal courts' rulings led to a Congressional investigation, in 1972, which found that a significant percentage of students with disabilities were not having their educational needs adequately met or were excluded from school entirely.
- In 1975, President Ford signed the Education for All Handicapped Children Act, otherwise known as Public Law 94-142. This law required all states that accepted money from the federal government to provide equal access to education for children with disabilities.

3

Individuals with Disabilities Education Act (IDEA)

THE IDEA WAS A LANDMARK LAW ENACTED IN 1990, ORIGINALLY KNOWN AS THE EDUCATION OF HANDICAPPED CHILDREN ACT OF 1975

- The federal statute was intended to address the inadequate educational services offered to children with disabilities and to combat the exclusion of such children from the public school system.
- Ensures that all children with an identified disability receive special education and related services.
- Ensures that the rights of children with disabilities and their families are protected under the law.
- Provides monitoring and accountability for the efforts of institutions providing services to students with disabilities.
- Provides assistance to states, localities, federal agencies, and educational service agencies in providing for the education of children with disabilities.

PART B AND PART C

- Part B of IDEA supports services for children ages 3-5 and 6-21—the preschool and school-age populations. Part C of IDEA supports services for infants and toddler

4

Important IDEA Case Law

SIGNIFICANT DECISIONS UNDER THE IDEA

Free and Appropriate Education (Two-Part Test)

FAPE is denied only if:

1. i) the procedural flaw impeded the child's right to FAPE, ii) significantly infringed the parents' opportunity to participate in the decision-making process, or iii) caused an actual deprivation of educational benefits. Winkelman v. Parma City Sch. Dist., 550 U.S. 516, 525-26 (2007).
2. It must be determined if the IEP developed pursuant to the IDEA is reasonably calculated to enable the child to receive "educational benefits." Bd. of Educ. of Hendrick Hudson Cent. Sch. Dist. v. Rowley, 458 U.S. at 206, 207 (1982). NOTE: Replaced by Endrew F.

- In 2017, the U.S. Supreme Court revisited and raised the standard for a free and appropriate public education (FAPE) by rejecting an educational program that was calculated to provide "merely more than de minimis" educational benefit and held that determined that, "to meet its substantive obligation under the IDEA, a school must offer an IEP that is reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances." Endrew F. v. Douglas County School District Re-1, 137 S. Ct. 988.
- The Court in Endrew F. also emphasized the requirement that "every child should have the chance to meet challenging objectives.

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Important IDEA Case Law (continued)

INDIVIDUAL EDUCATION PLAN (IEP):

- When reviewing an IEP, "[t]he 'reasonably calculated' qualification reflects a recognition that crafting an appropriate program of education requires a prospective judgment by school officials," and that "[a]ny review of an IEP must appreciate that the question is whether the IEP is reasonable, not whether the court regards it as ideal."
- The IEP is the means by which special education and related services are 'tailored to the unique needs' of a particular child."

IEP Three-Part Test:

1. The IEP must be analyzed in light of circumstances as they existed at the time of the IEP's formulation; in other words, an IEP is not to be judged in hindsight. M.B. v. Hamilton Se. Sch., 668 F.3d 851, 863 (7th Cir. 2011) (holding that an IEP can only be evaluated by examining what was objectively reasonable at the time of its creation); Roland M. v. Concord Sch. Comm., 910 F.2d 983, 992 (1st Cir. 1990) ("An IEP is a snapshot, not a retrospective. In striving for 'appropriateness,' an IEP must take into account what was, and was not, objectively reasonable when the snapshot was taken, that is, at the time the IEP was promulgated.").
2. An assessment of an IEP must be limited to the terms of the document itself. Knable v. Bexley Cty. Sch. Dist., 238 F.3d 755, 768 (6th Cir. 2001); Sytsema v. Acad. Sch. Dist. No. 20, 538 F.3d 1306, 1315-16 (8th Cir. 2008) (holding that an IEP must be evaluated as written).
3. Deference should be accorded to the reasonable opinions of the professional educators who helped develop an IEP. See Endrew F., 13 S. Ct. at 1001.

6

Eligibility for ESE Services and an IEP
Rule 6A-6.0331, F.A.C.

ELIGIBILITY FOR ESE SERVICES AND AN IEP ARE DRIVEN BY MEDICAL AND EDUCATIONAL EVALUATIONS AND BASED ON STUDENT'S EDUCATIONAL NEEDS

- The school district shall be responsible for conducting all initial evaluations necessary to determine if the student is eligible for ESE and to determine the educational needs of the student.
- Parent consent must be obtained for an initial evaluation which must be completed within sixty (60) school days (cumulative) of receipt of parent's consent for the evaluation.

To be found eligible for exceptional student education (ESE) services:

- The child must meet the specific criteria under the recognized disability categories, and "who, by reason thereof, needs special education and related services."
- Typically, this requires a showing that the child's disability adversely affects the student's performance in the educational environment and the student needs special education as defined in paragraph 6A-6.03411(1)(kk), F.A.C 34 C.F. R. 300.8(a)(1).

There are thirteen distinct categories of disability under IDEA including:

- 1) autism, 2) deaf-blindness, 3) deafness, 4) emotional disturbance, 5) hearing impairment, 6) intellectual disability, multiple disabilities, 8) orthopedic impairment, 9) other health impairment, 10) specific learning disability, 11) speech or language impairment, 12) traumatic brain injury, and 13) visual impairment.

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Eligibility for ESE Services and an IEP
Rule F.A.C. 6A-6.0331, F.A.C.

In conducting an evaluation, the school district:

1. Must use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the student, including information provided by the parent, that may assist in determining whether the student is eligible for ESE and the content of the student's IEP or EP, including information related to enabling the student with a disability to be involved in and progress in the general curriculum (or for a preschool child, to participate in appropriate activities), or for a gifted student's needs beyond the general curriculum;
2. Must not use any single measure or assessment as the sole criterion for determining whether a student is eligible for ESE and for determining an appropriate educational program for the student; and
3. Must use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.

In interpreting evaluation data for the purpose of determining if a student is an exceptional student and the educational needs of the student, each school district shall:

- Draw upon data and information from a variety of sources, such as aptitude and achievement tests, the student's response to interventions/instruction implemented, parent input, student input as appropriate, teacher recommendations, and information about the student's physical condition, social or cultural background, and adaptive behavior .

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Individual Education Plan (IEP)
Rule 6A-6.03028, F.A.C.

JUSTICE BRENNAN DESCRIBED THE IEP AS "THE CENTERPIECE OF THE STATUTE'S EDUCATION DELIVERY SYSTEM FOR DISABLED CHILDREN."

- An IEP must be developed, reviewed, and revised for each eligible student or child with a disability annually.
- A written notice of the meeting must be provided to the parents.
- The IEP meeting must be scheduled at a mutually agreed on time and place.
- Parents may invite other individuals who have "knowledge or special expertise regarding the student," including related services personnel as appropriate.
- The District must give provide copy of the IEP at no cost to the parents.

THE ROLE OF PARENTS IN DEVELOPING IEPS INCLUDES:

1. Providing critical information regarding the strengths of their student;
2. Expressing their concerns for enhancing the education of their student so that their student can receive FAPE;
3. Participating in discussions about the student's need for special education and related services;
4. Participating in the determination of how the student will be involved and progress in the general curriculum, including participation in the statewide assessment program and in district-wide assessments;
5. Participating in the determination of what services the school district will provide to the student and in what setting; and,
6. Participating in the determination of the course of study leading towards a standard diploma the student will pursue.

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Individual Education Plan (IEP)
Rule 6A-6.03028, F.A.C.

IEP TEAM PARTICIPANTS REQUIRED TO ATTEND:

1. The parents of the student;
2. Not less than one (1) regular education teacher of the student, if the student is or may be participating in the regular education environment.
3. Not less than one (1) special education teacher of the student, or where appropriate, not less than one special education provider of the student;
4. A representative of the school district who is qualified to provide or supervise the provision of specially designed instruction to meet the unique needs of students with disabilities, is knowledgeable about the general curriculum, and is knowledgeable about the availability of resources of the school district.
5. An individual who can interpret the instructional implications of evaluation results who may be a member of the IEP Team.
6. The student, if appropriate, and in all cases where a purpose of the meeting will be the identification of the student's transition services needs or consideration of postsecondary goals for the student and the transition services needed to assist the student in reaching those goals.

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Individual Education Plan (IEP)
Rule 6A-6.03028, F.A.C.

IEP TIMELINES:

1. An IEP must be developed within thirty (30) calendar days following the determination of a student's eligibility for special education and related services and be in effect prior to the provision of these services.
2. Meetings shall be held to develop, review and revise the IEP. A meeting shall be held at least annually to review each IEP and, as appropriate, revise its provisions in accordance with all aspects of this rule.
3. An IEP, which has been reviewed, and if appropriate, revised periodically, but not less than annually, must be in effect at the beginning of each school year for each eligible student with a disability within its jurisdiction.

CONSIDERATIONS IN IEP DEVELOPMENT, REVIEW, AND REVISION:

- The results of the initial or most recent evaluation or reevaluation of the student;
- As appropriate, the results of the student's performance on any general statewide or districtwide assessment;
- The academic, developmental, and functional needs of the student;
- In the case of a student whose behavior impedes the student's learning or the learning of others, strategies, including the use of positive behavioral interventions, supports, and other strategies to address that behavior;
- In the case of a student with limited English proficiency, the language needs of the student as those needs relate to the student's IEP;
- The communication needs of the student.
- Whether the student requires assistive technology devices and services.

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Individual Education Plan (IEP)
Rule 6A-6.03028, F.A.C.

CONTENT OF THE IEP

The IEP for a student must include:

1. A statement of the student's present levels of academic achievement and functional performance, including how the student's disability affects the student's involvement and progress in the general curriculum;
2. A statement of measurable annual goals, academic and functional goals, designed to meet the student's needs that result from the student's disability to enable the student to be involved in and make progress in the general curriculum;
3. A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the student and a statement of the classroom accommodations, modifications or supports for school personnel that will be provided for the student to advance appropriately toward attaining the annual goals;
4. A statement of any individual appropriate accommodations in the administration of statewide standardized assessments or district assessments of student achievement that are necessary in order to measure the academic achievement and functional performance of the student on the assessments.
5. The projected date for the beginning of the special education, services, accommodations and modifications and the anticipated frequency, location and duration of those services;
6. A statement of how the student's progress toward meeting the annual goals will be measured and when periodic reports on the progress the student is making toward meeting the annual goals.

Practice Tip: The present levels of academic achievement and functional performance should be as objective and measurable as possible.

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Continuum of Placement and Least Restrictive Environment (LRE)

LRE AND PLACEMENT DETERMINATIONS

Placement determinations shall be made in accordance with the LRE provisions of the IDEA:

1. To the maximum extent appropriate, students with disabilities, including those in public or private institutions or other facilities, are educated with students who are not disabled;
2. Special classes, separate schooling or other removal of students with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily; AND
3. A continuum of alternative placements must be available to meet the needs of students with disabilities for special education and related services, including instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions and a school district must make provision for supplementary services to be provided in conjunction with regular class placement.

Practice Tip: The child's LRE placement can be used to support more intensive levels of services, support, and transition planning.

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What is special education and related services?

SPECIALLY DESIGNED INSTRUCTION MEANS ADAPTING, AS APPROPRIATE TO THE NEEDS OF AN ELIGIBLE EXCEPTIONAL STUDENT, THE CONTENT, METHODOLOGY, OR DELIVERY OF INSTRUCTION TO ADDRESS THE UNIQUE NEEDS OF THE STUDENT THAT RESULT FROM THE STUDENT'S DISABILITY AND TO ENSURE ACCESS TO THE GENERAL CURRICULUM TO MEET THE EDUCATIONAL STANDARDS WITHIN THE JURISDICTION OF THE SCHOOL DISTRICT.

- Special education includes:
  a. Instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and,
  b. Instruction in physical education.
  c. Speech-language pathology services;
  d. Travel training; and,
  e. Career and technical education.
- Related services are defined in the regulations as transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, includes:
  - speech-language pathology and audiology; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services; medical services for diagnostic or evaluation purposes only; school health services; social work services in schools; parent counseling and training.

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Procedural Safeguards for Students with Disabilities

SCHOOL AND DISTRICTS ARE REQUIRED TO PROVIDE A NOTICE TO PARENTS OF THE PROCEDURAL SAFEGUARDS AT LEAST ONE TIME A SCHOOL YEAR AND IN OTHER SPECIFIC CIRCUMSTANCES.

- Child Find
- Prior Written Notice
- Access to Records
- Parental Consent
- Independent Educational Evaluation – at public expense
- Mediation
- State Complaint Procedures
- Due Process Hearing Request and Procedures
- Appeals
- Procedures when Disciplining Students with Disabilities
- Unilateral Placement by Parents of Students in Private Schools at Public Expense
- Requirements for Students Enrolled by Parents in Private Schools

Practice Tip: Students suspected of having a disability may trigger a state or district's child find obligations and protections from discipline that apply to students with disabilities, e.g., 10-day rule, manifestation hearing.

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Transition Planning

FLORIDA FOLLOWS THE IDEA UNDER FLORIDA STATUTES § 1003.5716:

- To ensure quality planning for a successful transition of a student with a disability to postsecondary education and career opportunities, during the student's seventh grade year or when the student attains the age of 12, whichever occurs first, an IEP team shall begin the process of, and develop an IEP for, identifying the need for transition services before the student with a disability enters high school or attains the age of 14 years, whichever occurs first, in order for his or her postsecondary goals and career goals to be identified.

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Transition Planning (continued)

THE PLAN MUST BE OPERATIONAL AND IN PLACE TO BEGIN IMPLEMENTATION ON THE FIRST DAY OF THE STUDENT'S FIRST YEAR IN HIGH SCHOOL.

This process must include, but is not limited to:

- **Consideration of the student's need for instruction in the area of self-determination and self-advocacy to assist the student's active and effective participation in an IEP meeting;**
- **(b) Preparation for the student to graduate from high school with a standard high school diploma pursuant to § 1003.4282 with a Scholar designation unless the parent chooses an Industry Scholar designation;**
- **Provision of the information to the student and his or her parent of the school district's high school-level transition services, career and technical education, and collegiate programs available to students with disabilities and how to access such programs. Information shall also be provided on school-based transition programs and programs and services available through Florida's Center for Students with Unique Abilities, the Florida Centers for Independent Living, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, and the Division of Blind Services. Referral forms, links, and technical support contacts for these services must be provided to students and parents at IEP meetings;**

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Transition Requirements

BOTH THE IDEA AND STATE LAW HAVE THE SAME GENERAL TRANSITION REQUIREMENTS:

- If there are changes to postsecondary or career goals included in an IEP, the parent must approve the changes.
- If a parent does not attend the meeting, the IEP will be sent home and will include contact information in case the parent does not approve.
- If the parent does not approve they should discuss their concern(s) with the rest of the IEP team, including the student.
- Parents may choose an independent reviewer to help decide if the change is appropriate.

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Transition IEPs (TIEPs)

EACH STUDENT'S IEP IS UNIQUE AND IS BASED ON THE STUDENT'S INDIVIDUAL NEEDS. AS STUDENTS APPROACH AGE 12, OR DURING THEIR 7TH GRADE SCHOOL YEAR, WHICHEVER OCCURS FIRST, NEW TRANSITION-RELATED REQUIREMENTS ARE ADDED TO THE IEP.

The Transition IEP process begins:

- **At age 12 or during 7th grade (whichever comes first)**
- **Age-appropriate transition assessments indicating the student's strengths, preferences and interests are documented.**
- **Document the need for self-determination and self-advocacy instruction.**
- **Discuss measurable postsecondary goals based on age-appropriate transition assessment in the following areas:**

1. **Education and/or training**
2. **Employment/Career**
3. **Independent Living (when appropriate)**

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Transition Planning Components

TRANSITION PLANS BEGINNING AT AGE 14 OR TO BE IN EFFECT WHEN THE STUDENT ENTERS HIGH SCHOOL MUST INCLUDE THE FOLLOWING AND BE UPDATED ANNUALLY:

- **A** statement of intent to pursue a standard high school diploma and pursue a scholar and/or industry scholar designation (scholar or industry scholar designations are encouraged, but not required).
- A description of how the student will fully meet the graduation requirements.
- Document discussion of the process for a student with a disability who meets the requirements for a standard high school diploma to defer the receipt of such diploma.
- The outcomes and additional benefits expected by the parent and the IEP team at the time of the student's graduation.

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Transition Planning Components (continued)

TRANSITION PLANS MUST ALSO INCLUDE THE FOLLOWING:

- A statement of appropriate measurable long-term postsecondary education and career goals based upon age-appropriate transition assessments related to training, education, employment, and, if appropriate, independent living skills and the transition services, including preemployment transition services and courses of study needed to assist the student in reaching those goals.
- If a participating agency responsible for transition services, other than the school district, fails to provide the transition services described in the IEP, the school district shall reconvene the IEP team to identify
- alternative strategies to meet the transition objectives for the student that are specified in the IEP. However, this does not relieve any participating agency of the responsibility to provide or pay for any transition service that the agency would otherwise provide to students with disabilities who meet the eligibility criteria of that agency.

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Transition Planning (continued)

At least 1 year before the student reaches the age of majority, provision of information and instruction to the student and his or her parent on self-determination and the legal rights and responsibilities regarding the educational decisions that transfer to the student upon attaining the age of 18. The information must include the ways in which the student may provide informed consent to allow his or her parent to continue to participate in educational decisions, including:

1. Informed consent to grant permission to access confidential records protected under the Family
2. Educational Rights and Privacy Act (FERPA) as provided in s. 1002.22.
3. Powers of attorney as provided in chapter 709.
4. Guardian advocacy as provided in s. 393.12.
5. Guardianship as provided in chapter 744.
6. Supported decision making agreements as provided in s. 709.2209.

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Transition Planning Components (continued)

IEP TO BE EFFECT AT AGE 15 AND 16:

- Must include all of the requirements from age 12/7th grade to review, update and if needed, revise IEP components.
- Review measurable postsecondary goals and update as needed.
- Reminder: age-appropriate transition assessment is an ongoing process. The data obtained through formal and informal assessments will be used to inform the transition components of the IEP.

IEPS TO BE EFFECT AT AGE 17 AND 18:

- Age 17 - Informing the student of the rights that will transfer, at least one year prior to the student's 18th birthday (must be documented).
- Age 17 – Provide instruction and information to the parent and student regarding the ways in which a student may provide informed consent to allow the parent to continue to participate in the student's educational decisions.
- Age 18 - Written notice of the transfer of rights to the student and parent when the student reaches his/her 18th birthday (must be documented)..

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SUMMARY OF PERFORMANCE

THE SUMMARY OF PERFORMANCE (SOP) DOCUMENTS A "CHILD'S ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE," INCLUDING "RECOMMENDATIONS ON HOW TO ASSIST THE CHILD IN MEETING THE CHILD'S POSTSECONDARY GOALS."

- The SOP is provided to a child whose eligibility for special education services has terminated "due to graduation from secondary school with a regular diploma, or due to exceeding the age eligibility for a free appropriate public education under State law" (Individuals with Disabilities Education Act of 2004 [IDEA], §614(c)(5)(B)).
- The SOP is useful to provide to postsecondary schools and programs to enable a student with a disability to obtain eligibility for Section 504 accommodations or modifications.
- Families and students must understand the implication of the SOP is it exits the student with a disability from ESE services, typically at the end of their graduation year.

Unless…

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DEFERRAL OF RECEIPT OF THE STANDARD DIPLOMA

ALL STUDENTS ENROLLED IN FLORIDA PUBLIC SCHOOLS WORK TOWARDS EARNING A STANDARD DIPLOMA. HOWEVER, CERTAIN STUDENTS WITH DISABILITIES MAY NEED TO EXTEND ENROLLMENT IN A SCHOOL DISTRICT PAST THE TIME THEY MEET GRADUATION REQUIREMENTS IN ORDER TO CONTINUE TO RECEIVE SUPPORTS AND SERVICES UNDER FREE AND APPROPRIATE PUBLIC EDUCATION (FAPE).

- A student with a disability who has an individual education plan that prescribes special education, transition planning, transition services, or related services through 21 years of age may continue to receive the specified instruction and services.
- Deferring receipt of a standard diploma is a process facilitated by an individual education plan (IEP) team that permits eligible students with disabilities an opportunity to continue FAPE (up through age 21 as determined by school districts) once students meet graduation requirements for a standard diploma.

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DEFERRAL OF RECEIPT OF THE STANDARD DIPLOMA (continued)

PER FLORIDA STATUTES § 1003.4282(8), THERE ARE TWO ESSENTIAL PARTS TO DEFERRAL ELIGIBILITY:

1. Has an individual education plan that prescribes special education, transition planning, transition services, or related services through age 21; and
2. Is enrolled in accelerated college credit instruction pursuant to s. 1007.27, industry certification courses that lead to college credit, an early college program, courses necessary to satisfy the Scholar designation requirements, or a structured work-study, internship, or pre-apprenticeship program.

Practice Tip: The decision to defer receipt of the standard diploma must be made by the IEP team and signed by a parent by no later than May 15th of the student's graduation year. It is important to lay this groundwork earlier though. *See* Florida Statutes § 1003.5716 and Rule 6A-109963, F.A.C..

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Special Needs Trusts

A SPECIAL NEEDS TRUST INCLUDES PROVISIONS DESIGNED TO PROTECT A CHILD OR AN ADULT WITH A DISABILITY'S PUBLIC BENEFITS WHICH ARE NEED-BASED (INCOME AND ASSET LIMITS)

- Beneficiaries of SNT's typically evidence a physical or mental disability that necessitates protection and oversight of their finances and public benefits.
- IEPs are typically requested by the Social Security Administration (SSA) and Medicaid to determine eligibility for disability-based benefits for disabled children.
- IEP's provide documentation of the individual's functional and academic levels which can be used to substantiate that the individual meets the criteria for public benefits.
- Trustees can use the IEP to better understand the limitations and abilities of the beneficiary of an SNT.

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Guardian Advocate

THE FLORIDA LEGISLATURE CREATED THE GUARDIAN ADVOCATE PROCESS AS AN EXPEDITED FORM OF GUARDIANSHIP FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

- The Florida legislature enacted the guardian advocate statute as an expedited form of guardianship for persons who have a specified developmental disability and reach 18, the age of majority.
- In Florida, a circuit court may appoint a guardian advocate, without an adjudication of incapacity, for a person with developmental disabilities if the person lacks the capacity to do some, but not all, of the tasks necessary to care for his or her person, property, or estate, or if the person has voluntarily petitioned for the appointment of a guardian advocate.
- A developmental disability is specifically defined as "a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.."
- At the hearing, the probate court will "consider all reports relevant to the person's disability, including, but not limited to, the person's current individual family or individual support plan, the individual education plan, and other professional reports documenting the condition and needs of the person."
- IEP teams are now required to inform parents and guardians that when their child reaches the majority age of 18, they will not be able to access their adult child's health records or take an active role in their IEP meetings unless they take legal action.

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Supported vs. Substituted Decision Making

MANY STATES INCLUDING FLORIDA REQUIRE ADVOCATES TO CONSIDER LESS RESTRICTIVE ALTERNATIVES TO GUARDIANSHIP WHEN APPROPRIATE.

- Florida along with certain other states has moved to a supported decision-making model to support persons with developmental disabilities when feasible. Florida Statutes § 709.2209.
- IEPs are a critical source of information for an advocate to assess the appropriate level of assistance, support, or oversight a person with a disability needs to maintain their independence to the maximum extent possible.
- In such cases, it will be necessary to ensure the person with a disability has the requisite capacity to authorize such decision-making instruments.
- Florida courts consider the least restrictive means available for safeguarding a person with a disability..

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ABLE Accounts

ABLE ACCOUNTS ARE TAX-ADVANTAGED SAVINGS ACCOUNTS FOR INDIVIDUALS WITH DISABILITIES.

- ABLE Accounts are tax-advantaged savings accounts for individuals with disabilities.
- ABLE accounts were created by the Stephen Beck Jr. Achieving a Better Life Experience Act of 2014 or ABLE Act.
- The ABLE Act limits eligibility to individuals with disabilities with an age of onset of disability before turning 26 years of age.
- If individuals meet this age requirement and are also receiving benefits under SSI and/or SSDI, they are automatically eligible to establish an ABLE account.
- If they are not a recipient of SSI and/or SSDI but still meet the age of onset disability requirement, they could still be eligible to open an ABLE account if they meet Social Security's definition and criteria regarding functional limitations and receive a letter of disability certification from a licensed physician or specialist.
- Accordingly, IEPs are another source of documentation that can be used to show the onset of the disability before the individual turned age 26.
- Florida participates in ABLE Accounts through ABLE United at: www.ableunited.com.

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Public Benefits

MOST PUBLIC BENEFITS PROGRAMS REQUIRE A SHOWING OF HOW THE DISABILITY IMPACTS MAJOR LIFE ACTIVITIES.

- Many public benefits programs rely on IEPs as a source of supporting documentation for benefits programs such as Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), Children's Medical Services (CMS) for Medicaid, Vocational Rehabilitation, and others.
- The Social Security Administration will typically request a copy of the IEP to determine if a child has "a physical or mental condition(s) that very seriously limits his or her activities."
- IEPs are often requested by postsecondary schools to verify eligibility for Section 504 or Americans with Disabilities Act (ADA) accommodations.
- Most IEPs are now created electronically which facilitates sharing the IEP with third parties.

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Contact Info:

Please feel free to contact me with any follow up questions or if you would like further information about the IEP development process.

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National Conference on Special Needs Planning and Special Needs Trusts

Friday
October 24, 2025

Passing the Baton: Trustee Resignation, Release, and Transition Challenges in Supplemental Needs Trusts

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Passing the Baton: Trustee Resignation, Release, and Transition Challenges in Supplemental Needs Trusts

Tara Anne Pleat, Esq.

I. Introduction

Supplemental Needs Trusts play a critical role in securing the long-term well-being of individuals with disabilities while preserving access to many means-tested public benefits. Many of these trusts will eventually face a key transition moment: the resignation of a trustee and the appointment of a successor. These transitions require thoughtful planning (when available), documentation, and a clear understanding of the legal and practical differences in the administration of first- and third-party SNTs.

II. Understanding the Trust Types: First-Party vs. Third-Party SNTs

Supplemental Needs Trusts (SNTs) are essentially "discretionary" spendthrift trusts, which by design allow a trustee to make distributions of any type for the benefit of a beneficiary with a disability. However, a supplemental needs trust will circumscribe this general grant of discretion by instructing the trustee not to exercise it in a fashion which would have an adverse impact on a beneficiary's eligibility for publicly or privately funded benefits, unless the trustee in the exercise of discretion determines that a distribution and the resulting impact on benefits is in the beneficiary's best interest.[1] If drafted properly, the principal and accumulated income of such trusts (both first-party and third-party, discussed below) are treated as "exempt" in determining financial eligibility for many means-tested government benefits.

While all supplemental needs trusts will follow this general rule, there are two discrete subsets of supplemental needs trusts: first-party supplemental needs trusts and third-party supplemental needs trusts. The line of demarcation between the two is drawn to identify the *source* of the property used to fund the trust and not necessarily the name of the settlor or beneficiary of the trust instrument, a fact which can lead to confusion for the practitioner and client alike.

Supplemental needs trusts which are designed to hold the property of *someone other than the person with the disability* are most commonly referred to as third-party supplemental needs trusts and will be referenced as such throughout this article. These are to be contrasted with supplemental needs trusts, which are designed to hold the property of *the person with the disability*, which will be referred to throughout as first-party supplemental needs trusts.[2]

Intuitively, this distinction makes sense. A third-party (defined in this context as someone other than the beneficiary, as well as someone other than a person who has a legal responsibility to support the beneficiary) can do with his or her property whatever he or she may want, including disinheriting the beneficiary with the disability altogether. To the extent the third party would like to create a trust that explicitly limits the availability of

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[1] Practitioners should confirm if their state law permits these kinds of distributions if they do in fact supplant available public benefits.

[2] These trusts are also referred to as self-settled trusts, OBRA '93 trusts, or (d)(4)(A) trusts (the latter two references being the common name and the relevant subsection of the federal legislation that authorized their use).

trust funds so that the beneficiary can continue to receive benefits from the Medicaid program or otherwise, the third party should have the right to do so.

By way of contrast, if an individual with a disability already owns assets that would otherwise need to be exhausted before government benefits were available, then there must be some accommodation in the rules of the benefit program itself before those assets can be disregarded. This accommodation is found in the federal Medicaid and Supplemental Security Income (SSI) statutes themselves.[3] Both of these benefit programs, which might otherwise penalize an applicant for divesting himself of assets that could be used for support (SSI) or medical care and services (Medicaid), have provided an *exception* to these general rules for assets that have been transferred to a first-party supplemental needs trust.[4] If the trust is properly drafted, the transfer of property to the trust will not disrupt benefit program eligibility, and the principal and accumulated income of the trust will be exempt from consideration while in the hands of the trustee.

Stated more simply, First-party SNTs are funded with the assets of the individual beneficiary, often because of litigation, inheritance, or retroactive benefit awards. These trusts are governed by federal law under 42 U.S.C. § 1396p(d)(4)(A) and must include a Medicaid payback provision, requiring reimbursement to the state upon the death of the beneficiary. They are often court-supervised and created through settlement proceedings, meaning any changes—including trustee resignation or distribution changes—may require judicial approval.

Third-party SNTs, by contrast, are funded with assets belonging to someone other than the beneficiary—typically a parent or grandparent. They are not subject to Medicaid payback requirements and tend to allow more flexibility in administration. Many third-party SNTs are privately drafted and do not require court oversight unless incorporated into a court settlement.

III. Beginning with the end in mind

One of the most effective ways to avoid complications during a trustee transition is to draft the trust instrument (whenever possible) with resignation and succession procedures clearly defined.

To simplify future transitions and reduce the risk of court or agency entanglement, careful drafting is essential. Trust instruments should name successor trustees outright or establish a clear mechanism for their appointment.

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[3] 42 U.S.C. §§ 1396p(d)(4)(A), 1382b(e)(5). Other program rules (Section 8, Food Stamps, etc.) treat transfers to first-party supplemental needs trusts in different ways. For trust beneficiaries participating in more than one program, attention should be given to each specific program's criteria.

[4] In New York, in 96 ADM-8, *OBRA '93 Provisions on Transfers and Trusts*, New York State Department of Social Services Transmittal (March 29, 1996), first-party supplemental needs trusts are referred to as "exception" trusts, reflecting the fact that contributions to such trusts do not generate a period of ineligibility for institutional-level Medicaid services.

Even when successor trustees are named in advance, transitions can falter if those individuals are unwilling or unable to serve when the time comes. Common reasons include lack of available funds to justify professional involvement, complex lifetime beneficiary needs, challenging family dynamics, or simply personal circumstances such as health or relocation. To avoid administrative dead-ends, trust instruments should include flexible provisions that allow for removal and replacement of named successors without court intervention, while preserving fiduciary integrity and beneficiary protections. For example:

> ***TRUSTEE'S NAME*** *and* ***TRUSTEE'S NAME*** *shall be the initial Co-Trustees of this Trust, with authority to serve independently of each other.*
>
> *If either* ***TRUSTEE'S NAME*** *or* ***TRUSTEE'S NAME*** *is removed by an order of a Court having competent jurisdiction, dies, becomes incapacitated, or is otherwise unwilling or unable to serve as Trustee, the remaining one of them shall serve as sole Trustee of the Trust.*
>
> *If both* ***TRUSTEE'S NAME*** *and* ***TRUSTEE'S NAME*** *are removed by an order of a Court having competent jurisdiction, die or are otherwise unwilling or unable to serve as Co-Trustees, the Grantor**s** nominate, constitute, and appoint*
> *as successor Trustee of this Trust.*
>
> *Notwithstanding the foregoing, the Grantor**s** (acting jointly while both are still living, or by the surviving Grantor if one has passed), shall retain the power to change the identity, succession, or otherwise amend the Trustee appointment provisions of Article IX of this Trust with or without cause, provided, however, that any corporate Trustee so appointed must be authorized to provide fiduciary services in the State of New York. Under no circumstances shall the Beneficiary be named as a Trustee. Any such amendment shall be made through a written and acknowledged statement by the Grantor**s**, and notice shall be provided to the same individuals and in the same manner outlined in paragraph E of this Article IX.*
>
> *In order to make prudent decisions in the exercise of this power,* ***both Grantors*** *shall be entitled, upon request, to copies of all financial statements related to this Trust* ***and any Trust created hereunder****. Upon the death of* ***both Grantors****, then _____ shall have the authority*

to exercise this power. If _____ is unable to exercise this power for any reason, then shall have the authority to exercise this power. The individual or individuals who are named herein to exercise this power shall be known as "Trustee Monitor(s)."

*The position of "Trustee Monitor" is not a fiduciary position or role and Grantor**s** direct that no Trustee Monitor shall be held to fiduciary standards due to his or her role as a Trustee Monitor. The Grantor**s** direct that no Trustee Monitor shall be found to have any duty and shall not incur any liability by reason of any error of judgment, mistake of law, or action of any kind taken or not taken, in connection with his or her actions or inactions as Trustee Monitor. Each Trustee Monitor shall be fully indemnified from the trust property against any claim or demand by any trust beneficiary or trust creditor or any other party relating to the administration of this Trust.*

*The Grantor**s** have created the position of Trustee Monitor so that trusted individuals may take steps, as provided for in this Trust Agreement, to help _____ by providing advocacy and support through communication with the Trustees, or by removing and replacing the Trustees without necessitating court involvement. If the Trustee Monitor does not act, then Court action remains available, just as Court action would otherwise be available to any beneficiary.*

*The Trustee Monitor may help to avoid the stress and expense of Court action by using the authority the Grantor**s** have provided in this Trust Agreement. But the future is uncertain and under no circumstances shall any Trustee Monitor acquire any duty to monitor this Trust or any duty to take action, and the Grantor**s** want to ensure that a Trustee Monitor is not punished by being held to a fiduciary standard simply because a Trustee Monitor may take action with respect to this Trust. Further, in the event a Trustee Monitor does take action with respect to this Trust, such action shall not be viewed as an assumption of ongoing responsibility, and the provisions of this section shall continue to apply.*

This type of clause ensures continuity in administration even when transitions do not go according to plan. It also empowers trust stakeholders to keep the trust functioning without unnecessary delay or litigation, especially in emotionally or financially strained

situations. In cases where the Trust beneficiary is competent, if there is no adverse treatment under state Medicaid law, the beneficiary can be given the authority to remove and replace or fill a vacancy in Trusteeship.

When possible, the Trust should be drafted to contemplate resignation without court approval and a mechanism for the release of a resigning Trustee. For Example:

> *A Trustee may resign at any time by giving a written and acknowledged notice, either delivered personally or sent by registered mail at least thirty (30) days prior to the effective date of such resignation, to the Co-Trustee, if one is then serving, to the Grantors, to the Beneficiary, (or if the Beneficiary shall be under a legal disability, to the Beneficiary's court appointed guardian or duly appointed agent), and to the then-serving Trustee Monitor(s). If at the time of resignation, the successor Trustee designated hereunder is unable or unwilling to serve, or if no successor has been designated by the Trustee Monitor(s) serving at the time, then the resigning Trustee shall have the authority to appoint an individual or corporate Trustee to serve authorized to provide fiduciary services in the State of New York.*
>
> *Any resignation pursuant to the provisions herein shall become effective immediately upon required notice to all parties, but no later than thirty (30) days after such written notice shall have been delivered as provided for herein. On or before the effective date of the resignation, the resigning Trustee shall deliver to the successor Trustee and to those persons entitled to notice of resignation a statement of all receipts and disbursements of the Trust, together with an inventory of the assets belonging to the Trust. In addition, the resigning Trustee shall transfer physical possession of the assets of the Trust to its successor. Thereafter, the resigning Trustee shall be discharged of any further duties and obligations as Trustee, although no Trustee shall be fully released from liability for its administration of the Trust prior to resignation without a judicial settlement of its accounts by a court of competent jurisdiction, or upon agreement by all interested parties at the time of such resignation. A duly appointed Agent under Power of Attorney or court-appointed Guardian shall have the authority to settle any such accounting on behalf of any beneficiary and to do so without Court involvement.*

Including a detailed resignation provision within the trust instrument offers a clear, efficient roadmap for trustee transitions without immediate court involvement. By specifying notice requirements, authority to appoint a successor in the absence of a designated replacement, and obligations for asset transfer and interim accounting, this clause ensures continuity of administration and reduces the risk of disruption to the beneficiary's support. It also balances practical efficiency with accountability by preserving the option for judicial settlement or informal approval by interested parties, providing flexibility for both private and court-supervised trusts.

IV. The Resignation Process: Steps and Requirements

Procedurally, the resignation of a trustee should begin with formal notice to all relevant parties, including co-trustees, the successor trustee, current and remainder beneficiaries, and the applicable Medicaid agency (in the case of a first-party trust). If the trust is court-supervised, the resignation must often be approved by the court, particularly where the trust was created under judicial authority.

Before initiating a resignation, a trustee has a continuing duty to (and should as a matter of practice) ensure that the transition will not jeopardize the trust's integrity or the beneficiary's well-being. This means updating and organizing all trust records, including financial statements, disbursement logs, correspondence with public benefits agencies, case managers and any care-related documentation. If an informal accounting has not been prepared recently, the trustee should compile one to provide a clear snapshot of the trust's current position and recent activity. Outstanding obligations, such as pending disbursements, reimbursements, or vendor payments, should be identified and either fulfilled or documented for the successor trustee.

Equally important is a coordinated handoff to the successor. This includes not only the transfer of trust assets and records but also practical onboarding support: making introductions to care managers or public benefits caseworkers if there is no formal (private case manager) or informal support (parent, family member or otherwise) managing this transition and ensuring that regular disbursement schedules are not disrupted. Whether this transition requires judicial approval depends on the trust instrument and applicable state law. In many jurisdictions, court approval is mandatory for resignations court-created trusts (whether testamentary or a first-party SNT), even if the trust document itself provides an alternative mechanism. When court approval is involved, the Trustee should be prepared to formally account for its activities as Trustee.

V. Accounting and Trustee Release[5]

At some point, every trustee seeking to be discharged must account to its beneficiaries. If those beneficiaries are competent and willing, they can "settle" the trustee's accounting voluntarily and without court order. This is often not an option for Trustees of Trusts who have a beneficiary who has diminished or diminishing capacity.

Some courts provide forms that trustees must use in summarizing financial activity. Some court forms are very simple, requesting only opening and ending balances and a summary of distributions made over the accounting year. Others are more elaborate and track unrealized gain and loss, allocate expenses to principal and income, and allow the trustee to provide additional information on explanatory schedules.

Used here, the term "informal accounting" refers to accountings which are filed with a court, an agency, or presented to a beneficiary for informational purposes. In some cases, they are required by statute, by court order or by the terms of the trust document. In others they are not required but are prepared voluntarily by a trustee to keep the beneficiaries informed of trust activity.

The format used for an informal accounting can vary. A year-end financial statement that a trustee provides to a beneficiary could be considered an informal accounting. A checkbook ledger and accompanying bank statements might be appropriate in some circumstances. If a trustee is required to account by court order and the court has a preferred form, then the trustee will use that form. If there is no court filing requirement, a trustee wishing to keep its beneficiaries informed of trust activity can use whatever form it deems appropriate. Some trustees may send financial statements, others may use a more elaborate format similar to what would be used in an estate accounting.

A proceeding for "judicial settlement" involves a petition to a court asking for review and approval of the trustee's accounting.[6]

State variation on accounting requirements

There is no requirement under the federal or many state statutes that a trustee prepare annual accountings of any type or with any frequency.[7] As a result, many trusts that are

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[5] This section of the materials is adapted from an article prepared by this author co-authored with Edward V. Wilcenski for the National Academy of Elder Law Attorneys (NAELA) newsletter and subsequently published in the New York State Bar Journal in a series of three articles. *See* Edward V. Wilcenski & Tara Anne Pleat, *Administration of Supplemental Needs Trusts, an Improved Approach*, New York State Bar Journal, Part 1 Mar. 2019 at 12 , Part 2 Mar. 2020 at 22, Part 3 Apr. 2020 at 40.

[6] These proceedings are filed with notice to all interested parties. In New York, the form of the accounting which must accompany the petition is promulgated by the Chief Administrator of the State of New York and is comprehensive. *See* SCPA § 106; Official Form JA-4, "Trust Accounting With Instructions".

[7] Such is the case in New York, where there is no statutory, regulatory, or administrative requirement that a trustee of any trust prepare annual accountings. Matter of Kaidirmouglou, NYLJ November 5, 2004 at page 28 (Sur. Ct. Suffolk Co. 2004); Matter of KeyBank, 58 Misc.3d 235 (Sur. Ct. Saratoga Co. 2017); Matter of Feuerstein, 147 A.D.3d 688 (First Dept. 2017).

managed for beneficiaries with diminished capacity are administered without ongoing oversight. If the trustee wants to resign during the beneficiary's life or seeks to have its accounts settled upon the beneficiary's death, the trustee's discretionary decisions will be subject to second guessing inherent in proceedings for judicial settlement of multi-year accountings.

The proactive trustee can mitigate the risk of belated challenge by keeping the beneficiaries regularly informed of trust activity, but the effectiveness of this approach will be determined in part by the accounting format used, the frequency of the disclosure, and the capacity of the beneficiary.

Accounting considerations for the SNT Trustee

The aspects of administration of trusts for individuals with diminished or diminishing capacity, communication challenges, unfamiliar government benefit programs in the context of SNTs, and the inability to informally settle accounts – present unique risks for these trustees.

Given these risks, a prudent trustee might be inclined to seek judicial approval of its actions on a regular – and perhaps an annual – basis. The trustee could petition for judicial settlement of its accounting or could seek "advice and direction" on a proposed distribution plan. Both proceedings present risks of their own, and neither approach – if undertaken annually - would be cost effective.

A trustee could present a formal accounting for judicial settlement on an annual basis.[8] Where the beneficiary has a cognitive disability, and regardless of whether a property guardian has been appointed, most courts will appoint a guardian *ad litem*. Some guardians *ad litem* are attorneys with significant experience with individuals with diminished and diminishing capacity, but many are not. Inexperienced guardians *ad litem* can complicate a proceeding for settlement.

Recommendations regarding accounting

To manage and mitigate risk, the trustee should take the following steps:

1. In states where an annual accounting is not required, the trustee should prepare an informal accounting of trust activity on an annual basis, and provide copies of the accounting to the beneficiary with the disability (if competent, or to the court appointed guardian or agent under power of attorney if not) and to the Medicaid program representative if the trust is a first party Supplemental Needs Trust.[9] If the beneficiary is a minor, the beneficiary's parents should also receive a copy.

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[8] SCPA 2208(3)(b).

[9] In the author's first party supplemental needs trust practice we provide copies of annual accountings to the Medicaid program representatives, and in our third-party trust practice to remainder beneficiaries when possible and practical.

In the context of Supplemental Needs Trusts the informal accounting should clearly delineate distributions which would have an impact on benefit eligibility, or which provide a derivative benefit to third parties, and should include clarifying information in the explanatory schedules as appropriate.

Finally, the informal accounting should be prepared in the same format that would be required in a proceeding for judicial settlement so that the trustee can move quickly to have its accounts settled if any party receiving a copy raises an issue.

2. On a periodic basis, the trustee's accounts should be judicially settled. Even if a trustee is providing comprehensive informal accountings on an annual basis to all beneficiaries and none of the beneficiaries raise an issue, the trustee should nonetheless petition for judicial settlement after several years in order to wipe the slate clean. Frequency will depend on a number of factors. If a trustee is making regular and significant distributions from a well-funded trust, it might petition for judicial settlement every few years. If the trust is modestly funded and relatively inactive, it might petition less frequently.

Circumstances which can complicate the settlement of a trustee's accounting (whether informally by agreement or by court order) are familiar to attorneys who represent trustees in contested accounting proceedings. Older financial records are lost or unavailable, a common occurrence in an era of bank consolidation. Trust officers retire, taking with them the first-hand knowledge of a beneficiary's circumstances and the basis for certain discretionary distributions. Relationships with beneficiaries may sour over time, increasing the likelihood of objections.

For trustees of trusts where the beneficiary is compromised in some way, there are additional variables and uncertainties. In the context of Supplemental Needs Trusts government benefit program rules change over time, and a distribution that might have had no impact on a particular benefit under a prior policy may now result in a penalty. New programs might emerge which provide funding for services that the trustee has been paying for with trust funds for many years. Finally, attorneys who represent the Medicaid program (in First Party Supplemental Needs Trusts) in proceedings for judicial settlement also retire, and their replacements may take a much more adversarial approach in settlement proceedings. Periodically seeking judicial settlement puts all parties on notice – the beneficiary with the disability, the Medicaid program (for first party Supplemental Needs Trusts), and the remainder beneficiaries – and requires them to present their objections for review by the court.

3. For significant transactions or transactions which would clearly result in a derivative benefit to someone other than the beneficiary that is not specifically contemplated in the Trust instrument, the trustee should consider seeking prior court approval.

This approach – comprehensive informal annual accountings, regular petitions for judicial settlement, and periodic applications for court approval - is antithetical to

traditional estate planning, where attorneys try to limit administrative expense and judicial oversight when drafting trusts, and where trustees try to avoid interaction with the courts. Advocates and family members may be concerned over the financial impact of this approach on the availability of funds for the trust beneficiaries who have trusts of more limited amounts. These are understandable concerns.

On the other hand, attorneys and other advocates do a disservice to beneficiaries and trustees when they fail to explain the level of exposure faced by the trustee (especially in the context of First Party supplemental needs trusts), or when they try to draft around the formalities associated with trust administration. If all trust beneficiaries are competent and capable of self-advocacy, estate planners can draft documents to minimize administrative responsibilities and the associated costs. If a trustee cuts corners in keeping records, providing financial statements, or filing tax returns, the beneficiaries may decide to look the other way rather than endure the time and expense of a formal accounting.

But such informal settlement is typically not an option for trusts with compromised beneficiaries, especially first party Supplemental Needs Trusts where the Medicaid program is one of the interested parties. Medicaid's priorities are contrary to those of the beneficiary with the disability and the remainder beneficiaries. The less the trustee spends during the beneficiary's life, the more that this statutory creditor will recover upon the beneficiary's death.

Informal accountings prepared and presented on an annual basis create a record of full disclosure which may serve as a basis to defend against objections in a proceeding for judicial settlement,[10] periodic judicial settlement limits the trustee's ongoing risk, and petitions for advice and direction protect future distributions from later challenge. And this is the case for all trust administrations

A trustee should not consider themselves fully released from fiduciary responsibility until either the court has approved the accounting and formally granted a discharge, or the successor trustee and all relevant beneficiaries (or their legal representatives) have executed a written release. Without such a release, a resigning trustee may remain exposed to future claims alleging breach of duty, mismanagement, or failure to properly administer the trust during their tenure. Proper documentation and formal closure are essential to protect the outgoing trustee from ongoing liability.

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[10] In New York, the failure to object may be considered 'ratification' and serve as a basis for a motion to dismiss the objections of an informed remainderman. Rajamin v. Deutsche Bank Nat'l Trust Co., 757 F.3d 79 (2d. Circuit 2014). Would the Medicaid program be similarly bound? One might argue that a government agency cannot be estopped. *See* Oxenhorn v. Fleet Trust Co., 94 NY2d 110 (1999). This position fails to recognize that in New York, the Medicaid program is named as a beneficiary by statute (N.Y. Social Serv. L. 366(2)(b)(*2*)(v)). In a state court proceeding for settlement of a trustee's accounts, the Medicaid program's interest should be no greater and no less than that of any other remainder beneficiary.

VI. Challenges in Transition

Even with careful drafting and a proactive approach, trustee transitions are rarely seamless. One of the most common challenges is documentation gaps, when records are incomplete, disbursement logs are disorganized, or communication histories supporting trust distributions are limited. These deficiencies can leave the successor trustee without a clear picture of the trust's financial standing or the beneficiary's current needs, and may result in their becoming unwilling to take on the role. This can be common in long standing trusts where there have been prior Trustee changes that were handled informally and now the current Trustee wishes to resign and obtain a full release.

In trusts subject to court supervision, especially first-party SNTs established through litigation or Guardianship proceedings, even routine transitions can require formal petitions and judicial approval depending on the applicable jurisdiction. Re-petitioning the court for distributions or to confirm a new trustee may be unavoidable, and local practice can vary significantly. Moreover, interpersonal conflict between family members or between professional and lay fiduciaries often complicates transitions, particularly when parties disagree about timing, control, or accountability. These issues can delay the acceptance of accountings or the execution of releases.

VII. Conclusion

Trustee resignation and succession in the context of Supplemental Needs Trusts is more than a procedural formality, it can be a fiduciary crossroads with lasting consequences for beneficiaries, families, public benefits, and future administration. Whether managing a first-party trust requiring court supervision and Medicaid oversight, or a privately administered third-party trust with greater drafting flexibility, the importance of careful planning, clear documentation, and appropriate judicial or beneficiary oversight cannot be overstated.

Trustees must navigate unique risks tied to diminished beneficiary capacity, shifting public benefits landscapes, and complex family dynamics, all while ensuring that transitions do not disrupt the essential support these trusts are designed to provide. Incorporating detailed transition provisions at the drafting stage when permissible and possible, maintaining consistent informal accountings, and embracing a proactive approach to successor appointments and releases can protect both trustees and downstream beneficiaries—ensuring continuity, reducing conflict, and upholding the trust's long-term purpose.

Passing the Baton: Trustee Resignation, Release, and Transition Challenges in Supplemental Needs Trusts

A Practical Guide for First- and Third-Party SNT Transitions

1

Overview

- Supplemental Needs Trusts (SNTs) preserve public benefit eligibility.
- Trustee transitions are inevitable and must be planned for.
- Different rules apply for first-party and third-party SNTs.
- Proper drafting and documentation are essential to avoid disruption.

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First-Party vs. Third-Party SNTs

- First-Party: Funded with beneficiary's own assets.
- Requires Medicaid payback; often court-supervised.
- Third-Party: Funded by others; no Medicaid payback.
- Typically, more flexible and less court-involved.

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3

Drafting for Transitions

- Name successor trustees and backup mechanisms.
- Include authority to approve accountings and releases.
- Allow non-judicial transition where permitted.
- Incorporate provisions for Medicaid payback in first-party SNTs.



4

Challenges in Successor Appointments

- Successors may decline due to lack of funds or complexity.
- Include flexible provisions to remove/replace unwilling successors.
- Use roles like Trustee Monitor to avoid court involvement.
- Maintain administrative continuity during transitions.



5

Resignation Provisions Sample

- 30 days written notice to key parties.
- Successor appointment authority if designated party unavailable.
- Final report of trust activity and asset transfer required.
- Full release only upon court settlement or party agreement.
- Permit transfer to Pooled Trusts?



6

Pre-Resignation Checklist

- Update and organize trust records.
- Prepare informal accounting.
- Identify pending disbursements.
- Coordinate asset and knowledge transfer to successor.

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Transition Risks

- Missing records delay handoff.
- Successor delays disrupt benefits.
- Court re-entry may be required.
- Family conflict complicates releases.
- Benefits interruption from poor timing.

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8

Accounting & Release Considerations

- Informal accountings promote transparency.
- Regular judicial settlement reduces long-term risk.
- Format informal reports to mirror formal court accountings.
- No full release until court approval or written agreement.

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9

Best Practices for Trustees

- Provide annual informal accountings to beneficiaries and agencies.
- Petition for judicial settlement periodically.
- Seek court approval for significant or third-party benefit transactions.
- Balance efficiency with legal protection.

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10

Conclusion

- Trustee transitions are high-stakes moments in trust administration.
- Proactive drafting and regular disclosures protect all parties.
- Plan to avoid disruption and preserve public benefits.
- With a proactive process and good planning when available, the baton can be passed smoothly.

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Thank you

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2025 Tax Update

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Tax Update
One Big Beautiful Bill Act (OBBBA-OB3 Act)

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1

"OB3 Act" or "OBBBA"

- Signed by President Trump on July 4, 2025. Public Law 119-21, formally titled "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14" but commonly known as the "One Big Beautiful Bill Act" ("the OB3 Act" or "OBBBA").
- The OB3 Act is 330 pages. 175 of the 330 pages are changes to the Internal Revenue Code.
- The OB3 Act made permanent most of the provisions of the 2017 Tax Cuts and Jobs Act (TCJA) that were scheduled to sunset at the end of 2025.

2

Provisions Still Set to Expire at the End of 2025

- The OB3 Act did not extend all the provisions from the 2017 Act that are scheduled to sunset at the end of 2025. Here is a partial list of provisions set to expire at the end of 2025:
  - The §51 work opportunity credit;
  - The §108(a)(1)(E) exclusion from gross income of discharge of indebtedness on a principal residence;
  - The 7-year recovery period for motorsports entertainment complexes under §168(e); and
  - Several of the empowerment zone tax incentives, including empowerment zone tax-exempt bonds under §1394 and the empowerment zone employment credit in §1396.

3

Federal Income Tax Brackets for 2025

Taxable Income Exceeding		Ordinary Income	Adjusted Net Cap Gain* & Qualified Dividends	Medicare Surtax on Earned Income**	Medicare Surtax on Net Investment Income
Single	Married Filing Jointly				
$0	$0	10%	0%	2.9%	0%
$11,925	$23,850	12%			
$48,350	$96,700		15%		
$48,475	$96,950	22%			
$103,350	$206,700	24%			
$197,300	*AGI over $250,000*	32%			
AGI over $200,000	$394,600			3.8%	3.8%
$250,525	$501,050	35%			
$533,400	$600,050		20%		
$626,350	$751,600	37%			

4

Federal Income Tax Rates Trust and Estates for 2025

Taxable Income Exceeding	Ordinary Income	Adjusted Net Cap Gain* & Qualified Dividends	Medicare Surtax on Net Investment Income
$0	10%	0%	0%
$3,150	24%		
$3,250		15%	
$11,450	35%		
$15,650	37%		
$15,900		20%	3.8%

5

Personal Exemptions Trusts-Estates

- The 2017 Act effectively repealed the deduction for personal and dependency exemptions for the years 2018 through 2025 by reducing the exemption amount in those years to zero.
- The 2017 Act expressly retained the regular personal exemption for “qualified disability trusts,” and the nominal personal exemptions currently in play for estates ($600) and trusts ($100 or $300).

6

Standard Deduction

Filing Status	2017 Standard Deduction	2018 Standard Deduction	2025 Standard Deduction (Pre-OB3 Act)	2025 Standard Deduction (Post-OB3 Act)
Married Filing Jointly	$12,700	$24,000	$30,000	$31,500
Head of Household	$9,350	$18,000	$22,500	$23,625
Unmarried	$6,350	$12,000	$15,000	$15,750
Married Filing Separately	$6,350	$12,000	$15,000	$15,750

7

Additional Standard Deduction

- The OB3 Act makes no changes to the inflation-adjusted additional standard deduction amount available to blind taxpayers and those age 65 and over. For 2025, the additional standard deduction amount for "the aged or the blind" is $1,600, or $2,000 if the taxpayer is also unmarried and not a surviving spouse.

8

Senior Deduction

A "qualified individual" (one who has attained the age of 65 before the end of the taxable year) receives a personal exemption deduction of $6,000.

A married couple can claim two exemptions on a joint return if both spouses have reached age 65 before the close of the taxable year.

The "senior deduction" is in effect from 2025 through 2028.

- The amount of the senior deduction is reduced once the taxpayer's modified adjusted gross income exceeds $75,000 for a single person, and $150,000 for a married couple filing a joint return.
- The senior deduction is reduced to zero once the taxpayer's modified adjusted gross income exceeds $175,000 for a single person and $250,000 for married couples filing jointly.

9

Child Tax Credit

Child Credit Feature	2001 - 2017	2018 - 2024*	2025 - beyond
Credit Amount	$1,000 per child	$2,000 per child; $500 per other dependent	$2,200 per child (as adjusted for inflation); $500 per other dependent
Phaseout Begins when AGI exceeds... Unmarried & Head of Household Joint Filers	 $75,000 $110,000	 $200,000 $400,000	 $200,000 $400,000
Phaseout Complete when AGI hits... Unmarried & Head of Household Joint Filers	 $95,000 $130,000	 $240,000 $440,000	 $240,000 $440,000
Refundable Portion	15% of earned income in excess of $3,000	15% of earned income >$2,500, not to exceed $1,400 per child (as adjusted for inflation)	15% of earned income >$2,500, not to exceed $1,400 per child (as adjusted for inflation)

10

Qualified Business Income Deduction

- The 2017 Act introduced §199A, which generally gives a qualifying taxpayer a deduction equal to 20 percent of the taxpayer's "qualified business income" ("QBI"). To qualify for the deduction, one must be a partner in a business entity taxed as a partnership, a shareholder of an S corporation, or a sole proprietor engaged in a trade or business. C corporations and its shareholders do not qualify for the deduction, nor do employees.

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Qualified Business Income Deduction

- Two restrictions on the QBI deduction apply once a taxpayer's taxable income exceeds a certain threshold. In 2025, that threshold is $197,300 ($394,600 for married couples filing a joint return). The first restriction is that if the business is a "specified service business."
- (1) involves the performance of services in the fields of health, law, accounting, actuarial science, performing arts, consulting, athletics, financial services, or brokerage services;
- (2) has as its principal asset the reputation or skill of one or more of its employees or owners; or
- (3) involves the performance of services consisting of investing and investment management, trading, or dealing in securities, partnership interests, or commodities),
- The deduction is reduced to zero once the taxpayer's taxable income is more than $50,000 over the threshold (or more than $100,000 over the threshold in the case of a married couple filing jointly).

12

Alternative Minimum Tax

- Individuals, estates, and trusts are subject to the alternative minimum tax (AMT). The minimum tax imposed is the amount by which tentative minimum tax exceeds the regular income tax liability for the year. There is a "tentative minimum tax" when "alternative minimum taxable income" (AMTI) exceeds the exemption amount. Taxpayers with high AMTIs face a phaseout of the exemption amount.
- The OB3 Act extends the higher exemptions and phaseouts indefinitely. Although the 2026 amounts are yet to be determined, the following table indicates the effect of the extensions:

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Alternative Minimum Tax

	2017			2018			2025		
Taxpayer	Joint Filers	Single	Estates and Trusts	Joint Filers	Single	Estates and Trusts	Joint Filers	Single	Estates and Trusts
AMT Exemption Amount	$84,500	$54,300	$24,100	$109,400	$70,300	$24,600	$137,000	$88,100	$30,700
Exemption phaseout begins when AMTI exceeds	$160,900	$120,700	$80,450	$1,000,000	$500,000	$82,050	$1,252,700	$626,350	$102,500

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Federal Estate Tax Exclusion Amount

- The 2017 Act doubled the basic exclusion amount under §2010(c)(3) from $5 million to $10 million with adjustments for inflation after 2011. The 2017 Act provided that the basic exclusion amount would revert to $5 million (adjusted for post-2011 inflation) after 2025. The OB3 Act prevents the reduction by resetting the basic exclusion amount to $15 million starting in 2026, with adjustments for inflation after 2026.
- The OB3 Act makes no changes to the portability election.
- The application of §1014, which provides a fair-market-value-at-date-of-death basis for property acquired from a decedent.

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Federal Estate Tax Exclusion Amount

For decedents dying in	The basic exclusion amount is	For decedents dying in	The basic exclusion amount is
2011	$5,000,000	2018	$11,180,000
2012	$5,120,000	2019	$11,400,000
2013	$5,250,000	2020	$1,158,000
2014	$5,340,000	2021	$11,700,000
2015	$5,430,000	2022	$12,060,000
2016	$5,450,000	2023	$12,920,000
2017	$5,490,000	2024	$13,610,000
		2025	$13,990,000
		2026	$15,000,000

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Charitable Deduction

- OB3 Act restores the special rule from 2021 that allows individuals who do not itemize their deductions to claim a "partial" deduction for charitable contributions of cash to public charities in the computation of taxable income. A deduction of up to $1,000 for a single person and $2,000 for joint filers.
- OB3 Act makes permanent the increase in the deduction limit for cash contributions to charitable organizations. Under prior law, a taxpayer could not deduct cash contributions in excess of 50% of the taxpayer's "contribution base" which is in most cases an amount equal to the taxpayer's adjusted gross income.

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Charitable Deduction

- For example, if a taxpayer donated $100,000 cash to a qualified charitable organization in a year in which the taxpayer's contribution base was $150,000, the taxpayer could deduct only $75,000 of the contribution in the year of donation. The remaining $25,000 would carry over to the next year as though the cash contribution was made in that year.

18

Charitable Deduction

- OB3 Act adds new §170(b)(1)(I) which imposes a 0.5-percent floor on donations by individuals.
- An individual can only deduct otherwise allowable charitable contributions to the extent such contributions, in the aggregate, exceed 0.5 percent of the taxpayer's contribution base.
- For example, if an individual taxpayer with a 2026 contribution base of $100,000 donates $10,000 to charity, the taxpayer can only deduct $9,500 in 2026 (0.5 percent of $100,000 =$500). Amounts disallowed under this rule carry over for up to five taxable years.

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Miscellaneous Itemized Deductions

- Prior to 2018, §68 generally reduced the amount of otherwise allowable itemized deductions once a taxpayer's adjusted gross income exceeded a certain inflation-adjusted threshold. In 2018, that threshold was $320,000 for married couples and $266,700 for unmarried individuals. For taxpayers with very high adjusted gross incomes, up to 80% of itemized deductions could be lost under this rule. But the 2017 Act suspended the application of this phaseout for the years 2018 through 2025.
- Starting in 2026, the amount of itemized deduction otherwise allowable for the taxable year shall be reduced by 2/37 of the lesser of: (1) the amount of such itemized deductions, or (2) the amount by which the taxpayer's taxable income (increased by the amount of itemized deductions)exceeds the dollar amount at which the 37% bracket begins with respect to the taxpayer.

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Miscellaneous Itemized Deductions

- For example, in 2026 an unmarried individual has an adjusted gross income of $1,000,000 and otherwise allowable itemized deductions of $100,000. Assume for 2026, the 37% bracket for unmarried individuals starts once taxable income exceeds $650,000. Under new §68, the individual's itemized deductions would be reduced by $5,405, computed as follows:
- Lesser of –
- (1) 2/37 of $100,000 in itemized deductions: $ 5,405, or
- (2) 2/37 of $350,000 excess of $1,000,000 taxable income over $650,000 threshold for 37% tax bracket $18,919
- $5,405 or the single individual's allowable itemized deduction is $94,595.

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Miscellaneous Itemized Deductions

- If the individual's adjusted gross income was only $700,000, §68 would reduce the itemized deductions by only $2,703:
- *Lesser of –*
- *(1) 2/37 of $100,000 in itemized deductions: $5,405*
- *or (2) 2/37 of $50,000 excess of $700,000 taxable income over $650,000 threshold for 37% tax bracket $2,703*
- ***$2,703***

22

Miscellaneous Itemized Deductions Trust and Estates

- Prior to OB3 Act, section 68(e) had a specific exception for the application of the limitation of miscellaneous itemized deductions for estates and trusts. OB3 Act removed the section 68(e) exception for estates and trusts. Thus, the same limitation that applies to individual taxpayers will now apply to estate and trusts.
- With the compressed tax brackets for estates and trusts, the 2/37th limitation is estimated to at $16,000 of taxable income (depending on inflation adjustments for 2026).

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Miscellaneous Itemized Deductions Trust and Estates

- For example, if a Complex Trust's gross income was $50,000 and had $25,000 of allowable miscellaneous itemized deductions. Assume for 2026, the Trust 37% tax bracket begins at $16,000. Section 68 would reduce the itemized deductions by:
- *Lesser of –*
- *(1) 2/37 of $25,000 in itemized deductions: $1,351.*
- *or (2) 2/37 of $34,000 excess of $50,000 taxable income over $16,000 threshold for 37% tax bracket $1,839*
- ***$1,351***

24

ABLE Accounts

- The 2017 Act contained three temporary modifications to ABLE accounts, all of which were to expire at the end of 2025. The OB3 Act extends all three modifications permanently.
- *First- Contribution Limits.* §529A(b)(2)(B) provides that once an amount of cash equal to the federal gift tax annual exclusion amount has been contributed to an ABLE account, the account's designated beneficiary generally may contribute an additional amount up to such beneficiary's compensation for the year or, if less, the federal poverty line for a one-person household. This increase in the annual contribution limit is now permanent.

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ABLE Accounts

- *Second- Saver's Credit.* The amount of any such additional contribution made by the designated beneficiary is eligible for the so-called "saver's credit" under §25B. This is now permanent.
- The OB3 Act provides for two additional changes to the saver's credit that take effect in 2027: (1) *only* the additional contributions made by designated beneficiaries to ABLE accounts will be eligible for the credit, as all other qualified retirement contributions will no longer be eligible; and (2) the maximum amount of the credit increases from $2,000 to $2,100.)

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ABLE Accounts

- *Three- Rollovers Between §529 Plans and ABLE Accounts*. The OB3 Act permanently allows amounts from a qualified tuition plan to be rolled over to an ABLE account without penalty as long as the ABLE account is owned either by the qualified tuition plan's designated beneficiary or the beneficiary's spouse, descendant, sibling, ancestor, stepparent, niece, nephew, aunt, uncle, first cousin, or in-law.
- Any amounts rolled over from a qualified tuition plan count toward the overall limit on amounts that can be contributed annually to an ABLE account. As was the case from 2018 through 2025, any rolled-over amount in excess of the contribution limit will be treated as ordinary income to the distributee.

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Limit on Deduction for Personal State and Local Taxes

- 2017 Act limited the total deduction a taxpayer could claim for state and local taxes unrelated to the taxpayer's trade or business or other profit-seeking activity to $10,000.
- OB3 Act retained a cap on the deduction for personal state and local taxes, now restricting the amount of the deduction to the "applicable limitation amount." The applicable limitation amount and the threshold amount for married couples filing jointly is the same as for unmarried taxpayers and heads of households.

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Limit on Deduction for Personal State and Local Taxes

- The applicable limitation amount, defined in new §164(b)(7), starts as a specific dollar amount:
- Taxable Year Beginning in — Applicable Limitation Amount
  - 2025 — $40,000
  - 2026 — $40,400
  - 2027 — $40,804
  - 2028 — $41,212
  - 2029 — $41,624
  - 2030 or later — $10,000

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Limit on Deduction for Personal State and Local Taxes

- If a taxpayer's "modified adjusted gross income" (a taxpayer's adjusted gross income increased by the amount of any excluded foreign earned income) for 2025 through 2029 exceeds the "threshold amount," the applicable limitation amount is reduced by 30% of the excess. In no case can the applicable limitation amount dip below $10,000.
- Taxable Year Beginning in — Threshold Amount
  - 2025 — $500,000
  - 2026 — $505,000
  - 2027 — $510,050
  - 2028 — $515,151
  - 2029 — $520,302

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Limit on Deduction for Personal State and Local Taxes

- For example, in 2025, a single taxpayer with a modified adjusted gross income of $510,000 can deduct up to $37,000 in personal state and local taxes paid in 2025:

• Modified AGI	$510,000		
• *Less* Threshold Amount	(500,000)		
• Excess		$10,000	
• X 30%		x 0.30	
• Reduction to Limitation Amount			$3,000
• Applicable Limitation Amount for 2025			$40,000
• *Less* Reduction to Limitation Amount (above)			($3,000)
• Maximum Personal SALT Deduction			**$37,000**

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Discharge of Student Loan Debt

- The 2017 Act excluded from gross income the cancellation of a student loan on account of the student's death or total disability where such cancellation occurred after 2017 and before 2026.
- The American Rescue Plan Act of 2021 made the exclusion applicable to all federal student loan forgiveness occurring from 2021 through 2025, regardless of the reason.
- The OB3 Act returns to the exclusion to its original scope (applicable only in cases of death or total disability) and makes it permanent.

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Deduction for Qualified Tips

- Starting in 2025, individuals can deduct up to $25,000 in "qualified tips" received during the year. This deduction is available through 2028. Like the temporary senior deduction and the qualified business income deduction, the deduction for qualified tips is allowed both to taxpayers who itemize and those who take the standard deduction, but the deduction is taken into account after the computation of adjusted gross income.
- *Qualified Tips.* Section 224(d)(1) generally defines "qualified tips" as "cash tips received by an individual in an occupation which customarily and regularly received tips on or before December 31, 2024, as provided by the Secretary." The OB3 Act requires Treasury to publish within 90 days of the date of enactment of the OB3 Act a list of occupations with customarily and regularly received tips on or before December 31, 2024.
- §224(d)(2) provides that tips received by someone engaged in (or employed by) a specified service business are not qualified tips. Section 224(d)(2) further requires that qualified tips must be "paid voluntarily without any consequence in the event of nonpayment" in an amount "determined by the payor" and must not be the subject of negotiation. Section 224(d)(3) clarifies that "cash tips" includes tips paid in cash, tips

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Deduction for Qualified Tips

- *Phaseout of Deduction*. Under §224(b)(2), the amount of the qualified tips deduction allowable under §224(a) is reduced by $100 for every $1,000 by which the taxpayer's modified adjusted gross income exceeds $150,000 for a single filer and, $300,000 for joint filers.
- For example, if an individual receives $50,000 in qualified tips in 2025 has a modified adjusted gross income of $200,000, the amount of the individual's §224(a) deduction for 2025 is $20,000: the $25,000 maximum deduction minus $5,000 ($50,000 excess modified adjusted gross income, divided by $1,000, multiplied by $100).
- The OB3 Act calls it "No Tax on Tips." A below-the-line deduction is not the same as an exclusion or even an above-the-line deduction. The deduction does not reduce an individual's adjusted gross income, only the individual's taxable income. Additionally, the deduction is limited to the first $25,000 in tips received, and the deduction only covers cash tips (not tips in kind) and any tips received are not exempt from payroll or self-employment taxes.

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Deduction for Qualified Overtime Compensation

- Starting in 2025, individuals can deduct up to $12,500 in "qualified overtime compensation" received during the year. This deduction is available through 2028. Like the deduction for qualified tips, the deduction for qualified overtime compensation is allowed both to taxpayers who itemize and those who take the standard deduction, but the deduction is taken into account after the computation of adjusted gross income.
- *Qualified Overtime Compensation.* "Qualified overtime compensation" is any compensation that is in excess of the regular rate at which an individual is employed that is required to be paid under federal law.
- *Phaseout of Deduction*. Section 225(b)(2) contains a phaseout provision that copies the one applicable to qualified tips. Under this rule, the amount of the qualified overtime compensation deduction otherwise allowable under §225(a) is reduced by $100 for every $1,000 by which the taxpayer's modified adjusted gross income exceeds $150,000 or $300,000, in the case of joint return filers.
- Same limitation as no tax on tips.

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Trump Accounts

- Trump accounts function as an individual retirement accounts (IRAs) for children under the age of 18. Trump accounts can only be created for the exclusive benefit of an "eligible individual," who: (1) will not have reached age 18 by the close of the calendar year in which the account is created, and (2) has been issued a social security number.
- *Contributions.* Trump accounts can be funded starting July 4, 2026. Contributions, which are not deductible, can be made in any calendar year before the year in which the beneficiary reaches age 18.
- For 2026 and 2027, the total amount that can be contributed to a Trump account is $5,000. Starting in 2028, the contribution limit is adjusted for inflation.

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Trump Accounts

- *Distributions. N*o distributions are allowed until the start of the calendar year in which the beneficiary reaches age 18. Once the beneficiary turns 18, a Trump account is treated like an IRA. A withdrawal is ordinary income to the beneficiary. Any withdrawals before the beneficiary reaches age 59.5 will incur a 10% penalty. Similar to IRAs there are exceptions to the 10% penalty for a first time home purchase, for qualified educational expenses, or for certain medical expenses.
- *ABLE Account Rollovers.* A Trump account can distribute funds to an ABLE account established for the benefit of the Trump account beneficiary without tax consequence, provided the rollover happens during the calendar year in which the beneficiary reaches age 17.

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Trump Accounts

- *Rollovers*. The funds from a Trump account can be rolled over into a new Trump account for the same beneficiary, but because a child can only be the beneficiary of a single Trump account, all funds from the old account must roll over into the new account. Qualified rollovers are not treated as contributions and do not give rise to federal income tax consequences.
- *Account Beneficiary's Death*. If the beneficiary dies before reaching age 18, the account ceases to be a Trump account and taxable amounts in the account are included on the beneficiary's final federal income tax return.
- If someone other than the beneficiary's estate acquires the beneficiary's interest in the Trump account upon the beneficiary's death, the taxable amounts are included in that person's gross income for the taxable year which includes the beneficiary's date of death.

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OB3 Act Provisions Not Covered

- Exclusion for Qualified Bicycle Commuting Reimbursements;
- Casualty Loss Deduction;
- Adoption Credit;
- Employer-Provided Child Care Credit;
- Child and Dependent Care Credit;
- Wagering Losses;
- Deduction for Interest Paid on Qualified Passenger Vehicle Loans;
- Section 529 Plan Withdrawals for Elementary and Secondary Schooling;
- Provisions Related to School Choice Programs;
- Exclusion for Employer Payment of Student Loans;
- Home Mortgage Interest Deduction;
- Deduction for Moving Expenses.

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OB3 Act Provisions Not Covered

- Excise Tax on Certain Private Colleges and Universities;
- Disguised Payments for Services Provided by a Partner to a Partnership;
- Excess Business Losses of Individuals, Partnerships, and S-Corporations;
- Opportunity Zones;
- Section 179 Expensing-Expensing of Depreciable Property;
- Qualified Small Business Stock;
- Qualified Farmland Property;
- Research and Experimental Expenditures;
- Limit on Deduction for Business Interest;
- Business Meals on Fishing Boats and at Fish Processing Facilities.

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Impact to SNTs and Beneficiaries

- Grantor Tax Rules –Impacted by Miscellaneous Itemized Deductions.
- Complex Trust Tax Rules – Impacted by Miscellaneous Itemized Deductions at trust level.
- Qualified Disability Trusts – Personal Exemption –no change.
- ABLE- no sunset for ABLE provisions.
- Trump Accounts- available resource after 18 –
- Modified Adjusted Gross Income (MAGI)
  - Overtime pay
  - Qualified Tips

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Case Law

- *Estate of Rowland v. Commissioner*, T.C. Memo. 2025-76, July 15, 2025 – Incomplete portability election resulted in additional taxes to the surviving spouse.
- *Estate of Griffin v. Commissioner*, T.C. Memo. 2025-47, May 19, 2025. Estate failed to make QTIP election for a specific bequest of $2M to an irrevocable trust for spouse.
- *Estate of Fields v. Commissioner,* T.C. Memo. 2024-90, September 26, 2024. assets transferred shortly before the decedent's death to a family limited partnership by the decedent's agent under a durable power of attorney are includible in the decedent's gross estate, denying valuation discounts claimed by the estate increasing the amount of federal estate tax due.
- *New Jersey v. IRS,* 2d. Cir., August 13, 2025 upheld the validity of SALT workaround regulations.

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Is The Trust An Employer?

Jason R. Bent

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Is The Trust An Employer?

Presentation Outline

I. **Introduction** to the Employee/Independent Contractor classification problem

A. The shift from "status" (Master/Servant) to "contract"

1. Richard Carlson, *Why the Law Still Can't Tell an Employee When It Sees One and How It Ought to stop Trying*, 22 Berk. J. Emp. & Lab. L. 295 (2001)

2. JOHN FABIAN WITT, THE ACCIDENTAL REPUBLIC: CRIPPLED WORKINGMEN, DESTITUTE WIDOWS, AND THE REMAKING OF AMERICAN LAW (2004).

B. The introduction and eventual survival of statutory employment protections during the New Deal, overcoming *Lochner* era substantive due process challenge.

C. The relevance of contractual characterization of a hiring relationship as "independent contractor" relationship, in light of bargaining power disparities

D. The scale of misclassification problem.

a. Kyla Miller, *The Misclassification Trend: How Independent Contractor Status Could Affect Consumers*, 28 Loy. Consumer L. Rev. 333 (2016)

b. Christopher Buscaglia, *Crafting a Legislative Solution to the Economic Harm of Employee Misclassification*, 9 U.C. Davis Bus. L.J. 111 (2009).

E. Brief identification of some statutory coverage issues most likely to be relevant to SNT scenarios, including federal payroll tax withholding, unemployment insurance, workers' compensation insurance coverage, wage and hour protections, and wage payment and collection protections.

F. The modern workplace and new difficulties in employee classification in the fissured workplace and gig/platform economy. Applicability to home caregivers.

1. DAVID WEIL, THE FISSURED WORKPLACE (2014)
2. Robert Sprague, *Updating Legal Norms for a Precarious Workforce*, 35 ABA J. Lab. & Emp. L. 85 (2020).
3. Kenneth Dau-Schmidt, *The Problem of "Misclassification" or How to Define Who Is An "Employee" Under Protective Legislations in the Information Age* (2019).
4. Griffin Pivateau & Gina Nerger, *The Worker Classification Dilemma: The IRS Test and the Platform Economy*, 53 Texas Tech. L. Rev. 535 (2021).

G. Overview of the three primary approaches to distinguishing between employees and independent contractors: (1) common law control test; (2) economic realities test; and (3) ABC test.

II. <u>The Common Law Control Test</u>

A. History and Development. Roots in the doctrine of *respondeat superior*, in the context of imposing tort liability on a principal for injuries caused by the negligence of the agent.

1. Restatement (Second) Agency 220(1)
2. Carlson, *Why the Law Still Can't Tell An Employee, supra*

B. Adoption as the default rule in federal statutory employment protections by U.S. Supreme Court in *Nationwide Mutual v. Darden*, 503 U.S. 318 (1992)

C. Development of the 12 factor (*Darden*) common law test: (1) skill required; (2) source of instrumentalities and tools; (3) location of work; (4) duration of

relationship between the parties; (5) whether hiring party has right to assign additional projects to the hired party; (6) extent of hired party's discretion over when and how long to work; (7) method of payment; (8) hired party's role in hiring and paying assistants; (9) whether the work is part of the regular business of the hiring party; (10) whether the hiring party is in business; (11) the provision of employee benefits; and (12) the tax treatment of the hired party. *Darden; Community for Creative Non-Violence v. Reid,* 490 U.S. 730 (1989).

III. The Economic Realities Test

A. Development in the context of the FLSA, with the broadest statutory definition of "employ" = "suffer or permit to work." 29 U.S.C. s. 203(e)(1).

B. Key focus of the inquiry is on "dependence" rather than "control," although there are some overlapping factors.

C. Factors: (1) degree of alleged employer's right to control the manner in which the work is to be performed; (2) alleged employee's opportunity for profit or loss depending upon their managerial skill; (3) alleged employee's investment in equipment or materials required for the task, or employment of helpers; (4) whether the service rendered requires a special skill; (5) degree of permanence of the working relationship; and (6) whether service rendered is an integral part of the alleged employer's business. *See Donovan v. DialAmerica Mktg*., 757 F.2d 1376 (3d Cir. 1985); *Sec. of Labor v. Lauritzen*, 835 F.2d 1529 (7th Cir. 1987).

D. Brief note on the "Hybrid" ("relative nature of the work") Test – a test that "encompasses both the 'right to control' and the 'economic realities' test. *See,*

e.g., D'Annunzio v. Prudential Ins. Co., 192 N.J. 110 (2007); *Franz v. Raymond Eisenhardt & Sons*, 732 F. Supp. 521 (D.N.J. 1990).

IV. The ABC Test

A. Thus far, only adopted (in whole or partially, in some form) at the state level, and not at the federal level; efforts to advance legislation at the federal level have not yet been successful.

B. The leading type of reform aimed at the misclassification issue in recent years.

C. Cataloguing states' adoption of the ABC test, whether in whole or partially.

1. Anna Deknatel & Lauren Hoff-Downing, *ABC on the Books and in the Courts: An Analysis of Recent Independent Contractor and Misclassification Statutes*, 18 U. Pa. J.L. & Soc. Change 53 (2015)
2. John Pearce II & Jonathan Silva, *The Future of Independent Contractors and Their Status as Non-Employees: Moving on From a Common Law Standard*, 14 Hastings Bus. L.J. 1 (2018).
3. Jon Shimabukuro, Cong. Research Service, *Worker Classification: Employee Status Under the NLRA, the FLSA, and the ABC Test* (2021).
4. Robert Sprague, *Using the ABC Test to Classify Workers: End of the Platform-Based Business Model or Status Quo Ante?*, 11 William & Mary Bus. L. Rev. 733 (2020).
5. Comprehensive adoptions in Massachusetts, New Jersey, California, and Oregon.

D. Operation of the ABC Test

1. Origin – Maine Employment Security Law, *see Pearce & Silva, The Future of Independent Contractors, supra*.
2. Name Origin – Mass. Gen. Laws. Ann. Ch. 149, s.148B
3. Application – Hargrove v. Sleepy's, LLC, 220 N.J. 289 (N.J. 2015); Eric Markovits, *Easy As ABC: Why the ABC Test Should Be Adopted as the Sole Test of Employee-Independent Contractor Status*, Cardozo L. Rev. de novo (2020).
4. Three Components of ABC Test: (A) purported employer neither exercised control over the work, nor had the *ability* to exercise control in terms of completion of work; (B) services provided were either outside the usual course of the business or performed outside of the all the places of business of the enterprise; and (C) enterprise that exists and can continue to exist independently of and apart from the particular service relationship. Must be stable and lasting, such that it will survive the termination of the challenged relationship.
5. Operation of the presumption and placement of burden of proof on the employer.

V. **Application to SNT Context**: Considering specific statutory employment protections most likely to be relevant in SNT contexts.

A. These are context specific determinations, such that individual could be "employee" for some statutory protections, but "independent contractor" for others. Highly individualized determinations driven by facts of individual cases.

B. Note the criticism of this resulting lack of predictability by Judge Easterbrook in concurrence in FLSA case, *Sec. of Labor v. Lauritzen*, 835 F.2d 1529 (7th Cir. 1987). "People are entitled to know the legal rules before they act, and only the most compelling reason should lead a court to announce an approach under which no one can know where he stands until litigation has been completed."

C. Payroll taxes and Withholding

    1. FICA – Federal Insurance Contributions Act, 26 U.S.C. 3101, et seq.
    2. FUTA – Federal Unemployment Tax Act, 26 U.S.C. 3301, et seq.
    3. Common law control test under *Darden* default; I.R.C., 26 U.S.C. s. 3121(d) definition of "employee"
    4. IRS Test – 20 factor test in making determination. See 26 C.F.R. s. 31.3121(d)-1, 31.3306(i)-1, 31.3401(c)-1.

D. State Unemployment Insurance coverage

    1. Several states have adopted ABC test in context of unemployment insurance coverage. *Pearce & Silva, The Future of Independent Contractors, supra*; Deknatel & Hoff-Downing, *ABC on the Books, supra*

E. Workers' Compensation

    1. ABC Test will apply in those states where more comprehensive adoption of ABC test. *Id.*
    2. Note most states (38) with workers' compensation coverage requirements for even very small employers, including as few as only 1 employee. States' early legislative responses to 1972 National Commission on State Workmen's Compensation Laws.

3. Workers' compensation is one area where, post-injury, the hiring entity will often *prefer* to be the employer of the hired individual ("employee"), because that conclusion triggers application of the workers' compensation exclusivity bar; no tort claim available to injured worker absent application of the "intentional tort" exception, and workers' compensation recovery is limited to medical expenses and statutorily-defined impairment compensation or income replacement (often 2/3 of pre-injury compensation, subject to statutory caps). Trade-off is no need to prove negligence, quick recovery resolved administratively, avoids litigation.

F. Federal Wage and Hour Protections – FLSA

1. Application of "Economic Realities" test, given broadest "suffer or permit to work" statutory language; uncertainty in application and misclassification abuse; Department of Labor enforcement.

G. State Wage and Hour Protections

H. State Wage Payment and Collection Laws

VI. <u>Who Is the Worker's "Employer?"</u>

A. Consider possible application of "joint employer" rules.

1. This can affect application of statutory protections by aggregation of the total number of employees; i.e., the employee-counting issue

2. Also can affect which parties are liable for violation of the employee statutory protection, defeating attempts at outsourcing employment liability. See, e.g., *Becerra v. Expert Janitorial*, 332 P.3d 415 (Wash.

2014) (state wage and hour); *Zheng v. Liberty Apparel*, 355 F.3d 61 (2d Cir. 2003) (federal wage and hour).

B. SNT Context – Is trustee the "employer" for purposes of statutory coverage, even where the trustee outsources employment management?

C. *Risk Management Strategies Inc. v. Texas Workforce Comm*., 464 S.W.3d 864 (Ct. App. Tex. 2015).

1. SNT specific context involving outsourcing of employment services.
2. Facts: RMS clients were financial institutions appointed as trustees of several SNTs. Beneficiaries of the trusts often need extensive in-home care, and caregiver is often a family member. Trustees outsource employment management of caregivers through "Client Services Agreement," whereby RMS agrees to "provide and perform . . . for and on behalf of the Trustee . . . employment and related services" for the individuals engaged in caring for the trust's beneficiary. This includes paying wages, collecting, reporting and payment of payroll taxes, and payment of unemployment insurance. The agreement provided that the parties agree that RMS would "do all acts necessary to employ or contract with individuals who will be the employees or independent contractors of RMS and that the Trustees shall not in any manner be deemed to be the employer of such persons."
3. RMS argued that, by contract, all the control over the caregivers was vested in RMS, and not in the SNT trustees.

4. Texas Workforce Commission determination that trustees were employers, not RMS; Commission's concern about the practice of "payrolling"
5. Judicial review and specific limitations in Texas; Texas Court of Appeals determination at pleading stage re: *ultra vires* challenge to Commission's action.

VII. Related Issue for Caregivers – Federal FLSA Exemption

A. History of FLSA exemption for caregivers

1. 1974 FLSA extended to cover "domestic service"
2. Exemption for domestic service employment – **companionship** services for individuals who (because of age or infirmity) are unable to care for themselves (Min. Wage and OT exemption); 29 U.S.C. s. 213(a)(15). Under current DOL regulations, this exemption does not include performance of medical tasks which typically require training and are performed by medical personnel, such as registered nurses, LPNs, or CNAs. 29 C.F.R. s. 552.6
3. Exemption for domestic service in household who **resides in** household (OT exemption only); 29 U.S.C. s. 213(b)(21); 29 C.F.R. 552.102
4. 2013 – DOL revision to regulation added important limitations on these exemptions.
    1. Companionship exemption as applied to "provision of **care**" (dressing, grooming, feeding, bathing, toileting) could not exceed 20% of hours worked. 2013 regulation placed focus on protection and fellowship.

2. Companionship and live-in domestic service by **third party employers** not exempt, "even if the employee is jointly employed by the individual or member of the family or household using the services. However, the individual or member of the family or household, even if considered a joint employer, is still entitled to assert the exemption." 29 C.F.R. s. 552.109. *See Home Care Association of America v. Weil*, 799 F.3d 1084 (D.C. Cir. 2015) (upholding 2013 regulation as applied to third-party employers, applying *Chevron* deference).

B. Notice of Proposed Rulemaking, Dept. of Labor, WHD, *Application of the Fair Labor Standards Act to Domestic Service*, 29 C.F.R. s.552 (July 2, 2025).

1. Intent to return to broader exemption for companionship and in-home caregivers. Includes: (1) reversal of limitation on third-party employer's ability to use exemption; (2) reversal of "companionship" limitations relating to 20% limit for "care," to fully include "care" along with "fellowship" and "protection" as covered by the exemption. Proposal would rescind 2013 regulation in its entirety and return to the 1975 regulations regarding domestic services.
2. Reversal of *Chevron* deference in *Loper Bright Enterp. v. Raimondo*, 603 U.S. 369 (2024), as basis for revisiting regulation. "The Department has thus far taken the position in litigation that the 2013 rule is still valid despite the 2024 Loper Bright decision, but is now taking a fresh look at arguments to the contrary. . . . In sum, the Department seeks to determine

whether, with respect to third party employers, its original interpretation of the section 13(a)(15) and 13(b)(21) exemptions is the better reading of the FLSA's statutory text."

C. Commentary: Joshua Vaughn, et al, Littler ASAP, *DOL Proposes Rule to Reinstate Companionship and Live-In Exemptions from Minimum Wage and Overtime for Third-Party Employers*, available at: https://www.littler.com/news-analysis/asap/dol-proposes-rule-reinstate-companionship-live-exemptions-minimum-wage-and

VIII. Related Issue for Caregivers – State Domestic Workers Bill of Rights Legislation

A. Domestic Worker Bill of Rights (DWBR)

1. See generally National Domestic Workers Alliance, available at: https://www.domesticworkers.org/programs-and-campaigns/developing-policy-solutions/domestic-workers-bill-of-rights/
2. California example. Kevin Rehwald, *Rights for Caregivers*, 42 L.A. Lawyer 26 (2019). Summary of key provisions.
3. Illinois example. See Cesar Rosado Marzan, *Personal and Political: How the Illinois Domestic Workers' Bill of Rights Connected Lives*, 57 U.C. Davis L. Rev. 3033 (2024). 820 ILCS 182/1, 182/5, 182/10, 182/90, 182/99. Summary of key provisions.

Is the Trust an Employer?

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1

Employee or I/C?

- Control (common law test)
- Economic Realities (dependence)
- Hybrid (either control OR dependence)
- ABC Test (trend in some states)

2

Control Test

- Origins in CL Agency – *respondeat superior* doctrine; should that extend to employment law protections?
- *Darden* (ERISA) – 12 factors to consider in determining control
- Default for federal statutes w/ unhelpful or circular definitions of "employee," "employer," or "employ"
- Many state WC statutes

3

Economic Realities

- Key is economic dependence
- Federal statutes where Congress indicates an intent to cover more broadly than the CL test
- FLSA – employ = "to suffer or permit to work"
- FMLA – incorporates FLSA definition
- Six factor test, but 2021 (Trump) DOL Rule revised to focus on 2 "core" factors
- 2024 (Biden) DOL Rule rev'd that focus, but current (Trump) DOL is not enforcing & considering rescission

4

Economic Realities

1. D's control over worker
2. Worker's opportunity for profit or loss
3. Worker's investment in equipment/materials
4. Whether the work requires special skill
5. Degree of permanence of the relationship
6. Whether the work is an integral part of D's business
   - Key Inquiry: Economic dependence; or "degree of independent business org. and operation"

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Economic Realities

Criticism:

"It is comforting to know that 'economic reality' is the touchstone. One cringes to think that courts might decide these cases on the basis of economic fantasy. But 'reality' encompasses millions of facts, and unless we have a legal rule with which to sift the material from the immaterial, we might as well examine the facts through a kaleidoscope. Which facts matter, and why?"

- Judge Frank Easterbrook

6

Economic Realities

"People are entitled to know the legal rules before they act, and only the most compelling reason should lead a court to announce an approach under which no one can know where he stands until litigation has been completed . . ."

- Judge Frank Easterbrook

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Hybrid

- Results in somewhat broader coverage
- Either control OR dependence
- Some courts have applied to:
  - ADA – disability
  - ADEA – age
  - Several different state statutes

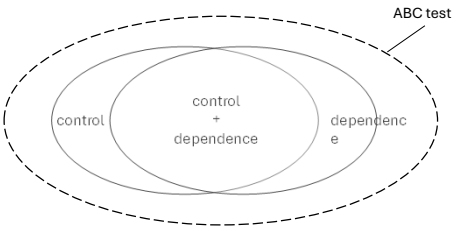
8

ABC Test

- Trend only in some states, not federal (…so far)
- Rebuttable presumption that worker is "employee," unless D carries its burden to show all 3:
  - **(A)** Absence of D's control
  - **(B)** Work performed outside D's usual course of business or outside all D's places of business
  - **(C)** Worker's enterprise can exist independently; would survive in the absence of the relationship with D

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Boundaries of Protection



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Examples From Other Contexts

- Beef boning workers – *Rutherford* (FLSA)
- Mattress delivery workers – *Hargrove* (NJ state W&H)
- Fed Ex home delivery drivers (NLRA, FLSA)
- Uber, Lyft, platform workers (CA state W&H)
- Commercial cleaners – *Mujo* (CT state W&H)
- Pickle harvesters – *Lauritzen* (FLSA)
- Exotic dancers – *Verma* (FLSA, PA state W&H)

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SNT Context

Federal payroll taxes & withholding

- FICA – 26 U.S.C. 3101
- FUTA – 26 U.S.C. 3301
- IRC – 26 U.S.C. 3121(d) definition "employee"
- *Darden* default rule = **Control Test**
- IRS 20 factor test for control
- New IRS emphasis on **3 categories**: behavioral control, financial control, and relationship of the parties

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SNT Context

State Unemployment Insurance

- About half of states have adopted some form of the ABC test in the context of unemployment insurance
- More common to see ABC test here than for other state employment laws

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SNT Context

State Workers' Compensation

- States with comprehensive adoption of ABC or adoption of ABC in WC statute
  (e.g., MA, NJ, CA, OR)
- Most states no longer exempt from WC insurance obligation based on # of employees
- But will worker prefer I/C classification (post-injury), due to WC exclusive remedy tort bar?

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SNT Context

Federal W&H - FLSA

- **Economic Realities** test
- Watch for DOL regulations for shifting emphasis on specific factors

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SNT Context

State W&H and Wage Payment Laws

- States with comprehensive adoption of ABC or specific adoption for W&H laws
- Trend is some states moving to ABC test; though other states have weakened their existing ABC test
- Many other states sticking with Economic Realities test

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Who is the Employer?

Consider possible application of "joint employer" rules. This mostly comes up in two ways:

1. Counting employees across entities for purposes of statutory coverage triggers
2. Determinations that multiple "employers" may be liable for violations

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Who is the Employer? SNT Context

Is the trustee an "employer" for purposes of statutory coverage, even where the trustee attempts to outsource employment & payroll management and control to a separate service provider?

Risk Mgmt Strategies v. Texas Workforce Comm., 464 S.W.3d 864 (Ct. App. Tex. 2015)

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Related Issue: FLSA Exemptions

Two relevant FLSA exemptions:

213(a)(15) – "employed in domestic service employment to provide **companionship services** for individuals who (because of age or infirmity) are unable to care for themselves"

213(b)(21) – "employed in domestic service in a household and who **resides in** such household"

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Related Issue: FLSA Exemptions

1974 – FLSA amended to cover "domestic service," but with exemptions for companionship services and live-in domestic services

2013 – DOL regulations revised in two critical ways:

(1) no companionship exemption if "provision of care" (dressing, grooming, feeding, bathing, etc.) exceeds 20% of hours worked; focus is meant to be on protection and fellowship; and

(2) no companionship or live-in domestic service exemption can be claimed by third-party employers, even if the employee is jointly employed by the individual or member of the family or household using the services

2025 – NPRM to reverse the two restrictions implemented by 2013 Rule

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RELATED ISSUE: State domestic workers bill of rights

- National Domestic Workers Alliance – summary of proposed legislative reforms available at:

  https://www.domesticworkers.org/programs-and-campaigns/developing-policy-solutions/domestic-workers-bill-of-rights/national-domestic-workers-bill-of-rights/

- California, Illinois, and other examples

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Thomas Smith

Friday, October 24th, 2025

I. Medicaid "Work Requirement" history from an Arkansas perspective.

a. The Patient Protection and Affordable Care Act (ACA) mandated states expand access to Medicaid to many adults with incomes up to 138% of the federal poverty level[1].

b. Later, the mandatory nature of Medicaid expansion was ruled unconstitutional[2].

c. However, over time 41 states and the District of Columbia have adopted some versions of Medicaid Expansion[3].

i. Also see **Exhibit A**.

d. Arkansas adopted a unique form of expanded Medicaid expansion in late 2013[4].

i. This form of Medicaid expansion uses Medicaid dollars to pay premiums to private insurers to provide coverage to the expanded group.

ii. This program is known as ARWorks or ARHome.

iii. So far this version of expanded Medicaid has survived myriads of legislative maneuvers.

e. Arkansas attempted its first "Work Requirement" in 2018[5].

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[1] H.R.3590 - 111th Congress (2009-2010): Patient Protection and Affordable Care Act, H.R.3590, 111th Cong. (2010), https://www.congress.gov/bill/111th-congress/house-bill/3590. *ACA*, Pub. L. No. 111-148, § 2001, 124 Stat. at 271.

[2] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012).

[3] Kaiser Family Foundation, Status of State Medicaid Expansion Decisions, KFF (Sept. 12, 2025), https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/

[4] Ark. Dep't of Human Servs., *Arkansas Health Care Independence Program ("Private Option") 1115 Waiver Application* 1 (Aug. 2, 2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-submission-ltr-08022013.pdf.

[5] Kaiser Family Foundation, *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees*, KFF (Dec. 18, 2018), https://www.kff.org/medicaid/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/.

i. The Work and Community Engagement ("WCE Requirement") requirement applied primarily to ARWorks beneficiaries ages 19 – 49[6].

1. Copy of Waiver Request attached as **Exhibit B.**
2. Arkansas Department of Human Services ("DHS") estimated approximately 69,000 recipients would be impacted by the WCE Requirement[7].

ii. There were a number of exceptions to the WCE Requirement. To be exempt the beneficiary needed to[8]:

1. Work at least 80 hours per month,
2. Attend school full time,
3. Receive SNAP benefits,
4. Receive TEA Cash Assistance,
5. Be medically frail or disabled,
6. Incapacitated in the short term or otherwise unfit for unemployment,
7. Caring for an incapacitated person,
8. Live in a home with a dependent child age 17 or younger,
9. Receive unemployment benefits,
10. Participate in a substance abuse treatment program, or
11. Be pregnant or entitled to postpartum care.

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[6] Ark. Dep't of Human Servs., *Work & Community Engagement: Proposed Evaluation Design & Strategy — Arkansas Works Evaluation Design* (Aug. 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf.
[7] Ark. Dep't of Human Servs., *Work & Community Engagement* , supra note 6, at 3.
[8] Ark. Dep't of Human Servs., *Work & Community Engagement* , supra note 6, at 4.

iii. Within 9 months of implementation approximately 18,000 Medicaid recipients lost coverage[9].

iv. Many Arkansans were not sure if policy actually went into effect[10].

v. Large percentages of persons impacted experienced delayed care and delayed access to medications[11].

vi. This first "work requirement" did not last long.

1. The United States District Court for the District of Columbia held the Department of Human Service's approval of the "work requirement" was arbitrary and capricious[12].
2. The Court held that the department had failed to demonstrate how the waiver furthered Medicaid's "core goal" of furnishing medical assistance to persons that struggle to afford it[13].
3. In support of it holding the Court relied heavily on previous case that dismissed Kentucky work requirement. *Stewart v. Azar, 313 F. Supp. 3d 237* (2018)[14].
4. Of course, the important point to note is that the Court was interpreting a regulation as opposed to a statute.

vii. Pathway to Prosperity

[9] Akeiisa Coleman and Sara Federman, "Work Requirements for Medicaid Enrollees" (explainer), Commonwealth Fund, Jan. 14, 2025. https://doi.org/10.26099/r361-mv95
[10] Id.
[11] Id.
[12] Grisham v. Azar 363 F. Supp. 3rd 165, 175 (2019).
[13] *Id.*
[14] *Id.*

1. Arkansas applied for an amended "work requirement" on January 28th, 2025 titled the "Pathway to Prosperity"[15].
    a. See **Exhibit C**.
2. As part of its waiver request the State of Arkansas noted that there are approximately 220,000 persons on it's Medicaid expansion program[16].
3. This Pathway to Prosperity is really just an amendment to the original "work requirement" waiver granted in 2018.
4. However, unlike the original waiver request, Pathway to Prosperity is designed to rely on personal interaction rather than technology to identify persons whom should receive "extra support to reach health and economic goals"[17].
5. The amended waiver notes that many Medicaid recipients should have received exemptions from the original waiver[18].
6. Pathways to Prosperity contemplates a program with no exemptions. Beneficiaries are either "on track" or "not on track" as defined by DHS[19].

viii. Status of Arkansas's Medicaid Work Requirement since passing of One Big Beautiful Bill Act ("OBBBA").

II. Work Requirement or Community Engagement – What is it and whom is covered?

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[15] Ark. Dep't of Human Servs., *Pathway to Prosperity 1115 Waiver Amendment* 1 (Jan. 28, 2025), https://governor.arkansas.gov/wp-content/uploads/Pathway-to-Prosperity-1115-Waiver-Amendment_DHS-Final_1.28.2025.pdf.
[16] Ark. Dep't of Human Servs., Pathway to Prosperity, supra note 15, at 5.
[17] Ark. Dep't of Human Servs., Pathway to Prosperity, supra note 15, at 11.
[18] Id.
[19] Ark. Dep't of Human Servs., Pathway to Prosperity, supra note 15, at 4.

a. National Medicaid "Work Requirement" is found in the One Big Beautiful Bill Act ("OBBBA").
    i. *One Big Beautiful Bill Act*, Pub. L. No. 119-21, 139 Stat. 72 (2025).
        1. Title VII – Finance
            a. Subtitle B – Health
                i. Chapter 1 – Medicaid
                    1. Subchapter D – Increasing Personal Responsibility
                        a. Section 71119 – Requirement for States to establish Medicaid community engagement requirements for certain individuals.
    ii. Now codified as 42 U.S.C. §1396a(xx) (2026).
b. There is actually no "work requirement". Rather the OBBBA refers to a "community engagement" requirement[20].
c. Community Engagement only applies to "applicable individuals"[21]
    i. Applicable Individuals are persons enrolled in a Medicaid expansion program[22].

[20] 42 U.S.C.S. §1396a(xx)(2) (2026).
[21] Id.
[22] 42 U.S.C.S. §1396a(xx)(9)A)(i)(I) (2026).

ii. As a result Community Engagement is anticipated to apply to approximately 22.8 % of all Medicaid beneficiaries[23],[24].

iii. See **Exhibit D**.

d. When does Community Engagement become effective?

i. No later than the first day of the first quarter that begins after December 31st, 2026. So, effectively sometime in early 2027[25].

e. What is Community Engagement?

i. Community Engagement is tested on a month-to-month basis[26].

ii. An applicable individual meets Community Engagement requirements in any given month if he or she[27]:

1. Works not less than 80 hours,
2. Completes not less than 80 hours of community service,
3. Enrolled in an educational program at least half time,
4. A combination of all the above,
5. Has monthly income not less than federal minimum wage X 80 hours, or
6. A seasonal worker as described in the statute[28].

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[23] Kaiser Family Foundation, *Medicaid Expansion Enrollment*, State Health Facts, KFF, https://www.kff.org/medicaid/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Sept. 22, 2025).
[24] Medicaid & CHIP, *Medicaid and CHIP Enrollment Data: Report Highlights*, Medicaid.gov, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights (last visited Sept. 22, 2025).
[25] 42 U.S.C.S. § 1396a(xx)(1) (2026).
[26] 42 U.S.C.S. § 1396a(xx)(2) (2026).
[27] Id.
[28] 42 U.S.C.S. §1396a(xx)(2)(G) (2026).

iii. Community Engagement includes a number of items other than "work" in the traditional sense.

f. Exemptions

i. There are numerous exemptions from Community Engagement. Persons exempted include:

ii. Specific Excluded Individuals[29]

1. Certain Native Americans as defined by statute[30],
2. Parent, guardian, caretaker relative, or family caregiver of a dependent child 13 or under or a disabled person[31],
3. A disabled veteran[32],
4. Is medically frail or has special medical needs including[33],
    a. A person who is blind or disabled,
    b. Has a substance abuse disorder,
    c. Has a disabling mental disorder,
    d. Has a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living,
    e. Serious or complex medical issues,
5. Who is a recipient of Temporary Assistance for Needy Families[34],

[29] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii) (2026)
[30] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(II) (2026)
[31] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(III) (2026)
[32] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(IV) (2026)
[33] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(V) (2026)
[34] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VI) (2026)

6. Member of a household receiving supplemental nutrition assistance program benefits[35],
7. Participating in a substance abuse rehabilitation program[36],
8. An inmate in a public institution[37], or
9. Who is pregnant or entitled to post-partum care[38].

iii. Those persons under the age of 19[39].

iv. Those persons entitled to Medicare Parts A & B[40].

v. Among others[41].

g. Verification

i. Community Engagement is, in theory, a program that an applicable individual qualifies for on a monthly basis[42].

ii. However, states are only required to verify compliance during an applicable individual's regularly scheduled redetermination of eligibility[43].

iii. States are required to establish processes and use reliable information available to the State without requiring, where possible, the applicable individual to submit information. So called ex parte verifications[44].

1. Examples of such information include payroll data or payments.

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[35] Id.
[36] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VII) (2026)
[37] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VIII) (2026)
[38] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(IX) (2026)
[39] 42 U.S.C.S. § 1396a(xx)(3)(A)(i)(II)(aa) (2026)
[40] 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(II)(bb) (2026)
[41] 42 U.S.C.S. § 1396a(xx)(3)(A)(i)(II)(cc) (2026)
[42] 42 U.S.C.S. § 1396a(xx)(2) (2026).
[43] 42 U.S.C.S. § 1396a(xx)(4) (2026).
[44] 42 U.S.C.S. § 1396a(xx)(5) (2026).

2. Standards for verification will be set by the Secretary of the Department of Health and Human Services[45].

h. Procedures for Non-Compliance with Community Engagement Requirement.

i. If a State cannot verify compliance then the State shall provide a notice of noncompliance[46].

1. The notice shall include information regarding

a. How an applicable individual may show actual compliance[47], or

b. Make a satisfactory showing that that the requirement does not apply to the individual[48], and

c. How such individual may reapply for medical assistance[49].

ii. States must give 30 calendar days from the date of the notice to:

1. Make a satisfactory showing of compliance[50], or

2. Make a satisfactory showing that the requirement does not apply[51], and

3. Continue to provide medical assistance during the 30-day notice period[52].

iii. If no satisfactory showing is found then the State must

1. Deny the application if applicable[53],

[45] Id.
[46] 42 U.S.C.S. § 1396a(xx)(6)(A)(i) (2026).
[47] 42 U.S.C.S. § 1396a(xx)(6)(B)(i) (2026).
[48] 42 U.S.C.S. § 1396a(xx)(6)(B)(ii) (2026).
[49] 42 U.S.C.S. § 1396a(xx)(6)(B)(iii) (2026).
[50] 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(I)(aa) (2026).
[51] 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(I)(bb) (2026).
[52] 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(II) (2026).
[53] 42 U.S.C.S. § 1396a(xx)(6)(A)(iii) (2026).

2. Disenroll the individual no later than the end of the month following the month in which the 30-day notice period ends; provided that
    a. The State determines there is no other basis for eligibility[54], and
    b. The individual is provided written notice and granted an opportunity for a fair hearing[55].

i. Outreach
    i. States are required to periodically notify applicable individuals of the Community Engagement requirement[56].
    ii. The notice / outreach shall include:
        1. How to comply with the Community Engagement requirement as well as an explanation of exceptions[57],
        2. The consequences of noncompliance[58],
        3. How to report changes to an individual's status[59].
    iii. Outreach shall be delivered by mail and in one or more additional forms such as telephone, text, internet website, or other commonly available electronic means[60].

III. Policy Discussion / Debate.

a. Why does this Community Engagement Requirement keep coming up?

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[54] 42 U.S.C.S. § 1396a(xx)(6)(A)(iii)(I) (2026).
[55] 42 U.S.C.S. § 1396a(xx)(6)(A)(iii)(II) (2026).
[56] 42 U.S.C.S. § 1396a(xx)(8)(A) (2026).
[57] 42 U.S.C.S. § 1396a(xx)(8)(A)(i) (2026).
[58] 42 U.S.C.S. § 1396a(xx)(8)(A)(ii) (2026).
[59] 42 U.S.C.S. § 1396a(xx)(8)(A)(iii) (2026).
[60] 42 U.S.C.S. § 1396a(xx)(8)(B) (2026).

i. A number of states have asked for a community engagement requirement at one time or another[61].

ii. The first Trump Administration approved 13 work requirement waivers[62].

iii. However, Arkansas was the only state that attempted to implement consequences such as loss of coverage[63].

iv. Even though Arkansas's first waiver was judicially dismissed, it has tried yet again with an amended waiver.

v. Preemption

1. For the time being the OBBBA has mandated community engagement on a national level[64].

b. Growth in Medicaid Spending.

i. Total Medicaid spending in 2002 was approximately $257.6 billion[65].

ii. Total Medicaid spending in 2022 was approximately $804 billion[66].

iii. More than 200% increase in 20 years.

iv. However, Medicaid spending has remained more or less consistent at 12.75% of the federal budget through this time period.

c. Numbers and Percentages of Persons impacted by Community Engagement.

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[61] Elizabeth Hinton, Robin Rudowitz, *5 Key Facts About Medicaid Work Requirements*, KFF, Feb 18, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/

[62] Id.

[63] Id.

[64] 42 U.S.C.S. §1396a(xx) (2026)

[65] Kaiser Family Foundation, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002*, KFF (Jan. 2013), https://www.kff.org/wp-content/uploads/2013/01/medicaid-spending-what-factors-contributed-to-the-growth-between-2000-and-2002.pdf

[66] Kaiser Family Foundation, *Medicaid Enrollment & Spending Growth: FY 2024 & 2025*, KFF (Oct. 23, 2024), https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2024-2025/. (kff.org)

i. Approximately 71 million people were enrolled in Medicaid in May 2025[67].

ii. Approximately 20 million are on a Medicaid expansion program[68].

d. Estimates of savings as a result of Community Engagement.

i. Approximately 8% (1,600,000) of persons on Medicaid expansion are not working due to retirement, inability to find work, or other reasons[69].

ii. The CBO estimates that over ten years the community engagement requirement will result in 5.2 million fewer persons on Medicaid and result in savings of $326 billion[70].

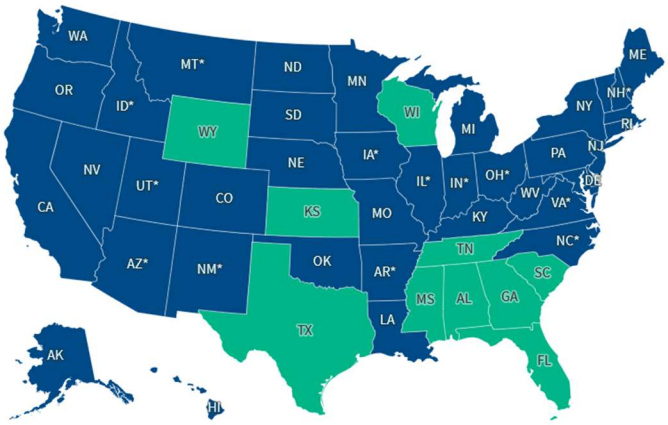
e. Are you convinced?

[67] KFF, *Medicaid and CHIP Enrollment Data: Report Highlights*, supra note 24.
[68] KFF, *Medicaid Expansion Enrollment*, supra note 23.
[69] Hinton, Elizabeth & Robin Rudowitz*, 5 Key Facts About Medicaid Work Requirements*, KFF (Feb. 18, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/.
[70] Elizabeth Hinton, Amaya Diana & Robin Rudowitz, A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law, KFF (July 30, 2025), https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

EXHIBIT A

Status of State Action on the Medicaid Expansion Decision

Adopted and implemented (41 states including DC) Not adopted (10 states)

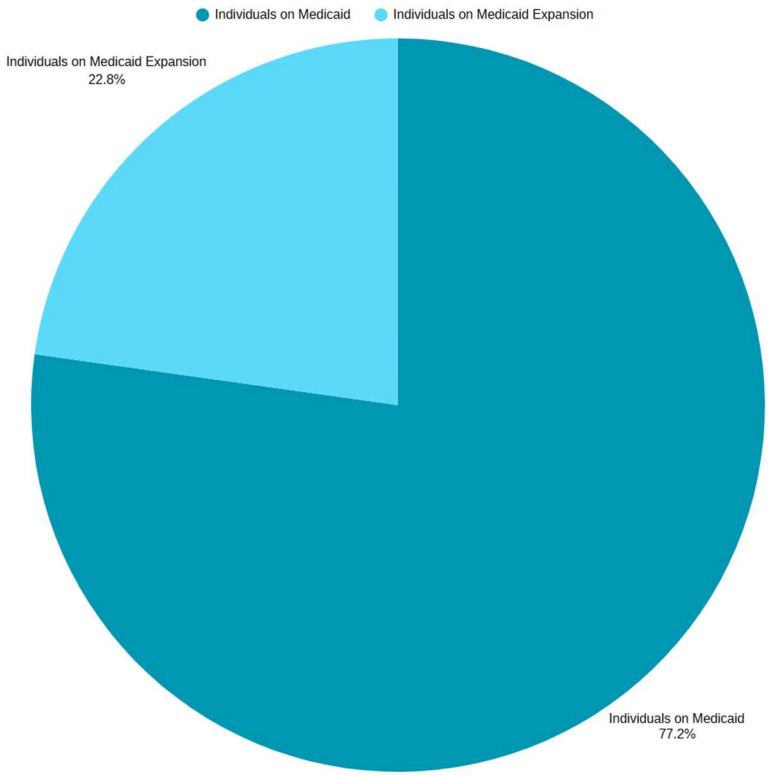


Note: * State has a trigger law that would end expansion coverage or require states to take steps to mitigate increases in state costs if federal funding for the expansion is reduced.

Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion and Searing, Adam. "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States." Say Ahhh! Georgetown Center for Children and Families, November 27, 2024 • Get the data • Download PNG

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Exhibit D[71],[72]



[71] KFF, *Medicaid and CHIP Enrollment Data: Report Highlights*, supra note 24.
[72] KFF, *Medicaid Expansion Enrollment*, supra note 23.



ARKANSAS WORKS
WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS

Medicaid Section 1115 Demonstration Project
Work Requirement Evaluation Design & Strategy

Arkansas Department of Human Services

Original Submission: May 2018
Amended Submission: August 2018

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Proposed Evaluation Design & Strategy for Section 1115 Demonstration Waiver Work and Community Engagement Amendment

1. Overview

Arkansas Works, as amended, is a Demonstration Project of national significance. Medicaid is the largest single means-tested public assistance program administered by the states. Its role in providing access to medical services for people in poverty and near poverty is well established.

Section 1901 of Title XIX, under the Social Security Act, provides, "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State to . . . help such families and individuals ***attain or retain capability for independence*** . . . ."[1] (Emphasis added.) The purpose of Medicaid, therefore, as defined by the statute, goes beyond paying for medical care.

Medicaid should not be a disincentive to work: work leads to independence and contributes to improved health, which are among the purposes of the Medicaid program. The rationale of the Work and Community Engagement (WCE) requirements are likewise intended to help individuals attain economic independence, lift themselves out of poverty and to improve their overall health. The overarching purpose of the work requirements (to help individuals attain economic independence) is in their interest, and therefore promotes the statutory objectives of the Medicaid program.

There is a long-documented correlation between employment and improved life circumstances.[2] For example, for individuals with substance abuse disorders, employment is generally viewed as an important component of recovery. Other correlative examples are set out in the graphic on page 3 of this document.

There is limited research, however, about the direct role of Medicaid in assisting people to increase work and wages sufficiently to rise out of poverty.

This proposed evaluation is meant to close the gap in available research regarding the correlation between Medicaid-required WCE, and the multiple positive effects on Medicaid beneficiaries.

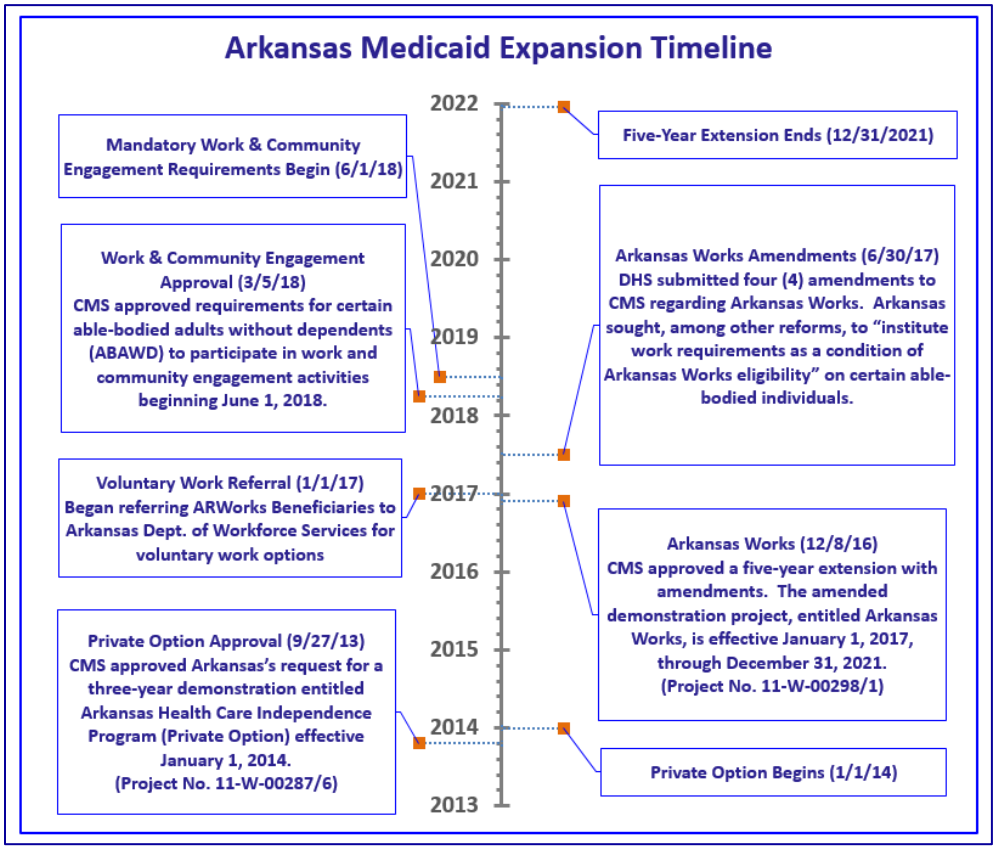
2. Arkansas Works Background and Timeline

As a largely-rural state with historically high unemployment, worse health and less education attained compared to other states, Arkansas presents a unique opportunity to turn around these statistics.

Beginning with the Arkansas Health Care Independence Program in 2014, Arkansas exercised its option to expand Medicaid coverage to 18- to 64-year olds with effective income of 138% of the federal poverty level (FPL) under the provisions of the Affordable Care Act (ACA). Also known as the Private Option, the expansion occurred through §1115 authority rather than through the

Medicaid state plan. This permitted the state, among other things, to provide coverage through insurance carriers rather than the Medicaid fee-for-service (FFS) delivery system. The insurance carriers that offer Qualified Health Plans (QHPs) for the Medicaid population also offer QHPs for individuals.

A consequence of this structure, the "Medicaid cliff," i.e., the point at which a rise in income results in the loss of health insurance coverage, no longer exists in Arkansas. Low-income workers who increase their earnings will still receive coverage and subsidies, but through tax credit subsidies rather than Medicaid.



In 2016, Arkansas Works ("ARWorks") amended the Private Option program. As part of the updated demonstration program, beginning in January 2017, the Arkansas Department of Human Services (DHS) referred all individuals enrolled in ARWorks to the Arkansas Department of Workforce Services (DWS). The referral allowed beneficiaries to voluntarily seek assistance with job training and job placement. However, from January to October 2017, only 4.7% of beneficiaries acted upon the referral and utilized the services provided by DWS. Of that number, 23% became employed through this process.

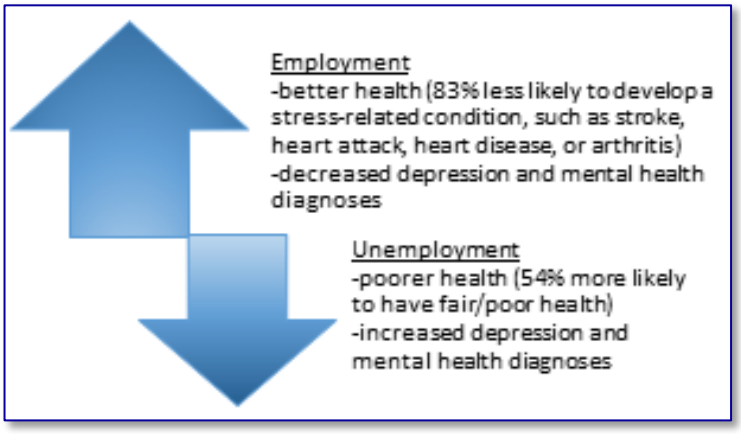
The June 2017 amendment requires certain able-bodied adults without dependents to participate in WCE requirements beginning June 1, 2018.[3]

In 2018, with the implementation of the ARWorks WCE requirements, Arkansas will be able to track mandatory referrals and test whether a "stronger incentive model is more effective in

encouraging participation."[4] The approved ARWorks amendment now requires approximately 69,000 abled-bodied individuals to engage in work activities, include education and training. Such requirements promote the objectives of Title XIX.

The benefits of the new requirements are multi-fold. First, individuals can continue to increase their earnings without losing the value of health insurance as there is no "Medicaid cliff" in Arkansas. In addition, finding employment has numerous tangible and intangible benefits:

- Improve the skill sets of individuals,
- Assist them to gain or increase employment, and
- Increase their earnings.



Each of these goals helps individuals to lift themselves out of poverty and to improve their overall health.

The purpose of this Evaluation Design is directed solely toward the amendment for implementation of the WCE requirement that will be in effect during the period June 1, 2018, through December 31, 2021. The evaluation will cover the implementation efforts, outcomes and effects (short-term and long-term, tangible and intangible), and sustainability of WCE requirements and activities as part of a lasting improvement to the social fabric and population health of all Arkansans.

3. Work and Community Engagement Overview

The ARWorks demonstration is targeted to individuals 19-49 years old. Based on data as of March 2, 2018, there were 171,449 ARWorks beneficiaries ages 19 – 49 (out of a total of 278,734). However, the majority of these individuals will meet at least of the exemption criteria. Approximately 69,000 have no initial exemption identified through system data.

Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including:

- Employment and self-employment of at least 80 hours a month,
- Medical frailty,
- Exemption from SNAP (Supplemental Nutrition Assistance Program) work requirement,
- Receipt of TEA (Transitional Employment Assistance) Cash Assistance, and
- Receipt of unemployment benefits.

Individuals will be required to participate in WCE requirements unless they meet the established criteria for exemption in the following table:

Exemption Criteria*	•Beneficiary's income is consistent with being employed or self-employed at least 80 hours per month •Beneficiary attends high school, an institution of higher education, vocational training, or job training on a full-time basis •Beneficiary is exempt from SNAP work requirements •Beneficiary is receiving TEA Cash Assistance •Medically frail / Disabled •Beneficiary is incapacitated in the short-term or is medically certified as physically or mentally unfit for unemployment •Beneficiary is caring for an incapacitated person •Beneficiary lives in a home with a dependent child age 17 or younger •Beneficiary is receiving unemployment benefits •Beneficiary is currently participating in a treatment program for alcoholism or drug addiction •Beneficiary is pregnant

**Exemption duration is discussed in the chart below on page 19.*

The exemptions may also provide a benefit. For example, many employers, including the State of Arkansas, require individuals who apply for employment to successfully pass a drug test prior to hiring. Treatment is a temporary means of demonstrating compliance with the WCE activities. Thus, successful treatment (the exemption) would therefore lead to employment (the ultimate goal).

Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Depending on the criteria, exemptions will be valid for the respective durations specified in the exemption chart. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues.

The demonstration will be phased-in by two age groups. Based on data as of March 2, 2018, there were 171,449 ARWorks beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Beginning June through September 2018, beneficiaries ages 30 – 49.

Based on the same data, there were 125,242 ARWorks beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four (4) months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months, and number of beneficiaries affected.

Month Work Requirement Begins	Renewal Months	Approximate #of Beneficiaries To report work activities
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682

September 2018	Oct, Nov, Dec	11,146
TOTAL		38,321

Data date: 3/2/2018

The 19- to 29-year-old age group will be phased in during 2019 between January and April.

Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. The promulgated Medicaid eligibility manual can be accessed from the main public DHS policy page.[5]

Arkansas has designed the WCE requirement for ARWorks to closely align with requirements in SNAP. SNAP work requirements can be found and reviewed online as part of the DHS/DCO policy manual.[6]

4. Evaluation Overview

This Evaluation Design is in addition to the previously approved Evaluation of ARWorks. It will be procured separately from the previously approved Evaluation due to the unique nature of WCE requirements. This feature makes the Demonstration resemble an income security program and will be evaluated accordingly.

The approved ARWorks amendment requires approximately 69,000 abled-bodied individuals to engage in work activities, which include education and training. This promotes the objectives of Title XIX as described in Section 1901: "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State to . . . help such families and individuals **attain or retain capability for independence** . . . ."[7] (Emphasis added.) The purpose of Medicaid, therefore, as defined by the statute, goes beyond paying for medical care. The purpose of the WCE requirements is to improve the skill sets of individuals, assist them to gain or increase employment, increase their earnings, and thereby helping them lift themselves out of poverty and to improve their overall health. The purpose of the work requirements, to help individuals attain economic independence, is in their interest, and therefore promotes the statutory objectives of the Medicaid program.

It is widely recognized that employment improves an individual's health:

- Work has a positive influence on an individual's health and security;
- Returning to work has significant health benefits, especially mental health benefits;
- Work has a positive intergenerational influence;
- People who work live longer and healthier lives; and
- Work has non-financial rewards including socialization, stabilization, and support.

The Demonstration Evaluation will therefore answer three core questions surrounding enforceable WCE requirements in Medicaid:

1	Does WCE requirements promote personal responsibility and work?
2	Does WCE requirements encourage movement up the economic ladder?
3	Does WCE requirements facilitate transitions from ARWorks to employer-sponsored insurance and Marketplace coverage?

The purpose of work requirements is well summarized in a November 9, 2016, paper by the Congressional Research Service (CRS): "Four primary rationales for such policies have historically been put forth: offsetting work disincentives inherent in social assistance programs; promoting a culture of work rather than one of dependency; rationing scarce taxpayer dollars to the truly needy; and combating poverty."[8] The CRS authors observe, "[e]mpirical studies have generally confirmed that providing social assistance has a work disincentive, though the size of that disincentive has historically been in dispute."[9]

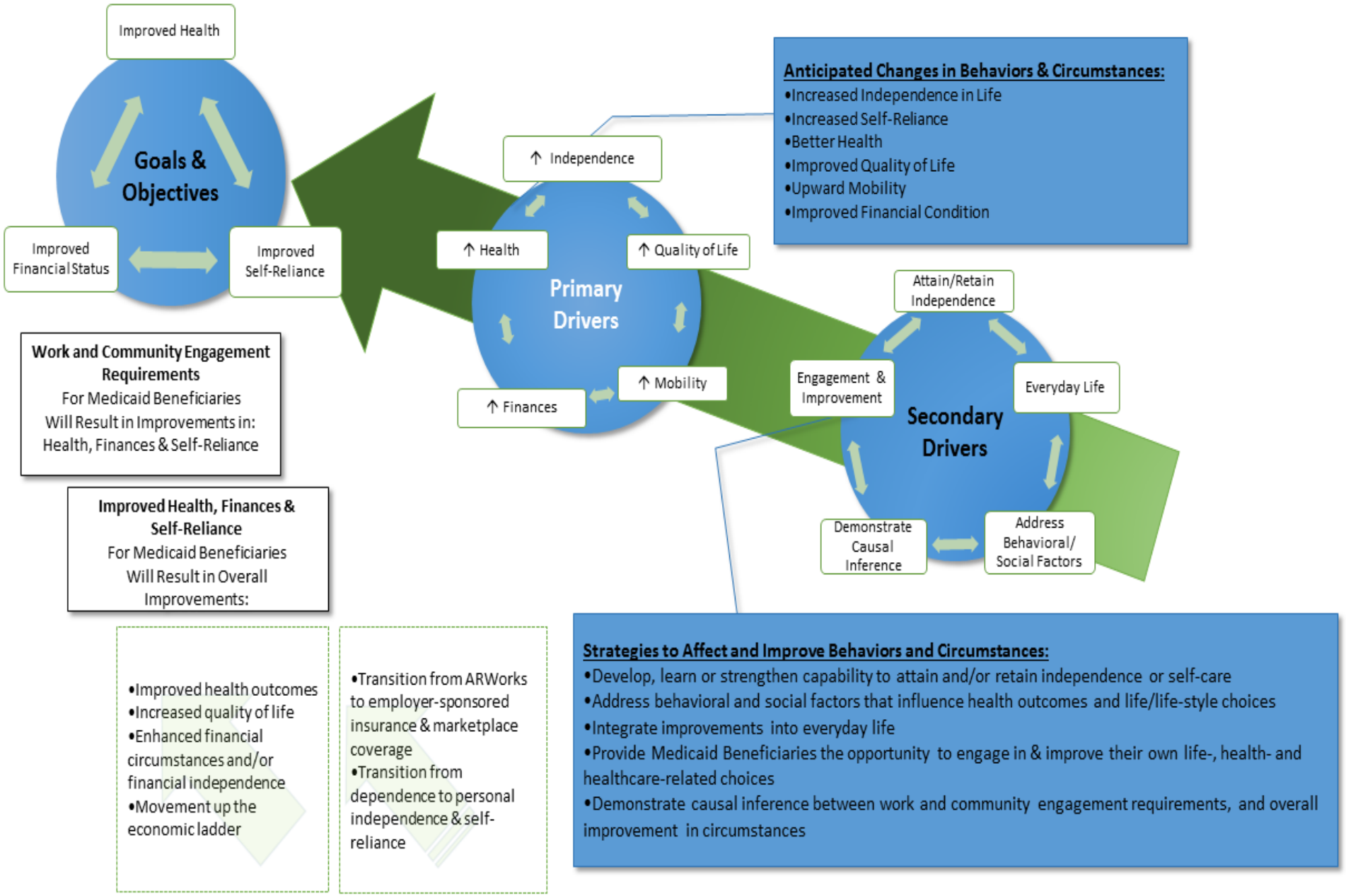
The relationship between not working and poverty is indisputable. According to CRS, the poverty rate for a family with a worker was 8.7% in 2015 compared to 90.8% for a family with no one who worked or had work-related benefits. The poverty rate for a family with a full-year, full-time worker was 4.2% in 2012 compared to 29.9% for a family with no full-year, full-time worker.[10]

Our hypothesis is that individuals enrolled in Arkansas Works sufficiently value health insurance coverage to comply with the work and community engagement activities which, over time, will lead to increased earnings and transition to other health insurance coverage.

Individuals will gain the understanding that increased earnings no longer results in the loss of access to necessary health care services. The continuation of coverage after a person earns more than the Medicaid income eligibility limits will demonstrate that Medicaid, with work requirements, is not a disincentive to work. DHS will be able to measure and report on participation but has not set targets given the unique nature of this Demonstration.

The purpose of the Demonstration is to increase earnings of individuals enrolled in ARWorks in order for them to rise above the poverty level. This pathway begins with notifying nonexempt individuals that they are subject to WCE requirements and ends when their earnings exceed the program parameters. The Evaluation will address the hypotheses about whether Medicaid WCE requirements result in sufficiently increasing income to rise above the poverty level.

The Driver Diagram on the next page sets out graphically the goals, as well as the primary and secondary drivers related to the enumerated goals.


Improved Health
Goals & Objectives
Improved Financial Status
Improved Self-Reliance
Anticipated Changes in Behaviors & Circumstances:
•Increased Independence in Life
•Increased Self-Reliance
•Better Health
•Improved Quality of Life
•Upward Mobility
•Improved Financial Condition
↑ Independence
↑ Health
↑ Quality of Life
Primary Drivers
↑ Mobility
↑ Finances
Attain/Retain Independence
Engagement & Improvement
Everyday Life
Secondary Drivers
Demonstrate Causal Inference
Address Behavioral/ Social Factors
Work and Community Engagement Requirements
For Medicaid Beneficiaries
Will Result in Improvements in:
Health, Finances & Self-Reliance
Improved Health, Finances & Self-Reliance
For Medicaid Beneficiaries
Will Result in Overall Improvements:
•Improved health outcomes
•Increased quality of life
•Enhanced financial circumstances and/or financial independence
•Movement up the economic ladder
•Transition from ARWorks to employer-sponsored insurance & marketplace coverage
•Transition from dependence to personal independence & self-reliance
Strategies to Affect and Improve Behaviors and Circumstances:
•Develop, learn or strengthen capability to attain and/or retain independence or self-care
•Address behavioral and social factors that influence health outcomes and life/life-style choices
•Integrate improvements into everyday life
•Provide Medicaid Beneficiaries the opportunity to engage in & improve their own life-, health- and healthcare-related choices
•Demonstrate causal inference between work and community engagement requirements, and overall improvement in circumstances

DHS will use a public Request for Proposal (RFP) process to procure the capabilities necessary for evaluation of the Demonstration. The Evaluation will use a combination of data sources including monthly data on enrollment and participation on all individuals who are not exempt. These data sets will be augmented by interviews with a statistically valid sample of individuals who remain on the program and those who leave the program. The successful bidder must have demonstrated experience in evaluating the impact of work requirements on participation in income security programs.

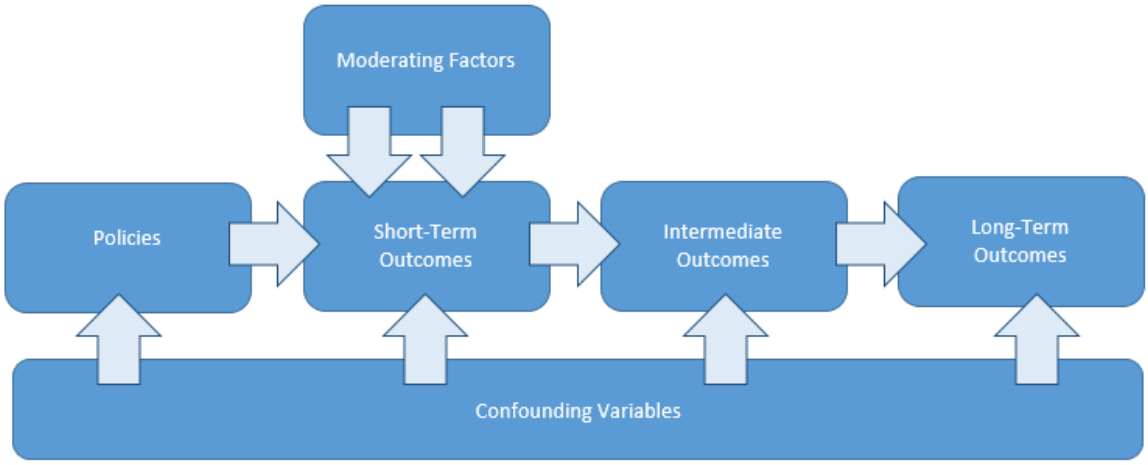
Evaluation questions will be developed in the RFP process and specific interview questions of participants will be developed by the successful bidder.

The following graphic sets forth the ultimate goals of the WCE requirements, as well as the primary and secondary drivers of the evaluation hypothesis:

5. Evaluation Design

The overall evaluation design will follow the process below, taking into consideration all factors that would influence Medicaid beneficiaries' choices, decisions, actions and outcomes:

Logic Process



Moderating Factors

- Number & type of exemptions and accommodations applicable or sought by beneficiaries
- Number & type of exemptions and accommodations applied or approved
- Number of beneficiaries disenrolled and reasons for disenrollment
- Reasons for remaining in ARWorks (i.e., due to WCE requirements or other reason(s))
- Reasons for leaving ARWorks (i.e., due to WCE requirements or other reason(s))
- Enrollment churn
- Accurate income reporting

Policies

- Direct Policies –
  - »Implement WCE requirements

»Tie requirements to continued enrollment in ARWorks
»Applies to and dovetails with other income security programs (e.g., TEA, SNAP)

- Work Strategies – Provide work and career training, which promotes the opportunity to:
  - »Learn a trade
  - »Take current training and skills to a higher level
  - »Receive placement services
  - »Decrease perception of reliance and increase independence
- Health and Healthcare Strategies – Advantages of improved health:
  - »Encourages taking control over health and health-related activities
  - »Promotes personal self-reliance
  - »Supports return-to-work strategies
- Identify and track work-related metrics and outcomes
- Provide the bridge to obtaining employer-sponsored or marketplace insurance

Short-Term Outcomes

- Culture of Work (i.e., promote a culture of work over dependency)
- Increased:
  - »Work history and experience assists with future employment opportunities
  - »Skills translates to promotions, job stability, marketable and transferable skills
  - »Computer literacy/internet/email experience by required use of the ARWorks Portal
- Positive impact on:
  - »Socialization opportunities
  - »Personal and life stability
  - »Support structure

Intermediate Outcomes

- Enhanced financial circumstances, and improved financial stability
- Improved health and personal security
- Decreased perception of challenges in life and for employment, promotion, etc.

Long-Term Outcomes

- Significant health and mental health benefits
- Upward mobility
- Financial independence
- Positive inter-generational influence
- Longer, healthier lives

Intermediate & Long-Term Outcomes

- Prioritization of governmental resources
- Increased sustainability of the Arkansas Medicaid program

with the goal of being able to provide medical assistance to those needing such programs

Confounding Variables

- Current work status
  - »Already working –
    - -Full time
    - -Part time
  - »Not working due to –
    - -School attendance
    - -Care-giving
    - -Illness or disability
    - -Another reason
- Social Determinants of Health
  - »Current health status and medical issues
  - »History of job instability or unemployment
  - »Education level
  - »Multi-generational poverty
  - »Support system (Lack of one)
  - »Housing & Food insecurity
- Life Disruptions (Major/Minor)
  - »Divorce
  - »Becoming a caretaker for family member
  - »Death of spouse/family member
  - »Unintended pregnancy
  - »Becoming homeless
  - »Natural disaster/catastrophe
- Personal Characteristics
  - »Learned behaviors
- Economic environment:
  - »Overall economy

»Personal goals and desires	»Location-specific economic factors (e.g., local, regional, rural, urban, etc.) »Strong/Weak job market (↑ or ↓ success)

The Evaluation population will consist of those individuals who are enrolled in ARWorks and were not initially exempt from the WCE requirements. The Evaluation population will include current and newly-enrolled beneficiaries. Their participation in ARWorks will be tracked over time. A subset of this group will be interviewed over time in order to understand the individual's reason(s) a person chose to participate or not.

There are 69,000 individuals that DHS estimates will not be initially exempt from the WCE requirements. This is a sufficiently large group to support a statistically reliable sample size. The Evaluation will use a variety of data sources including monthly enrollment data and the data under the Outcome Monitoring Plan ("Monitoring Plan") which will contain the following statistics:

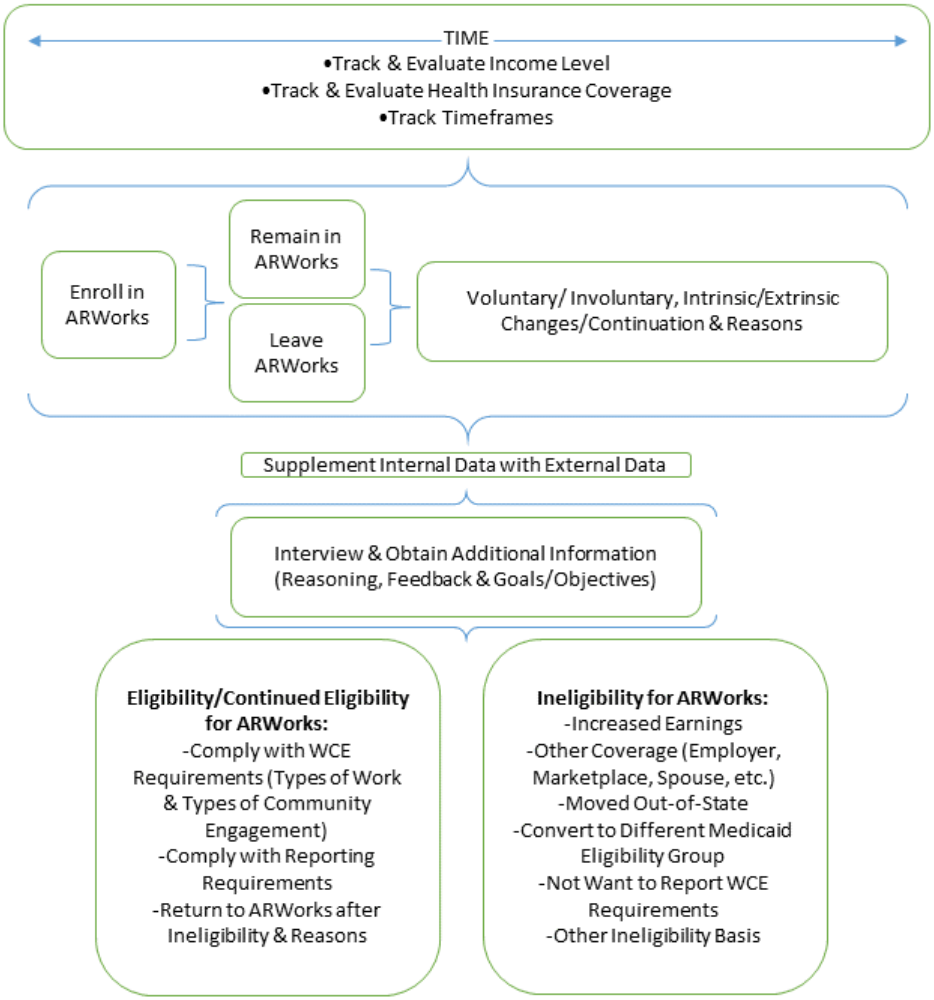
•Number and percentage of:	-individuals required to report each month -beneficiaries who are: »exempt from the community engagement requirement. »requesting good-cause exemptions from reporting requirements »granted good-cause exemption from reporting requirements »requesting reasonable accommodations -beneficiaries disenrolled for: »failing to comply with community engagement requirements »failing to report »failing to meet community engagement and reporting requirements -community engagement appeal requests from beneficiaries -applications made in-person, via phone, via mail and electronically
•Number, percentage and type of:	-reasonable accommodations provided to beneficiaries -community engagement good-cause exemptions: »requested »granted -reporting good-cause exemptions: »requested »granted

In addition, the Evaluation will include personal interviews with individuals to understand their reasons for their choices. Through their choices, individuals will create subgroups that will describe their experiences to remain or leave the program over time.

Remain – Those who remain on the program (or return to it) may do so for a variety of reasons that are important to understand: •Comply with WCE requirements in order	A sample of those who remain will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that

to maintain coverage •Convert to a different Medicaid eligibility group (pregnancy, disability) •Return to ARWorks, even after a loss of coverage for a new coverage year	appropriate questions from the National Health Interview Survey for adults will be used for this purpose.[11]
Leave – It is also critical to understand why individuals leave ARWorks, which may be categorized as voluntary/involuntary, intrinsic/extrinsic, or in multiple categories, from the beneficiary's and DHS's standpoint: •Earnings increased •Alternate coverage source (e.g., spouse) •Did not want to report •Moved out-of-state •Requested or Required closure •Noncompliance/Sanctioned (case closed)	A sample of those who leave will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that appropriate questions from the National Health Interview Survey for adults will be used for this purpose.

DHS anticipates that the WCE requirement cycle – and subsequent evaluation – will broadly follow this evolution of adherence or non-adherence:



By definition, everyone in the Evaluation group has low wages at the point-in-time in which they reported income at or below 138% FPL ($16,753 annually; $1,396 monthly for a single individual) and were enrolled in ARWorks. The Evaluation will examine how individuals who leave because of increased wages:

- Learned new skills
- Completed education
- Increased from part-time to full-time work

The Evaluation Period will use data from January 2018 through December 2021. Although the WCE activities do not begin until June 1, 2018, data prior to the implementation is necessary to set the baseline for comparison.

The principal measures are income levels and health insurance coverage. Overall, the experience of individuals will be analyzed over time, comparing their income and health insurance coverage at the end of the Demonstration on December 31, 2021, to their income and health insurance coverage on January 1, 2018. Additionally, a sample of participants will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that appropriate questions from the National Health Interview Survey (NHIS) for adults will be used for this purpose.

Data sources will include enrollment sets from DHS and from the Monitoring Plan. In addition, a statistically-valid sample population will be interviewed by a contractor selected through a RFP process.

There are two major challenges to be faced in the Evaluation:

1	Enrollment churn: Individuals moving on and off the program for reasons unrelated to work requirements.
2	Income is likely under-reported. Currently: »80.5% of able-bodied adults without dependents age 19 to 29 and »88% of able-bodied adults without dependents age 30 to 49 report income of 0 to 25% of the FPL.

CONTINUED ACCESS TO HEALTH CARE

Should individuals choose not to participate in the Medicaid work requirements and involuntarily leave their coverage, they will still have access to health care. Although it is one of the poorest states in the nation, Arkansas is fortunate to have more than 100 Community Health Center (CHC) service locations across the state. In addition, there are 13 Community Mental Health Centers (CMHC) that are responsible for providing services to uninsured individuals with mental health needs in regions that cover the entire state. These clinics are geographically dispersed throughout the state and cover counties with the highest poverty levels within the state.

The CHCs and CMHCs served many low-income Arkansans prior to adoption of the Adult Expansion Group regardless of their insurance status. They provide a "patient-centered model of healthcare delivery, offering comprehensive services to patients at each clinic." (See End Note 12.) Services include:

- Family medicine
- Internal medicine
- Pediatrics
- Obstetrics and gynecology
- Oral health
- Diagnostic and basic radiology services
- Mental health and behavioral healthcare
- Healthcare accessibility services like transportation and translation/interpretation

However, DHS anticipates that the successful RFP contractor will have the skills to mitigate these challenges.

The Monitoring Plan, described herein, provides additional information on the implementation of the Demonstration. The analytic methods will be described in detail through the RFP process and the successful contractor.

DHS fully expects this to be a rigorous Evaluation with sufficient data and protocols to strongly support this Demonstration Project of national significance. Additional information about the independent evaluator, the evaluation budget and supplementary timeline points and major milestones will be added at a future date because of the RFP process which generally is a six- to nine-month procurement process.

As the RFP is developed, and feedback is received from potential vendors, the Design Table for the Demonstration Evaluation, below, will continue to mature:

Research Question	Outcome Measures Used to Address the Research Question	Sample or Population subgroups to be compared	Data Sources	Analytic Method
Hypothesis 1: Work and Community Engagement requirements promote personal responsibility and work				
•Changes in work status before, during and after WCE requirements period over time •Changes in level of job placement and job security over time •Changes in level of independence over time •Changes in intrinsic perception of personal responsibility and ability for self-care over time	•Work situation, including FT, PT, seasonal, etc., including any changes •Utilization rate of services offered by Arkansas DWS •Determine measurement (how beneficiary measures the benchmark), baseline and subsequent changes in: »Job security »Independence »Personal Responsibility »Ability for self-care	•Medicaid beneficiaries without ARWorks exemptions/ accommodation •Medicaid beneficiaries with ARWorks exemptions/ accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Claims data •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process

Hypothesis 2: **Work and Community Engagement requirements encourage movement up the economic ladder**				
•Changes in level of income and benefits provided through work or other sources over time •Changes in level of housing and food security over time •Changes in intrinsic perception of: »Financial Success »Challenges faced to obtain an improved life •Changes in intrinsic perception of self-reliance over time	•Determine measurement (how Medicaid beneficiary subject to ARWorks requirements measures the benchmark), baseline and subsequent changes in: »Financial Success »Housing Situation »Food situation »Life challenges »Self-Reliance	•Medicaid beneficiaries without ARWorks exemptions/ accommodation •Medicaid beneficiaries with ARWorks exemptions/ accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Tax returns •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process
Hypothesis 3: **Work and Community Engagement requirements facilitate transition from ARWorks to employer-sponsored insurance or marketplace coverage**				
•Changes in health insurance coverage before and during WCE requirements period •Changes in health before and during WCE requirements period	•Track type, source and benefit level of health insurance •Determine measurement (how Medicaid beneficiary subject to ARWorks requirements measures the benchmark), baseline and subsequent changes in health situation	•Medicaid beneficiaries without ARWorks exemptions/ accommodation •Medicaid beneficiaries with ARWorks exemptions/ accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Claims data •Tax returns •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process

6. Outcome Monitoring Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018.

The planning, testing, implementation, and monitoring timeline is provided below:

•3/15/18	»Mass notice was issued to all ARWorks beneficiaries informing them of the change in the program and upcoming implementation of WCE requirements. »The notice instructed them that no additional action is required at that time and will encourage them to provide an email address to Arkansas DHS if they have not already.
•3/30/18	»Successful "go live" for the ARWorks online portal. »Beneficiaries are able to begin linking their secure online accounts and reporting exemptions.
•4/1/18	»New ARWorks beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the WCE. »These beneficiaries will have their begin dates for completing and reporting work activities set to begin the second month after approval.
•4/1/18 – 4/8/18	»Work requirement begin months will be set for beneficiaries 30 – 49 years of age. »Notices will be mailed to each individual with specific details about the WCE requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
•4/13/18	»The first data file of ARWorks beneficiaries containing specific information regarding WCE details were provided to Arkansas DWS, the Medicaid Beneficiary Relations vendor, and QHP carriers. »Outreach and education will begin. »Updated files will be provided weekly thereafter.
•5/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in June 2018 were mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. »Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. »Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
•6/1/18	»Implementation of mandatory work requirements begins for individuals ages

	30 - 49.
•6/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in July 2018 will be mailed individually tailored notices.
•7/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in August will be mailed individually tailored notices.
•7/30/18	»Monitoring phase begins. »First quarterly report will be submitted to CMS (Center for Medicare and Medicaid Services).
•8/8/18	»ARWorks beneficiaries ages 30 - 49 who are scheduled to begin the WCE requirement in September 2018 will be mailed individually tailored notices.
•10/30/18	»Second quarterly monitoring report will be submitted to CMS.
•11/1/18	»New ARWorks beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the WCE. »Their beginning dates for completing and reporting work activities set to begin the second month after approval.
•11/1/18 – 11/8/8	»Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age. »Notices will be mailed to each individual with specific details about the WCE requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
•12/8/18	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. »Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. »Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
•1/1/19	»Implementation of mandatory work requirements begins for individuals ages 19 - 29.
•1/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in February 2019 will be mailed individually tailored notices.
•1/30/19	»Third quarterly monitoring report will be submitted to CMS.
•2/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in March 2019 will be mailed individually tailored notices.
•3/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in April 2019 will be mailed individually tailored notices.
•4/30/19	»Fourth quarterly monitoring report will be submitted to CMS.

All of the data required to produce these Outcome Monitoring reports is owned by Arkansas DHS. With the exception of the good-cause exemption reports and the WCE appeal requests,

these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer.

A database outside of the eligibility system is being developed by DHS to track and report all good-cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

7. Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone.

No changes are needed to the current process for applications related to the addition of the WCE requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each DCO county office (DHS Division of County Operations) can access the vendor as needed to assist individuals.

Arkansas DHS also accepts applications from incarcerated individuals up to forty-five (45) days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release.

Applications received from beneficiaries who lost eligibility due to non-compliance with WCE requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process is available in a procedural desk guide.

Renewals are conducted monthly through an *ex-parte* process. Beneficiaries whose renewals cannot be completed *ex-parte* are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS.

ARWorks beneficiaries who are subject to WCE requirements will have their renewals completed by the same method as beneficiaries who are not subject to WCE activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the *ex-parte* renewal process from occurring.

Arkansas monitors Medicaid timeliness with data, and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports

can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally-facilitated marketplace for individuals determined to be ineligible for Medicaid.

No changes to this process are necessitated by the addition of the WCE process.

8. Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements

Once work requirements are implemented in June of 2018, ARWorks beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued ARWorks eligibility. Work requirements will not apply to ARWorks beneficiaries ages 50 and older.

Allowed Work Activities and Work Activity Hour Calculations

ARWorks beneficiaries ages 19–49 who are not exempt must engage in 80 hours of monthly WCE activities. ARWorks beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of the following activities as deemed appropriate by the state. ARWorks beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement.

Work Activity	Work Activity Hours
Employment or Self-Employment	•Reported income divided by Arkansas minimum wage = work activity hours
Going to school, job training, vocational, or other educational program	•English As a Second Language (ESL): 1 hour of instruction = 2.5 work activity hours •GED (General Equivalency Diploma)/Basic Skills/Literacy: 1 reported hour = 2 work activity hours •College/University: 1 credit hour = 2.5 work activity hours •High School: 1 hour of instruction = 2.5 work activity hours •Occupational Training: 1 hour of instruction = 2 work activity hours •Unpaid Job Training: 1 reported hour = 1 work activity hour •Vocational Training: 1 credit hour = 2.5 work activity hours
Volunteering	•1 reported hour = 1 work activity hour

Job Search or Job Search Training up to 39 total hours each month	•Job Search: 1 reported job contact = 3 work activity hours •Job Search Training: 1 reported hour = 1 work activity hour
Health Education Class up to 20 hours each year	•1 reported hour = 1 work activity hour
Any activity that satisfies the SNAP Work Requirement	•Determined by the SNAP program

Exemption from Work Requirements

ARWorks beneficiaries meeting one of the criteria below will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. Depending on the criteria, exemptions will be valid for the respective durations specified below.

When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval.

Exemption Criteria	Duration of Exemption
Beneficiary's income is consistent with being employed or self-employed at least 80 hours per month	Exemption valid until a change in circumstances or renewal
Beneficiary attends high school, an institution of higher education, vocational training, or job training on a full-time basis	Exemption valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is exempt from SNAP work requirements	Exemption valid for duration of SNAP exemption
Beneficiary is receiving TEA Cash Assistance	Exemption valid for duration that individual is receiving TEA Cash Assistance
Medically frail / Disabled	Exemption valid until a change in circumstance

Beneficiary is incapacitated in the short-term or is medically certified as physically or mentally unfit for unemployment	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is caring for an incapacitated person	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary lives in a home with a dependent child age 17 or younger	Exemption valid until a change in circumstances
Beneficiary is receiving unemployment benefits	Exemption valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is currently participating in a treatment program for alcoholism or drug addiction	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is pregnant	Exemption valid until end of post-partum care

Disenrollment for Failure to Meet Work Requirement

Beneficiaries who are subject to work requirements will lose eligibility for ARWorks if they fail to meet work requirements for any three (3) consecutive or non-consecutive months during the coverage year. Effective as of the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to reenroll in ARWorks.

ARWorks beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with WCE requirements will contain information about how to access primary and preventive care services at low or no cost at free health clinics and community health centers.[12] Closure of the ARWorks case will be transmitted to the InterChange Medicaid Management Information System (MMIS). Termination of the QHP premium payment is automated in the InterChange system.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the WCE requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Cúram eligibility system that has already passed CMS readiness review standards. DHS required

through contract with Cúram developers that the portal is mobile-device friendly and ADA-compliant (Americans with Disabilities Act).

Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality assurance process. Use of the portal promotes WCE goals by reinforcing basic computer literacy/skills, internet navigation, and communication via email – all of which provide the beneficiaries additional transferrable work-related skills.

This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the WCE requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from WCE requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS/DCO county offices. All notices provide instructions to contact the Access Arkansas Call Center or a DHS/DCO county office for help regarding WCE requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for ARWorks beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on the ARWorks public SharePoint site:

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and submit completion of WCE activities. The WCE portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system.

Exemptions must only be re-attested to by the beneficiary at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month.

The online portal is secure, mobile-device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries to prepare for this requirement, Arkansas DHS and the vendor-provided call center have conducted a campaign over the last several months where DHS encouraged beneficiaries to provide an email address. DHS also offered information about how to obtain free email addresses and assistance with setting up email addresses. DHS has been able to collect several thousand email addresses during this effort.

DHS has taken great care to make the reporting process as user-friendly as possible, and beneficiaries are provided a number of services related to the portal that will assist with this requirement:

- Password Reset: The portal allows beneficiaries to reset passwords through self-service.
- Customer Support:
  - »Technical assistance will also be available through the Access Arkansas call center for website and password issues.
  - »Beneficiaries who require assistance using the portal can receive assistance from several sources, including Arkansas DHS staff, call center agents, Arkansas DWS staff, or the beneficiary's QHP carrier.
  - »Each notice and flier regarding WCE direct beneficiaries who need help to contact the DHS via the toll-free call center or local DHS/DCO county office.
- Literacy Levels:
  - »Arkansas DHS worked with the University of Arkansas for Medical Sciences (UAMS) Center for Health Literacy team to help develop language for WCE notices and fliers.
  - »Similar verbiage was used on the portal for consistency and understanding at lower literacy levels.
- Interpretation/Translation: Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS/DCO county offices.
- Hours of Operation:
  - »The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades.
  - »The website displays a notice each time is offline for maintenance.
  - »Those outages when necessary are scheduled over weekends for minimal disruption.

»The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their WCE status for the current reporting month as well as history for the year-to-date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good-Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good-cause exemption. Circumstances that may lead to an approved good-cause exemption include, but are not limited to:

- Natural disaster,
- Hospitalization or serious illness,
- Birth or death of a family member living in the home, or
- Domestic violence.

Beneficiaries who have lost coverage due to non-compliance with the WCE requirement will have their cases reinstated without a new application if they are granted a good-cause exemption and are otherwise eligible.

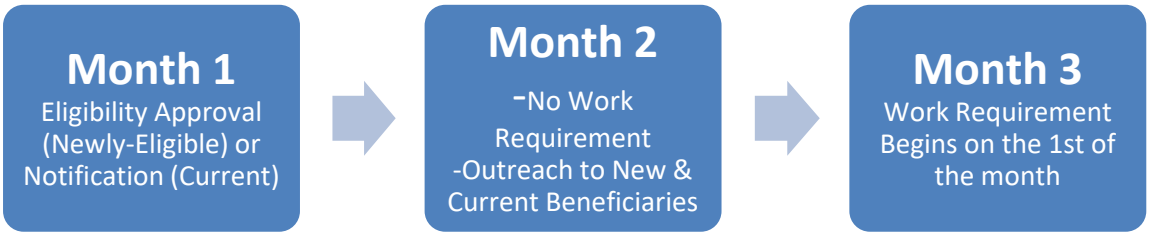
Information about good cause exemptions and how to request these is provided in all WCE notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good-cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly-approved ARWorks beneficiaries who are subject to the WCE requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the ARWorks program on any day during the month of April will be required to begin completing work activities on June 1st.

Through the implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period after notification will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance

with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, the Medicaid Beneficiary Relations vendor, and QHP carriers.



Over the last several months, Arkansas DHS has developed several educational tools regarding WCE requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the ARWorks program and the WCE requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This ARWorks toolkit is available online to the public so that partners and beneficiaries can access the information as needed. The ARWorks toolkit, with links to education and outreach information, can be found on the ARWorks public SharePoint site shown above.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with ARWorks beneficiaries who have provided email addresses through an electronic message to a secure inbox. The content of the notices will meet all requirements in the standards, terms, and conditions reflected in the approved §1115 waiver amendment. With the exception of good-cause exemption denials, all notices related to the WCE requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to WCE requirements have been developed and contain detailed information for beneficiaries.

Notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. Additionally, a good-cause exemption functionality is on the roadmap to be developed in within the DHS eligibility system.

A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each ARWorks qualified health plan carrier, the Arkansas Hospital Association, UAMS, and the Arkansas Department of Career Education. Input and participation is open to interested

stakeholder organizations. DHS is also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to ARWorks beneficiaries in this and other ways. Arkansas DHS has lead on this project.

As a result of this effort, an ARWorks Resource Dashboard and Interactive Resource Map has been developed for users to click county by county for specific information on local resource availability. The Resource Dashboard allows beneficiaries to located valuable and needed information for effectively complying with all WCE requirements.

The County-Specific Resources resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations.

Locations where beneficiaries and former beneficiaries can access free and reduced-cost health care have also been collected and made available in this map. DHS will include information in

notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the ARWorks information SharePoint site and will be updated quarterly and as new information becomes available.

An example of the ARWorks Resource Guide for Pulaski County, Arkansas, where Little Rock is located, is attached hereto as Attachment 1. The guides are down-loadable and have hyperlinks throughout for each easy access to additional resources.

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM (Payment Error Rate Measurement) and MEQC (Medicaid Eligibility Quality Control) requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence.

In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of ARWorks beneficiaries who are subject to WCE requirements to identify trends and potential anomalies that should also be reviewed for

accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error-prone areas.

The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the ARWorks case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to WCE requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in DHS/DCO county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual ARWorks and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing.

SNAP and ARWorks beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, the DHS Medicaid Beneficiary Relations vendor, and each QHP carrier. Information provided to carriers will be limited to ARWorks beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes:

- Contact information,
- Work and community engagement exemption and compliance information,
- Type of exemption,
- Number of months of cumulative non-compliance,
- Compliance status for the current month, and
- Renewal month.

This level of detail will allow DHS's partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Arkansas DHS has also leveraged its current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the WCE requirement. AFMC will do active outreach to educate ARWorks beneficiaries who need to complete WCE activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their

activities and to direct them to the Arkansas Department of Workforce Services, SNAP Employment and Training (SNAP E&T) vendors, or other resources as appropriate to help them comply with work requirements. Contractual requirements for WCE include an outreach period 30 days prior to the beginning of WCE requirements for existing ARWorks beneficiaries.

Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about WCE requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an ARWorks beneficiary is approved with WCE requirements. AFMC must successfully contact and educate 30% of existing ARWorks beneficiaries and 40% of newly-approved ARWorks beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to the DHS Cúram eligibility system. AFMC will also be receiving a daily and monthly file containing ARWorks beneficiaries with WCE requirements and their current status related to these activities. AFMC is required to make a minimum of two (2) attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in SNAP statewide in January 2016. Participation in SNAP E&T is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities.

Since inception of the SNAP work requirement, Arkansas DHS partnered with the United States Department of Agriculture (USDA) Food and Nutrition Services (FNS) to expand the SNAP program in Arkansas. Initially, SNAP E&T was available in thirteen (13) counties across Arkansas. As of July 2018, Arkansas now has increased the number of counties with a SNAP E&T program to sixty-six (66) out of seventy-five (75) counties – and the number of included counties continues to increase.

In each county where it is available, DHS has either a contract or sub-grant agreement in place with at least one SNAP E&T vendor. Each SNAP E&T vendor must have a physical location to provide employment and training services.

USDA/FNS has also approved Arkansas to pilot virtual SNAP E&T case management. This will also participants in rural counties to meet with their E&T case manager virtually by using a laptop available for this purpose in the DHS/DCO county office.

Point-in-time data comparison in March 2018 between the SNAP program and ARWorks has shown that approximately twenty-two to twenty-five percent (22-25%) of ARWorks beneficiaries also receive SNAP. DHS plans to leverage the expanded SNAP E&T program to assist individuals who are dually-eligible for SNAP and ARWorks: ARWorks beneficiaries can be referred to SNAP E&T vendors for appropriate for assistance with job search and training in order to meet WCE requirements.

SNAP E&T vendors already conduct outreach to engage SNAP recipients. SNAP recipients who are also enrolled in ARWorks may satisfy WCE requirements in both programs by participating in a SNAP E&T program. A list of these SNAP E&T vendors and locations are included in the ARWorks county-specific resource guide, and as Attachment 2 hereto.

Dual SNAP and ARWorks beneficiaries will be allowed to satisfy the WCE requirement for both programs by participating in and reporting in either SNAP or the ARWorks program. They will not be required to comply with or report separately to both programs to maintain continued eligibility.

The ARWorks, SNAP and TEA programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff.

END NOTES

[1] Section 1901 of the Social Security Act, under Title XIX – Grants to State for Medical Assistance Programs (www.ssa.gov/OP_Home/ssact/title19/1901.htm).

[2] *See, e.g.*, *How Does Employment – or Unemployment – Affect Health?*, Robert Wood Johnson Foundation Health Policy Snapshot, March 2013 Issue Brief (www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360, and *The Impacts of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors*, Pharr, Jennifer R., et al., (www.hindawi.com/journals/isrn/2012/483432/). Disadvantages developed by unemployed workers, as well as advantages inured to employed adults, include, but are not limited to:

- "Laid-off workers are 54 percent more likely than those continuously employed to have fair or poor health, and 83 percent more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis."
- "With respect to mental health, a 2010 Gallup Poll found that unemployed Americans were far more likely than employed Americans to be diagnosed with depression …".
- "The relationship between unemployment and poor health has been well documented."
- "Unemployed participants had significantly worse perceived mental health profiles …".
- "Studies have also demonstrated a positive correlation between employment and better health, improved self-confidence, self-esteem, and happiness."

Fortunately, a strong economy provides opportunities for lower-skilled workers. This includes younger workers, "mother headings families, and other groups not favored in the labor market." *An Overview of Economic, Social and Demographic Trends Affecting the US Labor Market*, Lerman, Robert I. and Stefanie R. Schmidt, The Urban Institute, Final Report, August 1999, at page 1 (www.dol.gov/oasam/programs/history/herman/reports/futurework/conference/trends/trends.pdf).

[3] *See* Arkansas's Amended Waiver Request (www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf). The purpose of the amendments is to "test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage." *Ibid*.

[4] *See* Letter dated March 5, 2018, from Ms. Seema Verma, CMS Administrator, to Ms. Cindy Gillespie, Director, Arkansas DHS, regarding approval of Arkansas's proposed amendment to the Arkansas Works program. On pages 3-4, Ms. Verma noted that:

> Arkansas' approach [to the WCE requirements] is informed by the state's experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities. CMS will therefore allow

Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

[5] On the Arkansas DHS public SharePoint site for DHS Policies and Publications (ardhs.sharepointsite.net/DHSPolicy/default.aspx), select "Division of County Operations Policies".

[6] Arkansas DHS/DCO Supplemental Nutrition Assistance Program (SNAP) Policy Table of Contents (ardhs.sharepointsite.net/DHSPolicy/DCOPublishedPolicy/Forms/SNAP.aspx).

[7] *See* End Note No. 1, *supra*.

[8] *Work Requirements, Time Limits, and Work Incentives in TANF, SNAP, and Housing Assistance*, Falk, Gene, Maggie McCarty and Randy Alison Aussenburg, Congressional Research Service, November 9, 2016, at page 2 (greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/R43400%20-%20Work%20Requirements,%20Time%20Limits,%20and%20Work%20Incentives%20in%20TANF,%20SNAP,%20and%20Housing%20Assistance_0.pdf).

[9] *Ibid*.

[10] *Ibid*., Table 5, at page 27.

[11] *See Detailed outline of core topics in the Redesigned National Health Interview Survey (NHIS) Sample Adult Questionnaire, Version: October 2017*, United States Center for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) (www.cdc.gov/nchs/data/nhis/AdultNHISRedesignTopics20171027.pdf).

[12] Community Health Centers of Arkansas (chc-ar.org/) maintains a list and map of all CHC locations across Arkansas at chc-ar.org/find-a-clinic/ and chc-ar.org/health-centers-map/. *See also* "About Us" (chc-ar.org/about-us/) and "What Are CHCs?" (chc-ar.org/what-are-chcs/).

ABBREVIATIONS AND ACRONYMS

ACA	Affordable Care Act
ADA	Americans with Disabilities Act
AFMC	Arkansas Foundation for Medical Care
ARWorks	Arkansas Works
CHC	Community Health Center
CMHC	Community Mental Health Centers
CMS	Center for Medicare and Medicaid Services
CRS	Congressional Research Service
DCO	Division of County Operations
DHS	Department of Human Services
DWS	Arkansas Department of Workforce Services
E&T	Employment and Training
ESL	English As a Second Language
FFS	fee-for-service
FNS	Food and Nutrition Services
FPL	federal poverty level
GED	General Equivalency Diploma
MEQC	Medicaid Eligibility Quality Control
MMIS	InterChange Medicaid Management Information System
NHIS	National Health Interview Survey
PERM	Payment Error Rate Measurement
QHP	Qualified Health Plan
RFP	Request for Proposal
SNAP	Supplemental Nutrition Assistance Program
TEA	Transitional Employment Assistance
UAMS	University of Arkansas for Medical Sciences
USDA	United States Department of Agriculture
WCE	Work and Community Engagement

ATTACHMENTS

Attachment 1	Arkansas Works – Pulaski County Resource Guide (22 pages/pdf)
Attachment 2	SNAP E&T Coordinator List (8 pages/Word)

Request to Amend the
ARHOME Section 1115 Demonstration Project

Project No. 11-W-00365/4

State of Arkansas

Department of Human Services

January 28, 2025

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Section I: Executive Summary

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS), respectfully requests approval of this amendment, "Pathway to Prosperity," to the current Arkansas Health and Opportunity for ME (ARHOME) Section 1115 Demonstration Project (waiver). The ARHOME program is Arkansas' Medicaid expansion that provides health care coverage to more than 220,000 able-bodied adults ages 19-64 with income at or below 138% of the Federal Poverty Level (FPL). Pathway to Prosperity establishes work and community engagement requirements for the Medicaid expansion population that will drive improved health and economic independence outcomes for working age nondisabled adults and their families.

This amendment reflects lessons learned from the state's efforts in 2018-2019 to institute work requirements as a condition of maintaining eligibility for Medicaid under the expansion program, then known as "Arkansas Works." Assessments of Arkansas Works showed that many people did not know whether they were subject to participation requirements and, if they were, what they needed to do monthly to demonstrate compliance.

Lessons learned include the importance of providing clear communications through multiple means, simplicity in design, and the need for personal interaction rather than over-reliance on technology. Pathway to Prosperity will use data-matching to identify individuals who could benefit from extra support to reach health and economic goals.

For nearly 50 years Medicaid covered only the elderly, people with long-term physical or intellectual disabilities, low-income children, and the parents/caretakers of dependent children whose household income was near or below the federal poverty level. The Affordable Care Act (ACA) changed that. A new eligibility group was created to allow states to make able-bodied working age adults eligible for Medicaid. These individuals are reasonably expected to be substantially engaged in the workforce. Indeed, many of these individuals are employed, though most are not working full-time, year-round.

Pathway to Prosperity will help provide a bridge over the "benefits cliff" that keeps people from moving into economic stability and off of public assistance. Title XI, which gives authority to the Secretary of the U.S. Department of Health and Human Services to approve demonstration programs and pilots under Section 1115, allows the Secretary to "waive" federal laws and regulations for the purpose of encouraging state and local governments to improve the effectiveness of certain public assistance programs.

Moreover, in the design of Pathway to Prosperity, DHS is cognizant of the situations and circumstances of the plaintiffs from the previous legal case brought against Medicaid work requirements, *Gresham v Azar*.[1] Pathway to Prosperity will address the courts' analysis that "… the Secretary's failure to consider *the effects of the project on coverage* alone renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the act (emphasis added)."[2] The Amendment makes significant policy and procedural changes from the previous version to respond to the question of coverage.

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[1] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[2] Ibid. p. 23

The design of Pathway to Prosperity also reflects the recent U.S. Supreme Court decision in *Loper Bright Enterprises v Raimondo*[3] in how the courts are to evaluate administrative actions. While Title XI of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority for determining the purposes of Title XIX of the Act, the lower courts in *Gresham v Azar* provide an important framework for evaluating how the Secretary must fulfill his responsibilities. Specifically, the courts applied their own interpretation as to whether the Secretary sufficiently assessed the impact of work requirements and community engagement on the core purpose of Medicaid to provide coverage.

To whom does Pathway to Prosperity Apply?

- Pathway to Prosperity applies to all individuals ages 19-64 who are eligible through the new adult expansion group, who have income ranging from 0% FPL to 138% FPL, and who are covered by a QHP.
- There are no exemptions to participation; individuals will be assessed by DHS as "on track" or "not on track" through data matching.
- Those who are identified as not on track will be provided the opportunity to receive focused care coordination services to support health and economic self-sufficiency.

Focused Care Coordination and Personal Development Plan

DHS will utilize data matching to identify individuals who appear to be not on track towards meeting their personal health and economic goals. If DHS confirms that an individual is not on track, it will coordinate with the QHPs to provide focused care coordination services to eligible individuals. These services include the establishment and monitoring of a Personal Development Plan (PDP).

Employment is vital to a person's long-term health as poverty is directly linked to poor health outcomes. A person who is unemployed will benefit from the support of focused care coordination to connect the individual with needed resources such as career training and transportation. In addition, individuals who are on a path to self-sufficiency may not be aware of the resources and opportunities available to them across Arkansas.

If a person is not employed, he or she must be engaged in qualifying advancement, learning, or service activities to be considered "on track." Advancement can come from a variety of activities including training, workforce development, apprenticeships and internships. Learning includes formal education, vocational education, and activities that enhance a person's skills such as through mentoring programs or life skills development. Service in one's community may be demonstrated in a variety of ways, including caring for a dependent child, an elderly parent, or a person with a disability.

Coverage Value & Consequences

Active participation in health and workforce development will become part of the expectation of receiving health care through a QHP. In January 2025, DHS will pay the QHPs an average monthly premium of $577.62, advanced cost sharing reduction payments of $202.17 per month and "wrap around" payments of $4.53. Together, these represent an average annual value of $9,411.72 per enrolled member. Coverage provided by Arkansas Medicaid pays not only for

[3] https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

medical treatment at the time of illness or accident, but for preventative services as well that can provide high value to individuals.

Despite these opportunities, some individuals will choose not to participate in any of these investments in their health. Individuals who refuse to cooperate with DHS and decline to use services and incentives covered by QHPs will have their ARHOME coverage suspended. Benefits can be restored if the individual chooses to get "on track" with their PDP.

Suspension from ARHOME Coverage

Individuals who decline to participate in Pathway to Prosperity workforce development will have their ARHOME coverage - QHP benefits - suspended through the end of the calendar year. They will not be disenrolled from the Medicaid program. To become "active" again and have full benefits restored, they need only notify DHS of their intention to cooperate with personal development plan requirements. As Pathway to Prosperity does not make compliance a condition of eligibility, individuals will not be required to complete a new Medicaid application unless they have passed the date for their annual redetermination of eligibility.

During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHP.

Normal appeal rights will be available to an individual who is suspended.

Section II: Background & Historical Narrative

Since 2014, Arkansas has provided health care coverage to the Medicaid new adult group made eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The Arkansas Department of Human Services (DHS) uses Medicaid funds to purchase coverage from Qualified Health Plans (QHPs), which are private health insurance plans licensed by the Arkansas Insurance Department (AID).

Arkansas currently provides health care coverage to more than 220,000 beneficiaries in this eligibility group. They are adults between the ages of 19 and 64 who are not enrolled in Medicare and who are either:

(1) childless adults with household income at or below 138% of the federal poverty level (FPL), or;
(2) parents with dependent children whose income is between 14% and 138% FPL.

Of the more than 220,000 adults in Medicaid expansion, approximately 188,000 individuals currently receive their benefits primarily through Qualified Health Plans (QHPs) through the authorities granted in the Arkansas Health and Opportunity for ME (ARHOME) waiver. The remainder of the new adult group receive their benefits in the Medicaid Fee-For-Service (FFS) delivery system. Most of these FFS individuals were recently determined eligible for Medicaid and are waiting to be enrolled in a QHP (the interim group). About 13,000 other individuals are "medically frail" and will remain in the FFS model of care because it provides additional services, such as personal care, that the QHPs do not. A small number of individuals may be enrolled into the Provider-led Arkansas Shared Savings Entity (PASSE) program due to the presence of a serious mental illness and confirmation of a need for Home and Community Based Services (HCBS) through an Independent Assessment (IA).

The current version of the ARHOME waiver was approved by the Centers for Medicare & Medicaid Services (CMS) to be effective January 1, 2022, through December 31, 2026. ARHOME is designed to improve the quality of services provided by the QHPs and the health of beneficiaries assigned to them. An amendment to ARHOME was approved in November 2022 to provide intensive care coordination services for certain targeted populations through Life360 HOMEs.[4] In 2024, the first Life360 Homes, serving pregnant women diagnosed as high risk went live.

The fundamental goal of this new Pathway to Prosperity amendment is to support Governor Sarah Huckabee Sanders' vision to assist low-income Arkansans enrolled in ARHOME with moving from government dependence to economic independence and ultimately to obtain health insurance coverage through employment or the individual insurance marketplace as do most Americans.

The Centers for Medicare & Medicaid Services (CMS) estimates that in 2025, 92.3% the U.S. population will have health care coverage. In the unique American system of health insurance, coverage in 2025 will be provided through the following sources[5]:

- Employer Sponsored Insurance: 177.8 million enrollees (52.6%)
- Medicaid: 79.4 million enrollees (23.5%)
- Medicare: 68.0 million enrollees (20.1%)
- Direct purchase (individual insurance market, subsidized and nonsubsidized): 38.3 million enrollees (11.3%)
- Children's Health Insurance Program (CHIP): 7.8 million enrollees (2.3%)
- Uninsured: 26.1 million individuals (7.7%)

According to the U.S. Census Bureau, insurance coverage varies by age and poverty level. "Adults ages 19-64 generally have lower coverage rates than those under age 19 and adults age 65 and older. That's because their coverage is directly tied to employment. They do not qualify for programs intended for children and only qualify for public programs under specific medical or income-level circumstances."[6]

Another Census study shows that "[a]dults age 65 and older are the least likely to be uninsured since they have near universal Medicare coverage. As a result, the uninsured rate for adults age 65 and older remained below 3.0% for all states in 2013, 2019, and 2023."[7]

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[4] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ca-11012022.pdf

[5] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected Table 17. Percentages are calculated by total population as individuals may have more than one source of coverage.

[6] https://www.census.gov/library/stories/2024/09/health-insurance-coverage.html#:~:text=Health%20Insurance%20Coverage%20by%20Age%20and%20Income%2Dto%2DPoverty%20Ratio&text=In%20each%20year%2C%20over%20three,10.3%25%20between%202020%20and%202023.

[7] https://www.census.gov/library/stories/2024/09/acs-health-insurance.html

The distribution among sources of coverage is somewhat different in Arkansas than the nation as a whole. Individuals are less likely to have employer coverage and are more likely to have Medicare or Medicaid coverage or to be uninsured in Arkansas.[8]

A Closer Look at the Uninsured

Reducing risk is the very core of insurance, that is, to protect against a future and unforeseeable financial loss by sharing the cost of insurance coverage with others. Health insurance both protects against financial loss and increases access to medical services. Coverage also varies by individuals' perceptions of affordability. According to a study by the National Center for Health Statistics, "[a]mong uninsured adults aged 18-64, the most common reason for being uninsured, affecting 7 in 10 (73.7%), was because they perceived that coverage was not affordable."[9]

The Congressional Budget Office (CBO) estimated that in 2019, nearly 30 million people were uninsured. However, 67% of the total number of people without health insurance were eligible to purchase coverage using a subsidy.

Coverage changes over time. In a study conducted for the National Center for Health Statistics (NCHS), 31.6% of the adults ages 18-64 who were uninsured in 2016 were uninsured for less than 12 months and 68.4% were "chronically uninsured." However, 55.8% of the 18–64-year-old adults who were chronically uninsured reported that their health was "excellent or very good" while only 11% of the chronically uninsured reported that their health was "fair or poor."

There are also differences in coverage based on gender and age. Males are more likely to be chronically uninsured (59.7% of total) than females. The oldest age group (45-64) were the most likely to be chronically uninsured (32% of total). Two-thirds of the chronically uninsured are employed, which suggests that coverage also varies by individuals' perceptions of "affordability." Moreover, only 10% are unemployed while 22.4% are not in the workforce.[10]

Together, the two studies are part of a larger body of research that shows there are several variables resulting in an individual becoming uninsured even though the person is eligible for subsidies for coverage, including Medicaid and CHIP which provide coverage at little or no cost.

Poverty is Linked to Poor Health and Premature Death

The population served under ARHOME live in households with income near or below the federal poverty level. It is well-documented that poverty is closely connected to poor health outcomes and even premature death. One study found that "experiencing poverty or near poverty (living at incomes below 200 percent of the federal poverty level) imposed the greatest burden and lowered quality-adjusted life expectancy more than any other risk factor …".[11]

Poverty is a "root cause" of poor health. DHS administers other human services programs in addition to the Medicaid program and provides links to workforce development programs that

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[8] https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[9] https://www.cdc.gov/nchs/data/databriefs/db382-H.pdf

[10] https://www.cdc.gov/nchs/data/nhis/earlyrelease/erchronicunins_1016_f.pdf

[11] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf p. 8.

can help reduce the risks associated with poverty. Addressing poverty serves the purpose of the Medicaid program.

Medicaid is an Anti-poverty Program but Presents a "Benefit Cliff"

Title XI, which gives authority to the Secretary of the U.S. Department of Health and Human Services (HHS) to approve demonstration programs and pilots under Section 1115, was added in 1962 with the purpose of encouraging states and local governments to redesign certain public assistance programs to improve the effectiveness of such programs. By allowing the Secretary to "waive" federal laws and regulations under Section 1115 authority, Congress and President John F. Kennedy offered states an opportunity to achieve better results for people in poverty. A Section 1115 waiver is a multi-year agreement (usually five years) negotiated between the Secretary of HHS and the Governor of a state. In exchange for federal funds, the state agrees to administer the new program in a manner that is budget neutral to the federal government and to evaluate whether the new program achieves its intended goals.

Medicaid was created in 1965 as a component of the "War on Poverty." However, it is widely recognized that the flaw in the design of many public assistance programs, including Medicaid, is as beneficiaries increase their household income, benefits are reduced. This is known as the "benefit cliff."

Individuals and their families face this cliff when the reduction in benefits is greater than the net financial gain. The existence of the benefit cliff is recognized by policy experts at all points along the political spectrum. For example, the National Conference of State Legislatures (NCLS) reported in "Introduction to Benefit Cliffs and Public Assistance Programs" "Benefits cliffs (the cliff effect) refer to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earnings."[12] "While minimum wages differ state to state, the risk of falling off a 'benefits cliff' is particularly likely for people making between $13 and $17 per hour. The economic consequences of benefits cliffs impact both families and employers: businesses are unable to meet their workforce needs because workers have a disincentive to increase hours or advance in a job, and families experience economic instability and limited economic mobility."[13] Many individuals reduce their risk by foregoing additional income, which typically impacts the number of hours worked over a year's time.

Moreover, employer-sponsored health insurance coverage typically includes a deductible and other cost-sharing obligations that must be paid by the employee. Individual health care marketplace plans also include out-of-pocket payments, even if the premium is 100% subsidized by the federal government. In contrast, premiums are prohibited for Medicaid coverage and cost-sharing is nominal.

For nearly 50 years Medicaid covered only the elderly, people with long-term physical or intellectual disabilities, low-income children, and the parents/caretakers of dependent children with household incomes near or below the federal poverty level. Individuals in these eligibility groups were generally limited from substantial engagement in the workforce and unable to quickly increase household income to earn their way out of poverty, or it was very unlikely that their disability would be cured, thus removing them from the Medicaid rolls.

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[12] https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs
[13] Ibid.

The “benefit cliff” was reduced for children with the creation of the state Children’s Health Insurance Program in the Balanced Budget Act (BBA) of 1997. States were allowed the option to extend coverage to children in families with higher income levels. In accepting federal funding, states also had greater flexibility in administering the program. CHIP helps to “smooth” out the cliff for families by phasing out the amount of subsidies (replaced by a family’s cost-sharing responsibilities) as income increases.

The” benefit cliff” for adults was potentially reduced by the Affordable Care Act (ACA). In contrast to the original Medicaid coverage groups, many of these individuals **are** reasonably expected to be substantially engaged in the workforce. Nationally, it is estimated that 42 percent of Medicaid beneficiaries aged 19-64 are employed. However, most are not working full-time, full-year jobs. Approximately 23 percent of this age group are not working due to a disability and another 35 percent are parents with dependent children.[14]

Full-time employment is the solution to poverty. The U.S. Census Bureau estimates that 20 million people, 10% of the total population of individuals age 18 to 64, were living in poverty in 2023. Only 1.8% of full-time workers were living in poverty, compared to 11.7% who worked part-time and 29.7% who did not work.[15]

The 2024 federal poverty level (FPL) for a single person was $15,060.[16] The minimum wage in Arkansas is now $11 per hour. A single person working full-time, year around (2080 hours) would earn $22,880, or 152% of FPL, exceeding the upper threshold for ARHOME eligibility (138% FPL). A person in this situation could be covered by employer sponsored insurance or qualify for subsidies to directly purchase coverage through the Marketplace.

Here is where the ACA diverged from the CHIP model. Rather than providing subsidies for individuals with income above the poverty level - as high as 400% FPL in CHIP - through the administrative structure of a state, the ACA provides its subsidies to people above the poverty level through the income tax system. Thus, individuals moving out of Medicaid are able to receive a subsidy to purchase individual coverage through the Marketplace if coverage is not available through an employer. Under the current structure in Arkansas, a person would be able to choose continued coverage in the same QHP with the same provider network.

In the unique American system of health insurance, the federal government subsidizes coverage across various sources including through subsidies for employer-sponsored health insurance without regard to income level through the tax code. According to a September 2023 report by the Congressional Budget Office (CBO), the federal government will provide subsidies totaling $25 trillion over the next ten years across Medicare ($11.7 trillion), Medicaid and CHIP ($6.3 trillion), employment-based coverage ($5.3 trillion), ACA marketplace plans ($1.1 trillion) and other federal sources ($0.6 trillion).[17]

As Chief Justice Roberts wrote in the Supreme Court decision, *NFIB v Sebelius*, which upheld the constitutionality of the ACA, “It [Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal

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[14] https://aspe.hhs.gov/sites/default/files/documents/779b6ef3fbb6b644cdf859e4cb0cedc6/medicaid-esi-unwinding.pdf

[15] https://www2.census.gov/library/publications/2024/demo/p60-283.pdf Table A-1 p.20

[16] https://www.govinfo.gov/content/pkg/FR-2024-01-17/pdf/2024-00796.pdf

[17] https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf

coverage. Indeed, the manner in which the [Medicaid] expansion is structured indicates that while Congress may have styled the expansion a mere alternation of existing Medicaid, it recognized it was enlisting the States in a new health care program."[18]Thus, Medicaid is a part of, rather than separate from, the rest of the health care coverage system.

The purpose of this waiver is to provide a bridge over the "benefits cliff" that discourages people from moving into the working class. Pathway to Prosperity will increase individuals' understanding of the value of health insurance and show individuals how to maintain health care coverage as they prepare to move out of poverty and support them on their pathway to independence.

It is significant that coverage for able-bodied working aged adults was added under the authority of the Social Security Act. The Act represents one of the most important social compacts among the American people, between workers and beneficiaries. The collective interdependence of Social Security is built on the foundation of individual workers. Without enough productive, healthy workers, Social Security will collapse. An individual's future benefits as a retiree are based on his/her own work history.

Public Health Emergency Unwind Reduced Medicaid Enrollment as was Expected

Some empirical evidence exists for what happens to health coverage for adults moving out of Medicaid into other coverage, but research is limited. Pathway to Prosperity will thus make a significant contribution to this body of knowledge. In estimating the potential impact of the Pathway to Prosperity amendment on coverage, DHS reviewed available research on changes in coverage among previously enrolled individuals whose coverage was terminated due to the end of the Public Health Emergency (PHE). For example, in August 2022, the HHS Assistant Secretary for Planning and Evaluation (ASPE) released an Issue Brief that found "[a]lmost one-third (2.7 million) of those predicted to lose eligibility are expected to qualify for Marketplace premium tax credits."[19] In April 2023, ASPE released an Issue Brief that found "[a]pproximately 2 million (15 percent) working Medicaid enrollees aged 19-64 also report having employer sponsored insurance …".[20] Thus, HHS itself expected individuals who lost Medicaid eligibility would move into other coverage.

The PHE unwind in Arkansas, saw enrollment in the new adult group with QHP coverage reach 307,819 individuals in September 2022. Two years later with the return to the normal eligibility redetermination process there are now nearly 190,000 covered through QHPs.

Lessons Learned

Arkansas and Kentucky were the first states to receive approval for implementing Medicaid work and community engagement requirements for their adult expansion populations. Both states were ultimately sued by plaintiffs who alleged they experienced harm from the requirements. This Pathway to Prosperity amendment reflects lessons learned from Arkansas's efforts in 2018-2019 to require working-age, nondisabled adults to participate in workforce activities as a condition of maintaining eligibility for Medicaid under the expansion program, then known as

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[18] https://supreme.justia.com/cases/federal/us/567/519/ p.54
[19] https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf
[20] https://aspe.hhs.gov/sites/default/files/documents/779b6ef3fbb6b644cdf859e4cb0cedc6/medicaid-esi-unwinding.pdf

"Arkansas Works." Assessments of Arkansas Works showed that many people did not know whether they were subject to participation requirements and, if they were, what they needed to do monthly to demonstrate compliance.

Other lessons learned include the importance of providing clear communications through multiple means, simplicity in design, and the need for personal interaction rather than over-reliance on technology. Pathway to Prosperity will use data-matching to identify individuals who could benefit from extra support to reach health and economic goals. However, one of the lessons learned in Arkansas Works is the limitation of data matching. Researchers at the Urban Institute found that "[d]espite DHS's efforts to identify exempt beneficiaries, advocates and various stakeholders were concerned that many enrollees were 'falling through the cracks.' They were particularly concerned about beneficiaries with medical conditions that prevented them from working. Two providers we spoke with told us they had patients with disabilities who should have received exemptions but had not."[21] Thus, DHS will not rely solely on data matching to assess individuals' needs for support.

In developing the Pathway to Prosperity framework, DHS also considered the lessons learned from the unwinding of the COVID PHE, which included further enhancements to the Arkansas Medicaid Enterprise System.

Some of these lessons are to:

- Apply new program requirements to the entire population in a more streamlined way. The previous work requirement was to be implemented in phases by age group over a two-year period and exempted certain populations, which resulted in confusion and uncertainty.
- Increase personal contact. The DHS and DHS-sponsored communications and interventions were too far removed to be utilized effectively.
- Simplify how engagement is demonstrated by discontinuing the previous monthly reporting requirement and using data matching and/or regular audits of activity/income in lieu of manual reporting by the beneficiary.

Data Matching, Success Coaching, and Personal Development Plan

DHS will identify individuals who may be most at risk for poor health outcomes due to long-term dependency. DHS will utilize data matching to identify ARHOME beneficiaries who appear to be not on track towards meeting their personal health and economic goals. Factors for identifying this group may include an individual's income level, employment history, educational status, whether a dependent child is in the household,[22] length of enrollment in ARHOME, and other criteria.

If data matching indicates that an individual is not on track, DHS will identify a Success Coaching resource to contact the individual to determine whether the individual could benefit from additional supports. Success Coaching is intensive care coordination engaging individuals to improve their health, employment, advancement, learning, and community engagement.

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[21] https://www.urban.org/research/publication/lessons-launching-medicaid-work-requirements-arkansas p.20.

[22] Current data matching shows that 58,241 ARHOME enrollees or 30.5% have a dependent child in the household

As the role of Success Coaching involves multiple functions, DHS is currently assessing public and private sector options for acquiring talent to fulfill these functions. DHS intends to leverage resources available through QHPs, state agencies such as Arkansas Workforce Centers and Arkansas Career and Technical Education, as well as local community partners.

By engaging the individual in Success Coaching, it may become clear that the individual is on track and does not need further assistance. The individual's information will be updated in the ARHOME case management system and in the Medicaid Enterprise System. If engagement with Success Coaching determines that the individual would benefit from additional support, the eligible individual will receive focused care coordination services, including the development and monitoring of a Personal Development Plan (PDP). An individual's PDP may include goals that address:

- Being healthy: being healthy is much broader than receiving a medical service; it includes the individual's physical, mental, and social well-being;
- Employed: employment is vital to a person's long-term health as poverty is directly linked to poor health outcomes;
- Advancing: advancement comes from a variety of activities including career training and workforce development;
- Learning: includes formal education, vocation education, and enhancing skills; and
- Serving: includes a variety of ways of supporting others in one's community and in one's own home.

Success Coaching will be delivered by entities that have experience working with individuals who face the challenges of poverty and will include training to provide focused care coordination services. Among other things, they will be thoroughly knowledgeable about resources available in the beneficiary's local community. They will develop the PDP with the individual which will include screening for Health-Related Social Needs (HRSN) and detailed actions for addressing those needs. Success Coaching training will include assisting individuals in understanding the long-term implications of employment including future Social Security benefits for dependents and retirees as well as maintaining health care coverage.[23]

Focused care coordination provided through Success Coaching will be an extra service not generally available to the Medicaid population. In addition, the QHPs are required by DHS to offer incentives to participate in health improvement and economic independence activities. These extra advantages to being enrolled in a QHP are not available to those covered through FFS delivery system.

Consequence

Despite these opportunities, DHS anticipates that some individuals will choose not to participate in any of these investments in their health and economic stability. Individuals who refuse to cooperate with DHS and decline to use services and incentives covered by QHPs will have their ARHOME coverage suspended. ARHOME benefits can be restored if the individual subsequently chooses to engage in Success Coaching to get "on track" with their PDP.

Coverage

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[23] See https://www.urban.org/research/publication/balancing-edge-cliff

In the design of the Pathway to Prosperity amendment, DHS is cognizant of the situations and circumstances of the plaintiffs involved in the work requirements litigation *Gresham v Azar*. Pathway to Prosperity will address the courts' analysis that "… the Secretary's failure to consider *the effects of the project on coverage* alone renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the act (emphasis added).[24] The Amendment makes significant policy and procedural changes from the previous version to respond to the question of coverage.

The design of Pathway to Prosperity also reflects the recent U.S. Supreme Court decision in *Loper Bright Enterprises v Raimondo*[25] in how the courts are to evaluate administrative actions. While Title XI of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority for determining the purposes of Title XIX of the Act, the lower courts in *Gresham v Azar* provide an important framework for evaluating how the Secretary fulfilled his responsibilities.[26]

For low-income, working age, able-bodied adults, Medicaid should be just a stop along an individual's pathway to a healthy life, and not the destination. With approval of the Pathway to Prosperity amendment, DHS will assist individuals achieve their own health goals including physical health, mental health, and social supports provided by QHPs, employers, workforce development, and faith and community partners. With such assistance, more Arkansans will find a pathway to achieve economic independence and self-sufficiency for themselves and their families. The amendment is designed to assist many more Arkansans to move from Medicaid into private insurance coverage.

2.1 Summary of Current ARHOME Section 1115 Demonstration

The current ARHOME waiver, approved for the period running January 1, 2022, through December 31, 2026, continues the preexisting structure in which Arkansas Medicaid purchases coverage from QHPs for the majority of program enrollees. Current benefit packages for QHPs and FFS also remained the same in the ARHOME renewal waiver.

Arkansas Medicaid currently provides coverage to more than 220,000 individuals in the new adult group. Approximately 188,000 of these individuals receive coverage through QHPs. Under the approved Demonstration, DHS makes monthly capitated payments to the QHPs to cover the cost of premiums. It also makes advanced cost sharing reduction (ACSR) payments to the QHPs to reimburse providers the cost of deductibles and copayments. The difference between the ACSR payments and actual cost sharing payments from the QHPs to providers is reconciled annually. The estimated total cost of the ARHOME program in calendar year 2024 was approximately $2.2 billion.

Another way to measure the value of the state's contribution to coverage is the Actuarial Value (AV) of these payments to QHPs. The QHPs also sell individual health insurance products available through the Federally Facilitated Marketplace (FFM). Health plans offered in the individual and small group markets, both inside and outside of the Exchanges must provide a

[24] Ibid. p. 23
[25] https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

[26] https://clearinghouse.net/doc/101905/

minimum AV for purposes of determining levels of coverage to a standard population. Under federal law, a Bronze Plan must have an AV of 60 percent which means the plan will cover 60% of expected total costs for health services for those enrolled in the QHP. The AV is 70% for a Silver Plan; 80% for a Gold Plan; and 90% for a Platinum Plan.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's FFM. As the state is prohibited from charging premiums and cost-sharing is limited to 5% of a household's income, the AV from the perspective of a Medicaid enrollee exceeds 94%. For those with income at or below 20% FPL (46% of ARHOME enrollees) who have no obligation for copayments, the AV is 100%.

When an individual's household income increases to above 138% FPL, the individual can remain in the same plan with the same Essential Health Benefits (EHB) and network of providers. This seamless transition is unique to Arkansas because of the 2014 waiver and provides a way for individuals to avoid the benefits cliff Medicaid enrollees typically face when their incomes increase. Although Medicaid would no longer pay premiums on behalf of an individual who is no longer eligible due to a higher income level, the majority likely would qualify for federal tax subsidies to cover all or some of their health care costs.

Everyone who is determined eligible for Arkansas Medicaid under the new adult group begins coverage in the Medicaid FFS delivery system. Approximately 24,000 beneficiaries per month are temporarily in FFS awaiting enrollment into a QHP. Beneficiaries may choose a QHP at time of enrollment. However, if a beneficiary does not pick a plan within 42 days of enrollment, DHS auto-assigns the beneficiary to a QHP.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package. QHPs form their own provider networks throughout the state and FFS does as well. DHS data analysis shows that the Medicaid FFS provider network (including primary care physicians and specialists) is similar to the number of providers in the networks offered by the QHPs. However, some providers may limit the number of Medicaid enrollees they serve due to lower Medicaid reimbursement rates. The QHPs pay providers at commercial rates.

Beyond benefits and provider networks, enrollment in a QHP provides certain advantages to beneficiaries compared to FFS. These include:

- A seamless transition to private insurance available in the Marketplace. This promotes continuity of care.
- Incentives (rewards) for their beneficiaries to participate in health improvement and economic independence initiatives. The QHPs are required by DHS purchasing guidelines and the annual Memorandum of Understanding (MOU) to offer incentives directly to the member or a provider along with EHB.
- Enhanced performance/outcomes requirements. The QHPs are required to meet performance measures in 23 reporting categories from the Medicaid Adult Core Set measures and 3 birth outcome reporting categories.

2.2 Overview of Program Goals

The current Demonstration's goals include, but are not limited to:

- Providing continuity of coverage for individuals;

- Improving access to providers;
- Improving continuity of care across the continuum of coverage;
- Furthering quality improvement and delivery system reform initiatives that are successful across population groups;
- Improving health outcomes for Arkansans, especially in maternal and infant health, rural health, behavioral health, and those with chronic diseases;
- Providing supports to assist beneficiaries, especially young adults in target populations, to move out of poverty; and
- Slowing the rate of growth in federal and state spending on the program so the demonstration will be financially sustainable.

In 2014, the uninsured rate for 19–to-64-year-olds in Arkansas was 17.7%. By 2023, the uninsured rate for this age group had declined to 12.5%.[27] However, despite the gains in health insurance coverage, Arkansas continues to struggle to improve its rankings among states for measuring health outcomes and for reducing poverty. For many Arkansans, health coverage alone has not been sufficient to improve their health and economic conditions.

Alleviating the effects of poverty upon beneficiaries, and the public as a whole, is a very important objective of the Medicaid program. In fact, the very first section of the Medicaid Act demonstrates the Congressional intent for appropriating federal funds to the program each fiscal year. The funds are to furnish: "1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and 2) rehabilitation and other services to **help such families and individuals attain or retain capability for independence or self care."**[28] This squares with one of the specified goals of the current waiver, which is "[p]roviding supports to assist beneficiaries, especially young adults in target populations to move out of poverty …".[29] Medicaid has been described as an anti-poverty program from its very origins. CMS and the U.S. Department of Health and Human Services (HHS) recognize the correlation between poverty, poor health, and shortened life expectancy. The *Healthy People 2020* report called poverty "an important public health issue" and stated, "researchers agree that there is a clear and established relationship between poverty and socioeconomic status, and health outcomes—including increased risk for disease and premature death."[30] The updated *Healthy People 2030* continues to recognize economic stability as a key social determinant of health, and the federal initiative includes several objectives aimed at reducing the proportion of people living in poverty and increasing employment in working-age people.[31]

The amendment aligns fully with the health objectives of ARHOME, as data show that poverty is closely connected to poor health outcomes and even premature death. According to the American Academy of Family Physicians paper, "Poverty and Health – The Family Medicine Perspective," "[p]overty affects beneficiaries insidiously in other ways that we are just beginning

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[27] https://www.commonwealthfund.org/datacenter/uninsured-adults
[28] 42 U.S.C.A. §1396-1 (emphasis supplied).
[29] Approved ARHOME Section 1115 Demonstration, p.8.
[30] National Center for Health Statistics. Healthy People 2020 Final Review. 2021. DOI: https://dx.doi.org/10.15620/cdc:111173
[31] Office of Disease Prevention and Health Promotion, https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

to understand. Mental illness, chronic health conditions, and substance use disorders are all more prevalent in populations with low income."[32]

The negative impact of long-term poverty does not just affect adults, but carries forward throughout the lifetimes of their children as well. According to a paper by the Urban Institute, "[b]eyond issues of economic inequality that arise when millions of children live in poor and persistently poor families, poor children can perpetuate the cycle as they become adults. Prior research shows that children who are born poor and are persistently poor are significantly more likely to be poor as adults, drop out of high school, have teen premarital births, and have patchy employment records than those not poor at birth …".[33] According to a study, "Early Childhood Development and Social Determinants," [t]he earliest years of a person's existence is thought to be the most crucial for his or her development. What happens to a child in the early years is crucial to the child's life course and developmental trajectory."[34]

Movement from one source of coverage to another is a routine feature of the American health insurance system. For example, the headline of a Georgetown University paper in February 2024 was "Marketplace Enrollment Surges Among Those Losing Medicaid Coverage During Unwinding."[35] On December 20, 2024, the headline from CMS was "HealthCare.gov Breaks New Record with 16.6 Million Consumers Signing Up for Coverage—The Highest Ever for January 1 Coverage."[36]

The relationship between income and health is well-established. Adults experiencing poverty may struggle to access adequate food, housing, or childcare, and subsequently experience elevated stress and associated health risks.[37] For example, adults living in poverty are at a higher risk of adverse health effects from obesity, smoking, and substance use. Additionally, older adults with lower incomes experience higher rates of disability and mortality.[38] Individuals with lower income are also less likely than individuals with higher income to access preventive healthcare, decreasing the likelihood that a health issue can be identified and addressed before it worsens.[39]

By contrast, raising one's income is associated not only with improved health, but greater quality of life. People with higher incomes report lower prevalence of disease, live longer, and report fewer feelings of worthlessness, hopelessness, and sadness.[40] Because of the close connection between poverty and poor health, policies that drive economic advancement can be associated directly to improved health outcomes. Research has found that earnings and asset development programs that increase the economic self-sufficiency of low-income families can offer promise for improving health.[41] Therefore, economic policies that create jobs and teach marketable skills not only foster economic success, but also lead to better health outcomes due to the strong

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[32] https://www.aafp.org/about/policies/all/poverty-health.html p.3
[33] https://www.urban.org/sites/default/files/publication/32756/412659-Child-Poverty-and-Its-Lasting-Consequence.PDF p. 9
[34] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9596089/pdf/cureus-0014-00000029500.pdf
[35] https://ccf.georgetown.edu/2024/02/07/marketplace-enrollment-surges-among-those-losing-medicaid-coverage-during-unwinding/
[36] https://www.cms.gov/about-cms/contact/newsroom
[37] https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks
[38] https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty
[39] https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks
[40] https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf
[41] *Id*.

connection between health and income.[42] Healthcare, or receiving services related to health conditions, whether that be preventive care or an emergency interdiction for an acute condition, is not an end in itself. The American Medical Association Code of Medical Ethics defines basic healthcare as a "fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives."[43]

This Pathway to Prosperity amendment will be part of beneficiaries' pathways as they seek to advance their careers and improve their lives, their families, and their communities. Some adults on Medicaid will create their own opportunities and find their own pathway to full employment and independence without assistance from government. Others are on track towards engagement but short of attaining economic independence. These beneficiaries may not be aware of the opportunities available to them and will benefit from stronger connections and more formal coaching. With that goal in mind, this amendment seeks to engage beneficiaries in their current circumstances and empower them to engage in accessing the opportunities that exist within each community.

Section III: Proposed Amendment

3.1 Requested Program Enhancements

The amendment will create new paths and opportunities for beneficiaries to improve their overall health and financial well-being. These tenets align directly with the objectives of the Medicaid program in several key aspects. First, the principal objective of the Medicaid program is to provide health care coverage. The Pathway to Prosperity amendment intends to increase the use of vital medical and social services. The Pathway to Prosperity amendment adds a new service, focused care coordination, which will lead to accessing resources an individual needs to address his/her HRSNs. As such, the amendment aligns with other very important objectives of the Medicaid program, as detailed in the Social Security Act, which include supporting beneficiaries as they attain or retain capacity for independence. [44]

The amendment recognizes there are significant differences in the characteristics of ARHOME enrollees. DHS can stratify the population by demographics including age, income level, family size and rural/urban communities. It should be expected that many participants will be enrolled temporarily. However, this will vary by age and income level. For example, the expected turnover rate for a 64-year-old is 100% as the individual will age out of Medicaid and move onto the Medicare program.

Data for assessing how long people are enrolled in ARHOME is skewed by the continuity of coverage provision that was in effect during the PHE and may not be reliable. DHS will

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[42] *Id*. (See also, Healthy People 2030, Employment Literature Summary available at https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment#cit34; Robert Wood Johnson Foundation, How Does Employment, or Unemployment, Affect Health? available at https://www.rwjf.org/en/insights/our-research/2012/12/how-does-employment--or-unemployment--affect-health-.html; Social Determinants of Health: Employment at https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Employment.)

[43] AMA Code of Medical Ethics, Opinion 11.1.1 *Defining Basic Health Care*, https://code-medical-ethics.ama-assn.org/ethics-opinions/defining-basic-health-care

[44] 42 U.S.C.A. §1396-1

recalculate the rate of beneficiaries who remains on Medicaid for each age group and income group annually.

DHS will use a combination of data to identify individuals most at risk for poor health outcomes due to long-term poverty. Such data includes, but is not limited to:

- Newly eligible: enrolled for 0-6 months
- Employment match:
    - Unemployed: household income at or below 20% of FPL
    - Under-employed: household income 21-80% FPL enrolled for 24+ months which may indicate at risk for long-term poverty
    - Employed: household income 81%-138% FPL enrolled for 36+ months which may indicate at risk for long-term poverty
- Medical claims match: Individuals who have been enrolled in a QHP for 6 months+ but have no medical claims and have not participated in any incentive offered by the QHP.

Role of Success Coaching

DHS will assign Success Coaching for individuals who are identified as most at risk of long-term poverty. As an individual engages in Success Coaching, additional information may show that the person is "on track" and has no need for the additional focused care coordination services.

If DHS confirms that an individual is not on track, Coaching will provide focused care coordination services to the eligible individual including the establishment and monitoring of a Personal Development Plan (PDP).

Being healthy is much broader than just receiving medical services, although determining whether an individual is accessing services is an important consideration. An individual's goals to become or remain healthy may include engaging in a wide range of activities including quitting smoking, increasing physical activity, and improving nutrition. Success Coaching might connect the individual to a variety of community resources. For example, more communities are adopting "food as medicine" strategies which might be part of an individual's PDP.

Employment is vital to a person's long-term health as poverty is directly linked to poor health outcomes. A person who is unemployed will benefit from the support of Success Coaching that can connect the individual with needed resources such as transportation.

Advancement comes from a variety of activities including training, workforce development, apprenticeships, and internships.

Learning includes formal education, vocational education, and a variety of activities that enhance a person's skills such as through a mentoring program.

Serving may be demonstrated in a variety of ways. For some, service in one's own home to care for a child, an elderly parent, or a person with a disability may be the person's highest priority at a given point in time.

Success Coaching will be delivered by entities experienced in working with individuals who face the challenges of poverty. Among other things, they will be thoroughly knowledgeable about resources available in the person's local community.

The complete focused care coordination planning process will include the following activities, at a minimum:

1. Reporting in a DHS-approved case management system;

2. Identifying any HRSN and assisting the individual access community services to address HRSN;
3. Development of an individualized PDP that facilitates access to opportunities for employment, education, and training, including technical skill development, resume writing, interview coaching and other job readiness preparations;
    a. the PDP should identify goals and measure progress over 3-, 6-, 9-, and 12-month periods
4. Tracking and documenting monthly progress which will eliminate the reporting requirement on the individual that was widely criticized in the Arkansas Works demonstration; and
5. Monitoring and follow-up activities, including verification of engagement and a final determination of progress toward the goals and steps laid out in their PDP.

Success Coaching will include responsibility for communicating with beneficiaries at least once a month, either in person or through virtual means (phone, text, Zoom, etc.). Within 30 days of contacting a beneficiary, Success Coaching must include development of the PDP based on the beneficiary's specific needs and personal goals. The PDP should outline a feasible pathway for meeting the individual's goals for independence, including maintaining health care coverage.

Beneficiaries will not be required to work a minimum number of hours per month, nor will they be required to report any activities to DHS outside of their required contacts with their Success Coaching entity. DHS will ensure language translation services are available for all beneficiaries, as needed.

Success Coaching entities will also have access to recent advancements in the state's technology infrastructure:

- SHARE: state health care information exchange
- Arkansas Data Hub
- LAUNCH: an online service for job seekers[45]
- CiviForm: a one-stop online form that shares individual information across state agency and job-seeker platforms

Early Movers

With the additional support of Success Coaching, DHS expects that some QHP enrollees will increase their income sufficiently to move above the Medicaid eligibility threshold. These individuals are "early movers," that is, they will move into other coverage sooner than expected compared to baseline data. DHS will survey these individuals annually to track their economic progress and health care coverage.

Suspension from ARHOME Coverage

If through Success Coaching it is determined that an individual is not on track and fails to cooperate, the Success Coaching entity may make a recommendation to suspend ARHOME coverage. The recommendation will be reviewed by a three-person DHS panel. If the

[45] https://jobseeker.launch.arkansas.gov/

suspension is approved, the individual will receive a written notice of the action with a right to appeal.

Individuals who decline to cooperate with Success Coaching will have their ARHOME coverage – QHP benefits - suspended through the end of the calendar year. They will not be disenrolled from the Medicaid program. To become "on track" and have QHP benefits restored, they will notify their Success Coaching entity of their intention to cooperate with their PDP. As Pathway to Prosperity does not make compliance a condition of eligibility, individuals will not be required to complete a new Medicaid application unless they have passed their date for their annual redetermination of eligibility.

During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHP.

Implementation

The Pathway to Prosperity amendment has an anticipated start date of January 1, 2026.

3.2 Impact of Proposed Amendments

3.2.1 Impact to Eligibility

Arkansas is not proposing any changes to Medicaid eligibility through this Section 1115 Demonstration Amendment request. The Pathway to Prosperity amendment will potentially impact all beneficiaries through communications on health and economic opportunities, providing focused care coordination services to those eligible for a personal development plan, and expanding the number of beneficiaries who are likely to receive HRSN through local community resources. However, these changes have no impact to individual underlying Medicaid eligibility.

3.2.2 Impact to Delivery System

In general, the state is requesting to continue the current adult eligibility group, with the same benefit packages and models of care that are currently utilized: QHPs, FFS, and PASSE.

Pathway to Prosperity will help identify the model of care most appropriate for an individual. For example, approximately 13,000 "medically frail" individuals in the new adult group remain in FFS where they are eligible to receive additional services not offered by the QHPs, such as personal care. An individual with a serious mental illness may be best served in the Provider-led Arkansas Shared Services Entity (PASSE) program. Pathway to Prosperity will continue to identify pregnant women with high-risk pregnancies who could benefit from the state's Maternal Life 360 ARHOME program. In that program, these women will receive home visiting services and intensive care coordination, including assistance in enrolling in the Women, Infants, and Children (WIC) program and for childcare subsidies.

Important information about income, family size, and disability is collected at the time an individual applies for coverage. Data matching may yield additional information about the individual that points to follow-up actions that are in the best interests of the individual. During the data matching and assignment of Success Coaching process, some beneficiaries may be found to benefit from enrollment in the PASSE program or moved to another Medicaid eligibility group due to a disability and into the FFS model of care.

3.2.3 Impact to Covered Benefits/Cost Sharing

The QHPs provide an Essential Health Benefit (EHB) Plan that meets the requirements of coverage available through the federal individual insurance Marketplace. A major benefit of QHP coverage is continuity of coverage. The QHPs provide health insurance coverage through the individual insurance Marketplace. Thus, an individual enrolled in a QHP whose income increases above Medicaid eligibility will be able to stay in the same plan with the same benefits and providers. This continuity of coverage (and with continuity of substantial federal subsidies) may help avoid disruption in medical treatment over time. In addition, the QHPs are required to offer incentives to their members that are not available to the general Medicaid population.

After Success Coaching has been assigned to an unemployed individual, he/she will have three months to demonstrate he/she is "on track." The potential outcomes for individuals are:

1. "On track" and QHP benefits continue;
2. QHP benefits are suspended for failure to complete a Personal Development Plan (PDP) or cooperate with their PDP;
3. QHP benefits are restored after the individual contacts DHS with agreement to cooperate with their PDP;
4. Moves to Other Medicaid model of care (FFS for medically frail or to the PASSE program for individuals with serious mental illness);
5. Moves to Other Medicaid eligibility group (due to a disability);
6. Moves to Other Coverage (no longer eligible for Medicaid due to increase in income or to Medicare);
7. Moves to Other Coverage or uninsured if Medicaid eligibility is not met at 12-month redetermination or:
8. Moves back to QHP if is redetermined to be eligible and chooses a QHP at open enrollment

A suspension of QHP benefits will be considered to be an "adverse action" and the individual will be provided a notice with instructions for filing an appeal. The Amendment does not make any changes to cost sharing.

Section IV: Requested Waivers and Expenditure Authority

The Demonstration will continue to operate all existing waivers and expenditure authorities pursuant to the Special Terms and Conditions (STCs) issued on December 21, 2021, and as amended on November 1, 2022.

In addition, DHS requests all necessary additional waiver and expenditure authority to implement the Amendment request, including at minimum, the following:

Amount, Duration, and Scope of Services and Comparability — **Section 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable DHS to offer focused care coordination services to the populations as described in this Amendment, which may vary and not otherwise be available to all beneficiaries in the same eligibility group.

To the extent necessary to enable DHS to suspend QHP benefits for beneficiaries who are not engaging in their QHP health plan.

Statewideness **Section1902(a)(1)**

To the extent necessary to enable DHS to provide focused care coordination services on a less than statewide basis.

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable DHS to limit beneficiaries' freedom of choice with respect to focused care coordination services.

To the extent necessary to enable Arkansas to limit the freedom of choice of providers for focused care coordination services to staff employed by the Arkansas Department of Human Services or other entities, including state agencies and private sector partner(s), under contract for such services.

Expenditures for Communications, Training, and Enhanced Case Management System

Expenditure authority is requested to support an automated call system, train entities to deliver Success Coaching, and procure a case management system necessary to support the development and tracking of Personal Development Plans.

Section V: Evaluation and Program Oversight

5.1 Evaluation and Demonstration Hypothesis

The primary intervention in Pathway to Prosperity is the focused care coordination services provided through Success Coaching. This intervention will be evaluated in the following areas:

1. Increase income/hours worked per week/month/year
2. Use of Health Care Coverage – increase appropriate utilization of services
3. Increase access to coverage through private insurance or maintain Medicaid coverage in most appropriate model of care
4. Address HRSN

Goal 1: Increase Income

With the guidance and counseling of Success Coaching, DHS anticipates that enrollees at every income level (unemployed, underemployed, and employed) will experience an increase in earnings over time.

Goal 2: Use of Health Care Coverage

Experience shows that coverage alone is not sufficient to improve health outcomes. Research demonstrates that the total cost of health care can be reduced by accessing services in the community rather than in emergency departments and by avoiding preventable hospitalizations. Under ARHOME, QHPs are required to offer incentives to improve the appropriate use of preventive and primary care services. However, there is a low take-up rate of these opportunities.

With the guidance and counseling of Success Coaching, DHS anticipates that a greater percentage of enrollees will access preventive and primary care services.

Goal 3: Increase Access to Private Insurance Coverage or Maintain Coverage in Most Appropriate Medicaid Model of Care

With the guidance and counseling of Success Coaching, DHS anticipates that many enrollees at every income level (unemployed, underemployed, and employed) will experience an increase in household income and cross the "benefit cliff" into private insurance coverage. Others will maintain coverage in the most appropriate Medicaid model of care.

Engagement with Success Coaching may result in eight potential outcomes related to coverage:

1. "On track" and QHP benefits continue;
2. QHP benefits are suspended for failure to complete a Personal Development Plan (PDP) or cooperate with their PDP;
3. QHP benefits are restored after the individual contacts DHS with agreement to cooperate and get "On track" with PDP;
4. Moves to Other Medicaid model of care (FFS for medically frail or the PASSE program for individuals with serious mental illness);
5. Moves to Other Medicaid eligibility group (due to a disability);
6. Moves to Other Coverage (no longer eligible for Medicaid due to increase in income or to Medicare); or
7. Moves to Other Coverage or uninsured if Medicaid eligibility is not met at 12-month redetermination.
8. Moves back to QHP if is redetermined to be eligible and chooses a QHP at open enrollment.

DHS will calculate an "Expected Move Rate" for each of these outcomes. As the PHE skewed the outcomes in prior years, DHS will start with data collected in 2024 and 2025. The Evaluation will compare the "Expected Move Rate" to "Actual Move Rate."

Goal 4: Address HRSN

With the guidance and counseling of Success Coaching, DHS anticipates that a greater percentage of enrollees will access community supports and services to address their HRSN. Data suggests that the greatest need for services are for nutritional assistance, transportation, and housing. As a rural state, transportation is especially important for maintaining employment.

The state views the following goals, hypotheses, and measures included in the existing ARHOME evaluation plan as relevant to the addition of focused care coordination from Success Coaching via this Amendment:

Goals and Hypotheses Table 1

Goal #	Goal Description	#	Hypothesis Description	Measure #	Measure	Comparisons
1	Increasing household income	A	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.A	Change in earnings reported for those who are unemployed (<21% FPL)	Expected Move Rate Beneficiaries not engaged with Success Coaching

		B	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.B	Change in earnings reported for those who are underemployed (<81% FPL) and enrolled for at least 24 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with their Success Coaching will experience an increase in household income	1.C	Change in earnings reported for those who are above 80% FPL and enrolled for at least 36 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
2	Improving utilization of services and appropriate-ness of care	A	Beneficiaries engaged with their Success Coaching will have greater use of preventive and other primary care services	2.A.1	Medicaid Adult Core Set Measures	Beneficiaries not engaged with Success Coaching
		B	Beneficiaries engaged with Success Coaching will have lower non-emergent use of emergency department services	2.B.1	Non-Emergent Emergency Department (ED) Visits	Beneficiaries not engaged with Success Coaching
				2.B.2	Emergent ED Visits	Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with Success Coaching will have lower use of potentially preventable emergency department services and lower incidence of preventable hospital	2.C.1	Preventable ED Visits	Beneficiaries not engaged with Success Coaching
				2.C.2	All-Cause Readmissions	Beneficiaries not engaged with Success Coaching
				2.C.3	Follow-Up After Emergency Department Visit for People with Multiple	Beneficiaries not engaged with Success Coaching

			admissions and readmissions		High-Risk Chronic Conditions	
3	Increase access to private coverage in crossing the benefit cliff	A	Beneficiaries engaged with Success Coaching will have an increased rate of private coverage	3.A	Comparisons of expected move rate to actual move rate	Beneficiaries not engaged with Success Coaching
	Maintain coverage in most appropriate model of care	B	Beneficiaries engaged with Success Coaching will maintain their coverage in the most appropriate Medicaid model of care	3.B	Comparisons of changes in model of care to historical changes	Beneficiaries not engaged with Success Coaching
4	Reducing health-related social needs (HRSN) through intervention	A	Beneficiaries engaged with Success Coaching will have fewer health-related social needs and improved HRSN compared to similar beneficiaries who are not engaged with Success Coaching	4.A.1	HRSN Population Comparisons	Beneficiaries not engaged with Success Coaching
		B	Beneficiaries engaged with Success Coaching will receive an appropriate intervention if they screen positive for a HRSN	4.B.1	HRSN Screening/Intervention	Beneficiaries not engaged with Success Coaching

5.2 Oversight, Monitoring, and Reporting

DHS will abide by all existing Demonstration reporting and quality and evaluation plan requirements, including the requirements outlined in the approved Monitoring Protocol. DHS will continue to monitor and track QHP performance and adherence to program expectations. Ongoing oversight of Life360 HOMEs will also remain a priority of the state as it tracks selected quality of care and health outcomes metrics for this key initiative. Finally, the state will incorporate tracking, monitoring, and reporting requirements as necessary for focused care coordination provided through Success Coaching. Quality of care and participant outcomes data will be collected and analyzed.

Section VI: Budget Neutrality Impact

The costs of the Pathway to Prosperity amendment to the ARHOME Section 1115 Demonstration Project (Project No. 11-W-00365/4) is primarily due to the addition of focused care coordination services that will be provided to certain individuals who meet the state's criteria for selection. There are limited additional costs associated with training for Success Coaching and enhancing the current infrastructure to upgrade the DHS case management system, including monthly update reports to track progress of individuals in the targeted groups, and screen and refer individuals for Health-Related Social Needs (HRSN). Total costs are estimated to be $42.8 million over the five-year period. The cost of services and infrastructure will be counted in the proposed Budget Neutrality limits and are expressed in Table 2 below:

Table 2

Capped Hypothetical Budget Neutrality Limits *(shown in millions)*

	Services	**Infrastructure**
Demonstration Year (DY)	Proposed Limit	Proposed Limit
DY01	$6.6	$4.1
DY02	$6.9	$0.6
DY03	$7.2	$0.6
DY04	$7.6	$0.6
DY05	$8.0	$0.6

Savings will be generated by suspending ARHOME benefits for a relatively small number of individuals for a temporary period of time. During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHPs nor for "wrap around services."

Savings will also be generated by individuals who move off Medicaid sooner than expected due to changes in household income.

In January 2025, DHS is projected to pay the QHPs an average monthly premium of $577.62, advanced cost sharing reduction payments of $202.17 per month and "wrap around" payments of $4.53 for a total PMPM of $784.31. Coverage provided by Arkansas Medicaid pays not only for medical treatment at the time of illness or accident, but for preventative services as well that provide high value to individuals.

Assumptions

The Pathway to Prosperity amendment represents a new approach to engaging beneficiaries. As such, there is limited empirical data for analysis. It is sufficiently different from the 2018-2019 work requirement period which suggests that data from that time is not applicable. Thus, DHS has based the impact of the amendment on reasonable assumptions to reflect a mid-point in a range of participation. Actual results over a five-year period will likely vary.

DHS assumes 50% of individuals assigned to Success Coaching will cooperate with DHS and be "on track" with no change in their QHP benefits; 25% of individuals will be "early movers" due to change in household income and move to other coverage; and 25% will fail to cooperate and will have their ARHOME coverage - QHP benefits - suspended. However, DHS assumes 50% of those who were suspended will inform DHS of their willingness to cooperate and thereby return to coverage.

Savings accrued due to early mover or suspension status is estimated to be an average of three months.

Estimated Savings Under Current Assumptions Table 3

	DY1	DY2	DY3	DY4	DY5	Total
Data Matching to Screen at Risk/Assign Success Coaching	18,450	23,575	25,625	30,750	32,800	
On Track	9,225	11,788	12,813	15,375	16,400	
25% Early Movers	4,613	5,894	6,406	7,688	8,200	
25% Failure to Cooperate: Suspended	4,613	5,894	6,406	7,688	8,200	
Saved Member Months (3X)	27,675	35,363	38,438	46,125	49,200	
Savings	$21,705,779	$28,567,215	$31,982,863	$39,630,818	$43,431,192	$165,217,870

The effective date of the amendment is expected to be January 1, 2026, which is Demonstration Year 5 of the current waiver. As waivers are typically approved for a period of five years, Table 3 presents a five-year budget impact which is estimated to be a total savings of $165.2 million and net savings of $122.8 million.

For a full development of these values please see the actuarial statement at *Attachment 1*.

Section VII: Public Notice & Comment Process

7.1 Overview of Compliance with Public Notice Process

In accordance with 42 CFR §431.408, DHS provided the public the opportunity to review and provide input on the Amendment through a formal thirty-day public notice and comment process which ran from date to be provided, through date to be provided. During this time, the state will hold two dedicated public hearings.

Public Notice

The state verifies that the abbreviated public notice of the Amendment application was published on date to be provided to the Arkansas Democrat-Gazette, the newspaper with widest circulation in each city with a population of 100,000 or more in accordance with 42 CFR §431.408(a)(2)(ii). In addition, DHS used its standard electronic mailing list of interested parties, comprised of more than 150 individuals and organizations, to notify the public of the Amendment, the public hearings, and the opportunity to comment on the waiver Amendment draft. While there are no federally recognized tribes in the state of Arkansas, DHS proactively reached out to tribal representatives in neighboring Oklahoma to ensure all interested parties were included in the electronic mailing list and able to participate in the public comment period.

A copy of the formal public notice shall be attached as *Attachment 2* and a copy of the abbreviated public notice document shall be attached as *Attachment 3*. Both documents, along with a copy of the complete Amendment draft, will also made available for viewing in hard copy format as well as on the state's website: https://humanservices.arkansas.gov/rules/arhome/.

Public Hearings

DHS will hold two public hearings during the notice and comment period in geographically diverse areas of the state. The hearings were attended by interested persons both in person and via the Zoom platform.

The state confirms that the two public hearings will be held on the following dates and physical locations, in addition to being available for statewide virtual participation, as scheduled and as publicized in the formal notice:

Public Hearing #1	Public Hearing #2
Date, time, and place to be provided	Date, time, and place to be provided

7.2 Summary of Public Comments & State Responses

To be added after the public comment period.

Section IX: State Contact

Name and Title: Janet Mann, Deputy Secretary of Programs and State Medicaid Director, Arkansas Department of Human Services

Telephone Number: (501) 682-1001

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Navigating Distance & Disability: Legal and Fiduciary Approaches to Remote Caregiving

Tara Anne Pleat, Esq.

Michael Cognetti, MS Ed., MBA

I. Introduction

Across the United States, families are growing more geographically dispersed. Children may relocate for work, spouses may reside separately due to healthcare needs, and siblings may live on opposite coasts. As these realities unfold, legal and fiduciary professionals are increasingly called upon to help clients manage care and decision-making responsibilities from a distance.

Nowhere is this more complex—or more emotionally charged—than in the context of disability. Individuals with physical, cognitive, or intellectual disabilities may rely on family members or fiduciaries not only for support and advocacy but also for critical financial and health-related decision-making. When those decision-makers are managing responsibilities from afar, the potential for miscommunication, oversight, or burnout rises sharply.

This program addresses the intersection of disability, fiduciary responsibility, and geographic distance. While focused primarily on trust administration, particularly Supplemental Needs Trusts (SNTs), it also encompasses surrogate decision-making tools such as powers of attorney and health care proxies. Through the lens of fiduciary duty, legal compliance, and ethical responsibility, we will examine how attorneys, professional fiduciaries, and lay trustees can structure support that is durable, legally sound, and person-centered, even from a distance.

II. Legal Framework for Remote Caregiving

Remote caregiving often requires navigating a patchwork of legal documents, state laws, and human dynamics. For fiduciaries—whether they are family members, attorneys, or professionals—having the proper legal authority is essential to ensure continuity of care, access to information, and compliance with public benefit rules. Several legal instruments form the backbone of remote caregiving, each offering distinct roles, powers, and limitations. These include Powers of Attorney, Health Care Proxies, HIPAA Authorizations, Supplemental Needs Trusts, and in some cases, Guardianship Orders.

Durable Powers of Attorney

Durable Powers of Attorney (POA) remain one of the most widely used legal tools for surrogate decision-making. It authorizes an agent—often a relative or professional fiduciary—to act on behalf of the principal in managing finances, entering contracts, accessing bank accounts, and applying for public benefits. In remote caregiving situations, a POA must be drafted with flexibility in mind. The agent may need to communicate with care providers, hire and pay care managers, access digital portals, or sign documents in another state.

Health Care Proxies and Advance Directives

Health Care Proxies and Advance Directives serve a complementary function by allowing a designated health care agent to make medical decisions if the individual becomes incapacitated. These proxies are especially important when the agent is not local. To be effective in remote caregiving, the health care proxy must be immediately accessible in emergencies, broadly drafted to authorize medical decision-making across state lines, and ideally supplemented with a statement of values or intent. Because states differ in how they recognize out-of-state proxies, families spread across multiple jurisdictions may need to execute multiple versions or create unified supplemental documentation.

HIPAA Authorizations

Alongside these tools, a HIPAA Authorization is critical. Even with a valid POA or health care proxy, medical institutions may refuse to release protected health information without a standalone, compliant HIPAA release. For remote caregivers and fiduciaries, the HIPAA release is often the practical key to advocacy. It should clearly name all authorized individuals, include current contact details, and expressly permit electronic communication. Naming alternates and including broad authorization language can ensure smoother access during crises.

Guardianship

In some cases, a court-appointed guardian may already be in place. Guardianship laws vary by state but typically provide decision-making authority over personal and/or financial matters. Where guardianship exists, the trustee or agent must work collaboratively with the guardian (assuming the Trustee and Guardian are not one and the same), recognizing that their powers may overlap or, in some cases, be limited by the court's orders. Guardianship can add both protection and complexity to remote caregiving. It is essential to understand whether the guardian has authority over medical decisions, residence, or financial oversight—and to determine how fiduciaries must coordinate with or defer to that authority in practice.

Supplemental Needs Trusts

When the individual with a disability is receiving—or is expected to receive—means-tested public benefits such as Medicaid or Supplemental Security Income (SSI), the existence of a Supplemental Needs Trust (SNT) is not merely likely; it is virtually a given. These trusts are foundational to long-term planning for individuals with disabilities who rely on programs that impose strict asset and income limitations. Whether established by a third party or funded with the beneficiary's own assets, the SNT is the primary legal vehicle for preserving benefit eligibility while enhancing quality of life.

For trustees administering these trusts from a distance, the challenges are significant and multifaceted. Disbursements must be made without the benefit of direct observation;

coordination is often required with residential providers, local agencies, and medical professionals who may never meet the trustee in person; and compliance with state-specific Medicaid and SSI rules must be maintained—even if the beneficiary and trustee live in different jurisdictions.

A well-drafted SNT should anticipate the demands of remote administration and authorize the trustee to build a trusted team on the ground. This may include hiring private case managers, disability advocates, daily money managers, or social workers—professionals who can serve as the trustee's eyes and ears while providing day-to-day support for the beneficiary. These partners play a crucial role in assessing needs, identifying services, and facilitating communication, all while preserving the independence of the trustee's judgment. Provisions in the trust instrument allowing for the retention and compensation of these individuals can be invaluable.

In addition, naming a co-trustee, trust protector, or trust advisor, depending on state law, may provide additional layers of oversight and accountability. These roles can also be structured to offer local presence or specialized knowledge that complements the skills and limitations of the primary trustee.

Ultimately, regardless of geography, the trustee remains subject to core fiduciary duties: prudence, loyalty, impartiality, and adherence to the trust's terms. Remote fiduciaries must maintain clear documentation, communicate proactively with all stakeholders, and regularly assess whether the trust's administration continues to meet the evolving needs of the beneficiary in both a compliant and compassionate manner. Layer on the payback provision in a First Party or Self-Settled Supplemental Needs Trust and that can be a tall order.

Supported Decision Making[1]

While traditional legal tools like Powers of Attorney and Guardianship provide the structural foundation for remote caregiving, they do not capture the full complexity of decision-making for individuals with disabilities. In recent years, Supported Decision-Making (SDM) has gained traction as a person-centered approach that emphasizes autonomy and self-determination. SDM involves identifying supporters, often family members, friends, or trusted professionals, who assist the individual in understanding information, weighing options, and communicating decisions.

Although SDM has been codified in a growing number of states and championed by disability rights advocates, from the authors' perspective it is important to recognize its practical and legal limitations. Unlike the power of attorney or guardianship, SDM does not create an agency relationship and does not confer legal authority to act on behalf of the individual. In most cases, it will not satisfy the requirements of third parties such as

[1] Convention on the Rights of Persons with Disabilities, art. 12, Dec. 13, 2006, G.A. Res. 61/106, U.N. Doc. A/RES/61/106, 2515 U.N.T.S. 3.

banks, medical providers, or public agencies, especially when significant legal, financial, or medical decisions are involved.

Moreover, in a world of increasing complexity and shrinking bandwidth, relying solely on SDM is often unrealistic. Professional fiduciaries, overstretched family members, and multidisciplinary care teams frequently lack the time, infrastructure, or legal clarity to navigate a fully supported decision-making framework without a formal surrogate structure in place. For this reason, while SDM principles may be valuable when layered into existing legal arrangements, SDM alone is likely not sufficient for individuals with significant support needs or complex benefit coordination.

That said, integrating SDM concepts into existing fiduciary frameworks can still be meaningful**.** When guardianship or POA is already in place, applying supported decision-making principles, such as involving the individual in discussions, soliciting their input, and respecting their preferences, can promote dignity, inclusion, and trust. Trustees and agents can also work with local supporters (e.g., residential staff, care managers) to enhance communication and ensure the beneficiary's voice is not lost in translation.

In the context of remote caregiving, this approach offers a more practical path forward**:** maintain legally sufficient tools like POAs and trusts while embedding SDM as a mindset, not a substitute. The goal is not to create parallel systems of support, but to bring a person-centered lens to the administration of authority that already exists.

III. Fiduciary Responsibilities and Remote Trust Administration

In practice, trustees, whether they are professionals or family members, must make day-to-day decisions that require far more than technical knowledge of the trust's terms. They are charged with duties of loyalty, prudence, and diligence, and those duties are especially tested in cases involving beneficiaries with diminished capacity. Administering a trust remotely adds another layer of complexity. To fulfill their obligations, trustees must establish reliable channels of communication with care providers, often across distance and through multiple intermediaries. They may need to engage local professionals, such as private care managers, who can provide critical context for the beneficiary's needs and environment. Trustees are also expected to maintain thorough records of their actions, documenting not just disbursements, but the reasoning and information behind them. Increasingly, trustees must rely on technology, shared calendars, secure messaging platforms, virtual meetings, and digital logs, to support accountability and oversight in ways that meet both fiduciary standards and the practical realities of distance.

A. Communication Protocols[2]

Trustees need information to make *informed* discretionary decisions. In a typical administration, the trustee can communicate directly with a competent adult beneficiary, and in the case of a minor a trustee can communicate with a legally responsible adult such as a parent. Communication is relatively straightforward and unencumbered.

Some beneficiaries with diminished capacity may lack the ability to communicate, or to do so effectively. They may not have court appointed guardians or voluntarily designated agents under power of attorney. They may lack informal supports like family members and friends, or those informal supports may be unreliable or ill-intentioned.

These practical challenges defy simple solution. If a compromised beneficiary needs a winter coat, the trustee may have the authority to purchase the coat, and the purchase may be an appropriate exercise of discretion. But how would the trustee know that the beneficiary needs a coat? How does the trustee buy an appropriate coat? How does the trustee get the information it needs to appropriately exercise its discretion and facilitate the purchase?

Identifying Sources of Information

Family members might be able and willing to provide relevant information. But what if the beneficiary has no reliable family members (or no *honest* or objective family members), no court appointed guardian, and no other reliable, informal advocates?

In some instances, beneficiaries might have Medicaid funded staff to provide this information, but the continued erosion of Medicaid funding for this type of service around the country has made this a less reliable option. Medicaid-funded care managers have increased caseloads, and disability provider agencies face high staff turnover (or are simply unable to locate staff in the first place). As a result, the trustee's affirmative obligation to make informed discretionary decisions[3] often cannot be met through communication with Medicaid funded staff alone.

If there is no credible family support, no court appointed guardian, and no reliable Medicaid funded staff, the trustee should consider retaining a private care manager, social worker or other advocate to serve as its "boots on the ground" to obtain information that

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[2] This section of the materials is adapted from an article prepared by this author co-authored with Edward V. Wilcenski for the National Academy of Elder Law Attorneys (NAELA) newsletter and subsequently published in the New York State Bar Journal in a series of three articles. *See* Edward V. Wilcenski & Tara Anne Pleat, *Administration of Supplemental Needs Trusts, an Improved Approach*, New York State Bar Journal, Part 1 Mar. 2019 at 12 , Part 2 Mar. 2020 at 22, Part 3 Apr. 2020 at 40.

[3] "Once the trustees were required to make themselves knowledgeable about [the beneficiary's] condition and his needs, and the availability of services that would enable them to provide for those needs, they began, and continue to use funds from his trust for the purposes [the testator] anticipated and so deeply desired.." Matter of the Accounting of J.P. Morgan Chase Bank, N.A, and H.J.P. as co-Trustees of the Mark C.H. Discretionary Trust of 1995 v. Marie H. [also referred herein as "Matter of J.P. Morgan], 956 N.Y.S.2d 856 (Sur. Ct. N.Y. Co. 2012).

the trustee can consider when making a distribution decision. Ideally and as earlier mentioned, the explicit authority to hire a private case manager, advocate or social worker without a reduction in any trustee's commissions will be drafted into the document.

Recommendations Regarding Communication

In determining whether a trustee of a trust for the benefit of a beneficiary with diminished capacity reasonably exercised discretion, judicial review should consider whether the trustee established an effective protocol for communication and a credible means of obtaining reliable information about the beneficiary's needs.

Upon being appointed the trustee should undertake the following analysis:

1. Is the beneficiary competent to correspond and advocate directly?

2. If the beneficiary cannot communicate directly, is there a court appointed guardian or agent under power of attorney who is able to speak reliably on behalf of the beneficiary and provide important information and documentation?[4]

3. Is the beneficiary supported by reliable[5] family members, friends or other informal advocates? While the trustee may be precluded from sharing information about the trust with individuals who lack legal authority to access it, the trustee is free to *receive* information from any credible source, supplementing whatever other information the trustee receives.

4. Does the beneficiary have program staff who could help communicate requests for goods and services to supplement what government benefit programs provide?

5. Can the trustee hire a private care manager or other advocate to provide periodic assessments and recommendations for distributions.?[6]

B. Approving Expenditures in line with Trust Terms

Professional trustees are required to have a basic knowledge and understanding of the rules governing investments, income taxes, and other financial issues common to all

[4] If all else fails, a trustee has the authority (in New York) to apply to a court for the appointment of a professional guardian who would have authority to obtain information and provide documentation that a trustee would need to make informed decisions. NY Mental Hygiene Law 81.06(a)(4).

[5] Whether a family member is "reliable" is also a judgment call.

[6] This was the recommendation of the court in Matter of JP Morgan, *supra n.* 50. It is important to note that the beneficiary resided in a residential program with 24-hour Medicaid funded staffing. Matter of JP Morgan at p. 369. The case illustrates the fact that a trustee's obligation to remain informed goes beyond simply ensuring that a beneficiary is participating in a Medicaid funded program and requires independent assessment and review.

fiduciary appointments. Most institutions have a process to review these issues on a regular basis.

In the context of Supplemental Needs Trusts – by their terms and by statute – require a trustee to consider factors that are outside the traditional realms of trustee expertise: the availability of public benefits and the means tested goods and services they provide, the adequacy of those goods and services, and the potential impact of a distribution on continuing eligibility.[7]

This requirement is a variation on a common theme found in cases analyzing a trustee's exercise of discretion. Government benefit programs represent a valuable source of funding for goods or services that the trustee must consider before making a discretionary distribution.[8] To adequately consider these other sources, the trustee must answer a few questions.

Determining whether a program pays for a good or service

This requires more than simply asking, "Is the beneficiary Medicaid eligible?" Medicaid is a payment source for certain goods and services, but the question for the trustee is whether Medicaid will pay for the specific good or service that the beneficiary needs. It is not uncommon for a beneficiary to be eligible for Medicaid (meaning that the Medicaid program is willing to pay for a good or service), but the good or service itself may be *unavailable*. This dilemma is often seen in Medicaid funded staffing, where the hourly rate paid to community-based staff is so low that service providers either cannot find people to fill the positions, or they are forced to hire individuals with minimal experience.[9]

Assessing adequacy of alternative options

To comply with the terms of the trust and the language of the governing some state statutes, the trustee of a supplemental needs trust must determine whether funds in the trust should be used to *supplement* (or supplant) an available good or service.

Consider a beneficiary in need of a wheelchair. Medicaid pays for a basic wheelchair, but the beneficiary might do better with a more expensive wheelchair that is a better fit

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[7] New York's statute defines a supplemental needs trust as a discretionary trust which, by its terms "prohibits the trustee from expending or distributing trust assets in any way which may supplant, impair or diminish government benefits or assistance for which the beneficiary may otherwise be eligible or which the beneficiary may be receiving; provided, however, that the trustee may be authorized to make such distributions to third parties to meet the beneficiary's needs for food, clothing, shelter or health care but only if the trustee determines…that the beneficiary's basic needs will be better met if such distribution is made." NY EPTL 7-1.12(a)(5)(ii).

[8] In re Levison's Will, 29 Misc. 2d 697 Sur. Ct. Rockland County 1961). Decisional law in this area focuses on the trust creator's intentions in determining whether the trustee should consider a beneficiary's other resources when making a discretionary distribution. There is no ambiguity with an SNT, as the requirement to consider other resources (government benefits) is written into the New York statute and the language of the document.

[9] In New York the issue has reached critical proportions. *See* testimony of Mark Van Voorst, Executive Director of NYSARC before the New York State Legislature warning of the impending crisis. https://nyassembly.gov/write/upload/publichearing/001100/002228.pdf (last visited February 28, 2021).

for her needs – safer, more comfortable, with more sophisticated positioning systems and other controls. The trustee might be able to acquire the chair immediately and without having to go through the Medicaid program's administrative review and approval process. The trustee has the discretion to pay for the better chair.

Consider a beneficiary with Medicaid funded staffing in the home. A beneficiary may be approved for three hours per day, two days per week. But the beneficiary and her family would rather not work with inexperienced Medicaid-funded staff, or they may want more hours of coverage. If there are funds in the trust to pay, then the trustee has the discretion to purchase those extra hours, or hire other, more experienced staff.

Before using trust assets to *supplement* (or supplant) a government funded good or service, the trustee should have some process in place to confirm what the program is providing, and some means of documenting that the beneficiary would benefit from other or additional goods or services.

This practice is conceptually the same as a fully discretionary trust which requires the trustee to consider other assets available to the beneficiary before exercising discretion to use trust funds to purchase a good or service for the beneficiary's benefit.

Impact of distributions on certain program eligibility

The same distribution from an SNT can impact different programs in different ways. For example, the payment of rent from a trust will have no impact on Medicaid[10] but may result in a reduction in a monthly SSI payment and an increase in the rent paid for HUD subsidized housing.[11]

The trustee is charged with knowing which benefit programs a beneficiary is participating in *at the time of the distribution,* understanding that many beneficiaries migrate in and out of different benefit programs based on changes in family composition, financial condition, and other circumstances, and knowing how the proposed distribution might impact those benefits.[12]

If a trustee exercises discretion and uses funds in the trust to pay rent so that the beneficiary can move into a nicer neighborhood, the trustee must understand the impact of its discretionary distribution on the SSI benefit, and document why the beneficiary would be better off with less monthly income but a better place to live.

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[10] 18 NYCRR 360-4.3(e).

[11] POMS SI 01120.200E.1.b; *see also* "The Impact of Special Needs Trusts on Eligibility for Subsidized Housing," *The Voice* Volume 5, Issue 4 (March 2011)(https://www.specialneedsalliance.org/the-voice/the-impact-of-special-needs-trusts-on-eligibility-for-subsidized-housing-2/ (last visited February 28, 2021)).

[12] New York's statute makes clear that "neither principal nor income held in trust shall be deemed an available resource to the beneficiary under any program of government benefits or assistance; however, *actual distributions from the trust may be considered to be income or resources of the beneficiary to the extent provided by the terms of any such program*." NY EPTL 7-1.12(b)(3) (emphasis added).

Recommendations regarding process development

Upon being appointed the trustee should promptly develop a plan to confirm government benefit eligibility and available goods and services, to assess whether those services and supports are adequate, and to review that information on a regular basis. The trustee should consider the following resources and suggestions:

1. For beneficiaries participating in a waiver program, disability service providers prepare periodic reports (often called Service Plans or Life Plans[13]) which include information on a beneficiary's preferences, health, family supports, and professional providers. Different programs have different reporting requirements, but most publicly funded programs will require a summary report of some type. These reports can often provide useful information on what services might be available through a government benefit program.[14] The trustee should regularly obtain these reports.

2. If a beneficiary has proactive and well-informed family members, they may be able to provide the trustee with information needed to determine whether a government benefit program is providing an adequate level of goods and services.

3. The trustee can hire a private care manager or other advocate to conduct a comprehensive review of benefit eligibility and available services and provide options for supplementing those benefits and supports.[15]

IV. Housing Transitions and Relocation

Among the most difficult and consequential decisions faced by remote fiduciaries are those involving housing transitions. Unlike routine disbursements for clothing or therapy, decisions about whether, when, and how a beneficiary should relocate involve a delicate interplay of safety concerns, service availability, benefit eligibility, family dynamics, and quality of life. For fiduciaries administering Supplemental Needs Trusts (SNTs), these transitions are rarely straightforward and often urgent.

A relocation may be prompted by a variety of factors: the closure of a group home, a decline in the beneficiary's health, a staffing shortage that leaves the current placement unsafe or unsustainable, or even the desire to bring the beneficiary closer to the trustee or family members. Trustees must weigh these considerations carefully while also determining whether they have sufficient, credible information about the beneficiary's

[13] For individuals served by the NYS Office of People With Developmental Disabilities, see Administrative Directive 18 ADM 06, "Transition to People First Care Coordination" (June 26, 2018).

[14] A word of caution is warranted here. Those with experience reviewing Life Plans (formerly called "Individualized Service Plans" or "ISPs") know that these documents often contain outdated and inaccurate information, largely a result of staff having too many reports to prepare and not enough time and experience to prepare them in a thorough and detailed fashion.

[15] In 2016, the New York State Bar Association Trust and Estates Section Subcommittee Reviewing Changes to EPTL 7-1.12 recommended that the statute be modified so as to require the trustee of a supplemental needs trust to investigate the need for a case manager, to retain a case manager where necessary, and to pay the case manager from trust funds. *See* Memorandum dated March 30, 2016, from Nina P. Silfen, Esq. Stephanie Hamberger, Esq., and Jonathan Byer, Esq. to Michael Schwartz, Esq., Chair of the Trust and Estate Administration Committee of the Trusts and Estates Section of the New York State Bar Association.

current circumstances, and whether a proposed move truly represents an improvement in care, support, or independence.

Importantly, housing decisions can carry significant Medicaid implications. State Medicaid programs vary in how they fund residential services, and a move across state lines may trigger new eligibility requirements or limit access to existing services. Trustees must therefore assess not only the logistics of the move, but also its impact on public benefits. In some cases, it may be more prudent to fund additional services to stabilize current placement than to initiate a disruptive relocation that risks benefit loss or service interruption.

Remote fiduciaries must also determine whether trust assets can, and should, be used to support the transition. This may include paying for a private housing advocate, funding transitional support, or covering initial living costs not reimbursable by Medicaid or that may adversely impact SSI. These decisions must be grounded in the trustee's discretion under the terms of the trust, but also informed by the beneficiary's preferences, stated goals, and overall well-being**.** When no guardian or advocate is available to assist with these judgments, or frankly even if there are, the trustee may need to hire a local care manager or other professional to provide a first-hand objective assessment.

Ultimately, decisions around housing transitions must strike a careful balance: proximity to the trustee or family should never come at the expense of continuity of care, and any disruption must be clearly in the best interest of the beneficiary. In all cases, trustees must document their reasoning, consult with all available sources of support, and ensure that their actions are not only permissible under the law and the trust instrument, but ethically and practically sound.

V. Embedding Best Practices in Remote Administration

Fulfilling fiduciary duties in the context of remote caregiving is a dynamic and ongoing responsibility. The complexity of administering a Supplemental Needs Trust (SNT) from a distance, particularly when the beneficiary has diminished capacity or limited support, requires more than legal compliance; it demands active engagement, thoughtful planning, and systems of accountability. Trustees must not only respond to needs as they arise, but also anticipate challenges and implement structures that ensure ongoing, informed decision-making.

To that end, fiduciaries are encouraged to adopt a set of core practices that support both the substantive and procedural aspects of trust administration. These practices begin with a thorough review of the trust instrument. Before authorizing any expenditure, the trustee must confirm that the distribution is permitted under the terms of the trust and, where relevant, under applicable public benefit regulations. Each decision should be backed by clear documentation, including not only the amount and purpose of the expenditure, but also the rationale and any supporting communications.

Regular communication with the care team is essential. Trustees should establish expectations with service providers, case managers, and residential staff regarding the frequency and format of updates. When HIPAA restrictions limit access to necessary records, properly executed authorizations should be obtained to enable the trustee to receive protected information. If these steps are impractical due to geographic or logistical barriers, the trustee should consider hiring a local care manager, social worker, or advocate who can conduct needs assessments and serve as an intermediary.

In complex or high-need situations, trustees may also benefit from appointing a co-trustee, trust protector, or advisory role with specialized knowledge or a local presence. Delegating certain monitoring responsibilities can enhance decision-making and ensure continuity, especially when the trustee cannot be physically present. Whether or not additional fiduciaries are involved, it is critical to maintain case notes that document the trustee's actions, thought processes, and communications. This not only supports accountability but also provides essential context for future decision-making and potential downstream judicial review.

VI. Conclusion

The administration of a Supplemental Needs Trust in the context of remote caregiving is no longer a niche concern, it is a growing reality in an era where families are increasingly dispersed and service systems are increasingly fragmented. Trustees, whether professional or familial, must navigate a maze of legal authority, public benefit rules, interpersonal dynamics, and logistical barriers to fulfill their obligations with diligence and compassion. This work requires more than adherence to statutory duties; it demands creativity, judgment, and the willingness to assemble a network of support that compensates for physical distance. Tools like powers of attorney, guardianship, and HIPAA authorizations provide critical scaffolding, but they are only effective when paired with thoughtful communication protocols, meaningful engagement with service providers, and a clear process for ongoing assessment and oversight. Ultimately, remote fiduciaries must embrace a model of administration that is proactive, flexible, and well-documented, one that honors both the intent of the settlor (in third party arrangements and the evolving needs of the beneficiary. With proper planning, partnerships, and process, trustees can meet the challenges of distance while preserving the integrity and purpose of the trust and the human they are charged to steward.

Navigating Distance & Disability

Legal and Fiduciary Approaches to Remote Caregiving

1

Introduction

- Families increasingly live far apart
- Care and decision-making often handled remotely
- Disability adds complexity to fiduciary roles
- Erosion of Medicaid Funded Service Systems

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Case Study: Leonard & Diane Overview

Leonard:

- 56 years old with lifelong intellectual disability
- No prior Medicaid/State Agency Support; cared for by parents at their home in rural community until their passing.
- Lives alone in senior housing with 24/7 staff (~$500K/year)
- Relocated to more populated community for access to housing, homecare, and medical providers

Diane:

- 64, lives in Idaho, guardian and SNT trustee
- Relies on solo care consultant in NY
- Runs her own business; successor has limited capacity

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Case Study: Assets and Fiduciary Challenges

Assets:

- SNT (~$4.2M): conflicting language re: 'primary needs'
- Guardianship Estate (~$7M): includes real estate, investments
- Multiple accounts complicate compliance and reporting

Fiduciary Issues:

- SNT ambiguity about allowable distributions
- High staffing costs threaten sustainability
- Diane oversees complex legal and financial matters remotely

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Case Study: Long Term Care and Succession Considerations

Care Oversight:

- Dependent on one consultant with no backup
- 1:1 staffing being faded slowly to reduce cost
- Staff turnover, cost, and oversight challenges persist

Housing and Benefits:

- Independent senior housing not ideal for needs
- State Agency options limited and potentially lower quality
- Leonard ineligible for Medicaid; planning needed

Succession and Sustainability:

- Diane aging and overwhelmed
- Successor unlikely to provide equivalent involvement
- Urgent need for sustainable plan and local supports

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Case Study: The Corporate Trustee Conundrum

Ampersand Trust Services is corporate trustee of a First-Party SNT

- Beneficiary: James, 37, with schizoaffective disorder and TBI
- SNT funded by PI settlement (~$500K in liquid assets)
- Lives in group home in rural western Pennsylvania
- Receives Medicaid waiver services, SSI, and SNAP
- Ampersand Trust is based in upstate New York; trust officer has never met James
- No involved family members; relies on provider communication

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Case Study: The Corporate Trustee Conundrum

1. Lack of Firsthand Knowledge:
•Frequent turnover of trust officers
•No direct contact with James or family supports

2. Inconsistent Communication:
• Vague or delayed distribution requests
• Minimal documentation from provider staff

3. Medicaid Substitution Issues:
• Requests for items potentially covered by Medicaid
• Ampersand lacks ability to verify service coverage

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Case Study: The Corporate Trustee Conundrum

4. Staffing Supplement Requests:
• Group home wants SNT to pay for private staff
• Uncertainty about Medicaid adequacy and impact

5. Oversight of Disbursements:
• Preparing for judicial review
• Incomplete records complicate justification

6. Limits on Hiring Local Help:
• Trust lacks express authority for care managers
• Internal policy requires legal review for fiduciary roles

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Legal Framework for Remote Caregiving

- Powers of Attorney
- Health Care Proxies
- HIPAA Authorizations
- Guardianship
- Supplemental Needs Trusts (SNTs)

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Durable Powers of Attorney

- Common tool for financial and legal decisions
- Must allow for remote/electronic access
- May need to be accepted in multiple jurisdictions
- Address HIPAA

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Health Care Decision Making

- Enables remote medical decision-making
- Should be accessible in emergencies
- Supplement with values statements when possible
- Supported Decision Making

11

HIPAA Authorizations

- Allows sharing of protected health info
- Critical for communication with providers
- Must be standalone, broad, and current
- Confirm if your state agencies have their own forms

12

Guardianship

- Court-appointed legal authority
- Understand scope and limitations under court order – Plenary vs. Least Restrictive Alternative
- Role in enrolling in and overseeing community-based services.

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Supported Decision-Making

- Supports autonomy in decision-making
- Does not create agency authority
- Works best when layered with legal tools like POAs, Health Care Directives, or non-plenary Guardianships

14

Supplemental Needs Trusts (SNTs)

- Essential for maintaining means-tested benefit eligibility
- Allows trustees to support quality of life
- Must consider state-specific benefit rules

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Remote Trust Administration

- Use care managers or local professionals
- Maintain clear records and rationale
- Ensure discretionary authority aligns with trust terms

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Unique Challenges of Trust Administration

The law and practice in traditional fiduciary administration presumes that a beneficiary is competent and capable of communication and self advocacy.

Administration of trusts for beneficiaries who are cognitively compromised and live at a distance can present unique challenges in communication and support.

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Unique Challenges of Trust Administration

- Beneficiary communication - beneficiary may be incapable of communication
- Documentation - family and informal supports may be unreliable, conflicted or dishonest, and formal supports (often through Medicaid funded programs) may be overworked or inept
- Distribution decisions must take into consideration rules and programs that are not within the traditional expertise of most fiduciaries, leaving a trustee unable to document the basis for its decision

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Establishing a Protocol for Communication

- Establish a communication protocol that includes:
  (1) the beneficiary if capable
  (2) guardian/agent if available
  (3) concerned family member/friend if appropriate
  (4) educators/program staff if available

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Establishing a Protocol for Communication

If there are no credible family supports, no court appointed guardian, no agent under power of attorney and no reliable Medicaid funded staff, the trustee should consider retaining a private case manager, social worker, or advocate to serve as its objective "boots on the ground" to obtain information the trustee can consider when making a distribution decision and otherwise support the beneficiary.

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Approving Distributions: Determining Whether a Program Pays

- What it really means when a beneficiary is Medicaid eligible
- Availability of goods and services, availability of staff - consider staffing shortages around the country
- Ensuring available public services are adequately utilized

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Approving Distributions: Adequacy of Alternatives

- Should a trustee supplement or supplant an available good or service?
- Availability vs. adequacy and appropriateness
- Before using trust assets to supplement or supplant a government funded good or service, trustees should have a process in place to confirm what the program is providing and a means to document the beneficiary would benefit from something better

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Approving Distributions: Adequacy of Alternatives

Establish a validation process.

- Assess whether family or other informal supports are reliable
- Determine whether Medicaid funded staff can provide answers and support
- Retain a private case manager or other paid advocate to provide objective assessment of program eligibility, use, and adequacy and who can make credible recommendations

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Impact of Distributions on Benefits

- Establish a process to verify financial benefits annually
- Establish a process to verify Medicaid funded and other available services on an annual basis
- Utilize a case manager or other professional to provide an annual assessment. These assessments serve as evidence that the trustee made an informed decision to supplement Medicaid funded supports and other publicly funded supports with private dollars and is relying on an objective source

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Practical Considerations for Remote Caregivers & Fiduciaries

- True Link Cards
- Technical Support
- Sibling/Natural Support
- Companions
- Quality of life

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Housing Transitions

- Weigh safety, services, and beneficiary goals
- Watch for Medicaid implications of relocation
- Always document decision rationale
- Trust owned Real Estate
- Location considerations

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Conclusion

Distance increases complexity, not discretion

Combine legal tools, judgment, and human insight

Build and support a team, even from afar

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Thank you!

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National Conference on Special Needs Planning and Special Needs Trusts

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The House is on Fire…Literally

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When the House Burns Down . . .

While attending Stetson's National Conference on Special Needs Planning and Special Needs Trusts in 2023, I learned that real property owned by a first party special needs trust that we as corporate trustee administered had suffered total loss in a fire, along with its contents. The real property was the home of the beneficiary and his parents, who are his guardians, and other family members, one of whom is also disabled. Thankfully, no one was hurt! But the journey of navigating the insurance claim, temporary living arrangements for the beneficiary and his family, and "allowable disbursements" as per Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), had begun. Much was learned in this process that I thought would be helpful to share with my fellow fiduciaries and attorneys who represent them.

The obvious first order of business was to submit the claim. We had recently switched from individual insurance policies to a master insurance policy, which had many advantages, some of which are as follows:

- Broad named insured to include the fiduciary and not just the beneficiary, protecting our institution as fiduciary;
- Generally competitive premium but with broader coverage;
- Guaranteed Replacement Cost v. Scheduled Replacement Cost;
- Significantly more substantial liability limits per occurrence/per location and in aggregate;
- Lower deductible;
- Broader sub-limited coverages including valuable articles, fine arts, business income, farm equipment, crops in storage, livestock, etc.; and
- Earthquake and Flood included rather than separate policies require.

Top priority was to provide alternative living arrangements for the beneficiary and their family. The master insurance policy provided for an amount under Loss of Use to be applied toward these expenses. The insurer contracted with a third party to facilitate the arrangements and payment for these expenses. Initially, that was a hotel stay immediately following the loss followed by a long-term rental to accommodate the beneficiary's need for accessibility and the family who are his caregivers. Typically, the claim for Loss of Use would be paid to the insured, which was the special needs trust. However, I was concerned with the special needs trust being able to pay the cost of the long-term rental for not only the beneficiary, but his family who were also displaced. As such, I ran interference immediately with the adjuster and asked that this portion of the claim be paid to the third-party contractor who, in turn, would pay the rental expense directly to the landlord. Thankfully, the adjuster understood and appreciated the issue and made this accommodation so as to avoid implications with the special needs trust and the beneficiary's eligibility for SSI and Medicaid or, alternatively, burdening the family with a pro rata share of the rental cost.

Next order of business was to plan for the reconstruction of the property. The insurer contracted with a construction consultant to develop a repair estimate to reconstruct the home and with another third party to prepare an estimate for replacement of the personal property contained in the home that was also destroyed. The construction consultant identified a contractor to construct the home with whom it and the insurer had previously worked so it was accustomed to

working within the parameters of the claim. Upon agreement on the repair or, rather, construction cost by the contractor and insurer, the contractor prepared a contract for us, as trustee, to execute, which set forth the total cost and when payments (3) were due as construction reached certain benchmarks.

I learned about the loss amount and its depreciation to arrive at the actual cash value. The actual cash value is what was to initially be paid to the insured, the special needs trust and, upon near completion, the depreciation amount would be paid, which coincided with when the final installment payment of the construction contract was due. The objective in not paying the total loss amount of the claim up front so as to avoid a windfall to the insured should the insured opt not to reconstruct the property. As trustee, we presented the option to the beneficiary's legal guardian. Why did we present the option to the beneficiary's legal guardian? The special needs trust had limited liquidity and it was an opportunity to add to that and prolong the life of the trust. Additionally, we expressed our concern about subjecting the home to the Medicaid payback upon the death of the beneficiary, whose life expectancy is diminished due to their condition. We explored with the parents, both of whom are employed, the opportunity and ability to purchase their own home. In the end, the parents/guardians decided to proceed with the reconstruction of the home.

Following the decision to proceed with the reconstruction, arrangements were made for the initial payment of the actual cash value amount to the special needs trust. We then turned our immediate attention to notifying our Medicaid agency about the destruction of the real property in a fire, the insurance claim, and anticipated disbursements from the special needs trust to the construction company pursuant to contract. In Arizona, anticipated disbursements must be approved by our Medicaid agency in advance. I provided Medicaid the Statement of Loss and explained what was being paid now, the actual cash value, and what would be paid later near completion of the construction, the depreciation amount, as well as the deductible the trust was required to pay, providing supporting documentation for these amounts. Medicaid approved the disbursements of the insurance proceeds received for construction of the home pursuant to contract, after which we signed the construction contract and made initial payment.

As you can imagine, the construction revealed additional costs that were negotiated between the contractor and insurer. As a result, additional funds were paid out to the special need needs trust to cover the additional costs. The adjuster assured us that additional costs would be covered given the substantial aggregate liability coverage available under the master policy. That would not have been the case with an individual insurance policy. Like most construction projects, as we neared the forecasted completion of twelve (12) months, we were advised that the construction would likely not be completed for another several months due to delays with permits, etc. The beneficiary and their family's lease was terminating at twelve (12) months. Fortunately, the third-party contractor was able to negotiate an extension of three (3) months at the same rate and just enough funds remained under Loss of Use coverage to cover the extension without the family having to be out-of-pocket their pro rata share.

As we neared the end of the construction and it came time to paint the exterior, we were required to submit the proposed paint and roof scheme to the Homeowner's Association (HOA) for consideration and approval. We had requested information from the HOA about approved

colors and materials in advance and obtained input from the parents/guardians regarding their preference. Fortunately, the HOA promptly approved the request. As an aside, during the construction, a violation notice was received from the HOA regarding the landscaping for which we sought a waiver for the duration of the construction and which was also approved. Recently, we received a violation notice regarding the paint of the exterior wall, which may have been overlooked, and are addressing that. Interestingly, the approved paint scheme has changed since the house itself was painted.

Now it was time to turn our attention to furnishing the home. As was the case with the determination of the value of the structure—actual and depreciated—a third party consultant was hired by the insurer to do the same with respect to the contents of the home or personal property. The actual cash value was initially paid to the special needs trust with the option to seek additional reimbursement of the replacement costs if it exceeded the actual cash value up to a certain amount. In this instance, it was not necessary to seek the reimbursement of the replacement cost beyond the actual cash value.

Unfortunately, the personal property was purchased by the parents, not the beneficiary nor his special needs trust, but the insured was the trust and, as such, the claim could only be paid to the trust. The master policy provided up to $50,000 in coverage for the personal effects and property of others but that, too, had to be paid to the special needs trust. We had to again seek Medicaid's approval to disburse funds to purchase personal property and, while I was at it, I made the case to Medicaid to disburse $50,000 to the parents as provided for in the master policy for them to replace their own personal property and personal effects. Surprisingly, Medicaid approved all disbursements!

The logistics were challenging. We had a True Link account/card and relied upon and utilized that for the parents/guardians to purchase items. We did not want to fund the entirety of the insurance proceeds for replacement of personal property to the account/card and instead, did so in increments of $20,000. We promptly learned that we could only fund the account/card $5,000/day for a total of $20,000 per month. True Link worked with us initially and provided a loan to the account so that the initial $20,000 was immediately available, which was paid off with the subsequent funding of $5,000/day. Timing was crucial as the beneficiary and their family had no place to store personal property while in the rental (which included rental furniture) but needed to have the bare essentials, such as beds, upon moving into the newly constructed home.

All were thrilled when the beneficiary and their family were able to return to their "new" home. Our experience with the insurer and its adjuster, as well as the contractor, was positive. And, surprisingly, Medicaid appeared sympathetic to the situation and approved what was requested based on the original submissions. Note, I spent a great deal of time preparing the submissions with supporting documentation, which served us well.

P.S. It's been more than a year and a half since this has concluded. We are now learning a hard lesson in that the insurer of our master policy is terminating our coverage and the only other insurer who will entertain providing us a comparable master policy has quoted a premium increase of about 25%, which is not affordable as we allocate this expense to our fiduciary accounts that hold real estate covered by the policy. We are now shopping for individual policies and my concern

is whether anyone will be willing to insure this home and, if so, at what expense. Moral of the story, vet the real estate that is coming in for insurance purposes, i.e., condition of the home, age and history of claims and repairs, location and exposure to risks, residents of the home and their activity, etc. and selectively add real estate to a master policy, while sticking with an individual policy for those properties that have the potential of impacting continued coverage under a master policy and cost.



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October 24, 2025

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The Great SNT Road Trip: First-Party SNT Beneficiaries Crossing State Lines

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I. Introduction

A. Beyond The Form – This Is How We Beat The Robots.

What separates an attorney who lists special needs planning on their website from a truly exceptional special needs attorney? The answer is not the quality of their first-party trust. Most attorneys can probably obtain an adequate form (and the AI robots will soon be able to do this, too).

Our actual value as special needs attorneys is in the counseling and our deep understanding of benefit systems. And the ultimate test of a special needs attorney's expertise may well be their ability to successfully transition a beneficiary moving into their state. Doing so requires an advanced ability to navigate every aspect of what is considered special needs law: understanding how to qualify for government benefits (Medicaid in particular), obtaining the appropriate community living supports and housing, understanding state trust law, navigating probate courts on guardianship and trust supervision, and just being an overall good counselor.

B. Medicaid's Original Sin – Navigating Medicaid's Federal-State Hybrid Complexity.

One of Medicaid's "original sins" is its structure as a federal-state hybrid program. Unlike Social Security and Medicare, which operate with relatively consistent nationwide standards, Medicaid presents unique challenges due to the extensive variations across states.

This creates some notable problems:

- **Clients start from scratch when they move to another state**. Medicaid does not transfer. Clients start from square one in the Medicaid process when they move to a new state.

- **Medicaid waiver programs are different from state to state**. When working across state lines for Medicaid, we literally speak different languages. It is not uncommon for two highly accomplished attorneys to talk past each other, not realizing they are

using entirely different terminology to describe the same services. Never assume Medicaid programs in your state work the same way in another state.

- **Waitlists**. Medicaid waiver programs can have waiting lists. Because beneficiaries are starting over, they must be prepared for the high likelihood of a long waitlist for services in the new state.

To navigate these complexities, a funded special needs trust can be a truly life-changing tool for an interstate move to help pay for the necessary team and likely gaps in services during the transition.

II. Drafting For Portability

Before discussing the transition of a beneficiary between states, we should first consider provisions to incorporate into our first-party special needs trusts that will facilitate easier transitions if our client needs to relocate in the future.

A. Authority To Relocate The Trust.

When a beneficiary relocates, it is advisable to relocate a first-party special needs trust due to state-specific Medicaid peculiarities. As such, if your jurisdiction permits it, it is almost always advisable to make it easy for the trust law and/or place of administration to move with the beneficiary.

This is a typical clause that we will use in Michigan:

> Authority to Relocate Trust. Every Trustee shall have the authority to move the place of administration of this Agreement to such jurisdiction(s) as Trustee deems appropriate. Such relocation may be done for the convenience of the Trustee, or for any other purpose consistent with the purpose for which this Trust was created. Accordingly, Trustee may, but is not required to, register this Agreement in such court(s) and at such times as Trustee deems appropriate. The laws governing this Agreement shall be the laws of the jurisdiction in which the Agreement is being administered**.**

B. Authority To Amend The Trust.

While first-party trusts must be irrevocable, it is crucial to know whether your jurisdiction will allow some limited trust amendment language. This language can be essential in enabling the beneficiary to make any necessary technical changes to the trust to comply with unique trust requirements.

In Michigan, we have never had issues with the following language:

Ability to Amend. To further the purposes of the Trust, including complying with the laws governing discretionary and "special needs" trusts, a Trustee may amend any administrative provision of the Trust in a writing signed and dated by the Trustee and delivered to those individuals entitled to accountings. Trustee may amend the Trust to ensure continuing eligibility or to secure eligibility for public benefit programs including, but not limited to, Supplemental Security Income (SSI), Medicaid, or any other government benefit program. If the law or regulations governing eligibility change, Trustee may amend the Trust, or if any provision of this original Trust fails to meet requirements of SSI, Medicaid, or any other government benefit program, Trustee may amend the Trust to comply with any such provisions. If Beneficiary shall move to another jurisdiction, Trustee may amend the Trust to comply with the laws of such jurisdiction in order to maintain Beneficiary's eligibility. A Trustee may not amend the dispositive provisions of this Trust or alter the discretionary nature of the Beneficiary's interest in the Trust. The Trustee may not remove or alter the obligation of the Trustee to reimburse the state or states that have provided Medical assistance to the Beneficiary of this Trust. Any exercise of this power that causes a Beneficiary to no longer be eligible for Medicaid, SSI, or any other government benefit is void. Any valid exercise of this power of amendment shall take effect on the date the amendment is signed by the Trustee. Trustee shall notify Social Security Administration and Medicaid in writing of such Amendment.

C. Trustee Succession.

The rules regarding who can serve as a trustee differ significantly from state to state. For example, in Michigan, only individuals or banks are permitted to serve as trustees.[1] However, even among banks, not all possess national charters, which may further limit their ability to serve as trustees in every state.

Additionally, even if a trustee is eligible to serve in the receiving state, practical considerations may still make it unwise for them to do so. As we know, the administration of special needs trusts is governed by varying rules from state to state (and possibly county by county). Appointing a more local trustee who understands local regulations and practices may be the wiser choice.

Given these complexities, it may be prudent to ensure the special needs trust has sufficient flexibility for a trustee (or trust protector) to appoint successor trustees without requiring court approval. A sample provision that works in our jurisdiction:

> Any acting Trustee shall have the authority, by a writing executed with the same formalities as this document, to appoint additional successor Trustees[options][after the named individuals above.]/[. This authority includes the option of naming

[1] MCL 487.11105(2).

successor Trustees to serve before those named above.] This notwithstanding, Beneficiary shall never be appointed Trustee.*

*In drafting such provisions, it is important to clarify that the beneficiary can never serve as trustee. This ensures that there is no potential for the beneficiary to gain control over the trust, which could lead to conflicts of interest or compromise the trust's purpose.

Additionally, the POMS now clearly allow for the transfer of a d4A to a d4C trust (or secondary d4A trust).[2] There may be situations in which transferring the trust to a pooled trust in another state is appropriate, especially if the trust corpus is modest or if there is no suitable individual or professional trustee available in the receiving state. Should you consider drafting a provision to allow transferring the trust to a pooled trust in case that is the best option if a beneficiary moves to a different state? Some sample language that might work in a first-party special needs trust:

> If, at any time during the life of the Beneficiary, the Trustee determines it is in the best interest of the Beneficiary, the Trustee may transfer all or a portion of the trust assets to a trust established for the sole benefit of the Beneficiary that meets the requirements of 42 U.S.C. § 1396p(d)(4)(C) or a secondary trust that meets the requirements of 42 U.S.C. § 1396p(d)(4)(A).[3] Such a transfer is permissible only if the receiving trust qualifies as a trust defined by the above-referenced statutes, is for the same Beneficiary, and complies with all Medicaid and Supplemental Security Income (SSI) rules and regulations, including those regarding state Medicaid paybacks, then in effect. Additionally, Trustee may only make the transfer if it is permitted under applicable federal and state law, including, but not limited to, relevant Social Security and Medicaid rules and regulations.

Caution: As with any drafting, such a clause should be used thoughtfully. Administrative rules can change quickly, and you are always at risk of being out of compliance. It may be better not to include such a clause and rely on other provisions (e.g., decanting laws) to make such a distribution *if* ever needed.

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[2] See POMS 01120.199.E.2:
Exception for transfers to a secondary trust upon early termination
An early termination provision in a section 1917(d)(4)(A) special needs trust or section 1917(d)(4)(C) pooled trust does not need to meet the above criteria if the provision allows solely for a transfer of the beneficiary's assets to a secondary section 1917(d)(4)(A) or section 1917(d)(4)(C) trust of which the same individual is the beneficiary.

The early termination provision must contain specific limiting language that precludes the early termination from resulting in disbursements other than to the secondary section 1917(d)(4)(A) or section 1917(d)(4)(C) trust or to pay for the administrative expenses listed in SI 01120.199E.3 in this section and in SI 01120.201F.4.

[3] The reference to a secondary d4A trust may or may not be desirable. *See also* discussion about decanting below.

III. Building And Defining The Team

As we know, administering a special needs trusts always take a village. And when a beneficiary moves to a different state, many members of that village need to be substituted. Therefore, the attorney and trustee must consider who the team will be and what role each team member will play.

Special needs planning attorneys will typically be the quarterbacks in a state-to-state transition. But in a transfer, there are commonly two attorneys, and each of their roles should be defined:

- **Originating attorney**: This is most normally the drafting attorney or the attorney who assists with the administration of the trust. The originating attorney's jobs are primarily: (1) find the receiving attorney; (2) set expectations for the trustee/beneficiary; (3) collect information necessary for it to be "translated" by the receiving attorney; and (4) assist with any local court actions that might be necessary to facilitate the transfer.

- **Receiving attorney**: This is the attorney in the state that the beneficiary is moving into, and who will be doing the bulk of the work. This role could include: (1) assisting in translating how the beneficiary's services would convert in the new state; (2) advising on appropriate professionals in the receiving state to accept the trust; (3) reviewing the trust and advise if it requires modifications; (4) advising how best to make those modifications for the receiving state's government benefits; (5) advising if any court petitions will need to be filed and leading those filings; (6) applying for government benefits; and (7) advising on ongoing administration.

Note: The originating attorney's most important job is finding a qualified attorney in the receiving state. To this end, it is essential to remember that there can be significant differences within the state as well. In Michigan, what an attorney knows in the Detroit area is different from what they know in Grand Rapids, which is very different from what they know in the Upper Peninsula.

But once the originating attorney locates a qualifying receiving attorney, that originating attorney should defer to the receiving attorney as much as possible.

Beyond this, the attorneys should identify what other professionals might be useful:

- **Trustee**: As discussed above, is the trustee transitioning to the new state, or will a new trustee be required? And if a new trustee is required, what modifications will need to be made to the trust?

- **Accountant/CPA**: Because first-party trusts are grantor trusts, taxation is usually just passed through to the individual's tax return. Still, a local accountant is likely necessary to comply with state and local taxes, as well as potentially with trust accounting requirements.

- **Financial Planner**: It is generally easy for financial advisors to get registered in a new state, but this should not be assumed. A new financial planner may be required in the new state. It might also just be practical to have a financial planner closer to where the trustee or beneficiary lives.

- **Nonprofit Agencies**: It is always important to know what nonprofit agencies, such as the local Arc, may exist to help with transitions.

- **Care Manager / Government Benefits Advocate / Special Education Advocate**: It is usually *not* cost-effective for an attorney to do the on-the-ground legwork to assist with an interstate transfer, which could include assisting with the move itself, finding providers and caregivers, assisting with actual benefit applications, and navigating Individualized Education Programs (IEPs) in special education or person-centered plans in adulthood. One person or group may be able to do all of this, or it might require multiple people.

- **Guardian / Agents**: A new guardian and/or agents for powers of attorney may be required in the new state.

When you build a team, it is always best to make it economical, which usually means starting with natural supports (family/friends/neighbors), then looking at nonprofit resources, and then finally paid professionals.

III. Ten Steps For A Successful Move

A. Step One: Understanding The Reason For The Move.

The first step is seemingly obvious: *Why is the beneficiary moving*? A *routine* move—such as a parent's job transfer, relocating closer to extended family, or a planned transition to better services usually allows time to prepare and anticipate. It also typically means that a lot of natural family support will be in place, which may not require as extensive a team in the new state.

Crisis moves, by contrast, happen with little warning. Examples include a primary caregiver's death, a sibling's sudden assumption of care, or another unexpected change that forces relocation. In these cases, the transition may need to happen quickly, and the

individual's natural support may look very different from what existed in the original state. That shift, in turn, will drive what team needs to be built to fill gaps, stabilize care, and preserve continuity of benefits and services.

B. Step Two: Gather Originating State's Benefits And Services.

As noted earlier, Medicaid does not travel well across state lines and can be like speaking a different language from state to state. Families also often lack the language to describe what the individual actually receives.

For this reason, I highly recommend that the originating state attorney (or, if that attorney is not involved, the receiving attorney) assist the individual in articulating in plain English, what services are currently being provided and avoiding Medicaid jargon if possible. This will be of immense help to the receiving attorney in advising on services in the new state.

The first step is always identifying the benefits the individual already receives. Entitlement programs such as Social Security Disability (including the Childhood Disability benefit) will travel well. However, even an entitlement like Medicare, which is a national program, requires some reassessment because new Medicare Advantage plans or Dual Eligible Special Needs Plans may be necessary.

But Medicaid is different, and a family must effectively "start over" in the new state. What families are usually most concerned about are "community living supports," which allow an individual to avoid institutionalization. In plain English, some examples of these services can include:

- Current housing arrangements
- Daily living skills
    - Help with cooking and meal preparation.
    - Laundry and other household chores (routine or heavy cleaning).
    - Bathing, eating, dressing, grooming, and personal hygiene.
    - Shopping for food and daily necessities.
    - Cooking.
- Assistance with budgeting and paying bills
- Community participation
    - Transportation to and from community activities (but not to medical appointments).
    - Support to attend classes, volunteer, vote, or enjoy recreation (movies, concerts, parks).
    - Help with socialization and building relationships.
- Medication management and health monitoring

- Family respite hours

Clearly, if someone has been involved in a person-centered planning process, the resulting document may provide most of this information. (It is called an Individualized Plan of Service (IPOS) in Michigan.) For minors, the Individualized Education Plan (IEP) may serve as a similar function.

Again, avoid jargon. Do not say "the client receives Habilitation Supports Waiver CLS hours." Instead, say the beneficiary "has a worker who comes over for five hours a day to assist with meals and medications." This will significantly assist the receiving attorney in aligning the supports in the new state.

C. Step Three: Start Translating The Originating State's Services Into The Receiving State's Services.

We are already on Step 3, and you haven't had me review the trust? It is too easy for attorneys to focus on what we know best (usually trust drafting and financial eligibility) and lose sight of what clients care about – the services they need in their day-to-day lives.

Additionally, many of these services have waiting lists. Therefore, it is essential to establish expected timelines upfront. This may also include helping families understand both what is currently available (which is likely less ideal) and what better servicers might be available in the future. Upfront candor prevents later disappointment, and you can help the family find interim supports before the ideal Medicaid services take effect.

This is also where it might be best to introduce a care manager, or someone who typically charges less than you, to work with the family to coordinate the new services that are needed. This is especially important if the beneficiary lives in a different area of your state where you are less familiar with the service offerings.

D. Step Four: Review Financial Eligibility.

Never assume that the receiving state has the same non-trust financial eligibility requirements as the originating state. Odds are they do not.

Additionally, a special needs trust has limited control over income, but Medicaid income eligibility can vary significantly from state to state.

Income

Here are some income questions to consider:

- **Is the client going from a Section 1634 state to a Section 1634 state?**

If a client has Supplemental Security Income (SSI) and is moving between two Section 1634 states, the Medicaid eligibility process should be more straightforward because both states rely on the Social Security Administration to determine eligibility through SSI. In these states, qualifying for as little as $1 of SSI results in automatic Medicaid eligibility, which should eliminate the need for a detailed Medicaid application.

This contrasts with the eight SSI Criteria States,[4] where a separate Medicaid application may be necessary despite SSI eligibility, and the eight Section 209(b) States,[5] where Medicaid eligibility rules can be more restrictive than SSI standards. If a client with SSI is moving into one of these states, the receiving attorney will likely have to conduct a more thorough financial review.

- **Client receives Childhood Disability Benefits (formerly DAC) benefits. Will this be disregarded in the receiving state?** Under 42 USC §1383c(c), states must disregard any increase in Social Security benefits in determining Medicaid eligibility when a child transfers from being an SSI recipient to receiving childhood disability benefits (formerly, DAC benefits) on a parent's Social Security record. But what if the beneficiary never received SSI? States vary widely on how they handle this (which is an issue the Special Needs Alliance is trying to address).

- **If a client does not have SSI, does the client meet the incoming state's Medicaid income requirements?**

If a moving client does not have SSI, Medicaid eligibility becomes more complex. Here is a quick breakdown of three categories to consider:

  - **Does the state have a "categorically needy" category above SSI?** A state may have a "categorically needy" income cap that will allow a client to obtain full Medicaid at an income level *higher* than SSI income, usually up to the Federal Poverty Level of $1,305/month ($338/month higher than SSI.[6]

[4] SSI Criteria States: Alaska, Idaho, Kansas, Nebraska, Nevada, Oklahoma, Oregon, and Utah.
[5] 209(b) States: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia.
[6] According to the Kaiser Family Foundation, in 2025, 28 states allowed Medicaid eligibility for seniors and people with disabilities at some amount above the federal SSI rate: Alaska, Arizona, Arkansas, California, Connecticut, the District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin. Kaiser Family Foundation, Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025 (April 7, 2025).

- **Does the beneficiary qualify for a "medically needy" program?** States can create an optional "medically needy" Medicaid category where an individual's income is otherwise too high for "categorically needy" coverage. Instead, these individuals qualify for Medicaid coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy populations do not have to offer the same benefit package to them as they offer to the categorically needy, so it is typically less ideal.[7]

- **Does the beneficiary qualify for a Medicaid Buy-In Program?** All but three states have some form of Medicaid buy-in program for working individuals. If a beneficiary has earned income (i.e., income from working), they may be eligible for a state's Medicaid buy-in program. These programs typically have higher Medicaid asset and income limits to encourage individuals with disabilities to participate in the workforce. If there are few other options, it is often possible to find just enough work for an individual with a disability to qualify for these programs.

This is not an exhaustive list and may also include programs related to the expansion of Medicaid (where income is based on modified adjusted gross income (MAGI)) and special income groups typically designed for older adults, which may be suitable for your beneficiary.

- **If a client has too much income, what options might you have?** If a client has too much income under the receiving state's policies, consider:

    - Can the income be assigned to a special needs trust? *See* POMS SI 01120.200(G)(1)(d).

    - Can a Miller Trust be used? About half of the states allow the use of a Miller Trust under 42 USC 1396p(d)(4)(B).

[7] According to the Kaiser Family Foundation, in 2025, 34 states have medically needy programs for individuals with disabilities. These states include Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. Kaiser Family Foundation, Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025 (April 7, 2025).

- Can you work with an advocacy organization to earn just enough income to get into a Medicaid buy-in (i.e., work) program?

- Are the state's spend down rules reasonable, and are there tricks you can do to accelerate the spend down? In some states, the spend down limits might be very reasonable to meet. Alternatively, there could be strategies to accelerate the spend down in the receiving state, such as billing at the beginning of the month or submitting unpaid bills. So even if you cannot work around a spend down, there may be tricks to minimize its impact.

If you still have an income issue, consider what options might be available in the receiving state (or were relied upon in the originating state):

Assets

Because the beneficiary has a first-party special needs trust, assets will likely be less of an issue in the receiving states. Still, every state has variations. Examples:

- Does the originating state have a higher asset limit than the receiving state?
- Was the beneficiary on expansion Medicaid in the originating state?
- Again, is the state a 209(b) that might have different rules than SSI regarding assets?
- What is the receiving state's definition of a homestead?
- Are there retirement assets that the two states treat differently?
- Are there joint assets that the two states treat differently?
- Are there any other unusual asset issues in the originating state?

E. Step Five: Will Court Supervision Need To Be Transferred?

Is the SNT currently under court supervision? If not, then in most cases, the receiving state will not require court involvement simply because the beneficiary has moved, and you can skip this step. That said, each state has its own rules, and some states have statutes or court rules that can impose supervision even where the originating state did not require supervision.

If the trust is court-supervised, the analysis changes. Courts in the originating state will generally not release jurisdiction until the receiving court has acted either by formally assuming supervision or by issuing an order confirming jurisdiction.

There is no standardized procedure for transferring a court-supervised first-party trust. Typically, the transfer process will involve:

1. Petitioning the originating court for permission to transfer the trust.
2. Providing the originating court's order to the receiving jurisdiction.
3. Petitioning the receiving court to open a file and accept jurisdiction and/or supervision.
4. Submitting the acceptance order back to the originating court.
5. Filing a final accounting with the originating court so that it may close its file.

This process can vary in detail. Additionally, for the sake of efficiency, this process should be considered in conjunction with whether the trust requires modification by a court or whether a guardianship needs to be transferred.

It is also important to distinguish court supervision from reporting obligations to a state Medicaid agency. Medicaid agencies may have their own rules regarding trust reporting and approval, but these are separate from the question of whether a court has jurisdiction over the trust itself.

Transferring a court-supervised trust can be frustratingly costly and time-intensive, so attorneys need to ensure they set client expectations early.

F. Step Six: Review The First-Party Trust And Plan For Any Modifications.

When a beneficiary moves between states, the receiving state's attorney must clearly review the first-party d4A trust and evaluate:

- Whether the trust complies with that state's statutes governing first-party SNTs (if any) and the state's general rules regarding trusts.
- Any specific Medicaid agency policies that may affect exempting the trust from Medicaid qualification and the administration of the trust.
- If moving between Social Security regions, any variations between those Social Security regions.
- Regional or local requirements, particularly in counties where court supervision may be imposed.

The last point is important. Some counties within a state have their own expectations about trust requirements. For example, Michigan as a state does not impose detailed drafting requirements on first-party special needs trust, but Kent County (Grand Rapids) has very specific guidelines. For this reason, if supervision is going to be required, it is important to

involve an attorney not only licensed in the receiving state, but also familiar with the practices of the county or region where the beneficiary will reside.

If modifications are needed, the drafting should be handled by the receiving attorney, and the process should be coordinated between the originating and receiving attorney.

The types of changes that may be required include:

- Appointing a new trustee.
- Adding provisions required by the new state.
- Updating governing law or administrative provisions.

Where the trust already contains flexible drafting provisions such as those discussed above, these modifications can often be handled efficiently with limited effort. However, if the document lacks flexibility, other tools may be necessary. Options include:

- **Nonjudicial settlement agreements**. Under the Uniform Trust Code and in most states, a nonjudicial settlement might be an option to change certain provisions of the trust. This will, however, be limited to the types of revisions authorized explicitly by the state's nonjudicial settlement agreement statute. Additionally, a revision through a nonjudicial settlement agreement may not allow you to present a clean trust to a government agency for review.
- **Decanting**. Decanting, if permitted by your state, may allow you to have the best of both worlds: a clean trust for the receiving state without court involvement. But be careful! The concern with decanting is that, in most states, it effectively terminates a trust and pours those assets into a new trust. Remember, if a first-party trust terminates, it could trigger early termination, which would result in a Medicaid payback.

  Luckily, in 2020, the Social Security Administration seems to allow a first-party decanting:

  > ***POMS SI 001120.199.D.7: Decanting***
  >
  > Trust decanting generally refers to the distribution or transfer of trust property from one trust to one or more other trusts, usually with more favorable terms. Decanting may involve the early termination of the first trust, or the effect of decanting may be materially the same as the effect of an early termination. In such a situation, ***we generally evaluate the decanting provision under the instructions on early termination in this section. However, decanting can***

be complex and can vary depending on applicable State law. It may be appropriate for the RO to seek input from OPLaw.

POMS SI 001120.199.E.2: Exception for transfers to a secondary trust upon early termination

An early termination provision in a section 1917(d)(4)(A) special needs trust or section 1917(d)(4)(C) pooled trust does not need to meet the above criteria if the provision allows ***solely for a transfer of the beneficiary's assets to a secondary section 1917(d)(4)(A)*** or section 1917(d)(4)(C) trust of which the same individual is the beneficiary.

The early termination provision must contain specific limiting language that precludes the early termination from resulting in disbursements other than to the secondary section 1917(d)(4)(A) or section 1917(d)(4)(C) trust or to pay for the administrative expenses listed in SI 01120.199E.3 in this section and in SI 01120.201F.4.

It does seem that you can decant a first-party SNT. But as the POMS says, decanting "can be complex" and therefore risky. It may be better to do a court modification.

- **Court modification**. The gold standard remains court modification. With a court modification, you can likely restate the trust in a manner acceptable to the receiving state without issue. And if the trust is supervised and will require court petitions anyway, it probably is not much additional cost to ask for a modification.

Pooled trusts under 42 U.S.C. § 1396p(d)(4)(C) generally present fewer complications when a beneficiary moves to another state. For clients likely to move frequently, this may be a reason to recommend a pooled trust rather than a standalone d4A trust.

G. Step Seven: Does Legal Authority Over The Beneficiary Need To Be Transferred?

When a beneficiary relocates to a new state, one of the most significant questions is whether existing legal authority arrangements (i.e., guardianships, powers of attorney, or supported decision-making agreements) will need to be recognized or recreated.

Guardianship Transfers

If the beneficiary is subject to a guardianship, all but three states (Texas, Michigan, and Florida) have adopted the Adult Guardianship and Protective Proceedings Jurisdiction Act (UAGPPJA). In those states, the typical process involves:

1. Petition in the originating state and get a provisional order of transfer.
2. With the provisional order, petition the receiving state to accept the transfer.
3. The originating court then issues a final order terminating jurisdiction, and the receiving court issues a final order accepting jurisdiction.

In non-uniform states, however, no consistent process exists and the originating and receiving attorneys will have to work together on the transfer.

Powers of Attorney and Healthcare Documents

Although powers of attorney for finances and health executed in one state should, in theory, be valid in another under principles of full faith and credit, the practical reality is different. Local hospitals, banks, and service providers are far more likely to accept documents prepared under their own state's laws. Best practice, therefore, is to execute new powers of attorney and healthcare documents promptly after relocation.

Supported Decision-Making Agreements

Most states now have statutes governing supported decision-making arrangements, and yet there is almost no uniformity between the states! Thus, it is probably increasingly crucial for the originating and receiving attorneys to include support decision-making arrangements in their transfer discussions. What is being done in the originating state, and what might be required in the receiving state? In some states, probate courts will require proof that supported decision-making was attempted before granting a new guardianship.

H. Step Eight: Plan For Costs And Gaps In Transitions.

Even in the best-planned moves, there are almost always costs beyond the routine expenses of daily living. Substantial trust assets will often be needed for transition expenses. These typically include the direct costs of moving (transportation, packing, and relocation), professional fees (such as attorneys, care managers, and possibly court costs for guardianship or trust supervision transfers), and short-term funding of services while the beneficiary waits for new state programs to commence.

One of the realities to prepare families for is the near-universal challenge of service gaps. As emphasized, Medicaid services do not automatically transfer between states, and each new application requires its own approval process.

Planning for the gap requires addressing several considerations:

- **Waitlist duration**: How long before services are likely to begin in the new state? Some waivers maintain years-long waitlists.

- **Interim care arrangements**: Who will provide day-to-day support during the gap?
- **Financing strategy**: How will these interim services be funded? Is there family that will be providing additional financial or time support? Does the trust hold sufficient resources to bridge an extended gap in supports?

Medicaid can, of course, be retroactive for up to three months (to be reduced to two months under the Big Beautiful Bill). While this might help with medical expenses, it does little to get community living supports.

In practical terms, a transition often means that the trust is called upon to bear the financial burden. Attorneys should prepare families for this reality from the outset, ensuring realistic expectations regarding budgeting and the appropriate use of care managers.

I. Step Nine: Advise On Ongoing Administration.

Once the transfer of services has been completed and eligibility in the receiving state is secured, the receiving attorney's work is not finished. Clients must be advised on the ongoing administration of the trust and clarifying the scope of the attorney's role going forward.

Invariably, the receiving state's rules are going to be different than the originating state's rules. Even though a client may have been managing a first-party special needs trust for years, you cannot assume they are familiar with navigating administration in the new state. Clients need explicit advice on what to expect, particularly in relation to supervision and reporting requirements. Some states impose strict reporting obligations, including mandatory accountings to the Medicaid agency, while others are more hands-off.

Your approach will also depend significantly on the sophistication of the trustee. A sophisticated trustee with numerous first-party special needs trusts in the state will likely require minimal handholding, whereas a family member trustee will likely require more support.

Here, you, as the receiving attorney, need to decide if you are "in" or "out" of the representation, and make it clear to the client what you will be doing. Being "half in" is dangerous.

If you are "in," you will need to develop a system to track ongoing administration. This is not your typical administration. First, there's no definitive end date. Second, you must ensure that both your state's trust laws and government benefit rules are followed. In other words, you have to track both trust and Medicaid accounting and reporting requirements.

If you are "out," you need to ensure that you clearly end the engagement. Because misunderstandings in this area can easily lead to client dissatisfaction or liability exposure, attorneys should consider providing a standardized letter or memo that outlines common pitfalls in ongoing trust administration before closing the file.

J. Step Ten: Minimize Payback And Estate Recovery.

Minimizing the potential state payback and/or estate recovery is frequently overlooked when dealing with a first-party special needs trust that includes a payback provision. Nevertheless, we cannot assume that the rules in the originating state will be the same in the receiving state, so common strategies need to be evaluated.

Some common considerations:

- Is there a house, and if so, are there strategies to avoid payback or minimize exposure under the receiving state's estate recovery rules? (Also, are there strategies to give homestead property tax exemptions?)

- Has a prepaid funeral been purchased? (States vary on how strict they are on paying for a funeral before the payback, although you should always assume the state will be very strict and not allow it.)

- How should vehicles be titled (and insured) to remain compliant given the driver is usually different than the beneficiary?

- Does the receiving state have specific rules on caregiver contracts if the trust will pay for personal care?

- Does the state allow distributions from a first-party trust to an ABLE account regularly?

These are common issues, but this list is by no means exhaustive. Reviewing this with your client will ensure there are no unexpected surprises as different rules may apply in the originating state.

IV. Practical Tips For Your Practice

1. Build *YOUR* Team. I have emphasized the importance of building a team for the beneficiary, but you also need to start building your own team. Again, any attorney can market special needs planning by drafting a trust. What separates advanced practitioners is their ability to provide truly holistic services.

No attorney can know everything. Special needs planning is surprisingly nuanced and complex. That is why you must surround yourself with trusted professionals, whether you hire them internally or develop relationships with them externally. You will need:

- Care managers.
- Accountants who understand trust accounting.
- Special education experts.
- Adult community living supports advocates.
- Benefits specialists.
- Local nonprofit organizations (e.g., your local Arc).
- Administrative hearing experts.
- Social Security disability specialists.
- Quality financial planners.
- Professional guardians.

This is surely not a comprehensive list. Some of this can be done in-house. But I am not aware of any firm that can do all of this. You want to be the quarterback and the go-to resource for families. That requires having a team ready to handle most anything that comes your way.

2. **Respect Jurisdictional Boundaries**. Nothing frustrates a receiving attorney more than an originating attorney who undertakes all the work and then requests a quick review from the receiving attorney. Your role is to guide the client to a strong receiving attorney. The receiving attorney is licensed in that jurisdiction and will bear the legal liability for the work. They will also be responsible for the client's long-term needs in the new state. Stay in your jurisdictional lane. There is more than enough work to go around. By respecting boundaries, you will not only build better professional relationships but also gain valuable insights along the way.

3. Outline the Plan in Advance. In breaking down steps, I do not mean to suggest there is a strict sequence. In practice, the more effective approach is to review all steps upfront and develop a basic outline addressing all the stages. Some steps may require little or no attention, while others will need significant focus. By outlining everything in advance, you can identify efficiencies such as combining court appearances or selecting the right care management advisor.

Also, this presentation is an idealized world. In the real world, families and trusts are working with limited resources. By outlining everything in advance, you can allocate time and money where they matter most.

4. Manage Expectations Carefully. Families already know that moving is stressful, but most do not appreciate how complicated it is to move Medicaid and the accompanying services to a new state. Families should be frustrated. Attorneys should sympathize, but be candid about the time, cost, and potential challenges up front. Under-promise and over-deliver. If the client still does not understand the time and cost, this may not be the right client for you.

5. Differentiate Yourself Through Community Medicaid Expertise. For attorneys new to this field, one of the most effective ways to distinguish yourself is by developing a deep understanding of the labyrinth of adult community living services under Medicaid. Too few special needs attorneys dedicate the time to learn about these programs available, the governing regulations, and the appeals processes. This work is considerably more complex than nursing home planning, which is why too few attorneys undertake it, and precisely why there is a demand for knowledgeable advocates.

The children of baby boomers are now adults, and the combination of government funding pressures and a caregiver shortage has become a serious national humanitarian concern. By understanding this area, you stand to help desperate clients, set yourself apart in the special needs legal profession, and contribute to a better system for all.

CHALGIAN & TRIPP LAW OFFICES PLLC

The Great SNT Road Trip: First-Party SNT Beneficiaries Crossing State Lines

Christopher W. Smith

Stetson University National Conference on Special Needs Planning and Special Needs Trusts

October 24, 2025

smith@mielderlaw.com | (248) 799-2711 | Chalgian & Tripp Law Offices Michigan

1

Section I. Introduction

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Beyond the Form: Beating the Robots

- Trust forms are not how we differentiate
- Our Real Value: Counseling, navigating, and problem-solving
- An interstate transition might be the ultimate test!

3

Medicaid's "Original Sin"

- Federal—state hybrid: no uniformity
- Medicaid ≠ portable
- Waitlists and start-over realities
- Difficult to translate Medicaid terminology between states.

4

The Value Of An SNT In Transitions

01. SNT as the bridge tool during gaps

02. Funding for move, professionals, and interim supports

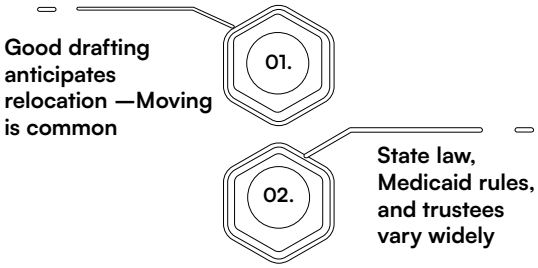
03. Understand your budget up front before proceeding!

5

Section II. Drafting for Portability

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Prelude: Why Draft for Portability?



7

Drafting: Authority To Relocate The Trust



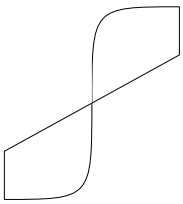
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Drafting: Authority to Amend

- Trust requirements can vary state by state (and over time).
- If allowed, a carefully limited ability to amend paragraph should be considered.

9

Drafting: Trustee Succession



- Trustee eligibility and expertise differs state by state
- Include some authority to appoint successors
- Include the ability to transfer to a pooled trust under 42 U.S.C. § 1396p(d)(4)(C)?

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Section III. Building And Defining he Team

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Building the Team

- **Originating Attorney:** Locate successor counsel, set expectations, handle any local court filing, and help with translation to the receiving attorney.
- **Receiving Attorney:** Advise on financial eligibility and potential trust modification, assist with new Medicaid/government benefit eligibility, help build a new team, and handle any local court filings.

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Other Essential Professionals

01. Trustees, accountants, planners

02. Nonprofits and care managers

03. Guardians and agents

Cost hierarchy: family/friends → nonprofits → paid experts

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Section IV. Ten Steps for a Successful Move

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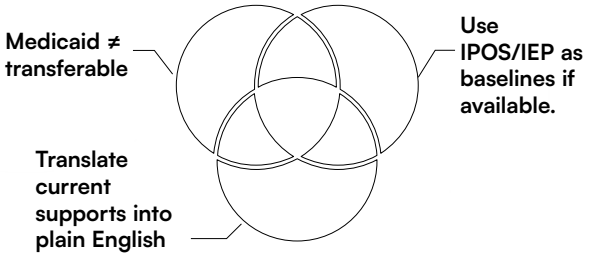
Step 1: Understand The Reason For The Move

01. Planned vs. crisis relocation

02. Drives timing, team, and intensity of work

15

Step 2: Gather Originating State Benefits



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Step 3: Translate Services Into New State

- Receiving attorney should help explains what existing services mean in new state.
- Anticipate waitlists and timelines
- Engage care managers for coordination

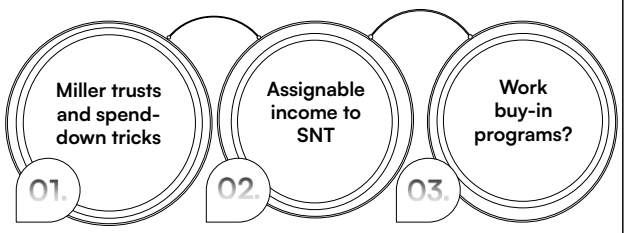
17

Step 4: Review Financial Eligibility

- Income and resource rules vary state to state
- Section 1634 vs. 209(b)/SSI Criteria States
- SSI vs. Childhood Disability (DAC) Benefits
- Categorically Needy / Medically Needy / Medicaid Buy-Ins

18

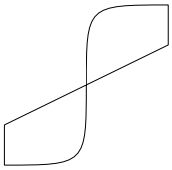
Step 4 (Cont.): Income Strategies



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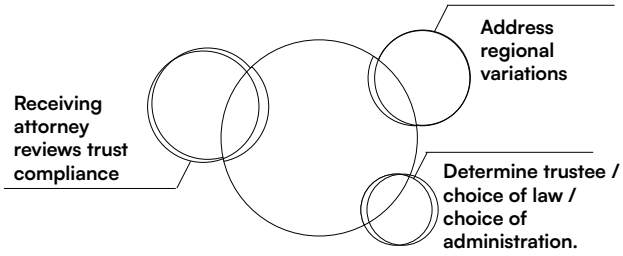
Step 5: Court Supervision Transfer?

- Verify if current SNT is court-supervised
- Typically a multi-step petition process
- Distinguish court supervision from Medicaid reporting
- Manage expectations—costly and slow



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Step 6: Review and Modify the Trust



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Step 6: Tools to Modify the Trust

- Nonjudicial Settlement Agreement
- Merger
- Decanting (POMS SI 01120.199)
- Court modification

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Step 7: Transfer Of Legal Authority

- Guardianships under UAGPPJA process
- Representative Payee
- New Powers Of Attorney
- Don't Forget Supported Decision-making!

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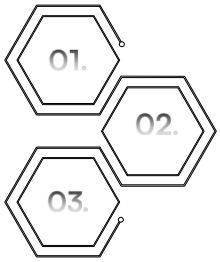
Step 8: Plan for Costs and Gaps

- Anticipate moving and professional expenses
- Plan for gap in Medicaid coverage
- Budget interim supports

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Step 9: Ongoing Administration

Explain new reporting/ supervision rules



Clarify your ongoing role ("in" or "out")

Provide standardized closing letter to clients

25

Step 10: Minimize Payback and Estate Recovery

- Review all exempt assets, particularly houses and vehicle titling.
- Verify rules regarding d4A distributions to ABLE accounts
- Ensure prepaid funeral.
- Note other state-specific issues (e.g., care contracts / rent agreements).

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Section V. Practical Tips For Your Practice

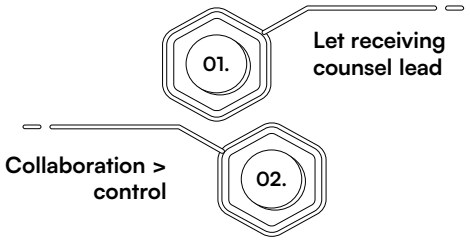
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Tip 1: Build YOUR Team

- No one knows all areas
- Partner with care managers, accountants, advocates, planners
- Be the quarterback

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Tip 2: Respect Jurisdictional Boundaries



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Tip 3: Outline the Plan in Advance

01. Review all steps before starting

02. Budget

03. Find Efficiencies (e.g., Combine court appearances).

30

Tip 4: Manage Expectations

- Families underestimate complexity
- Be candid on time, cost, and frustration
- Under-promise and over-deliver

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Tip 5: Differentiate Through Community Medicaid Mastery

- Deep knowledge of community-based Medicaid is rare
- Very complex / hyper local
- Way to differentiate yourself

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If I Knew Then What I Know Now: Wisdom from Experienced SNT Attorneys

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