2020

Highlights of the elder law masters

Indiana Continuing Legal Education Forum (ICLEF)

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INDIANA CONTINUING LEGAL EDUCATION FORUM

HIGHLIGHTS OF THE ELDER LAW MASTERS

Agenda

8:45 A.M.	Login to Webcast
8:55 A.M.	Welcome and Introduction
9:00 A.M.	COVID-19, Retirement Accounts and Some Other Medicaid Issues *- Dennis K. Frick*
9:45 A.M.	Estate Recovery *- Connie L. Bauswell*
10:30 A.M.	Coffee Break
10:45 A.M.	Advance Care Planning *- Keith P. Huffman*
11:30 A.M.	Secure Act: Changes Elder Law Attorneys Need to Know *- Rebecca W. Geyer*
12:15 P.M.	Q & A / Adjourn

September 9, 2020

HIGHLIGHTS OF THE ELDER LAW MASTERS

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Claire E. Lewis

Law Office of Claire E. Lewis, Indianapolis

Claire E. Lewis has more than thirty years of experience in the field of elder law. A founding member and first Chair of the Indiana State Bar Association's Elder Law Section, she currently serves as Chair of its Public Policy Committee. An active member of the National Academy of Elder Law Attorneys (NAELA), Lewis was a founding member and first President of the Indiana chapter of NAELA and was re-elected as President of the organization for 2016. She recently completed her term on the Executive Committee of the Estate Planning Section of the Indianapolis Bar Association. Lewis completed six years of service on the Board of Directors of CICOA Aging and In-Home Solutions (formerly the Central Indiana Council on Aging), serving as Secretary of the Board during her last two year term. She also completed a term of six years on the Board of Directors of the Alzheimer's Association of Indiana for which she chaired its Mission and Outreach Committee.

Lewis was called upon by the State of Indiana to provide the initial review of the exams to be given to attorneys seeking the CELA (Certified Elder Law Attorney) certification. As a member of the Advisory Panel on Attorney Specialization for the Indiana Commission for Continuing Legal Education, she was involved in the initial approval of the elder law certification in the state of Indiana.

As former Director of the Senior Law Project of the Legal Services Organization of Indiana, Lewis headed the Indiana sub-state Ombudsman Program for Central Indiana, promoting quality of care and nursing home residents' rights for Indiana's most vulnerable citizens.

Editor of the Indiana State Bar Association's popular book, the Laws of Aging (formerly the Legal Reference for Older Hoosiers), Lewis has authored or co-authored numerous papers and booklets on elder law issues including Medicaid in Indiana, Advance Directives, Medicaid for the Aging and Disabled in Indiana, Guardianship and Alternatives, The Legal Rights of Indiana Nursing Home Residents, and Housing Alternatives for the Older Person.

Lewis is a regular faculty member and program chair for the Indiana Continuing Legal Education Forum (ICLEF). For the past several years, she has chaired ICLEF'S Elder Law Institute, Advanced Medicaid Forum, and Advanced Elder Law Forum. Lewis is also a regular faculty member for educational seminars presented by the Indianapolis Bar Association (IBA), chairing the Medicaid Updates seminar in both 2002 and 2003 and Long Term Care Updates in 2004 and providing the Medicaid updates segment of its "What's New?" annual workshop in 2005 and 2006. She has also chaired seminars from

2006 through the present for the IBA covering such topics as Medicaid Estate Recovery, the effect of the Deficit Reduction Act on Medicaid eligibility issues, and Special Needs Trusts. She has been a guest professor at the McKinney School of Law in Indianapolis, focusing primarily on topics that relate to elder law. Lewis has served in an advisory capacity to Medicaid workers throughout the state and trained caseworkers, attorneys, and elder care professionals on Medicaid rules and regulations and other issues impacting older adults.

Lewis was named a Super Attorney in Elder Law by Indianapolis Monthly magazine for 2005 through 2016. Lewis was also named one of the Top 25 Women Lawyers in Indiana for 2008 and 2011 by Indianapolis Monthly and a Five Star Wealth Manager from 2008 through 2014 by Indianapolis Monthly. She was selected by her peers as one of the "Best Lawyers in America" in the area of elder law for more than ten years as announced by "Best Lawyers" and U.S. News Media Group, the publisher of U.S. News and World Reports and the nation's leading source of rankings and service journalism, and she is the lawyer of the year in elder law for 2016. Lewis was awarded the Indiana State Bar Foundation's Law Related Education Award in October of 2005 and received the Indiana State Bar Association's GP and Solo Practice Hall of Fame Award for 2009. Lewis was named most valuable attorney of the year by the Indiana Chapter of the National Academy of Elder Law Attorneys for 2013.

Lewis was named as a Fellow of Indiana State Bar Foundation in 2010 and a Master Fellow in 2014. Established in 1979, the Fellows are an elite group of Indiana attorneys who demonstrate commitment to the ideals of the Foundation in advancing justice, promoting public understanding of the law, and enhancing the legal professions' performance of its ethical responsibilities. Only 1,000 Indiana attorneys are currently members of this select group. In 2012, she was also inducted as a Fellow of the Indianapolis Bar Foundation.

Connie L. Bauswell

Law Office of Connie L. Bauswell, Valparaiso

Connie L. Bauswell practices in the areas of elder law, estate planning and administration, veteran's benefits, and special needs planning. Connie is a member of the National Academy of Elder Law Attorneys (NAELA). As a NAELA member, Connie served on the Professionalism and Ethics Committee, which is revised NAELA's Aspirational Standards. She is also an active member of the Indiana Chapter of NAELA, serving as a board of director for several years and as the Indiana Chapter President for 2013-2014. Connie is a member of the Special Needs Alliance, which is an invitation-only national network of lawyers dedicated to disability and public benefits law.

Connie is a member of the Elder Law Section (Vice Chair for 2016-2017; Committee Chair, Education Committee 2016-2017; and Secretary-Treasurer for 2015-2016), the Probate, Trust and Real Property Section of the Indiana State Bar Association, the Porter County Bar Association, and Lake County Bar Association. She is a charter member of ElderCounsel. In addition, she is a graduate of the Veterans Benefits Institute. She serves on the Board of Directors of the National Elder Law Foundation, the only national certifying program for elder law and special needs attorneys.

Connie received her B.A. in Politics from the University of Dallas, magna cum laude. In 1996, Connie received her Juris Doctorate from the Indiana University Maurer School of Law. In May 2012, Connie earned her LL.M. in Elder Law, with Distinction, from Stetson University College of Law. In addition, she has earned the designation of CELA, which means she is "Certified as an Elder Law Attorney by the National Elder Law Foundation". She is also an Adjunct Professor at Valparaiso University School of Law, where she teaches Elder Law.

Connie practices law at the Law Office of Connie L. Bauswell, which has offices in Valparaiso and Schererville. She can be reached at 219-548-0980 or connie@conniebauswell.com. Connie welcomes invitations to speak on a variety of topics related to her practice.

DENNIS FRICK is the Director of the Senior Law Project of Indiana Legal Services, Inc., Indianapolis, which represents older adults in 20 central Indiana counties. He has represented clients in administrative appeals and in state and federal court. He is Past Chair of the Elder Law Section of the Indiana State Bar Association and is also a member of the National Academy of Elder Law Attorneys and the American Bar Association. He is a Director of the Indiana Chapter of the National Academy of Elder Law Attorneys and of the Indiana State Guardianship Association. He has been a frequent trainer on elder law issues for Indiana Continuing Legal Education Forum and for the Senior Law Project. He is a contributing author of the *Laws of Aging* published by the Indiana Bar Foundation.

Rebecca W. Geyer

Rebecca W. Geyer & Associates, PC, Carmel

Rebecca W. Geyer is the founder of Rebecca W. Geyer & Associates, PC where her practice concentrates in estate planning, estate and trust administration, elder law, tax planning, and business services. A board certified Indiana trust and estate specialist* and a Fellow of the American College of Trust and Estate Counsel, Rebecca is also an adjunct professor of elder law at the Indiana University Robert H. McKinney School of Law.

Rebecca completed her undergraduate degree at Indiana University, majoring in Political Science. She went on to earn her Juris Doctor in 1998 at the Indiana University Maurer School of Law. An avid volunteer in both the legal community and the Indianapolis community at large, Rebecca often speaks and writes on estate planning and elder law topics, and annually provides pro bono legal services to individuals through her work with the Indianapolis Bar Association and the Albert and Sara Reuben Senior Resource and Community Center.

As a frequent lecturer and seminar presenter, Rebecca has authored numerous seminars with ICLEF, ISBA, IBA, and National Business Institute. Her recent presentations include “Alternatives to Guardianship,” “Elder Law Update,” “Estate Planning Under Our Guardianship Statutes,” “Estate Planning with Retirement Assets” and “Estate Planning for Same-Sex Couples in Light of Obergefell.”

Rebecca is Secretary of the Indianapolis Bar Association, Past President of the Indianapolis Bar Foundation, a former Chair of the Elder Law Section of the Indiana State Bar Association, and a Past President of the Indiana Section of the National Academy of Elder Law Attorneys (NAELA). She served on the Board of Governors of the Indiana State Bar Association from 2016-2018. Since 2014, Rebecca has been named to the prestigious list of Super Lawyers® for estate planning, and has been designated as one of the top 50 attorneys in Indiana and one of the top 25 women lawyers in Indiana in since 2016 by Law & Politics Magazine and Indianapolis Monthly. She was also named to the Indianapolis Business Journal’s 2014 40 Under 40 Class, which recognizes individuals making a difference in their professions and communities prior to the age of 40. In 2018, Rebecca was recognized by the Indianapolis Bar Association for service to the profession, and was awarded the Indianapolis Bar Association’s Dr. John Morton Finney Award for Excellence in Legal Education in 2013. Rebecca also volunteers in the community where she serves as Past President of Congregation Beth-El Zedeck, and Treasurer of the Indianapolis Section of the National Council of Jewish Women.

Rebecca is chair of the Indianapolis Bar Association's Estate Planning and Administration Section, and a member of its Women and the Law Division. Her professional memberships also include the Probate, Trust and Real Property Section and the Elder Law Section of the Indiana State Bar Association, the Indiana Probate Review Committee, Estate Planning Council of Indiana, and the National Academy of Elder Law Attorneys. Rebecca was recognized as a distinguished fellow by the Indianapolis Bar Foundation in 2010.

*Certified by the Indiana Trust and Estate Specialty Board

H & B LAWYERS

Keith P. Huffman

Keith P. Huffman

Keith P. Huffman was born in Toledo, Ohio, on July 20, 1951. Mr. Huffman received his undergraduate education from Adrian College and his legal education from Indiana University and was admitted to the Bar in 1980. Mr. Huffman is a member of the National Academy of Elder Law Attorneys and served as the President of the Indiana Chapter of the National Academy of Elder Law Attorneys. Mr. Huffman is a Past Chairperson-Elect for the Elder Law Section of the Indiana Bar Association. Mr. Huffman is a member of the Ethics Committee at Bluffton Regional Medical Center, Chairperson of the Aging & In-Home Services Board of Directors, and a member of the Fort Wayne Lutheran Hospital Institutional Review Committee. Keith Huffman was named the Citizen of the Year by the Wells County Chamber in 2003 and was named as the outstanding member of the Indiana National Academy of Elder Law Attorneys in 2009. Mr. Huffman was named the Powley Award winner for 2016. This national award is given to a National Academy of Elder Law member who has demonstrated a commitment to promote in the minds of the general public, a general understanding of the rights and needs of the elderly and disabled.

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Section One

COVID-19, Retirement Accounts, and Some Other Medicaid Issues

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Section One

COVID-19, Retirement Accounts, and Some Other Medicaid Issues.....Dennis Frick Claire Lewis

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COVID-19, Retirement Accounts, and Some Other Medicaid Issues

I. Medicaid Changes Due to COVID-19

The current COVID-19 pandemic has resulted in several temporary changes in Medicaid rules and the processing of applications and appeals.

The county Division of Family Resource (DFR) offices were closed to in-person visits from mid-March to early July, 2020, but all counties reopened their offices during the week of July 6, 2020. Online and telephone services continue to operate; all scheduled appointments occur by telephone. SNAP (food stamp) applications are a priority, which may delay some Medicaid processing, though applications are still to be processed within required guidelines.

States, including Indiana, are receiving a temporary increase of 6.2% in the share of expenses that the federal government pays. This increase will continue until the end of the calendar quarter in which the public health emergency ends. § 6008, Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127 (2020). The public health emergency is declared by the Secretary of the Department of Health and Human Services (HHS) and ends when the Secretary declares that the emergency no longer exists. 42 U.S.C. § 247d.

Workers should be less stringent on verification requirements and more willing to accept written statements when it is difficult to obtain documentation. A document posted on FSSA's website states that effective May 22, 2020, eligibility will be determined based on the answers given on the application or at the interview and that supporting verifications **will not be required.** FSSA is encouraging applicants to answer every question on the application. FSSA will continue to use electronic data sources for verification and may request documentation if it finds a conflict. FSSA can request documentation after the emergency ends. Although a person can be prosecuted for

intentionally giving false information to obtain benefits, it appears that overpayment claims should not be processed even if it is later determined that a person should not have been found eligible. See "Changes to Indiana health coverage application processing during public health emergency," https://www.in.gov/fssa/files/Changes%20to%20Indiana%20health%20coverage%20application%20processing%20during%20public%20health%20emergency.pdf, Appendix A.

Medicaid redeterminations are being auto-renewed for 12 months.

No Medicaid cases are being terminated effective March 31, 2020 until the end of the month in which the public health emergency ends. The only cases being terminated are due to death, voluntary withdrawal, or moving out of the state. § 6008(b)(3), FFCRA. CMS' Families First Coronavirus Response Act – Increased FMAP FAQs, updated as of April 13, 2020, pp. 4-7. See Appendix B, pp. 22-25.

Medicaid benefits cannot be decreased until the end of the month in which the public health emergency ends. CMS' Increased FMAP FAQs at p. 6 state:

> Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, **states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends**, and still qualify for increased FMAP.

Appendix B, p. 24 (emphasis added). For example, if a nursing home resident has an increase in income, the resident's monthly liability should not be increased. But if the resident has a decrease in income, the resident's liability is to be lowered. A resident already on Medicaid who enters a nursing home will not have a liability assessed. A nursing home resident who applies for Medicaid will have a liability assessed using normal income budgeting.

This appears to mean that a current recipient who makes a transfer will not be penalized during the emergency. There does not appear to be any provision to reduce benefits retroactively once the emergency is over. For example, suppose Bob is in a nursing home receiving Medicaid, sells his house, and gifts the proceeds, resulting in a 12 month penalty period that should have started June 1, 2020 and run through May 31, 2021. If the emergency ends in October, 2020, it appears FSSA should only be able to assess a penalty for November, 2020 through May, 2021. Because FSSA will have a backlog of changes to process once the emergency is declared to have ended, there likely will be delays in changes being processed once the emergency is declared to have ended.

Appeal hearings are being held by telephone. (Now that county offices have been reopened, it is possible that in-person hearings will resume).

If an appellant is receiving continuing benefits as a result of an appeal, Hearings & Appeals will not schedule a hearing, hold a hearing, or release a hearing decision. This is because benefits are not to reduced during the emergency. See "FSSA Office of Hearings and Appeals - COVID - 19 Frequently Asked Questions," Appendix C.

Eligibility standards, methodologies, or procedures cannot be more restrictive than what was in place on January 1, 2020. This continues until the end of the quarter in which the public health emergency ends.§ 6008(b)(1), FFCRA.

The $1,200 stimulus payment is not counted as income when received, and it is not counted as a resource for the 12 months after the month of receipt, because it is treated as a federal tax refund that receives the protections provided by 26 U.S.C. § 6409. The result of this is that in effect the resource limit is increased by $1,200 for the 12 months after receipt of the stimulus payment.

There is a $600 per week supplement to unemployment compensation benefits in addition to the base benefit. This supplement ended in late July, 2020. The $600 supplement was not counted as income for Medicaid but the base benefit still counted. § 2104(h), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. L. No. 116-136 (2020).

Case managers are conducting waiver assessments and reviews by telephone or virtually rather than in person. Verbal authorization for signatures by recipients can be accepted. Although in-home services are essential and can continue as needed, some services are being adjusted. Telehealth and telemedicine has been expanded, and some waiver services are adjusted to virtual services. Many adult day facilities are becoming certified as attendant care, homemaker, and unskilled respite providers. Adult day services in facilities were initially suspended but many have again been providing in-person services.

All cost-sharing is suspended during the public health emergency. Members who typically had copayments do not have any copayments applied. This applies to all Indiana health care programs and includes pharmacy copayments. A nursing home or waiver liability is not a "cost share" so a liability can be set for a new applicant, but not increased, during the emergency.

Premiums and Personal and Wellness Responsibility (POWER) Account contributions are waived from March 2020 through August 2020. This applies to the Children's Health Insurance Program (CHIP), HIP, and Medicaid for Employees with Disabilities (MED Works). All members who made payments for the month of March or any future months will have those payments applied as credits on their account when payments are required again.

Many of the Prior Authorization requirements have been suspended. This includes the 20 one-way trip limitation and 50-mile restriction for all in-state ground transportation. All in-state

ground transports must be medically necessary, and the transportation provider must maintain the supporting documentation.

Pharmacies are allowed to fill prescriptions with name-brand drugs if the generic drug is out of supply. Pharmacies can also fill some prescriptions early and can fill maintenance prescriptions for 90-days, if requested.

Most if not all counties adopted emergency rules under Administrative Rule 17, approved by the Indiana Supreme Court, that extend filing deadlines. Most likely, these rules will extend the time limits for estate recovery and any other court filing time limits. Check the rule in the applicable county at https://www.in.gov/judiciary/5578.htm.

II. Retirement Accounts

A. Retirement Accounts Owned by an Applicant or Recipient

The DFR changed its policies in 2018 and 2019 concerning how retirement accounts are treated for Medicaid applicants and recipients. Until June 15, 2018, IHCPPM § 2615.15.00 provided that retirement accounts owned by the applicant or recipient were countable to the extent they were available. The retirement account was countable if it could be liquidated. An account or funds that could not be withdrawn without leaving employment was unavailable and not countable. The countable value was the amount that could be currently withdrawn minus any penalty for early withdrawal. Taxes due or withheld were not deducted when determining the countable value.

By a transmittal change issued June 15, 2018, the DFR changed its policy to make qualified retirement accounts exempt if regular, periodic payments were being made from the account. IHCPPM § 2615.15.00 as amended June 15, 2018, provided:

> When regular, periodic payments are being received on a retirement account, the account is no longer a countable resource and the payments are considered unearned income. If the IRA has sporadic withdraws, then this is a conversion of resources and is not income but remains a resource.[18]
>
> ———————
>
> [18] [20 C.F.R.] § 416.1121 [Supplemental Security Income (SSI) regulation on "Types of unearned income."]

Under this revised policy, if one was receiving regular (relatively equal) payments periodically, whether that be monthly, quarterly, or annually, then the account was exempt as a resource and the payments were treated as countable income. This policy was applied to any regular, periodic payments, not just qualified minimum distributions.

On April 30, 2019, the DFR reverted to its pre-June 15, 2018 policy for new applications filed on or after May 1, 2019. For applications filed before May 1, 2019, it retained the June 15, 2018 policy exempting retirement accounts issuing regular, periodic payments. The Section as amended does not clearly state what policy applies for applications filed before May 1, 2019 and what policy applies to applications filed on or after that date. But DFR policy staff has stated that the intent is to change the treatment of accounts with regular, periodic payments. The DFR has reverted to its pre-June 15, 2018 policy on retirement accounts for new applications filed on or after May 1, 2019 and treats retirement accounts as countable, even if income is being received, if the account can be liquidated. The DFR is not applying the policy change to persons already receiving Medicaid on May 1, 2019 whose account was exempted or to persons with an application pending on May 1, 2019.

The DFR has now decided that the SSI rules do not require that retirement accounts producing regular income be exempt. The language in the Social Security Administration's Program Operations Manual System (POMS) § SI 01120.210 is fairly vague. *Blaylock v. Harris*, 531 F.Supp. 24 (W.D. Mo. 1981) (a liquid resource cannot be excluded as essential for the self support of an SSI claimant) and *Johns v. Astrue*, 2011 U.S. Dist. LEXIS 65906 (E.D. Ark. 2011) ("Although the Court

appreciates his father's concerns about the consequences of making a premature withdrawal from an IRA, ... it is clear that a retirement account is a 'resource.'") found retirement accounts to be countable for SSI.

Even though FSSA on October 15, 2018 issued transmittal changes deleting language that since 2014 had given applicants and recipients an opportunity to dispose of "non-liquid" personal property that could not be liquidated within twenty workdays, IHCPPM § 2615.15.00 retains a paragraph stating that if verification is provided showing that the processing time for withdrawing funds from a retirement account is more than twenty working days, then the account is only considered available "after the individual agrees to withdraw the funds from the account and documented timeframe has passed." The non-liquid property rule has been retained for retirement accounts. This appears to be intentional, as a transmittal on February 15, 2019 deleted a reference to the IHCPPM section on presumption of liquidity but retained the twenty day test.

B. Retirement Accounts Owned by an Ineligible Spouse

Retirement accounts, including funds held in IRAs, work-related pension plans administered by an employer or union, or Keogh plans for self-employed persons, that are owned by an ineligible spouse are not counted. IHCPPM § 2615.15.00, 20 C.F.R. 416.1202(a)(1). The SSI regulation at 20 § C.F.R. 416.1202(a)(1) refers to an ineligible spouse who is living with an eligible spouse.

Since Indiana became an SSI state in 2014, the DFR has not counted an IRA or other qualified retirement account owned by a community spouse as a countable resource at the snapshot date or eligibility date. It has applied the exemption for an ineligible spouse to community spouses.

In January, 2020, with no advance notice, the DFR suddenly began counting a community spouse's retirement accounts. After the NAELA Chapter protested, the DFR suspended the change

but stated that it still intended to proceed with this change in policy. It stated that it did not intend to promulgate a rule but instead intended to revise the IHCPPM in June, 2020 and begin counting community spouse accounts on July 1, 2020. The NAELA Chapter provided the DFR with its objections to this change and continued to assert that, even if a change can be made, the DFR must do it through a rule change for the reasons in Section III, below. The DFR agreed to review NAELA's response before proceeding. **The DFR then agreed not to change its policy until it goes through the rulewriting process.** The DFR may have agreed in part because it cannot adopt more restrictive eligibility rules during the pandemic. See Section I, above. The DFR has not yet published any notice of intent to promulgate a rule and has not indicated when it may proceed with publication. It is unlikely it will proceed during the current pandemic.

Some states count community spouse retirement accounts in spousal cases, while some do not. The ones that count these accounts reason that because the community spouse is allowed to keep a resource allowance, the retirement account should go into the pot with the other assets, and the community spouse will still be allowed to keep a share as determined by the allowance. Other states either view the community spouse's accounts as protected due to the SSI rules or they recognize that the accounts should be looked at differently because the funds are specifically set aside for retirement and because there can be serious tax consequences if the account(s) must be liquidated suddenly.

The case law is split, with one case saying the community spouse's retirement accounts cannot be counted, two cases saying they do count, and two cases saying it is up to the state to decide whether to count them.

- A Wisconsin appeals court decided a community spouse's IRA cannot be counted, because it is not countable under SSI, and the state must apply the SSI resource rules in spousal cases.

Keip v. Wis. Dep't of Health & Family Servs., 232 Wis. 2d 380, 606 N.W.2d 543 (Wisc. Ct. App. 1999).

• The 10th Circuit Court of Appeals decided that 42 U.S.C. § 1396r-5 is ambiguous and that it is the state's decision whether or not to count a community spouse's retirement account. *Houghton v. Reinertson*, 382 F.3d 1162 (10th Cir. 2004). An Arkansas appeals court agreed and ruled likewise. *Ark. Dep't of Human Servs. v. Pierce*, 2014 Ark. 251, 435 S.W.3d 469 (Ark. 2014).

• Ohio and New Jersey appeals courts decided that 42 U.S.C. § 1396r-5 requires that the community spouse's retirement account be counted. *Mistrick v. Div. of Med. Assistance & Health Servs.*, 154 N.J. 158, 712 A.2d 188 (N.J. 1998); *Martin v. State Dep't of Human Servs.*, 130 Ohio App. 3d 512, 720 N.E.2d 576 (Ohio Ct. App. 1998).

Each of these cases seeks to harmonize the language of 42 U.S.C. § 1396r-5. Although § 1396r-5(a)(1) says the section supercedes other sections, § 1396r-5(a)(3) says the section does not affect the determination of what constitutes a resource. That is, SSI methodology and standards apply. § 1396r-5(c)(5) says that "resources" do not include resources excluded under 42 U.S.C. § 1382(a) or (d). While community spouse retirement accounts are not specifically listed there, NAELA has asserted that the community spouse retirement accounts fall under § 1382b(a)(3)'s exemption of property essential for self support.

The DFR asserts that the SSI exemption for an ineligible spouse's retirement accounts does not apply because 20 C.F.R. § 416.1202(a)(1), the SSI regulation containing the exemption for a non-eligible spouse, refers to a spouse "living with" a non-eligible spouse. The "living with" language is used because SSI rules do not count any resources of a spouse who is not living with the applicant spouse. When § 1396r-5 says to use SSI's resource methodology, it must be referring to

the resource rules for spouses who live together; otherwise, none of the community spouse's resources would be counted. Thus, the phrase "living with" in 20 C.F.R. § 416.1202(a)(1) does not show that it does not apply in the spousal impoverishment situation. *Keip* explained: "although it is true that the SSI rule which excludes an ineligible spouse's IRA as a countable asset applies only if the spouses are living together, that is because assets of the ineligible spouse are only deemed attributable to the eligible spouse if the couple is living together." 232 Wis. 2d at 395.

42 U.S.C. § 1396r-5 requires that none of the community spouse's income be counted. A qualified retirement account consists of income that was deposited into the account while working plus earnings on the account. A retirement account consists solely of income, so it is consistent with § 1396r-5 that it be fully exempt.

Even if FSSA proceeds with its intended change and begins counting retirement accounts owned by a community spouse, it cannot apply a new policy in cases where benefits have already been approved. Although *Houghton* allowed Colorado to count a community spouse's retirement accounts, it ruled that once the institutionalized spouse was found eligible, the state could not at annual review begin counting the accounts and make the institutionalized spouse ineligible.

For so long as a community spouse's retirement account is not counted, if a retirement account is transferred from the applicant spouse to the ineligible spouse, then it will no longer be a countable resource. One can file a legal separation action and seek an order to transfer a retirement account, such as an IRA, from the applicant spouse to the ineligible spouse. This is a nontaxable transfer under 26 U.S.C. § 408(d)(6). A Qualified Domestic Relations Order (QDRO) is needed to transfer a qualified plan such as a 401(k), 403(b), or similar plan. A QDRO is not required for the transfer of an IRA, but one should talk to the IRA company to see what it will require for a transfer.

C. Income on an Institutionalized Spouse's Retirement Account that is Payable to the Community Spouse.

One must determine to which spouse income belongs. 42 U.S.C. §1396r-5(b)(2) provides that if the instrument specifies how income is to be paid, then that controls. If the instrument does not provide, then the "name on the check" rule governs. That is, the income is attributed to the spouse whose name is on the check. If income is payable to both spouses, then it is attributed one-half to each. IHCPPM §2805.15.05.05 does not refer to the instrument but instead looks only to the "name on the check." "Consider income paid in the name of one individual to be the income of that individual." The presumptions in the statute can be defeated by a preponderance of the evidence. 42 U.S.C. §1396r-5(b)(2)(D). For example, if the provisions of a written instrument show that income is owned other than the way the name appears on the check, then one can use the fair hearing procedure to challenge the "name on the check" presumption.

Using the "name on the check" rule, if an institutionalized spouse owns an IRA which is annuitized and directs that the income be paid to the community spouse, then the income should be treated as being the income of the community spouse. In *Hotmer v. Ind. Family & Soc. Servs. Admin*., 2020 Ind. App. LEXIS 272, 2020 WL 3526013 (Ind. Ct. App. June 30, 2020), copy at Appendix D, Mr. Hotmer purchased two irrevocable annuities, not in retirement accounts, which provided for the monthly payments to be paid to Mrs. Hotmer. FSSA denied Mr. Hotmer's application for nursing home Medicaid eligibility because it counted the income as belonging to Mr. Hotmer, which placed his income above the Special Income Level. Upon appeal, the Administrative Law Judge reversed based on the name on the check rule because the payments were payable to Mrs. Hotmer and thus not Mr. Hotmer's income. FSSA appealed the decision and on agency review FSSA reversed and ruled that Mr. Hotmer owned the income because he owned the annuities. The Court

of Appeals ruled that the income had been transferred to Mrs. Hotmer and per 42 U.S.C. § 1396r-5 was to be counted as Mrs. Hotmer's income. As of the publication of this paper, FSSA had not yet petitioned for transfer but was likely to do so.

III. FSSA Must Use Formal Rulemaking When it Changes Policy Not Required by an Existing Regulation.

Although FSSA has a set of regulations in the Indiana Administrative Code that address various aspects of Medicaid, FSSA frequently makes significant changes in policy by modifying its Indiana Health Care Program Policy Manual (IHCPPM) without promulgating a rule change. Indiana's Administrative Procedure Act determines when rulemaking is needed.

Ind. Code § 4-22-2 sets procedures which a state agency must follow for rulemaking. I.C. § 4-22-2-13(a) provides that the chapter "applies to the addition, amendment, or repeal of a rule in every rulemaking action." Subsection (c)(1) provides that the rulemaking requirements do not apply to "a resolution or directive of any agency that relates solely to internal policy, internal agency organization, or internal procedure and does not have the effect of law." I.C. § 4-22-2-3 provides the following definitions:

> (b) "Rule" means the whole or any part of an agency statement of general applicability that:
>
> > (1) Has or is designed to have the effect of law; and
> > (2) Implements, interprets, or prescribes:
> > > (A) Law or policy; or
> > > (B) The organization, procedure, or practice requirements of an agency.
>
> (c) "Rulemaking action" means the process of formulating or adopting a rule. The term does not include an agency action.

For rulemaking actions, I.C. § 4-22-2 provides a detailed set of procedures designed to afford the public notice of the proposed change and the opportunity to comment on the proposed changes.

In addition, both the Attorney General and the Governor must approve any rule or amendment to a rule.

The Indiana Supreme Court addressed agency authority and action in *Indiana State Bd. of Pub. Welfare v. Tioga Pines Living Ctr.*, 622 N.E.2d 935 (Ind. 1993), when nursing homes sued to challenge rules on nursing home rate reimbursement. The Court stated at p. 939:

> It is elementary that the authority of the State to engage in administrative action is limited to that which is granted it by statute and that administrative action within such limitation has the force of law. *Blue v. Beach* (1900), 155 Ind. 121, 56 N.E. 89. Administrative action is often categorized as either rulemaking or adjudicatory. *Blinzinger v. Americana Healthcare Corp.* (1984), Ind. App., 466 N.E.2d 1371. Rulemaking includes the process of formulating or adopting a rule. I.C. § 4-22-2-3 (Burns 1993).

When adjudicatory action is not involved, the change FSSA is making is rulemaking. In *Blinzinger v. Americana Healthcare Corp.*, 466 N.E.2d 1371 (Ind. Ct. App. 1984), a nursing home challenged a directive from state Medicaid freezing the rates of facilities involved in decertification proceedings. The court found that this was a rule and thus invalid. It stated that rulemaking looks to the future. The directive was applied prospectively to all providers similarly situated, it was applied as though it had the effect of law, and it affected the substantive rights of providers, so the court concluded that it was a rule which was invalid because not promulgated. The court also stated that the directive did not relate solely to internal policies. Compare this with *Gorka v. Sullivan*, 671 N.E.2d 122 (Ind. Ct. App. 1996), where the court ruled that rates for transportation providers did not need to be promulgated; only the rulemaking method needed to be promulgated.

When FSSA seeks to make a significant change in policy that is not consistent with an already promulgated regulation, then it is obligated to make the change through the rulemaking process. For example, FSSA has broad regulations at 405 I.A.C. § 2-1.1-5 and 8 that for the aged, blind, and disability category it will utilize the SSI income and resource definitions and exclusions

as set forth in the SSI statute and regulations. Thus, FSSA can make changes in policy to continue to apply the SSI rules to this category. But when FSSA makes other changes in policy that go beyond its existing regulations, it should be obligated to use formal rulemaking and obtain public comment.

IV. Using A "More Than Half Share" Administrative Hearing for a Waiver Applicant

One way in which the spousal impoverishment rules are more favorable to applicants is that there are ways to obtain a higher spousal resource share than the amount listed by computing the one-half share. Even though the resource limit using the spousal impoverishment rules is much higher than the $3,000 resource limit for a married couple living in the community, the spousal share can potentially be increased by means of a successful administrative hearing or by a court order. The administrative hearing process provides a simple mechanism to raise the spousal share in some situations. Its use is limited for nursing home residents due to the "income first" rule; this section will focus on its potential use for Medicaid waiver applicants.

Federal law provides that either spouse can request a fair hearing to request a greater community spouse resource allowance. 42 U.S.C. §1396r-5(e)(2)(c) provides:

> If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

If the community spouse's income, including any interest or other income generated by the resources making up the spousal share, is less than her monthly income maintenance standard using the standard formula (spousal income standard plus excess shelter allowance but no more than the maximum maintenance standard), then the community spouse should be allowed to keep enough resources to generate the income needed to raise the income to the monthly needs allowance. DFR

workers do not have the authority to apply this exception even though it involves a straightforward mathematical calculation. Instead, the law directs Administrative Law Judges (ALJs) to make the determination. This important exception is commonly referred to as a "**more than half share**" appeal.

An important factor in determining whether the community spouse has sufficiently low income to qualify for a greater share is whether one considers only the community spouse's own income, or whether one also considers the amount of the institutionalized spouse's income which the community spouse will be allowed to keep as her spousal income allowance once Medicaid eligibility is established. Before the enactment of the DRA in 2006, HHS gave states the option of counting the community spouse's income either way. The method of considering the potential allowance that the community spouse can receive after eligibility is approved is commonly referred to as the "income first" approach. The United States Supreme Court approved this approach in *Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 151 L. Ed. 2d 935, 122 S. Ct. 962 (2002). **In the Deficit Reduction Act of 2005 (DRA), Congress mandated that states utilize "income first" for persons entering a nursing home (or being approved for waiver services) on or after February 8, 2006. 42 U.S.C. §1396r-5(d)(6).** Indiana did not use the "income first" position before the passage of the DRA, but it now applies this concept to nursing home residents who began institutionalization on or after February 8, 2006.

Examples:

> Mrs. Carter entered a nursing home on April 1, 2020, while Mr. Carter remains at home. They have $100,000 countable resources as of her snapshot date. Suppose Mr. Carter has $1,200 of income. Using the formula to determine the community spouse maintenance standard, suppose the DFR determines that his monthly income needs, including excess shelter expenses, are $2,500. Suppose also that the DFR determines that Mrs. Carter has income of $1,000 per month which can be allocated to her husband. With his and Mrs. Carter's income, he will still need another $300

per month of income to meet his needs. Suppose that the highest CD rate at her bank is 2%. At a 2% return, he would need to have $180,000 of assets to produce $300 of income (2% x $180,000 = $3,600 annual return; $3,600/12 = $300/mo income). Thus, an ALJ will find that Mr. Carter needs to keep all of the $100,000. Mrs. Carter will be eligible for Medicaid without needing to spend down resources to $52,000.

Mr. and Mrs. Nixon (he in nursing home, she at home) have $100,000 countable resources as of the snapshot date. Using the formula to determine the community spouse maintenance standard, suppose the DFR determines that her monthly income needs, including excess shelter expenses, are $2,200. Suppose also that she has income of $1,600 per month, and that Mr. Nixon has income of $2,000 per month. If Mr. Nixon entered the nursing home before February 8, 2006, the DFR will only consider Mrs. Nixon's income. The DFR will determine that she needs an additional $600 per month of income to meet her needs, and she should be allowed to keep enough assets to generate $600 per month of income. If Mr. Nixon entered the nursing home on or after February 8, 2006, the DFR will consider Mr. Nixon's income. Since he has sufficient income so that he can give her $600 per month once he is approved for Medicaid, the DFR will rule that she has no need to keep additional resources to generate additional income.

The result of the "income first" rule is that most couples where one spouse is in a nursing home will not be able to utilize this approach. One should be alert to this approach, since some couples will have low enough income to qualify using this.

Although the use of this approach is limited for nursing home residents, it appears to be much more available for waiver applicants, because much less if any income of a married waiver applicant will be allocated to the community spouse. The personal needs allowance for a waiver applicant is equal to the Special Income Level (SIL), currently $2,349, compared to $52 for a nursing home resident. Thus, if the waiver applicant has income below the SIL, there will be no income allocated to the community spouse. Even if the waiver applicant has income above the SIL, the community spouse allocation will be much lower than for a nursing home applicant.

Example:

> Suppose in the example above, Mr. Nixon is applying for a waiver. His income is less than the SIL, so he has no income which can be allocated to Mrs. Nixon. In an administrative appeal, she should be allowed to keep all of the $100,000 of resources because more resources than that are needed to generate $600 per month income.

Although there are many planning tools one can use for a married couple when one member of the couple is institutionalized or is applying for a waiver, the value of the more than half share appeal is that nothing needs to be done with the resources other than transferring them to the community spouse. One does not need to spend down, purchase an annuity, or use a promissory note. The resources can be maintained as they are, simply being transferred to the community spouse. One should be aware of the possibility of using this tool for a married waiver applicant with a community spouse with income below the community spouse's maintenance standard.

Eric Holcomb, Governor
State of Indiana

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May 19, 2020

Changes to Indiana health coverage application processing during public health emergency

Effective May 22, 2020, and for the duration of the public health emergency, the Office of Medicaid Policy and Planning will relax certain rules to support Hoosiers who qualify for health coverage benefits. Eligibility will be determined based on the answers given on the application (or at interview) and will not require supporting documentation. This change will allow us to approve coverage more quickly for people who are eligible. After the public health emergency declaration is lifted, we may reach out for documentation.

Please encourage applicants to answer every question on the application. For example: if they have no income, they should mark "No" and not leave it blank. Where the application asks for the amount of income, the applicant should enter "$0." If the person has a job but is not currently working, they should include the employer's name and indicate $0 income for all household members.

FSSA will continue to use electronic data sources to help verify income, citizenship status and other eligibility factors whenever possible. If this information conflicts with the information on the application, FSSA may ask for paper documentation.

If the applicant leaves any questions blank and, therefore, FSSA cannot determine eligibility, we will need to ask for additional documents and it will take longer to process the application.

If someone is applying on the basis of blindness or disability or due to being age 65 or older, an interview will be scheduled and the time and date communicated to the applicant via the mail. Except for certain legal agreements and trusts, FSSA will accept information given during these interviews and will and will not require supporting documentation until after the public health emergency ends.

Applicants should be advised that they are still required to provide complete and correct information to the best of their knowledge. A person who receives benefits by intentionally giving false information or by failing to report information may be criminally prosecuted under state and federal law.

Appendix B

Families First Coronavirus Response Act – Increased FMAP FAQs

Updated as of 4/13/2020**

On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state and territory's [1] Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-19[2], including any extensions, terminates.

A. General Questions

1. Which states are eligible for the 6.2 percentage point FMAP increase?

All states and territories are eligible for the increased FMAP, provided they meet the requirements of section 6008(b) and (c) of the Families First Coronavirus Response Act. While CMS has not conducted reviews for state compliance, we believe that all states can take steps to be compliant and earn the enhanced funding, and CMS will provide technical assistance to states on this issue. The specific criteria that states and territories must meet in order to qualify for the increased FMAP is described in section C of this FAQ document (below).

2. Does the 6.2 percentage point FMAP increase apply to all match rates used in determining how much Federal Financial Participation (FFP) states receive for Medicaid expenditures?

In general, the increased FMAP is available for allowable Medicaid medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate defined in the first sentence of section 1905(b) of the Act. The increase does not apply with respect to the following Medicaid expenditures: Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b). ****Updated to remove Community First Choice.**

- Adult group expenditures matched at the "newly eligible" FMAP specified in section 1905(y) of the Act.
- Adult group expenditures matched at the "expansion state" FMAP specified in section 1905(z) of the Act.

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[1] Unless specifically noted, each reference to a state or states in these FAQs includes a reference to the District of Columbia and the territories.

[2] The emergency period is defined in paragraph (1)(B) of section 1135(g) of the Act, as amended by H.R. 6074—The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123). The Secretary's determination that a public health emergency exists was issued on January 31, 2020 with an effective date of January 27, 2020. The declaration is available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

- Expenditures for family planning services eligible for 90% match as specified in section 1903(a)(5).
- Expenditures for services "received through" an IHS facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100% match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies.
- Expenditures matched at 100% for individuals in Qualifying Individuals programs.
- Health home services under section 1945 of the Act when these are matched at 90% as specified in section 1945(c)(1). After the initial enhanced FMAP period for these services that is described in section 1945(c)(1), they will be matched at the state's regular FMAP, which might be subject to the 6.2 percentage point increase under section 6008(a).
- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b).

3. Is the increased FMAP available for Medicaid DSH expenditures?

Yes, if the expenditures are matched at the 1905(b) FMAP and the state and the expenditures otherwise meet the qualifying requirements (the expenditures were incurred during the applicable time period, the state meets the requirements in section 6008(b) and (c) of the FFCRA).

4. Does the 6.2 percentage point FMAP increase apply to Children's Health Insurance Program expenditures and expenditures for individuals eligible on the basis of breast and cervical cancer that are matched at the "enhanced" FMAP (EFMAP) under section 2105(b) of the Act?

Not directly. The EFMAP in section 2105(b) of the Act is calculated using the FMAP as defined in the first sentence of section 1905(b) of the Act as a "base." Therefore, generally, as the 1905(b) FMAP increases for a state, the EFMAP also increases for the state, though not in the exact same amount. Therefore, the EFMAP will increase for states coinciding with the duration of the 6.2 percentage point increase to the FMAP.

Please note that under section 2105(b) of the Act, the EFMAP for CHIP expenditures only is increased by 11.5 percentage points for the Federal Fiscal Year (FY) 2020 (October 1, 2019 through September 30, 2020) with a cap of 100% for this same period. The 100% cap will still apply as the maximum match rate for CHIP expenditures. For FY 2021 and after, the EFMAP under section 2105(b) of the Act is capped at 85%. Optional Breast and Cervical Cancer expenditures are matched at the unincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase described above).

Optional Breast and Cervical Cancer expenditures under section 2105(b) of the Act are matched at the unincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase for CHIP expenditures described above).

Example of the Impact of the 6.2 percentage point FMAP Increase on the Section 2105(b) EFMAP Calculation

	Without 6.2 percentage point FMAP Increase	**With** 6.2 percentage point FMAP Increase
1905(b) FMAP	50%	56.2%
EFMAP Calculation	(50% x 0.7) +0.3	(56.2% x 0.7) +0.3
EFMAP (non-CHIP)	65%	69.34%
EFMAP for CHIP (FY 2020)	76.5% (65% + 11.5%)	80.84% (69.34% + 11.5%)

5. For which period is the FMAP increase available?

Section 6008(a) of the FFCRA states that the increased FMAP is available for each calendar quarter occurring during the public health emergency. As the public health emergency for COVID-19 was declared by the Secretary of Health and Human Services on January 31, 2020, the increased FMAP is available for qualifying expenditures that were incurred on or after January 1, 2020 and through the end of the quarter in which the public health emergency including any extensions, ends. At the time the public health emergency period for COVID-19 ends, CMS will inform states.

6. How do states know whether an otherwise qualifying expenditure falls within the period for which the increased FMAP is available?

States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. For purposes of determining which FMAP applies, expenditures are considered to be incurred based on when the state makes a payment to a provider, not based on the date of service. The quarter in which the State makes a payment is the quarter in which the expenditure will be considered to be incurred, and the FMAP applicable to that quarter is the appropriate FMAP for that claim.

7. Is the increased FMAP available for services provided under waivers and section 1115 demonstrations?

Yes, if the expenditures are matched at the FMAP defined in the first sentence of 1905(b) and the state and the expenditures otherwise meet the qualifying requirements in section 6008 of the FFCRA.

8. Are states required to submit a State Plan Amendment (SPA) to be eligible for the 6.2 percentage point FMAP increase?

No, states are not required to submit a SPA to be eligible for the FMAP increase. However, only expenditures matched at the FMAP defined in the first sentence of 1905(b) that are incurred by states that meet the qualifying requirements in section 6008 of the Families First Coronavirus Response Act are eligible for the increased FMAP.

B. Requirements for States to Receive Increased FMAP

1. **What must a state do to receive a 6.2 percentage point temporary increase to the federal medical assistance percentage (FMAP)?**

   To qualify for the temporary FMAP increase, states must, through the end of the month when the public health emergency ends:

   a. Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).

   b. Not charge premiums that exceed those that were in place as of January 1, 2020

   c. Cover, without impositions of any cost sharing, testing, services and treatments—including vaccines, specialized equipment, and therapies—related to COVID-19.

   d. Not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, or becomes enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state (continuous coverage requirement).

   These requirements became effective on March 18, 2020. More information on these conditions is provided below.

2. **What is the maintenance of effort (MOE) requirement in the FFCRA? What types of eligibility and enrollment changes can states make to respond to the current emergency and still receive temporary increased FMAP?**

   States may not impose eligibility standards, methodologies, or procedures that are more restrictive than those that were in place on January 1, 2020, in order to receive increased FMAP during the emergency period. States may continue to make temporary or permanent eligibility and enrollment changes that are less restrictive during the emergency period, such as lowering premiums, easing burden associated with verification requirements, and streamlining the application process, as permitted by law, including under any applicable federal waiver or modification authorities. CMS is available to provide technical assistance to any state that implemented any such more restrictive standards, methodologies, or procedures between January 1, 2020 and enactment of the FFCRA.

3. **Can states increase premiums under the state plan (or waiver) after January 1, 2020 and still receive temporary increased FMAP?**

   No. A state that increases premiums for any beneficiaries above the amounts in effect on January 1, 2020 is not eligible for the temporary increased FMAP.

4. **Are states required to cover any COVID-related services as a condition of receiving the temporary increased FMAP?**

   Yes. States must cover, under the state plan (or waiver), testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporary increased FMAP is claimed.

5. **Which items and services must states exempt from cost sharing in order to be eligible for the temporary increased FMAP?**

   States may not impose deductibles, copayments, coinsurance or other cost sharing charges for any services described in question C.4., above – i.e., testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies – in the quarter in which the temporary increased FMAP is claimed.

6. **Are states required to provide continuous coverage for all Medicaid beneficiaries through the end of the month in which the emergency period ends?**

   Yes. In order to receive the temporary FMAP increase provided under section 6008 of the FFRCA, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state.

7. **If a state has already terminated coverage for individuals enrolled as of March 18, 2020, what actions should the state take? Must those individuals have their coverage reinstated?**

   To receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid during the emergency period effective March 18, 2020, unless the beneficiary voluntarily requested to be disenrolled, or is no longer a resident of the state. States that want to qualify for the increased FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination.

8. **Does continuous coverage for the emergency period apply to individuals who are receiving benefits during a period of presumptive eligibility?**

   Individuals who have been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan, and are therefore not "enrolled" and subject to the requirements for continuous coverage described under section 6008 of the FFCRA.

9. **Do the requirements to provide continuous coverage during the emergency period apply to individuals who were determined ineligible prior to March 18, 2020, but who continue to receive services pending an appeal?**

   Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends.

10. **Do the requirements to provide continuous coverage apply to CHIP?**

    No. States do not need to maintain coverage in CHIP in order to receive the temporary increase in the Medicaid federal medical assistance percentage (FMAP) provided under section 6008 of the FFRCA. However, the Maintenance of Effort (MOE) required under section 2105(d)(3) of the Social Security Act continues to apply.

11. **Should states continue to conduct redeterminations and act on reported or identified changes in circumstances during the emergency period?**

    The FFCRA does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances. States may also continue to conduct periodic data matching between regular beneficiary renewals, consistent with states' verification plans. However, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid on or after March 18, 2020, until the end of the month in which the emergency period ends, unless such individual is no longer a resident of the state or requests voluntary termination. This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown.

12. **If a state receives information during the emergency period that would make a beneficiary eligible for a different eligibility group, must the state keep the beneficiary enrolled in the group in which he or she is currently enrolled?**

    To receive the increased FMAP under the FFCRA, states may not terminate coverage for beneficiaries enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, unless the beneficiary voluntarily requests termination from the program or is considered to no longer be a resident of the state. Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP.

13. During the emergency period, should states still terminate Medicaid coverage for deceased individuals?

Yes. Individuals who are determined to be deceased are no longer residents of the state. States may terminate coverage for deceased individuals and remain eligible for receipt of the increased FMAP. States should communicate this clarification to their managed care plans.

C. Flow of Federal Funds and State Reporting

1. Will CMS be releasing funding all at once or through multiple grant awards?

We are prioritizing issuing grant awards to states for additional funding associated with the increased FMAP retroactive to January 1, 2020 first. The first set of grant awards will include increased funding for the period January 1, 2020 through March 31, 2020. We will then provide additional funds based upon state budget estimates for the April 1, 2020 through June 30, 2020. As with all Medicaid grant award funding, these funds will be reconciled against claimed and allowable expenditures when states file their quarterly CMS-64 expenditure reports.

2. When will CMS send the FFP associated with the increased FMAP to states?

We are currently processing grant awards to fund the increase match for the period beginning January 1, 2020 through March 31, 2020. We expect that states will receive the funds in their Payment Management System (PMS) account no later than Wednesday, March 25, 2020. We intend to issue funding for the increased match associated with the quarter beginning April 1, 2020 as close to April 1, 2020 as possible.

3. How did CMS calculate the amount of the grant awards associated with the increased FMAP?

CMS used budget estimates reported and certified by states on the Form CMS-37 in the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) for the quarter ending March 31, 2020 (Q2 FY 2020) to estimate the additional amount of federal funds that would be due States as a result of the 6.2 percentage point FMAP increase. The amount of the additional grant award that each state receives for Q2 FY 2020 will be equal to the difference between the estimated federal share recalculated for Q2 FY 2020 to include the FMAP 6.2 percentage point increase and the federal share previously reported and certified in MBES/CBES for Q2/FFY 2020 by the state for the Q2 FY 2020 budget submission.

We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAPs; however, in the meantime, we are providing additional funds to states in estimated amounts described above. Once MBES/CBES is reprogrammed to utilize the increased FMAPs, the system will automatically determine the correct amount of federal funds related to the increased FMAPs, and apply such FMAPs for the actual claimed expenditures that were incurred on or after January 1, 2020, and before the end of the emergency period. Per our standard Medicaid grant award reconciliation process, CMS will reconcile all amounts advanced to the state, including estimated amounts based on the increased FMAP, to actual

Medicaid expenditures reported by the state for the relevant quarter and recover any unexpended amounts or pay any additional amounts due to the state.

4.The increased FMAP is available for expenditures incurred as early as January 1, 2020. Can states draw all funding associated with the increased FMAP as soon as they receive it?

If the state meets all applicable requirements and conditions established within section 6008 and other applicable existing federal requirements, it can draw funds associated with allowable Medicaid expenditures that have already been incurred and are eligible for the increased match. A state may not draw funds for expenditures it has not yet incurred, expenditures incurred prior to January 1, 2020, or expenditures that are not otherwise eligible for the increased FMAP.

5.Will grant awards issued relating to the increased FMAP be subject to adjustment or are they set amounts?

In calculating grant awards for the increased FMAP associated with the quarter ending March 31, 2020, we used estimated expenditures submitted and certified by states on the Form CMS-37. The final determination of allowability of expenditures eligible for the increased FMAP and any necessary reconciling grant awards will be determined after all the actual expenditures for the quarter have been submitted by the states and reviewed by CMS. At that time, final reconciling grant awards will be issued to reflect the amounts that the states are finally due based on federal requirements, including those specified in the Families First Coronavirus Response Act. Consistent with our existing practice and federal requirements, any overpayment or underpayment will factor into (be offset against or added to) the grant award for the following quarter.

6. What happens if a state determines that its spending will exceed its budget estimate? Will additional funding be available?

Consistent with existing practice, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs, including those eligible for the 6.2 percentage point increased FMAP. Should any state need additional funds before the end of a quarter, they may request them through a supplemental request to the extent that the state and its expenditures qualify for the increased FMAP and have a permissible source of non-Federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

7. How will CMS expect states to document and differentiate which expenditures they are claiming at the increased FMAP rate and expenditures matched at other rates?

Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. We will be performing oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed. We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the Families First Coronavirus Response Act, including reporting of budget estimates and expenditures eligible for the increase FMAP. We intend to issue further guidance and

offer training to states as soon as possible on reporting budget estimates on the CMS-37 and quarterly expenditures on the Form CMS-64.

8. Are there special reporting requirements for the Form CMS-64 or Form CMS-37 (i.e., separate lines or a separate report for the increased FMAP)?

We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the Families First Coronavirus Response Act, including reporting of budget estimates and expenditures eligible for the increased FMAP. We intend to issue further guidance and offer training to states as soon as possible.

9. Will CMS expect states to document and differentiate which draws from its Payment Management System (PMS) account are applicable to the increased FMAP rate and which expenditures are matched at other rates? If so, how?

Consistent with existing requirements, states must document expenditures and draws to ensure a clear audit trail for use of federal funds. We expect states, on a quarterly basis, to provide CMS with a breakout of the total amount of PMS draws by quarter that are related to expenditure eligible for the increase FMAP and the total amount of PMS draws that were *not* for expenditures related to the increased FMAP. CMS expects states to provide this information as soon as possible at the end of every quarter. In line with our current processes, we will continue to reconcile states' PMS subaccounts with actual expenditures once states report them in MBES/CBES and CMS reviews the expenditures for accuracy and allowability. States' total draws in PMS are expected to equal the actual total expenditures reported for such quarter/fiscal year in MBES/CBES.

10. Does the increased FMAP only pertain to state expenditures or does it also pertain to collections and overpayments?

All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 6.2 percentage point FMAP increase.

11. If a state recovers a provider payment that was originally claimed by the state with the 6.2 percentage point increased FMAP, should it return the FFP associated with the recovery at the increased FMAP?

Yes, recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP.

D. Requesting Increased FMAP

1. To be eligible for the 6.2 percentage point FMAP increase, section 6008(c) of the Families First Coronavirus Response Act provides that states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under 1923 of

the Act than was required on March 11, 2020. Will CMS require states and territories to demonstrate compliance with this provision prior to receiving the increased FMAP?

While states are required to ensure compliance with this section, CMS will not require that states submit a demonstration of compliance prior to drawing FFP associated with the increased FMAP. Instead, CMS will require states to attest to compliance. If this attestation is determined to be incorrect such that the state does not satisfy the conditions under section 6008(c) of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

2. Will CMS require that states attest to meeting the requirements of section 6008 of the Families First Coronavirus Response Act when drawing the FFP associated with the increased FMAP?

Yes. States must attest that they will assure compliance with the requirements in sections 6008(b) and (c) of the Families First Coronavirus Response Act. If this attestation is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

3. How will states attest? What should states send in and to whom? Will CMS approve the attestation? May states draw funds before the attestation is approved? Must states attest before each draw down?

By drawing funds from the increased FMAP account in the Payment Management System (PMS), each state is "attesting" that: it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP is applicable; and that the conditions under which the increased FMAP is available are met. The attestation includes specific agreement with enumerated requirements of sections 6008(b) and (c) of the Families First Coronavirus Response Act. To minimize the need for separate review, avoid state burden, and expedite providing funding to states, CMS has included these requirements as attestations in each grant award letter to the states. The grant award letter indicates that only after the state has assured itself that it meets all of the requirements under which the increased FMAP and associated funds were available, is it free to draw such funds. This process is referred to as a "passive attestation" under which each state did not need to send in a written confirmation that it met the requirements prior to receiving its funds; rather, by simply drawing down the funds the state was attesting that it had carefully considered all attestations and that it met those requirements. If this is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

4. Does CMS intend to issue more specific guidance on the requirements relating to political subdivisions in section 6008(c)?

Section 6008(c) modifies section 1905(cc) of Act by providing that, to be eligible for the increased FMAP under section 6008(a) of the Families First Coronavirus Response Act, states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under

1923 of the Act than was required on March 11, 2020. CMS has already issued guidance about section 1905(cc) of the Act, including most recently through State Medicaid Director Letter #10-023 on November 9, 2010. States should refer to this guidance regarding requirements of section 1905(cc). Of note, for increased FMAP available under section 6008 of the Families First Coronavirus Response Act, the reference to ''December 31, 2009'' in section 1905(cc) of the Act shall be deemed to be a reference to ''March 11, 2020.''

Appendix C

FSSA Office of Hearings and Appeals - COVID-19 Frequently Asked Questions

General Questions

What changes are there from normal operations due to COVID-19?

There are two changes made to how the Office of Hearings and Appeals operates:

1. OHA is now only conducting hearings by telephone in order to comply with the Governor's stay-at-home order while Division of Family Resources offices are closed to the public.
2. If you have a health coverage (Healthy Indiana Plan, Hoosier Healthwise, Hoosier Care Connect or Traditional Medicaid) appeal and are receiving continued benefits pending your appeal, we are not scheduling the appeal, holding the hearing or releasing decisions. If you are not receiving continued benefits, your case will be processed normally.

Both of these changes have specific sections, below.

I received a letter about my case being placed on hold, what do I need to do?

If you are satisfied with receiving continued benefits for now, you don't need to do anything. If you no longer want to receive continued benefits and want your appeal to proceed, see the question "**Can you change my case so I'm no longer receiving continued benefits?**" under the Continued Benefits section, below.

When do these changes end?

Under the Families First Coronavirus Relief Act, individuals receiving health coverage on or after March 18, 2020, must continue to receive continuous coverage until the end of the month when the COVID-19 emergency period ends. All current appeals where the individual has continued benefits will be placed on hold until the emergency period ends.

OHA will continue to hold only telephone hearings until the Stay-At-Home order is lifted and local DFR offices are open to the public again.

Telephone Hearings

When will I have my hearing?

Once accepted, you will receive a Notice of Telephonic Hearing ("scheduling letter"), which will tell you when to call in for your hearing.

If your health coverage appeal has been placed on hold (see the section titled "Continued Benefits") your case will not be scheduled until after the emergency period ends.

How does a telephone hearing work?

On your scheduling letter, you will be provided a toll-free number to call and a pass-code. When it's time to call in to your hearing, follow those instructions to be connected to the administrative law judge.

Please note that you must call in to that number, the judge will not be calling you.

How do I contact OHA with questions about my appeal?

You can email OHA directly at oha@fssa.in.gov or fax us at 317-232-4412

You can call us locally at 317-234-3488, or toll-free at 866-259-3573. Calls will be answered or returned Monday-Friday, 8 a.m. to 3 p.m. EDT.

If you have questions about your eligibility case, want continued benefits or want them removed, or want to apply for benefits please instead call the Division of Family Resources at 800-403-0864.

The OHA staff is not authorized or trained to answer questions about your benefits.

How do I reach someone for my pre-hearing conference?

The pre-hearing conferences are a discussion between the parties: Yourself and your representatives as well as the Division of Family Resources. These do not include the administrative law judge. Pre-hearing conferences are strongly encouraged but not required. You may contact the Division of Family Resources for your pre-hearing conference by calling 800-403-0864.

The goal is a clear understanding of the action being appealed and why it was taken. If this resolves the issues to both parties' satisfaction the appeal may be withdrawn. If the issues are not resolved the hearing will remain scheduled.

Can I have a face-to-face hearing instead?

OHA is complying with the governor's stay-at-home order and is only holding telephone hearings at this time. If you still wish to have a face-to-face hearing, please submit this request to OHA. If OHA determines it is appropriate to grant your request, your case will not be able to be heard until OHA resumes in-person hearings at a later, yet-to-be determined date. This will result in a delay in processing your appeal.

Why was my appeal scheduled?

OHA is still able to hold telephone hearings in a timely process, so if you request an appeal we will still attempt to hold it via telephone.

If your appeal is for your health coverage (Healthy Indiana Plan, Hoosier Healthwise, Hoosier Care Connect or Traditional Medicaid) and you think you are getting continued benefits, please contact us so we can review your case and place it on hold. Reach us by telephone at 317-234-3488, toll free at 866-259-3573, by email to oha@fssa.in.gov or fax us at 317-232-4412.

How do I request a reschedule of my case or request that it be reopened?

Please send a written or typed request for a reschedule or reopen by email to oha@fssa.in.gov or fax us at 317-232-4412. We cannot accept verbal requests for reopens or reschedules.

My appeal isn't on hold, when will it be scheduled?

Once the appeal is accepted, we will mail a scheduling letter to you. If you do not receive a scheduling letter within ten days, please contact us by email to oha@fssa.in.gov or fax us at 317-232-4412.

How do I submit evidence for my case?

The parties are to provide each other copies of their exhibits within 20 days of the date on the scheduling notice. Submissions to the state may be made by fax to 800-403-0864 or mail to:

FSSA DFR Document Center
P.O. Box 1810
Marion, IN 46952

The exhibits must be prepared according to the instructions on the scheduling letter. Please ensure you are including your name and the appeal number on your exhibits so they're attached to the correct case.

The appeal number is a ten digit number starting with "450," which may be found on your scheduling letter.

If the administrative law judge directs you to submit additional evidence, you may fax it to 317-232-4412 or email it to oha@fssa.in.gov – additional evidence must still be prepared correctly.

Continued Benefits

Why is OHA not processing health coverage appeals with continued benefits?

This is required under the Families First Coronavirus Response Act passed by Congress. With the current health crisis, it's important that as many people as possible have access to affordable health care. We are putting cases where you are receiving continued benefits on hold, so you can continue to receive your health coverage during the health emergency.

Do I qualify for continued benefits?

OHA does not make this determination.

In many cases if you are appealing within 30 days of the date on the notice telling you that your benefits were reduced or discontinued, you might qualify for continued benefits. If you were denied at application, you have no benefits to continue. You must be an Indiana resident to receive continued benefits.

Can you give me continued benefits for my appeal?

OHA does not change your benefits, including granting or denying continued benefits. This is solely the responsibility of the Division of Family Resources. You can contact DFR at 800-403-0864.

My application was denied, how do I get coverage?

You can apply for benefits online at https://www.fssabenefits.in.gov

Can you change my case so I'm no longer receiving continued benefits?

OHA does not make the determination on if you are getting continued benefits, however you may opt-out of receiving them by contacting the Division of Family Resources at 1-800-403-0864. The stay was put in place to prevent people from losing health coverage during the current health emergency, so please consider this option carefully before calling.

Which programs does this impact?

The hold on processing health coverage appeals covers all FSSA health programs, including HIP and CHIP. This does not affect TANF or SNAP (formerly known as food stamps) benefits, though if you qualify for continued benefits for TANF or SNAP, you will still receive them while waiting for your telephone hearing. We are not holding any appeals face-to-face at this time, only over the phone.

I have withdrawn from continued benefits and want my hearing, what do I do?

Please contact OHA to have your case scheduled by sending an email to oha@fssa.in.gov or fax us at 317-232-4412. If continued benefits have been removed, we can have your appeal scheduled for hearing.

What happens when cases are no longer on hold?

When OHA is given permission, we will start to schedule these cases. If your county is affected by a stay-at-home order or you request a telephone hearing, these will continue to be over the phone, otherwise they may be conducted face-to-face when the local DFR offices are open to the public again at a later date.

What happens to my case if it is scheduled for a telephone hearing when face-to-face hearings are allowed again?

If your case was already scheduled for a telephone hearing, it will remain a telephone hearing unless you request otherwise.

I don't want my hearing any more. How do I have it dismissed?

For SNAP, you may call OHA at 317-234-3488, toll free 866-259-3573, or contact DFR at 800-403-0864 to verbally request a withdrawal

For all appeals, you may email us at oha@fssa.in.gov, fax us at 317-232-4412, fax to DFR at 800-403-0864, or send U.S. Mail to:

FSSA Office of Hearings and Appeals
402 W. Washington Street, Room E034 MS04
Indianapolis, IN 46204-2739

Or

FSSA DFR Document Center
P.O. Box 1810
Marion, IN 46952

Reviews

Is my agency review case affected by any of this?

Since agency review only reviews the decision already made by the administrative law judge, this process is not affected by the pause.

Is my judicial review case affected by any of this?

Judicial review is performed by the courts, not FSSA. Please contact the court where you have filed for judicial review. OHA compliance with judicial review is not affected by this situation.

Contact Us

You can email OHA directly at oha@fssa.in.gov or you can call us locally at 317-234-3488, toll-free at 866-259-3573

If you have questions about your eligibility case, want continued benefits or want them removed, or want to apply for benefits please instead call the Division of Family Resources at 800-403-0864.

OHA can only answer questions about the hearing process, not your benefits.

Appendix D

Hotmer v. Ind. Family & Soc. Servs. Admin.

Court of Appeals of Indiana

June 30, 2020, Decided; June 30, 2020, Filed

Court of Appeals Case No. 19A-PL-2694

Reporter
2020 Ind. App. LEXIS 272 *; 2020 WL 3526013

Randy L. Hotmer, Appellant-Petitioner, v. Indiana Family and Social Services Administration, Appellee-Respondent

Prior History: **[*1]** Appeal from the Clark Circuit Court. The Honorable William A. Dawkins, Magistrate. Trial Court Cause No. 10C02-1807-PL-82.

Outcome
Reversed and remanded.

Core Terms

annuity, monthly, eligibility, Annuitant, spouse

Case Summary

Overview
HOLDINGS: [1]-Affirming an Indiana Family and Social Services Administration (FSSA) ruling denying Medicaid eligibility to an annuitant in a nursing home was error because the annuity contract documents that made the monthly payments to his wife were irrevocable, so the annuitant could not change the payee and make the payments available to him without breaching the contracts, so FSSA's denial of Medicaid benefits was arbitrary and capricious.

LexisNexis® Headnotes

Administrative Law > Judicial Review > Standards of Review > Arbitrary & Capricious Standard of Review

Administrative Law > Judicial Review > Standards of Review

HN1[] **Standards of Review, Arbitrary & Capricious Standard of Review**

In an appeal involving an administrative agency's decision, an appellate court's standard of review is governed by the Indiana Administrative Orders and Procedures Act, and courts are bound by the same standard of review as the trial court. Courts do not try the case de novo and do not substitute the court's judgment for that of the agency. Courts will reverse the administrative decision only if it is: (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (2) contrary

to a constitutional right, power, privilege, or immunity; (3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (4) without observance of procedure required by law; or (5) unsupported by substantial evidence. A decision is arbitrary and capricious when it is made without consideration of the facts and lacks any basis that may lead a reasonable person to make the decision made by the administrative agency.

Administrative Law > Judicial Review > Standards of Review > Deference to Agency Statutory Interpretation

Administrative Law > Judicial Review > Standards of Review > Exceeding Statutory Authority

HN2[] **Standards of Review, Deference to Agency Statutory Interpretation**

A court may not overturn an administrative determination merely because it would have reached a different result. An interpretation of statutes and regulations by an administrative agency charged with the duty of enforcing those regulations and statutes is entitled to great weight unless this interpretation would be inconsistent with the law itself. Although an appellate court grants deference to an administrative agency's findings of fact, no such deference is accorded to its conclusions of law. The burden of demonstrating the invalidity of the agency action is on the party who asserts the invalidity.

Public Health & Welfare Law > ... > Medicaid > Eligibility > Categorically & Medically Needy Claimants

HN3[] **Eligibility, Categorically & Medically Needy Claimants**

To qualify for Medicaid, an applicant must meet both an income-eligibility test and a resources-eligibility test. If either the applicant's income or the value of the applicant's resources is too high, the applicant does not qualify for Medicaid.

Public Health & Welfare Law > ... > Medicaid > Eligibility > Categorically & Medically Needy Claimants

HN4[] **Eligibility, Categorically & Medically Needy Claimants**

Pursuant to *42 U.S.C.S. § 1396p(c)(2)(B)(i)*, an individual who has applied for Medicaid benefits shall not be ineligible for medical assistance to the extent that assets-such as annuity payments-were transferred to the individual's spouse for the sole benefit of the individual's spouse.

Constitutional Law > Supremacy Clause > Federal Preemption

Public Health & Welfare Law > ... > Medicaid > Eligibility > Categorically & Medically Needy Claimants

HN5[] **Supremacy Clause, Federal Preemption**

To the extent that a State policy conflicts with *42 U.S.C.S. § 1396r-5*, it is invalid.

Counsel: ATTORNEY FOR APPELLANT: Ralph C. Melbourne, Church Langdon Lopp & Banet, LLC, New Albany, Indiana.

ATTORNEYS FOR APPELLEE: Curtis T. Hill, Jr., Attorney General; Benjamin M. L. Jones, Deputy Attorney General, Indianapolis, Indiana.

Judges: Crone, Judge. Bailey, J., concurs. Altice, J., concurs in result without opinion.

Opinion by: Crone

Opinion

Crone, Judge.

Case Summary

P1 Randy L. Hotmer purchased two irrevocable annuities; pursuant to the annuities' contract documents, the monthly payments were made to his wife. Hotmer, who was in a nursing home, applied for Medicaid benefits with the Indiana Family and Social Services Administration (FSSA). FSSA ruled that because Hotmer was the owner of the annuities, the income from the annuities must be attributed to him, and because that income resulted in Hotmer exceeding the income limit for Medicaid eligibility, FSSA denied his application. Hotmer petitioned for judicial review of FSSA's ruling, and the trial court affirmed. Hotmer now appeals, arguing that FSSA erred in attributing the annuity income to him and in denying his application. We agree and **[*2]** therefore reverse and remand for further proceedings.

Facts and Procedural History

P2 The relevant facts are undisputed. Hotmer was born in 1948. In April 2017, he entered a nursing home for long-term care. Over the next few months, he filled out applications for and ultimately purchased two eight-year annuities, one from Elco Mutual and one from NGL. On the applications, Hotmer directed that the monthly checks be made out to his wife as payee, and he also named her as the primary beneficiary who would be entitled to receive any remaining payments after his death. The annuity contract documents list Hotmer as the annuitant, or the owner, of the annuities, and state that the applications are part of the contracts. The Elco Mutual contract states, "Annuity payments will be made to the Owner, or as otherwise directed by the Owner, beginning on the Annuity Date." Appellant's App. Vol. 3 at 40. The contract further states, "This contract is irrevocable. It may not be transferred, assigned, surrendered or commuted during Your lifetime.... Neither the Annuitant nor the Beneficiary may be changed." *Id.* at 41. The NGL contract states, "[NGL] will make annuity payments to the Annuitant commencing on the **[*3]** Annuity Date." *Id.* at 45. The contract further states, "This Contract is irrevocable. It may not be altered, transferred, assigned, surrendered or commuted during Your lifetime.... Neither the Annuitant nor any Beneficiary may be changed." *Id.* at 47.

P3 In October 2017, Hotmer applied for Medicaid benefits with FSSA, which administers the Medicaid program in Indiana. The local FSSA office determined that the annuity payments belonged to Hotmer as the owner of the annuity, and it denied his application on the basis that those payments boosted his monthly income above the applicable eligibility limit.[1] Hotmer petitioned for administrative review of that decision. An administrative law judge (ALJ) overturned the denial based on *42 U.S.C. § 1396r-5(b)(2)(A)(i)* (*Section 1396r-5*), which states,

> in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides[,] if payment of income is made solely in the name of the institutionalized spouse [Hotmer] or the community spouse [his wife], the income shall be considered available only to that respective spouse[.]

The ALJ concluded that because the annuity

[1] Absent the annuity payments, Hotmer's monthly income is approximately $200 below the limit. Each of the annuity payments exceeds $200.

payments were made solely in the name of Hotmer's wife, they were considered available only to his wife, and **[*4]** therefore Hotmer's income did not exceed the limit.

P4 FSSA petitioned for review of the ALJ's decision. FSSA's ultimate authority remanded to the ALJ with instructions to examine the evidence and *Section 1396r-5* in their entirety, further address the issue of income, and provide findings and conclusions to support her decision. On remand, the ALJ found that Hotmer's annuities,

> of which he is the owner/annuitant, is [sic] being paid directly to [his wife] for her benefit only. [Hotmer] does not have access to the monthly income. [His wife] is the recipient of the monthly payments which are deposited into her account for her use only. Therefore the annuity income is not countable under [Hotmer's] countable monthly income.

Appellant's App. Vol. 2 at 49.

P5 FSSA again petitioned for review, and FSSA's ultimate authority issued a decision that reads in relevant part,

> After review of the evidence, it is clear that [Hotmer] is the owner of the annuities and as owner the income source must be attributed to him regardless of who he has assigned as a payee. [Hotmer's] income must be used for his care since he applied for Medicaid. *42 CFR 435.608* states, "(a) As a condition of eligibility, the agency must require applicants **[*5]** and beneficiaries to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so." The State's original decision to deny Medical Assistance to the Aged to [Hotmer] for the application dated October 20, 2017 is sustained.

Id. at 21. Hotmer petitioned for judicial review of the decision pursuant to the Indiana Administrative Orders and Procedures Act (the Act). After a hearing, the trial court affirmed FSSA's decision. Hotmer now appeals.

Discussion and Decision

HN1[☎] P6 In an appeal involving an administrative agency's decision, our standard of review is governed by the Act, and we are bound by the same standard of review as the trial court. *Walker v. State Bd. of Dentistry, 5 N.E.3d 445, 448 (Ind. Ct. App. 2014)*, *trans. denied*. "We do not try the case de novo and do not substitute our judgment for that of the agency." *Id.*

> We will reverse the administrative decision only if it is: (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (2) contrary to a constitutional right, power, privilege, or immunity; (3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (4) without observance of **[*6]** procedure required by law; or (5) unsupported by substantial evidence.

Id. (citing *Ind. Code § 4-21.5-5-14*). "A decision is arbitrary and capricious when it is made without consideration of the facts and lacks any basis that may lead a reasonable person to make the decision made by the administrative agency." *Ind. Real Estate Comm'n v. Martin, 836 N.E.2d 311, 313 (Ind. Ct. App. 2005)*, *trans. denied* (2006).

HN2[☎] P7 "[A] court may not overturn an administrative determination merely because it would have reached a different result." *Walker, 5 N.E.3d at 448*. "An interpretation of statutes and regulations by an administrative agency charged with the duty of enforcing those regulations and statutes is entitled to great weight unless this interpretation would be inconsistent with the law itself." *Id.* "Although an appellate court grants deference to an administrative agency's findings of fact, no such deference is accorded to its conclusions of law." *Id.* "The burden of demonstrating the invalidity of the agency action is on the party who asserts the invalidity." *Id. at 449*.

P8 For background purposes, we note that Congress established Medicaid in 1965 "to provide medical assistance to needy persons whose income and resources are insufficient to meet the expenses of health care." *Brown v. Ind. Family & Soc. Servs. Admin., 45 N.E.3d 1233, 1236 (Ind. Ct. App. 2015)*. "The program operates through a combined scheme **[*7]** of state and federal statutory and regulatory authority. States participating in the Medicaid program must establish reasonable standards for determining eligibility, including the reasonable evaluation of an applicant's income and resources." *Id.* (citation omitted). *HN3*[↑] "To qualify for Medicaid, an applicant must meet both an income-eligibility test and a resources-eligibility test. If either the applicant's income or the value of the applicant's resources is too high, the applicant does not qualify for Medicaid." *Id.* (citation omitted).

P9 In this case, we are concerned only with Hotmer's income eligibility. *HN4*[↑] Hotmer notes that, pursuant to *42 U.S.C. § 1396p(c)(2)(B)(i)*, an individual who has applied for Medicaid benefits "shall not be ineligible for medical assistance ... to the extent that ... assets" - such as annuity payments[2] - "were transferred to the individual's spouse ... for the sole benefit of the individual's spouse." Here, it is undisputed that Hotmer transferred the annuity payments to his wife for her sole benefit. And because those payments are made solely in her name, the income shall be considered available only to her pursuant to *Section 1396r-5*.[3] According to FSSA, Hotmer is entitled to those payments as the owner **[*8]** of the annuities and failed to "take all necessary steps to obtain" them pursuant to *42 C.F.R. § 435.608*, and therefore that income must be attributed to him.[4]

P10 We disagree. The annuity contracts, which include the annuity applications on which Hotmer named his wife as payee, are irrevocable, i.e., "[u]nalterable; committed beyond recall." BLACK'S LAW DICTIONARY (11th ed. 2019). Consequently, Hotmer could not change the payee and make the payments available to him without breaching the contracts.[5] We therefore conclude that FSSA's denial of Hotmer's application for Medicaid benefits was arbitrary and capricious, and we reverse and remand for further proceedings consistent with this decision.[6]

P11 Reversed and remanded.

Bailey, J., concurs.

Altice, J., concurs in result without opinion.

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[2] *See 42 U.S.C. § 1396p(h)(1)* (defining "assets" in pertinent part as "all income and resources of the individual and of the individual's spouse"), -(2) (providing that "income" has meaning given in *42 U.S.C. § 1382a*, which defines "income" as "both earned income and unearned income[,]" the latter of which includes "any payments received as an annuity").

[3] FSSA's ultimate authority did not contradict the ALJ's finding that Hotmer's wife deposits the payments into an account for her use only.

[4] FSSA cites Section 2805.15.00 of the Indiana Health Coverage Program Policy Manual, which reads in pertinent part, "The individual who has title to the proceeds of a payment or property is the individual who 'owns' the income. If the income is received by an individual's legal representative or guardian, the individual still owns the income." There is no indication that Hotmer's wife is his legal representative or guardian, and *HN5*[↑] to the extent that this policy conflicts with *Section 1396r-5*, it is invalid. *See Knox Cty. Ass'n for Retarded Citizens, Inc., 100 N.E.3d 291, 300 (Ind. Ct. App. 2018)* (invalidating state regulation that conflicted with federal law), *aff'd on reh'g, **107 N.E.3d 1111***.

[5] On appeal, at least, FSSA has not specifically argued that Hotmer was obligated to make the annuity payments available to himself before he applied for Medicaid benefits. Accordingly, we do not address Hotmer's contention that such an argument is meritless.

[6] Consequently, we need not address Hotmer's argument that FSSA deprived him of due process by citing *42 C.F.R. § 435.608* as a basis for denying his application for the first time in its final decision. We do note, however, that the regulation requires that an applicant be given an opportunity to make a good-cause showing, and it is questionable whether Hotmer was given that opportunity below.

Section Two

Estate Recovery

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Section Two

Advanced Elder Law 2020
Estate Recovery[1]

By: Connie L. Bauswell

"All Is a Riddle, and a Key to a Riddle... Is Another Riddle."
Ralph Waldo Emerson

Sources of Legal Authority Regarding Estate Recovery

1. Federal law requires that states pursue estate recovery. 42 U.S.C. 1396(p)(b) generally requires states to have an estate recovery program; requires states to make claims against a Medicaid recipient's probate estate; and gives states the option to assert claims against certain types of non-probate transfers. See §3810 of CMS State Medicaid Manual at *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals* for federal policy provisions regarding estate recovery.
2. IC §12-15-9 and 405 IAC 2-8: Statutes and regulations that establish Indiana's estate recovery program.
3. IHCPPM §4650.00.00: Indiana FSSA's estate recovery manual provisions.

Who does this affect?

1. Age of Medicaid Recipient. Preferred claim for Medicaid coverage paid after age 55. 42 U.S.C. §1396(p)(b)(1)(B); IC §12-15-9-1. (For Medicaid provided after October 1, 1993, no claim can be enforced unless Medicaid recipient was 65 years or older when the benefits were received. (Note: if a Medicaid recipient, regardless of age, is a beneficiary of a self-settled trust, there is payback to the State of Indiana to the extent Medicaid benefits were paid out at any time during recipient's life.)
2. Type of Medicaid Coverage Received. Is the Medicaid recipient a QMB Beneficiary? Did Medicaid pay for Medicare Part B premiums? Did the Medicaid recipient receive a different type of Medicaid, such as HIP 2.0 or Medicaid for the Aged, Blind and Disabled?

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[1] This outline uses material from the Indiana Senior Law Project's Medicaid Manual.

a. No claim can be asserted against Medicare B premiums paid by Medicaid. IHCPPM §4650.00.00.

b. Federal law states there should be no estate recovery against QMB Beneficiaries. 42 U.S.C. §1396p(b)(1)(B)(ii) and 42 U.S.C. §1396a(a)(10)(E).

But, CMS State Medicaid Manual 3810(A)(3) gives states the option to not recover against the estate of an individual who only receives QMB, but the state must recover QMB benefits paid out if the individual received help with both "full" Medicaid and QMB.

Good argument exists that there should be no recovery for QMB if the individual receives other Medicaid benefits.

3. Who survives the Medicaid recipient?

a. Surviving Spouse, child under 21 or any child that is blind or disabled? No estate recovery. 42 U.S.C. §1396(p)(b)(2). No delayed recovery in Indiana against spouse or minor or disabled child.

b. Indiana statute says that there is no claim against real estate or personal property while needed for the support of the surviving spouse, dependent children under age 21, or a dependent who is non-supportive because of blindness or other disability. IC §12-15-9-2(1)and (2). FSSA does not require that the survivor show a need for the property as 405 IAC 2-8-1(c) and (d) and IHCPPM §4650.05.00 follow federal law.

c. Although federal law and state statute use the term "disabled child", IC §12-15-9-2 seems to include any disabled dependent, as "a dependent who is nonsupporting because of blindness or other disability."

Estate for Medicaid Estate Recovery Purposes

1. Applies to the Medicaid recipient's "estate".
2. "Estate" includes
   a. All real and personal property and other assets included in the probate estate.
   b. Any interest in real property owned by the decedent at the time of death that was conveyed to the individual's survivor through joint tenancy with rights of survivorship, if that tenancy was created after June 30, 2002.

c. Any real or personal property conveyed through a nonprobate transfer. (See discussion below).

d. Any sum due after June 30, 2005 to a person after the death of the Medicaid recipient that is under the terms of an annuity contract purchased after May 1, 2005, with the assets of the Medicaid recipient.

3. Exclusions from the definition of "estate" for Medicaid purposes:

a. Personal effects, ornaments or keepsakes? No estate recovery. IC §12-15-9-2(3).

b. Proceeds of a life insurance policy that names a beneficiary.

c. Real property of the Medicaid recipient that was subject to a life estates at the time of death.

d. Non-probate assets that Medicaid determined were exempt or unavailable assets or that were transferred out of the probate estate before May 1, 2002 are excluded from the definition of estate in IC §12-15-9-0.5. IC §12-15-9-0.8. (Before 2002, the definition of estate only included probate assets.). See discussion below "What is a nonprobate asset for Medicaid purposes?" and "What is not a nonprobate asset for Medicaid purposes?"

e. Sum due from an annuity contract bought before May 1, 2005.

f. Assets protected by an Indian Partnership Long Term Care Insurance policy.

g. As noted above, all of the Medicaid recipient's assets if he or she is survived by a spouse, child under the age of 21 or a disabled or blind child of any age. (See discussion above and §12-15-9-2 and §12-15-9-5.)

3. What is a nonprobate transfer for Medicaid purposes?

a. Property conveyed thru a nonprobate transfer as defined by IC §32-17-13-1 included as the estate. IC §12-15-9-0.5. Nonprobate transfer is a transfer that the transferor, immediately before death, had the power, acting alone, to prevent the transfer of the property by revocation or withdrawal and to use the property for his or her own benefit or to discharge claims in his or her probate estate. IC §32-17-13-1(a)(2). TOD transfer qualifies. IC §32-17-13-1(e)

b. Joint financial accounts with a survivorship interest as long as the Medicaid recipient had full access to the funds before death are nonprobate.

4. What is not a nonprobate transfer for Medicaid purposes?
    1. Survivorship interest for real estate held as tenants by the entireties;
    2. Life insurance policy or annuity;
    6. Death proceeds on a life insurance policy or annuity[2];
    4. IRA or like account or plan;
    5. Benefits under an employee benefit plan.

    Note: Statute does not specifically state, but a remainder interest in real estate is not a nonprobate transfer because the remainder vests upon creation of that interest and the life estate owner cannot prevent the property from passing to the remainder owner when the life estate owner dies. IC §32-17-13-1(b)(1).

Types of Assets Subject to Estate Recovery

1. Real property, including real property conveyed to another by joint tenants with rights of survivorship. Real estate owned as a JTWROS could be considered a nonprobate transfer based on the above, but a statute specifically states that real estate held as JTWROS is included in the definition of the estate IF the joint tenancy was created after June 30, 2002. Does not apply to JTWROS created before July 1, 2002. IC §12-15-9-0.5(a)(2).[3]
2. Money remaining in the Medicaid recipient's bank account(s);
3. Money in the nursing home account. Bulletin BT200726 is the 2007 FSSA Bulletin to nursing homes notified them to send account proceeds to OMPP. See *provider.indianamedicaid.com/ihcp/Bulletins/BT200726.pdf.*

[2] Under IC §12-15-9-7 an individual that receives annuity payments as a beneficiary under a policy owned by the Medicaid recipient is liable to the State of Indiana for Medicaid benefits paid.

[3] Claim extends to the Medicaid recipient's interest at death but what is actually meant is what the Medicaid recipient held immediately before death.

FSSA does not require that funds be sent to OMPP but some facilities still do so. Note: 410 IAC 16.2-3.1-6(h) states that nursing homes have to transfer funds in resident's trust account within thirty (30) days of resident's date of death.

4. Funds remaining in Qualified Income Trust. At death, make a check payable to "Treasurer, State of Indiana" and mail to the Estate Recovery Program, Family and Social Services Administration, 402 W. Washington Street, Rm. W374 MS07, Indianapolis, Indiana 46204. Note, funds must be sent to the State only to the extent Medicaid benefits were paid out. To find out how much is owed, contact 1.877.267.0013 or EstateRecovery@fssa.in.gov. Medicaid providers have one (1) year from the date of death to file a claim for payment from Medicaid.
5. Funds remaining in a funeral trust after the funeral has been paid in full. Funeral expenses may be paid before Medicaid's claim is paid, with the following limitations:
    a. IC §12-15-9-1: funeral exemption is $350.00
    b. IC §29-1-14-9(a)(2) and IC §12-14-17-4 and 5: Funeral exemption is $1,750 for funeral expenses and $400.00 for cemetery expenses. (FSSA allows $2,150 total and does not consider how it is apportioned. But IC §12-14-7-4 and 5 only allows these funeral expenses to be paid if the recipient did not have a prepaid funeral plan. Even if a prepaid plan was nominal and did not pay for the entire funeral and cemetery costs, these statutory sections do not apply.
6. Annuities purchased after May 1, 2005, including annuities that do not name the State of Indiana as a beneficiary;
7. Assets in a revocable living trust that were transferred into the trust after May 1, 2002. Property held in a revocable living trust where the grantor has the power to either revoke the trust or withdraw all of the funds is considered a nonprobate asset that is part of the estate for estate recovery purposes. Note: If a third party's agreement is required to revoke the trust or withdraw assets, it does not fall within the definition. (Irrevocable trusts are excluded.)

Mechanics of Estate Recovery Against Nonprobate Transfers.

1. Recovery against nonprobate transfers: Same process used by a creditor to make claims against nonprobate transfers except OMPP is not subject to the same time limits is the nonprobate asset was not disclosed to Medicaid.
2. IC §32-17-13: procedure to enforce a claim against a nonprobate estate. IC §12-15-9-0.6(a).
3. IC §32-17-13-2: transferee of a nonprobate transfer liable to the extent of the Medicaid claim if there are not enough probate assets to satisfy Medicaid's claim.
4. If estate is opened and claim is allowed, Medicaid must make a written demand on the personal representative of the estate to proceed against the nonprobate transferee. If the personal representative elects to do so, he or she then sues the nonprobate transferee seeking payment to the estate.
5. If the personal representative does not pursue the nonprobate transferee, then Medicaid can sue the nonprobate transferee in the name of the Medicaid recipient's estate at its expense. IC §32-17-13-7(f).
6. Time limitations for Medicaid recipients that die or or after June 30, 2018 IF the assets were reported to DFR[4]:
    a. 5 month time limit after date of death for filing claim and delivering notice to nonprobate transferee. IC §32-17-13-7(d).
    b. 7 months or not later than 30 days after allowance of the claim: time limit to make a written demand to the personal representative and each nonprobate transferee that the personal representative proceed against the nonprobate transferees. IC §32-17-13-(7)(e).[5]
    c. If the claim is not allowed/disallowed within the time frame set forth in IC §29-1-14-10, then the claimant must petition to set the claim for trial. This must be done within 30 days of the deadline for the allowance or disallowance of the claim. IC §32-17-13-7(f).

[4] Note that this requires that the asset be disclosed, not the nonprobate transfer.

[5] Demand can be filed with the filing of the claim in the estate, but the demand still must be filed no later than 7 months after death or 30 days after the final allowance of the claim, whichever is last. IC §32-17-13-7(j).

d. As a creditor, can sue the nonprobate transferee in the name of the estate if the personal representative fails or refuses to do so within 30 days of a written demand. IC §32-17-13-7(g). Can be by separate lawsuit against nonprobate transferee. IC §32-7-13-6. Creditor must sue within 9 months of death or after final allowance of the claim within the earlier of 30 days after the personal representative files the notice that he or she will not commence a proceeding or 90 days after final allowance of the claim if the personal representative does not file a claim and does not file a notice of the intent to not pursue the claim. IC §32-17-13-8(a). Note: If claimant files suit and recovers, they can keep the proceeds recovered up to the extent of the claim. Does not have to share pro rate with other claimants, unless other claimants intervened in the lawsuit. IC §32-17-13-10.

7. Time limitations for Medicaid recipients if the assets were not reported to DFR: No time limit for OMPP to pursue a claim.
8. The personal representative is not obligated to pursue a claim and there is no liability for if the personal representative declines in good faith. IC §32-17-13-7(g).

Mechanics of Estate Recovery Against Probate Assets

1. Attorney General's Office, on behalf of the State, opens estates when it believes there is property to collect. Estate Recovery gets a monthly list of deceased Medicaid recipients and has access to a database that shows heirs and assets. Death records and commercial databases are monitored, as are probate fillings via the on-line docket. County offices may notify as well.
2. When is a claim filed? State gets notice that the Medicaid recipient has died and has an estate, regardless of value.
3. Requirement that notice be sent as of July 1, 2018 if Decedent was 55 years of age of older at time of death. IC §29-1-7-7(d). Send notice to Medicaid Estate Recovery Program, Indiana Family and Social Services Administration, 402 W. Washington Street, W374 MS 07, Indianapolis, Indiana 46204.

4. No time limit for FSSA to file a claim or open and estate because FSSA is a governmental entity. IC §29-1-14-1(a). Only limitation is 10 year general residual statute of limitations. IC §34-11-1-2. Special rules exist with regards to real estate as explained in #6 below.
5. If FSSA does not file a claim after being given notice, then the estate can be made supervised and closed under IC §29-1-17-2 with a final report and accounting and decree of distribution. If FSSA does not appeal, the decree is final and should preclude a later claim by the State.
6. Real estate rules. Real estate cannot be sole to pay the debts and obligations of the decedent or the costs of administration if estate is not opened for 5 months after the date of death and letters of administration or testamentary are not issued within 7 months of the date of death. IC §29-1-7-15.1(b). Only way around this is if the majority of the distributees consent or if the statute imposing the restriction expressly permits the court to approve the prohibited action. Prohibition exists regardless of court order to the contrary. IC §29-1-10-21. Note: Effective July 1, 2018, if the estate is opened after 5 months and the personal representative sells the real estate, the proceeds from the sale are not subject to a claim by the State for Medicaid benefits paid out. IC §29-1-7-15.2.

Compromise and Negotiation of Claims

1. Claim can be compromised if doing so is in the State's best interest, such assets cannot be easily liquidated; the existence of the claim or the claim amount is disputed. Compromises must be in writing and approved by the Attorney General and Governor. IC 4-6-2-11.
2. Trial Court does not have discretion to reduce the amount of a valid claim. In the Matter of Estate of Cripe, 660 N.E. 2d 1062 (Ind. Ct. App. 1996).

Undue Hardship Requests

1. Exists if enforcing the State's claim will cause a beneficiary to be eligible or remain eligible for public assistance or complete loss of an income-producing asset and the beneficiary has no other source of income or if based on the facts of the specific case, compelling circumstances exist.

2. Modest value homesteads, worth less than 50% of the average home in the county, should be given special consideration as an undue hardship. CMS State Medicaid Manual §3810(c). Note: Indiana's regulations do not contain this provision, but Estate Recovery has said that it will not pursue a home worth less than $40,000.00 and other times has opened an estate.
3. Criteria for undue hardship found at 405 IAC 2-8-2 and IHCPPM §4650.20.10.
4. Use State Form 48259, Application for Hardship Waiver at https://www.in.gov/fssa/ompp/3446.htm or email a request for hardship at EstateRecovery@fssa.in.gov.
5. OMPP decides whether to grant an undue hardship request.

Miscellaneous Issues

1. Small Estate Affidavit. State may try to use this by sending it to third parties to demand that funds be sent. However, the small estate affidavit is not an available tool for creditors to demand payment. Instead, it is used for third parties to pay a distributee. IC §29-1-8-1.
2. Ethical Duties. See Ethics Committee of Indiana State Bar's Ethics Opinion No. 2 of 2003 at www.inbar.org. Attorney assisting with an application for consent to transfer a bank account does not have a duty to notify the State.

3810. MEDICAID ESTATE RECOVERIES

Under the estate recoveries provisions in '1917(b) of the Act, you must recover certain Medicaid benefits correctly paid on behalf of an individual. The following instructions explain the rules under which you must recover from an individual's estate Medicaid benefits correctly paid and incorrectly paid.

A. Adjustment and Recovery.--You must seek adjustment or recovery of medical assistance correctly paid on behalf of an individual under your State plan as follows.

1. Permanently Institutionalized Individuals.--In the case of permanently institutionalized individuals who the State determines cannot reasonably be expected to be discharged and return home, including individuals who qualify as both permanently institutionalized individuals and who are at least 55 years old, you must seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien, at a minimum, of amounts spent by Medicaid on the person's behalf for services provided in a nursing facility, ICF/MR, or other medical institution. These amounts also include Medicare cost sharing for qualified Medicare beneficiaries (QMBs) to the extent that the Medicare cost sharing was for these institutional services. At your option, you may also recover amounts up to the total amount spent on the individual's behalf for medical assistance for other services under the State plan. The date on which you determine the individual to be permanently institutionalized does not affect which expenditures you must or may recover from the individual or his or her estate. If you elect to recover all medical assistance, it would include assistance furnished prior to the time you determined the individual to be permanently institutionalized. If you only elect to recover for expenditures for institutional services, you must recover for all institutional services furnished to the individual, regardless of whether they were furnished during the current stay in the facility. Your State plan must reflect the medical assistance subject to recovery. Recoveries must be made from the individual's estate (after death) or from the proceeds of the sale of the property on which a lien has been placed.

Permanently institutionalized individuals are persons of any age who are inpatients in a nursing facility, ICF/MR, or other medical institution as defined in 42 CFR 435.1009, and who must, as a condition of receiving services in the institution under your State plan, apply their income to the cost of care, as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832. You must specify in your State plan the process by which you will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home, the notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. States are not required to use the supplemental security income intent to return home rule for purposes of determining whether an individual is permanently institutionalized for purposes of estate recovery. This rule applies only to eligibility determinations.

2. Individuals Age 55 or Older.--You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance. You must recover up to the total amount spent by Medicaid on the person's behalf, but only for spending on nursing facility services, (which includes skilled nursing facility and intermediate care facility for the mentally retarded services), home and community based services, as defined in "1915(c) and (d), 1929, and 1930 of the Act, and

related hospital and prescription drug services. Related hospital and prescription drug services are any hospital care or prescription services provided to an individual while receiving nursing facility services and home and community-based services. These amounts also include Medicare cost sharing for QMBs to the extent that the Medicare cost sharing was for nursing facility services, home and community-based services, and related hospital and prescription drug services described above. At your option, you may also recover additional amounts up to the total amount spent on the individual's behalf for medical assistance for any other items or services under your State plan. List these other items and services in your State plan. Recovery is limited to medical assistance for services received at age 55 or thereafter.

3. Individuals With Long Term Care Insurance Policies.--

a. Adjustment or Recovery Required.--Except as provided in '3810.A.3.b, you must seek adjustment or recovery from the individual's estate for all Medicaid costs for nursing facility and other long term care services if (1) assets or resources are disregarded to the extent of payments made under a long term care insurance policy, or (2) assets or resources are disregarded because the individual received (or is entitled to receive) benefits under a long term care insurance policy.

b. Assets or Resources Disregarded/Not Disregarded.--If you had an approved State plan, as of May 14, 1993, (California, Connecticut, Indiana, Iowa, and New York) which provided for the disregard of assets or resources in determining eligibility for medical assistance either to the extent that payments are made under a long term care insurance policy, or because an individual has received or is entitled to receive benefits under such a policy, you are not required to seek adjustment or recovery from the individual's estate for Medicaid costs for nursing facility and other Medicaid long term care expenses. While HCFA cannot compel you to recover any amounts from the estates of these individuals, you are free to do so if consistent with the terms of your State plan.

4. Adjustment or Recovery Limitations.--Adjustment or recovery can only be made after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21, or a blind or disabled child as defined in '1614 of the Act. For Guam, Puerto Rico, and the Virgin Islands, any surviving child's blindness or permanent or total disability would be determined under the definitions found in the State plan program for providing assistance to the blind or permanently and totally disabled. If a lien is placed on an individual's home, adjustment or recovery can only be made when (1) there is no sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time, and (2) there is no son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she has been providing care which permitted the individual to reside at home rather than in an institution.

B. Definition of Estate.--Specify in your State plan the definition of estate that will apply.

1. Probate Definition.--At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law.

2. Optional Definition.--In addition to property and assets under the probate definition, you may include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

3. Special Rule for Individuals With Long Term Care Insurance.--In the case of individuals described in '3810.A.3.a, you must use the definition of estate as described in subsection B.2.

C. Undue Hardship.--Where estate recovery would work an undue hardship, adjustment or recovery is waived. Establish procedures and standards for waiving estate recoveries when they would cause undue hardship. You may limit the waiver to the period during which the undue hardship circumstances continue to exist. Describe your policy in your State plan. You have flexibility in implementing an undue hardship provision. However, your undue hardship waiver protection does not apply to individuals with long term care insurance policies who became Medicaid eligible by virtue of disregarding assets because of payments made by a long term care insurance policy or because of an entitlement to receive benefits under a long term care insurance policy. California, Connecticut, Indiana, Iowa, and New York must apply their undue hardship rules to all individuals, including those eligible for Medicaid by virtue of State plan provisions related to the purchase of a long term care insurance policy.

1. Undue Hardship Defined.--Undue hardship might exist when the estate subject to recovery is the sole income-producing asset of the survivors and income is limited (e.g., a family farm or other family business which produces a limited amount of income when the farm or business is the sole asset of the survivors). The legislative history of '1917 of the Act states that the Secretary should provide for special consideration of cases in which the estate subject to recovery is (1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, (2) a homestead of modest value, or (3) other compelling circumstances. HCFA suggests that you consider the examples listed above in developing your hardship waiver rules, but does not require you to incorporate these examples once you have considered whether they are appropriate for determining the existence of an undue hardship.

In considering your criteria, you may conclude that an undue hardship does not exist if the individual created the hardship by resorting to estate planning methods under which the individual divested assets in order to avoid estate recovery. You may adopt a rebuttable presumption that if the individual obtained estate planning advice from legal counsel and followed this advice, the resulting financial situation would not qualify for an undue hardship waiver.

D. Collection Procedures.--You must adopt procedures under which individuals who will be affected by recovery of amounts of medical assistance will have the right to apply for an undue hardship waiver. These procedures must, at a minimum, provide for advance notice of any proposed recovery. They must also specify the method for applying for a waiver, the hearing and appeal rights, and the time frames involved. You should specify the procedures used for collection, which must be reasonable. In the situation where recovery is not waived because of undue hardship and heirs of the estate from which recovery is sought wish to satisfy your recovery claim without selling a non-liquid asset subject to recovery, you may establish a reasonable payment schedule subject to reasonable interest. You may also undertake partial recovery to avoid an undue hardship situation.

E. Adjustment or Recovery Not Cost Effective.--You may waive adjustment or recovery in cases in which it is not cost effective for you to recover from an individual's estate. The individual does not need to assert undue hardship. You may determine that an undue hardship exists when it would not be cost effective to recover the assistance paid. You may adopt your own reasonable definition of cost effective. However, any methodology you use for determining cost-effectiveness must be included in your State plan. If you made individuals eligible for Medicaid because of a long term care insurance policy or disregard of income because of the purchase of long term care insurance, you are restricted from using this waiver authority unless you had as of May 14, 1993, an approved State plan which provided for long term care insurance-related disregards from income. In that event, you can use the undue hardship exception as a basis for applying a cost effectiveness test to individuals who became eligible based upon long term care insurance-related disregards.

F. Placement of TEFRA Liens.--You are not required to use TEFRA liens in '1917(a) of the Act. Section 13612 of OBRA 1993 did not mandate the use of TEFRA liens. The TEFRA liens allow you to place liens on certain types of property and recover specific types of payments as described in subsections F.1 and F.2. You may use liens as a mechanism/tool to recover medical assistance incorrectly paid as indicated in F.1. or correctly paid on behalf of certain permanently institutionalized individuals, as indicated in subsection F.2.

1. Incorrect Payments.--You may place a lien against an individual's property, both personal and real, before his or her death because of Medicaid claims paid or to be paid on behalf of that individual if a court determines that benefits were incorrectly paid for that individual.

2. Correct Payments.--You may place a TEFRA lien against the real property of an individual at any age before his or her death because of Medicaid claims paid or to be paid for that individual when (1) he/she is an inpatient of a medical institution and must, as a condition of receiving services in the institution under your State plan, apply his/her income to the cost of care (as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832), and (2) the agency determines that the person cannot reasonably be expected to return home as specified in '3810.A.1. The State's authority to place a lien after the individual's death is not restricted by the TEFRA lien provisions.

G. Restriction on Placement of TEFRA Liens.--You may not place a TEFRA lien, as indicated in subsection F.2, on an individual's home if any of the following individuals are lawfully residing in the home: (1) the spouse, (2) the individual's child who is under age 21 or blind or disabled, as defined in '1614 of the Act, in States (or blind or permanently and totally disabled in Guam, Puerto Rico, and the Virgin Islands), or (3) the individual's sibling (who has an equity interest in the home and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution).

H. Termination of Liens.--You must dissolve any lien imposed as provided in subsection F.2 on an individual's real property when that individual is discharged from the medical institution and returns home.

I. Notice.--

1. General Notice.--You should provide notice to individuals at the time of application for Medicaid that explains the estate recovery program in your State.

2. Recovery or Adjustment Notice.--You should give a specific notice to individuals affected by the proposed recovery whenever you seek adjustment or recovery. In the case that the individual is dead, the notice should be served on the executor or legally authorized representative of the individual's estate. The executor or legally authorized representative should be required to notify individuals who would be affected by the proposed recovery. In the situation where there is no executor or legally authorized representative, the State should notify the family or the heirs. The notice should include, at a minimum, the action the State intends to take, reason for the action, individual's right to a hearing, method by which he/she may obtain a hearing, procedures for applying for a hardship waiver, and the amount to be recovered. An administrative hearing is not required if State law provides for court review as the next appellate step.

J. Effective Date of New Provision.--Section 13612 of OBRA 1993 does not apply to individuals who died before October 1, 1993. This section applies to Medicaid payments beginning on or after October 1, 1993.

K. Delayed Compliance Date.--If legislation other than for appropriating funds is needed in order to meet these requirements, you may request a delayed compliance date through the HCFA regional office.

L. Effective Date - States With Estate Recovery Programs in Effect Prior to October 1, 1993.--If you had an estate recovery program approved under your State plan and in operation prior to October 1, 1993, for individuals of any age who are determined permanently institutionalized prior to October 1, 1993, you may recover from the estate or upon sale of the property subject to a lien for all services correctly paid before October 1, 1993. You may also recover for services paid for before October 1, 1993, from the estate of an individual age 65 or older when that person received medical assistance. Recovery for these services is in accord with the features of your approved plan in effect prior to October 1, 1993.

3812 TREATMENT OF CONTRIBUTIONS FROM RELATIVES TO MEDICAID APPLICANTS OR RECIPIENTS

Section 1902(a)(17) of the Social Security Act (the Act) provides that a State plan must include reasonable standards for determining Medicaid eligibility that do not take into account the financial responsibility of any individual for any applicant or recipient of Medicaid unless the applicant or recipient is the individual's spouse, or child under age 21, or a child over age 21 who is blind or disabled. Under Medicaid regulations (42 CFR 435.602 and 436.602), States may consider only the income and resources of spouses as available to each other; and income and resources of parents as available to children under age 21, or children over 21 if they are blind or disabled. The income and resources of any other relative are not considered available to the individual. While the regulations do not deal with contributions actually made by relatives, any voluntary contributions actually made by relatives or friends are to be taken into account by the State in determining Medicaid eligibility. It should be noted, however, that this policy is not related to, nor does it affect, rules on deeming of income for purposes of determining eligibility.

The law and regulations permit States to require adult family members to support adult relatives without violating the Medicaid statute by the use of a statute of general applicability. Such contribution requirements are permissible as a State option. There are two legally supportable interpretations of section 1902(a)(17)(D) of the Act upon which to base this policy. First, if support is required under a State statute of general applicability, and not under a State plan requirement applicable only to Medicaid recipients, the statute would not violate the requirements of 1902(a)(17)(D) of the Act that a State plan cannot take into account the financial responsibility of relatives other than parents or spouses. Second, section 1902(a)(17)(D) of the Act can be interpreted as prohibiting only the "deeming" of income (that is, the assumption that income is available to the Medicaid applicant or recipient whether or not it is actually received), except in limited specified circumstances. Thus, a policy which would permit States to consider only income actually received even though relative contributions are required by a general support statute, would not be in violation of section 1902(a)(17)(D). Furthermore, such a policy is consistent with section 1902(a)(17)(B), which provides for taking into account only such income and resources as are actually available.

Required contributions must be imposed under a State statute of general applicability, and cannot be imposed just as a State plan provision. This means that the law cannot limit provisions requiring contributions from relatives. The State may not assume that these funds are available, nor may a State reduce its payments to Medicaid providers in anticipation of the receipt of a relative's payment. Within these guidelines, the State may determine who is a relative, how much relatives must contribute under the statute of general applicability, and the methods of enforcement. Amounts actually received by an applicant or recipient as a result of a State support statute of general applicability that requires the contribution must be counted as income in determining Medicaid eligibility.

It should be noted that third party liability regulations at 42 CFR 433, subpart D, do not apply to collections pursuant to a statute of general applicability. Third party liability is expressly limited by 42 CFR 435.602 and 436.602 to spouses and parents, as noted above.

42 U.S. Code § 1396p - Liens, adjustments and recoveries, and transfers of assets

U.S. Code Notes

(a) IMPOSITION OF LIEN AGAINST PROPERTY OF AN INDIVIDUAL ON ACCOUNT OF MEDICAL ASSISTANCE RENDERED TO HIM UNDER A STATE PLAN

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be

expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) ADJUSTMENT OR RECOVERY OF MEDICAL ASSISTANCE CORRECTLY PAID UNDER A STATE PLAN

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older

when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)

(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (I) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance

or Social Security Number should be on the payment. The check and/or money order are receipts of payment. Financial Management will post all payments.

If no referral has been made prior to the repayment, an eligibility worker must complete the referral screen BVBR immediately so the claim can be established and repayments can be accepted.

4650.00.00 CLAIMS AGAINST THE ESTATE

Under the provisions of the Social Security Act (42 USC 1396p) the state is required to recover certain Medicaid benefits correctly paid on behalf of an individual from the individual's estate.[3]

The circumstances under which a recovery claim must be filed are explained in this and the following sections.

Upon the death of a Medicaid recipient, the total amount paid for medical coverage, except as explained in Section 4650.05 and Section 4650.20.10, is allowed as a preferred claim against the estate of such person in favor of the state. All assets owned by the deceased individual at the time of death, including both real and personal property, become a part of the estate, even if no probate proceedings are initiated in court. The estate does not include property held jointly with rights of survivorship, property held in trust, or life insurance proceeds paid to the deceased's survivors or other beneficiaries.

The claim provision is applicable to all categories of MA, including the categories providing limited coverage, except for SLMB (MA J) and QI (MA I and MA K). This exception applies to recipients who die on and after May 1, 1999 and is applicable to the state's payment of the Medicare premiums. Amounts paid for Medicare premiums under any MA Category will not be recovered from the recipient's estate. For recipients whose death occurred before October 1, 1993, the claim includes benefits paid for services provided after the recipient became 65 years of age. For recipients whose death occurs after October 1, 1993, the claim includes benefits paid for services provided

1) After the recipient became age 55 if the services were provided after October 1, 1993, and

2) After the recipient became age 65, if the services were provided before October 1, 1993.

In addition, a claim against the estate can be filed for the amount of Medicaid benefits "incorrectly paid" on behalf of

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[3] IC 12-15-9-1; Social Security Act, Section 1917(b)(1)

a recipient regardless of age.[4]

It is not required that there be a previous court judgment as to the amount of Medicaid benefits incorrectly paid. However, the existence of such a court judgment would expedite the probate proceedings when the claim against the estate is filed.

4650.05.00 NON-ENFORCEMENT OF CLAIM

If a spouse survives the recipient, recovery shall be made after the death of the surviving spouse. Only those assets that were included in the recipient's probate estate are subject to recovery after the surviving spouse's death.[5]

If the recipient (or the recipient's spouse upon his or her death) is survived by a dependent child, no recovery shall be made while the child is under age twenty-one (21) or is a dependent who is non-supporting due to blindness or disability by SSI standards.[6]

In addition a claim may not be enforced against the personal effects, ornaments, or keepsakes of the deceased.[7]

Resources that are protected under the Indiana Long Term Care Program (ILTCP) are not subject to recovery from the recipient's estate. Refer to Section 2615.25.15 concerning the ILTCP.[8] A claim may be waived if it is not cost effective to pursue the claim. If the cost of collection is equal to or exceeds the amount that can be collected, then it is not cost-effective to pursue the claim.

4650.10.00 FILING THE CLAIM

Estate administration may be accomplished using one of the following three procedures: supervised administration (the normal procedure), unsupervised administration, or by a "no administration" procedure. The process for filing claims depends on the type of estate administration procedures used.

When estates are administered under the supervised and unsupervised administration procedures, the probate court first appoints a personal representative to administer the estate. The personal representative then "opens" the estate. Once an estate is opened for probate, a notice to

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[4] IC 12-15-2-19

[5] IC 12-15-9-5

[6] IC 12-15-9-2

[7] IC 12-15-9-2

[8] 405 IAC 2-8-1(e)(2)

creditors is published in the legal notices of a local newspaper of general circulation. After published notification, there is a five-month period during which creditors of the deceased individual may submit claims against the estate. While the five-month time limit does not apply to governmental entities, it is important for the DFR to submit claims as soon as possible. The DFR should file the claim within five-months whenever possible.

A systematic and regular review of the legal notices and the probate docket of the county probate court are to be made by the DFR to ascertain whether or not an estate has been opened for any deceased MA recipients. As soon as the DFR learns that an estate has been opened, the DFR should initiate the process for filing a claim with the probate court.

Estates with a gross value under $50,000 and meeting certain other legally established conditions, may be settled using the "no administration" procedure. In these cases, there are no probate court proceedings, and a claim by small estate affidavit may be used to claim assets.

A claim by small estate affidavit cannot be made until forty-five (45) days have elapsed since the death of the decedent. The affidavit must be made by or on behalf of the DFR and state the following: 1)the value of the gross probate estate wherever located (less liens and encumbrances) does not exceed fifty thousand dollars ($50,000); 2) forty-five (45) days have elapsed since the death of the decedent 3)no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and 4) the claimant is entitled to payment or delivery of the property.[9]

When preparing a claim, the DFR is to request from the Office of Medicaid Policy and Planning (OMPP), via State Form 6533, Medicaid Expenditures Request, and the total amount of Medicaid expenditures paid on behalf of the individual. The address is: OMPP, ATTN: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204. The claim against the estate should be filed with the Clerk of the Probate Court as soon as possible. (However, when a small estate claim affidavit is used, it is presented to whoever is holding assets of the deceased, and is not filed with the Clerk of Probate Court). The form on which the claim is filed may be obtained from the

4650.10.05 Recovery from Special Needs Trusts

Funds remaining in a "special needs trust", as defined in Section 2615.75.20.05, are to be recovered after the recipient's death.

[9] IC 29-1-8-1

These claims will not require the preparation of an affidavit or filing with the probate court. Because the terms of the trust require the trustee to pay any remaining funds to the state up to the amount of Medicaid expenditures, the state's claim is to be presented to the trustee for payment. This is accomplished by letter to the trustee signed by the local DFR office manager with documentation of expenditures attached. The claim includes all Medicaid expenditures on behalf of the deceased, regardless of age.

4650.15.00 OPENING AN ESTATE

If an estate is not opened and the heirs have no intention of doing so, any interested party (such as a creditor) may petition the court to open an estate and to request the appointment of an administrator. Prior to petitioning the court, these cases should be evaluated by the DFR in conjunction with an FSSA attorney, to determine if there are sufficient assets in the estate to offset the cost of opening and administering the estate. If not, opening an estate should not be initiated.

Cases in which there are sufficient assets should be referred to the FSSA attorney to prepare and file with the court, a petition to open an estate and appoint an administrator.

4650.20.00 PRIORITY OF THE CLAIM

Payment of debts from resources in the estate of the decedent is made in accordance with legally-established priorities. Priority in the payment of claims is important whenever the estate of the deceased is insolvent (such as when the total amount of all claims against the estate exceeds the assets of the estate). If the amount of the DFR claim is not satisfied in full after distribution of the estate assets, such debt must be considered cancelled.

The FSSA attorney should be consulted regarding the order of priority of the DFR claim in relation to that of other claimants.

4650.20.05 Compromise Of Claims

IC 4-6-2-11 provides "No claim in favor of the state shall be compromised without the written approval of the governor and the attorney general, and such officers are hereby empowered to make such compromise when in their judgment, it is the interest of the state so to do."

This applies to situations where the State agrees to accept less than the amount that is available and to which it is legally entitled. If the estate is insolvent and the State will receive the entire balance of the estate after payment of claims that have higher priority, that is not a

compromise and it does not require the approval of the governor and attorney general.

The settlement must be in the State's best interest. In most cases for which a compromise is approved, there is some reason that the claim would be risky to pursue. Some examples are when 1) another claim arguably has priority such as expenses of last illness, 2) there is a dispute as to the amount of the claim, or 3) the asset is a land contract or other asset that is not easily liquidated and the State agrees to accept cash in a lesser amount.

Procedure for Approval

The DFR or the FSSA attorney should submit to the Office of Medicaid Policy and Planning (OMPP), attn: Estate Recovery Specialist, in writing, the following information: 1) the amount of the claim, 2) available assets in the estate, 3) the proposed settlement, and 4) the reason for settlement, and 5) why it is in the best interest of the state to accept the settlement. OMPP will forward the information to the collection section of the attorney general's office for final action.

4650.20.10 Waiving Estate Claims For Undue Hardship

The Medicaid program's claim against the estate of a deceased recipient must be waived if enforcement of the claim would result in undue hardship for an heir.[10]

The decision to approve or deny an application for a waiver of the estate recovery claim will be made by the Office of Medicaid Policy and Planning based on information provided by DFR staff and the FSSA attorney in accordance with the following procedures.

1. At the time a claim is filed, a notice is to be included with the claim, explaining the undue hardship provisions and the process for applying for a waiver of the state's claim. An application (State Form 48259/OMPP 003) is to be provided upon request to an heir who wishes to apply for a waiver.

2. The hardship applicant will complete the form and return it, along with supporting documentation, to the attorney or designated local DFR office staff person. The applicant must indicate one of four situations as the basis for his claim:

    a. Enforcement of the state's claim will cause the applicant to become eligible for public assistance;

[10] IC 12-15-9-6; 405 IAC 2-8-2

b. Enforcement of the state's claim will cause the applicant to remain dependent on public assistance;
c. Enforcement of the state's claim will result in the complete loss of the applicant's sole source of income and the beneficiary's income does not exceed the Federal Poverty Level (FPL);
d. Other compelling circumstance (the applicant must describe).

3. If the applicant indicates only the last category, other compelling circumstances, the application is to be immediately forwarded to the Office of Medicaid Policy & Planning, attn: Estate Recovery Specialist, Indiana Government Center South, 402 West Washington St., Indianapolis, IN 46204. If any of the other three situations are checked by the applicant, the local DFR office must make the appropriate determination, attach all documentation to the application and forward it to the OMPP.

4. If the applicant specifies hardship category 2a or 2b, the DFR must determine if the hardship applicant would be eligible for TANF, Medicaid, Food Stamps, or SSI if he/she loses access to the asset(s) in the deceased recipient's estate. The caseworker's determination must show the eligibility result as if the applicant owned the asset and as if he did not own it. For example:

> A recipient and his non-disabled son live together on a farm. The son works on the farm and his father shares the farm income with him. The property is in the recipient's name only and when he dies the property becomes subject to estate recovery. The son, who is beneficiary of the estate, applies for a hardship waiver claiming that without the income from the property, he will become eligible for Food Stamps. The DFR must make a Food Stamp eligibility determination. (The son does not need to actually file a Food Stamp application.) The caseworker determines that if the applicant were to own the farm, he would not be eligible for Food stamps due to the income he would have from the farm. Without the farm and its income, he meets Food Stamp eligibility requirements. Therefore, if the state enforces its claim against the estate, the son would become eligible for assistance.

In the above example, assume that father and son do not live together. The son is employed and he and his family receive Food Stamps. When his father dies, he files a hardship application claiming that if he could be allowed to inherit the farm he would no longer need Food Stamps. The

caseworker's determination shows that if he owned the farm he would lose Food Stamp eligibility.

The hardship applicant is responsible for providing all necessary verifications. Caseworkers should apply the usual verification requirements in a hardship determination, and inform the applicant in writing of the documentation that he must provide to substantiate the hardship claim. The caseworker will need to inform the applicant of the various types of acceptable verification; however, the responsibility for obtaining the verification rests solely with the applicant. The determination must be made within 30 days of receipt of the application and forwarded to the OMPP. If the applicant does not provide necessary verification within 30 days, the caseworker must indicate such in a letter accompanying the application to the OMPP. The letter should specify the verifications that the applicant failed to submit and a copy of the caseworker's notification to the applicant concerning the need for verifications should be included.

5. If a hardship applicant claims that his only source of income comes from the property in the estate, the caseworker must determine whether or not that income is less than the FPL. The standards effective 2/24/98 are as follows:

Family Unit	Annual Standard
1	$ 8,050
2	10,850
3	13,650
4	16,450
5	19,250
6	22,050
7	24,850
8	27,650
Each additional, add	2,800

For this determination, "family unit" is defined as a group of persons related by birth, marriage, or adoption who live together. In determining the amount of income to compare to the standard, the caseworker will consider: 1) gross income from employment, 2) all unearned income, and 3) net self-employment income and rental income in accordance with the methodologies used for the aged, blind, and disabled Medicaid categories. The applicant is responsible for providing the necessary verifications.

6. The Office of Medicaid Policy and Planning will make a decision to approve or deny the application and will issue a Notice of Action, State Form 48260/OMPP 0004, to the applicant within 45 days of the application date. A copy of the notice will be sent to the FSSA attorney. An applicant has the right to appeal the decision.

405 Ind. Admin. Code 2-8-1

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Current through July 15, 2020

Section 405 IAC 2-8-1 - Claims against estate for benefits paid

Next Section
Section 405 IAC 2-8-1.1 - Claims against estate; exemption

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-9; IC 12-15-39.6-10

Sec. 1.

(a) Upon the death of a Medicaid recipient fifty-five (55) years of age or older, the office of Medicaid policy and planning (office) shall seek recovery from the recipient's estate for medical assistance paid on behalf of the recipient after the recipient became fifty-five (55) years of age or

older. Recovery shall be made for benefits provided prior to October 1, 1993, only if the recipient was sixty-five (65) years of age or older at the time the benefits were provided.

(b) As used in this section, "estate", with respect to a deceased recipient, shall include all of the following:

(1) All real and personal property and other assets included within the recipient's estate as defined for purposes of state probate law.

(2) Any interest in real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship, if the joint tenancy was created after June 30, 2002.

(3) Any real or personal property conveyed through a nonprobate transfer. As used in this section, "nonprobate transfer" means a valid transfer, effective at death, by a transferor who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and:

(A) use the property for the benefit of the transferor; or

(B) apply the property to discharge claims against the transferor's probate estate.

The term does not include a transfer of a survivorship interest in a tenancy by the

entireties real estate or payment of the death proceeds of a life insurance policy.

(c) If the recipient is survived by a spouse, recovery shall be made after the death of the surviving spouse. Only those assets that are included in the recipient's estate as defined in subsection (b) are subject to recovery.

(d) If the recipient is survived by a child, no recovery shall be made while the child is either:

(1) under twenty-one (21) years of age; or

(2) blind or disabled as defined in 42 U.S.C. 1382c.

(e) A claim may not be enforced against the following assets:

(1) Personal effects, ornaments, or keepsakes of the deceased.

(2) Assets of an individual who purchases a long term care insurance policy that are disregarded pursuant to IC 12-15-39.6-10.

(3) Nonprobate assets that were determined exempt or unavailable for purposes of the decedent's Medicaid eligibility prior to May 1, 2002.

(4) Assets that the decedent transferred through a nonprobate transfer prior to May 1, 2002.

(f) The office may waive the application of this section in cases of undue hardship pursuant to section 2 of this rule.

405 IAC 2-8-1

Office ofthe Secretary of Family and Social Services; 405 IAC 2-8-1; filed May 1, 1995, 10:45 a.m.: 18 IR 2226; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1563; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:55 a.m.: 26 IR 731; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA
Readopted filed 11/13/2019, 11:54 a.m.: 20191211-IR-405190487RFA

405 Ind. Admin. Code 2-8-1.1

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Section 405 IAC 2-8-1.1 - Claims against estate; exemption

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1.1.

(a) This section applies only to real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship.
(b) The office may enforce its claim against property described in subsection (a) only to the

Previous Section
Section 405 IAC 2-8-1 - Claims against estate for benefits paid

Next Section
Section 405 IAC 2-8-2 - Undue hardship due to Medicaid estate recovery

extent that the value of the recipient's combined total interest in all real property described in subsection (a) subject to the claim exceeds seventy-five thousand dollars ($75,000).
(c) This section expires January 1, 2008.

405 IAC 2-8-1.1

Office ofthe Secretary of Family and Social Services; 405 IAC 2-8-1.1; filed Oct 10, 2002, 10:55 a.m.: 26 IR 732; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984; readopted filed Sep 19, 2007, 12:16p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA Readopted filed 11/13/2019, 11:54 a.m.: 20191211-IR-405190487RFA

405 Ind. Admin. Code 2-8-2

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Current through July 15, 2020

Section 405 IAC 2-8-2 - Undue hardship due to Medicaid estate recovery

Previous Section
Section 405 IAC 2-8-1.1 - Claims against estate; exemption

Authority: IC 12-13-5-3; IC 12-15-1-10; IC 12-15-9-6

Affected: IC 12-15-9; IC 29-1-14-9

Sec. 2.

(a) The office may waive the enforcement of the state's claim, in whole or in part, if enforcement of the state's claim will result in substantial and undue hardship for the surviving beneficiaries of the decedent's estate. The state's claim is

suspended as long as the undue hardship condition continues to exist. This rule is not applicable to undue hardships encountered by Medicaid applicants due to:

(1) the imposition of transfer of property penalties; or

(2) rules related to the availability of trusts.

(b) For purposes of this section, undue hardship exists only if enforcement of the state's claim would result in one (1) or more of the following conditions:

(1) Causing a beneficiary of the decedent's estate to become eligible for public assistance. As used in this section, "public assistance" means

(A) Aid to Families with Dependent Children;

(B) Medicaid;

(C) food stamps; or

(D) Supplemental Security Income.

(2) Causing a beneficiary of the decedent's estate who is currently eligible for public assistance to remain dependent on that public assistance.

(3) The complete loss of an income-producing asset or assets when the:

(A) beneficiary of the decedent's estate has no other source of income; and

(B) beneficiary's income does not exceed one hundred percent (100%) of the poverty level as determined annually by the U.S. Department of Health and Human Services.

(4) Other compelling circumstances as determined on a case-by-case basis by the office.
Undue hardship does not exist in circumstances where the state's recovery simply results in a loss of a preexisting standard of living.

(c) To be eligible for consideration for an undue hardship waiver, the beneficiary of the decedent's estate must, with the exception noted in this subsection, be a member of the immediate family of either the deceased recipient or the deceased recipient's spouse. For purposes of this section, "immediate family" means a:

(1) spouse;

(2) child;

(3) grandchild;

(4) great-grandchild;

(5) parent;

(6) grandparent;

(7) brother; or

(8) sister.

In exceptional circumstances, if good cause is shown, a person other than an immediate family member may be eligible for consideration for an undue hardship waiver.

(d) The office shall notify the executor or personal representative of the deceased Medicaid recipient's estate of the state's claim against the estate and the affected beneficiary's right to apply for an undue hardship waiver. Application for an undue hardship waiver shall:

(1) be submitted to the office on such forms as may be designated by the secretary;

(2) include:

(A) the name of the deceased recipient;

(B) the name of the person filing the application;

(C) the relationship of the applicant to the deceased;

(D) an explanation of the basis for requesting an undue hardship waiver;

(E) documentation of the existence of one (1)

or more of the conditions described in subsection (b);

(F) other information as may be deemed necessary by the secretary; and

(G) a statement attesting to the accuracy of the information contained in the application;

(3) be signed by the applicant; and

(4) be filed with the office within ninety (90) calendar days of the date that the executor or personal representative of the deceased's estate receives notification of the state's claim.

(e) The office shall review and rule on an application for a waiver of the state's claim within forty-five (45) calendar days of the receipt of a properly completed waiver application.

(f) If the office determines that an undue hardship does not exist, the office shall:

(1) notify the applicant of its decision in writing; and

(2) inform the applicant of his or her right to request an administrative hearing and the procedures for filing an appeal.

An appeal and request for hearing must be filed within thirty (30) days of receipt of the office's decision that an undue hardship waiver has been denied.

(g) The office may not grant an undue hardship waiver if the granting of the waiver will result in the payment of claims to other creditors with a lower priority standing in accordance with IC 29-1-14-9.

(h) The office may deny an undue hardship waiver if the granting of the waiver will not result in the abatement of the undue hardship.

405 IAC 2-8-2

Office ofthe Secretary of Family and Social Services; 405 IAC 2-8-2; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1564; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR- 405130241RFA

Readopted filed 11/13/2019, 11:54 a.m.: 20191211-IR-405190487RFA

410 Ind. Admin. Code 16.2-3.1-6

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Current through July 15, 2020

Section 410 IAC 16.2-3.1-6 - Protection of resident funds

Previous Section
Section 410 IAC 16.2-3.1-5 - Notification of changes

Next Section
Section 410 IAC 16.2-3.1-7 - Grievances

Authority: IC 16-28-1-7

Affected: IC 16-28-5-1

Sec. 6.

(a) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(b) Upon written authorization of the resident, the facility must hold, safeguard, manage, and

account for personal funds of the resident deposited with the facility.

(c) Unless otherwise required by federal law, the facility must deposit any residents' personal funds in excess of fifty dollars ($50) in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to his or her account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(d) The facility must maintain residents' personal funds that do not exceed fifty dollars ($50) in a noninterest bearing account, interest bearing, or petty cash fund.

(e) The facility must establish and maintain a system that assures a full, complete, and separate accounting according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(f) The facility must:

(1) provide reasonable access during normal business hours to the funds in the account;

(2) return to the resident in not later than fifteen (15) calendar days, upon written request,

all or any part of the resident's funds given to the facility for safekeeping; and

(3) provide reasonable access during normal business hours, to the written records of all financial transactions involving the individual resident's funds upon request.

(g) The individual financial record must be provided to the resident or his or her legal representative upon request of the resident and through quarterly statements.

(h) Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within thirty (30) days the resident's funds, and a final accounting of those funds, to the individual or the probate jurisdiction administering the resident's estate.

(i) The facility must purchase surety bond insurance, or otherwise provide assurance satisfactory to the state survey agency, to assure the security of all personal funds of residents deposited with the facility.

(j) The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

(k) For purposes of IC 16-28-5-1, a breach of:

(1) subsection (a), (b), (c), (d), (e), (f), (g), (h), or (j) is a noncompliance; and

(2) subsection (i) is a nonconformance.

410 IAC 16.2-3.1-6

Indiana State Department of Health; 410 IAC 16.2-3.1-6; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1531, eff Apr 1, 1997; errata filed Apr 10, 1997, 12:15 p.m.: 20 IR 2414; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA; readopted filed Sep 11, 2013, 3:19 p.m.: 20131009-IR-410130346RFA Readopted filed 11/13/2019, 3:14 p.m.: 20191211-IR-410190391RFA

PROVIDER BULLETIN

BT200726 OCTOBER 4, 2007

To: All Long Term Care Providers

Subject: Patient Trust Accounts

Overview

Indiana Department of Health regulation [410 IAC 16.2-3.1-6(h)] requires that nursing facilities convey, within thirty days of a resident's death, the resident's personal funds deposited with the facility, and a final accounting of those funds, to persons administering the resident's estate.

The Office of Medicaid Policy and Planning (OMPP) is a creditor of the estate of a person who received Medicaid benefits after he or she turned fifty-five years old pursuant to 42 USC 1396p and I.C. 12-15-9. Medicaid has a priority claim to repayment, and the nursing facility should send to OMPP residents' personal accounts pursuant to the standards reported in this bulletin.

Determining Whether Funds Should be Sent to the State

At the death of a resident, OMPP should receive the resident's account fund if:

- The resident was at least fifty-five years old
- The resident was a Medicaid recipient
- The resident is not survived by a spouse
- The resident is not survived by a dependant child under twenty-one years old
- The resident is not survived by a dependant child who is blind or disabled
- The resident had a pre-paid funeral arrangement, and
- No estate has been or will be opened in probate court.

Information Facilities Should Send when Remitting Resident Account Funds

When sending funds to OMPP, include the following information:

- Name of the resident
- Resident's Medicaid recipient identification number (RID #) or case number
- Resident's date of death
- Amount of funds remitted for each resident (if more than one)
- Reason the funds are being returned to Medicaid
- Name of the facility where the recipient resided

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

- Name and telephone number of a facility contact person.

Remittances should be made payable to "Treasurer, State of Indiana" and mailed to the following address:

FSSA Claims Repayment
P.O. Box 1007
Indianapolis, IN 46262-1007

Contact Information

Questions can be directed to Michael Staresnick by email at Mike.Staresnick@fssa.in.gov or by telephone at (317)232-2121or toll free at (877) 267-0013.

If you need additional copies of this bulletin, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

Opinion No. 2 of 2003

Editor's Note: The opinions of the Legal Ethics Committee of the Indiana State Bar Association are issued solely for the education of those requesting opinions and the general public. The Committee's opinions are based solely upon hypothetical facts related to the Committee. The opinions are advisory only. The opinions have no force of law.

The Legal Ethics Committee of the Indiana State Bar Association ("Committee") has been requested to provide an advisory opinion with respect to issues raised by the following hypothetical facts:

Facts

Mother is an 80-year-old widow who has resided in a nursing home since shortly after the death of her husband eight years ago. She became eligible for Medicaid after spending down her assets, which happened two years ago. Since that time, Medicaid has provided about $25,000 in benefits to her. Mother's brother just passed away, though, and she inherited $110,000 from his estate, rendering her ineligible for further Medicaid until her assets are again spent down. She opened two bank accounts with her inheritance, one which she owned individually and a savings account which she opened with her son, an adult and her only child, as joint tenants with right of survivorship. Each account began with $55,000. One year later, Mother died. At that time, the individually owned account balance was $40,000, and the joint account, which had remained untouched, had grown to $58,000. Mother had no other property.

Son, as Mother's sole heir, retained Lawyer to open an intestate estate with Son as personal representative. Lawyer did so and arranged to have notice of administration published in the newspaper, also asking Son to give him a list of Mother's creditors so he could arrange for notice by mail to them. Son made the list, and Lawyer had the clerk send notice to all of the creditors on the list.

Lawyer further helped Son fill out an Application for Consent to Transfer for the joint account, and submitted the application to the assessor's office. The assessor, noting that the property transfers to Son would not exceed his $100,000 inheritance tax exemption, consented to the transfer of the joint account to Son.

Since Son had helped Mother with her finances following the death of her husband, he knew that Mother had been on Medicaid prior to receiving the inheritance. Lawyer, on the other hand, had no actual notice that Mother had ever been on Medicaid. Under Scenario 1, Son inadvertently left off the list of Mother's creditors given to Lawyer the Office of Family & Children ("OFC"), the state agency responsible for Medicaid. Under Scenario 2, Son knew OFC should be on the list, but deliberately left it off, knowing his inheritance from the estate would be larger if OFC did not get notice and file a claim. Under Scenario 3, Son told Lawyer that OFC was a creditor, but instructed Lawyer not to give OFC notice. Under Scenario 4, Son instructed Lawyer not to give OFC notice, and Lawyer thereafter terminated his representation of Son. Under Scenario 5, Mother lived long enough that there was only $20,000 left in her individually titled bank account at the time of her death; in effect, Mother left only a small estate capable of being transferred without opening an estate administration through the court. Assume for Scenario 5 that Son tells Lawyer that Mother at one time received Medicaid.

Issues

May or must Lawyer give notice to OFC that Mother is deceased or that an estate has been opened for Mother? May or must Lawyer inform a tribunal that OFC is a creditor or that Son has failed to give OFC proper notice?

Applicable statutes, regulations

I.C. 6-4.1-8-8 provides that without a consent to transfer, property held jointly may not be transferred to the survivor, except where the survivor is a spouse or the property is a joint checking account.

145 IAC 4.1-8-3 provides that except for transfers to a spouse or transfers of a checking account, a consent to transfer must be obtained before property held jointly by a resident decedent and another may be transferred to the survivor, and further provides that to ensure that the transfer will not jeopardize the collection of inheritance tax, the consent shall not exceed 80 percent of the property until the inheritance tax is paid.

I.C. 12-15-9-1 provides that upon the death of a Medicaid recipient, the amount of Medicaid paid after the recipient became age 55 must be allowed as a preferred claim in the recipient's estate, that the affidavit of a person designated by the Indiana Secretary of Human Services is evidence of the amount of the claim, and that the claim is payable in accordance with I.C. 29-1-14-9 after funeral expenses for the recipient and the recipient's spouse, expenses of last illness of the recipient and the recipient's spouse, and the expenses of administration of the estate, including attorney fees.

I.C. 29-1-7-7 provides in pertinent part that notice of the issuance of letters upon the opening of an estate shall be published, that notice shall be served by mail on all heirs, devisees and known creditors, and that the personal representative shall serve notice on creditors who are known or reasonably ascertainable within one month of first publication or as soon as possible after one month. It further provides that if the personal representative fails to give notice to a known or reasonably ascertainable creditor within the one month period, the creditor may submit a claim within an additional two months after the date notice is given, though a claim will be barred if not filed within nine months of death.

I.C. 29-1-8-1 provides in pertinent part that a small estate affidavit may be used to claim property of a decedent without a court order or proceeding where the property consists of personal property not exceeding $25,000.

I.C. 29-1-14-1 provides in pertinent part that except as provided in I.C. 29-1-7-7, claims against a decedent's estate, other than claims for costs of administration and claims of the United States or the state or any subdivision are forever barred unless filed within three months of the date of first published notice, and further provides that all claims barrable after the three-month time-bar are forever barred if not filed within nine months after death.

I.C. 29-1-14-9 provides that claims shall be classified and paid in the following order: 1) costs of administration; 2) funeral expenses; 3) survivor's allowance under I.C. 29-1-4-1; 4) debts and taxes of the United States; 5) medical expenses of the last illness; 6) debts and taxes of the state of Indiana; and 7) all other claims.

I.C. 32-4-1.5-7 provides that multi-party accounts are liable for claims, taxes and expenses of administration

including survivor's allowance if estate assets are insufficient; provides that a written demand to assert the liability must be made upon a personal representative; and provides that sums recovered by the personal representative under the statute shall be administered as a part of the decedent's estate.

Applicable Rules of Professional Conduct

R.P.C. Rule 1.2 provides in pertinent part that a lawyer shall abide by a client's decision concerning the objectives of representation, although a lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent. Further, when a lawyer knows the client expects assistance not permitted to the lawyer, the lawyer shall consult with the client regarding the limitations on the lawyer's conduct.

R.P.C. Rule 1.6 provides in pertinent part that a lawyer shall not reveal information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation, though a lawyer may reveal such information to the extent the lawyer reasonably believes necessary to prevent the client from committing any criminal act.

R.P.C. Rule 1.9 provides in pertinent part that a lawyer who has formerly represented a client in a matter shall not thereafter use information relating to the representation to the disadvantage of the former client except as Rule 1.6 or Rule 3.3 would permit or require or when the information has become generally known.

R.P.C. Rule 1.16 provides in pertinent part that a lawyer shall withdraw from representing a client where the representation will result in a violation of the rules of professional conduct or other law, and that a lawyer may withdraw if it can be accomplished without material adverse effect on the client's interests where the client persists in a course of conduct the lawyer believes is criminal or fraudulent or where the client insists upon pursuing an objective the lawyer considers imprudent.

R.P.C. Rule 3.3 provides in pertinent part that a lawyer shall not knowingly fail to disclose a material fact to a tribunal when disclosure is necessary to avoid a client's criminal or fraudulent act, and further provides that this duty applies even if disclosure is of information otherwise protected by Rule 1.6.

R.P.C. Rule 4.1 provides in pertinent part that a lawyer shall not knowingly fail to disclose that which the law requires to be revealed.

Analysis

Who is the client under all scenarios

Who is the client in an estate administration was addressed in ISBA Legal Ethics Committee Opinion No. 4 of 1997. There, it was concluded that a lawyer represents not "the estate" or interested persons such as creditors, taxing authorities and distributees, but represents instead the personal representative in his fiduciary capacity. Lawyer's ethical obligations to a client runs to Son and not to OFC, though Lawyer has ethical obligations to OFC as a third party, as discussed hereinbelow.

The Comment to Rule 1.2 raises a concern. It states that "[w]here the client is a fiduciary, a lawyer may be charged with special obligations in dealing with a beneficiary." The term beneficiary is not defined in the Rules of Professional Conduct, but *Black's Law Dictionary, Abridged Fifth Edition*, defines "beneficiary" as "one who benefits from act of another," and also mentions the context of a trust, where a beneficiary is "a person who has any present or future interest, vested or contingent . ... Person for whose benefit property is held in trust." With a trust, a trust creditor would not be within the meaning of the term beneficiary, so a lawyer representing a trustee would not owe a trust creditor any Rule 1.2 special obligation. With an estate, the Probate Code speaks in terms not of beneficiaries but of interested persons: "'Interested persons' means heirs, devisees, spouses, creditors, or any others having a property right in or claim against the estate of a decedent being administered. This meaning may vary at different stages and in different parts of a proceeding and must be determined according to the particular purpose and matter involved." (I.C. 29-1-1-3) Although it is potentially problematic that a beneficiary owed the special obligations by a lawyer representing a fiduciary under the R.P.C. might be equivalent to an interested person for Probate Code purposes including a creditor, the distinction does not alter the analysis under any of the scenarios analyzed. It can be assumed arguendo that the R.P.C.'s "beneficiary" and the Probate Code's "interested person" are equivalent for present purposes, though such equivalence is by no means clear.

Consent to transfer under all scenarios

The purpose of the statutes and regulations regarding the Consent to Transfer mechanism is to ensure payment of Indiana Inheritance Tax, which is imposed upon property transfers which take place because of death. While the Multi-Party Account law at I.C. 32-4-1.5-7 provides that resort may be made to multi-party account funds where a decedent's probate estate is insufficient to pay claims, it also provides that written demand to assert the liability must be made upon a personal representative, and that anything recovered by the personal representative from a multi-party account shall be administered as a part of the decedent's estate. A decedent's estate must be opened for a personal representative to be appointed, so the legislature intended for creditor claims of a decedent to be resolved through a probate estate, whether the funds to pay claims come from the probate estate or nonprobate property such as a multi-party account.

There is no duty of notice on the part of an applicant filing an Application for Consent to Transfer apart from the duties imposed upon personal representatives to notify creditors. Since Son has no duty to notify OFC upon filing an Application for Consent to Transfer, Lawyer would not have an obligation under Rule 4.1(b) to make a disclosure required by law. There would also not be a fraud involved in the sense of "[a] false representation of a matter of fact ... which deceives and is intended to deceive another so that he shall act upon it to his legal injury." (*Black's Law Dictionary, supra*) Without a crime or fraud in Son's Application for Consent to Transfer, Lawyer's assistance to Son with the Application does not run afoul of the Rule 1.2(d) proscription from assisting a client in conduct a lawyer knows is criminal or fraudulent. Neither is there any tribunal under Rule 3.3(a)(2) to which Lawyer owes a duty of candor.

Whether Lawyer knows or does not know of Son's plans not to notify OFC is not significant. Where Son has no duty to notify OFC upon his filing an Application for Consent to Transfer, and filing the Application without giving notice is not a fraud, Lawyer does not violate any ethical obligation by failing to notify OFC of the filing or by assisting Son in preparing and filing the Application.

Scenario 1

Pursuant to I.C. 29-1-7-7, Son "shall" serve notice of administration on all known or reasonably ascertainable creditors. Under the facts, OFC is a known creditor, but even if Son were not actually aware the Medicaid benefits were provided to Mother, OFC is likely a reasonably ascertainable creditor, since any investigation of Mother's circumstances would reveal that she received Medicaid benefits for two years. Son thus has a duty to provide actual notice of administration to OFC.

Under I.C. 29-1-7-7, the consequence of failing to provide notice to a known or reasonably ascertainable creditor is that a claim filed more than three months from the date of first publication of notice will not be untimely. An OFC claim for Medicaid, however, is not subject to the three months' bar, as OFC is an agency of the state, not subject to the three month's time-bar pursuant to I.C. 29-1-14-1. OFC's claim would be timely whenever filed, even more than nine months from date of death.

In the event the estate is fully administered and closed without OFC having filed a claim, there are Probate Code provisions which would enable OFC to re-open the estate even after closing (*see, e.g.*, I.C. 29-1-7.5-6, where fraud, misrepresentation or inadequate disclosure related to settlement of an unsupervised estate are alleged, and I.C. 29-1-17-13, where mistake, fraud or willful misconduct are alleged in a supervised estate). Further, there may be remedies against the estate distributees (*see* I.C. 29-1-7.5-5, where undischarged claims not barred may be prosecuted against unsupervised estate distributees). It is also worthy of note that OFC has the same ability to learn of deaths and pending estate administrations as claimants who are not known and not reasonably ascertainable, namely, it can watch for obituaries of persons against whom OFC may have a claim and for published legal notices of the opening of an estate.

While Son clearly has the duty to give OFC actual notice of administration, Lawyer under the facts does not know OFC is a creditor. While Rule 4.1(b) prohibits a lawyer from knowingly failing to disclose that which is required by the law to be revealed, disclosure would only be required where Lawyer knows OFC is a creditor. Lawyer further would not know client's conduct is criminal or fraudulent (if it is), which otherwise would have prevented Lawyer from assisting Son under Rule 1.2(d). In addition, without knowing OFC is a creditor, Lawyer is bound by the Rule 1.6 obligation not to reveal information relating to Son's representation, although giving notice to estate creditors including OFC might be said to have been impliedly authorized under the Probate Code notice provisions. Finally, while a tribunal is involved once an estate is opened, Lawyer's obligation to disclose facts to the tribunal necessary to avoid assisting in any fraud or crime by Son is again dependent on Lawyer's knowledge, which is absent in Scenario 1. Lawyer thus commits no violation of the Rules of Professional Conduct under Scenario 1.

Scenario 2

The analysis of Lawyer's ethical obligations where an estate has been opened is not different from that under Scenario 1. Whether a Rule 4.1(b) duty to disclose that which by law ought to be disclosed, or a Rule 1.2(d) obligation not to counsel Son to engage in or assist Son in the commission of a fraud or crime, or a Rule 3.3(a)(2) obligation to disclose a fact to the tribunal necessary to avoid assisting Son in a crime or fraud, Lawyer's lack of knowledge that OFC is a creditor means that Lawyer commits no violation of the Rules of Professional Conduct when Lawyer represents Son as personal representative in the estate administration. Further, while Lawyer might be justified by Rule 1.6(a) in breaching a client confidence on the grounds that notifying known and reasonably ascertainable creditors is required in an estate administration and thus impliedly authorized in order to represent Son as personal representative, the concept of "information relating to the representation" in Rule 1.6(a)

necessarily implies knowledge of the information; if Lawyer does not know, Lawyer cannot disclose it even if Rule 1.6(a) permits him to disclose it. Under Scenario 2, Lawyer commits no violation of the Rules of Professional Conduct.

Scenario 3

Lawyer's knowledge that Son intends not to notify OFC of Mother's estate changes Lawyer's obligation to OFC and to the tribunal. Son has a clear duty to provide the notice, and Lawyer, while bound by Rule 1.2(a) to abide by Son's decision, is required by Rule 1.2(e) to counsel Son that Lawyer cannot assist in conduct which is criminal or fraudulent.

It may be that Son's conduct in failing to give notice to OFC, while a breach of duty, is not a crime or fraud. Under I.C. 29-1-14-1, the remedy for failure to give a creditor notice is that the creditor's otherwise untimely filed claim will not be untimely. Since OFC is exempt from the filing deadlines altogether, and the constructive notice of publication in a newspaper is adequate for other categories of creditors, OFC is not without some notice, and is not at all without a remedy from the legal consequences of Son's failure to give notice. If Son's conduct is not a crime or fraud, Lawyer may continue to represent Son in the estate administration and honor Son's demand that OFC not receive notice without violating Rule 3.3(a)(2). It should be noted, however, that Lawyer is permitted by Rule 1.16(b)(3) to withdraw from representing Son, conditioned only upon there not being a material adverse effect on Son's interests, if Lawyer finds that Son's disregarding of Lawyer's advice to give OFC notice is imprudent.

If Lawyer continues representing Son, Lawyer must take care that Lawyer does not assist Son in making a false representation to the court that all known or reasonably ascertainable creditors have received notice. A personal representative of an unsupervised estate is required in a closing statement pursuant to I.C. 29-1-7.5-4 to state that he has provided notice to creditors as required under I.C. 29-1-7-7(c) and (d). In a supervised estate, I.C. 29-1-16-5 requires the personal representative in a petition to settle and allow an account to specify to the court the persons to whom distribution is to be made and the amounts to which each is entitled. If Lawyer were to prepare either a closing statement containing a false statement that creditors were given proper notice or a petition to settle and allow by proposing distribution of a net estate to heirs or devisees without honoring OFC's priority under I.C. 29-1-14-9, Lawyer would be knowingly making a false statement of material fact to a tribunal prohibited by Rule 3.3(a)(1). At the point where the personal representative is required to make a statement that creditors have received proper notice, Lawyer cannot assist Son without violating Rule 3.3(a)(1).

Even if Lawyer would be permitted to continue in the representation, Lawyer's knowing assistance to Son in securing a larger inheritance through failing to give OFC notice is fraught with peril, as Son's conduct might be seen by some to constitute fraud or a crime. Under Rule 1.2(d), a lawyer shall not assist a client in engaging in conduct which is criminal or fraudulent. Further, under Rule 1.16(a)(1), a lawyer shall withdraw from a representation where the lawyer will be called upon to violate the Rules of Professional Conduct or some other law. Finally, under Rule 3.3(a)(2), a lawyer shall not knowingly fail to disclose a fact to a tribunal necessary to avoid a client's crime or fraud. Lawyer first must counsel Son that Lawyer cannot assist (Rule 1.2(e)) and give Son the opportunity to provide OFC the notice required by law. If Son insists that OFC not receive notice, and such conduct constitutes a fraud or crime, Lawyer shall withdraw. The withdrawal can be "quiet," not communicating any red flag to the court about the reason for the withdrawal, or "noisy," where Lawyer indicates that his withdrawal is mandated by the Rules of Professional Conduct, allowing the court to infer that there is a

problem with the client's conduct. In either event, Lawyer's withdrawal permits Lawyer to maintain Son's confidentiality but honors Lawyer's duty to the tribunal under Rule 3.3 and to OFC under Rule 4.1, since after withdrawal, Lawyer no longer has those duties. (*See*, however, Scenario 4, where Son is a former client of Lawyer rather than a current client.)

Although Lawyer has a duty not to reveal a client's confidences under Rule 1.6, there are a number of possible bases under which Lawyer would be permitted to reveal to the Court that OFC is a creditor or to OFC that an administration is pending. One of these is found in Rule 1.6(a) itself, where a lawyer is permitted to make disclosures impliedly authorized to carry out the representation. Another is contained in Rule 1.6(b), where a lawyer may reveal information reasonably necessary to prevent a client's criminal act (although it may be that notice to OFC is not reasonably necessary to prevent Son from committing a crime, either because what Son is doing is not a crime or because other circumstances make disclosure not reasonably necessary to prevent a crime). One final basis is the Rule 4.1(b) requirement that in order to be truthful to a non-client, a lawyer must disclose what is required by law to be revealed, here that an estate administration has been opened, which gives rise to a duty under the Probate Code to provide notice to creditors. Lawyer's subverting of Son's instructions and revealing Son's confidential information is problematic. While arguably authorized, it resolves the conflict between Rules 1.6 and 1.2 on the one hand, and making a disclosure required by law on the other, in favor of disregarding the duty of confidentiality and overriding a client's directions as to the objectives of the representation. Such a resolution offers no ethical safe harbor to attorneys who may instead safely choose to quietly withdraw.

Rule 1.6(a) expressly permits a lawyer to make disclosures impliedly authorized to carry out the representation. It could be argued that because the notice provisions of the Probate Code require Son to give notice to known creditors, Lawyer could add OFC's name to the list of creditors to receive notice, Son's direction notwithstanding, because giving OFC notice is impliedly authorized for Lawyer to represent Son in carrying out his duties as personal representative. Lawyer would arguably not be in violation of Rule 1.2 or Rule 1.6 by adding OFC's name to the list. (Lawyer would also be honoring the "special obligation" Lawyer may have to OFC as a possible beneficiary of Lawyer's client Son as a fiduciary under the Comment to Rule 1.2.) Doing so, however, would mean that Lawyer is disclosing something Son expressly told him not to disclose, and Lawyer may well decide that withdrawal is a better option.

Rule 1.6(b)(1) authorizes a lawyer to reveal a client's information which would otherwise be confidential where disclosure is reasonably necessary to prevent the client from committing a criminal act. While it is beyond the scope of this opinion to analyze whether Son's conduct might constitute some crime, for this purpose it will be assumed arguendo that a crime might be implicated. The inquiry then is whether Lawyer's disclosure is reasonably necessary to prevent Son's crime. It may be that the failure to give actual notice to an agency of the state as a creditor is not reasonably necessary, since the remedy for failing to give notice is an extension of time to file a claim, and the state already has no bar to the time within which it must file a claim. If so, Lawyer is required by Rule 1.6 to maintain Son's confidential information and not give OFC notice. If not, Lawyer would be permitted by Rule 1.6(b)(1) to reveal the information, although, as discussed above, many lawyers would choose to withdraw from the representation rather than breach the client's confidence and disregard the client's objective.

Rule 4.1(b) further requires Lawyer to disclose what is required by law to be revealed. Since the notice provisions of the Probate Code require notice be given to known creditors, Lawyer's duty of truthfulness to third parties means that Lawyer shall give OFC notice where Lawyer knows OFC is a creditor. Once Lawyer has terminated

his representation, however, he would no longer have a Rule 4.1(b) duty to disclose.

Although there are rationales for revealing Son's confidential information that OFC is a creditor, many lawyers again would terminate the representation rather than to reveal the confidential information and disregard Son's objectives. Further, while it may be possible for Lawyer to continue to represent Son up to the point where Son will be making a false statement to the court, it might be prudent for Lawyer to terminate the representation at the earliest opportunity rather than to continue the representation, reveal the confidential information, and seek to justify the breach of the confidence.

Scenario 4

Where Son is a former client of Lawyer's, Rule 1.9 is implicated. While Lawyer shall not use information relating to representing Son to Son's disadvantage, Rule 1.9(b) expressly cross-references Rule 1.6 or Rule 3.3. As discussed with Scenario 3, Rule 1.6(b)(1) would permit Lawyer to reveal information he reasonably believed necessary to prevent Son from committing a crime. If Son's conduct does not constitute a crime, Lawyer is bound by Rule 1.6 not to reveal a client's confidential information, and by Rule 1.9 not to reveal a former client's confidential information, so Lawyer may not reveal to OFC that an estate administration has been opened without violating the Rules of Professional Conduct. If Son's conduct is a crime, Lawyer may reveal to OFC that an estate administration has been opened and not be in violation of the Rules of Professional Conduct.

Similarly, Rule 3.3 by the terms of Rule 1.9(b) applies to a former client as it does to a current client. Lawyer would be required to disclose to the court the fact that OFC is an estate creditor if Son's conduct constitutes a fraud or a crime and disclosure is reasonably necessary to prevent a fraud or crime. If Son's conduct is not a fraud or crime, or if disclosure is not necessary to prevent a fraud or crime, Lawyer is bound by Rule 1.6 not to reveal a client's confidential information, and by Rule 1.9 not to reveal a former client's confidential information. Therefore, Lawyer may not inform the tribunal that OFC is a creditor without violating the Rules of Professional Conduct. If, however, Son's conduct is a fraud or crime and Lawyer's revealing to the court that OFC is a creditor is reasonably necessary to prevent Son's fraud or crime, Lawyer is required by Rule 3.3(a)(2) and Rule 1.9 to disclose to the court that OFC is a creditor, and Lawyer commits no Rule 1.6 violation by doing so.

Scenario 5

As is the case with a Consent to Transfer, the law does not require notice to creditors where an estate administration is not opened, so Son breaches no duty by failing to give notice to OFC. Mother's funds are, however, subject to the claims of Mother's creditors, limited to nine months from date of death for non-governmental creditors and not limited in the case of governmental creditors. In the event that OFC some day causes Mother's estate to be opened and files its claim, Son will be required to return the funds from Mother's bank account to the estate.

Whether Lawyer violates the Code of Professional Responsibility in assisting Son with a small estate affidavit turns upon whether not opening an estate administration and not notifying known and reasonably ascertainable creditors such as OFC is a fraud or crime. If so, Rule 1.2(d) prohibits Lawyer from preparing the small estate affidavit, and Rule 1.16(a) would require Lawyer to withdraw from the representation. Rule 3.3 is not implicated, as no tribunal is involved, and Rule 4.1 is not implicated, as no law requires notice to creditors where no estate is

opened. If Son's conduct does not constitute a fraud or crime, Lawyer is not prohibited from assisting Son with the small estate affidavit and commits no violation of the Code of Professional Responsibility by failing to disclose anything to OFC or to a tribunal.

There is no statutory duty to open an estate regardless of the value of a decedent's assets at death. Unless the estate is a small estate, however, such assets will not be able to be transferred. It also follows that where no estate is opened, there is no duty to give notice to potential estate claimants. Absent a duty to open an estate or a duty to notify creditors where no estate is opened, Son commits no fraud or crime by transferring Mother's bank account funds through the use of a small estate affidavit. Son as "person acting on behalf of the distributes" under a small estate affidavit (I.C. 29-1-8-3) would be a fiduciary with duties to persons entitled to a distribution from the estate property, including OFC. If Son having obtained possession of assets fails to make distribution to OFC, Son commits a breach of this fiduciary duty. If, however, Son commits no crime or fraud thereby, Lawyer violates no Rule of Professional Conduct in assisting Son by preparing a small estate affidavit and instructing Son on its use.

SEC.403; P.L.192-1986, SEC.2; P.L.305-1987, SEC.2; P.L.98-2004, SEC.46.

IC 4-6-2-7 Repealed

Formerly: Acts 1889, c.71, s.10. Repealed by P.L.4-1988, SEC.4.

IC 4-6-2-8 Reports

Sec. 8. It shall be the duty of the attorney general to make a biennial report to the governor of the business and condition of the attorney general's office, and to make a report to the auditor of state at the end of each fiscal year of all collections made by the attorney general and the manner of disbursement.

Formerly: Acts 1889, c.71, s.12. As amended by P.L.215-2016, SEC.39.

IC 4-6-2-9 Reports of officers; money collected by attorney general

Sec. 9. (a) It shall be the duty of any officer or person from whom the attorney general, or any of the attorney general's deputies or assistants, shall collect or receive money due the state, to report at once to the auditor of state, on blanks to be furnished by the attorney general, the sum or sums received or collected.

(b) The auditor of state shall keep a record of the reports described in subsection (a).

Formerly: Acts 1889, c.71, s.13. As amended by P.L.215-2016, SEC.40.

IC 4-6-2-10 Law books

Sec. 10. Such law books as the Supreme Court in their judgment shall deem necessary for use in the attorney-general's office shall be purchased and paid for out of any money in the treasury not otherwise appropriated.

Formerly: Acts 1889, c.71, s.14.

IC 4-6-2-11 Compromise of claims

Sec. 11. No claim in favor of the state shall be compromised without the approval of the governor and attorney-general, and such officers are hereby empowered to make such compromise when, in their judgment, it is the interest of the state so to do.

Formerly: Acts 1889, c.71, s.15.

IC 4-6-2-12 Authority of the attorney general to investigate human trafficking

Sec. 12. (a) The attorney general has the same authority as a law enforcement agency (as defined in IC 35-47-15-2) to:

(1) access (as defined in IC 35-43-2-3); and

(2) maintain;

information regarding a violation of IC 35-42-3.5-1 through IC 35-42-3.5-1.4 (human trafficking).

(b) The attorney general may assist with the investigation and prosecution of an alleged violation of IC 35-42-3.5-1 through IC 35-42-3.5-1.4 (human trafficking). However, the attorney general does not have the power to arrest or criminally prosecute individuals for a violation of IC 35-42-3.5-1 through IC 35-42-3.5-1.4.

As added by P.L.162-2014, SEC.1. Amended by P.L.144-2018, SEC.2.

(1) The provision of burial rights if necessary.

(2) The opening and closing of a burial plot and provision of an outer container.

(3) The service required by the cemetery authorities.

(b) If the division determines that the estate of the deceased is sufficient to pay all or part of the cemetery's expenses, the division:

(1) shall pay eight hundred dollars ($800) for expenses that the cemetery has incurred; and

(2) may recover the amount paid by the division under this section as a preferred claim from the estate of the deceased.

[Pre-1992 Revision Citations: 12-1-5-11 part; 12-1-6-11 part; 12-1-7.1-13 part.]

As added by P.L.2-1992, SEC.8. Amended by P.L.273-1999, SEC.88; P.L.9-2006, SEC.2; P.L.205-2013, SEC.187.

IC 12-14-17-3.5 Superior claim

Sec. 3.5. Except for a claim for the costs and expenses of administration, a claim filed under sections 2(c) and 3(b) of this chapter is a superior claim.

As added by P.L.9-2006, SEC.3.

IC 12-14-17-4 Funeral expenses payment; contributions excluded in determining amount

Sec. 4. The division:

(1) may not consider a combined total of one thousand seven hundred fifty dollars ($1,750) that is contributed by:

(A) friends;

(B) relatives; and

(C) the resources of the deceased; and

(2) may consider any amount that exceeds one thousand seven hundred fifty dollars ($1,750) contributed by:

(A) friends;

(B) relatives; and

(C) the resources of the deceased;

when determining the amount to be paid to the funeral director for expenses under this chapter. However, the resources of the deceased may not be used if the deceased has prepaid funeral expenses that were excluded as a resource for Medicaid eligibility under IC 12-15-2.

[Pre-1992 Revision Citations: 12-1-5-11 part; 12-1-6-11 part; 12-1-7.1-13 part.]

As added by P.L.2-1992, SEC.8. Amended by P.L.118-1997, SEC.3; P.L.9-2006, SEC.4.

IC 12-14-17-5 Cemetery expenses payment; contributions excluded in determining amount

Sec. 5. The division:

(1) may not consider a combined total of four hundred dollars ($400) that is contributed by:

(A) friends;

(B) relatives; and

(C) the resources of the deceased; and

(2) may consider any amount that exceeds four hundred dollars ($400) contributed by:

(A) friends;

(B) relatives; and

(C) the resources of the deceased;

when determining the amount to be paid to the cemetery for expenses under this chapter. However, the resources of the deceased may not be used if the deceased has prepaid funeral expenses that were excluded as a resource for Medicaid eligibility under IC 12-15-2.

[Pre-1992 Revision Citations: 12-1-5-11 part; 12-1-6-11 part; 12-1-7.1-13 part.]

As added by P.L.2-1992, SEC.8. Amended by P.L.118-1997, SEC.4; P.L.9-2006, SEC.5.

IC 12-14-17-6 Claims for expenses

Sec. 6. (a) The funeral director and the cemetery representative shall file a sworn claim with the county office indicating expenses incurred due to the death of a recipient.

(b) With respect to supplemental assistance to the blind and persons with disabilities, a sworn claim must be verified and forwarded to the division for payment.

[Pre-1992 Revision Citations: 12-1-5-11 part; 12-1-6-11 part; 12-1-7.1-13 part.]

As added by P.L.2-1992, SEC.8. Amended by P.L.4-1993, SEC.95; P.L.5-1993, SEC.108.

IC 12-15-9 Chapter 9. Death and Funeral Expenses; Claims Against an Estate

IC 12-15-9-0.5 "Estate" and "nonprobate transfer"

Sec. 0.5. (a) As used in this chapter, "estate" includes:

(1) all real and personal property and other assets included within an individual's probate estate;

(2) any interest in real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship, if the joint tenancy was created after June 30, 2002;

(3) any real or personal property conveyed through a nonprobate transfer; and

(4) any sum due after June 30, 2005, to a person after the death of a Medicaid recipient that is under the terms of an annuity contract purchased after May 1, 2005, with the assets of the Medicaid recipient.

(b) As used in this chapter, "nonprobate transfer" has the meaning set forth in IC 32-17-13-1.

As added by P.L.152-1995, SEC.5. Amended by P.L.178-2002, SEC.82; P.L.224-2003, SEC.78; P.L.246-2005, SEC.107; P.L.149-2012, SEC.3; P.L.163-2018, SEC.1.

IC 12-15-9-0.6 Claim against assets transferred by nonprobate transfer; time limit

Sec. 0.6. (a) This section applies to the enforcement of claims against assets transferred by a nonprobate transfer involving a deceased transferor who dies before, on, or after July 1, 2018.

(b) The office's claim against assets transferred by a nonprobate transfer may be enforced as set out in IC 32-17-13.

(c) Except as provided in subsection (d), enforcement of a claim against assets transferred by a nonprobate transfer must be commenced within the time limits provided in IC 32-17-13.

(d) The time limits provided in subsection (c) do not apply to any assets that were not reported to the county office of the division of family resources.

As added by P.L.178-2002, SEC.83. Amended by P.L.1-2003, SEC.54; P.L.145-2006, SEC.87; P.L.44-2009, SEC.12; P.L.163-2018, SEC.2; P.L.231-2019, SEC.4.

IC 12-15-9-0.7 Repealed

As added by P.L.178-2002, SEC.84. Amended by P.L.224-2003, SEC.79. Repealed by P.L.246-2005, SEC.230.

IC 12-15-9-0.8 Limitation on definition of estate

Sec. 0.8. Any nonprobate assets:

(1) that the office determined were exempt or unavailable assets; or

(2) that were transferred out of the probate estate;

before May 1, 2002, may not be included in the definition of estate under this chapter.

As added by P.L.178-2002, SEC.85.

IC 12-15-9-1 Amount of claim; preference

Sec. 1. Upon the death of a Medicaid recipient, the total amount of Medicaid paid on behalf of the recipient after the recipient became fifty-five (55) years of age must be allowed as a preferred claim against the estate of the recipient in favor of the state. The affidavit of a person designated by the secretary to administer this section is evidence of the amount of the claim and is payable after the payment of the following in accordance with IC 29-1-14-9:

(1) Funeral expenses for the recipient, not to exceed three hundred fifty dollars ($350).

(2) The expenses of the last illness of the recipient that are authorized or paid by the office.

(3) The expenses of administering the estate, including the attorney's fees approved by the court.

[Pre-1992 Revision Citation: 12-1-7-25(a).]

As added by P.L.2-1992, SEC.9. Amended by P.L.152-1995, SEC.6; P.L.246-2005, SEC.108; P.L.149-2012, SEC.4.

IC 12-15-9-2 Property exempt from enforcement

Sec. 2. A claim may not be enforced against the following:

(1) Real estate of a recipient while it is necessary for the support, maintenance, or comfort of the surviving spouse, a dependent child less than twenty-one (21) years of age, or a dependent who is nonsupporting because of blindness or other disability.

(2) Personal property necessary for the support, maintenance, or comfort of the surviving spouse, a dependent child less than twenty-one (21) years of age, or a dependent who is nonsupporting because of blindness or other disability.

(3) Personal effects, ornaments, or keepsakes of the deceased.

[Pre-1992 Revision Citation: 12-1-7-25(b).]

As added by P.L.2-1992, SEC.9. Amended by P.L.152-1995, SEC.7.

IC 12-15-9-5 Claims against the estate of a recipient's spouse prohibited

Sec. 5. The office may not file a claim against the estate of a recipient's surviving spouse.

As added by P.L.152-1995, SEC.8. Amended by P.L.246-2005, SEC.109; P.L.149-2012, SEC.5.

IC 12-15-9-6 Waiver in cases of undue hardship; rules

Sec. 6. Notwithstanding sections 2 and 5 of this chapter, the office may waive the application of this chapter in cases of undue hardship. The office of the secretary shall adopt rules under IC 4-22-2 establishing criteria for hardship waivers that are consistent with guidelines of the Secretary of the United States Department of Health and Human Services.

As added by P.L.152-1995, SEC.9.

IC 12-15-9-7 Reimbursement; proceeds of annuity contracts

Sec. 7. A person receiving beneficiary payments from an annuity contract of a deceased Medicaid recipient is liable to the state for reimbursement of Medicaid benefits:

(1) paid to; or

(2) on behalf of;

the deceased Medicaid recipient to the extent of any payments that are received by the person under a annuity contract purchased after May 1, 2005.

As added by P.L.246-2005, SEC.110.

IC 29-1-8 Chapter 8. Dispensing With Administration

IC 29-1-8-0.1 Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to sections 1 and 3 of this chapter by P.L.118-1997 do not apply to an individual whose death occurs before July 1, 1997.

(2) The amendments made to sections 1 and 4.5 of this chapter by P.L.61-2006 apply to the estate of an individual who dies after June 30, 2006.

As added by P.L.220-2011, SEC.472.

IC 29-1-8-1 Small estates; payment upon presentation of affidavit; vehicle or watercraft; securities; insurance death benefit; safe deposit box; digital asset

Sec. 1. (a) Forty-five (45) days after the death of a decedent and upon being presented an affidavit that complies with subsection (b), a person:

(1) indebted to the decedent; or

(2) having possession of personal property or an instrument evidencing a debt, an obligation, a stock, or a chose in action belonging to the decedent;

shall make payment of the indebtedness or deliver the personal property or the instrument evidencing a debt, an obligation, a stock, or a chose in action to a distributee claiming to be entitled to payment or delivery of property of the decedent as alleged in the affidavit.

(b) The affidavit required by subsection (a) must be an affidavit made by or on behalf of the distributee and must state the following:

(1) That the value of the gross probate estate, wherever located, (less liens, encumbrances, and reasonable funeral expenses) does not exceed:

(A) twenty-five thousand dollars ($25,000), for the estate of an individual who dies before July 1, 2006; and

(B) fifty thousand dollars ($50,000), for the estate of an individual who dies after June 30, 2006.

(2) That forty-five (45) days have elapsed since the death of the decedent.

(3) That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction.

(4) The name and address of each distributee that is entitled to a share of the property and the part of the property to which each distributee is entitled.

(5) That the affiant has notified each distributee identified in the affidavit of the affiant's intention to present an affidavit under this section.

(6) That the affiant is entitled to payment or delivery of the property on behalf of each

distributee identified in the affidavit.

(c) If a motor vehicle or watercraft (as defined in IC 9-13-2-198.5) is part of the estate, nothing in this section shall prohibit a transfer of the certificate of title to the motor vehicle if five (5) days have elapsed since the death of the decedent and no appointment of a personal representative is contemplated. A transfer under this subsection shall be made by the bureau of motor vehicles upon receipt of an affidavit containing a statement of the conditions required by subsection (b)(1) and (b)(6). The affidavit must be duly executed by the distributees of the estate.

(d) A transfer agent of a security shall change the registered ownership on the books of a corporation from the decedent to a distributee upon the presentation of an affidavit as provided in subsection (a).

(e) For the purposes of subsection (a), an insurance company that, by reason of the death of the decedent, becomes obligated to pay a death benefit to the estate of the decedent is considered a person indebted to the decedent.

(f) For purposes of subsection (a), property in a safe deposit box rented by a decedent from a financial institution organized or reorganized under the law of any state (as defined in IC 28-2-17-19) or the United States is considered personal property belonging to the decedent in the possession of the financial institution.

(g) For purposes of subsection (a), a distributee has the same rights as a personal representative under IC 32-39 to access a digital asset (as defined in IC 32-39-1-10) of the decedent.

Formerly: Acts 1953, c.112, s.801; Acts 1965, c.379, s.2; Acts 1971, P.L.406, SEC.1; Acts 1975, P.L.288, SEC.12. As amended by Acts 1977, P.L.2, SEC.80; Acts 1977, P.L.298, SEC.1; P.L.71-1991, SEC.15; P.L.77-1992, SEC.5; P.L.118-1997, SEC.16; P.L.59-2000, SEC.1; P.L.61-2006, SEC.4; P.L.51-2014, SEC.3; P.L.137-2016, SEC.1; P.L.163-2018, SEC.9; P.L.231-2019, SEC.13; P.L.56-2020, SEC.4.

IC 29-1-8-1.5 Affidavit to obtain date of death values for personal property, accounts, and intangible property belonging to a decedent; form of affidavit; duty to furnish information to the affiant

Sec. 1.5. (a) This section does not apply to the following:

(1) Real property owned by a decedent.

(2) The contents of a safe deposit box rented by a decedent from a financial institution organized or reorganized under the law of any state (as defined in IC 28-2-17-19) or the United States.

(b) After the death of a decedent, a person:

(1) indebted to the decedent; or

(2) having possession of:

(A) personal property;

(B) an instrument evidencing a debt;

(C) an obligation;

(D) a chose in action;

(E) a life insurance policy;

(F) a bank account; or

(G) intangible property, including annuities, fixed income investments, mutual funds, cash, money market accounts, or stocks;

belonging to the decedent;

shall furnish the date of death value of the indebtedness or property and the names of the known beneficiaries of property described in this subsection to a person who presents an affidavit containing the information required by subsection (c).

(c) An affidavit presented under subsection (b) must state:

(1) the name, address, Social Security number, and date of death of the decedent;

(2) the name and address of the affiant, and the relationship of the affiant to the

decedent;

(3) that the disclosure of the date of death value is necessary to determine whether the decedent's estate can be administered under the summary procedures set forth in this chapter; and

(4) that the affiant is answerable and accountable for the information received to the decedent's personal representative, if any, or to any other person having a superior right to the property or indebtedness.

(d) A person presented with an affidavit under subsection (b) must provide the requested information within three (3) business days after being presented with the affidavit.

(e) A person who acts in good faith reliance on an affidavit presented under subsection (b) is immune from liability for the disclosure of the requested information.

(f) A person who:

(1) is presented with an affidavit under subsection (b); and

(2) refuses to provide the requested information within three (3) business days after being presented with the affidavit;

is liable to the estate of the decedent.

(g) A plaintiff who prevails in an action to compel a person presented with an affidavit under subsection (b) to accept the authority of the affiant or in an action for damages arising from a person's refusal to provide the information requested in an affidavit presented under subsection (b) shall recover the following:

(1) Three (3) times the amount of the actual damages.

(2) Attorney's fees and court costs.

(3) Prejudgment interest on the actual damages from the date the affidavit was presented to the person.

As added by P.L.95-2007, SEC.7.

IC 29-1-8-2 Personal property; payments; delivery; transfer; release

Sec. 2. The person paying, delivering, transferring, or issuing personal property or the evidence thereof pursuant to affidavit is discharged and released to the same extent as if the person dealt with a personal representative of the decedent. The person is not required to see to the application of the personal property or evidence thereof or to inquire into the truth of any statement in the affidavit. If any person to whom an affidavit is delivered refuses to pay, deliver, transfer, or issue any personal property or evidence thereof, it may be recovered or its payment, delivery, transfer, or issuance compelled upon proof of their right in a proceeding brought for the purpose by or on behalf of the persons entitled thereto. Any person to whom payment, delivery, transfer, or issuance is made is answerable and accountable therefor to any personal representative of the estate or to any other person having a superior right.

Formerly: Acts 1953, c.112, s.802; Acts 1975, P.L.288, SEC.13. As amended by P.L.194-2017, SEC.3.

IC 29-1-8-3 Disbursement and distribution of estate

Sec. 3. (a) As used in this section, "fiduciary" means:

(1) the personal representative of an unsupervised estate; or

(2) a person appointed by a court under this title to act on behalf of the decedent or the decedent's distributees.

(b) Except as otherwise provided in this section, if the value of a decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of:

(1) an amount equal to:

(A) twenty-five thousand dollars ($25,000), for the estate of an individual who dies before July 1, 2006; and

(B) fifty thousand dollars ($50,000), for the estate of an individual who dies after June 30, 2006;

IC 29-1-10-21 Authority of personal representatives; circumstances in which a court order may allow an action that the personal representative is prohibited from taking

Sec. 21. (a) All authority to act with respect to an estate administered under IC 29-1-7 and IC 29-1-7.5 is vested exclusively in the personal representative.

(b) If this article prohibits an action by the personal representative, the prohibition restricts the personal representative, regardless of court order, unless:

(1) a majority in interest of the distributees expressly consent to the proposed action; or

(2) the statute imposing the restriction expressly permits a court to approve the prohibited action.

As added by P.L.99-2013, SEC.4.

(e) The court shall order the limitation described in subsection (b) inapplicable to a claimant's claim concerning the sale of real estate if any interested person files a motion for findings under this subsection and the court finds that the following conditions apply:

(1) A petition for administration was filed in court under section 5 of this chapter not later than five (5) months after the decedent's death.

(2) More than thirty (30) days have elapsed since the petition was filed.

(3) The claimant is a reasonably ascertainable creditor under section 7 of this chapter.

(4) The claimant filed a claim in the estate not later than seventy-five (75) days after the date on which the petition for administration was filed, or not later than thirty (30) days after the date on which the petitioner serves the notice required in subsection (c), whichever is later.

(5) The petitioner has not satisfied the provisions of subsection (c).

(f) The title of any real estate or interest therein purchased in good faith and for a valuable consideration from the heirs of any person who died seized of the real estate shall not be affected or impaired by any devise made by the person of the real estate so purchased, unless:

(1) the will containing the devise has been probated and recorded in the office of the clerk of the court having jurisdiction within five (5) months after the death of the testator; or

(2) an action to contest the will's validity is commenced within the time provided by law and, as a result, the will is ultimately probated.

(g) Except as provided in subsection (h), the will of the decedent shall not be admitted to probate unless the will is presented for probate before the latest of the following dates:

(1) Three (3) years after the individual's death.

(2) Sixty (60) days after the entry of an order denying the probate of a will of the decedent previously offered for probate and objected to under section 16 of this chapter.

(3) Sixty (60) days after entry of an order revoking probate of a will of the decedent previously admitted to probate and contested under section 17 of this chapter.

However, in the case of an individual presumed dead under IC 29-2-5-1, the three (3) year period commences with the date the individual's death has been established by appropriate legal action.

(h) This subsection applies with respect to the will of an individual who dies after June 30, 2011. If:

(1) no estate proceedings have been commenced for a decedent; and

(2) an asset of the decedent remains titled or registered in the name of the decedent;

the will of the decedent may be presented to the court for probate and admitted to probate at any time after the expiration of the deadline determined under subsection (g) for the sole purpose of transferring the asset described in subdivision (2). A will presented for probate under this subsection is subject to all rules governing the admission of wills to probate.

Formerly: Acts 1973, P.L.289, SEC.1; Acts 1975, P.L.288, SEC.8. As amended by P.L.263-1989, SEC.1; P.L.238-2005, SEC.11; P.L.95-2007, SEC.5; P.L.36-2011, SEC.4; P.L.163-2018, SEC.6; P.L.231-2019, SEC.8.

IC 29-1-7-15.2 Sale of real estate; permitted use of proceeds

Sec. 15.2. (a) This section applies to real estate subject to section 15.1(b) of this chapter, if all distributees consent to the sale of the real estate under IC 29-1-10-21.

(b) The proceeds of the sale of real estate described in subsection (a) will retain the same protection that section 15.1(b) of this chapter provides to real estate. Such proceeds can only be used to satisfy a debt or obligation of the deceased person or costs of administration of the decedent's estate if the distributees consent to the personal representative's use of the proceeds to satisfy the debts, obligations, or costs of administration.

As added by P.L.163-2018, SEC.7.

IC 29-1-14 Chapter 14. Claims Against the Estate

IC 29-1-14-0.1 Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to sections 2, 13, 17, and 19 of this chapter by P.L.118-1997 do not apply to an individual whose death occurs before July 1, 1997.

(2) The amendments made to sections 1, 2, 8, 10, 16, 18, 19, and 21 of this chapter by P.L.252-2001 apply to the estate of an individual who dies after June 30, 2001.

As added by P.L.220-2011, SEC.477.

IC 29-1-14-1 Limitations; filing; claims barred or not; liens; tort claims

Sec. 1. (a) Except as provided in IC 29-1-7-7, all claims against a decedent's estate, other than expenses of administration and claims of the United States, the state, or a subdivision of the state, whether due or to become due, absolute or contingent, liquidated or unliquidated, founded on contract or otherwise, shall be forever barred against the estate, the personal representative, the heirs, devisees, and legatees of the decedent, unless filed with the court in which such estate is being administered within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(b) No claim shall be allowed which was barred by any statute of limitations at the time of decedent's death.

(c) No claim shall be barred by the statute of limitations which was not barred at the time of the decedent's death, if the claim shall be filed within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(d) All claims barrable under subsection (a) shall be barred if not filed within nine (9) months after the death of the decedent.

(e) Nothing in this section shall affect or prevent any action or proceeding to enforce any

mortgage, pledge, or other lien upon property of the estate.

(f) Nothing in this section shall affect or prevent the enforcement of a claim for injury to person or damage to property arising out of negligence against the estate of a deceased tort feasor within the period of the statute of limitations provided for the tort action. A tort claim against the estate of the tort feasor may be opened or reopened and suit filed against the special representative of the estate within the period of the statute of limitations of the tort. Any recovery against the tort feasor's estate shall not affect any interest in the assets of the estate unless the suit was filed within the time allowed for filing claims against the estate. The rules of pleading and procedure in such cases shall be the same as apply in ordinary civil actions.

Formerly: Acts 1953, c.112, s.1401; Acts 1961, c.287, s.1; Acts 1975, P.L.288, SEC.20. As amended by Acts 1980, P.L.179, SEC.1; P.L.154-1990, SEC.9; P.L.252-2001, SEC.16.

IC 29-1-14-2 Actions; definite statement; personal representative actions; deductions from claims

Sec. 2. No action shall be brought by complaint and summons against the personal representative of an estate for the recovery of any claim against the decedent or the decedent's estate, except in the enforcement of claims for injury to person or damage to property arising out of negligence as provided in section 1 of this chapter, but the holder thereof, whether such claim be due or not, shall file a succinct definite statement thereof in the office of the clerk of the court in which the letters were issued. The clerk shall send by United States mail or by personal service an exact copy of such statement to the personal representative of the estate. Any claims of the personal representative against the decedent shall be made out and filed in the office of the clerk of the court in which the letters were issued. If any claim against the decedent is founded upon any written instrument, alleged to have been executed by the decedent, the original or a complete copy thereof, shall be filed with the statement, unless it is lost or destroyed, in which case its loss or destruction must be stated in the claim. The statement shall set forth all credits and deductions to which the estate is entitled and shall be accompanied by the affidavit of the claimant or the claimant's agent or attorney, that the claim, after deducting all credits, set-offs, and deductions to which the estate is entitled, is justly due and wholly unpaid, or if not yet due, when it will or may become due, and no claim shall be received unless accompanied by such affidavit. If the claim is secured by a lien on any real or personal property, such lien shall be particularly set forth in such statement, and a reference given to where the lien, if of record, will be found. If the claim is contingent, the nature of the contingency shall also be stated. No statement of claim need be filed as provided in this section as to those claims which are paid by the personal representative within three (3) months after the date of the first published notice to creditors or the period allowed under IC 29-1-7-7. However, in instances where a cause of action was properly filed and commenced against a decedent prior to the decedent's death, the same shall be continued against the personal representative or successors in interest of the deceased, who shall be substituted as the party or parties defendant in such action, and in such instance it shall not be necessary for the claimant to file a claim as herein provided. In any action thus continued the recovery, if any, shall be limited as otherwise provided by law.

Formerly: Acts 1953, c.112, s.1402; Acts 1959, c.179, s.1; Acts 1961, c.287, s.2; Acts 1965, c.144, s.1; Acts 1975, P.L.288, SEC.21. As amended by P.L.118-1997, SEC.20; P.L.252-2001, SEC.17.

IC 29-1-14-3 Future claims; payment; bonds

Sec. 3. Upon proof of a claim which will become due at some future time, the court shall allow it at the present value thereof, and payment may be made as in the case of an absolute claim which has been allowed: Provided, if the obligation upon which such claim was founded was entered into before January 1, 1954, payment may be made as above, if the

creditors agree thereto. If payment is not made as above provided, the court may order the personal representative to retain in his hands sufficient funds to satisfy the claim upon maturity; or if the distributees shall give a bond to be approved by the court for the payment of the creditor's claim in accordance with the terms thereof, the court may order such bond to be given in satisfaction of such claim and the estate may be closed.
Formerly: Acts 1953, c.112, s.1403. As amended by Acts 1982, P.L.171, SEC.36.

IC 29-1-14-4 Actions; joint contracts and judgment

Sec. 4. No action shall be brought by complaint and summons against any personal representative and any other person or persons, or his or their legal representatives, upon any contract executed jointly, or jointly and severally, by the deceased and such other person or persons, or upon any joint judgment founded thereon; but the holder of said contract or judgment shall enforce the collection thereof against the estate of the decedent only by filing his claim as provided in section 2 of this chapter.
Formerly: Acts 1953, c.112, s.1404. As amended by Acts 1982, P.L.171, SEC.37.

IC 29-1-14-5 Joint contracts and judgments deemed joint and several

Sec. 5. Every contract executed jointly by the decedent with any other person or persons, and every joint judgment founded on such contract, shall be deemed to be joint and several for the purpose contemplated in section 4 of this chapter; and the amount due thereon shall be allowed against the estate of the decedent as if the contract were joint and several.
Formerly: Acts 1953, c.112, s.1405. As amended by Acts 1982, P.L.171, SEC.38.

IC 29-1-14-6 Secured claims, allowance, and payment

Sec. 6. The allowance and payment of secured claims shall be made in accordance with the "Uniform Act Governing Secured Creditors Dividends in Liquidation Proceedings," IC 30-2-7.
Formerly: Acts 1953, c.112, s.1406. As amended by Acts 1982, P.L.171, SEC.39.

IC 29-1-14-7 Contingent claims; payment; bond of distributee

Sec. 7. Contingent claims which cannot be allowed as absolute debts shall, nevertheless, be filed in the court. If allowed as a contingent claim, the allowance shall state the nature of the contingency. If such claim shall become absolute before distribution of the estate, it shall be paid in the same manner as absolute claims of the same class. In all other cases the court may provide for the payment of contingent claims in any one of the following methods.

(a) The creditor and personal representative may determine, by agreement, arbitration or compromise, the value thereof, according to its probable present worth, and upon approval thereof by the court, it may be allowed and paid in the same manner as an absolute claim.

(b) The court may order the personal representative to make distribution of the estate but to retain in his hands sufficient funds to pay the claim if and when the same becomes absolute; but for this purpose the estate shall not be kept open longer than two (2) years after distribution of the remainder of the estate has been made; and if such claim has not become absolute within that time, distribution shall be made to the distributees of the funds so retained, after paying any costs and expenses accruing during such period and such distributees shall be liable to the creditor to the extent of the estate received by them, if such contingent claim thereafter becomes absolute. When distribution is so made to distributees, the court may require such distributees to give bond for the satisfaction of their liability to the contingent creditor.

(c) The court may order distribution of the estate as though such contingent claim did not exist, but the distributees shall be liable to the creditor to the extent of the estate received by them, if the contingent claim thereafter becomes absolute; and the court may require such distributees to give bond for the performance of their liability to the contingent creditor.
Formerly: Acts 1953, c.112, s.1407.

IC 29-1-14-8 Contingent claims; liability of distributees; contribution

Sec. 8. If a contingent claim shall have been filed and allowed against an estate, and all the assets of the estate including the fund, if any, set apart for the payment thereof, shall have been distributed, and the claim shall thereafter become absolute, the creditor shall have the right to recover thereon in the court having probate jurisdiction against those distributees whose distributive shares have been increased by reason of the fact that the amount of said claim as finally determined was not paid out prior to final distribution, provided an action therefor shall be commenced within three (3) months after the claim becomes absolute. Such distributees shall be jointly and severally liable, but no distributee shall be liable for an amount exceeding the amount of the estate or fund so distributed to him. If more than one (1) distributee is liable to the creditor, the distributee shall make all distributees who can be reached by process parties to the action. By its judgment the court shall determine the amount of the liability of each of the defendants as between themselves, but if any be insolvent or unable to pay his proportion, or beyond the reach of process, the others, to the extent of their respective liabilities, shall nevertheless be liable to the creditor for the whole amount of the debt. If any person liable for the debt fails to pay the person's just proportion to the creditor, the person shall be liable to indemnify all who, by reason of such failure on the person's part, have paid more than their just proportion of the debt, the indemnity to be recovered in the same action or in separate actions.

Formerly: Acts 1953, c.112, s.1408; Acts 1975, P.L.288, SEC.22. As amended by P.L.252-2001, SEC.18; P.L.1-2002, SEC.124.

IC 29-1-14-9 Classification of claims; preferences

Sec. 9. (a) All claims shall be classified in one (1) of the following classes. If the applicable assets of the estate are insufficient to pay all claims in full, the personal representative shall make payment in the following order:

(1) Costs and expenses of administration, except funeral expenses, expenses of a tombstone, and expenses incurred in the disposition of the decedent's body.

(2) Reasonable funeral expenses, expenses of a tombstone, and expenses incurred in the disposition of the decedent's body. However, in any estate in which the decedent was a recipient of public assistance under IC 12-1-1 through IC 12-1-12 (before its repeal) or any of the following, the amount of funeral expenses having priority over any claim for the recovery of public assistance shall not exceed the limitations provided for under IC 12-14-6, IC 12-14-17, and IC 12-14-21:

TANF assistance.
TANF burials.
TANF IMPACT/J.O.B.S.
Temporary Assistance to Other Needy Families (TAONF) assistance.
ARCH.
Blind relief.
Child care.
Child welfare adoption assistance.
Child welfare adoption opportunities.
Child welfare assistance.
Child welfare child care improvement.
Child welfare child abuse.
Child welfare child abuse and neglect prevention.
Child welfare children's victim advocacy program.
Child welfare foster care assistance.
Child welfare independent living.
Child welfare medical assistance to wards.
Child welfare program review action group (PRAG).
Child welfare special needs adoption.

Food Stamp administration.
Health care for indigent (HCI).
ICES.
IMPACT (food stamps).
Title IV-D (ISETS or a successor statewide automated support enforcement system).
Title IV-D child support administration.
Title IV-D child support enforcement (parent locator).
Medicaid assistance.
Medical services for inmates and patients (590).
Room and board assistance (RBA).
Refugee social service.
Refugee resettlement.
Repatriated citizens.
SSI burials and disabled examinations.
Title XIX certification.

(3) Allowances made under IC 29-1-4-1.

(4) All debts and taxes having preference under the laws of the United States.

(5) Reasonable and necessary medical expenses of the last sickness of the decedent, including compensation of persons attending the decedent.

(6) All debts and taxes having preference under the laws of this state; but no personal representative shall be required to pay any taxes on any property of the decedent unless such taxes are due and payable before possession thereof is delivered by the personal representative pursuant to the provisions of IC 29-1.

(7) All other claims allowed.

(b) No preference shall be given in the payment of any claim over any other claim of the same class, nor shall a claim due and payable be entitled to a preference over claims not due. *Formerly: Acts 1953, c.112, s.1409; Acts 1955, c.258, s.5; Acts 1965, c.371, s.1; Acts 1975, P.L.288, SEC.23. As amended by Acts 1976, P.L.125, SEC.6; Acts 1979, P.L.268, SEC.5; P.L.2-1992, SEC.788; P.L.161-2007, SEC.39; P.L.149-2012, SEC.8; P.L.99-2013, SEC.6; P.L.81-2015, SEC.17.*

IC 29-1-14-10 Allowance; disallowance; expenses of administration

Sec. 10. (a) On or before three (3) months and fifteen (15) days after the date of the first published notice to creditors, the personal representative shall allow or disallow each claim filed not later than three (3) months after the date of the first published notice to creditors, and as to any claim filed not later than nine (9) months after the decedent's death by a claimant (other than the United States, the state, or a subdivision of the state) who did not receive notice of administration under IC 29-1-7-7, the personal representative shall allow or disallow the claim not later than fifteen (15) days after the date of filing of the claim.

(b) The personal representative shall allow or disallow each claim filed by the United States, the state, or a subdivision of the state on or before the later of:

(1) three (3) months and fifteen (15) days after the first published notice to creditors; or

(2) fifteen (15) days after the date on which the United States, the state, or a subdivision of the state filed the claim.

(c) The personal representative shall make appropriate notations on the margin of the claim and allowance docket showing the action taken as to the claim, or, in a jurisdiction that has implemented electronic filing, by making appropriate notations of the action taken as to the claim according to rules established by the Indiana supreme court, or if the Indiana supreme court adopts no rule regarding the notations, then by local rules established by the court where the claim is filed.

(d) If a personal representative determines that the personal representative should not allow a claim in full, the claim shall be noted "disallowed". The clerk of the court shall give

written notice to a creditor if a claim has been disallowed in full or in part. In a jurisdiction that has implemented electronic filing, written notice to a creditor concerning a disallowed claim, in full or in part, shall be given according to rules established by:

(1) the Indiana supreme court; or

(2) local rules established by the local court where the claim is filed if rules from the Indiana supreme court have not yet been promulgated.

(e) All claims that are disallowed, or are neither allowed nor disallowed within the deadlines provided in subsection (a) or (b), shall be set for trial in the probate court upon the petition of either party to the claim. The personal representative shall make an appropriate notation of any compromise or adjustment on the margin of the claim and allowance docket, or in a jurisdiction that has implemented electronic filing, by making appropriate notations of the action taken as to the claim according to rules established by the Indiana supreme court, or if the Indiana supreme court adopts no rule regarding the notations, then by local rules established by the court where the claim is filed. If the personal representative, after allowing a claim and before paying it, determines that the claim should not have been allowed, the personal representative shall change the notation on the claim and allowance docket from "allowed" to "disallowed" and give written notice to the creditor. If a claim has been paid in full or in part, the creditor shall:

(1) release the claim to the extent that the claim has been paid; and

(2) give written notice to the clerk of the court of the release.

(f) Claims for expenses of administration may be allowed upon application of the claimant or of the personal representative, or may be allowed at any accounting, regardless of whether or not they have been paid by the personal representative.

Formerly: Acts 1953, c.112, s.1410; Acts 1975, P.L.288, SEC.24. As amended by P.L.154-1990, SEC.10; P.L.252-2001, SEC.19; P.L.163-2018, SEC.10; P.L.231-2019, SEC.17.

IC 29-1-14-11 Inquiry into correctness; liability on bond

Sec. 11. Before allowing or paying claims against the estate he represents, it shall be the duty of every personal representative to inquire into the correctness of all claims against the estate and make all available defenses thereto, and if he fails so to do, he shall be liable on his bond, at the suit of any person interested in the estate, for all damages sustained by the estate in consequence of such neglect.

Formerly: Acts 1953, c.112, s.1411.

IC 29-1-14-12 Trial; pleading; dismissal

Sec. 12. (a) When any claim is transferred for trial, it shall not be necessary for the personal representative to plead any matter by way of answer, except a set-off or counter-claim, to which the plaintiff shall reply. If the personal representative pleads any other matter by way of defense, the claimant shall reply thereto; the sufficiency of the statement of the claim, or any subsequent pleading, may be tested by appropriate pleadings, and if objection be made that the assignor of a claim not assigned by endorsement is not a party to the action, leave shall be given the claimant to amend by making him a party to answer to his interest in the claim and to sue out process against the assignor to answer in that behalf. And if it shall be shown to the court that any person is bound with the decedent in any contract which is the foundation of the claim, the court shall direct that the claim be amended by making such person a defendant in the action, and process shall be issued against and served upon him, and thereafter the action shall be prosecuted against him as a codefendant with such personal representative and judgment shall be rendered accordingly.

(b) If any claimant fails to attend and prosecute his claim at the time the same shall be set down for trial, the court shall dismiss the claim; and any subsequent prosecution of the claim against the estate shall be at the costs of the claimant, unless good cause for such failure to prosecute be shown.

Formerly: Acts 1953, c.112, s.1412. As amended by Acts 1978, P.L.132, SEC.7.

IC 29-1-14-13 Trial of claims; judgment; set-off or counterclaim

Sec. 13. The trial of a claim under this chapter shall be conducted as in ordinary civil cases, and if the finding is for the claimant the court shall allow the claim in full or in part, and costs, to be paid out of the assets of the estate under section 19 of this chapter. If the claim sued on is secured by a lien upon property of the deceased, the date and extent shall be ascertained and fixed by the finding and judgment. If the finding is in favor of the personal representative upon a set-off or counter-claim, judgment shall be rendered thereon as in ordinary cases. If a set-off or counter-claim is pleaded, and the claim is afterward dismissed, the personal representative may nevertheless proceed to trial and judgment on the set-off or counter-claim.

Formerly: Acts 1953, c.112, s.1413. As amended by P.L.118-1997, SEC.21.

IC 29-1-14-14 Petitions; defend claims; objections to payment

Sec. 14. (a) In all cases when a claim is filed against the estate, and before it is paid, any person interested in the estate, upon written petition to the court, shall be allowed, at his expense, to defend such claim, and until such claim is adjudicated the personal representative shall not pay the same.

(b) In all cases when a claim against the estate is paid by the personal representative, without payment thereof having been ordered by the court, whether or not such claim has been filed, any person interested in the estate may raise whatever objections he may have to the payment of such claim by filing his objections to the next account of the personal representative, as provided in IC 29-1-16-7.

Formerly: Acts 1953, c.112, s.1414. As amended by Acts 1982, P.L.171, SEC.40.

IC 29-1-14-15 Execution; final process; payment; mortgages, pledges, or liens; enforcement

Sec. 15. No execution or other final process shall be issued on any allowance or judgment rendered upon a claim against a decedent's estate for the collection thereof out of the assets of the estate, but all such claims shall be paid by the personal representative in full or pro rata, in due course of administration; provided, however, the provisions of this section shall not be construed to prevent the enforcement of mortgages, pledges or other liens upon real or personal property in an appropriate proceeding.

Formerly: Acts 1953, c.112, s.1415.

IC 29-1-14-16 Liens and mortgages, enforcement; sale of real estate; exception

Sec. 16. Unless an earlier date is authorized by the judge of the court having jurisdiction of the decedent's estate no proceedings shall be instituted before the end of three (3) months from the death of the decedent to enforce the lien of any judgment rendered against the decedent in his lifetime upon real estate or to enforce any decree specifically directing the sale of such real estate to discharge any lien or liability created or suffered by the decedent, nor shall any suit be brought before that time against the heirs or devisees of the deceased to foreclose any mortgage or other lien thereon; and in case of suit to foreclose any mortgage or other lien thereon, the personal representative shall be made a party defendant thereto; and if the personal representative shall be diligently prosecuting his proceedings to sell the real estate of the deceased for the purpose of making assets to discharge such liens, further proceedings for the sale thereof by the holders of liens thereon shall be stayed, upon the application of the personal representative. This section does not apply to cases where, before the end of the three (3) months, the real estate shall have been sold by the personal representative subject to liens thereon, nor to mortgages and judgments in favor of the state.

Formerly: Acts 1953, c.112, s.1416; Acts 1975, P.L.288, SEC.25. As amended by

P.L.252-2001, SEC.20.

IC 29-1-14-17 Personal representative claims

Sec. 17. (a) Whenever a claim in favor of a personal representative against the estate the personal representative represents that accrued before the death of the decedent is filed against an estate, with the affidavit of the claimant attached, the claim shall not be acted upon by the personal representative unless all interested persons who would be affected by the allowance of the claim consent in writing to it. If all interested persons do not consent to the payment of that claim, the judge shall appoint a special personal representative who shall examine the nature of the claim. If the special personal representative determines that the claim is just, the special personal representative shall allow the claim. If the special personal representative believes it is in the best interests of the estate to oppose the claim, the special personal representative may:

(1) employ counsel to represent the special personal representative;

(2) disallow the claim; and

(3) ask the court to set the claim for trial.

The special personal representative and the special personal representative's counsel shall be paid out of the estate fees for services that the court determines reasonable and appropriate.

(b) Claims of personal representatives shall not be deemed civil actions or proceedings for the purpose of determining court costs, unless the court arranges for active opposition provided in this section.

Formerly: Acts 1953, c.112, s.1417. As amended by Acts 1978, P.L.132, SEC.8; P.L.118-1997, SEC.22.

IC 29-1-14-18 Compromise of claims

Sec. 18. The personal representative may, if it appears for the best interests of the estate, compromise any claim against the estate, whether due or not due, absolute or contingent, liquidated or unliquidated, but if such claim is not filed such compromise must be consummated within three (3) months after the date of the first published notice to creditors. In the absence of prior authorization or subsequent approval by the court, no compromise shall bind the estate.

Formerly: Acts 1953, c.112, s.1418; Acts 1975, P.L.288, SEC.26. As amended by P.L.252-2001, SEC.21.

IC 29-1-14-19 Payment of claims; bond or security of creditor; report of insolvency

Sec. 19. (a) The personal representative at any time shall pay the claims as the court shall order if the claims are filed within three (3) months after the date of the first published notice to creditors or the period allowed under IC 29-1-7-7, if applicable, and the court may require bond or security to be given by the creditor to refund such part of such payment as may be necessary to make payment in accordance with this title.

(b) Prior to the expiration of three (3) months after the date of the first published notice to creditors or the period allowed under IC 29-1-7-7, the personal representative, if the estate clearly is solvent, may pay any claims that the personal representative believes are just and correct, whether or not the claims have been filed. The personal representative may require bond or security to be given by the creditor to refund any part of the payment as the court may subsequently order. The personal representative, following all such payments, shall include them in the personal representative's next account and they shall be considered proper payments under this title if they are approved by the court as a part of the account.

(c) Upon the expiration of three (3) months after the date of the first published notice to creditors or the period allowed under IC 29-1-7-7 and the final adjudication of all claims filed against the estate, the personal representative shall proceed to pay the claims that have been allowed against the estate in accordance with this title that the personal representative

has not paid.

(d) If it appears at any time that the estate is or may be insolvent, that there are insufficient funds on hand, or that there is other good or sufficient cause, the personal representative may report that fact to the court and apply for any necessary order.

Formerly: Acts 1953, c.112, s.1419; Acts 1975, P.L.288, SEC.27. As amended by P.L.154-1990, SEC.11; P.L.118-1997, SEC.23; P.L.252-2001, SEC.22.

IC 29-1-14-20 Mortgage; pledge; lien; payment; renewal; extension

Sec. 20. When any assets of the estate are encumbered by mortgage, pledge or other lien, the personal representative may pay such encumbrance or any part thereof, renew or extend any obligation secured by the encumbrance or may convey or transfer such assets to the creditor in satisfaction of his lien, in whole or in part, whether or not the holder of the encumbrance has filed a claim, if it appears to be for the best interest of the estate. As to any such conveyance or transfer the personal representative must obtain prior authorization of the court and as to any such payment, renewal or extension the personal representative must obtain prior authorization or subsequent approval of the court. The making of such payment shall not increase the share of the distributee entitled to such encumbered assets unless otherwise provided by will.

Formerly: Acts 1953, c.112, s.1420.

IC 29-1-14-21 Adverse claims; notice; trial

Sec. 21. When any person claims any interest in any property in the possession of the personal representative adverse to the estate, the person may file, prior to the expiration of three (3) months after the date of the first published notice to creditors, a petition with the court having jurisdiction of the estate setting out the facts concerning such interest, and thereupon the court shall cause such notice to be given to such parties as it deems proper, and the case shall be set for trial and tried as in ordinary civil actions.

Formerly: Acts 1953, c.112, s.1421; Acts 1975, P.L.288, SEC.28. As amended by P.L.252-2001, SEC.23.

IC 32-17-13 Chapter 13. Liability of Nonprobate Transferees for Creditor Claims and Statutory Allowances

IC 32-17-13-1 "Nonprobate transfer"; transfers involving multiple party accounts, motor vehicles, and watercraft

Sec. 1. (a) As used in this chapter, "nonprobate transfer" means a valid transfer, effective at death, by a transferor:

(1) whose last domicile was in Indiana; and

(2) who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and:

(A) use the property for the benefit of the transferor; or

(B) apply the property to discharge claims against the transferor's probate estate.

(b) The term does not include a transfer at death (other than a transfer to or from the deceased transferor's probate estate) of:

(1) a survivorship interest in a tenancy by the entireties real estate;

(2) a life insurance policy or annuity;

(3) the death proceeds of a life insurance policy or annuity;

(4) an individual retirement account or a similar account or plan; or

(5) benefits under an employee benefit plan.

(c) With respect to a nonprobate transfer involving a multiple party account, a nonprobate transfer occurs if the last domicile of the depositor whose interest is transferred under IC 32-17-11 was in Indiana.

(d) With respect to a motor vehicle or a watercraft, a nonprobate transfer occurs if the transferee obtains a certificate of title in Indiana under IC 9-17.

(e) A transfer on death transfer completed under IC 32-17-14 is a nonprobate transfer.

As added by P.L.165-2002, SEC.11. Amended by P.L.143-2009, SEC.40; P.L.6-2010, SEC.22; P.L.36-2011, SEC.10; P.L.125-2012, SEC.408; P.L.198-2016, SEC.661; P.L.163-2018, SEC.15.

IC 32-17-13-2 "Claimant"; "nonprobate transferee"; liability of nonprobate transferee

Sec. 2. (a) As used in this chapter, "claimant" means the surviving spouse or a surviving child, to the extent that statutory allowances are affected, or a person who has filed a timely claim in a deceased transferor's probate estate under IC 29-1-14, and is entitled to enforce the claim against a transferee of a nonprobate transfer.

(b) As used in this chapter, "nonprobate transferee" means a person who acquires an interest in property by a nonprobate transfer.

(c) Except as otherwise provided by statute, a transferee of a nonprobate transfer is subject to liability to a deceased transferor's probate estate for:

(1) allowed claims against the deceased transferor's probate estate; and

(2) statutory allowances to the decedent's spouse and children;

to the extent the decedent's probate estate is insufficient to satisfy those claims and allowances.

(d) The liability of the nonprobate transferee may not exceed the value of nonprobate transfers received or controlled by the nonprobate transferee.

(e) The liability of the nonprobate transferee does not include the net contributions of the nonprobate transferee.

As added by P.L.165-2002, SEC.11. Amended by P.L.163-2018, SEC.16.

IC 32-17-13-3 Priority of liability to probate estate

Sec. 3. Nonprobate transferees are liable for the insufficiency described in section 2 of this chapter in the following order:

(1) As provided in the deceased transferor's will or other governing instrument.

(2) To the extent of the value of the nonprobate transfer received or controlled by the trustee of trusts that can be amended, modified, or revoked by the decedent during the deceased transferor's lifetime. If there is more than one (1) such trust, in proportion to the relative value of the trusts.

(3) Other nonprobate transferees in proportion to the values received.

As added by P.L.165-2002, SEC.11. Amended by P.L.163-2018, SEC.17.

IC 32-17-13-4 Beneficiary interests in trusts

Sec. 4. Unless otherwise provided by the trust instrument, interest of beneficiaries in all trusts incurring liabilities under this chapter shall abate as necessary to satisfy the liability as if all of the trust instruments were a single trust.

As added by P.L.165-2002, SEC.11. Amended by P.L.101-2008, SEC.11.

IC 32-17-13-5 Apportionment of liability by instrument

Sec. 5. (a) A provision made in an instrument may direct the apportionment of the liability among the nonprobate transferees taking under that or any other governing instrument.

(b) If a provision in an instrument conflicts with a provision in another instrument, the later provision prevails.

As added by P.L.165-2002, SEC.11.

IC 32-17-13-6 Enforcement proceedings; jurisdiction

Sec. 6. (a) Upon due notice to a nonprobate transferee, the liability imposed by this chapter is enforceable in proceedings in Indiana in the county where:

(1) the transfer occurred;

(2) the transferee is located; or

(3) the probate action is pending.

(b) A proceeding under this chapter may be commenced as a separate cause from a cause in which a probate action is pending with respect to a deceased transferor of a nonprobate transfer by filing a complaint against a nonprobate transferee as a defendant and serving a summons and a complete copy of the complaint to each defendant under the Indiana Rules of Trial Procedure.

As added by P.L.165-2002, SEC.11. Amended by P.L.163-2018, SEC.18.

IC 32-17-13-7 Commencement of proceedings; requirements; time limits; immunity of personal representative

Sec. 7. (a) This subsection applies to a proceeding commenced under this chapter and a deceased transferor who died before July 1, 2018, if the personal representative or claimant commences the proceeding before January 1, 2020. A proceeding under this chapter may not be commenced unless the personal representative of the deceased transferor's estate has received a written demand for the proceeding from a claimant.

(b) This subsection applies to a proceeding commenced under this chapter and a deceased transferor who died before July 1, 2018, if the personal representative or claimant commences the proceeding before January 1, 2020, and the claimant files a timely claim in the deceased transferor's estate before July 1, 2018. If the personal representative declines or fails to commence a proceeding within sixty (60) days after receiving the demand, a person making the demand may commence the proceeding in the name of the decedent's estate at the expense of the person making the demand.

(c) This subsection applies to a proceeding commenced under this chapter and a deceased transferor who died before July 1, 2018, if the personal representative or claimant commences the proceeding before January 1, 2020, and the claimant files a timely claim in the deceased transferor's estate before July 1, 2018. A personal representative who declines, in good faith, to commence a requested proceeding incurs no personal liability for declining to commence a proceeding.

(d) This subsection applies to a proceeding commenced under this chapter with respect to a deceased transferor who dies after June 30, 2018. A proceeding under this chapter may not be commenced unless:

(1) the claimant files a claim in the deceased transferor's estate and delivers a copy of the claim to each nonprobate transferee known by the claimant not later than five (5) months after the deceased transferor's death;

(2) the claimant delivers a written demand for the proceeding to:

(A) the personal representative of the deceased transferor's estate; and

(B) each known nonprobate transferee; and

(3) except as provided in subsection (j), the written demand has been filed in the estate not later than seven (7) months after the deceased transferor's death.

(e) This subsection applies to a proceeding commenced under this chapter and concerning a deceased transferor who dies after June 30, 2018. The written demand must include the following information:

(1) The cause number of the deceased transferor's estate.

(2) A statement of the claimant's interest in the deceased transferor's estate and nonprobate transfers, including the date on which the claimant filed a claim in the deceased transferor's estate.

(3) A copy of the claim attached as an exhibit to the written demand.

(4) A description of the nonprobate transfer, including:

(A) a description of the transferred asset, as the asset would be described under IC 29-1-12-1, regardless of whether the asset is part of the decedent's probate estate, subject to the redaction requirements of the Indiana administrative rules, established by the Indiana supreme court;

(B) a description or copy of the instrument by which the deceased transferor established the nonprobate transfer, subject to the redaction requirements of the Indiana administrative rules, established by the Indiana supreme court; and

(C) the name and mailing address of each nonprobate transferee known by the claimant.

(f) This subsection applies to a proceeding commenced under this chapter and concerning a deceased transferor who dies after June 30, 2018. A proceeding under this chapter may not be commenced on behalf of a claimant if the personal representative has neither allowed nor disallowed the claimant's claim within the deadlines in IC 29-1-14-10(a) and IC 29-1-14-10(b), unless the claimant's petition to set the claim for trial in the probate court under IC 29-1-14-10(e) has been filed within thirty (30) days after the expiration of the deadlines applicable to the allowance or disallowance of claims under IC 29-1-14-10(a) and IC 29-1-14-10(b).

(g) If the personal representative declines or fails to commence a proceeding under this chapter within thirty (30) days after receiving the written demand required under subsection (a) or (d), a person making the demand may commence the proceeding in the name of the

deceased transferor's estate at the expense of the person making the demand and not of the estate.

(h) A personal representative who declines in good faith to commence a requested proceeding incurs no personal liability for declining.

(i) Nothing in this section shall affect or prevent any action or proceeding to enforce a valid and otherwise enforceable lien, warrant, mortgage, pledge, security interest, or other comparable interest against property included in a nonprobate transfer.

(j) This subsection applies to a proceeding commenced under this chapter and concerning a deceased transferor who dies after June 30, 2018. A claimant may file the written demand required in subsection (a) or (d) concurrently with the claimant's filing of a claim in the deceased transferor's estate, but the claimant shall deliver the written demand not later than the later of:

(1) seven (7) months after the deceased transferor's death; or

(2) thirty (30) days after the final allowance of the claimant's claim.

As added by P.L.165-2002, SEC.11. Amended by P.L.6-2010, SEC.23; P.L.163-2018, SEC.19; P.L.231-2019, SEC.41; P.L.56-2020, SEC.15.

IC 32-17-13-8 Deadline for commencement of proceedings

Sec. 8. (a) This subsection applies to a proceeding commenced under this chapter with respect to a deceased transferor who died before July 1, 2018, if the personal representative or claimant commences the proceeding before January 1, 2020. A proceeding under this chapter must be commenced not later than nine (9) months after the deceased transferor's death. However, a proceeding on behalf of a creditor whose claim was timely filed may be commenced within:

(1) sixty (60) days after the final allowance of the claim; or

(2) ninety (90) days after demand is made under section 7 of this chapter if the personal representative declines or fails to commence a proceeding after receiving the demand.

(b) This subsection applies to a proceeding commenced under this chapter with respect to a deceased transferor who dies on or after June 30, 2018. A proceeding under this chapter must be commenced not later than nine (9) months after the deceased transferor's death, but a proceeding on behalf of a claimant whose claim was timely filed in the deceased transferor's estate may be commenced after the final allowance of the claim within the earlier of:

(1) thirty (30) days after the personal representative files in the deceased transferor's estate after final allowance of the claim a written notice that the personal representative does not intend to commence a proceeding under this chapter; or

(2) ninety (90) days after final allowance of the claim if:

(A) the personal representative declines or fails to commence a proceeding after receiving the demand under section 7 of this chapter; and

(B) the personal representative does not file a written notice in the deceased transferor's estate that the personal representative does not intend to commence a proceeding under this chapter.

As added by P.L.165-2002, SEC.11. Amended by P.L.6-2010, SEC.24; P.L.163-2018, SEC.20; P.L.231-2019, SEC.42.

IC 32-17-13-9 Release of obligor or trustee from liability for transfer of assets to nonprobate transferee

Sec. 9. Unless written notice asserting that a deceased transferor's probate estate is insufficient to pay allowed claims and statutory allowances has been received from the deceased transferor's personal representative, the following rules apply:

(1) Payment or delivery of assets by a financial institution, registrar, or another obligor to a nonprobate transferee under the terms of the governing instrument controlling the transfer releases the obligor from all claims for amounts paid or assets delivered.

(2) A trustee receiving or controlling a nonprobate transfer is released from liability under this section on any assets distributed to the trust's beneficiaries. Each beneficiary, to the extent of the distribution received, becomes liable for the amount of the trustee's liability attributable to that asset imposed by sections 2 and 3 of this chapter.

As added by P.L.165-2002, SEC.11. Amended by P.L.163-2018, SEC.21.

IC 32-17-13-10 Recovery of value of nonprobate transfer from nonprobate transferee; intervention

Sec. 10. (a) If the personal representative of a deceased transferor's probate estate commences a separate proceeding under this chapter and recovers all or part of the value of the nonprobate transfer from the nonprobate transferees, the personal representative must:

(1) include the value in the inventory of the deceased transferor's probate estate; and

(2) pay or distribute the value as the personal representative would pay or distribute other assets of the deceased transferor's probate estate.

(b) If:

(1) the personal representative of a deceased transferor's probate estate declines or fails to commence a proceeding under this chapter after receiving written demand;

(2) the person making the written demand commences a timely and proper action under this chapter; and

(3) the person making the written demand recovers all or part of the value of the nonprobate transfer from the nonprobate transferees;

the person making the written demand may retain the recovered value without remitting it to the personal representative of the deceased transferor's probate estate.

(c) If one (1) or more claimants of the deceased transferor's estate intervenes in the separate proceeding, the court shall enter an order allocating the recovered value among the plaintiff and other claimants according to the priorities of their claims in the deceased transferor's estate, and allow the plaintiff to retain plaintiff's costs and reasonable attorney's fees from the recovered value.

(d) Any claimant that recovers assets under this section must file a satisfaction or partial satisfaction of the claimant's claim in the deceased transferor's probate estate to the extent of the recovered value within thirty (30) days after the recovery.

As added by P.L.163-2018, SEC.22.

IC 34-11 ARTICLE 11. LIMITATION OF ACTIONS

IC 34-11-1 Chapter 1. Statutes of Limitation Generally

IC 34-11-1-1 Compilation of statutes of limitation not exhaustive

Sec. 1. This article is not intended to be an exhaustive compilation of all statutes of limitation in the Indiana Code. In addition to the statutes of limitation that appear in this article, other statutes of limitation may appear outside this article.

[1998 Recodification Citation: New.]

As added by P.L.1-1998, SEC.6.

IC 34-11-1-2 Cause of action arising on, before, or after September 1, 1982

Sec. 2. (a) A cause of action that:

(1) arises on or after September 1, 1982; and

(2) is not limited by any other statute;

must be brought within ten (10) years.

(b) A cause of action that:

(1) arises before September 1, 1982; and

(2) is not limited by any other statute;

must be brought within fifteen (15) years.

(c) This section does not apply whenever a different limitation is prescribed by statute.

[Pre-1998 Recodification Citation: 34-1-2-3.]

As added by P.L.1-1998, SEC.6.

APPLICATION FOR UNDUE HARDSHIP WAIVER

State Form 48259 (7-97) / OMPP 0003

The information contained on this form is **CONFIDENTIAL** according to I.C. 12-15-27.

* The request for your Social Security number is **VOLUNTARY** and you are not required to supply it according to 42 CFR 435.910.

1. Name of applicant		2. Telephone number ( )
3. Street address		
4. City	5. State	6. ZIP code
7. County	8. Social Security number *	
9. Name of the deceased		10. Deceased's date of birth
11. Deceased's Social Security number *	12. Deceased's medicaid recipient identification number (*if known*)	

13. What is your relationship to the deceased?

☐ Spouse ☐ Parent ☐ Sister ☐ Grandchild

☐ Child ☐ Grandparent ☐ Brother ☐ Great-grandchild

☐ Other (*please specify relationship*) _____

14. Please indicate which of the following conditions is the basis for your claim of undue hardship:

☐ Enforcement of the state's claim will cause the applicant to become eligible for public assistance;

☐ Enforcement of the state's claim will cause the applicant to remain dependent on public assistance;

☐ Enforcement of the state's claim will result in the complete loss of the applicant's sole source of income;

☐ Other compelling circumstances, as described in #20 below.

15. Do you currently receive benefits under any of the following programs? (*check all that apply*)

☐ Temporary Assistance for Needy Families

☐ Medicaid

☐ Food Stamps

☐ Supplemental Security Income (SSI)

16. If you receive benefits under any of the above programs, please indicate your Recipient Identification Number:

17. Will enforcement of the state's claim result in a reduction in your current income? If your answer is yes, explain below.

☐ Yes ☐ No

18. Please list all sources of income and the amounts you currently receive from each source. Indicate the frequency (weekly, bi-weekly, monthly, quarterly, annually) for each reported amount. Please attach supporting documentation (pay stubs, bank statements, dividend statements etc.)

SOURCE	AMOUNT
	per
	per
	per
	per
	per

19. Please list the property that you expect to receive from the deceased's estate. Include real estate, cash, bank accounts, stocks, bonds, and other tangible property. You need not list personal effects or keepsakes.

20. Please describe any other relevant factors or circumstances that you think should be considered in reviewing this request for a waiver of the state's claim. (Attach additional sheets if necessary.)

Please attach supporting documentation to support your claim of undue hardship.

I affirm that the foregoing information and any attachments are true and accurate to the best of my knowledge.

Signature of applicant	Date (month, day, year)

Submit completed form and supporting documentation to:

Section Three

Advance Care Planning in Indiana

Keith P. Huffman
Dale, Huffman & Babcock
Bluffton, Indiana

Section Three

Advance Care Planning in Indiana.....Keith P. Huffman

Discussion Outline

ADVANCE CARE PLANNING
IN INDIANA

Discussion Led by Keith P. Huffman

- What can we do to improve advance care planning in Indiana?
    - House Bill 1317—Proposed improvements prepared by Jeff Dible

- What can we do to promote advance care planning in Indiana?
    - Honoring Choices Indiana
    - Indiana Patient Preferences Coalition
    - Proposed National POLST Form/Map
    - Five Wishes Sample Form
    - Supported Decision Making Advance Directives
    - C-TAC—Improving Best Practices for Advance Care Planning

Link to the version of HB 1317 passed by the House in on January 30, 2020:

http://iga.in.gov/static-documents/f/0/9/7/f097d317/HB1317.03.ENGH.pdf

NOTE: Within the new chapter 7 (Indiana Code title 16, article 36, chapter 7) that would have been added by House Bill 1317, none of the 40 new sections would have been given "official" headings until after full enactment. The content or subject matter of each new section is described below in an unofficial heading (by Jeff Dible) in ***bold italics****.*

Amendments to existing Indiana Code provisions that would have been made by HB 1317 are shown in black strikethrough font [deletions] or bold underscored font [insertions].

Proposed 2021 changes to the text of the Engrossed House Bill 1317 are shown in tracked changes format, with additions in blue underscored font and with deletions in red strikethrough font.

NEW 2021 amendment to IC 16-36-1-3 [1]

Sec. 3. (a) Except as provided in subsections (b) 1 through (d), **(e),** unless incapable of consenting under section 4 of this chapter, an individual may consent to the individual's own health care if the individual is:

(1) an adult; or

(2) a minor and:

(A) is emancipated;

(B) is:

(i) at least fourteen (14) years of age;

(ii) not dependent on a parent or guardian for support;

(iii) living apart from the minor's parents or from an individual in loco parentis; and

(iv) managing the minor's own affairs;

(C) is or has been married;

(D) is in the military service of the United States;

(E) meets the requirements of section 3.5 of this chapter; or

(F) is authorized to consent to the health care by any other statute.

(b) A person at least seventeen (17) years of age is eligible to donate blood in a voluntary and noncompensatory blood program without obtaining parental permission from a parent or guardian.

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[1] Subsection (a) of I.C. § 16-36-1-3 has remained mostly unchanged since it was enacted in 1987 as part of the original "health care consent act." The amendments to this section, as shown above and on the next page, were included in the Conference Committee Report (early March 2020) for House Bill 1326. That Conference Committee Report did not pass.

(c) A person who is sixteen (16) years of age is eligible to donate blood in a voluntary and noncompensatory blood program if the person has obtained written permission from the person's parent or guardian.

(d) An individual who has, suspects that the individual has, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment of the individual.

(e) Before a health care provider may provide care to an unemancipated minor, the health care provider shall, before or at the initial appointment for treatment, make a reasonable effort to contact the unemancipated minor's parent or guardian for consent to provide the treatment and document in writing each attempt the health care provider made to contact the parent or guardian of the unemancipated minor. If, after the health care provider has made a reasonable attempt to contact the unemancipated minor's parent or guardian before or at the initial appointment for treatment, either:

(1) the health care provider is unable to make contact; or

(2) the parent or guardian of the unemancipated minor refuses to provide consent for treatment;

the health care provider shall act in the manner that is in the best interests of the unemancipated minor.

ENGROSSED HOUSE BILL 1317, SECTION 29. IC 16-36-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, ~~2020~~2021]:

IC 16-36-1-4
Incapacity to consent; invalid consent

Sec. 4. (a) An individual described in section 3 of this chapter may consent to health care unless, in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care.

(b) A consent to health care under section 5, 6, or 7 of this chapter is not valid if:

(1) the health care provider has knowledge that the individual has indicated contrary instructions in regard to the proposed health care; ~~even if the individual is believed to be incapable of making a decision regarding the proposed health care at the time the individual indicates contrary instructions.~~ **and**

(2) the individual has not been determined to be incapable of consenting to health care by:

(A) an order of a probate court under section 8 of this chapter; or

(B) the individual's attending physician under subsection (a).

SECTION 30. IC 16-36-1-7, AS AMENDED BY P.L.81-2015, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, ~~2020~~2021]:

Sec. 7. (a) An individual who may consent to health care under section 3 of this chapter may appoint another representative to act for the appointor in matters affecting the appointor's health care.

(b) An appointment and any amendment must meet the following conditions:

(1) Be in writing.

(2) Be signed by the appointor or by a designee in the appointor's presence **before January 1, 2023.**

(3) Be witnessed by an adult other than the representative.

(c) The appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

(d) The authority granted becomes effective according to the terms of the appointment.

(e) The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the appointor regains the capacity to consent.

(f) Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the appointor, except when the appointor is capable of consenting.

(g) In making all decisions regarding the appointor's health care, a representative appointed under this section shall act as follows:

(1) In the best interest of the appointor consistent with the purpose expressed in the appointment.

(2) In good faith.

(h) A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:

(1) The appointor.

(2) The appointor's legal representative if one is known.

(3) The health care provider if the representative knows there is one.

(i) An individual who is capable of consenting to health care may revoke:

(1) the appointment at any time by notifying the representative orally or in writing; or

(2) the authority granted to the representative by notifying the health care provider orally or in writing.

SECTION 39. IC 16-36-7 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, ~~20202021~~]:

Chapter 7. Health Care Advance Directives

IC 16-36-7-1
Suicide and euthanasia not authorized; non-exclusivity; reliance on other written directives

Sec. 1. (a) A death as a result of the withholding or withdrawal of life prolonging procedures in accordance with:

(1) a declarant's advance directive; or

(2) any provision of this chapter;

does not constitute a suicide.

(b) This chapter does not authorize euthanasia or any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(c) This chapter does not establish the only legal means that an individual may use to:

(1) communicate or confirm the individual's desires or preferences to receive or refuse life prolonging treatment or other health care; or

(2) give one (1) or more other persons authority to consent to health care or make health care decisions on the individual's behalf.

(d) This chapter does not affect the consent provisions set forth in:

(1) IC 16-34;or

(2) IC 16-36-2-3.5.

~~(d)~~(e) Nothing in this chapter prohibits a health care provider from relying on a document that:

(1) is signed by an adult who has not been determined to be incapacitated; and

(2) in the context of the relevant circumstances, clearly communicates the individual's intention to give one (1) or more specified persons authority to consent to health care or make heath care decisions on the individual's behalf.

~~A health care provider who reasonably relies in good faith on a document signed under this subsection is immune from liability under section 36 of this chapter even if the document is not witnessed or acknowledged in the manner required for an advance directive under section 24 of this chapter.~~

IC 16-36-7-2
"Advance directive" defined

Sec. 2. As used in this chapter, "advance directive" means a written declaration of a declarant who:

(1) gives instructions or expresses preferences or desires concerning any aspect of the declarant's health care or health information, including the designation of a health care representative, a living will declaration made under IC 16-36-4-10, or an anatomical gift made under IC 29-2-16.1; and

(2) complies with the requirements of this chapter.

IC 16-36-7-3
"Best interests" defined

Sec. 3. As used in this chapter, "best interests" means the promotion of the individual's welfare, based on consideration of material factors, including relief of suffering, preservation or restoration of function, and quality of life.

IC 16-36-7-4
"Declarant" defined

Sec. 4. As used in this chapter, "declarant" means a competent adult who has executed an advance directive.

IC 16-36-7-5
"Declaration" defined

Sec. 5. As used in this chapter, "declaration" means a written document, voluntarily executed by a declarant for the declarant under section ~~23~~ 28 of this chapter.

IC 16-36-7-6
"Electronic" defined [2]

Sec. 6. As used in this chapter, "electronic" has the meaning set forth in IC 26-2-8-102(7).

IC 16-36-7-7
"Electronic record" defined [3]

Sec. 7. As used in this chapter, "electronic record" has the meaning set forth in IC 26-2-8-102(9).

IC 16-36-7-8
"Electronic signature" defined [4]

Sec. 8. As used in this chapter, "electronic signature" has the meaning set forth in IC 26-2-8-102(10).

IC 16-36-7-9
"Health care" defined

Sec. 9. As used in this chapter, "health care" means any care, treatment, service, supplies, or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including preventive, therapeutic, rehabilitative, maintenance, or palliative care, and counseling.

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[2] The cross-reference is to the definition of "electronic" in the Indiana Uniform Electronic Transactions Act (UETA): "'Electronic' means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities."

[3] The cross-reference is to the UETA definition of "electronic record": "' Electronic record' means a record created, generated, sent, communicated, received, or stored by electronic means."

[4] The cross-reference is to the definition of "electronic signature" in the Indiana UETA statute: "'Electronic signature' means an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record."

IC 16-36-7-10
"Health care decision" defined

Sec. 10. As used in this chapter, "health care decision" means the following:

(1) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life prolonging procedures and mental health treatment, unless otherwise stated in the advance directive.

(2) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.

(3) The right of access to health information of the declarant reasonably necessary for a health care representative or proxy to make decisions involving health care and to apply for benefits.

(4) The decision to make an anatomical gift under IC 29-2-16.1.

IC 16-36-7-11
"Health care facility" defined

Sec. 11. As used in this chapter, "health care facility" includes the following:

(1) An ambulatory outpatient surgical center licensed under IC 16-21-2.

(2) A health facility licensed under IC 16-28-2 or IC 16-28-3.

(3) A home health agency licensed under IC 16-27-1.

(4) A hospice program licensed under IC 16-25-3.

(5) A hospital licensed under IC 16-21-2.

(6) A health maintenance organization (as defined in IC 27-13-1-19).

IC 16-36-7-12
"Health care provider" defined

Sec. 12. As used in this chapter, "health care provider" means any person licensed, certified, or authorized by law to administer health care in the ordinary course of business or practice of a profession.

IC 16-36-7-13
"Health care representative" defined

Sec. 13. As used in this chapter, "health care representative" means a competent adult designated by a declarant in an advance directive to:

(1) make health care decisions; and

(2) receive health information;

regarding the declarant. The term includes a person who receives and holds validly delegated authority from a designated health care representative.

IC 16-36-7-14

"Health information" defined [5]

Sec. 14. As used in this chapter, "health information" has the meaning set forth in 45 CFR 160.103.

IC 16-36-7-15

"Incapacity" and "incapacitated" defined

Sec. 15. As used in this chapter, "incapacity" and "incapacitated" mean that an individual is unable to comprehend and weigh ~~relativer~~relevant information and to make and communicate a reasoned health care decision. For the purposes of making an anatomical gift, the terms include an individual who is deceased.

IC 16-36-7-16

"Informed consent" defined

Sec. 16. As used in this chapter, "informed consent" means consent voluntarily given by an individual after a sufficient explanation and disclosure of the subject matter involved to enable that individual to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedure, and to make a knowing health care decision without coercion or undue influence.

IC 16-36-7-17

"Notarial officer"

Sec. 17. For purposes of this chapter, "notarial officer" means a person who is authorized under IC 33-42-9-7 to perform a notarial act as defined in IC 33-42-0.5-18. The term includes a notary public.

IC 16-36-7-18

"Observe"

Sec. 18. For purposes of this chapter and with respect to a declarant and a witness or a notarial officer, "observe" means to perceive another's actions or expressions of intent through the senses of eyesight or hearing or both. A person is able to "observe" another's actions or expressions of intent even if the person uses technology or learned skills to:

(1) Assist the person's capabilities of eyesight or hearing or both; or

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[5] The cross-reference is to the definition of "health information" in the HIPAA privacy regulations: "*Health information* means any information, including genetic information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual."

(2) Compensate for an impairment of the person's capabilities of eyesight or hearing or both.

IC 16-36-7-19
"Presence," "present," and "in the presence of"

Sec. 19. With respect to a declarant, witness, or notarial officer who signs or participates in the signing of an advance directive or other document under this chapter, "presence," "present," and "in the presence of" mean that throughout the process of signing and witnessing or signing and notarizing the advance directive or other document:

(1) The declarant and the witnesses or the declarant and the notarial officer either:

(A) are directly present with each other in the same physical space; or

(B) are able to interact with each other in real time through the use of any audiovisual technology now known or later developed; or

(C) are able to speak to and hear each other in real time through telephonic interaction;

(2) The notarial officer or the witnesses are able to positively identify the declarant by viewing a government-issued photo I.D. of the declarant, or by receiving accurate answers from the declarant about the declarant's residence address, date of birth, or other identifying personal information; and

(3) Each witness or the notarial officer is able to interact with the declarant and each other witness (if any) by observing:

(A) the declarant's expression of intent to execute an advance directive or other document under this chapter;

(B) the declarant's actions in executing or directing the execution of the advance directive or other document under this chapter; and

(C) if the advance directive or other document is executed with the participation of signing witnesses, the actions of each other witness in signing the advance directive or other document.

The requirements of subdivisions (2) and (3) are satisfied even if the testator and the notarial officer or one or all witnesses use technology to assist with one or more of the capabilities of hearing, eyesight or speech to compensate for impairments of any one or more of those capabilities.

IC 16-36-7-~~17~~20
"Proxy" defined

Sec. ~~17~~20. As used in this chapter, "proxy" means a competent adult who:

(1) has not been expressly designated in a declaration to make health care decisions for a particular incapacitated individual; and

(2) is authorized and willing to make health care decisions for the individual under section ~~38~~42 of this chapter.

IC 16-36-7-~~18~~21
"Reasonably available" defined

Sec. ~~18~~21. As used in this chapter, "reasonably available" means a health care representative or proxy for an individual who is:

(1) readily able to be contacted without undue effort; and

(2) willing and able to act in a timely manner considering the urgency of that individual's health care needs or health decisions.

IC 16-36-7-~~19~~22
"Sign"; use of electronic signature

Sec. ~~19~~22. As used in this chapter, "sign" includes the valid use of an electronic signature.

IC 16-36-7-~~20~~23
"Signature" defined

Sec. 20. As used in this chapter, "signature" means the authorized use of the name or mark of a declarant or other person to authenticate an electronic record or other writing. The term includes an electronic signature and an electronic notarial certificate completed by a ~~notary public~~notarial officer.

IC 16-36-7-24
"Telephonic interaction"

Sec. 24. In this chapter, "telephonic interaction" means interaction through the use of any technology, now known or later developed, that enables two or more persons to speak to and hear each other in real time, even if one or more of those persons cannot see each other.

IC 16-36-7-~~21~~25
"Treating physician" defined

Sec. ~~21~~25. As used in this chapter, "treating physician" means a licensed physician who is overseeing, directing, or performing health care to an individual at the pertinent time.

IC 16-36-7-~~22~~26
"Written" and "writing" defined

Sec. ~~22~~26. As used in this chapter, "written" and "writing" include the use of any method to inscribe information in or on a tangible medium or to store the information in an electronic or other medium that can retrieve, view, and print the information in perceivable form.

IC 16-36-7-~~23~~27
Individuals' right to consent to own health care; minors

Sec. ~~23~~27. (a) Except when an individual has been determined to be incapacitated under section ~~31~~35 of this chapter, an individual may consent to the individual's own health care if the individual is:

(1) an adult; or

(2) a minor, and:

(A) is emancipated;

(B) is:

(i) at least fourteen (14) years of age;

(ii) not dependent on a parent or guardian for support;

(iii) living apart from the minor's parents or from an individual in loco parentis; and

(iv) managing the minor's own affairs;

(C) is or has been married;

(D) is in the military service of the United States; or

(E) is authorized to consent to health care by another statute.

(b) A person at least seventeen (17) years of age is eligible to donate blood in a voluntary and noncompensatory blood program without obtaining ~~parental~~ permission from a parent or guardian.

(c) A person who is sixteen (16) years of age is eligible to donate blood in a voluntary and noncompensatory blood program if the person has obtained written permission from the person's parent or guardian.

(d) An individual who has, could be expected to have exposure to, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment, including preventive treatment, of the individual.

(e) If:

(1) an individual:

(A) has a signed advance directive that is in effect; and

(B) has not been determined to be incapacitated under section 31 of this chapter; and

(2) the individual's decisions and the health care representative's decisions present a material conflict;

the health care decisions by that individual take precedence over decisions made by a health care representative designated in that individual's advance directive.

(f) Before a health care provider may provide care to an unemancipated minor, the health care provider shall, before or at the initial appointment for treatment, make a reasonable effort to contact the unemancipated minor's parent or guardian for consent to provide the treatment and document in writing each attempt the health care provider made to contact the parent or guardian of the unemancipated minor. If, after the health care provider has made a reasonable attempt to contact the unemancipated minor's parent or guardian before or at the initial appointment for treatment, either:

(1) the health care provider is unable to make contact; or

(2) the parent or guardian of the unemancipated minor refuses to provide consent for treatment;

the health care provider shall act in the manner that is in the best interests of the unemancipated minor.

~~(f)~~(g) Nothing in this chapter prohibits or restricts a health care provider's right to follow or rely on a health care decision or the designation of a health care representative on a permanent or temporary basis that is:

(1) made by a competent individual described in subsection (a);

(2) communicated orally by the individual to a health care provider in the direct physical presence of the individual; and

(3) reduced to or confirmed in writing by the health care provider on a reasonably contemporaneous basis and made a part of the health care provider's medical records for the individual.

~~(g)~~(h) If:

(1) an individual later signs an advance directive under section ~~24~~28 of this chapter; and

(2) the advance directive conflicts with the recorded earlier oral instructions of the individual with respect to health care decisions or the designation of a health care representative;

the advance directive controls.

IC 16-36-7-~~24~~28

Contents of advance directive; methods for signing; witnessing or notarization

Sec. ~~24~~28. (a) An advance directive signed by or for a declarant under this section may accomplish or communicate one (1) or more of the following:

(1) Designate one (1) or more competent adult individuals or other persons as a health care representative to make health care decisions for the declarant or receive health information on behalf of the declarant, or both.

(2) State specific health care decisions by the declarant.

(3) State the declarant's preferences or desires regarding the provision, continuation, termination, or refusal of life prolonging procedures, palliative care, comfort care, or assistance with activities of daily living.

(4) Specifically disqualify one (1) or more named individuals from:

(A) being appointed as a health care representative for the declarant;

(B) acting as a proxy for the declarant under section ~~38~~42 of this chapter; or

(C) receiving and exercising delegated authority from the declarant's health care representative.

(b) An advance directive under this section must be signed by or for the declarant using one (1) of the following methods:

(1) Signed by the declarant in the presence of two (2) adult witnesses or in the presence of a ~~notary public~~notarial officer.

(2) Signing of the declarant's name by another adult individual at the specific direction of the declarant, in the declarant's ~~direct physical~~ presence, and in the presence of the two (2) adult witnesses or a ~~notary public~~notarial officer. However, an individual who signs the declarant's name on the advance directive may not be a witness, the ~~notary public~~notarial officer, or a health care representative designated in the advance directive.

(c) An advance directive signed under this section must be witnessed or acknowledged in one (1) of the following ways:

(1) Signed in the declarant's direct physical presence by two (2) adult witnesses, at least one (1) of whom may not be the spouse or other relative of the declarant.

(2) Signed or acknowledged by the declarant in the presence of a ~~notary public~~notarial officer, who completes and signs a notarial certificate under IC 33-42-9-12 and makes it a part of the advance directive.

If the advance directive complies with either subdivision (1) or (2), but contains additional witness signatures or a notarial certificate that is not needed, the advance directive is still validly witnessed and acknowledged. A remote online notarization or electronic notarization of an advance directive that complies with IC 33-42-17 complies with subdivision (2) of this subsection.

(d) A competent declarant and the witnesses or a notarial officer may complete and sign an advance directive in two or more counterparts in tangible paper form, with the declarant's signature placed on one original counterpart and with the signatures of the witnesses (if any) or the notarial officer's signature and certificate on one or more different counterparts in tangible paper form, so long as the declarant and the witnesses or notarial officer comply with the "presence" requirement as defined in section 19 of this chapter, and so long as the text of the advance directive states that it is being signed in separate paper counterparts. If an advance directive is signed in counterparts under this subsection:

(1) the declarant;

(2) a health care representative who is designated in the advance directive,

(3) a person who supervised the signing of the advance directive in that person's presence; or

(4) any other person who was present during the signing of the advance directive;

must combine all of the separately signed paper counterparts of the advance directive into a single composite document that contains all the text of the advance directive, the signature of the declarant, and the signatures of the witnesses (if any) or the notarial officer. The person who combines the separately signed counterparts into a single composite document must do so within ten (10) business days after the person receives all of the separately signed paper counterparts. Any scanned copy, photocopy, or other accurate copy of the composite document which contains the complete text of the advance directive and all signatures will be treated as validly signed under this section. The person who creates the single composite document under this subsection may include information about compliance with this subsection in an optional affidavit that is signed under section 41 of this chapter.

(e) If facts and circumstances, including but not limited to physical impairments or physical isolation of a competent declarant, make it impossible or impractical for the declarant to use audio-visual technology to interact with the witnesses or the notarial officer and to satisfy the "presence"

requirement under section 19 of this chapter, the declarant and the witnesses or the declarant and the notarial officer may use telephonic interaction, as defined in section 24 of this chapter, throughout the signing process. A potential witness or a notarial officer cannot be compelled to use telephonic interaction alone to accomplish the signing of an advance directive under this section. If an advance directive is signed using telephonic interaction under this subsection:

(1) The witnesses or the notarial officer, as the case may be, must be able to positively identify the declarant by receiving accurate answers from the declarant about the declarant's date of birth, residence address, or other identifying personal information;

(2) The text of the advance directive must state that the declarant and the witnesses or the notarial officer used telephonic interaction throughout the signing process to satisfy the "presence" requirement;

(3) The advance directive is presumed to be valid if it recites that the declarant and the witnesses or the notarial officer signed the advance directive in compliance with Indiana law; and

(4) Any health care provider or other person who disputes the validity of the advance directive has the burden of proving the invalidity of the advance directive or non-compliance with this subsection by a reasonable preponderance of the evidence.

~~(d)~~(f) If a declarant resides in or is located in a jurisdiction other than Indiana at the time when the declarant signs a writing that communicates the information described in subsection (a), the writing must be treated as a validly signed advance directive under this chapter if the declarant was not incapacitated at the time of signing and if the writing was:

(1) signed and witnessed or acknowledged in a manner that complies with subsections (b) and (c); or

(2) signed in a manner that complies with the applicable law of the jurisdiction in which the declarant was residing or was physically located at the time of signing.

IC 16-36-7-~~25~~29

Additional provisions permitted in advance directive

Sec. ~~25~~29. An advance directive signed by a declarant under this section may contain any of the following additional provisions:

(1) A provision that delays:

(A) the effectiveness of an instruction or decision by the declarant; or

(B) the effectiveness of the authority of a designated health care representative;

until a stated date or the occurrence of a specifically defined event.

(2) If the advance directive explicitly provides that a health care decision or instruction or the authority of one (1) or more health care representatives is to be effective upon the future incapacity, disability, or incompetence of the declarant, a provision that:

(A) specifies the person or persons who are authorized to participate in the determination of incapacity, disability, or incompetence and the evidence or information to be used for the determination;

(B) is not more stringent than the procedure described in section 31 of this chapter; and

(C) does not allow a medical determination by a physician, psychologist, or other health care professional to be superseded by the subjective judgment or veto of another person or by nonmedical evidence regarding the declarant's capacity or incapacity.

(3) A provision that terminates the authority of a designated health care representative on:

(A) a stated date; or

(B) upon the occurrence of a specifically defined event.

(4) A provision that designates two (2) or more health care representatives as having authority to act individually to make health care decisions for the declarant in a specified order of priority.

(5) A provision that designates two (2) or more health care representatives and permits them to act individually and independently, or that requires them to act jointly, on a majority vote basis, or under a combination of requirements to make all health care decisions or specified health care decisions for the declarant. The advance directive may include a provision for a successor health care representative to act according to different requirements.

(6) A provision that states a fee or presumptive reasonable hourly rate for the compensation that a health care representative may collect for acting on behalf of the declarant or providing caregiving services to the declarant.

(7) A provision that prohibits a health care representative from collecting compensation for acting under the advance directive.

(8) A provision that requires a professional adviser or other additional person to witness, ratify, or approve the declarant's ~~oral or written~~ revocation or amendment of a designation of one (1) or more health care representatives within the advance directive.

(9) A provision that:

(A) prohibits a designated health care representative from consenting to mental health treatment for the declarant; or

(B) designates a different health care representative to consent to mental health treatment.

(10) A provision that designates an adult individual or another person as an advocate with the authority to:

(A) receive:

(i) health information about the declarant; and

(ii) information and documents from a health care representative about the health care representative's actions on behalf of the declarant;

(B) monitor, audit, and evaluate the actions of a health care representative designated by the declarant; and

(C) take remedial action in the best interests of the declarant, including revoking or limiting the authority of any health care representative or filing a petition with a court for appropriate relief.

(11) Any other provision concerning the:

(A) declarant's health care or health information; or

(B) implementation of the declarant's advance directive.

IC 16-36-7-~~2630~~
Sample form of advance directive; state health department authority

Sec. ~~2630~~. (a) The state department of health shall develop a sample form for an advance directive that is consistent with this chapter. The sample form must contain the following provisions:

(1) A provision that states a declarant's preferences or desires about providing, continuing, terminating, or refusing life prolonging procedures, palliative care, comfort care, or assistance with activities of daily living.

(2) A provision that designates one (1) or more health care representatives to make health care decisions for a declarant or to receive health information on behalf of a declarant, or both.

The sample form may include boxes that can be checked, signed, or initialed to select provisions that are optional but permitted under section 25 of this chapter.

(b) A declarant is not required to use any official or unofficial form to prepare and sign a valid advance directive.

IC 16-36-7-~~2731~~
Delivery of advance directive to health care representative and health care providers

Sec. ~~2731~~. (a) A complete copy of the signed and witnessed or notarized advance directive must be given to each health care representative who:

(1) is specifically designated by name in the advance directive; and

(2) has authority to make health care decisions that are immediately effective under the explicit terms of the advance directive or under section ~~3034~~(1) of this chapter.

If the advance directive is signed with electronic signatures, a complete copy that is generated or converted from the original electronic record and that is viewable and printable is valid and may be relied upon as the equivalent to the original.

(b) A declarant who has capacity is responsible for giving a complete copy of the declarant's advance directive to a health care provider. If a declarant has signed an advance directive but lacks the capacity to make health care decisions or provide informed consent, any health care representative designated in the advance directive or any other interested person shall give a complete copy of the declarant's advance directive to a health care provider. Upon receipt of the

declarant's advance directive, the health care provider shall put a copy of the advance directive in the declarant's medical records.

IC 16-36-7-~~28~~32
Methods for amendment or revocation of advance directive

Sec. ~~28~~32. (a) The declarant who signs an advance directive may revoke that advance directive by any of the following:

(1) Signing, in a manner that complies with section ~~24(b) and 24(c)~~28 of this chapter, another advance directive.

(2) Signing, in a manner that complies with section ~~24(b) and 24(c)~~28 of this chapter, a document that:

(A) states in writing that the declarant is revoking the previously signed advance directive; and

(B) confirms the declarant's compliance with any explicit additional conditions for valid revocation that are stated in the advance directive.

(3) Orally expressing the declarant's present intention, in the direct physical presence of a health care provider, to:

(A) revoke the entire advance directive;

(B) revoke a designation of one (1) or more health care representatives within the advance directive; or

(C) revoke one (1) or more specific health care decisions or one (1) or more desires or treatment preferences within the advance directive.

However, if a declarant has not been determined to be incapacitated under section 31 of this chapter, the declarant always has the right to orally revoke a health care decision that is included within an advance directive under section ~~24~~28(a)(2) of this chapter or a statement of desires or treatment preferences that is included within an advance directive under section ~~24~~28(a)(3) of this chapter, despite any contrary wording in the advance directive.

(b) Until a health care representative or health care provider has actual knowledge of a valid revocation of an advance directive:

(1) actions and health care decisions by a health care representative designated in the advance directive are valid and binding on the declarant; and

(2) health care providers may continue to rely on health care decisions by the health care representative.

(c) A declarant who has signed a valid advance directive may amend or restate that advance directive in a writing that is signed in compliance with section ~~24(b)~~28 of this chapter and witnessed or acknowledged in compliance with section ~~24~~28(c), (d) or (e) of this chapter. The amendment or restatement may take any action that could have been included in the former or original advance directive.

IC 16-36-7-~~29~~33
Delegation of authority by health care representative

Sec. ~~29~~33. (a) Except when the terms of the advance directive explicitly prohibit or restrict delegation, a health care representative who is designated by name in an advance directive may make a written delegation of some or all of the health care representative's authority to one (1) or more other competent adults or other persons, on a temporary or open ended basis as stated in the written delegation document.

(b) A written delegation document under this section must be signed in compliance with section ~~24(b)~~28 of this chapter and witnessed or acknowledged in compliance with section ~~24~~28(c), (d) or (e) of this chapter.

(c) A written delegation of authority that does not state an expiration date continues until it is revoked, in a manner complying with section ~~28~~32 of this chapter, by the competent declarant or by the health care representative who signed the written delegation.

(d) If the advance directive explicitly states a date or event that triggers termination of the advance directive or termination of the authority of a health care representative who makes a written delegation under this section, the delegated authority terminates upon the triggering event or expiration date.

IC 16-36-7-~~30~~34
Rules and presumptions for interpreting advance directives

Sec. ~~30~~34. An advance directive must be interpreted to carry out the known or demonstrable intent of the declarant. The following presumptions apply to an advance directive unless the terms of the advance directive explicitly prevent a presumption from applying:

(1) If the advance directive does not state a delayed effective date or a future triggering event for effectiveness, the advance directive is effective immediately upon signing and witnessing or acknowledgment in compliance with section ~~24~~28 of this chapter. However, if the declarant has capacity to consent to health care, the declarant has the right to make health care decisions, give consent, or provide instructions that supersede or overturn any decision that is made or could be made by the declarant's health care representative.

(2) If the advance directive does not explicitly state an expiration date or a triggering event for termination, the advance directive and the authority of each designated health care representative continues until the death of the declarant or until an earlier valid revocation of the advance directive.

(3) If an advance directive designates two (2) or more health care representatives and does not specify that:

(A) the health care representative's respective authority to act is subject to an order of priority; or

(B) the health care representatives must act jointly or on a majority vote basis;

each health care representative has concurrent authority to act individually and independently to make health care decisions for the declarant. If two (2) or more health care representatives who are required to act jointly disagree about a health care decision,

or if two (2) or more health care representatives who are authorized to act independently give conflicting instructions to a health care provider, the health care provider may decline to comply with the conflicting instructions, and in an urgent or emergency situation, the health care provider may provide treatment consistent with the instructions of one (1) physician who examines or evaluates the declarant.

(4) If:

(A) an individual signs more than one (1) advance directive at different times; and

(B) the later signed advance directive does not explicitly state that one (1) or more of the previous advance directives by the declarant remain in effect;

each previous advance directive is superseded and revoked by the last signed advance directive.

(5) Unless the advance directive explicitly provides otherwise, each health care representative who is designated in an advance directive continues to have authority after the death of the declarant to do the following:

(A) Make anatomical gifts on the declarant's behalf, subject to any previous written direction by the declarant.

(B) Request or authorize an autopsy.

(C) Make plans for the disposition of the declarant's body, including executing a funeral planning declaration on behalf of the declarant under IC 29-2-19.

(6) Each health care representative who is designated in an advance directive and who has current authority to act is a personal representative of the declarant for purposes of 45 CFR Parts 160 through 164.

(7) If an advance directive explicitly provides that the authority of one (1) or more health care representatives is to be effective upon the future incapacity, disability, or incompetence of the declarant but if the advance directive does not specify a method or procedure for determining the incapacity, disability, or incompetence of the declarant:

(A) the health care representative's authority to act becomes effective upon a determination that the declarant is incapacitated that is stated in a writing or other record by a physician, licensed psychologist, or judge; and

(B) each health care representative who is designated in the advance directive is authorized to act as the declarant's personal representative under 45 CFR 164.502(g) to obtain access to the declarant's information, and to communicate with the declarant's health care providers, for the purpose of gathering information necessary for determinations under this subdivision.

(8) Each health care representative who is designated in an advance directive and who has current authority to make health care decisions for the declarant has authority to consent to mental health treatment for the declarant.

(9) If the advance directive is silent on the issue of compensation for a health care representative designated in the advance directive, then each health care representative is entitled to receive the following:

(A) Reasonable compensation from the declarant's property for services or acts actually performed by the health care representative and for the declarant.

(B) Reasonable reimbursement from the declarant's property for out-of-pocket expenses actually incurred and paid by the health care representative from the health care representative's own funds in the course of performing services or acts for the declarant under the advance directive.

Any health care representative may waive part or all of the compensation or expense reimbursements that the health care representative would be entitled to receive under the terms of the advance directive or under this subdivision.

(10) If an advance directive explicitly provides that the authority of a health care representative is effective only at times when the declarant is incapacitated or unable to consent to health care, then unless the advance directive explicitly states another procedure:

(A) the health care representative's authority becomes effective when a determination of the declarant's incapacity is noted in the declarant's medical records under section ~~34~~35(c) of this chapter; and

(B) the health care representative's authority becomes inactive when the declarant regains capacity.

(11) If the authority of a health care representative under the advance directive is effective immediately upon signing by the declarant, the health care representative's authority may be rescinded or superseded by the direct decisions of the declarant at all times when the declarant has not been determined to be incapacitated.

(12) If:

(A) an advance directive designates one (1) or more health care representatives;

(B) a health care representative is not reasonably available to act for the declarant; and

(C) the declarant is incapacitated or not competent to make personal health care decisions;

then subject to any order of priority explicitly stated in the advance directive, each health care representative designated in the advance directive must be given the opportunity to exercise authority for the declarant.

(13) If explicitly allowed or required in the advance directive, each person who may act as a proxy for the declarant under sections ~~38~~42 and ~~39~~43 of this chapter, if an advance directive had not existed, has the right to make a written demand for and to receive from a health care representative a narrative description or other appropriate accounting of the actions taken and decisions made by a health care representative under the advance directive. Notwithstanding any provision in the advance directive, a health care representative who prepares a narrative description or accounting in response to a written demand is entitled to reasonable compensation for the time and effort spent in doing so.

(14) Notwithstanding any provision in the advance directive, if a declarant is not competent to amend or revoke the declarant's advance directive, then a person who may

act as a proxy for the declarant under sections ~~38~~ 42 and ~~39~~ 43 of this chapter has the right to petition a probate court with jurisdiction over the declarant for any of the following relief:

(A) An order modifying or terminating the advance directive.

(B) An order removing a health care representative or terminating the authority of a person who holds delegated authority under the advance directive, on the grounds that the health care representative or person is not acting or is declining to act in the best interests of the declarant.

(C) An order directing a health care representative to make or carry out a specific health care decision for the declarant.

(D) An order appointing a new or additional health care representative, on the grounds that all health care representatives designated in the advance directive are not reasonably available to act.

Before issuing an order under this subdivision, the court must hold a hearing after notice to the declarant, to each health care representative, and any other person whose rights or authority could be affected by the order, and to any persons who have the highest priority under sections ~~38~~ 42 and ~~39~~ 43 of this chapter to serve as a proxy for the declarant if an advance directive had not existed. An order issued under this subdivision must be guided by the declarant's best interests and the declarant's known or demonstrable intent.

IC 16-36-7-~~31~~35

Presumption that individual has capacity; determining incapacity

Sec. ~~31~~35. (a) For purposes of this section, the term "declarant" includes an individual who has not executed an advance directive or who has no unrevoked advance directive in effect.

(b) A declarant is presumed to be capable of making health care decisions for the declarant unless the declarant is determined to be incapacitated. The declarant's desires are controlling while a declarant has decision making capacity. Each physician or health care provider must clearly communicate to a declarant who has decision making capacity the treatment plan and any change to the treatment plan before implementation of the plan or a change to the plan. Incapacity may not be inferred from a person's voluntary or involuntary hospitalization for mental illness or from the person's intellectual disability.

(c) When a declarant is incapacitated, a health care decision made on the declarant's behalf by a health care representative is effective to the same extent as a decision made by the declarant if the declarant were not incapacitated. However, if:

(1) a health care representative makes and communicates a health care decision; and

(2) a health care provider concludes that carrying out that health care decision would be medically inappropriate or clearly contrary to the declarant's best interests;

then the health care provider has the same right to refuse to carry out that decision as if that decision were made and communicated directly by the declarant at a time when the declarant was not incapacitated.

(d) If a declarant's capacity to make health care decisions or provide informed consent is in question, the declarant's treating physician shall evaluate the declarant's capacity and, if the treating physician concludes that the declarant lacks capacity, enter that evaluation in the declarant's medical record.

(e) If the treating physician is unable to reach a conclusion under subsection (d) about whether the declarant lacks capacity, the treating physician and other health care providers shall treat the declarant as still having capacity to make health care decisions and provide informed consent, until a later evaluation occurs under this section after the passage of time or after a change in the declarant's condition.

(f) This chapter does not limit the authority of a probate court under IC 29-3 to make determinations about an individual's incapacity or recovery from a period of incapacity.

(g) A determination made under this section that a declarant lacks capacity to make health care decisions may not be construed as a finding that a declarant lacks capacity for any other purpose.

IC 16-36-7-~~32~~36

Presumptive authority and responsibilities of health care representative

Sec. ~~32~~36. (a) Except when a health care representative's authority has been expressly limited by the declarant in an advance directive, the health care representative, in accordance with the declarant's instructions made while competent, has the following authority and responsibilities:

(1) The authority to act for the declarant and to make all health care decisions for the declarant at all times when the health care representative's authority is in effect, subject to the right of the competent declarant to act directly and personally.

(2) The authority and responsibility to be reasonably available to consult with appropriate health care providers to provide informed consent.

(3) The authority and responsibility to act in good faith and make only health care decisions for the declarant that the health care representative believes the declarant would have made under the circumstances if the declarant were capable of making the decisions, taking into account the express or implied intentions of the declarant or if the declarant's express or implied intentions are not known, the declarant's best interests.

(4) The authority and responsibility to provide written consent using an appropriate form when consent is required, including a physician's order not to resuscitate (IC 16-36-~~6~~5 or IC 16-36-6).

(5) The authority to be provided access to the appropriate health information of the declarant.

(6) The authority to apply for public benefits, including Medicaid and the community and home options to institutional care for the elderly and disabled (CHOICE) program, for the declarant and have access to information regarding the declarant's income, assets, and banking and financial records to the extent required to make application.

(b) The health care representative may authorize the release of health information to appropriate persons to ensure the continuity of the declarant's health care and may authorize the admission, discharge, or transfer of the declarant to or from a health care facility or other heath or residential facility or program licensed or registered by a state agency.

(c) If, after a declarant has designated one (1) or more health care representatives in an advance directive, a court appoints a guardian of the declarant's person, the authority of each designated health care representative continues unless the appointing court modifies or revokes the authority of one (1) or more health care representatives after a hearing upon notice under section ~~3034~~(14) of this chapter. The court may order a health care representative to make appropriate or specified reports to the guardian of the declarant's person or property.

IC 16-36-7-~~33~~37
Responsibilities and rights of health care providers that receive advance directive

Sec. ~~33~~37. (a) A health care provider furnished with a copy of a declarant's advance directive shall make the declarant's advance directive a part of the declarant's medical records. If a change in or termination of the advance directive becomes known to the health care provider, the change or termination must be noted in the declarant's medical records.

(b) If a health care provider believes that an individual may lack the capacity to give informed consent to health care, then, until the individual is determined to have capacity under section 31 of this chapter, the health care provider shall consult with:

(1) a health care representative designated by the declarant; or

(2) if a health care representative has not been designated or if a health care representative is not reasonably available to act, a proxy under section ~~38~~42 of this chapter;

who has authority and priority to act and who is reasonably available to act.

(c) Subject to the right of a competent declarant to directly make and communicate health care decisions for the declarant and to rescind a health care decision by a health care representative who is designated in an advance directive, the following conditions apply:

(1) A health care provider may continue to administer treatment for the declarant's comfort, care, or the alleviation of pain in addition to treatment made under the decision of the health care representative.

(2) Subject to subdivision (3), a health care provider shall comply with a health care decision made by a health care representative if the decision is communicated to the provider.

(3) If a health care provider is unwilling to comply with a health care decision made by a health care representative, the provider shall do the following:

(A) Notify the health care representative of the health care provider's unwillingness to comply with the decision.

(B) Promptly take all steps necessary to transfer the responsibility for the declarant's health care to another health care provider designated by the health care representative. However, a health care provider who takes steps for a transfer does not have a duty to look for or identify another health care provider who will accept the declarant.

However, if a health care provider is unwilling to comply with a health care decision made by a health care representative, and the declarant's health condition would make transfer of the declarant untenable or unadvisable, this subsection does not prohibit the

health care provider from following the health care provider's dispute resolution procedure with the objective of reaching a decision in the best interest of the declarant.

IC 16-36-7-~~34~~38
Actions of health care representative after declarant's death

Sec. ~~34~~38. If a health care representative designated in an advance directive has authority to:

(1) make an anatomical gift on behalf of the declarant;

(2) authorize an autopsy of the declarant's remains; or

(3) direct the disposition of the declarant's remains;

under either the explicit provisions of the advance directive or section ~~30~~34(5) of this chapter, the anatomical gift, autopsy, or remains disposition is considered the act of the declarant or of the person who has legal authority to make the necessary decisions.

IC 16-36-7-~~35~~39
Health care representative's right to access declarant's health information

Sec. ~~35~~39. (a) A health care provider shall give a health care representative authorized to receive information under an advance directive the same access as the declarant has to examine and copy the declarant's health information and medical records, including records relating to mental health and other medical conditions held by a physician or other health care provider.

(b) The access to records under this section must be given at the declarant's expense and may be subject to reasonable rules of the provider to prevent disruption of the declarant's health care.

(c) A health care representative may release information obtained under this section to any person authorized to receive the information under IC 16-39.

IC 16-36-7-~~36~~40
Protection of health care providers from liability

Sec. ~~36~~40. (a) A health care provider or other person who acts in good faith reliance on an advance directive or on a health care decision made by a health care representative with apparent authority is immune from liability to the declarant and to the declarant's heirs or other successors in interest to the same extent as if the health care provider or other person had dealt directly with the declarant and if the declarant had been competent and not incapacitated.

(b) A health care provider is not responsible for determining the validity of an advance directive.

IC 16-36-7-~~37~~41
Affidavit ~~provided by health care representative~~provided to health care providers or others

Sec. ~~37~~41. (a) A health care representative designated in an advance directive or a person who was present during the signing of the advance directive may furnish to a health care provider or other person an affidavit that states, to the best knowledge of the health care representative:

(1) that the document attached to and furnished with the affidavit is a true copy of the named declarant's advance directive that is currently in effect;

(2) that the declarant is alive;

(3) that the advance directive was validly executed;

(4) if the effectiveness of the health care representative's authority to act under the advance directive begins upon the occurrence of a certain event, that the event has occurred and the health care representative has authority to act;

(5) if the health care representative who furnishes the affidavit does not have the highest priority to act under the explicit terms of the advance directive, an explanation that all health care representatives who are identified in the advance directive as having higher priority are not reasonably available to act; and

(6) that the relevant powers granted to the health care representative have not been altered or terminated.

An affidavit signed and furnished under this section may include, but is not required to include, information based on the affiant's personal knowledge about the manner in which the advance directive was signed under subsection (b) and subsections (c), (d), or (e) of section 28 of this chapter. An affidavit under this section must be signed, sworn to, and acknowledged by the ~~health care representative~~affiant in the presence of a ~~notary public~~notarial officer, ~~or~~ unless ~~if~~ the health care representative swears to ~~s~~ or affirms ~~to~~ the accuracy of the affidavit's contents under the penalties for perjury.

(b) A health care provider or other person who:

(1) relies on an affidavit described in subsection (a); and

(2) acts in good faith;

is immune from liability that might otherwise arise from the health care provider's or other person's actions in reliance on the advance directive that is the subject of the affidavit.

IC 16-36-7-~~38~~42

Authority of proxies to make health care decisions in absence of advance directive

Sec. ~~38~~42. (a) For purposes of this section, the term "declarant" includes an individual who has not executed an advance directive or who does not have an advance directive currently in effect.

(b) This section applies only if a declarant is not capable of consenting to health care, and:

(1) the declarant has not executed an advance directive under this chapter or who does not have an advance directive currently in effect; or

(2) the declarant has executed an advance directive and the health care representative designated in the advance directive is not willing, able, or reasonably available to make health care decisions for the declarant.

(c) Except as provided in section ~~39~~43 of this chapter, health care decisions may be made for the declarant by any of the following individuals to act as a proxy, in the following decreasing order of priority, if an individual in a prior class is not reasonably available, willing, and competent to act:

(1) The judicially appointed guardian of the declarant or a health care representative appointed under IC 16-36-1-8 or section ~~3034~~(14) of this chapter.

(2) A spouse.

(3) An adult child.

(4) A parent.

(5) An adult sibling.

(6) A grandparent.

(7) An adult grandchild.

(8) The nearest other adult relative in the next degree of kinship who is not listed in subdivisions (2) through (7).

(9) A friend who:

(A) is an adult;

(B) has maintained regular contact with the individual; and

(C) is familiar with the individual's activities, health, and religious or moral beliefs.

(10) The individual's religious superior, if the individual is a member of a religious order.

(d) Any health care decision made under subsection (c) must be based on the proxy's informed consent and on the decision the proxy reasonably believes the declarant would have made under the circumstances, taking into account the declarant's express or implied intentions. If there is no reliable indication of what the declarant would have chosen, the proxy shall consider the declarant's best interests in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

(e) Before exercising the incapacitated declarant's rights to select or decline health care, the proxy must attempt to comply in good faith with:

(1) the instructions, desires, or preferences, if any, stated by the declarant regarding life prolonging procedures in an advance directive executed under IC 16-36-1, IC 16-36-4, or IC 30-5; and

(2) IC 16-36-6, if a valid POST form (as defined by IC 16-36-6-4) executed by the patient is in effect.

However, a proxy's decision to withhold or withdraw life prolonging procedures must be supported by evidence that the decision would have been the one the declarant would have chosen had the declarant been competent or, if there is no reliable indication of what the declarant would have chosen, that the decision is in the declarant's best interests.

(f) If there are multiple individuals at the same priority level under this section, those individuals shall make a reasonable effort to reach a consensus as to the health care decisions on behalf of the declarant who is unable to provide health care consent. If the individuals at the same priority level disagree as to the health care decisions on behalf of the individual who is unable to provide health care consent, a majority of the available individuals at the same priority level controls.

(g) Nothing in this section shall be construed to preempt the designation of persons who may consent to the medical care or treatment of minors established under IC 16-36-1-5(b).

IC 16-36-7-~~39~~43
Persons not authorized to serve as proxies

Sec. ~~39~~43. The following individuals may not serve as a proxy under section ~~38~~43 of this chapter:

(1) An individual specifically disqualified in the declarant's advance directive.

(2) A spouse who:

(A) is legally separated; or

(B) has a petition for dissolution, legal separation, or annulment of marriage that is pending in a court;

from the individual.

(3) An individual who is subject to a protective order or other court order that directs that individual to avoid contact with the declarant.

(4) An individual who is subject to a pending criminal charge in which the declarant was the alleged victim.

IC 16-36-7-~~40~~44
Material conflicts between multiple documents; latest directive controls

Sec. ~~40~~44. If a declarant has become and remains incapacitated and has previously executed a valid advance directive under this chapter and executed:

(1) an appointment of a health care representative executed under IC 16-36-1 before January 1, 2023;

(2) a durable power of attorney granting health care powers and executed under IC 30-5 before January 1, 2023; or

(3) a similar advance directive executed by the declarant under the laws of another state in which the declarant was physically present at the time of signing; and

if a material conflict exists between multiple documents described in this section or if a material conflict exists between the health care decisions that different health care representatives or other authorized agents propose to make under the multiple documents, or if there is a material difference between the documents, then the document signed last by the declarant and the authority of the named representatives or agents in that document controls.

ENGROSSED HOUSE BILL 1317, SECTION 51. IC 30-5-5-16, AS AMENDED BY P.L.81-2015, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, ~~2020~~2021]:

IC 30-5-5-16
Health care powers; religious tenets; funeral planning declaration

Sec. 16. (a) This section does not prohibit an individual capable of consenting to the individual's own health care or to the health care of another from consenting to health care administered in good faith under the religious tenets and practices of the individual requiring health care.

(b) Language conferring general authority with respect to health care powers means the principal authorizes the attorney in fact to do the following:

(1) Employ or contract with servants, companions, or health care providers to care for the principal.

(2) Consent to or refuse health care for the principal who is an individual in accordance with IC 16-36-4 and IC 16-36-1 by properly executing and attaching to the power of attorney a declaration or appointment, or both.

(3) Admit or release the principal from a hospital or health care facility.

(4) Have access to records, including medical records, concerning the principal's condition.

(5) Make anatomical gifts on the principal's behalf.

(6) Request an autopsy.

(7) Make plans for the disposition of the principal's body, including executing a funeral planning declaration on behalf of the principal in accordance with IC 29-2-19.

(c) Notwithstanding any other law, a document granting health care powers to an attorney in fact for health care may not be executed under this chapter after December 31, 2022. However, if a power of attorney that is executed after December 31, 2022, is written to grant both:

(1) health care powers; and

(2) nonhealth care powers under this chapter;

to an attorney in fact, the health care powers are void, but all other powers granted by the power of attorney will remain effective and enforceable under this article.

ENGROSSED HOUSE BILL 1317, SECTION 52. IC 30-5-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, ~~2020~~2021]:

IC 30-5-5-17
Consent to or refusal of health care

Sec. 17. (a) If the attorney in fact has the authority to consent to or refuse health care under section ~~16(2)~~ **16(b)(2)** of this chapter, the attorney in fact may be empowered to ask in the name

of the principal for health care to be withdrawn or withheld when it is not beneficial or when any benefit is outweighed by the demands of the treatment and death may result. To empower the attorney in fact to act under this section, the following language must be included in an appointment under IC 16-36-1 **or IC 16-36-7** in substantially the same form set forth below:

> I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

(b) Nothing in this section may be construed to authorize euthanasia.

NOTE: The following amendments were proposed in the Senate after HB 1317 was passed by the House. These amendments were included in a proposed Conference Committee Report (for House Bill 1326) which did not receive a Senate vote.

The sole purpose of these amendments is to update the "Out of Hospital Do Not Resuscitate" statute, I.C. 16-36-5, so that the same three types of health care providers (physician, advanced practice registered nurse, and physician assistant) who can approve a DNR order as part of a POST form can also approve an out-of-hospital DNR order.

NEW **IC 16-36-5-1.1**
"Attending"

Sec. 1.1. As used in this chapter, "attending" means the physician, advanced practice registered nurse, or physician assistant who has the primary responsibility for the treatment and care of the patient.

IC 16-36-5-9
"Representative"

Sec. 9. As used in this chapter, "representative" means a person's:

(1) legal guardian or other court appointed representative responsible for making health care decisions for the person;

(2) health care representative appointed under IC 16-36-1;

(3) health care representative appointed under IC 16-36-7; or

~~(3)~~(4) attorney in fact for health care appointed under IC 30-5-5-16.

Credits

As added by P.L.148-1999, SEC.12

IC 16-36-5-10
Certification as qualified person

Sec. 10. An attending physician, advanced practice registered nurse, or physician assistant may certify that a patient is a qualified person if the attending physician, advanced practice registered nurse, or physician assistant determines, in accordance with reasonable medical standards, that one (1) of the following conditions is met:

(1) The person has a terminal condition (as defined in IC 16-36-4-5).

(2) The person has a medical condition such that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-11
Execution of declaration

Sec. 11. (a) A person who is of sound mind and at least eighteen (18) years of age may execute an out of hospital DNR declaration.

(b) A person's representative may execute an out of hospital DNR declaration for the person under this chapter only if the person is:

(1) at least eighteen (18) years of age; and

(2) incompetent.

(c) An out of hospital DNR declaration must meet the following conditions:

(1) Be voluntary.

(2) Be in writing.

(3) Be signed by the person making the declaration or by another person in the declarant's presence and at the declarant's express direction.

(4) Be dated.

(5) Be signed in the presence of at least two (2) competent witnesses.

(d) An out of hospital DNR declaration must be issued on the form specified in section 15 of this chapter.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-12
Issuance of DNR order

Sec. 12. An out of hospital DNR order:

(1) may be issued only by the declarant's attending physician, advanced practice registered nurse, or physician assistant; and

(2) may be issued only if both of the following apply:

(A) The attending physician, advanced practice registered nurse, or physician assistant has determined the patient is a qualified person.

(B) The patient has executed an out of hospital DNR declaration under section 11 of this chapter.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-13
Transfer of patient to another physician

Sec. 13. (a) An attending physician, advanced practice registered nurse, or physician assistant who does not issue an out of hospital DNR order for a patient who is a qualified person may transfer the patient to another physician, who may issue an out of hospital DNR order, unless:

(1) the attending physician, advanced practice registered nurse, or physician assistant has reason to believe the patient's declaration was not validly executed, or there is evidence the patient no longer intends the declaration to be enforced; and

(2) the patient is unable to validate the declaration.

(b) Notwithstanding section 10 of this chapter, if an attending physician, advanced practice registered nurse, or physician assistant, after reasonable investigation, does not find any other physician willing to honor the patient's out of hospital DNR declaration and issue an out of hospital DNR order, the attending physician, advanced practice registered nurse, or physician assistant may refuse to issue an out of hospital DNR order.

(c) If the attending physician, advanced practice registered nurse, or physician assistant does not transfer a patient under subsection (a), the attending physician, advanced practice registered nurse, or physician assistant may attempt to ascertain the patient's intent and attempt to determine the validity of the declaration by consulting with any of the following individuals who are reasonably available, willing, and competent to act:

(1) A court appointed guardian of the patient, if one has been appointed. This subdivision does not require the appointment of a guardian so that a treatment decision may be made under this section.

(2) A person designated by the patient in writing to make a treatment decision.

(3) The patient's spouse.

(4) An adult child of the patient or a majority of any adult children of the patient who are reasonably available for consultation.

(5) An adult sibling of the patient or a majority of any adult siblings of the patient who are reasonably available for consultation.

(6) The patient's clergy.

(7) Another person who has firsthand knowledge of the patient's intent.

(d) The individuals described in subsection (c)(1) through (c)(7) shall act in the best interest of the patient and shall follow the patient's express or implied intent, if known.

(e) The attending physician, advanced practice registered nurse, or physician assistant acting under subsection (c) shall list the names of the individuals described in subsection (c) who were consulted and include the information received in the patient's medical file.

(f) If the attending physician, advanced practice registered nurse, or physician assistant determines from the information received under subsection (c) that the patient intended to execute a valid out of hospital DNR declaration, the attending physician, advanced practice registered nurse, or physician assistant may:

(1) issue an out of hospital DNR order, with the concurrence of at least one (1) physician documented in the patient's medical file; or

(2) request a court to appoint a guardian for the patient to make the consent decision on behalf of the patient.

(g) An out of hospital DNR order must be issued on the form specified in section 15 of this chapter.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-15
Form

Sec. 15. An out of hospital DNR declaration and order must be in substantially the following form:

OUT OF HOSPITAL DO NOT RESUSCITATE

DECLARATION AND ORDER

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE

DECLARATION

Declaration made this _____ day of _____. I, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below. I declare:

My attending physician or an advanced practice nurse or physician assistant working under that physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this out of hospital DNR declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration.

Signed

Printed name

City and State of Residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Printed name _____ Date_____

Witness _____ Printed name _____ Date_____

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I,_____, the attending physician, advanced practice registered nurse, or physician assistant of _____, have certified the declarant as a qualified person to make an out of hospital DNR declaration, and I order health care providers having actual notice of this out of hospital DNR declaration and order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the out of hospital DNR declaration is revoked.

Signed

_____

Date

Printed name

Medical license number

Credits

As added by P.L.148-1999, SEC.12.

IC 16-36-5-16
Keeping of copies

Sec. 16. Copies of the out of hospital DNR declaration and order must be kept:

(1) by the declarant's attending physician, advanced practice registered nurse, or physician assistant in the declarant's medical file; and

(2) by the declarant or the declarant's representative.

Credits

As added by P.L.148-1999, SEC.12.

IC 16-36-5-17
Identification devices

Sec. 17. (a) The emergency medical services commission shall develop an out of hospital DNR identification device that must be:

(1) a necklace or bracelet; and

(2) inscribed with:

(A) the declarant's name;

(B) the declarant's date of birth; and

(C) the words "Do Not Resuscitate".

(b) An out of hospital DNR identification device may be created for a declarant only after an out of hospital DNR declaration and order has been executed by a declarant and an attending physician, advanced practice registered nurse, or physician assistant.

(c) The device developed under subsection (a) is not a substitute for the out of hospital DNR declaration and order.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-18
Revocation

Sec. 18. (a) A declarant may at any time revoke an out of hospital DNR declaration and order by any of the following:

(1) A signed, dated writing.

(2) Physical cancellation or destruction of the declaration and order by the declarant or another in the declarant's presence and at the declarant's direction.

(3) An oral expression by the declarant of intent to revoke.

(b) A declarant's representative may revoke an out of hospital DNR declaration and order under this chapter only if the declarant is incompetent.

(c) A revocation is effective upon communication to a health care provider.

(d) A health care provider to whom the revocation of an out of hospital DNR declaration and order is communicated shall immediately notify the declarant's attending physician, advanced practice registered nurse, or physician assistant, if known, of the revocation.

(e) An attending physician, advanced practice registered nurse, or physician assistant notified of the revocation of an out of hospital DNR declaration and order shall immediately:

(1) add the revocation to the declarant's medical file, noting the time, date, and place of revocation, if known, and the time, date, and place that the physician, advanced practice registered nurse, or physician assistant was notified;

(2) cancel the out of hospital DNR declaration and order by entering the word "VOID" on each page of the out of hospital DNR declaration and order in the declarant's medical file; and

(3) notify any health care facility staff responsible for the declarant's care of the revocation.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-19
Health care provider duties

Sec. 19. (a) A health care provider shall withhold or discontinue CPR to a patient in an out of hospital location if the health care provider has actual knowledge of:

(1) an original or a copy of a signed out of hospital DNR declaration and order executed by the patient; or

(2) an out of hospital DNR identification device worn by the patient or in the patient's possession.

(b) A health care provider shall disregard an out of hospital DNR declaration and order and perform CPR if:

(1) the declarant is conscious and states a desire for resuscitative measures;

(2) the health care provider believes in good faith that the out of hospital DNR declaration and order has been revoked;

(3) the health care provider is ordered by the attending physician, advanced practice registered nurse, or physician assistant to disregard the out of hospital DNR declaration and order; or

(4) the health care provider believes in good faith that the out of hospital DNR declaration and order must be disregarded to avoid verbal or physical confrontation at the scene.

(c) A health care provider transporting a declarant shall document on the transport form:

(1) the presence of an out of hospital DNR declaration and order;

(2) the attending physician's, advanced practice registered nurse's, or physician assistant's name; and

(3) the date the out of hospital DNR declaration and order was signed.

(d) An out of hospital DNR identification device must accompany a declarant whenever the declarant is transported.

Credits

As added by P.L.148-1999, SEC.12.

IC 16-36-5-20
Health care provider liability

Sec. 20. A health care provider who in good faith and in accordance with reasonable medical standards:

(1) participates in the withholding or withdrawal of CPR from a declarant:

(A) by whom an out of hospital DNR declaration and order has been executed under this chapter; or

(B) who has revoked an out of hospital DNR declaration and order when the health care provider has no notice of the revocation; or

(2) provides CPR to a declarant:

(A) when the health care provider has no notice of the out of hospital DNR declaration and order; or

(B) after a revocation of an out of hospital DNR declaration and order;

is not subject to criminal or civil liability and may not be found to have committed an act of unprofessional conduct.

Credits

As added by P.L.148-1999, SEC.12.

16-36-5-21
Presumption of validity

Sec. 21. (a) If a declarant is incompetent at the time of the decision to withhold or withdraw CPR, an out of hospital DNR declaration and order executed under this chapter is presumed to be valid.

(b) For purposes of this chapter, a health care provider may presume in the absence of actual notice to the contrary that the declarant was of sound mind when the out of hospital DNR declaration and order was executed.

(c) The fact that a declarant executed an out of hospital declaration may not be considered as an indication of the declarant's mental incompetency.

Credits

As added by P.L.148-1999, SEC.12.

IC 16-36-5-22
Petition for review

Sec. 22. (a) A person may challenge the validity of an out of hospital DNR declaration and order by filing a petition for review in a court in the county in which the declarant resides.

(b) A petition filed under subsection (a) must include the name and address of the declarant's attending physician, advanced practice registered nurse, or physician assistant.

(c) A court in which a petition is filed under subsection (a) may declare an out of hospital DNR declaration and order void if the court finds that the out of hospital DNR declaration and order was executed:

(1) when the declarant was incapacitated due to insanity, mental illness, mental deficiency, duress, undue influence, fraud, excessive use of drugs, confinement, or other disability;

(2) contrary to the declarant's wishes; or

(3) when the declarant was not a qualified person.

(d) If a court finds that the out of hospital DNR declaration and order is void, the court shall cause notice of the finding to be sent to the declarant's attending physician, advanced practice registered nurse, or physician assistant.

(e) Upon notice under subsection (d), the declarant's attending physician, advanced practice registered nurse, or physician assistant shall follow the procedures under section 18(e) of this chapter.

Credits

As added by P.L.148-1999, SEC.12.

IC 16-36-5-26
Effect upon chain of proximate cause

Sec. 26. The act of withholding or withdrawing CPR, when done under:

(1) an out of hospital DNR declaration and order issued under this chapter;

(2) a court order or decision of a court appointed guardian; or

(3) a good faith medical decision by the attending physician, advanced practice registered nurse, or physician assistant that the patient has a terminal illness;

is not an intervening force and does not affect the chain of proximate cause between the conduct of a person that placed the patient in a terminal condition and the patient's death.

Credits

As added by P.L.148-1999, SEC.12.

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Honoring Choices® Indiana Community Partners

Central Indiana Care Coordination Coalition ACP Workgroup (CICCC-ACP workgroup)
Contact: Jim Fuller
E-mail: jfuller@indypatientsafety.org
Located in: Marion County ☆

Indiana Patient Preference Coalition
Contact: Susan Hickman
600 Barnhill Drive, e419, Indianapolis, IN 46202
317-274-0032
Website: www.indianapost.org
E-mail: hickman@iu.edu
Located in: Marion County ☆

Indianapolis Coalition for Patient Safety, Inc.
Contact: Jim Fuller
317-223-3090
E-mail: jfuller@indypatientsafety.org
Located in: Marion County ☆

LifeStream Services, Inc.
1701 Pilgrim Boulevard, Yorktown, IN 47396
765-759-1121 or 800-589-1121
Website: www.lifestreaminc.org
E-mail: I&A@lifestreaminc.org
Located in: Delaware County

Northeast Indiana Coalition for Advance Care Planning (NICA)
Affiliated Organizations or Group Members: Aging & In-Home Services of Northeast Indiana, Parkview Health, Lutheran Hospital, Dale, Huffman, Babcock Lawyers, IPFW, Visiting Nurse
2927 Lake Avenue, Fort Wayne, IN 46805
260-745-1200, extension 334
E-mail: ACP@agingihs.org
Located in: Allen County ●

Putnam County Hospice and Palliative Care Association
Contact: Tammy Hunter, Director
1542 S. Bloomington Street, Greencastle, IN 46135
765-655-2524
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Located in: Putnam County ◆

Qsource
Contact: Tracy Harvey
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E-mail: Tracy.Harvey@area-G.hcqis.org
Add'l Contact: Marcia Landon, 765-505-3597
Add'l Contact E-mail: Marcia.Landon@area-G.hcqis.org
Located in: Marion County ☆

The University of Southern Indiana's New Harmony Conversations Team
c/o Kevin Valadares
University of Southern Indiana
8600 University Blvd, Evansville, IN 47712
812-461-5277
E-mail: nhconversations@hotmail.com
Located in: Vanderburgh County ▲

Wabash Valley Care Coalition
1606 N. 7th Street, Terre Haute, IN 47803
812-238-7295
Community Presentations: Jim McGuire, Union Health, jmcguire@uhhg.org, 812-238-7295
One-on-One Health Consultations: Sarah Glendening, Union Health, sglendening@uhhg.org, 812-238-4770
Provider Presentations: Lisa Bell, Kindred Hospice, lisa.bell@gentiva.com, 812-478-3250
Palliative Care & Consultation: Tammy Hunter, Putman Co. Hospice and Palliative Care Association, thunter@pchosp.org
Located in: Vigo County ✦

Honoring Choices®
INDIANA

Respecting Choices®
PERSON-CENTERED CARE

Honoring Choices®
MINNESOTA

Respecting Choices and Honoring Choices Collaboration

Respecting Choices (RC) and Honoring Choices (HC) are national leaders in advance care planning. Both have unique histories that include significant collaboration and similarities as well as differences. This information is intended to enhance understanding of the relationship between these two entities, clarify any confusion, and promote collaboration.

Respecting Choices is a non-profit organization that works with conveners, health organizations, and communities to implement advance care planning (ACP) and shared decision making in serious illness (SDMSI). Honoring Choices Minnesota is a statewide, collaborative ACP initiative of the Twin Cities Medical Society that 1) supports communities, organizations, and healthcare systems in developing ACP programming and resources, and 2) serves as the convener of a national network of independent Honoring Choices state or region-specific ACP initiatives.

A shared goal of both Respecting Choices and Honoring Choices is to promote collaboration and align delivery of ACP in ways that best meet the needs of organizations engaging the people they serve in ACP...essentially ensuring all Americans have access to high-quality ACP. For example, a statewide Honoring Choices program may select to use Respecting Choices as well as the Center to Advance Palliative Care (CAPC) and Vital Talk if that best meets the needs of their participating organizations and the diverse populations in their communities. Essentially, Respecting Choices and Honoring Choices work together to ensure cohesive, consistent delivery of services.

	Respecting Choices	Honoring Choices
Who we are	• A national non-profit organization • Provides programs that ensure all individuals and their families are engaged and supported to prepare for future healthcare decisions and that those decisions are in line with goals and values • Provides consultation working with conveners, health systems/organizations and communities to implement a system for ACP and SDMSI	• A multi-state/region national network of independent ACP programs licensing the Honoring Choices brand, sharing its mission, and utilizing its model • HC national network convened by Honoring Choices Minnesota (HCM), a collaborative, statewide ACP initiative of the Twin Cities Medical Society which strives to make ACP the community's standard of care for all adults and ensure that every person's healthcare choices are clearly defined and honored • HCM serves as a convener, connector, and coordinator for ACP programming with communities, organizations, and healthcare systems in MN
Mission	• To guide organizations and communities to effectively implement and sustain systems that provide person-centered care	• To promote standard practices, education materials, and systems that result in consistent delivery of ACP across care settings and communities
ACP programs	• ACP and SDMSI programs address key design elements and focus on systems to support the process • Provides full implementation, education, and consultation services	• Uses one or more of these programs to achieve their mission: Respecting Choices; Vital Talk; The Conversation Project; Serious Illness at Ariadne Labs; National POLST program; CAPC, and state-based programs.

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MINNESOTA

	Respecting Choices®	Honoring Choices® Minnesota
Integration	• Approach results in a system including entire healthcare team and connects with community efforts, using consistent language, strategies, and processes across sites and over time • Consults with organizations to integrate RC model with other ACP/SDMSI programs	• Supports and coordinates collaborative, community-specific ACP programming with communities, organizations, and healthcare systems in MN
Education	• Facilitator, Instructor, Faculty certification including communication skills development courses to meet needs of different populations • Professional-level online + classroom curricula • CEUs available for nurses and social workers • CME/MOC available for physicians and advance practitioners	• Has own ACP Facilitator training for healthcare professionals and community volunteers; outreach and engagement opportunities for communities at-large • Some national network partners choose to use the RC Facilitator training or a variety of educational trainings
Materials	• Support materials for implementation and for conversations (e.g., decision aids, fact sheets) as well as patient/community engagement and education materials and online modules; available in English and Spanish; ability to translate into other languages • Resources available at www.respectingchoices.org	• MN-specific healthcare directive forms available in seven languages: English, Spanish, Somali, Hmong, Russian, Chinese, and Arabic • National Network partners offer state-specific multi-lingual ACP documents • Information sheets on aspects of ACP and life-sustaining treatment options; culturally specific ACP resources, and free online videos and tools available at www.honoringchoices.org
Communication	• Consulting services through customized agreements • Quarterly Faculty and Instructor conference calls that promote collaboration through sharing best practices/challenges and strategies for spread and sustainability • Monthly e-newsletters	• Semi-annual Honoring Choices Conference • Ongoing advisory conversations to expand and guide statewide ACP initiative • Quarterly national network conference calls to share tools/program updates/information • Periodic e-newsletters, referrals/connections for collaboration and partnerships
Customization	• "Freedom within a Framework" allows for harmony between flexibility and fidelity • The Framework, developed from 25 years of research & practice, encourages customization to address unique circumstances and needs of each customer and those they serve	• ACP training, resources, and tools are available for customization by any participating community, organization, or healthcare system

We would like to extend our gratitude to Ellen DiPaola, who led this effort, and to the National Advisory Committee, comprised of both RC and HC members, for their significant contributions. Thank you!

Stephanie Anderson, DNP, RN
Respecting Choices, Executive Director

Kerry Hjelmgren
Honoring Choices Minnesota, Executive Director

Contact information:

Respecting Choices
Matthew Isbell, misbell@respectingchoices.org; respectingchoices.org; 608-473-1025

Honoring Choices National Network
Kerry Hjelmgren; khjelmgren@metrodoctors.com; honoringchoices.org; 612-362-3704

Keith Huffman

From: Respecting Choices <info@respectingchoices.org>
Sent: Wednesday, June 17, 2020 1:03 PM
To: Keith Huffman
Subject: Respecting Choices Extends Use of COVID-19-Specific Materials

Respecting Choices®

PERSON-CENTERED CARE

June 2020

Ongoing Availability of Respecting Choices COVID-19 Resources

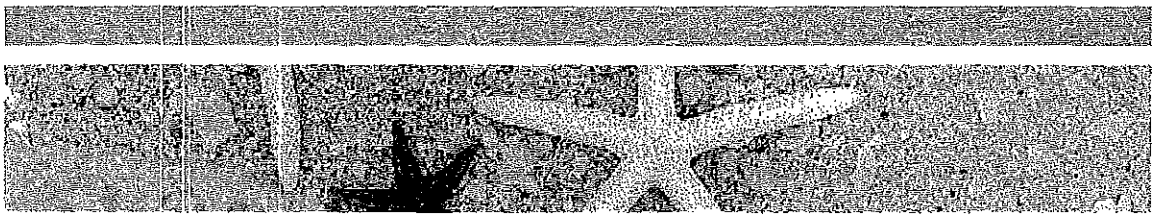
Respecting Choices (RC) is proud to be among the many organizations that worked rapidly to meet the needs of clinicians and communities as they faced the challenges of the COVID-19 pandemic.

In March, RC created a complimentary tool kit for widespread use, grounded in our 20-year history of experience and research but specific to the unique circumstances that COVID-19 created for patients and families. The tools were designed to be used as stand-alone materials without additional educational "training" requirements. The need for these tools is unfortunately lasting longer than we hoped due to ongoing persistence of the disease. **For that reason, these COVID-19-specific materials will remain available to use through the end of 2020.**

These complimentary materials include the Proactive Care Planning for COVID-19 conversation guides, scheduling guides, and patient/family facing materials that describe the importance of knowing treatment preferences before a medical crisis, especially in the context of COVID-19.

After June 30, 2020, the Respecting Choices Nationally Certified Decision Aids, which are more broadly applicable for individuals with any serious illness, will remain available for purchase. Click here to purchase RC

Decision Aids at our Online Store. If you are interested in a Subscription Agreement for RC Decision Aids (with ability to co-brand), click **here.**



A SYSTEM FOR PERSON-CENTERED DECISION MAKING THAT TRANSFORMS HEALTHCARE

608-473-1025 · info@respectingchoices.org

P.O. Box 258, Oregon, WI 53575

About The Indiana POST Program

The Indiana Patient Preferences Coalition (IPPC) is a coalition of professionals in health care, ethics, law, and senior services committed to honoring patient treatment preferences. Key timepoints in the Development of the Indiana POST are noted below.

> **2010** – The group first formed to explore the development of the Indiana version of the POLST Paradigm (www.polst.org).
> **2012** – Legislation to create the Indiana POST introduced by Representative Tim Brown, MD (R – Crawfordsville).
> **2013** – Indiana POST legislation reintroduced by Representative Brown as HB 1182. It passed unanimously in the House (95 to 0) and
>
> law, taking effect July 1, 2013.
> **2016** – A revised version of the Indiana POST Form was issued by the Indiana State Department of Health in December 2016.
> **2018** – Legislation introduced by Representative Cindy Kirchhofer (R – District 89) to update the POST legislation and modify the Indiana Health Care Consent Act. HB 1119 passed unanimously in the House (91 – 0) and Senate (49-0), taking effect July 1, 2018.

Indianapolis Medical Society Article on POST (reprinted with permission) provides background information about the development of the original Indiana POST legislation.

The IPPC Officers

The following individuals serve as officers for The Indiana Patient Preferences Coalition. Download our bylaws by clicking here.

Lindsay Weaver, MD

IPPC Executive Director

Assistant Professor of Clinical Emergency Medicine,

Susan Hickman, PhD

IPPC Associate Director

Professor, Indiana University School of Nursing

Co-Director, IUPUI RESPECT Center

Katie Hougham, HFA, MBA

IPPC Secretary

Associate Vice President of Population Health

Aging and In Home Services of N.E. Indiana

Supporting Organizations

The following organizations provided public support for legislation to create and update the Indiana POST Program.

- Center for Parish Nurses
- CICOA Aging & In-Home Solutions
- Coalition of Advance Practice Nurses of Indiana
- Community Health Network
- Elder Law Section, Indiana State Bar Association
- Health & Hospital Corporation
- Honoring Choices Indiana
- Indiana AARP
- Indiana Health Care Association
- Indiana Hospital Association
- Indiana Medical Directors Association
- Indiana Osteopathic Association
- Indiana Rural Health Association
- Indiana State EMS Commission
- Indiana State Medical Association
- Indiana Academy of Family Physicians
- Indiana Alzheimer's Association
- Indiana Association for Area Agencies on Aging
- Indiana Association for Home and Hospice Care
- Indiana Chapter of the American College of Emergency Physicians
- Indiana Chapter of the National Academy of Elder Law Attorneys
- Indiana Fire Chiefs Association
- Indiana Geriatrics Society
- Indiana State Nurses Association
- IU Health Goshen
- IU Health Systems
- Lutheran Hospital of Indiana
- Memorial Hospital and Health Care Center
- Q-Source
- St. Mary's Health, Evansville

NOTICE

This is the National POLST Form and can only be *completed* in states that have adopted it (it is valid in most states). Check with your POLST Program (www.polst.org/map) to determine if your state uses this version.

National POLST Form

The National POLST Form is a portable medical order. Health care professionals should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

This form should be obtained from a health care provider.
It should not be provided to patients or individuals to complete.

Printing the National POLST Form

1. **Do not alter this form.**

2. This national form must be adopted by the state before it can be completed in that state as a valid POLST form. Find your POLST Program contact at www.polst.org/map – this is because some states have added information on page 2, have added a border, or have requirements about the color of the form.

3. Print BOTH pages as a double-sided form on a single sheet of paper.

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ___/___/_____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) *Verbal orders are acceptable with follow up signature.*

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/_____ | **Phone #:** ( )

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed: _____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

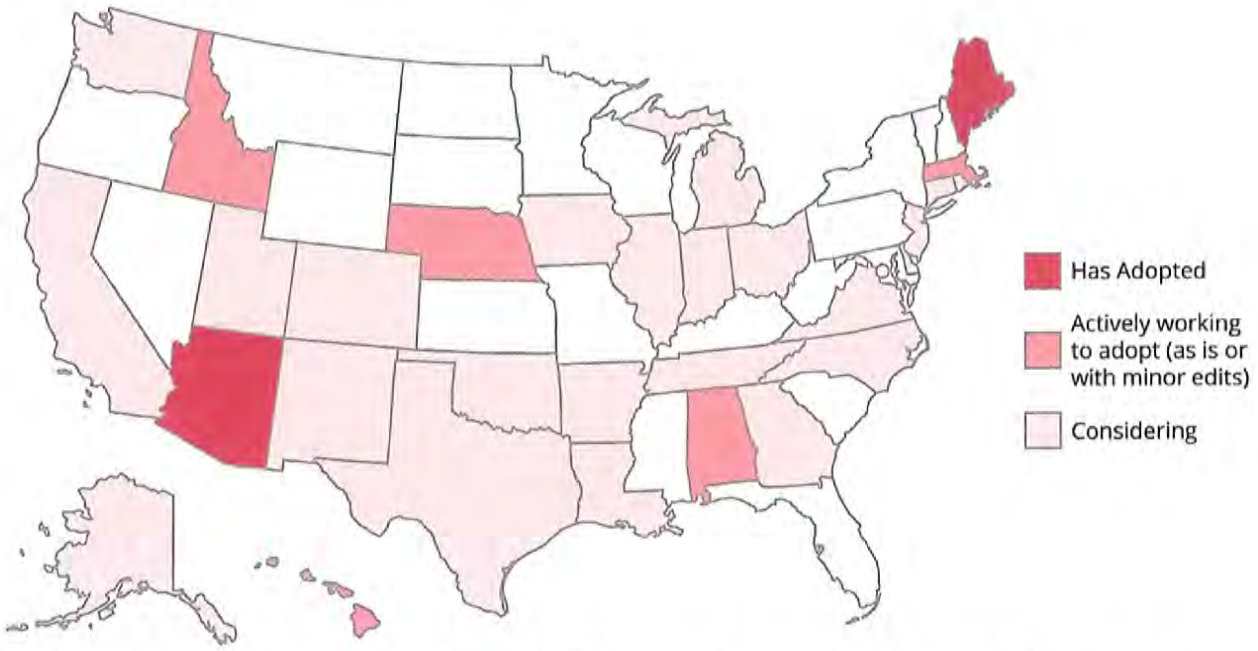
- **Completing a POLST form:**
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form:** destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers:** destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker

National POLST
www.polst.org

National POLST: Adoption of National POLST Form

As of June 2020



This map shows whether a state has adopted or is considering adopting the National POLST Form. The vision of National POLST is for states to adopt national standards, resulting in greater consistency of process, improved patient care and greater patient control and direction over medical treatment. National POLST undertook this project of creating a national form to improve form consistency because a single form makes it easier, among other things:

- For providers to recognize a POLST form and how to correctly interpret and follow POLST form orders, thereby enabling them to honor patient treatment preferences;
- To conduct research and quality assurance activities, creating shared data for generalizable knowledge and ability to improve POLST; and
- To more broadly educate patients and providers about POLST so the process and form are understood and appropriately implemented consistently everywhere.

National POLST encourages all POLST Programs to consider adopting the National POLST Form either as is or with minor edits, thereby reducing the variation among forms.

The National POLST Form was released on September 3, 2019 and represents almost two years of interviews, consensus building, feedback on several iterative versions of the form and compromise among national POLST leaders, POLST Program leaders, national partners and other stakeholders.

Each state chooses what POLST form to use. While a state may not have adopted the National POLST Form for its providers to use in *completing* the form, all providers—regardless of the state in which they practice—should be able to accept the National POLST Form as a valid medical order wherever it is presented.

Some states have legislative or regulatory barriers that make adopting the National POLST Form impossible at this time. More information is available at polst.org/form-providers

- **Adopted**: these are the programs that have adopted the National POLST Form as their state form
- **Actively working to adopt**: these are programs who have notified the National Office that they are actively working to adopt the form, likely within the next year. They are either adopting the form as is or with minor edits.
- **Considering**: these are programs who have notified the National Office that their program is or will be considering adopting the form sometime in the next five years (several states have periodic revisions of their form and are waiting until that time to consider the change).

If you have any questions about how your state is listed, contact admin@polst.org or your program leader (click on your state at www.polst.org/map for contact information).

FIVE WISHES®

MY WISH FOR:

1. The Person I Want to Make Care Decisions for Me When I Can't
2. The Kind of Medical Treatment I Want or Don't Want
3. How Comfortable I Want to Be
4. How I Want People to Treat Me
5. What I Want My Loved Ones to Know

print your name

birthdate

Five Wishes

There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important—how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed it is valid under the laws of most states.

What Is Five Wishes?

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association's Commission on Law and Aging, and the nation's leading experts in end-of-life care. It's also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won't have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants. You can be there for them when they need you most. You will understand what they really want.

How Five Wishes Began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC's Today Show and in the pages of *Time* and *Money* magazines. Newspapers have called Five Wishes the first "living will with a heart and soul." Today, Five Wishes is available in 27 languages.

Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 19 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States

If you live in the **District of Columbia** or one of the **42 states** listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law:

Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kentucky	Nevada	Tennessee
California	Louisiana	New Jersey	Vermont
Colorado	Maine	New Mexico	Virginia
Connecticut	Maryland	New York	Washington
Delaware	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wisconsin
Georgia	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Pennsylvania	
Idaho	Missouri	Rhode Island	

If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state's legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. *AND*
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

First Choice Name _____ Phone _____

Address _____ City/State/Zip _____

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Second Choice Name _____ Third Choice Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone _____ Phone _____

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: **(Please cross out anything you don't want your Agent to do that is listed below.)**

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

Close to death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location_____.
- The following person knows my funeral wishes: _____.

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

_____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

_____

_____

_____

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

_____

_____

_____

Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, _____, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature:_____

Address:_____

Phone:_____ Date:_____

Witness Statement - (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)

_____	_____
Signature of Witness #1	Signature of Witness #2
_____	_____
Printed Name of Witness	Printed Name of Witness
_____	_____
Address	Address
_____	_____
Phone	Phone

Notarization - Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF_____ COUNTY OF_____

On this _____ day of _____, 20_____, the said _____, _____, and _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires:

_____
Notary Public

What To Do After You Complete Five Wishes

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:

_____

_____

_____

Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, and Vermont Must Follow Special Witnessing Rules.

If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

_____
Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

_____
Name

_____
Address City/State/Zip

_____
Phone

My primary care physician is:

_____
Name

_____
Address City/State/Zip

_____
Phone

My document is located at:

_____

_____

_____

_____

Cut Out Card, Fold and Laminate for Safekeeping

Here's What People Are Saying About Five Wishes:

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

Cheryl K.
Longwood, Florida

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

Susan W.
Flagstaff, Arizona

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

Diana W.
Hanover, Illinois

To Order:

Call (888) 5-WISHES to purchase more copies of Five Wishes, the Five Wishes DVD, or Next Steps guides. Ask about the "Family Package" that includes 10 Five Wishes, 2 Next Steps guides and 1 DVD at a savings of more than 50%. For more information visit Aging with Dignity's website, or call for details.

(888) 5-WISHES or (888) 594-7437
www.agingwithdignity.org

Aging with Dignity

P.O. Box 1661
Tallahassee, Florida 32302-1661

 Aging with Dignity wishes to thank Oregon Health Decisions for contributing to the drafting of wish number two, and Kate Callahan, Charles Sabatino, and Tere Saenz for their help.

Supported Decision-Making Agreement

WINGS Working Interdisciplinary Networks of Guardianship Stakeholders

This agreement should be reviewed by all parties to the agreement. The form of communication shall be appropriate to the needs and preferences of each party. The adult should sign in the presence of a notary. Each Supporter will acknowledge by signature his/her/their role as determined by the adult.

This document is not intended to create an agency agreement between the adult and any Supporters listed in this document. Supporters do not owe a fiduciary duty to the adult subject to the agreement, and have no authority to make decisions for the adult.

If you have any questions about your legal rights, please talk to an attorney.

Notice to Third Parties: Under Indiana law, a request or decision made or communicated with the assistance of a supporter shall be recognized as the request or decision of the adult. An agreement that complies with Indiana Code 29-3-1-14(7) is presumed valid. A party may rely on the presumption of validity unless the party has actual knowledge that the agreement was not validly executed. A person who, in good faith, relies on or declines to honor an authorization in an agreement is not subject to civil or criminal liability or to discipline for unprofessional conduct. A supporter who performs supported decision making in good faith as specified in an agreement is immune from civil or criminal liability resulting from the adult's decision unless the act or omission amounts to fraud, misrepresentation, recklessness, or willful or wanton misconduct.

Today's date is:

My full name is:

My date of birth is:

My telephone number is:

My address is:

My e-mail address is:

I want to have people I trust help me make decisions. The people who will help me are called **Supporters**. I can say what kind of help my supporters will give me.

I understand:

☐ I can talk to an attorney before I sign this agreement.

☐ This agreement is because I want Supporters to help me make decisions.

☐ My Supporter cannot make decisions for me.

☐ My Supporter is not liable for any consequences or decisions I make unless my Supporter's actions or omissions amount to fraud, misrepresentation, recklessness, or willful or wanton misconduct.

☐ I can end or change this agreement when I want to. I must let my Supporters know about any changes I make to this agreement. Anyone with a copy of the agreement should get a copy of the change in writing.

☐ I can change my list of Supporters when I want to.

☐ My Supporter(s) can quit if he/she/they wants to.

If I have more than one Supporter in any area, I want those Supporters to work jointly (together) unless I note otherwise below or in the Supporter Appointment Addendum.

I want support to help me make decisions about:

☐ **Finances**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

☐ **Physical Health**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

(Continued next page)

☐ **Mental Health**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

☐ **Legal Matters**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

(Continued next page)

☐ **Services and Supports**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

☐ **Education**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

(Continued next page)

☐ **Work**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

☐ **Community Living/Housing**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

(Continued next page)

☐ **Other**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

☐ **Other**

Supporter(s):

How I want help:

Topics/Tasks for specific help:

(Continued next page)

I understand that certain documents may give my Supporters more authority in my life or access to my personal information. I am including those documents as part of this agreement:

- ☐ Authorization for Release of Records
  - ☐ Health Insurance Portability and Accountability Act (HIPAA) Release
  - ☐ Family Educational Rights and Privacy Act (FERPA) Release
  - ☐ Other Release
- ☐ Letters of Guardianship [☐ Temporary / ☐ Permanent]
  - ☐ Guardianship of the Person and Estate
  - ☐ Guardianship of the Person
  - ☐ Guardianship of the Estate
- ☐ Power of Attorney
- ☐ Protective Order
- ☐ Educational Surrogate Authorization
- ☐ Trust Documents
- ☐ Health Care Representative Authorization
- ☐ Psychiatric Advanced Directive
- ☐ Representative Payee Authorization
- ☐ Living Will
- ☐ Other

List of Supporters

Supporter Name	Addendum Attachment No.

Signature of Adult

This supported decision-making agreement starts right now and will continue until the agreement is stopped by me. I have reviewed, agree with, and understand all the information contained in this agreement.

My signature: _____

My full name: _____

Today's date: _____

Guardian Consent (*if applicable*)

I am the legal guardian for the above-named individual. I consent to this Agreement.

Notes or limitations (if any):

_____

My signature: _____

My full name: _____

Today's date: _____

Signature of Notary

State of _____

County of _____

This document was acknowledged before me on _____ (date)

by _____ (name of person completing this form).

_____ _____

Signature of Notary Printed Name of Notary

Notary Seal, if any:

My commission expires _____

WARNING: PROTECTION FOR ADULTS WITH A DISABILITY

If a person who receives a copy of this agreement or is aware of the existence of this agreement has cause to believe that the adult with a disability is being abused, neglected, or exploited by the supporter, the person shall report the alleged abuse, neglect, or exploitation to **Indiana Adult Protective Services** at **(800) 992-6978**.

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C-TAC
COALITION TO TRANSFORM ADVANCED CARE

Evidence-Based Best Practices for Improving State-Level C-TAC ACT℠ Index Results

ADVANCE CARE PLANNING

May 19, 2020

PRODUCED IN COLLABORATION WITH

DISCERN HEALTH

C-TAC COALITION to TRANSFORM ADVANCED CARE

DISCERN HEALTH

CONTENTS

Value of Advance Care Planning

ACP was selected as an ACT Index measure because it captures a process that has the potential to improve the experiences of individuals during periods of serious or sudden illness when their decision-making capacity is lost, as well as at the end of their lives, while reducing out-of-pocket and system-wide healthcare costs that might otherwise be incurred from unwanted or unnecessary treatment.

A 2017 consensus panel defined ACP as follows:

> "(1) Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.
>
> (2) The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.
>
> (3) For many people, this process may include choosing and preparing another trusted person or persons to make medical decisions in the event the person can no longer make his or her own decisions."[11]

Advance care planning improves the value of care and increases quality of care and outcomes while decreasing costs to patients and the healthcare system.

Prior research has shown that ACP improves experience of care for patients and families. When compared to patients who did not receive ACP services, patients who engaged in ACP reported increased satisfaction with the information provided to them in the hospital, how much they were listened to by their providers, and their involvement in decision-making.[12,13] Studies have shown that ACP can also improve goal concordant care and reduce post-traumatic stress, depression, and anxiety in family members and caregivers of individuals with serious illness.[14,15] Patients who participate in ACP conversations are also more likely to be admitted to hospice earlier, and longer hospice stays are associated with better quality of life.[16]

Research also suggests that ACP may reduce hospitalizations and unwanted procedures. These studies associate increased ACP with lower rates of patient ventilation, resuscitation, intensive care unit admissions, and hospitalization rates.[17,18] Additionally, ACP can help identify which procedures are unwanted and reduce unnecessary treatment, leading to a decrease in costs in the 12 months prior to a patient's death.[19]

ACT Index Advance Care Planning Measure

The ACT Index ACP measure captures the percentage of Medicare beneficiaries using two ACP Current Procedural Terminology (CPT) codes and is calculated using Medicare fee-for-service (FFS) claims data. In 2016, the Centers for Medicare & Medicaid Services (CMS) added CPT codes 99497 and 99498 to the Medicare Physician Fee Schedule (PFS), making voluntary ACP a reimbursable service for Medicare beneficiaries under the PFS and the Hospital Outpatient Prospective Payment

System (OPPS).[20] As discussed further below, while ACP is appropriate for individuals at any age or stage of health, the ACT Index ACP measure only captures Medicare FFS beneficiaries.

Before the introduction of these CPT codes, physicians could only bill for ACP discussions that occurred during an introductory "Welcome to Medicare" appointment for new beneficiaries.[21] CMS defines voluntary ACP as "a face-to-face service between a physician (or other qualified health care professional) and a patient discussing advance directives with or without completing relevant legal forms." These codes are described in **Table 1.**

Table 1. Medicare Billing Codes for ACP

Billing Code	Description
99497	"Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate."[22]
99498	"Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes."[23]

CPT 99497 reimburses providers for up to 30 minutes of ACP with the patient and their family member or caregiver with a minimum discussion length of 16 minutes. CPT 99498 reimburses the provider for an additional 30 minutes of ACP discussions. Providers who can perform ACP services are health care professionals using a team-based approach to include "physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician."[24]

Providers can bill for ACP services using the new Medicare billing codes on the same day or a different day as most other appointments where they provide other evaluation and management (E/M) services. The CPT codes can also be used "during the same service period as transitional care management services or chronic care management services and within global surgical periods." There is no limit on the number of times a provider can bill for ACP services in a year, as a patient's wishes may change if their health status changes.[25]

Providers are prohibited from reporting codes 99497 and 99498 on the same date of service as certain critical care services.[26] Advance care planning discussions are only covered with no cost to a patient during their Annual Wellness Visit (AWV); if these discussions occur in any other context, the patient will be responsible for paying Medicare Part B copays for the service.[27] These limitations are discussed in more detail below.

Providers can furnish ACP services in facility and non-facility settings, as there are no place-of-service limitations for providers.[28] A 2019 study of 2016 and early 2017 Medicare claims and Census Bureau

data found that in 2016, internists billed Medicare for the most ACP claims (65%), followed by family physicians (22%), gerontologists (5%), and oncologists/hematologists (0.3%). The study also found that most patients with ACP claims were female, over age 85, enrolled in hospice, and died in the study year.[29,30]

An ACP conversation may include discussion of advance directives (AD) but completing an AD is not a requirement to bill for the ACP service. ADs are legal documents that specify the types of medical care a person would like to receive if they are unable to make the decision.[31] Under the Medicare ACP codes, providers can bill for end-of-life planning discussions with or without the creation of an AD.[32] **Table 2** below describes ADs and other types of ACP documents that may be generated as a result of the ACP process.

Table 2. Types of Documents That May Result from ACP

Document	Description
Advance Care Plan	Expression of the person's wishes written by the *person*.[33]
Advance Directive	According to the National Cancer Institute (NCI), an AD is a "legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness or injury."[34]
Living Will	The American Cancer Society (ACS) defines a living will as "a legal document used to state future health care decisions only when a person becomes unable to make those decisions or choices on their own. The living will is only used at the end of life if a person is terminally ill, or permanently unconscious."[35] A living will describes the types of life-sustaining treatments a person would or would not like to receive, including dialysis, tube feeding, life support, etc.[36] A living will is a common type of advance directive.[37]
Medical Power of Attorney	ACS defines medical power of attorney as a document in which a person names a proxy to make healthcare decisions on their behalf if they become unable to do so. A physician must certify that the patient is unable to make their own decisions.[38] A medical power of attorney is a common type of advance directive.[39]
POLST (portable medical orders)	According to National POLST, "The POLST form is a portable medical order communicating patient treatment wishes to other providers, including emergency personnel, when the patient lacks capacity to speak for him/herself."[40] POLST forms are created by providers after discussion with patients. The acronym was popularized as "Physician Orders for Life-Sustaining Treatment", but National POLST has updated the term to "portable medical orders" because the use of POLST extends beyond physicians, and "life-sustaining treatment" may be value-laden and less descriptive of what is included.

Limitations to Measuring Advance Care Planning

Limitations to Billing for ACP under Medicare

Measuring the rate of ACP using CPT codes has several limitations. First, ACP conversations shorter than 16 minutes are not reimbursable using the Medicare CPT billing codes, and some providers may find it difficult to integrate ACP discussions of this length into their clinical workflows.[41] CMS suggests

that providers bill to a different E/M service code if the ACP conversation is shorter than 16 minutes, "provided the requirements for billing the other E/M service are met."[42] Therefore, some ACP services may be captured through E/M codes beyond the 99497 and 99498 CPT billing codes, and would not be counted towards the ACT Index measure score.

Further, Medicare reimbursement alone may not be high enough to incentivize providers to have ACP discussions; physicians are reimbursed about $80 for the first 30 minutes of ACP discussions and $75 for an additional 30 minutes.[43]

Place-of-service limitations affect the ability to use "incident-to" billing, which is required for non-providers to bill for ACP services. "Incident-to" billing requires that a supervising physician must be available in person to participate in the service as needed and address questions.[44,45] For example, if ACP is performed in a hospital by a social worker, nurse, or chaplain, then the services cannot be billed to Medicare.

As noted above, Medicare beneficiaries do not have to pay for ACP discussions that occur during their yearly Medicare Wellness Visits, but they are responsible for paying Medicare Part B copayments if the ACP discussions happen at any other time.[46] This may dissuade patients from having ACP discussions during non-wellness appointments.

Limitations of the ACP ACT Index Measure

The ACP Index measure is presented as a proxy for the relative levels of ACP from state to state. By its definition, the ACP measure does not capture all ACP conversations that may occur. For example, the ACP Index measure captures the percent of traditional FFS Medicare beneficiaries who receive ACP services in a state and does not account for Medicare Advantage (MA) beneficiaries.

Not all ACP services are billed and, conversely, not all ACP codes reflect high quality ACP, documentation, or goal concordant care.

Conversely, conversations related to ACP may occur with medical staff or non-medical professionals who are not covered by (or eligible for) the billing codes included in the measure. The measure also does not capture the quality of the ACP conversations that occur, whether they result in advance directives or POLST completion, or whether the care that patients ultimately receive is concordant with the wishes they discuss in ACP conversations and express in the documents they complete.

Finally, these ACP data are relatively new, as the CPT codes went into effect in 2016. Some of the observed increases in ACP since 2016 may be due to providers improving their awareness of and ability to capture the new ACP CPT codes. From 2016 to 2017, C-TAC found that the number of Medicare beneficiaries with ACP claims increased by approximately 70% and the number of providers billing for ACP services increased by about 48%.[47] Of note, billing for ACP remains low across states, with the US national value of the 2017 Medicare FFS beneficiaries with ACP at 2.12% (See **Appendix A: State Interview Considerations** for more information).

Section Four

Secure Act: Retirement Account Changes Every Elder Law Attorney Needs to Know

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Section Four

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PowerPoint Presentation

SECURE ACT: RETIREMENT ACCOUNT CHANGES EVERY ELDER LAW ATTORNEY NEEDS TO KNOW

Rebecca W. Geyer
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IMPORTANT TERMINOLOGY

Applicable distribution period (ADP) = the time period in which distributions must be withdrawn from the account

- The optimal situation would be to use the beneficiary's life expectancy as the ADP

Required minimum distributions (RMDs)= the amount that must be withdrawn on an annual basis from the retirement account

- More can be withdrawn, the RMD is the floor for withdrawals

Stretch = the ability to withdraw RMDs over the life expectancy of an individual

- The ADP is the life expectancy of the individual
- Allows funds to continue to grow in the account, tax-deferred

CALCULATING RMD

- In each year in which a distribution is required, the prior year end account balance (as of 12/31) by a life expectancy factor called the divisor or Applicable Distribution Period ("ADP")
- ADP is obtained from an IRS table
- The RMD must be withdrawn by the end of the distribution year; failure to withdraw the RMD amount results in a 50% penalty and the filing of Form 5329
- Withdrawing more than the RMD in a given year does not give a participant a credit against future RMDs; each year is handled individually

DECEDENT'S RMD

- On the participant's death, the beneficiary must take the participant's RMD if the participant didn't take it prior to his death
- Did the participant die before or after his RBD which is April 1 of the year after the participant reaches the age of 72?
- If the decedent died after his RBD, was the RMD taken before the date of death?
- If already taken, the beneficiary is not required to take any additional distributions in the participant's year of death
- If the decedent died after his RBD but before he took his RMD, the RMD must be distributed to the beneficiary during the year of death.

BEFORE THE SECURE ACT

Most beneficiaries could stretch RMDs over their life expectancy

- Must be a *designated beneficiary* (have a heartbeat)
  - If not a designated beneficiary, then the ADP is 5 years
- For trusts, the beneficiaries of the trust will be treated as been designated as beneficiaries
  - If *all* beneficiaries under the trust entitled to receive distributions from the retirement account are individuals, the beneficiary with the shortest life expectancy is the designated beneficiary for purposes of determining the ADP

DESIGNATED BENEFICIARY

- Beneficiary must be living and identifiable so life expectancy can be calculated
- If a group of beneficiaries is named, such as children, all beneficiaries must be individuals, and the oldest beneficiary's life expectancy is used
- If even a dollar is paid to a non-individual such as a charity as of the beneficiary finalization date (9/30 of the year after the participant's death), the participant is deemed to have no designated beneficiary
- Trusts can be beneficiaries if they qualify as see-through trusts

THE SECURE ACT:

WHAT'S CHANGED?

Key Changes

- Required Beginning Date (RBD): the date when distributions are required to begin. Changed from the year owner reaches age 70½ to the year owner reaches 72.

- No age cap on contributions to Traditional IRAs. Still need to be earning income. Prior to year 2020, the age cap was the year the owner reached 70 ½.
  - No changes for Roth IRAs. Can still contribute at any age.

    - *Both of these changes seem to be in response to longer life expectancies and people working longer.*

- Looser rules for annuities in 401(k) plans:
  - Pre-SECURE – employers had to hire costly financial experts to audit an annuity provider's books or do it themselves.
  - Post-SECURE – employers can now rely on state insurance departments in making a determination whether an insurer can deliver on promises.
  - Also, extension of "safe harbor" protections for plan sponsors when they select annuities.

THE SECURE ACT:

WHAT'S CHANGED?

Key Changes

- Funds in inherited retirement plans must be distributed out of the plan by 10 years (the "10-year rule"), with certain exceptions. There are no RMDs during the 10-year period. This is the so-called "Death of the Stretch."

- Prior to year 2020, inherited retirement plans could be distributed over the life expectancy of the Designated Beneficiary (the "Stretch"). The Stretch still applies to retirement plans in which the owner died prior to January 1, 2020.

- Prior planning frustrated by increased income taxes, loss of creditor protection, and loss of centralized asset management.

EXCEPTIONS TO THE 10-YEAR RULE

Eligible Designated Beneficiary

- Surviving Spouse (the pre-2020 rules still apply)
- Minor Child
- Disabled individual as defined in IRC 72(m)(7)
- Chronically ill individual as defined in IRC 7702B(c)(2)
- Individual not more than 10 years younger than the deceased retirement plan owner
  - Must be EDB on the date of death of the account owner. One-time determination.

IF THE ELIGIBLE DESIGNATED BENEFICIARY IS THE SURVIVING SPOUSE…

Nothing changes:

1. Treat it as his/her own retirement plan by designating himself/herself as the account owner;
2. Treat it as her/his own by rolling it over into her/his IRA, qualified employer plan, 403(a) plan, 403(b) plan, or 457 plan; or
3. Treat himself/herself as the beneficiary rather than the owner.
4. No RMDs required until the spouse reaches his or her RBD (72 under the SECURE Act), but this is only available if the spouse has total control over the disposition of the plan assets
5. If beneficiary is a trust for the benefit of the spouse, spouse would need to be trustee with the power to control distributions. Otherwise, no spousal rollover and the life expectancy of the spouse must be used to determine RMDs. Distributions to the surviving spouse would begin when the IRA owner dies, not at the spouse's RBD

Benefits of treating as your own – RMDs at age 72, can make contributions, and can roll over any amount into or out of the inherited plan

CHARITIES ARE NOT DESIGNATED BENEFICIARIES

- Since charities are not individuals, they are not designated beneficiaries
- Combining a charity as beneficiary with individuals means the IRA has no designated beneficiary per IRS rules
- If client wishes to name a charity as beneficiary, consider establishing separate accounts for the charity and for individual beneficiaries

IF THE DESIGNATED BENEFICIARY IS A CHARITY…

- Charities are not eligible designated beneficiaries, but do not pay income taxes on funds received
- Combining a charity as beneficiary with individuals means the IRA has no designated beneficiary per IRS rules
- If client wishes to name a charity as beneficiary, consider establishing separate accounts for the charity and for individual beneficiaries

IRS FIXES – CASH OUT A BAD BENEFICIARY

- If a charity and an individual were named as beneficiaries of an IRA, it is still possible for the individual to take distributions over his or her life expectancy if the charity is cashed out before September 30 of the year after the year of the participant's death
- September 30 of the year after the year of the participant's death is known as the Beneficiary Finalization Date

IRS FIXES - DISCLAIMER

- A bad beneficiary may also disclaim prior to the Beneficiary Finalization Date
- Beneficiary can disclaim if they meet all the requirements of IRC Sec. 2518 and the disclaimer is made prior to the Beneficiary Finalization Date
- While the general disclaimer requirements of IRC Sec. 2518 require the disclaimer to be made within 9 months after the date on which the transfer creating the interest is made, for purposes of this fix, the nine-month period can never end after September 30 of the year following the IRA owner's death
- Disclaimers are generally used to eliminate an older individual as a countable beneficiary

IRS FIXES – SEPARATE ACCOUNTS

- Another cure to multiple beneficiary problems is to establish separate accounts
- Rule does not apply to multiple beneficiaries who take their interest through a trust named as beneficiary of a retirement plan; must designate the separate accounts instead
- To have separate accounts, must follow these rules:
  - The beneficiaries' interests must share pro rata in post-death gains and losses;
  - The division of a single account into separate accounts must be established by 12/31 of the year after the year of the participant's death to determine the ADP;
  - If established after 12/31 of the year after the year of the participant's death, the separate accounts are still effective for all other purposes other than the designated beneficiary rules. ADP continues to be the ADP which applied to the combined accounts on the Beneficiary Finalization Date

IF THE ELIGIBLE DESIGNATED BENEFICIARY IS A MINOR CHILD…

- An owner's children under the age of 18 (age of majority defined by state) have RMDs based on life expectancy.
- Once a child reaches the age of 18, then 10-Year Rule applies. Plan assets have to be paid out by age 28.
- This exception does not apply to owner's adult children, grandchildren, or stepchildren.

IF THE ELIGIBLE DESIGNATED BENEFICIARY IS A DISABLED INDIVIDUAL...

SECURE Act does not cite to 42 USC § 1382c(a)(3) – disability standard for SSI for aged, blind, and disabled.

Instead, it cites to IRC § 72(m)(7): "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration."

Very similar standards. IRC § 72(m)(7) changes "continuous period of not less than twelve months" to "long-continued and indefinite duration."

IF THE ELIGIBLE DESIGNATED BENEFICIARY IS A CHRONICALLY ILL INDIVIDUAL...

SECURE Act cites to IRC § 7702B(c)(2), modified: Certified by a licensed health care practitioner, within the preceding 12-month period, that the individual:

- (i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for an indefinite period reasonably expected to be lengthy in nature due to loss of functional capacity.
- (ii) having a level of disability similar to the level of disability described in clause (i), or
- Requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

IF THE ELIGIBLE DESIGNATED BENEFICIARY IS LESS THAN 10 YEARS YOUNGER THAN DECEASED PLAN OWNER…

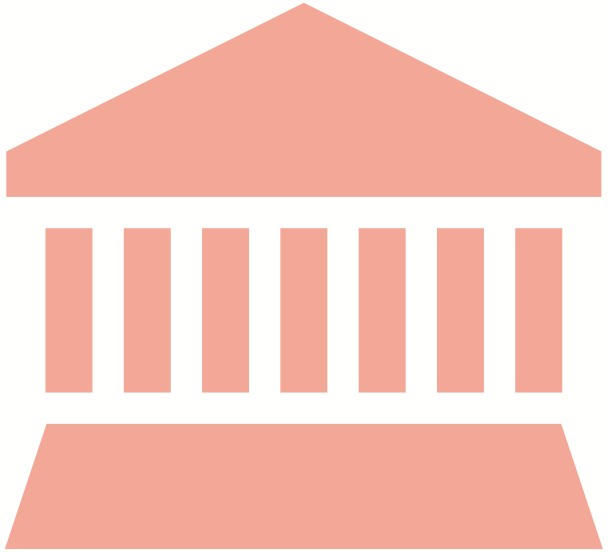
Use the life expectancy of the EDB instead of the 10-Year Rule.

Could be similar to the "Stretch" if the retirement plan owner died at a young age.

STRETCH RULES FOR ELIGIBLE DESIGNATED BENEFICIARIES

RMDs over the lifetime of the EDB.

Stretch only lasts until termination of EDB status. At that point, 10-year rule starts, even if EDB dies and successor beneficiary is also an EDB.



PLANNING IN LIGHT OF SECURE ACT

Retirement plan holders should review their estate plans now to decide if:

- Beneficiary designations need to be updated.
- Wills and/or trusts need to be revised, especially if they contain a conduit trust intended to hold retirement plan funds and preserve the Stretch.

CONDUIT SEE-THROUGH TRUSTS

- Concept: Protection for larger accounts by distributing RMDs to the beneficiary, thus realizing the Stretch, but protecting the balance of the plan for future years. Useful for a spendthrift beneficiary.
- New language for conduit trusts under SECURE Act: Must distribute within 10 years of owner's death unless "eligible designated beneficiary."
- Conduit QTIPs still work while surviving spouse is alive.
- Conduit trusts for children are potentially a bad outcome.

CONDUIT TRUST VS. ACCUMULATION TRUST

Conduit Trust Pros	Conduit Trust Cons
• Reduced "Stretch" over 10 years instead of life expectancy of beneficiary	• Reduced "Stretch" over 10 years instead of life expectancy of beneficiary
• Protects spendthrift beneficiaries up to 10 years	
• Still taxed at the beneficiary's individual income tax rate instead of trust income tax rate	

CONDUIT TRUST VS. ACCUMULATION TRUST

Accumulation Trust Pros	Accumulation Trust Cons
• Stretch distributions out as long as possible, limited only by rule against perpetuities	• Taxed at the highest trust tax rate of 37% upon death of account owner for amount over $12,950
• Protects spendthrift beneficiaries for potentially their entire lives	
• Avoids beneficiary receiving potentially large lump sum 10 years after death of account owner	

PLANNING CONSIDERATIONS

Pre-SECURE: IRA owner named conduit trust as beneficiary of IRA and rest of assets distributed outright to beneficiaries.

- Strategy – IRA is distributed over life expectancy, and the beneficiaries can have the rest now.

Post–SECURE:

- IRA owner may now want the non-retirement assets to be held in an accumulation trust with trustee discretion, while the retirement funds are distributed within 10 years of death.
- The trustee of the non-retirement assets could make discretionary distributions to perhaps approximate what the prior plan might have accomplished.
  - Creditor protection and estate tax shelter benefits

PLANNING CONSIDERATIONS:

CHARITABLE REMAINDER TRUSTS

IRA owner establishes a charitable remainder trust (CRT) and revises IRA beneficiary to designate the CRT as beneficiary:

- Basically mimics the Stretch that was available before SECURE.
- Annuity or unitrust payments to the non-charity beneficiaries over life expectancy or for term of years:
  - Noncharitable beneficiaries only subject to income tax as they receive distributions (generally on a LIFO basis).
  - At least 10% remainder, on a present value basis, must go to charity at termination of the CRT (works best when Applicable Federal Rate is higher).
- Life insurance could be purchased to replace the assets going to charity.

PLANNING CONSIDERATIONS:

REVISING EXISTING CONDUIT TRUSTS

Conduit Trusts are still viable, just not as effective in reducing income taxes, protecting spendthrifts, or just providing professional management.

- May still make sense for older beneficiaries and/or spendthrift beneficiaries that may mature.
- Convert language from RMDs to 1/10 of the original principal each year for 9 years, then the balance in the 10th year.
- Convert from conduit trust to accumulation trust to give Trustee discretion to pay out RMDs or retain them.
  - Pros – creditor protection, asset management, divorce protection.
  - Cons – income accumulated within a trust is often taxed at top income tax rate (currently 37%).

- Possible options for client who did not revise:
  - Decant trust – I.C. 30-4-3-36
  - Modification – I.C. 30-4-3-24.4

PLANNING CONSIDERATIONS:

SPECIAL NEEDS TRUSTS

Relevant SNT characteristics:

- ✓ Distributions fully discretionary
- ✓ Accumulation trusts (as opposed to conduit trusts)
- ✓ Do not require RMDs

SNT Qualifies for Stretch if:

- ✓ Disabled beneficiary is “eligible designated beneficiary”
- ✓ Disabled beneficiary is the only beneficiary

PLANNING CONSIDERATIONS:

DISCLAIMING

IRA owner died in 2019 leaving $1 million IRA to surviving spouse with 3 children as contingent beneficiaries.

- Pre-SECURE rules apply.
- Wife has 9 months from date of death to disclaim (all or a portion), allowing children the option to “Stretch” their shares.