

GUARDIANSHIP MATTERS

MEDICARE PART D - MEDICARE'S NEW PRESCRIPTION DRUG PROGRAM

PREPARED BY: MARY FRANCES CARR, ESQ., JONES & WILCENSKI, PLLC

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NYSARC, Inc. GUARDIANSHIP PROGRAM STATISTICS AS OF MARCH 2006

Court Appointed

Primary Guardianships:	296
Standby Guardianships:	200
Alternate Standby Guardianships:	274
TOTAL:	770

Pending Court Decrees

Primary Guardianships:	45
Standby Guardianships:	21
Alternate Standby Guardianships:	14
TOTAL:	80

Many have likely heard by now of Medicare Part D, Medicare's new prescription drug program, which became effective January 1, 2006. Medicare Part D is a federally subsidized prescription drug program for the disabled and elderly. As a result, many guardians and family members of individuals with disabilities and the elderly will have to become familiar with Medicare Part D's program basics.

Timeline for Enrollment; Varying Costs and Coverage

Medicare Part D is available through private health insurers who contract directly with Medicare to offer Part D plans, which vary in costs and drug coverage. Information on the variety of plans available can be obtained at www.medicare.gov. In an enrollment period that began November 15, 2005 and that now continues through May 15, 2006, disabled or elderly Medicare beneficiaries can voluntarily purchase Medicare Part D prescription drug coverage without paying a late enrollment penalty. A low-income subsidy, for those

with limited income and resources, can help those who qualify with the costs of Medicare Part D. Dual eligibles (defined below) and Medicare Savings Program enrollees are deemed eligible for the subsidy and will be automatically enrolled. Others who qualify may apply at their local Social Security Administration office or on-line at www.ssa.gov, where general information on the criteria for qualifying for the subsidy is also available. For anyone who enrolled in a Medicare Part D plan by December 31, 2005, prescription coverage should have begun January 1, 2006. For those enrolling after January 1, 2006, coverage should begin the first of the month following enrollment. Guardians and family members should be prepared to devote a significant amount of time to analyzing an individual's prescription needs and costs in order to choose an appropriate plan from the more than 40 Medicare Part D prescription drug plans available in New York State.

"Dual Eligibles" - Those Enrolled in Both Medicare and Medicaid

For those individuals known as "dual eligibles", defined as those who receive both

Medicare and Medicaid benefits, their Medicaid prescription drug coverage was replaced by Medicare Part D drug coverage effective January 1, 2006. Those who met the definition of "dual eligible" last year had between November 15, 2005 and December 31, 2005 to enroll in a Medicare Part D of their choice. Otherwise, effective January 1, 2006, they were scheduled to be automatically enrolled in a plan randomly selected for them by the Center for Medicare and Medicaid Services (CMS), the federal agency responsible for administering Medicare Part D. This underscores the need for guardians and family members of dual eligible individuals to monitor the Medicare Part D plan in which an individual is enrolled to be sure that plan best meets that person's prescription needs. Dual eligibles are permitted to switch plans in any given month.

Unlike other Medicare recipients who have a choice as to whether or not to enroll in Medicare Part D, dual eligibles in New York State are required to participate in a Medicare Part D prescription plan in order to receive all other Medicaid benefits.



OFF THE SHELF—

PLANNING FOR THE FUTURE

BY: L. MARK RUSSELL AND ARNOLD E. GRANT

BOOK REVIEWED BY: MARY MEACHEM, LIBRARIAN, NYSARC, INC.

This volume is the completely revised fifth edition of a book first published in 1993. It has been a standard reference in the field of disabilities for over ten years. The authors, both attorneys, have over 30 years of experience dealing with future planning and helping family members and their loved ones who have disabilities through the planning process. This edition stresses the importance of “providing a meaningful life for a child with a disability after your death”. It is a book based on common sense and practical experience.

Planning for the Future is written for both parents and professionals, eliminating legalese and jargon, and takes the reader through the entire planning process in a simple easy to understand step-by-step method. It forces parents to seriously consider what their priorities are for their child, if the parents were to die today. It makes parents ask the questions: Where would my child live? Who would advocate or care for my child? Will there be sufficient money available for my child’s comfort? Will my child be happy, healthy and secure? To answer these questions serious thought and consideration must be given to residential options, education plans, employment possibilities, social/recreational choices, religious life, medical care, advocacy and guardianship /trustee decisions.

It is here that this volume is most helpful by providing crucial information and plenty of sample checklists and forms along with explanatory examples. Throughout the entire text, they include over forty must-do TIPS. Particularly useful is the chapter on a detailed description of a child’s needs, preferences and routines which they call the “letter of intent”. Yearly updates are necessary to keep up with the current changes and needs of your child.

This is not a book to supplant the need for an attorney. Just the opposite, its strongpoint is to help you to prepare and organize your thoughts before consulting with a lawyer. The sections on guardianship, wills and trusts will not only enlighten you, but will prevent you from making costly mistakes by not doing things legally. It is also very helpful in its discussions of how to deal with government agencies in obtaining and understanding government benefits. I am at a loss to think of a question that is not answered in the book.

Though it is a little pricey at \$89.95, I highly recommend it for the valuable information and the peace of mind it will bring to you.

It can be purchased from: Planning for the Future, Inc.
86 W. King Henry Court
Palatine, IL 60067
(847) 991-7451

NYSARC, INC. CORPORATE GUARDIANSHIP TRAINING



Chapters are encouraged to contact Michael O’Brien, Esq., at the NYSARC, Inc. State Office to schedule future trainings for their Board of Directors, Guardianship Committees, program staff and families on any of the following topics: Guardianship; the Health Care Decisions Act and End-of-Life Care; the NYSARC, Inc. Policies and Procedures on Withholding/Withdrawal of Life Sustaining Treatment; Advance Directives; or Issues of Consent and Capacity.

Mike can be reached at (518) 439-8311 ext: 228 or obrienm@nysarc.org.

MEDICARE PART D

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Therefore, if a dual eligible refuses to enroll or disenrolls from Medicare Part D, he or she may lose all of his or her Medicaid benefits. This has posed a substantial problem for many dual eligibles with retiree coverage who may have been notified by their employer or union that enrolling in Medicare Part D would cause them to lose their union or employer-provided health care benefits. If these dual eligibles lose their health care coverage, they and any family members covered by such plans may be unable to get that coverage back. As a result, the New York State Department of Health has issued an exception in such situations, which now allows impacted dual eligibles to disenroll from Medicare Part D and still maintain Medicaid benefits. (Please note that if enrolling in a Medicare Part D plan only jeopardizes prescription coverage under the employer or union plan, the exemption does not apply and the individual must enroll in order to preserve Medicaid coverage.) Such disenrollment should be coordinated through the dual eligible's local Department of Social Services to be sure all administrative requirements are met.

Dual eligibles, their guardians and family members also need to be aware of potential coverage gaps involving medications that were previously paid for under the Medicaid program which may not now be covered under Medicare Part D. When Congress created Medicare Part D's drug benefit, it determined that certain types of medications would not be covered. Therefore, certain medications will not appear on the list of covered medications offered by Medicare Part D's prescription drug plans. The concern is that many Medicaid recipients will not be able to access through Medicare Part D all of the drugs they have been stabilized on

or will require in the future. However, after January 1, 2006, Medicaid should continue to cover the excluded drugs that it previously paid for, such as benzodiazepines (i.e. anti-anxiety medications. Brand names include Ativan, Valium or Xanax), barbiturates (i.e. anticonvulsants. Brand names include Alurate, Barbital or Luminal) and over-the-counter medications. Additionally, New York State Medicaid will provide time limited coverage for necessary medications not covered under a plan's formulary, provided, however, that a dual eligible's doctor goes through a rather complicated appeals process. If a plan denies an appeal, the individual will, for a time-limited period, be covered under what is known as the Medicaid "wraparound". However, once this coverage expires the individual will either have to pay for the entire cost of the medication or try another drug approved by the plan. This limited coverage is scheduled to expire on June 30, 2006 unless it is extended.

Recent Legislative Action

As one might expect with such a dramatic change to the prescription coverage of millions of disabled and elderly across the nation, the transition for many to Medicare Part D has not been a smooth one. As many guardians or family members have no doubt witnessed, many of New York's more than 500,000 dual eligible individuals have been impacted, with many encountering difficulty getting prescriptions filled and paid for since their conversion to Medicare Part D on January 1, 2006 as a result of a variety of program glitches. Consequently, some of those impacted have had to pay for expensive medications out of pocket. In response, the Governor took executive action and New York's Legislature also voted unanimously in the first week of February 2006 to

safeguard prescription drug coverage for New York's disabled and the elderly. These actions call for the state to cover costs for medications not properly covered until the operational problems associated with Medicare Part D's implementation have been resolved.

Medicare Part D's Many Parts

Medicare Part D is comprised of many parts, though only a sampling of issues have been touched on here. Suffice it to say there are benefits and limitations of the program depending on a number of factors, including current drug expenses, other federal benefits and the class into which one falls: those with no prescription drug coverage, those who currently have employer or retirement coverage, those with coverage as good or better than Medicare Part D and those who are dual eligibles. The time for guardians and family members to be aware of Medicare Part D is now so that they can understand how it impacts individuals with disabilities and the elderly and assist them in obtaining appropriate prescription coverage.

Mary Frances Carr, Esq. is an attorney with the law firm of Jones & Wilcenski, PLLC, located in Clifton Park, New York. She practices in the areas of Elder Law and Long Term Care Planning, Special Needs Estate Planning, and Trust, Estate and Tax Planning. She is a member of the National Academy of Elder Law Attorneys, the Elder Law Section of the New York State Bar Association and its Medicaid and Real Estate/Housing Committees and is a member of the Advisory Board of the Beacon Pointe Memory Care Community an assisted living community focused on the memory impaired located in Clifton Park, New York.

Mary Frances has spoken frequently on the topic of Medicare Part D, educating other professionals and the public on the topic. She would like to thank John Kemmer of NYSARC, Inc. for his assistance in preparing this article.

CATCH 22: PROMOTING AUTONOMY/PROTECTING BEST INTERESTS SDMC/DNR/HEALTH CARE PROXY/MEDICAL DECISIONS

PREPARED BY: PATRICIA W. JOHNSON, ESQ.

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As advised in a previous Newsletter column, *First Do No Harm* (Quality of Care Newsletter, Issue 78, Spring 2000) (http://www.cqcapd.state.ny.us/counsels_corner/78cc.htm), protecting the rights of people with diminished capacity in many cases requires balancing their rights to aggressive medical treatment with appropriate palliative care. Another tension in promoting the rights of people with disabilities is protecting the individual's autonomy and providing appropriate care and treatment. New laws are being implemented and proposed and will be discussed in this article which highlights the need for appropriate standards and procedures to assure protection of individual autonomy and appropriate care. A model for this balancing act is the Surrogate Decision-Making Committee Program, which first and foremost protects the right of a person with capacity to make a medical decision for him/herself. Even if determined to be incapacitated, full consideration is given to the person's current and previous preferences, values and beliefs, if known. Both the capacity and "best interests" decisions are made with thoughtful review of the pertinent facts and patient opinions, if any, by an independent decision-making panel with additional independent oversight provided by the Mental Hygiene Legal Service representative and other interested parties. Decisions may be appealed to a court of law by the individual and other involved parties. See, *Medical Consent: An Act to Establish Surrogate Decision-Making Committees* (Quality of Care Newsletter, Issue 23, March-April 1985) (http://www.cqcapd.state.ny.us/counsels_corner/cc23.htm).

Do Not Resuscitate Law (DNR)

Prior to the SDMC Program and the adoption of the Do Not Resuscitate (DNR) Law, surrogate medical decisions for those who were unable to make their own decisions were made informally by next of kin or medical professionals, or formally through the appointment of guardians or other court-appointed fiduciaries or proceedings. With the DNR law, a means for some surrogate decision-making regarding cardiopulmonary resuscitation (CPR) was created which provided oversight without the formality, possible delay, and expense of a court proceeding for those who could not decide on their own when resuscitation may not be appropriate. With the support of the Task Force on Life and the Law, special protections were incorporated for people with disabilities, often the most vulnerable in our society.

Autonomy Protection

These protections for the individual's autonomy include a review by two physicians to determine whether a hospitalized person can or cannot make his/her own DNR decision. When the person has a mental illness, a doctor with specialized qualifications must make one of the physician determinations; when a person has a developmental disability, a physician or psychologist with qualifications in that field must make one of the determinations of incapacity. In another way, the DNR protects the autonomy of the individual by providing that a surrogate decision is not needed if a person has already made the decision in writing, dated and signed in the presence of two witnesses who also sign the decision, at a point in time when the person had the capacity to make such a decision. Notwithstanding such prior decision, the attending physician is to

consult with the patient, if they have capacity, at the time the DNR order is issued.

Protections of Appropriate Care and Treatment

The DNR law protections of the individual's right to appropriate care include the following:

- ◆ A DNR decision is not a decision regarding other forms of treatment; palliative care must be provided to the patient;
- ◆ If the person had previously made a capacitated decision regarding DNR, that decision is to be respected. However, in the case of a dispute at the time of the need for cardiopulmonary resuscitation, a medical provider is protected if s/he provides CPR in good faith;
- ◆ Surrogates who are not appointed by the individual can act under this law, but only when the person has a terminal illness (death expected within one year); or the person is permanently unconscious; or CPR would be medically futile (re-arrest would occur in a short period of time before death occurs); or the CPR would be an extraordinary burden given the person's medical condition (not their disability) and the expected outcome of the resuscitation.

Balancing Rights

The law balances the rights of any person including those with disabilities, providing that surrogates are required to protect the person's autonomy by making the CPR decision based upon the person's wishes, including a consideration of their religious and moral beliefs. When such wishes are

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unknown and unascertainable, the surrogate is to make the decision in the person's best interests. These standards for decision-making by surrogates can be expected to be enforced for residents of mental hygiene facilities through the law's requirement that notice of a decision by the two doctors that the person lacks capacity is to be given to the mental hygiene facility director where the person resides/resided, if any. Also, notice of a DNR decision is to be provided to the mental hygiene facility director, if given by the individual or a surrogate on the individual's behalf. These notices provide a means for oversight of the decisions and the possibility for dispute mediation or court review, if necessary.

Protections for Residents and Non-Residents Alike

Dispute mediation is also available for any known disputes among surrogates. For any individual, the DNR law contemplates that the attending physician will refer the patient's case to dispute mediation, or at least another physician, if the attending physician disagrees with the surrogate's decision. A final protection for the person's autonomy is the required notice to the patient of a surrogate's consent to DNR. These protections have been helpful in balancing the need for appropriate palliative and aggressive treatment and protecting the autonomy of the individual. Problems have arisen when the procedures in the law have not been employed (see *Do Not Repeat*, Commission newsletter <http://www.cqcapd.state.ny.us/newsletter/issue89/89donotrepeatsituation.htm>) and when the physician erroneously employs standards from the health care proxy law, when the DNR surrogate was not personally designated by the individual and the health care proxy law is not applicable. In such a case, a distant relative was elevated wrongfully to the role of "health care

agent" with fewer protections than afforded under the DNR law.

Health Care Proxy Law

This law provides the means for the capacitated individual to plan and arrange for whom s/he would like to make decisions for him/herself if the person is not capable of making major medical decisions. Since the individual selects the agent to act on his or her behalf, it is appropriate that the person's authority to act is less restricted and subject to a lower level of oversight than under the DNR law. The risk for people with questionable capacity is that procedures are needed to assure that the person is acting out of his or her own free will; that is, in a knowing, intelligent and voluntary manner. The wonderful benefit for such people is their autonomy: if they can be assisted in making a knowing decision, they have directed who they want to act on their behalf. Their privacy can be protected and they may be less likely to be the subject of a protracted dispute among differing interested parties.

The health care proxy law recognizes this risk/benefit balance by providing for a presumption of capacity, but also providing protections to the mental hygiene facility residents: their proxy designations are to be witnessed by a person with special qualifications and a person who is independent from the facility. Standards regarding an assessment of incapacity thus empowering the person's agent to act are similar to those in the DNR law, as well as the requirements for notice of the incapacity decision to the mental hygiene facility director. The mental hygiene facility employees may not act as the agent. However, the standards regarding the need for a specific medical condition: terminal illness, permanent unconsciousness, medical futility, or extraordinary burden are not applied to the health care agent decisions, nor are the additional notice requirements applicable for any treatment decision other than issuance

of a DNR order. The agent is directed to make decisions based upon the person's wishes, if known or ascertainable and, if not, based upon the patient's best interests. The agent must reasonably know or ascertain the person's wishes regarding artificial nutrition and hydration in order to make artificial nutrition and hydration decisions.

As mentioned above, it is important for the attending physician to recognize which law applies to his/her patient. Affording a relative or close friend the full gamut of decision-making authority that is given to the person's health care agent personally appointed by the patient was not the intent of the health care proxy law.

Family Health Care Decision Proposal

For many years, bills have been introduced in the Legislature to provide broader authority to next of kin and close friends to make medical decisions for patients who failed to appoint an agent to act on their behalf when they become incapacitated to make their own decisions. Assuming that protections are put in place similar to those in the DNR law to provide for independent review prior to the effectiveness of the decision and standards for the surrogate decisions, it may be a good idea to empower surrogates, as many people have not executed and are reluctant to execute advance directives and the court system is not always invoked. New York has enacted such standards for persons with guardians appointed pursuant to Article 17-A of the Surrogate Court Procedure Act. While it may not be realistic to expect the appointment of such guardians for all persons with mental retardation and developmental disabilities, and while this law does not, at this time, apply to guardians for persons with mental illness and who do not also have a diagnosis of mental retardation or developmental disability, these

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REGIONAL UPDATES - A VIEW ON REGIONAL GUARDIANSHIP COMMITTEE MEETINGS AND ACTIVITIES

The following represents a summary of some of the meetings, discussions and activities engaged in by the Chapters in their respective Regional Sub-Committees during the period from October 20, 2005-March 23, 2006. Chapters can contact Erica F. Berman at the NYSARC, Inc. State Office at bermane@nysarc.org for further details on these meetings.

Region # 1- Southeast Region Facilitator -Nancy Succoso, Westchester County Chapter

March 23, 2006 –Regional Meeting was held at the Rockland County Chapter, Congers, New York.

- ◆ NYSARC, Inc. Staff provided an update on legal and legislative activities, and Court Decisions concerning hospice, and the Health Care Decisions Act, including the Court of Appeals Decision on the Matter of MB.
- ◆ Guardianship staff shared innovative practices and challenging issues.
- ◆ A new set of questions on peer partnering developed by Barb Wale and the Chapters in the Western Region was distributed and discussed.
- ◆ Chapters discussed the Conference on Future Care Planning scheduled for May 17-19, 2006, which will cover topics such as the Health Care Decisions Act, ethics, spirituality, consent, capacity, and other issues of interest.
- ◆ Sharing the outcomes of peer partnering experiences will occur at the next meeting.

Region # 2- Finger Lakes Region Facilitated by Barb Wale Monroe County Chapter

January 26, 2006- Regional meeting was held at the Monroe County Chapter, Rochester, New York.

- ◆ Chapters were provided with the legal/legislative updates of NYSARC, Inc. and the May 2006 conference topics as referenced in Region 1.
- ◆ The majority of the meeting was spent participating in group activities developing the basis of a new peer partnering evaluation tool.



Region # 3 - Mid Hudson Region Facilitated by Steve Ramos Ulster-Green Counties Chapter **February 17, 2006 – Regional meeting was held at the Dutchess County Chapter in Poughkeepsie, New York**

- ◆ Chapters were provided with the legal/legislative updates of NYSARC, Inc. activities and the May 2006 conference topics as discussed in Region 1.

- ◆ Steve Ramos discussed a NYSOPTS proposal as a collaborative effort between several of the chapters in the region.
- ◆ Chapters discussed the possibility of merging and/or attending the next Regional Southeast Region #1 meeting in March.

Region # 4 - Central Region Facilitated by Debra Gallagher Onondaga County Chapter **October 20, 2005, January 11, and March 15, 2006 – Regional meetings were held at the Onondaga County Chapter in Syracuse, New York.**



- ◆ Chapters were provided with the legal/legislative updates of NYSARC, Inc. and the May 2006 conference topics as referenced in Region 1.
- ◆ Chapter representatives spent time planning a regional meeting in Syracuse to be scheduled sometime in October of 2006.

Region # 5 – Northeast Region Facilitated by Patty Paduano Saratoga County Chapter

December 12, 2005 and March 13, 2006-Regional meetings were held at the Saratoga County Chapter in Saratoga, New York.

- ◆ Chapters were provided with the legal/legislative updates of NYSARC, Inc. activities and May 2006 conference topics as referenced in Region 1.
- ◆ It was decided after a lengthy discussion that some of the Guardianship Coordinators would help draft an article for the Guardianship Newsletter on *Guardian vs. Consumer's Best Interest: Finding the Balance.*



VIRGINIA GUARDIANSHIP CONFERENCE FEATURES NEW YORK BIOETHICIST

The Virginia Guardianship Association, Virginia Elder Rights Coalition and the Mid-Atlantic Chapter of the National Association of Geriatric Care Managers are holding their 2006 Joint Conference, on April 3 - 4, 2006, with a track sponsored by the Virginia Board for People with Disabilities.

The conference is being held at the Woodlands Hotel and Suites in Williamsburg, VA, within walking distance of Colonial Williamsburg.

The keynote speaker is the nationally recognized bioethicist, Nancy Dubler, who will speak on her new book, *Bioethics Mediation*. She is Director of the Division of Bioethics, Montefiore Medical Center, New York. Her work focuses on contemporary issues in bioethics, law and society, including bioethics consultation with a focus on mediation, care for vulnerable populations and research ethics.

The conference will include two additional plenary sessions; A panel on "Treating the Objecting Mentally Ill Ward: What is a Guardian to Do?" and "A View of Guardianship From the Bench and the General Assembly" by a Virginia judge and former legislator.

The range of workshops include the following plus many more:

- ◆ "Legal and Financial Aspects of Continuing Care Retirement Communities"
- ◆ "But I Don't Want to Leave! Challenging an Involuntary Nursing Home Discharge"
- ◆ "Preventing and Litigating Fiduciary Abuse Cases: Fiduciary Accountings, Contesting Estate and Trust Matters, and Contested Guardianships"
- ◆ "Negotiating the Medicare Drug Benefit Maze"
- ◆ "A Crisis in Older Adult Mental Health Care"
- ◆ "Elder Mediation Unbound"
- ◆ "Abuse of Older Adults with Lifelong Disabilities"

- Erica F. Berman

GUARDIANSHIP: A COMPARISON OF ARTICLE 17-A AND ARTICLE 81 GUARDIANSHIP LAWS

An easy-to-read document comparing provisions of Article 17-A of the Surrogate's Court Procedure Act and Article 81 of the Mental Hygiene Law has been prepared by well-known disability law attorney, Lisa K. Friedman, Esq. and is being made available electronically for anyone interested in having a copy.

The different sections of the guardianship statutes are laid out in a chart format, describing the requirements for each approach to guardianship. What kind of guardianship, including plenary (full) vs. tailored powers is outlined, along with who the subject of the proceedings are, when guardianship is deemed necessary, which Court the guardianship petition is filed, the costs for the proceedings, who can file or apply to the Courts for guardianship, what is required, and who is notified about the petition being filed. After the Petition is filed, the Court may or may not hold a hearing. This also is outlined in the chart, along with the standard that is applied by the Court in determining the need for guardianship, what the Court issues as proof of the guardianship appointment and authority, the powers and duties of the Guardian, modification of Guardianship, medical consent issues and confirmation proceedings.

Please contact Erica F. Berman at the NYSARC, Inc. State Office at bermane@nysarc.org if you would like to have this document sent to you through e-mail.

INFORMATIVE WEBSITES

American Association on Mental Retardationwww.aamr.org

American Association on Mental Retardation promotes progressive policies, sound research, effective practices, and universal human rights for people with intellectual disabilities.

American Bar Association - Commission on Law & Agingwww.abanet.org

The ABA's project on guardianship law includes links to related subjects, such as elder abuse, the Wingspan Conference, assisted Living and Home Equity conversion.

Caring Todaywww.caringtoday.com

Practical, relevant articles for family caregivers. One of the goals is to help caregivers manage stress, and learn to find time for oneself, even if just for a few minutes a day.

National Hospice and Palliative Care Organization (NHPCO)www.nhpc.org

NHPCO is the largest non-profit membership organization representing hospice and palliative care programs in the United States. The organization is committed to improving end of life care, expanding access to hospice care and enhancing quality of life for people dying in America and their loved ones.



A family-based organization working with and for people who have mental retardation and other developmental disabilities

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standards have been invoked by courts of law looking for guidance regarding end of life decisions when treatment seemed an undue burden. Consideration should be given to these standards to assure protection of any person without capacity and no self-appointed surrogate. Nevertheless, people with disabilities are subjected to at least three distinct risks: over-treatment; under-treatment; and exclusion from the decisions that affect their lives. For these

people, standards and a means to easily mediate the application of the standards are particularly important.



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SAVE THIS DATE!

May 17-19, 2006

5th Annual Capital District Conference on
Future Care Planning

**“Preparing for the Future by
Planning for the Present”**

Agency Sponsors

**New Visions
(Albany County Chapter)
NYSARC, Inc.**

NYSARC, Inc.

**Rensselaer County
Chapter NYSARC, Inc.**

**Saratoga County Chapter
NYSARC, Inc.**

**Schenectady County
Chapter
NYSARC, Inc.**

**Schoharie County Chapter
NYSARC, Inc.**

Special Evening Presentation

May 17, 2006

*Health Care Decisions Act: The Status of
Retroactivity of Guardians, and Future
Implications for End-of-Life Decisions*

TOPICS

- ◆ Issues of Capacity, Consent and Sex
- ◆ Guardianship and the Health Care Decisions Act
- ◆ Health Care Decisions Act (HCDA) and Surrogate Court Practices
- ◆ Guardianship in Practice
- ◆ Self-Advocates' Perspective on Guardianship and other Issues
- ◆ Basic Financial Planning
- ◆ Consent and Medical Decision Making
- ◆ Ethics
- ◆ Consent and Capacity/End-of-Life Care Issues
- ◆ Spiritual Aspects of End-of-Life Issues
- ◆ Hospice Care for People with Developmental Disabilities
- ◆ Guardianship vs. Health Care Proxies
- ◆ Hospital and Nursing Home Treatment, Care and Consent Issues

May 17-19, 2006

The Desmond
Colonie, New York

**For More Information
Contact: Patty Scheels
(518) 372-1160**