Legal (and Other) Issues in Article 81 Guardianship

2024 NYPWA Summer Conference

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Morgan R. Thurston, Esq., Assistant Welfare Attorney Onondaga Co. Dept. of Law
Mark E. Maves, Esq., Counsel, NYPWA

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Introduction

Mental Hygiene Law Article 81 (MHL Art. 81) is one of the two adult guardianship statutes in New York State law. A local social services district's adult protective service (APS) might find itself involved in an MHL Art. 81 case in a number of different contexts. These can include situations where APS is considering guardianship for an APS client, or where a third party has petitioned for guardianship for an APS client. In certain cases, a Commissioner, or the LDSS, in their official capacity, gets appointed to serve as guardian, sometimes without even being told that they have been nominated.

The objectives of our program is to try to answer some of the questions that have been submitted to us over the last few months and also offer some information that you might find helpful in these cases going forward. One particular issue that we do not really have a good answer to is the lack of uniformity in how these cases are handled by the courts across the State, notwithstanding that MHL Article 81 is the same for everyone. Unfortunately, the law seems to be applied differently sometimes, from county to county.

Basis for Appointment of LDSS as Guardian

The LDSS has a statutory and regulatory requirement to pursue MHL Art. 81 guardianship in certain circumstances and a regulatory duty to serve as guardian for an APS client if there is no one willing and able to serve responsibly. The LDSS should always view guardianship as the most restrictive intervention that it can invoke, so, when considering guardianship, the LDSS should review all less restrictive alternatives. The petition will require that issue to be addressed, and at any hearing there will have to some proof that less restrictive alternatives have been considered, and that they are not appropriate given the facts of the case.

Social Services Law §473:

> 1. In addition to services provided by social services officials pursuant to other provisions of this chapter, such officials shall provide protective services in accordance with federal and state regulations to or for individuals without regard to income who, because of mental or physical impairments, are unable to manage their own resources, carry out the activities of daily living, or protect themselves from physical abuse, sexual abuse, emotional abuse, active, passive

or self neglect, financial exploitation or other hazardous situations without assistance from others and have no one available who is willing and able to assist them responsibly. Such services shall include:

(c) **arranging, when necessary, for** commitment, **guardianship**, or other protective placement of such individuals either directly or through referral to another appropriate agency, provided, however, that **where possible, the least restrictive of these measures shall be employed before more restrictive controls are imposed;**

18 NYCRR 457.6 Serving involuntary clients:

(a) General. When the district believes that there is a serious threat to an adult's well being and that the adult is incapable of making decisions on his or her own behalf because of mental impairments, the social services official has a responsibility to pursue appropriate legal intervention in accordance with the provisions of sections 473 and 473-a of the Social Services Law, articles 9, 15 and 81 of the Mental Hygiene Law, article 8 of the Family Court Act and article 17-A of the Surrogate's Court Procedure Act, even though such intervention may be against the wishes of or without the knowledge of the adult at risk. The districts must employ the least restrictive intervention necessary to effectively protect the adult. The immediacy and seriousness of the threat to the individual will determine whether crisis intervention procedures and/or other legal procedures are warranted as set forth in subdivisions (b) and (c) of this section.

(c) Other legal procedures. There are other procedures established in the Mental Hygiene Law and the Surrogate's Court Procedure Act to be utilized in non-crisis situations in order to provide long range planning or protection to certain PSA clients. These procedures require more time to implement than afforded in emergency or crisis situations. In appropriate situations the district must:

(1) initiate efforts to arrange for the appointment of a guardian in accordance with the provisions of article 81 of the Mental Hygiene Law;

(2) serve in the capacity of guardian in those situations in which a PSA client is in need of a guardian and no one else is willing and able to serve responsibly; or

MHL Art. §81.03 specifically states that an LDSS may serve as a guardian of the person or property in an MHL Art. 81 guardianship:

(J) **"guardian" means** a person who is eighteen years of age or older, a corporation, or **a public agency, including a local department of social services, appointed in accordance with terms of this article by the supreme**

court, the surrogate's court, or the county court to act on behalf of an incapacitated person in providing for personal needs and/or for property management.

MHL Art. 81 also gives specific authority to an LDSS to commence an MHL Art. 81 proceeding:

> Mental Hygiene Law §81.06 Who May Commence a Proceeding
>
> (a)(6)- **a person otherwise concerned with the welfare of the person alleged to be incapacitated**. **For purposes of this section a person otherwise concerned with the welfare of the person alleged to be incapacitated may include** a corporation, **or a public agency, including the department of social services in the county where the person alleged to be incapacitated resides regardless of whether the person alleged to be incapacitated is a recipient of public assistance.**

We have a number of questions and issues that relate to the appointment of the LDSS as guardian.

Issue: Conflict of interest between the DSS interest as payor of public assistance versus a fiduciary duty to the incapacitated person as their guardian.

In *Matter of Bessie C. (Commissioner of Cayuga County Dept. of Social Servs*.), 225 AD2d 1027 (4th Dept., 1996), the 4th Department reversed the Supreme Court appointment of the DSS as guardian, holding that:

> In considering the eligibility of a potential guardian, the court is mandated to consider several factors, including "any conflicts of interest between the person proposed as guardian and the incapacitated person" (Mental Hygiene Law § 81.19[d][8]). The Social Services Law defines as a preferred creditor a public welfare official like the Commissioner of DSS (see, Social Services Law §2[1], [8]), who seeks to recoup payments or resources from the recipient of public assistance (Social Services Law § 104 [1]; see, Matter of Lainez, 79 A.D.2d 78, 79–80, 435 N.Y.S.2d 798, affd 55 N.Y.2d 657, 446 N.Y.S.2d 942, 431 N.E.2d 303). Thus, the Commissioner of DSS has a conflict of interest with Bessie C. and should not have been appointed guardian of her property. A neutral, disinterested person should be appointed guardian of the property of the incapacitated person.
>
> For the same reason, it was error to appoint the Commissioner of DSS special guardian of the incapacitated person for the purpose of exercising her right of election. The neutral, disinterested guardian of her property should make application to the court to exercise that function if he or she is so advised.

Notwithstanding the *Bessie C.* case, there is little in the way of subsequent case law that suggests that conflict of interest has been successfully raised by LDSS's.[1]

Issue: Which LDSS is responsible to serve as guardian?

A question submitted to us put forth the following:

> Any guidance on making arguments as to which County's PSA/DSS should be appointed guardian? We have been named guardian several times now over individuals in nursing/facility care outside of our County solely on the premise that they had either resided here previously (despite there being no likelihood of their ever leaving facility care) or own property that is located here, and I have had a difficult time knowing how to argue against that. Once all of such property were disposed of and no other nexus exists, would it be possible/proper to move to transfer guardianship to DSS in the County in which the AIP now resides (in a facility)?

This question arises when an Article 81 petition is filed on the county in which the AIP is hospitalized, or residing in a nursing home or other placement, but is from a different county, or is receiving APS or public assistance in a different county.

There is currently little guidance on this issue, however in 2023, the Appellate Division, Third Department did issue a decision which partially addresses the issue. In *Matter of Kimberly DD*., 220 AD3d 1091 (3rd Dept., 2023), while holding that Supreme Court did not abuse its discretion in appointing Washington County as guardian, in view of Saratoga County's status under SSL §62 as respondent's residence for purposes of medical assistance and public assistance or care, the court found that Saratoga County's Commissioner should serve as respondent's guardian. Under SSL §62(5)(d), when a person who was admitted to a nursing home located in a district other than the district in which she was then residing is or becomes in need of medical assistance, the social services district from which she was admitted shall be responsible for providing such medical assistance. Saratoga County was the IP's residence district under SSL §62 and was and continuing to provide medical assistance to her. The court further held that the statute also charges the residence district with providing "public assistance or care" and in that regard, under Social Services Law §473, a resident social services district must also provide "protective services" to an individual in need, including services arranging, when necessary, for guardianship either directly or through referral to another appropriate agency.

While the *Kimberly DD* decision gives some guidance in a case where the subject of the guardianship is placed in a nursing home, the Third Department did not say that

[1] For example, see *Matter of New York State Office of Mental Health*, 80 Misc3d 655 (Supreme Court, Monroe County, 2023) for an example of where this was unsuccessfully raised.

Supreme Court abused its discretion in making its determination, so there may be other cases where the county in which the IP is placed is named as opposed to the county responsible for public assistance. There are also other situations where the subject of a guardianship is not placed in a nursing home, instead perhaps is a public assistance recipient in County A, but goes into a hospital in County B and becomes the subject of a guardianship petition in County B. In other cases, the adult is not currently receiving public assistance, but the live in County A, and wind up in a hospital in County B and require a guardian, but there is no individual able and willing to serve responsibly, so an LDSS is required to serve.

It is our understanding that OCFS intends to issue some guidance on this issue, although we do not know the extent to which that guidance will address the other circumstances.

Another situation that comes up is when an LDSS was appropriately appointed as guardian for a person in their county, but the IP relocates to another county or to another State. Because APS is county based, and there is no statutory, regulatory, or other authority to transfer the guardianship, the appointed LDSS has to come up with some way to make its statutorily required visits as well as other duties to ensure the welfare of the incapacitated person.

In an unreported decision, a court did change the LDSS appointed as temporary guardian from the county in which the AIP was hospitalized to the county from which the AIP was from. In *Matter of United Health Servs. Hosps., Inc.* (J.W.), 82 Misc3d 1218(A) (Supreme Court, Broome County, 2024) the court discharged the Commissioner of Broome County DSS and the Commissioner of the Tioga County DSS, as temporary guardian of J.W. after determining that determined that the Tioga County DSS was a more appropriate agency to handle J.W.'s affairs on a temporary basis, based on his residency in Tioga County prior to his admission to UHS. Although this decision did not specify whether or not the AIP was receiving public assistance of any kind, it did indicate that one of the powers being requested was the power to make a Medicaid application for the AIP.

Issue: We are getting pulled into a lot of Guardianships lately, and as an interested party, we do not have much say in the outcome. How do you typically handle this? Do you file motions where you feel that the DSS should not be named?

We have had an explosion of guardianships over the last two years. I try to go to all of the cases we are noticed on because when I do not show up on we typically get appointed. Our Surrogate as acting Supreme handles all the guardianships and I am over there all the time. The Court does a good job of not appointing us if there is anyone else that can possibly do it so I do not ever file a motion requesting not to be appointed.

As far as the debt collection request, our Court doesn't dismiss those proceedings but does make sure that the facility is seeking all the necessary parties. You can make

sure that the facility attorney puts in adequate proof that the guardianship is proven and necessary. We have had a bigger problem with facility attorneys delaying the hearing or not submitting orders timely in what I believe is an effort to extend provisional Medicaid coverage, so our Court has taken over drafting the orders and we get them done quickly.

Issue: When a Commissioner is appointed, do they have authority to delegate functions for decision making to subordinate staff?

When a Commissioner is appointed, they are appointed in their official capacity as Commissioner of the LDSS. The appointment should so state, for example: "_____, and Successors, as Commissioner of _____ Department of Social Services."

When a Commissioner or LDSS is named as guardian, the day to day guardianship duties may be designated to LDSS staff, which would often be APS. This principle was stated in the case of *Matter of Sutkowy (Wallace)*, 270 AD2d 943 (4th Dept., 2000). In that case, from Onondaga County, the Fourth Department held that "…the OCDSS Commissioner may delegate the duties of guardianship to staff, but the OCDSS Commissioner is ultimately responsible, as the head of the agency, if the staff fails to discharge those duties appropriately."

Given that ruling, APS should be clear on the delegation, and perhaps make certain duties, such as major medical or end of life decisions, remain the responsibility of upper-level management, even the Commissioner themself. There is a delegation form in the Appendix.

In Onondaga County, I have been able to just have the Department named as the Guardian which avoids having to deal with any changes when the commissioner changes. We still sign delegations however.

Issue: Hospital and Other Facility Discharges to DSS Via Guardianship

A recurring issue in many counties is the utilization of guardianship by hospitals and other facilities as a discharge to an LDSS.

This question was submitted regarding general discharges:

> Hospitals routinely discharge guardianship clients with higher level needs for DSS to find care. We consider these unsafe discharges. This is often after the hospital discharge unit has attempted to find an appropriate long-term care placement for the client but they are not accepted by any facilities because of their behaviors/mental health issues and/or sex offender status. They are discharged homeless to DSS. What legal recourse do we have to prevent this dumping on APS?

90 ADM-40, which is still an active OCFS directive, indicates that NY State Health Department regulations (10 NYCRR 405.9(f)) require hospital staff to develop discharge plans for all patients in need of post-hospital care and to assist patients in obtaining any services that they will need in the community. The following conditions must be met before a patient may be discharged:

- the patient must be determined by a physician to be medically ready for discharge;
- the hospital must ensure that the patient has a discharge plan that meets the patient's post-hospital needs;
- the hospital must ensure that all necessary post-hospital services are in place or reasonably available to the patient; and
- the patient will be discharged to a safe environment.

However, 10 NYCRR 405.9(f) has been amended a few times since 1990, including the section on hospital discharges, which is now found in section (h). The discharge section now reads:

> (h) Discharge. (1) The hospital shall ensure that each patient has a discharge plan which meets the patient's post-hospital care needs. No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient.
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> (2) The hospital shall have a discharge planning coordinator responsible for the coordination of the hospital discharge planning program. The discharge planning coordinator shall be an individual with appropriate training and experience as determined by the hospital to coordinate the hospital discharge planning program.
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> (3) The hospital shall ensure:
>
> (i) that discharge planning staff have available current information regarding home care programs, institutional health care providers, and other support services within the hospital's primary service area, including their range of services, admission and discharge policies and payment criteria;
>
> (ii) the utilization of written criteria as part of a screening system for the early identification of those patients who may require post-hospital care planning and services. Such criteria shall reflect the hospital's experience with patients requiring post-hospital care and shall be reviewed and updated annually;
>
> (iii) that upon the admission of each patient, information is obtained as required to assist in identifying those patients who may require post-hospital care planning;

(iv) that each patient is screened as soon as possible following admission in accordance with the written criteria described in subparagraph (ii) of this paragraph and that this screening is coordinated with the utilization review process;

(v) that each patient identified through the screening system as potentially in need of post-hospital care is assessed by those health professionals whose services are appropriate to the needs of the patient to determine the patient's post-hospital care needs. Such assessment shall include an evaluation of the extent to which the patient or patient's personal support system can provide or arrange to provide for identified care needs while the patient continues to reside in his/her personal residence;

(vi) that for each patient determined to need assistance with post-hospital care, the health professionals whose services are medically necessary, together with the patient and the patient's family/representative shall develop an individualized comprehensive discharge plan consistent with medical discharge orders and identified patient needs;

(vii) that each patient determined to need assistance with post-hospital care and the patient's family/representative receive verbal and written information regarding the range of services in the patient's community which have the capability of assisting the patient and the patient's family/representative in implementing the patient's individualized discharge plan which is appropriate to the patient's level of care needs;

(**viii) that the patient and the patient's family/representative shall have the opportunity to participate in decisions regarding the selection of post-hospital care consistent with and subject to any limitations of Federal and State laws. Planning for post-hospital care shall not be limited to placement in residential health care facilities for persons assessed to need that level of care, but shall include consideration of noninpatient services such as home care, long-term home health care, hospice, day care and respite care**;

(ix) that when residential health care facility placement is indicated, the patient and the patient's family/representative shall be afforded the opportunity, consistent with and subject to any limitations of Federal and State laws, to participate in the selection of the residential health care facilities to which applications for admission are made.

(x) that contact with appropriate providers of health care and services is made as soon as possible, but no later than the day of assignment of alternate level of care status and that each patient's record contains a record of all such contacts including date of contact and provider response as well as a copy of any standard assessment form, including but not limited to any hospital/community patient review instrument as contained in section 400.13 of this Title and any

home health assessment, completed by the hospital for purposes of post-hospital care;

(xi) that relevant discharge planning information is available for the utilization review committee; and

(xii) the development and implementation of written criteria for use in the hospital emergency service indicating the circumstances in which discharge planning services shall be provided for a person who is in need of post emergency care and services but not in need of inpatient hospital care.

Notwithstanding the amendments to the regulation, the hospital still has primary responsibility for discharge planning and that includes the participation of the patient and/or their family or representative in the decision making involved in the plan. A section of the regulation that is not mentioned in 90-ADM-40 is 10 NYCRR 405.9(a), which says:

(a) *General.* (1) The governing body shall establish and implement written admission and discharge policies to protect the health and safety of the patients and shall not assign or delegate the functions of admission and discharge to any referral agency and shall not permit the splitting or sharing of fees between a referring agency and the hospital.

In addition to hospitals, an LDSS may also encounter situations where other service providers attempt to have an LDSS appointed as guardian in order to discharge an adult from their program. These include OPWDD certified or operated facilities, mental health treatment facilities, and substance abuse treatment facilities.

OPWDD certified or operated facilities are required by 14 NYCRR 633.12 to afford their clients an opportunity to object to any proposed discharge and remain at the facility while the objection process is underway.[2] In this context, "discharge" includes:

- Agency refusal to allow an individual receiving services to return to his certified residence or day program following a period of hospitalization;
- Agency refusal to allow an individual receiving services to return to his certified residence or day program following a home visit or other extended absence, including those instances where individuals engage in a prolonged home visit for personal or medical reasons, including those related to the current COVID-19 public health emergency;

[2] *Matter of Developmental Disabilities Institute, Inc., v New York State Office for People with Developmental Disabilities*, 214 AD3d 1101 (3rd Dept., 2023)

- Agency refusal to allow an individual receiving services to return to his certified residence or day program because the Agency feels it can no longer provide appropriate care to that individual.[3]

14 NYCRR 818.5 includes the requirements for discharge plans from in-patient substance abuse treatment facilities:

> (e) *Discharge and planning for level of care transitions*.
>
> (1) The discharge planning process shall begin as soon as the patient is admitted and shall be considered a part of the treatment planning process. The plan for discharge and level of care transitions shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the discharge plan must also be developed in consultation with the patient's parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law Section 22.11.
>
> (2) Discharge should occur when:
>
> (i) the patient meets criteria documented by the OASAS level of care determination protocol for an alternate level of care and has attained skills in identifying and managing cravings and urges to use substances, stabilized psychiatric and medical conditions, and has identified a plan for returning to their community;
>
> (ii) the patient has received maximum benefit from the service provided by the program; or
>
> (iii) the individual is disruptive and/or fails to comply with the program's written behavioral standards, provided that the individual is offered a referral and connection to another treatment program and discharge is otherwise in accordance with Part 815[4] of this Title.
>
> (3) No patient shall be discharged without a discharge plan which has been completed and reviewed by the multi-disciplinary team prior to the discharge of the patient. This review may be part of a regular treatment/recovery plan review. The portion of the discharge plan which includes the referrals for continuing care shall be given to the patient upon discharge. This requirement shall not apply to patients who leave the program without permission, refuse continuing care planning, or otherwise fail to cooperate.

[3] Letter of Leslie Fuld, Deputy Commissioner, Division of Quality Improvement, OPWDD. SUBJECT: Due Process and Inappropriate Discharge from Residential Programs and Services; DATE: September 9, 2020. The full text is in the Appendix.

[4] 14 NYCRR Part 815 (Patient's Rights) includes 14 NYCRR 815.7 which includes discharge.

(4) The discharge plan shall be developed by the clinical staff member, who, in the development of such plan, shall consider the patient's self-reported confidence in maintaining their health and recovery and following an individualized safety plan. The clinical staff member shall also consider an assessment of the patient's home and family environment, vocational/educational/employment status, and the patient's relationships with significant others. The purpose of the discharge plan shall be to establish the level of clinical and social resources available to the individual post-treatment and the need for the services for significant others. The plan shall include, but not be limited to, the following:

(i) identification of any other treatment, rehabilitation, self-help and vocational, educational and employment services the patient will need after discharge;

(ii) identification of the type of residence, if any, that the patient will need after discharge;

(iii) identification of specific providers of these needed services;

(iv) specific referrals and initial appointments for these needed services;

(v) the patient, and their family/significant other(s) shall be offered naloxone education and training and a naloxone kit or prescription; and

(vi) an appointment with a community based provider to continue access to medication for addiction treatment.

Part 2 of the question submitted about hospital discharges has to do specifically with proposed discharges from Office of Mental Health facilities:

We are fielding requests from OMH housing providers suggesting we need to file guardianship petitions on folks they find difficult to serve. We even received a guardianship appointment for a person in a state psychiatric placement recently. I am very concerned that there is a push by OMH providers to suggest local DSS's should become guardian of folks for whom OMH has no effective supportive housing. They are suggesting that some folks with incredibly difficult and dangerous behaviors are lacking competency due to the severity of their MH illness, and therefore they think DSS should be guardian. We all know DSS does not have access to structured OMH housing placements for these high needs people so I am at a loss as to what the thinking is and what folks expect us to do to help them meet their needs if the very system designed to serve them cannot do it. It seems like a potential abuse of the Article 81 statute and a way for OMH to circumvent their responsibility to serve difficult high-needs folks in their system. I think ideas to defend against these would be very helpful.

The statute pertaining to the discharge of persons of in-patient at facilities licensed by the Office of Mental Health, MHL §29.15, does include that the LDSS must cooperate with the discharge planning from those facilities, although the discharge planning responsibility does lie with the facility:

(f) The discharge or conditional release of all clients at developmental centers, patients at psychiatric centers or patients at psychiatric inpatient services subject to licensure by the office of mental health shall be in accordance with a written service plan prepared by staff familiar with the case history of the client or patient to be discharged or conditionally released and *in cooperation with appropriate social services officials and directors of local governmental units*. In causing such plan to be prepared, the director of the facility shall take steps to assure that the following persons are interviewed, provided an opportunity to actively participate in the development of such plan and advised of whatever services might be available to the patient through the mental hygiene legal service: the patient to be discharged or conditionally released; an authorized representative of the patient, to include the parent or parents if the patient is a minor, unless such minor sixteen years of age or older objects to the participation of the parent or parents and there has been a clinical determination by a physician that the involvement of the parent or parents is not clinically appropriate and such determination is documented in the clinical record and there is no plan to discharge or release the minor to the home of such parent or parents; and upon the request of the patient sixteen years of age or older, a significant individual to the patient including any relative, close friend or individual otherwise concerned with the welfare of the patient, other than an employee of the facility.

(g) A written service plan prepared pursuant to this section shall include, but shall not be limited to, the following:

1. a statement of the patient's need, if any, for supervision, medication, aftercare services, and assistance in finding employment following discharge or conditional release, and

2. a specific recommendation of the type of residence in which the patient is to live and a listing of the services available to the patient in such residence.

3. A listing of organizations, facilities, including those of the department, and individuals who are available to provide services in accordance with the identified needs of the patient.

4. The notification of the appropriate school district and the committee on special education regarding the proposed discharge or release of a patient under twenty-one years of age, consistent with all applicable federal and state laws relating to confidentiality of such information.

5. An evaluation of the patient's need and potential eligibility for public benefits following discharge or conditional release, including public assistance, medicaid, and supplemental security income.

6. Material providing information related to extreme risk protection orders, pursuant to article sixty-three-A of the civil practice law and rules. Such information may be provided to the patient or, upon consent of the patient, to an authorized representative who has actively participated in the patient's treatment plan. Such information may only be provided if the director of the facility and such facility's clinical staff who worked directly with the patient determine through an evaluation and assessment, that there is the presence of a mental health diagnosis or symptoms of a mental illness exhibited by the patient, which indicates the patient may be at substantial risk of physical harm to himself or herself, or has made threats of or attempts at suicide. Such determination and the basis for it shall be included in the written clinical record.

An inpatient facility operated or licensed by the office of mental health shall provide reasonable and appropriate assistance to the patient, in cooperation with local social services districts, in applying for benefits identified in the written service plan pursuant to paragraph five of this subdivision, prior to discharge or conditional release.

(h) It shall also be the responsibility of the director of any department facility from which a client or patient has been discharged or conditionally released, in collaboration, when appropriate, with appropriate social services officials and directors of local governmental units, to prepare, to cause to be implemented, and to monitor a comprehensive program designed:

1. to determine whether the residence in which such client or patient is living, is adequate and appropriate for the needs of such patient or client;

2. to verify that such patient or client is receiving the services specified in such patient's or client's written service plan; and

3. to recommend, and to take steps to assure the provision of, any additional services.

If you have a situation where the hospital is using guardianship as a means of discharging the patient to DSS, you may be able to raise arguments based upon the above to oppose the appointment of the LDSS. This is particularly so if the patient is not actually ready for discharge, but the facility is petitioning for a guardian to be appointed if the person *may* be ready for discharge at some point in the future.

However, if the adult is ready for discharge and a guardian is necessary, and there is no other person able and willing to serve responsibly, chances are that the LDSS will be appointed. See *Matter of New York State Office of Mental Health*, 80 Misc.3d 655 (Supreme Court, Monroe County, 2023).

LDSS's should also raise the issue that no guardian may be granted to power to:

consent to the voluntary formal or informal admission of the incapacitated person to a mental hygiene facility under article nine or fifteen of this chapter or to a chemical dependence facility under article twenty-two of this chapter;[5] or

consent in perpetuity to the administration of psychotropic medication to the incapacitated person, over their objection and without any further judicial review or approval[6]

Another objection would be the appointment of an LDSS when there is a suitable person in the AIP's family circle who is qualified to serve. As a general proposition, the court will not appoint strangers as either a guardian of the person or the property unless it is impossible to find someone within the family circle who is qualified to serve. *Matter of Gustafson*, 308 AD2d 305, (1st Dept. 2003). The problem with this objection is that there does not seem to be any reported cases where the court has appointed an individual over an LDSS. For example, in the Matter of United Health Servs. Hosps., Inc. (J.W.), case mentioned earlier, the court found that the mother, who was the only individual suggested as an alternative guardian to DSS, was not an appropriate person to serve as guardian.

If the LDSS is nominated, and is aware of individuals who might be appropriate to serve, they should consider contacting the individuals to see if they would be interested in serving. This leads us to the next issue.

Issue: Failure of the non-DSS petitioner to notice relatives or others as required by MHL

Discharge planning generally requires the hospital or other facility to include family members and others in discharge planning. Similarly, in an Article 81 guardianship, the petitioner is obliged by MHL 81.07 requires that notice of the guardianship proceeding be provided to:

(g) Notice of the proceeding.

1. Persons entitled to notice of the proceeding shall include:

(i) the following persons, other than the petitioner, who are known to the petitioner or whose existence and address can be ascertained by the petitioner with reasonably diligent efforts: the spouse of the person alleged to be incapacitated, if any; the parents of the person alleged to be incapacitated, if living; the adult children of the person alleged to be incapacitated, if any; the

[5] See MHL §81.22(b)(1)

[6] See Matter of Rhodanna CB, 36 AD3d 106 (2nd Dept., 2006)

adult siblings of the person alleged to be incapacitated, if any; the person or persons with whom person alleged to be incapacitated resides; and

(ii) in the event no person listed in subparagraph (i) of this paragraph is given notice, then notice shall be given to at least one and not more than three of the living relatives of the person alleged to be incapacitated in the nearest degree of kinship who are known to the petitioner or whose existence and address can be ascertained by the petitioner with reasonably diligent efforts; and

(iii) any person or persons designated by the alleged incapacitated person with authority pursuant to sections 5-1501, 5-1505, and 5-1506 of the general obligations law, or sections two thousand nine hundred five and two thousand nine hundred eighty-one of the public health law, if known to the petitioner; and

(iv) if known to the petitioner, any person, whether or not a relative of the person alleged to be incapacitated, or organization that has demonstrated a genuine interest in promoting the best interests of the person alleged to be incapacitated such as by having a personal relationship with the person, regularly visiting the person, or regularly communicating with the person; and

(v) if it is known to the petitioner that the person alleged to be incapacitated receives public assistance or protective services under article nine-B of the social services law, the local department of social services; and

(vi) if the person alleged to be incapacitated resides in a facility, the chief executive officer in charge of the facility; and

(vii) if the person alleged to be incapacitated resides in a mental hygiene facility, the mental hygiene legal service of the judicial department in which the residence is located; and

(viii) such other persons as the court may direct based on the recommendation of the court evaluator in accordance with subparagraph (xvii) of paragraph five of subdivision (c) of section 81.09 of this article.

A question submitted for this program was:

> Many facilities are filing petitions to have a guardian appointed are not addressing adequately the available alternative resources (i.e. relatives, etc.) that have been explored. Further, when they do name some relatives, there is no address or phone numbers or anything about how the potential resource cannot/won't be the guardian. This ends up creating more work for county APS to explore what should be the petitioner's duty. How can we address this lack on the part of the petitioners (usually facilities where the AIP is residing who just want to be paid)?

There is limited caselaw on the effects of a failure to give proper notice, however there are two cases that stand for the position that the failure to give notice to the above parties prohibits the matter to proceed to a hearing:

In *In re John T*., 42 AD3d 459 (2d Dept.2007) the 2nd Department found that where the petitioner had failed to provide notice to the nursing home where the AIP was confined, that the court could not impose the petitioner's attorney's fees[7] against the nursing home ("Holliswood"):

> In the absence of notice to Holliswood, the Supreme Court improperly proceeded with the hearing and improvidently awarded attorneys' fees and disbursements as against it. Holliswood should have been informed that the guardianship hearing would serve as a factual predicate for the award of attorneys' fees and disbursements against it, particularly since the petitioner had only requested in her papers that her attorneys be paid a reasonable fee from Mr. T.'s assets. The Supreme Court should have advised Holliswood that it was considering the imposition of fees and costs and/or sanctions, and afforded it a full opportunity to be heard in order to explain why it had refused to release Mr. T. from its facility for more than three months.

Citing the John T. case, in *In re St. Francis Hosp.,* 26 Misc3d 1213(A) (Supreme Court, Dutchess County, 2010) the court noted that:

> Counsel for the AIP asserts that the instant petition was not served upon the AIP's wife, mother, father or sister. Additionally, it is alleged that Mr. Rose receives benefits and that the Dutchess County Department of Social Services was not noticed with the instant proceeding. Mental Hygiene Law § 81.07(g) requires that each of those individuals is entitled to timely notice of the proceedings. While it is true that this court could not proceed to a hearing without proper notice to the individuals required by MHL § 81.07 (In re John T., 42 AD3d 459 [2d Dept.2007]), the failure to provide such notice does not render the petition jurisdictionally defective under the statute.

Based upon the two cases above, you might consider raising an objection to the hearing or the appointment until the petitioner has made proper notification, or has certified to the court that they have made efforts to locate individuals entitled to notice. That will probably not reduce the legwork that APS will need to do in finding these individuals themselves, but some courts might take offense to the lack of effort by the hospital.

Issue: We are getting pulled into a lot of Guardianships lately, and as an interested party, we do not have any say in the outcome. How do you typically handle this? Do you file motions where you feel that the DSS should not be named?

[7] The Second Department also noted that the imposition of the attorney fees against Holliswood was not authorized by Mental Hygiene Law article 81.

We have had an explosion of guardianships over the last 2 years. I try to go to all of the cases we are noticed on because when I do not show up on we typically get appointed. In Onondaga County, the Surrogate as acting Supreme handles all the guardianships. The Court does a good job of not appointing us if there is anyone else that can possibly serve, so I do not ever file a motion requesting not to be appointed. The Court also will allow me to interject (either by questioning witness or updating the Court on our involvement) in proceedings where we may be appointed as guardian despite not formally seeking to intervene or cross petition.

For an interesting examination on intervening in Article 81 guardianships see: https://nysba.org/chaos-in-the-courts-a-procedural-solution-to-rein-in-contested-article-81-cases/

A recurring question is how to respond when the guardianship is filed by a nursing home to have the guardian file a Medicaid application.

> We also field many guardianship petitions from nursing homes for the sole purpose of getting Medicaid open. They accept folks into their NHs and then as soon as they don't think family is going to follow through on the Medicaid documentation needed, they allege incompetency and file a petition, but will admit if we can find a way to open Medicaid without being appointed guardian, they will withdraw the petition. It's almost always just about the Medicaid and not any other actual need for us to be appointed guardian. In other words, they will admit they wouldn't have filed to have us appointed but for the need to get Medicaid open. As you know, when we end up appointed guardian, so much more work is involved. It would be wonderful to have another mechanism to address the need to obtain financial records to open Medicaid that is short of having us appointed guardian. Any ideas in this area would be very helpful.

Similar Issue: How do you handle firms filing Guardianships just as a way to collect a debt?

As far as the debt collection request, our Court doesn't dismiss those proceedings but does make sure that the facility is seeking all the necessary parties. You can make sure that the facility attorney puts in adequate proof that the guardianship is necessary and that the adequate powers are included. A bigger problem with facility attorneys delaying the hearing or not submitting orders timely in what may be an effort to extend provisional Medicaid coverage. Pursuant to the New York State Medical Assistance Reference Guide (MARG) Ownership and availability at p. 502:

> "If an A/R is alleged to be incapable of managing his/her own finances and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income and resources, as appropriate, are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. The income and resources, as

> appropriate, are considered unavailable to the A/R prospectively and for a retroactive period of three months."

Onondaga County Surrogate's Court has taken over drafting the Art. 81 orders and they are done quickly.

And additional, related question is whether there are alternative to full guardianship in the above situation or when there is some property to be disposed of by the guardian.

> The guardian was appointed to handle all of the property issues, which are now resolved, or where the primary purpose was to file a Medicaid application, and that has been accomplished, and now there is nothing left for the guardian to do.

One thing that the LDSS could consider is asking the court to appoint them as a special guardian under MHL §81.16 for the purpose of handling the above issues, once they are resolved to the court's satisfaction, the special guardian is relieved.

Uncooperative Incapacitated Persons

Issue: How can the LDSS serve uncooperative clients, and service providers who refuse to cooperate with the LDSS when the LDSS is appointed as guardian?

The following questions illustrate a number of difficulties that a guardian might encounter.

> We have been progressively receiving more and more guardianship assignments for individuals who have been declared "incapacitated" but continue to reside in the community. We have found these clients to be incredibly difficult. Often they refuse to speak with us, refuse to allow us in their homes, and refuse to attend appointments and assessments we set up for them. Law enforcement does not provide assistance, even when shown the Order of Guardianship and/or Commission of guardian. Medical professionals will frequently provide information directly to the client, instead of Department staff. Further, many of these medical professionals aren't even aware of our involvement because the IP does not disclose this.
>
> Is there a mechanism by which we can ensure the IP is engaging with us and receiving necessary services?
>
> How much liability do we face in these cases where we cannot enter the IP's home or force them to attend medical treatment?

There are no easy answers to these questions. Unfortunately, some courts are of the view that when an LDSS is appointed as guardian, that they function as some sort of

"guardian angel" able to swoop down and pluck the incapacitated person out of harm's way. It is even more difficult if the incapacitated person's issues are mental health related, since MHL Article 81 is really not meant to serve as an alternative to mental health treatment.

The first suggestion would be to ensure that the LDSS is receiving notice and participating in the guardianship hearings. If these guardianships are being utilized by petitioners looking to dump their problems on the LDSS then that should be objected to.

If there are mental health aspects to the AIP's, the earlier mentioned restrictions should be raised to the court, that no guardian may be granted to power to:

> consent to the voluntary formal or informal admission of the incapacitated person to a mental hygiene facility under article nine or fifteen of this chapter or to a chemical dependence facility under article twenty-two of this chapter;[8] or
>
> consent in perpetuity to the administration of psychotropic medication to the incapacitated person, over their objection and without any further judicial review or approval[9]

An LDSS does not have any dispensation from them, and cannot be granted any powers greater than that of any other individual. When a guardian is appointed, they should be granted, consistent with the IP's functional level, powers sufficient to provide for the IP. At the hearing, if the LDSS is going to be appointed, it should be requesting powers to have access to the IP, the IP's abode, to all confidential records, including medical and financial, and access to all service providers for the IP.

If the LDSS is in need of additional powers, its recourse is to petition under MHL §81.36 for additional powers.

Liability issues in this area would likely come from failure to request additional powers if necessary, as well as not exercising those that are granted. Staff that is carrying out the guardianship responsibilities should be hyper-vigilant in thoroughly documenting issues with service providers and others who are not cooperating.

Issues in Property Management

Issue- What are best practices for property management when the Commissioner is appointed as guardian of property?

This issue could easily take up an entire session. Some fundamentals to consider are:

[8] See MHL §81.22(b)(1)

[9] See Matter of Rhodanna CB, 36 AD3d 106 (2nd Dept., 2006)

1. What powers does the guardian have?
2. Do the powers give the guardian everything they need to discover and gather the property assets of the IP?
3. What property does the IP have, including any income streams?
4. What liabilities does the IP have?
5. What is the living situation of the IP? Is that subject to change?
6. Is the IP financially supporting anyone?
7. What assets does the LDSS have in the way of supports to the property management guardian, such as:
    - Accounting
    - Real estate (if there is real property to be sold)
    - Personal property sales (if property needs to be sold to support the IP, or if the IP is going to be placed out of the home and must downsize, etc.)

Note that if the guardian needs to retain such services as a realtor or accountant, that the LDSS is not required to utilize the Part 36 list, but must be mindful of its own procurement policies.

Issue- Disposition of property of the IP when they are placed in a chronic care facility

One of the more heart- rending issues that a guardian will face is the placement of the incapacitated person from their home to chronic care placement. Almost always, this is going to result in a very considerable downsizing of the IP's personal property. The question is:

> What is the best practice for DSS in going about cleaning out the IP's former apartment and handling belongings? If the belongings are of little monetary value (e.g. clothing, small household goods, small furnishings), what must DSS do with the belongings? Can DSS donate the belongings? If so, are there guidelines to where DSS may donate goods?

The first issue is whether or not the guardian has the power to dispose of the property. Second, if they do have that power the guardian can sell, donate, or throw out the property as they deem appropriate, although they do have to remember that the property remains that of the incapacitate person, so they have to be acting according to the wishes of the IP, if known and otherwise in the IP's best interests. If the incapacitated person is able to communicate their wishes as to the disposition of the property, then that should be taken into consideration as well, including their wishes as to keepsakes that they might retain based upon space in their placement.

Issue- tax filings for incapacitated persons

You may find that the incapacitated person has, among other financial issues, issue with the various taxing authorities. A question that we received was about what to do if the if the IP owes the IRS money?

The general answer would be, assuming that the guardian powers include handling tax matters, for the guardian to contact the particular agency involved with the tax issue. It would also be a good start to check the agency website to find out the best way to make contact, and also to see if the website provides any guidance.

For example, although the IRS website does not give a direct answer, it does have a section entitled "What if I can't pay my taxes?" that mentions some payment options. Because you are the guardian and not the individual taxpayer, you will have to provide a copy of your Commission, and probably do some explaining as to what guardianship means in New York State.

The above advice would also apply to working with other creditors of the incapacitated person. A key difference between governmental and non-governmental creditors is that some income streams and other assets are exempt from collection by non-governmental creditors, so you want to keep that in mind when you are negotiating with the various creditors.

Issue- Commingled funds

Another problem that a property management guardian might face is a joint bank account with the incapacitated person and a family member or other individual. Sometimes DSS discovers that the family member was taking utilizing the IP's funds. In one reported case, the attorney for the incapacitated person filed a motion to allocate the commingled funds between the two persons on the joint account. In *Matter of Williams (E.S.),* 79 Misc3d 1227(A) (Supreme Court, Broome County, 2023), the Court allocated commingled funds between a mother and daughter, both of whom had Art. 81 guardians, so that a pooled trust could be set up for the daughter and a guardianship account for the mother. There were not allegations of the misuse of the funds by either party in that case. If there is an issue of who has ownership of the funds in the joint account, you should be figuring out the sources of the funds, since if they are traceable, it will be easier for the court to allocate them properly. If there are direct deposits, for sources such as Social Security, pensions, etc. this will be easier. If it appears that the other person on the account is financially exploiting the incapacitated person to the extent that a crime has been committed, APS must report that to law enforcement.[10]

[10] See Social Services Law §473(5)

Issue- Court Examiner Charges- payment sources

Court examiners are permitted to receive compensation from the estate of the incapacitated person for their review of the guardian reports and other duties. Their compensation is set by court rule or by administrative order. For example:

4th Department- 22 NYCRR 1015.16

(c) Compensation.

(1) Initial Reports. For the examination of an initial report, a court examiner is entitled to a fee of $100 together with reimbursement for reasonable and necessary disbursements.

(2) Annual Reports. For the examination of an annual report, a court examiner is entitled to reimbursement for reasonable and necessary disbursements and a fee fixed pursuant to the following fee schedule:

Closing balance of estate examined	**Fee**
under $5,000	$150
$5,001-$25,000	$200
$25,001-$50,000	$250
$50,001-$100,000	$300
$100,001-$150,000	$400
$150,001-$225,000	$500
$225,001-$350,000	$600
$350,001-$500,000	$700
$500,001-$750,000	$800

$750,001-$1,000,000	$900
Over $1,000,000	$1,000

(3) The fee shall be calculated on the net value of the estate at the close of the calendar year for which the annual report has been filed. Upon a showing of extraordinary circumstances, a fee in excess of the fee fixed by the schedule may be awarded.

(4) An application for a fee for an estate with a value of $5,000 or less shall be made by standard voucher and shall be approved by the Presiding Justice or the designee of the Presiding Justice.

(5) An application for a fee for an estate with a value of more than $5,000 shall be set forth in the report of the court examiner and shall be approved by order of the Presiding Justice for payment by the estate. The court examiner shall serve a copy of the order approving payment on the guardian, committee or conservator, and shall file a copy of the order with the clerk of the court that appointed the guardian.

(6) A guardian, committee or conservator may apply to the Presiding Justice for review and reconsideration of any fee on the ground of excessiveness. Such application shall be in writing and shall be made within 20 days of service by the court examiner of the order directing payment of the fee from the estate.

We received the following question, from a county in the 4th Department.

Generally, in order to file a final report, the guardian must zero out the accounts of the IP such that there are no funds left. Then the Court Examiner reviews the final report. The Court Examiner charges a fee for this but of course the County no longer has any funds of the IP to pay the Court Examiner's final bill. Most Court Examiner seek to have their final bill paid by the state but several have invoiced us and then motioned to hold us in contempt when we could not pay.

How should we be handling this and how are other counties doing it? Should we be holding funds in escrow when we close out the IP's account to pay the Court Examiner down the road?

Mental Hygiene Law § 81.32 (Examination of initial and annual reports) sets forth the sources of payment for the court examiners.

> (f) Expenses of examination. The expenses of the examination shall be payable out of the estate of the incapacitated person examined if the estate amounts to five thousand dollars or more, or, if the estate amounts to less than this sum, by the county treasurer of the county or, within the city of New York by the comptroller of the city of New York, out of any court funds in his or her hands.

When deciding whether or not to set money aside from the incapacitated person's estate to pay the court examiner, you have to be mindful of what other debts the estate has. Under *Matter of Shannon*, 25 NY3d 345 (2015), upon the death of the incapacitate person, unless otherwise ordered by the court upon motion by the guardian on notice to the person or entity to whom guardianship property is deliverable, and the court examiner, the guardian may retain, pending the settlement of the guardian's final account, guardianship property equal in value to the claim for administrative costs, liens and debts. The phrase "administrative costs, liens and debts" has been interpreted by *Shannon* to mean those costs, liens and debts related to the administration of the guardianship. These include court examiner fees, guardian fees, attorney fees, and any filing fees for final report.

When paying expenses at the outset of the guardianship, you should also be mindful of *Matter of Hart (D.S.)*, 79 Misc3d 1101 (Supreme Court, Chemung County, 2023) In that case the DSS guardian filed for the discharge of the guardianship after the death of the IP. In reviewing the final accounting, the Court decided to surcharge the guardian for failing to pay the court evaluator's and IP's counsel fees. The Court found that the IP had sufficient funds at the time of the guardianship appointment and that the fees should have been paid as a priority over other expenses of the IP.

APPENDIX

DELEGATION OF AUTHORITY

I, _____, am the Commissioner of Social Services for the County of

_____ and the duly appointed Guardian for_____.
A copy of the Commission to Guardian is attached.

1. Pursuant to this authority granted to me, I hereby appoint, designate and delegate to _____ a caseworker in the Adult Protective Services unit of the _____ County Department of Social Services, whose signature

is_____the power to conduct any and all banking transactions on behalf of_____.

3 . Before accepting this Delegation and each time _____ conducts any transactions under this Delegation please ask to view her valid, current Onondaga County Employee Photo Identification.

_____
Commissioner, _____ County Dept. of Social Services

STATE OF NEW YORK)

COUNTY OF _____ ss.:

On the _____ day of _____, 20__ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity and that by his signature on the instrument, the individual, or the person on behalf of which the individual acted, executed the instrument.

_____ **NOTARY PUBLIC**

The actual letter, in pdf form, can be found here:
Executive Office Letterhead
https://opwdd.ny.gov/system/files/documents/2021/03/inappropriate-discharge-memo-update_9.8-1.pdf

TO: DDSOO Directors
Executive Directors of Voluntary Agencies
DDRO Directors

FROM: Leslie Fuld, Deputy Commissioner
Division of Quality Improvement

SUBJECT: Due Process and Inappropriate Discharge
from Residential Programs and Services

DATE: September 9, 2020

Individuals receiving services certified or operated by OPWDD, including individuals residing in certified residential facilities, must be afforded the due process required by OPWDD regulations at 14 NYCRR 633.12: Objection to Services Process, as well as OPWDD's Community Placement Procedures. These rights apply whenever a provider proposes to modify the provision of services, to discharge an individual from their residential or nonresidential facility, program or service, to reduce, suspend or terminate an HCBS waiver service, and/or to initiate changes to an individualized service plan including Life Plans.

Providers must implement internal procedures to resolve objections to services and, in the event these procedures cannot effectuate resolution, actions must be taken which comport the requirements of 14 NYCRR 633.12. These actions include compliance with the regulatory procedures required to discharge an individual from their certified residence or program by, among other requirements, providing notice of the provider's intended action and notifying the individual of their right to object and to have a hearing. Frequently noted examples of inappropriate discharges include, but are not limited to, the following agency actions when such actions are taken without following the process set forth in 14 NYCRR 633.12:

- Agency refusal to allow an individual receiving services to return to his certified residence or day program following a period of hospitalization;

- Agency refusal to allow an individual receiving services to return to his certified residence or day program following a home visit or other extended absence, including those instances where individuals engage in a prolonged home visit for personal or medical reasons, including those related to the current COVID-19 public health emergency;

• Agency refusal to allow an individual receiving services to return to his certified residence or day program because the Agency feels it can no longer provide appropriate care to that individual.

Regardless of the purported reason, a provider's refusal to allow an individual to return to his or her residence or other service program is considered a discharge. Therefore, providers must adhere to the procedures outlined in 14 NYCRR 633.12 and the corresponding OPWDD Community Placement Procedures. This process requires that the individual or the representative of the individual be given the opportunity to object to the discharge and, ultimately, be afforded the opportunity to have a hearing scheduled by OPWDD. Please remember that, if the individual or their advocate objects to the proposed discharge or other proposed change to a service, placement and/or services should remain in place pending conclusion of the 633.12 process.

A provider's attempt to inappropriately discharge an individual is a violation of 14 NYCRR 633.12, as well as Article 16 of the NYS Mental Hygiene Law. In accordance with the OPWDD Accountability Initiative, OPWDD will impose appropriate fines for any such violations and may take additional adverse certification actions as needed. Questions regarding the objection and hearing processes can be directed to the appropriate Regional Office.

cc: Deputy Commissioners
Associate Deputy Commissioners
Provider Associations

*OPWDD Community Placement Procedures are available online at: https://opwdd.ny.gov/system/files/documents/2020/01/community_placement_procedures-green-book.pdf