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ASSERTING CHOICE

Health Care, Housing, and Property—Planning for Lesbian, Gay, Bisexual, and Transgender Older Adults

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Although in their infancy, rights for lesbian, gay, bisexual, and transgender (LGBT) older adults are continuing to be developed and defined. Advocates are forging tools and resources to be used in pressing issues—such as health care, housing, and property rights—of relevance to the LGBT community. For example, LGBT older adults should be able to make informed health care choices and have available before them suitable choices for their health and welfare. LGBT older adults must be able to rent an apartment or buy a home with a person of choice, unfettered by discrimination. LGBT older adults need to know that they have viable choices in estate and incapacity planning and how to use the law to protect those choices.

Health care issues we discuss are planning for discharge from Medicare-participating facilities, the emerging field of transition care, and what advocates and LGBT older adults should know in order to protect the rights of LGBT adults who are in nursing facilities and other long-term care settings. We then turn to housing and discuss how LGBT older adults can protect their housing rights; we use subsidized rental housing as an example. We conclude with a discussion of how advocates and LGBT older adults can use legal tools such as advance directives for health care, wills, and trusts to assure that LGBT older adults' choices and preferences are made known and legally binding.

Health-Facility Discharge Planning and Transitional Care

LGBT older adults, like many others, often find that they are unprepared and without the information and knowledge they need to make an informed decision about their care at and after discharge from a health care facility. In exploring health care planning options, those who advocate on behalf of LGBT older adults should strive to understand the cultural and social context in which they will be giving advice. LGBT older adults are more likely to comply with proposed health care planning, realize the importance of treatment approaches and goals, and make better choices leading to favorable health care outcomes when they feel comfortable with the person giving advice.

As a prelude to discussing discharge or transition care plans, LGBT older adults, their friends, and advocates must take the following steps: (1) read carefully all documents that purport to explain the patients' rights to services; (2) question treating physicians, nurses, social workers, home health agency providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services; (3) voice opinions and concerns about care, and participate fully in all care decisions; and (4) think carefully about where the LGBT adults will live after discharge, who will assist them, and what equipment and ser-

vices will be needed at home, in the home of another, in an institutional setting (such as a skilled nursing facility), or in a community-based setting (such as an assisted-living facility or hospice).

We use the Medicare program below as a health care frame because it is a health care benefit that can and should be used by qualified LGBT persons 65 or older as well as younger disabled persons who qualify for the program.¹ Further, the obligation to give notice and discharge planning that is set out in the Medicare program can be used as a model for structuring health care advocacy more broadly.

Medicare-participating hospitals, skilled nursing facilities, and hospices are all required to have discharge plans, which serve to give beneficiaries the opportunity to plan for postcare. Medicare-participating hospitals, skilled nursing facilities, hospices, and home health agencies as well must comply with notice requirements, which can also serve as a planning tool. Because discharge planning in the home health care setting is less well developed, we offer suggestions on how the home health agency notice requirements can serve as a point at which further planning should occur. And we touch on the emerging field of transitional care, which coordinates care and allows for planning as one moves from one health facility to another.

Medicare-Participating Hospitals. Hospitals participating in Medicare must have a “discharge planning process” for patients.² The elements of discharge planning are detailed by statute and regula-

tion.³ The Medicare agency—the Centers for Medicare and Medicaid Services (CMS)—has made it a condition of Medicare participation that hospitals make available discharge-planning services to Medicare beneficiaries who are “likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning” and to other patients, even non-Medicare patients, upon their request.⁴ Discharge planning allows LGBT older adults to exercise a measure of direction and control over how their post-hospital needs will be met.

Medicare-participating hospitals must meet the following discharge-planning guidelines and standards:

- Identify patients who without discharge-planning services “are likely to suffer adverse health consequences upon discharge.”
- Give to those patients identified above and others who request it a discharge-planning evaluation.
- Complete the discharge-planning evaluation in a timely manner.
- Indicate in the discharge-planning evaluation whether the patient is likely to need posthospital services such as hospice care, and the availability of such services as Medicare-participating extended care services in the patient’s area of residence.
- Include in the patient’s medical record the discharge-planning evaluation so that it may be used when making the discharge plan; the evaluation results must be discussed with the patient.⁵

¹In general, persons 65 and older and entitled to social security or railroad retirement benefits pursuant to Section 202 of the Social Security Act (42 U.S.C. § 402) are automatically entitled to and enrolled in Medicare Part A (see 42 U.S.C. § 426) and deemed to have enrolled in Medicare Part B (see 42 U.S.C. § 1395p(f)). Others who are not qualified under the above provisions and are citizens of the United States or lawfully resident aliens who have resided in the United States for five years or more may purchase Medicare for a monthly premium (see 42 U.S.C. §§ 1395o(2) and 1395i-2). Further, persons under 65 who meet eligibility requirements under the Social Security Disability Insurance program may qualify for Medicare benefits after applicable waiting periods (42 U.S.C. § 426(b)(2)).

²Omnibus Reconciliation Act of 1986, Pub. L. No. 99-509, § 9305(c), 100 Stat. 1874 (1989), §1861(e), (ee), codified at 42 U.S.C. § 1395x(ee).

³42 U.S.C. § 1395x(ee)(6)(B); 42 C.F.R. § 482.43 (2009). See also Alfred J. Chiplin Jr., *Breathing Life into Discharge Planning*, 13 ELDER LAW JOURNAL 1 (2005), and *Medicare Discharge-Planning Regulations: An Advocacy Tool for Beneficiaries*, 29 CLEARINGHOUSE REVIEW 152 (June 1995). State discharge-planning laws are another option for lesbian, gay, bisexual, and transgender (LGBT) older adults. Several state laws are identified in the articles cited above.

⁴42 C.F.R. § 482.43(a), (b)(1) (2009).

⁵42 U.S.C. § 1395x(ee)(2)(A)–(E); 42 C.F.R. § 482.43 (2009).

While the statute requires hospitals to devise a discharge planning process that will ensure a smooth transition to post-hospital care, neither the statute nor regulations set forth specific steps that the discharging hospital must take to meet that requirement. The health care bills under consideration by Congress have some form of care coordination.⁶

The notice requirements for Medicare-participating hospitals are different from those for Medicare-participating skilled nursing facilities, home health agencies, and hospices. Medicare-participating hospitals must meet certain notice requirements with respect to termination and denial of services. Such hospitals are required to deliver to beneficiaries within two days of admission the “Important Message from Medicare.”⁷ This general notice gives information about the patient’s rights, especially discharge and appeal rights.⁸ The beneficiary is to give the health care facility a signed copy of the “Important Message from Medicare” notice as far in advance of discharge as possible but no more than two calendar days before discharge; if discharge falls within two calendar days of admission, the patient is not required to give the follow-up signed notice.⁹

Medicare-Participating Skilled Nursing Facilities. Skilled nursing facilities as part of their discharge-planning obligations must develop a comprehensive care plan for each resident.¹⁰ This plan is based on periodic comprehensive assessments of the patient’s condition, needs, and capacities, such as discharge potential.¹¹ The Medicare-participating nursing facility must conduct initial and periodic comprehensive assessments of its Medicare residents and their potential for discharge.¹² The facility must do a quarterly review assessment of the beneficiary.¹³ The skilled nursing facility must give to the patient a discharge summary before discharge.¹⁴ And the facility must “provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.”¹⁵ The preparation and orientation requirement applies to discharges to a private residence, to another nursing facility, or to another type of residential facility.¹⁶ The facility must develop a postdischarge plan of care (a result of the discharge planning process), based in part on the assessment of continuing care needs. The purpose of the postdischarge plan is to ensure that the individual’s

⁶The House and Senate versions of the Patient Protection and Affordable Care Act, H.R. 3590, emphasize fostering care management and provider coordination. The major tools will be through payment for accountable care mechanisms (meeting established quality measures), developing chronic care management strategies, and payment incentives to providers for care coordination.

⁷42 C.F.R. § 405.1205 (2009) (Traditional Medicare); 42 C.F.R. § 422.620 (2009) (Medicare Advantage); 72 Fed. Reg. 17169 (April 6, 2007); Centers for Medicare and Medicaid Services, Department of Health and Human Services, No. 100-04, Medicare Claims Processing Manual ch. 30, § 200.3.1—Delivery of the Important Message from Medicare, <http://www.cms.hhs.gov/Manuals/IOM/list.asp> (Internet-only manual) (2008). See Centers for Medicare and Medicaid Services, Department of Health and Human Services, Form CMS-R-193, An Important Message from Medicare About Your Rights (2007), www.cms.hhs.gov, <http://bit.ly/8JTp4F>. See also Centers for Medicare and Medicaid Services, Department of Health and Human Services, No. 11376, Planning for Your Discharge (2008). This pamphlet is being reviewed by beneficiaries and others. The revised pamphlet will be available on the Medicare beneficiary’s website, www.medicare.gov.

⁸The “Your Medicare Discharge Rights” segment of the notice is prominently displayed on the first page of the document.

⁹42 C.F.R. §§ 405.1205(c)(2), 422.620(c)(2) (2009).

¹⁰42 U.S.C. § 1395x(h); 42 C.F.R. § 483.20(b), (k) (2009).

¹¹42 C.F.R. §§ 483.20, 483.20(b), 483.20(b)(xvi) (2009).

¹²*Id.* § 483.20.

¹³*Id.* § 483.20(c).

¹⁴*Id.* § 483.20(f).

¹⁵*Id.* § 483.12(a)(7).

¹⁶*Id.* § 483.12. Further, the language of Section 482.12 is not bound by where, outside the facility, the resident is to be transferred.

needs will be met after discharge from the facility into the community.¹⁷

Medicare beneficiaries who are at risk of discharge or termination of services from a Medicare-participating skilled nursing facility, home health agency, or hospice also have notice and appeal rights.¹⁸ The health care provider must give written notice to the patient before termination of service.¹⁹ The written notice must be given in some cases at least two days before the last service. If this is not feasible, then the notice must be given no later than the next to the last time services are furnished.²⁰ The written notice triggers the Medicare beneficiary's right to request an expedited determination from the quality improvement organization, which must render a decision within seventy-two hours of the request.²¹

Medicare-Participating Hospice Requirements. Medicare-participating hospice programs' discharge planning process must take into account the possibility that a patient's condition might change so as to preclude the patient from continuing to be certified as terminally ill.²² CMS regulations specify that "the discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill."²³ As noted above, Medicare-participating hospices must give written notice to the patient before termination of service and no later

than the next to the last time services are furnished; the notice triggers the Medicare beneficiary's right to request an expedited determination from the quality improvement organization.²⁴

Medicare-Participating Home Health Agencies. Discharge-planning rights in the home health agency context are not as well developed as in other care settings. We instead focus on the information that home health agencies are required to give their Medicare patients regarding the patient's care, treatment, and discharge. The home health agency must give its Medicare patients information in advance about the care and treatment that the agency is to provide and any changes in that care or treatment that may affect the individual's well-being.²⁵ The beneficiary has the right to participate in planning care and treatment or changes in care or treatment.²⁶ The home health agency must also inform the Medicare patient orally and in writing (in advance of coming under the care of the agency) of any changes in the charges for items or services to be provided as well as the beneficiary's rights and entitlements under Medicare.²⁷ A home health agency is required to give written or oral notice by using the home health advanced beneficiary notice to its Medicare patients when the agency believes that Medicare will not pay for an item, service, or procedure and when there is a change in the patient's condition that the agency believes will result in Medicare not covering an

¹⁷*Id.* § 483.20(f)(3).

¹⁸42 U.S.C. § 1395ff(b); 42 C.F.R. §§ 405.1200, .1202 (2009).

¹⁹42 C.F.R. § 405.1200(b) (2009).

²⁰*Id.* § 405.1200(b)(1).

²¹42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.1202 (2009). A quality improvement organization is an entity comprising physicians, nurses, and other health care persons who are under contract with the Centers for Medicare and Medicaid Services (CMS) to review the quality of care received by Medicare beneficiaries (see Peer Review Improvement Act of 1982, 42 U.S.C. §§ 1320c-1320c-12). Fifty-three quality improvement organizations each are responsible for a state, territory, or the District of Columbia. For general and contact information, see www.ahqa.org, or call 800-MEDICARE.

²²42 C.F.R. § 418.26(d)(1) (2009).

²³*Id.* § 418.26(d)(2).

²⁴*Id.* § 405.1200(b); 42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.1202 (2009).

²⁵42 C.F.R. § 484.10(c)(1) (2009).

²⁶*Id.* § 484.10(c)(2).

²⁷*Id.* § 484.10(e).

item, service, or procedure.²⁸ This notice is to give the beneficiary the opportunity to decide whether to appeal to the quality improvement organization for a formal determination. Home health agencies must comply with the discharge and termination notice requirements detailed for skilled nursing facilities and hospices.²⁹

Transitional Care. Transitional care or “care transitions” is a care coordination tool that has been developed as a response to the question of how older adults should move between various care settings. The leading proponents of transitional care define it as “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.”³⁰ Not a Medicare term or notion and broader than the discharge process, transitional care embraces preparation of the patient to optimize continuity and coordination of practitioners and services across settings.

Transitional care services particularly apply to people who have medical conditions that require managing and coordinating services from various health care providers across multiple care settings. Transitional care encompasses the sending and receiving aspects of the transfer, logistical arrangements, education of the patient and family, and coordination among health professionals. Transitional care seeks to assure that the patient’s care plan as developed in one care setting is communicated to the next set of care providers, that the necessary steps before and after a patient transfer are fully and properly executed, and that information about

the care delivered in the sending care setting is communicated to the receiving care team.³¹ In this regard, care coordination and transitional care can be understood as complementary disciplines that seek to minimize care fragmentation and reduce poor care outcomes.

Nursing-Facility Residents and the Right to Choose

LGBT older adults who rely on long-term care facilities to help with daily life activities are at significant risk of discrimination, abuse, and neglect. The Federal Nursing Home Reform Act, enacted in 1987, is a comprehensive federal statute that creates a minimum set of standards of care and rights for people living in Medicare- or Medicaid-certified nursing facilities.³² LGBT older adults may seek to enforce the Act through administrative complaint or, according to at least one federal court, through Section 1983 litigation.

The Federal Nursing Home Reform Act. Congress passed the Nursing Home Reform Act to provide oversight and inspection of nursing facilities participating in Medicare and Medicaid programs. A nursing facility is required by the Act to “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”³³ Participating facilities must perform a comprehensive assessment of each resident and, based on that assessment, develop a comprehensive care plan for each resident.³⁴ The comprehensive care plan must have measurable objectives and timetables to maintain or improve a resident’s medi-

²⁸*Id.* § 484.10(a)(1)–(2). See Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, *supra* note 7.

²⁹42 C.F.R. § 1200 (2009).

³⁰Eric A. Coleman & Chad Boulton, *Improving the Quality of Transitional Care for Persons with Complex Care Needs*, 51 JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 566 (2003) (American Geriatrics Position Statement).

³¹For a broad discussion of transitions and patient care, see *id.*; see also the Care Transitions Program website, www.caretransitions.org/index.asp, for publications and links to organizations engaged in care transitions.

³²Federal Nursing Home Reform Act, § 4211 of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, 101 Stat. 1330, 42 U.S.C. § 1395i-3 (Medicare), 42 U.S.C. § 1396r (Medicaid). Regulations at 42 C.F.R., Part 483, apply to Medicare-participating skilled nursing facilities and Medicaid-participating nursing facilities. The Act is referred to by some as “the Reform Law.”

³³42 U.S.C. §§ 1395i-3(b)(2), 1395i-3(d)(1)(A), 1396r(b)(2), 1396r(d)(1)(A).

³⁴*Id.* §§ 1395i-3(b)(2)–(3), 1396r(b)(2)–(3); 42 C.F.R. § 483.20(b), (k) (2009).

cal, nursing, and mental and psychosocial needs.³⁵

The Federal Nursing Home Reform Act and its implementing regulations have a variety of “quality-of-life” requirements that afford residents of nursing homes and rehabilitation and health-related care and service facilities the right to control aspects of their lives.³⁶ One example of a quality-of-life requirement is the right to “free choice”—the right, among others, to choose a physician and to be informed about care and treatment.³⁷ Another is the right to “reasonable accommodation of individual needs and preferences.”³⁸ Nursing facilities must allow residents to choose a room with a person of the resident’s choice if both parties consent to the choice.³⁹ The right to choose a room is detailed in CMS interpretive guidelines for long-term care facilities, which are used by state nursing-facility surveyors to evaluate facility compliance with the Act.⁴⁰ Other rights spelled out in the guidelines are the rights to privacy and dignity.⁴¹

Quality-of-life provisions are not bound by reference to marriage or sexual orientation or gender identity or expression. The Federal Nursing Home Reform Act does not limit its protections to a specific class of individuals, making the Act particularly relevant to LGBT nursing-facility residents. By focusing on the health and welfare of residents, rather than on a protected class such as sex or race, the Act does not require the plaintiff to prove the rea-

son for a defendant’s adverse action, just that the action is a violation of the statute. Nursing facilities are legally obligated to protect the rights of each resident to be treated with dignity and respect, to make personal decisions, and to be free from physical or mental abuse or involuntary seclusion.⁴² Advocates should use these legal obligations to assert the quality-of-life rights of any set of consenting adult residents.

Enforcing LGBT Residents’ Rights.

Countless stories about Federal Nursing Home Reform Act violations depict LGBT nursing-facility residents as being isolated, abused, and denied the right to personal autonomy because of their sexual orientation or gender identity or expression. Glen Francis, executive director of the Griot Circle, a community-based organization serving the needs of LGBT older adults of color in New York City, recalls the severe abuse that one of its members suffered while living in a nursing home. This member, says Francis, was an “out lesbian”—“She was tied down to her bed and had bed sores all over her body. The staff took issue with her sexuality. They kept her in a room and wouldn’t let her out.”⁴³

According to the Third Circuit’s recent landmark decision, *Grammer v. John J. Kane Regional Centers—Glen Hazel*, nursing-home residents may bring a private right of action under Section 1983 against government-run nursing homes for violating the Federal Nursing Home Reform

³⁵*Supra* note 34.

³⁶42 U.S.C. §§ 1395i-3(b)(1), 1395r(b)(1). See 42 C.F.R. § 483.5 (2009) (definitions).

³⁷42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i).

³⁸*Id.* §§ 1395i-3(c)(1)(A)(v)(I), 1396r(c)(1)(A)(v)(I).

³⁹42 C.F.R. § 483.15(b)(3) (2009); and see Centers for Medicare and Medicaid Services, Department of Health and Human Services, No. 100-07, State Operations Manual, Appendix PP—Guidance to Surveyors for Long-Term Care Facilities, F 242 (2009) (known as “F-tag 242”), <http://bit.ly/9St1TZ>. F-tags are part of the numbering system in Appendix PP. F-tags are guidance tools used by surveyors who are responsible for the review of a facility’s compliance with Medicare conditions of participation.

⁴⁰Centers for Medicare and Medicaid Services, State Operations Manual, *supra* note 39. The interpretive guidelines give breadth and expansion to Nursing Home Reform Act implementing regulations.

⁴¹42 U.S.C. §§ 1395i-3(c)(1)(A)(v)(I), 1396r(c)(1)(A)(v)(I); 42 C.F.R. § 483.10(e) (2009) (privacy and confidentiality). And see Centers for Medicare and Medicaid Services, State Operations Manual, *supra* note 39, at F164 (known as “F-tag 164”).

⁴²42 U.S.C. §§ 1395i-3(c)(1), 1396r(c)(1); 42 C.F.R. §§ 483.15, 483.25 (2009).

⁴³Telephone interview by Natalie Chin with Glen Francis, Executive Director, Griot Circle, in New York, N.Y. (2008).

Act because of inadequate treatment and care.⁴⁴ The plaintiff in *Grammer* alleged that a Medicaid-funded county nursing home failed to provide proper care to her mother; that her mother developed ulcers, became malnourished, and died of sepsis.⁴⁵ The Third Circuit held that “[t]he language used throughout the [Federal Nursing Home Reform Act] is explicitly and unambiguously rights-creating.”⁴⁶ Moreover, the statute “is constructed in such a way” that nursing-home residents have “explicitly identified rights, such as ‘the right to be free from physical or mental abuse, ... involuntary seclusion, and any physical or chemical restraints imposed for the purposes of discipline or convenience....’”⁴⁷

The rights created by the Nursing Home Reform Act enable LGBT older adults to choose what reflects their needs. Thus a nursing home that fails to respect the gender identity or expression of a male-to-female transgender resident by forcing her to room with a male resident, requiring her to dress in traditionally male clothing, and refusing to refer to her by the appropriate gender pronoun may be violating the Act.

Residents of long-term care facilities seeking redress for Federal Nursing Home Reform Act violations may, as an alternative to litigation, file a complaint with their state’s survey agency.⁴⁸ Confidentiality is crucial to the already vulner-

able long-term-care-facility residents who lodge complaints. The confidentiality of residents who file a complaint may be maintained in two ways. First, any employee involved with the complaint process is prohibited from revealing the identity of the complainants. Second, during the investigation, the complaint surveyor accesses multiple files of patients with similar profiles, referred to as a “sample.”⁴⁹ In theory, facility employees cannot deduce who filed the complaint because the complaint surveyor accesses more than one file.

The nursing-home complaint procedures, however, suffer from shortcomings, according to a 2005 report published by the U.S. Government Accountability Office.⁵⁰ The report found such problems with the complaint process as the failure of state complaint surveyors to identify nursing-home deficiencies and delays, ranging from weeks to months, in the investigation of complaints by residents, family members, or staff members alleging harm to residents.⁵¹

Recently a woman reached out to staff members of an LGBT community center after she was forced into isolation from other nursing-home residents because she was perceived to be gay. For advocates in LGBT aging, the Federal Nursing Home Reform Act potentially empowers our clients and holds nursing homes such as this one accountable.

⁴⁴*Grammer v. John J. Kane Regional Centers—Glen Hazel*, 570 F.3d 520, 524–28 (3d Cir. 2009) (recipient of federal funds required to comply with the Medicaid Act and its implementing regulations as well as Nursing Home Reform Act). The plaintiff in *Grammer* brought an action under 42 U.S.C. § 1983 against a federally funded nursing home for the deprivation of civil rights guaranteed by federal statutory law and the U.S. Constitution. By contrast, claims against private nursing homes have been unsuccessful (see, e.g., *Prince v. Dicker*, 29 F. App’x 52 (2d Cir. 2002) (no private cause of action under Nursing Home Reform Act against a private nursing home); *Brogdon v. National Healthcare Corporation*, 103 F. Supp. 2d 1322, 1330–32 (N.D. Ga. 2000)).

⁴⁵*Grammer*, 570 F.3d at 522.

⁴⁶*Id.* at 532.

⁴⁷*Id.* at 530 (citing 42 U.S.C. § 1396r(c)(1)(A)).

⁴⁸42 C.F.R. § 483.10(b)(7)(iv). See Centers for Medicare and Medicaid Services, Medicare, Survey and Certification—General Information, Contact Information, <http://bit.ly/593LK6> (“If you have specific concerns about the quality of care you or a loved one received in a state or federally certified health care facility, you may file a formal complaint with your state’s survey agency.”).

⁴⁹CMS sets the guidelines that states must follow when a complaint is filed (see Centers for Medicare and Medicaid, State Operations Manual, *supra* note 39, ch. 5).

⁵⁰U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-06-117, REPORT TO CONGRESSIONAL REQUESTERS, NURSING HOMES: DESPITE INCREASED OVERSIGHT, CHALLENGES REMAIN IN ENSURING HIGH-QUALITY CARE AND RESIDENT SAFETY (2005), www.gao.gov/new.items/d06117.pdf.

⁵¹*Id.* at 4. Even so, advocates should not forgo using the complaint process. While the quality of review varies from state to state, a review may bring about improvements in the quality of care that patients receive.

Public Housing Protections for LGBT Older Adults Under State and Local Laws: Sarah’s Case

Consider a hypothetical case: Sarah and Julia, a committed same-sex couple, lived together in their New York City Housing Authority apartment for more than fifteen years.⁵² Only Julia’s name was on the apartment lease. Shortly after Julia passed away, the housing authority initiated eviction proceedings against Sarah. Julia’s daughter, seeking help for Sarah, contacted a legal aid organization. The daughter said:

We are afraid that Sarah is going to lose her home.” My mom refused to attend family events if Sarah wasn’t there. She was supposed to be buried with my grandfather, but said that she wanted to be buried with Sarah. They were not open about their relationship but it was understood that they were a couple.⁵³

One year after moving into her housing authority apartment Julia met Sarah. Several years into their relationship, Sarah lost her job and, for health reasons, was no longer able to work. She qualified for Social Security Disability Insurance but was unable to afford her small one-bedroom Brooklyn apartment. Julia suggested that Sarah move in with her. Shortly after Sarah moved in, Julia submitted a written request to the housing authority manager that Sarah become a legally authorized permanent household member.⁵⁴ After several months passed without a response from management, Julia went to the local office to inquire about her application. The employee asked what her relationship was to Sarah. Surprised,

Julia said that she was her life partner. The woman abruptly said that only persons related by blood or marriage qualified to become permanent residents and that her application would be denied.

Over the years the family repeatedly attempted to get Sarah added to the lease, but the manager always told them that if Sarah was not family, she was not allowed to be added to the family composition. Intimidated and fearful that she would be evicted and that Julia, who had recently suffered a stroke, would end up in a nursing home, Sarah continued to live in their apartment without being added to the family composition. All the while, Julia submitted annual income affidavits listing Sarah’s income. Shortly after Julia passed away, Sarah, then 70, was evicted from their home.⁵⁵

Legal advocates fighting housing discrimination against LGBT older adults such as Sarah must rely heavily on state and local nondiscrimination laws. In Sarah’s case a claim of sexual orientation discrimination under New York’s Sexual Orientation Non-Discrimination Act could have been initiated against the housing authority.⁵⁶ But Sarah and Julia, who grew up in a time of institutionalized homophobia, might have been afraid or unwilling to reveal intimate details about their relationship. And, with Julia’s poor health, litigation might not have been an option. Sarah and Julia had another avenue to preserve Sarah’s housing security: the housing authority’s own policies. At the time the New York City Housing Authority’s policy defined family for purposes of adding a permanent resident as “[t]wo or more unrelated person(s), regardless of sex, living together as a cohesive family group

⁵²This case study is a hypothetical based on several actual situations (see, e.g., *McFarlane v. New York City Housing Authority*, 780 N.Y.2d 135, 137 (N.Y. App. Div. 2004); *Gill v. Hernandez*, 865 N.Y.S.2d 843 (N.Y. Sup. Ct. 2008), for cases with legal issues similar to that of Sarah’s and with good outcomes for the person seeking tenancy).

⁵³*Id.*

⁵⁴A tenant applying for New York City Housing Authority public housing is required to disclose income and the persons who will reside in the apartment, also known as the “family composition.” A request to add someone to the family composition must be made by the current tenant and must be in writing. If eligibility requirements are met, the total family income will be calculated and the new rent determined.

⁵⁵See, e.g., *McFarlane*, 80 N.Y.2d at 137 (“a showing that the [public housing authority] knew of, and took no preventive action against, the occupancy by the tenant’s relative, could be an acceptable alternative for compliance with the notice and consent requirements”).

⁵⁶N.Y. EXEC. LAW § 296.2-a (2009).

in a sharing relationship.”⁵⁷ Under housing authority policy Sarah and Julia qualified as family members, and Sarah would have qualified for succession rights as a remaining family member. Nonetheless, homophobia and intimidation by housing authority employees led to Sarah’s eviction.

Federal law defines certain types of families, but state and local public housing authorities have wide discretion to broaden the definition of “family.”⁵⁸ State and local public housing regulations, like the Federal Nursing Home Reform Act, are not bound by references to marriage, sexual orientation, or gender identity or expression. Springfield, Illinois, for example, defines family as “[t]wo or more persons who have a family type relationship.”⁵⁹ The housing authority of Montgomery, Alabama, defines family to compose of “two or more persons who are not so related, but are regularly living together, [who] can verify shared income or resources.”⁶⁰ But even where the definition of family is sufficiently broad, LGBT older adults wanting to live together as a family may still suffer discrimination by public housing authority managers unwilling to recognize their relationship, as Sarah’s case demonstrates.

The U.S. Department of Housing and Urban Development (HUD) last year announced that it would propose rules to “clarify that the term ‘family’ as used to describe eligible beneficiaries of our public housing and [Section 8] voucher

programs include[s] otherwise eligible lesbian, gay, bi-sexual or transgender individuals and couples.”⁶¹ These proposed rules are the result of longtime advocacy to remedy discrimination against LGBT individuals in public housing and in the Section 8 Rental Voucher Program.⁶²

HUD’s commitment to expand the definition of family to cover housing security protections for LGBT individuals and families in subsidized housing is a step forward in the fight against LGBT discrimination. Meanwhile, advocates for the LGBT aging community can continue to utilize state and local rules and regulations, which may be more discrete, to extend legal protections to LGBT older adults.

Estate and Incapacity Planning Problems for LGBT Persons

Advocates should advise their LGBT older adult clients that whether they are in a committed relationship, they should take control of their financial and personal affairs. Advocates can help LGBT adults to arrange their affairs and name beneficiaries in a way that will allow them the maximum degree of autonomy even if they begin to decline physically or cognitively. Those LGBT adults who are in a committed relationship and who cannot or choose not to marry may want to use financial, estate, and health care planning to have a measure of protection for themselves and their partner.

⁵⁷New York City Housing Authority, Management Manual, as amended by General Management Directive 3692 (revised)—Occupancy and Remaining Family Member Policy Revisions, Overview (2002). The new policy, effective November 24, 2002, narrows the eligibility requirements for unrelated persons wanting to become permanent residents. The New York City Housing Authority now requires that the tenant of record and prospective tenant produce a New York City-issued Certificate of Domestic Partnership Registration, *id.*, ch. 4 subdiv. 4, § F(4)(a)(2), as amended by General Management Directive 3692 at 3 (July 11, 2003).

⁵⁸24 C.F.R. § 5.403 (U.S. Department of Housing and Urban Development regulation “not limited to” factors listed); *Gill*, 865 N.Y.S.2d at 851–53; U.S. Department of Housing and Urban Development, Public Housing Occupancy Guidebook 24 (2003), <http://bit.ly/5pCd29>.

⁵⁹Springfield Department of Community Relations, Springfield Public Housing Information, <http://bit.ly/7r8yU1>.

⁶⁰Montgomery Housing Authority Housing Choice Voucher (Section 8) Administrative Plan 68 (2008), www.mhatoday.org. See also Housing Authority of the City of Pittsburgh, Admissions and Continued Occupancy Policy § 8.1 (family is defined as a “group of people related by blood, marriage, adoption or affinity that live together in a stable family relationship”).

⁶¹Press Release, U.S. Department of Housing and Urban Development, Obama Administration to Ensure Inclusion of the LGBT Community in HUD Programs (Oct. 21, 2009) (HUD. No. 09-206), <http://bit.ly/10ces9>; see also generally U.S. Department of Housing and Urban Development, Public Housing Occupancy Guidebook, *supra* note 58.

⁶²Section 8 rental vouchers allow income-eligible families to choose privately owned rental housing, and the public housing authority generally pays the landlord the difference between 30 percent of household income and the cost of rent.

Most state statutes governing estate and health and incapacity planning favor legal spouses and biological family members. The statutes' default provisions apply if an individual has no valid will or fails to designate an agent for property management or health care decision making in the event of incapacity. In all but a very few jurisdictions, for example, intestacy statutes require that a decedent's property be distributed to biological relatives, not to a longtime partner, child of a partner, or entity that might be preferred by the older adult as the beneficiary of the estate.⁶³ A spouse or blood relative is typically given priority over all others in a contested guardianship or conservatorship proceeding. But LGBT persons can use documents such as simple wills, powers of attorney, and health care directives to help ensure that their wishes regarding the management and disposition of their property, and their choices about who can be involved with or make decisions about the health care they receive, are honored.⁶⁴

Estate Planning. Low-income and middle-class LGBT older adults are not likely to have assets that require sophisticated estate-planning strategies. Many LGBT older adults can dispose of their estates largely through beneficiary designations on life insurance policies, investments such as money market accounts or mutual funds, and pensions and other retirement savings, all of which do not re-

quire probate. Often financial institutions can assist individuals in setting up accounts so that those accounts will pass to a designated beneficiary outside probate.

Real property and personal property such as bank accounts, if held in joint tenancy with right of survivorship, do not become part of the estate and will not, except in rare circumstances, implicate probate. A bank account in which the LGBT older adult names a person to whom the account is "payable on death" also does not implicate probate. In a few jurisdictions, a transfer-on-death deed, which transfers title to real property to a successor owner at the death of the owner, can be filed.⁶⁵ A transfer-on-death deed has an advantage over conveying a joint tenancy ownership interest to another in that it may be revoked at any time. Another alternative is to use gifts to distribute one's estate before death. Gifts that fall below the federal or state limits on gifting do not count toward the lifetime maximum gifting limits.⁶⁶

Advocates should encourage LGBT persons with retirement savings such as individual retirement accounts (IRAs) or pensions to name a beneficiary to ensure that the proceeds go to a person of their choosing. The Pension Protection Act of 2006 extended protections to LGBT persons with IRAs or pensions.⁶⁷ Before the enactment of the Act, a non-spouse beneficiary of an IRA or pension was required at the death of the owner to

⁶³See, e.g., Uniform Probate Code §§ 2-101 to 2-114.

⁶⁴Many scholarly and practical resources discuss the special considerations that go into estate and incapacity planning for LGBT individuals (see generally, e.g., A. Spencer Bergstedt, *Estate Planning and the Transgender Client*, 30 WESTERN NEW ENGLAND LAW REVIEW 675 (2008); Frank S. Berall, *Estate Planning Considerations for Unmarried Same or Opposite Sex Cohabitants*, 23 QUINNIPIAC LAW REVIEW 361 (2004); Aimee Bouchard & Kim Zadworny, *Growing Old Together: Estate Planning Concerns for the Aging Same-Sex Couple*, 30 WESTERN NEW ENGLAND LAW REVIEW 713 (2008); Lisa M. Cukier, *Marriage and Estate Planning Under Goodridge v. DPH*, BOSTON BAR JOURNAL, Nov.–Dec. 2004, at 14; Nancy Levit, *Cohabitation, Domestic Partnerships, and Nontraditional Families: Annotated Bibliography*, 22 JOURNAL OF THE AMERICAN ACADEMY OF MATRIMONIAL LAWYERS 169 (2009); Steven Wallace Schmitt, *Financial Challenges Facing the Gay and Lesbian Community*, WESTCHESTER BAR JOURNAL, Fall–Winter 2005, at 29; National Center for Lesbian Rights, *Planning with Purpose: Legal Basics for LGBT Elders* (2009), <http://bit.ly/aaat8V7>.

⁶⁵As of December 14, 2009, the following states had transfer-on-death deed statutes: Arizona, Arkansas, Colorado, Kansas, Missouri, Minnesota, Montana, Nevada, New Mexico, Ohio, Oklahoma, and Wisconsin. The National Conference of Commissioners of Uniform State Laws recently approved a Uniform Real Property Transfer on Death Act (see nccusl.com/Update?ActSearchResults.aspx).

⁶⁶Individuals who have reason to think that they will be in need of long-term care within five years and expect to apply for Medicaid to pay for that care should be extremely cautious about making gifts because the gifts will be presumed to be uncompensated transfers and will result in periods of ineligibility to receive Medicaid. LGBT couples also need to know that they generally are not entitled to the same protection from Medicaid liens on real property that is typically enjoyed by heterosexual married persons.

⁶⁷Pension Protection Act of 2006, Pub. L. No. 109-280, 120 Stat. 780 (2006) (codified as an amendment to 29 U.S.C.A. ch. 18 (2007)). See the Congressional Research Service's summary of the bill as enacted, <http://bit.ly/7qIU7V>.

take the entire amount in the account as a lump-sum distribution. This had costly tax consequences for the beneficiary. Now nonspousal beneficiaries, such as domestic partners, may, like spousal beneficiaries, take distribution over five years or over the beneficiary's expected lifetime. The Pension Protection Act also gave LGBT couples the right to use the retirement plan hardship distribution law, which permits early withdrawals from an IRA or pension account in cases of hardship or financial emergency.

Advocates should advise LGBT adults to execute a will for those properties and assets that cannot be managed by or through the designation of a beneficiary or by the form of ownership of the property or asset. The will itself names the personal representative or executor (the person responsible for managing the estate) and can direct that the representative or executor receive compensation beyond what is statutorily authorized. A valid will may assure that property that has little market value but much sentimental value will be distributed to persons whom the LGBT adult, not the state, has chosen. LGBT individuals who die without a will cannot ensure that their property is left to anyone other than a blood relative or control who will manage their estate. Legal aid organizations, law school clinical programs, and state bar groups sometimes offer free or sliding-fee will clinics for lower-income adults, veterans, and professionals such as first responders.⁶⁸

Planning for Incapacity. Two documents that for many low-income LGBT older adults are even more important than a will are the durable power of at-

torney for property management and the advance directive for health care. These two documents enable LGBT persons to designate an individual or entity to manage their affairs in the event that they become unable to do so.

A durable power of attorney for property is a creature of state law and so must comply in form, substance, and manner of execution with the relevant statutory provisions. In many states a person may use a statutory form to delegate authority to an agent or agents.⁶⁹ An LGBT older adult may use the durable power of attorney to name a partner as agent to pay bills, conduct banking or beneficiary transactions, or even sell real property. But the agent must be chosen carefully. The durable power of attorney has been called “a license to steal” inasmuch as the document can be used by an unscrupulous agent to strip the assets of the grantor of that power in very short order. Nevertheless, third parties are bound to honor a durable power of attorney. An agent who does not violate any fiduciary duties to the principal has priority over any other individual with respect to managing the financial affairs of an incapacitated principal.⁷⁰

A health care directive, which everyone should have regardless of sexual orientation or age, is of particular importance to LGBT individuals. An advance directive for health care is a written document that typically has two functions.⁷¹ First, a health care directive instructs on a variety of health care and medical issues such as the type of medical treatment to be applied in various situations, pain management, place of end-of-life care, organ donation, and many other matters. Often

⁶⁸First responders are persons such as emergency management technicians, emergency nurses, physicians, and paramedics who are generally the first people to respond in the event of medical emergencies and disasters (see U.S. Department of Homeland Security, Homeland Security Presidential Directive 8 (Dec. 13, 2003), <http://bit.ly/11heFb>).

⁶⁹See, e.g., MINN. STAT. § 523.23 (2009) (statutory short-form power of attorney).

⁷⁰A principal may need to execute—in addition to a durable power of attorney—special documents to serve as representative payee for a social security beneficiary (see Social Security Administration, Representative Payee Program, www.ssa.gov/payee/). To file tax forms and deal with the Internal Revenue Service, see Internal Revenue Service, Topic 311: Power of Attorney Information, www.irs.gov/taxtopics/tc311.html. Some brokerage houses and other financial institutions regularly refuse to honor generic durable powers of attorney, but such a refusal is held to violate state law (see, e.g., *Maenhoudt v. Stanley Bank*, 115 P. 3d 157 (Kan. App. 2005)).

⁷¹Advance directives for health care are often called “living wills.” The term “living will,” however, describes a document of limited purpose that permits terminal patients to specify that they do not want life-prolonging treatment in certain circumstances. Living-will statutes have been largely superseded by advance-health-care-directive laws (see, e.g., Minnesota Living Will Act, MINN. STAT. § 145B (repealed 1998)).

it captures the principal's religious and spiritual values, which guide health care providers as they attempt to determine the best course of care for a patient. Second, a health care directive permits the principal to name a person or persons who can make health care decisions on behalf of the principal in the event of incapacity. A majority of states have health care surrogacy laws that provide a statutory hierarchy of health care decision makers for a person who does not name a health care agent through an advance directive. With few exceptions, these surrogacy statutes exclude in this hierarchy domestic partners, close friends, or others whom an LGBT person might prefer to blood relatives.

A health care directive may also specify who may and may not visit. It also implicitly serves as a Health Insurance Portability and Accountability Act release allowing health care providers to release medical information to the agent. The health care directive can be used to nominate a proposed guardian. If a guardian is needed, this nomination, though not dispositive, must be given weight in the guardianship proceeding.

Trusts. Most low- and middle-income individuals have little reason to establish a trust. In a few situations, however, a trust can be a useful means for managing even relatively modest assets. For example, a so-called pet trust can be used to provide for the care of a beloved pet. The party establishing the trust can name as trustee an organization or person who will ensure that money in the pet trust is used for the sole benefit of the pet.⁷² Many elderly persons, LGBT or otherwise, worry greatly about what will happen to their cherished animal companions after death. A pet trust offers some peace of mind to these elders even if the money available to provide for the pet is not much.

Special-needs and supplemental-needs trusts are special kinds of trusts—they

can make funds available to disabled persons who are receiving Medicaid benefits without compromising their eligibility for the benefits.⁷³ In light of the intricacies of the law in this area, attorneys should be careful when setting up these kinds of trusts. In many jurisdictions a custodial trust can serve a function similar to that of a durable power of attorney. A custodial trust has the added protection of clear and enforceable fiduciary obligations imposed on a trustee.⁷⁴ If a person intends to bequeath property to a minor or to a person who lacks money-management skills, a trust should be established either during the person's lifetime or via the will, and the trustee should be named as the beneficiary of this request.



LGBT older adults may not have the information necessary to make good choices and protect their rights in health care, rental housing, or estate planning. Advocates can become more informed of the ways in which they can help LGBT older adults plan for the future. The Medicare discharge-planning process and Nursing Home Reform Act give LGBT older adults statutory rights that meet their specific needs. Knowledge of specific health care, housing, and financial-planning rights can go a long way to improve choices and ensure that the wishes of LGBT older adults are carried out. Local housing authority regulations can be used to secure long-term housing for LGBT partners. Proposed HUD regulations may strengthen housing protections for LGBT older adults and their families who live in subsidized housing. LGBT older adults and couples have particular challenges in financial and estate management. Advocates should advise LGBT older adults to use wills, trusts, advance health care directives, and the like to ensure that their wishes for property and health management are followed.

COMMENTS?

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—The Editors

⁷²See, e.g., Uniform Trust Code § 408 (2005) (Trust for Care of Animal).

⁷³See generally THOMAS D. BEGLEY JR. & ANGELA E. CANELLOS, SPECIAL NEEDS TRUSTS HANDBOOK (2009).

⁷⁴See, e.g., Uniform Custodial Trust Act (1998).



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