

PREPARED BY THE
ESSEX COUNTY
BAR ASSOCIATION
COMMITTEE ON THE
RIGHTS OF PERSONS
WITH DISABILITIES and
SPONSORED BY THE
NEW JERSEY STATE BAR
FOUNDATION

DISABILITY LAW

A L E G A L P R I M E R

SIXTH EDITION

Foreword to the Sixth Edition

The New Jersey State Bar Foundation, the Essex County Bar Association, and its Committee on the Rights of Persons with Disabilities are pleased to offer *Disability Law: A Legal Primer (Sixth Edition)*, as a free public education service.

The information in this booklet is presented to help explain laws concerning persons with disabilities. It does not constitute legal advice, which can only be given by an attorney. The booklet is based upon laws in effect as of November 2014.

Copies of *Disability Law: A Legal Primer (Sixth Edition)* may be ordered online through the New Jersey State Bar Foundation's website or by calling 1-800 FREE LAW. Copies of the primer are also available for download through the Foundation's website (njsbf.org) in a pdf format. Copies may also be obtained by writing to the New Jersey State Bar Foundation, New Jersey Law Center, One Constitution Square, New Brunswick, NJ 08901.

***Disability Law: A Legal Primer (Sixth Edition)* was made possible by funding from the IOLTA Fund of the Bar of New Jersey.**

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Acknowledgements

This primer was prepared by the Essex County Bar Association Committee on the Rights of Persons with Disabilities and funded by the New Jersey State Bar Foundation. Special thanks to Ellen Cloran Yesukevich, Esq., who coordinated receipt of the contributions for this edition, and to Marie Davis and Joseph Young, Esq., who edited this edition. Thanks also to Mark Levin, Esq., Cecilia Lindenfesler, Esq. and Ruth Lowenkron, Esq. for their work in assembling this publication. Finally, we extend our gratitude to all of the legal experts, whose names appear at the end of each section, for their contribution of time and knowledge in updating the primer for this sixth edition.

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Americans with Disabilities Act (Overview)

What is the Americans with Disabilities Act?

The Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 *et seq.*, signed into law on July 26, 1990, is landmark civil rights legislation that grants broad civil rights protection by prohibiting discrimination on the basis of disability in the areas of employment (Title I), public service and transportation (Title II), public accommodations (Title III) and telecommunications (Title IV). Almost all provisions of the ADA are currently in force. The phase-in of some provisions extended to the year 2010, the date by which existing inter-city rail stations must be accessible.

Who is protected by the ADA?

To be included under protections of the Americans with Disabilities Act a person must have a disability, or have a relationship or association with an individual with a disability. An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment. In response to U.S. Supreme Court decisions that interpreted those protected by the ADA narrowly, Congress amended the ADA in 2008, broadening terms within the definition of “disability” and enlarging the pool of individuals protected by the Act. Under the amendments, an impairment must be considered in its active or unmitigated state. As a result, an individual is protected even if their impairment is intermittent or can be mitigated. The ADA does not specifically name all included impairments. The ADA, however, does not consider current drug or alcohol abuse, gambling, homosexuality, bisexuality, or kleptomania as disabilities.

How does the ADA affect employment?

Title I requires employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-

related opportunities available to others, including recruitment, hiring, promotions, training, pay, social activities, and termination. (This issue is discussed further in the Workplace section of this booklet.)

How does the ADA affect transportation?

The transportation provisions of the Americans with Disabilities Act, Title II, cover all public transportation services, such as buses, rail transit, subways, commuter rails and Amtrak. Public transportation authorities may not discriminate against people with disabilities in the provision of their services. Compliance with ADA requirements for accessibility must be made in newly purchased vehicles and good faith efforts must be made to purchase or lease accessible used buses, re-manufacture buses in an accessible manner, and provide para-transit where a fixed route bus or rail system is operated. Para-transit is a service where individuals who are unable to use regular transit systems independently because of a physical or mental impairment are picked up and dropped off at their destinations. All new bus and rail stations must be accessible. When altering primary function areas, accessible routes must be provided if the costs of doing so are not disproportionate to the overall costs of the alterations. (This issue is discussed further in the Transportation section of this booklet.)

How does the ADA affect public entities?

The Americans with Disabilities Act prohibits discrimination against persons with disabilities by public entities, which are defined as state and local government entities and any of their instrumentalities. Public entities may not exclude persons with disabilities, treat them differently than persons who do not have a disability, impose criteria that tend to screen them out, make unnecessary inquiries into the existence of a disability, or retaliate against any person with a disability who attempts to enforce his or

her ADA rights. Public entities must make reasonable modifications in policies and provide auxiliary aids and services to persons with disabilities. Public entities, unlike public accommodations, are not obligated to remove architectural barriers so long as their programs, as a whole, are accessible to persons with disabilities.

How does the ADA affect places of public accommodation?

The Americans with Disabilities Act prohibits exclusion, segregation, and unequal treatment of persons with disabilities in places of public accommodation. Places of public accommodation are non-government entities that are open to the public. They include privately operated transportation, commercial facilities, and entities that own, lease, or operate facilities such as restaurants, retail stores, hotels, movie theaters, private schools, convention centers, doctors' offices, homeless shelters, zoos, funeral homes, daycare centers, sports stadiums, and fitness clubs. Public accommodations must also comply with specific requirements related to architectural standards for new and altered buildings and remove barriers in existing buildings where it is easy to do so without much difficulty or expense, given the public accommodation's resources. (This issue is discussed further in the Architectural Barriers section of this booklet.) Effective communication for people with hearing, vision, or speech disabilities must also be available. Transportation services provided by private entities are also covered. In addition, courses and examinations related to professional, educational, or trade-related applications, licensing, certification, or credentialing must be provided in a place and manner accessible to people with disabilities.

How does the ADA affect telecommunications?

Federal Communications Commission (FCC) regulations require that Americans with Disabilities Act-related telecommunications services be provided by common carriers (telephone companies). Services are geared toward enhanced telecommunications for persons with

hearing and speech impediments, but the ADA includes a requirement that federally funded public service announcements be closed-captioned for persons with hearing impairments. The FCC has set minimum standards for telecommunications relay services.

How does the ADA affect people who are institutionalized?

In *Olmstead v. L.C.*, 526 U.S. 1037 (1999), the United States Supreme Court confirmed the ADA's community integration mandate and required that states provide community-based housing and support services for persons with significant disabilities. The *Olmstead* mandate applies to persons with physical or mental disabilities. *Olmstead* complaints can be filed with the U.S. Department of Health and Human Services' Office for Civil Rights.

How can these ADA provisions be enforced?

Employment complaints must be filed with the U.S. Equal Employment Opportunity Commission (EEOC) within 180 days of the date of discrimination, or 300 days if the charge is filed with a designated state or local fair employment practice agency. Individuals may file a lawsuit in federal court only after they receive a "right to sue" letter from the EEOC. Charges of employment discrimination on the basis of disability may be filed at any EEOC field office. Listings for EEOC field offices may be found in most telephone directories under "U.S. Government." Complaints of public service and public accommodation violations may be filed with the U.S. Department of Justice within 180 days of the date of discrimination. Complaints against public services and public accommodations may also be filed in federal court. Telecommunications complaints may be filed with the FCC.

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Architectural Barriers

What are architectural barriers?

Architectural barriers are physical barriers in buildings, parks, transportation services or elsewhere that make access by people with disabilities difficult, if not impossible.

Does the Americans with Disabilities Act (ADA) provide for removal of architectural barriers in public accommodations?

Yes. The ADA provides for the removal of architectural barriers in all public accommodations where such removal is “readily achievable.” If removal is not “readily achievable,” alternative methods of providing the services must be offered. Also, an alteration or renovation of the primary function area in a building must be made accessible. New construction must be accessible; however, elevators are generally not required in buildings under three stories or with less than 3,000 square feet per floor, unless the building is a shopping center, transportation terminal, or the office of a healthcare provider.

Does the ADA provide for removal of architectural barriers in public services?

As long as public services otherwise make their programs accessible to persons with disabilities, they may not be required to remove architectural barriers. State and local governments must prepare a transition plan to ensure that individuals with disabilities are not excluded from services, programs, or activities because a building is inaccessible. This includes plans for the installation of curb cuts and ramps.

Are there any tax deductions that may be taken by a business that pays for the removal of architectural barriers?

Yes. Pursuant to the Internal Revenue Code, 26 U.S.C. § 190, the cost of removing existing architectural and transportation barriers may be fully deducted by businesses, up to a maximum of \$15,000 for each taxable year. This includes

removal of such existing barriers as steps, narrow doorways, and inaccessible parking spaces. However, comprehensive renovations or normal replacement of depreciable property are not deductible under this act. Under the Internal Revenue Code, a “small business” may take a general business credit of up to \$5,000 for expenditures made after November 5, 1990, to comply with the ADA. Included are costs related to removing architectural, communication, and transportation barriers; providing interpreters, readers, or similar services; and modifying or acquiring equipment or material. Under Title 26, Section 44, a “disabled access credit” may be taken by an “eligible small business” in an amount equal to 50 percent of the eligible access expenditures for the taxable year, which exceed \$250 but are less than \$10,250.

Which other federal laws cover architectural barriers?

The Architectural Barriers Act (ABA), 40 U.S.C. § 451 *et seq.* and the Fair Housing Amendments Act (FHAA), 42 U.S.C. § 601 *et seq.* also cover architectural barriers. The ABA provides that certain buildings constructed with federal funds must be designed and constructed to be accessible to persons with disabilities. Generally, when a public building is financed by the federal government, or may be the place of employment or residence of a person with a disability, it must be accessible. The FHAA prohibits discriminatory practices in the sale and rental of housing and in the design and construction of certain dwellings, such as multi-family dwellings covered by the act. (This issue is discussed further in the Housing section of this booklet.)

Which state laws cover architectural barriers?

Under New Jersey’s Barrier-Free Code, N.J.S.A. 52:32-4, and New Jersey’s Barrier-Free Sub-Code, N.J.A.C. 5:23-7.1 *et seq.*, all “public buildings” constructed or substantially remodeled since 1977 must be made accessible. “Public buildings” are those used by the general public, even if built or owned by a private person, partnership, or corporation.

These include residential buildings with four or more dwelling units, hotels, motels, office buildings, and other business establishments, restaurants and shopping centers, theaters, concert halls, museums and libraries, recreational facilities, public transportation terminals and stations, and auto service stations.

What types of accommodations does New Jersey's Barrier-Free Code require?

The Barrier-Free Code sets out accessibility standards for walkways, parking lot spaces, ramps, entrances, doors, corridors, stairs, floors, elevators, wheelchair lifts, public toilet rooms, water fountains, public telephones, and warning signals.

Are any public buildings exempt from New Jersey's Barrier-Free Code?

Yes. Some buildings that are exempt from the barrier-free requirements are one-, two-, and three-family residences; warehouse storage areas; and all buildings used for hazardous activities. Residential townhouses (generally two- or more-story residential units) are also exempt. However, townhouse units in buildings with elevators are subject to the architectural barrier codes.

Does New Jersey's Barrier-Free Code apply to public buildings constructed before 1977?

In some cases, when such buildings are remodeled, the law requires that they be accessible. For example, when remodeling entrances, stairs, elevators, or public toilet rooms in a public building, these areas must be changed to provide access according to the code. If substantial repairs or alterations are made to a public building constructed before 1977, all or part of the building may have to be made barrier-free.

How is the Barrier-Free Code enforced?

Most municipalities have a designated building code official to enforce the accessibility regulations. The New Jersey Department of Community Affairs is the enforcing

agency for the state. Violations of the code should be reported to the enforcing agencies, and the decisions of the enforcing agencies may be appealed through the state courts.

Does New Jersey law require housing to be both accessible and affordable?

In December 2004, the Council on Affordable Housing, the agency responsible for administering New Jersey's Fair Housing Act, adopted new regulations, including N.J.A.C. 5:94-4.21(a), requiring that 10 percent of all affordable townhouse units proposed in a municipality's fair share plan be accessible to persons with disabilities.

Which laws affect accessibility of voting places?

The Americans with Disabilities Act covers voting place accessibility for state and local elections. Additionally, under the Voting Accessibility for the Elderly and Handicapped Act (VAEHA) of 1984, 42 U.S.C. § 197ee *et seq.*, each political subdivision responsible for conducting elections must assure that polling places for federal elections are accessible to voters who are elderly or who have a disability, except in an emergency or when the state's chief election officer determines that no such place is available within the election district and there is no substitute method of voting available, such as transferring the voter to an accessible site. The Help America Vote Act (HAVA) requires "voting systems" be "accessible for individuals with disabilities, including non-visual accessibility for the blind and visually impaired. All sites were required to comply with the VAEHA by 1992 and with the HAVA by 2006. A person denied access due to disability or the U.S. attorney general may file a lawsuit in the appropriate federal district court regarding inaccessible polling places.

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Commitments

May a person with a mental illness be committed and detained against his or her will?

Yes. A person can be involuntarily committed to a psychiatric hospital if a court determines the following: the person has a mental illness; the mental illness causes the person to be dangerous to self, others, or property; appropriate services are not available in the community; and the person is not willing to accept appropriate treatment voluntarily. N.J.S.A. 30:4-27.2(m).

How is mental illness defined?

Mental illness is defined as “a current substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality.” Mental illness does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome, or developmental disability unless it results in the severity of impairment defined above. The term mental illness is not limited to psychosis. N.J.S.A. 30:4-27.2(r).

What does “dangerous to self” mean?

“Dangerous to self” means that “by reason of mental illness, the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his or her need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical harm or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy the need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available.” In 2009, the law was amended to provide that the determination whether a person is a danger to self “shall take into account a person’s history, recent behavior and any recent act, threat or serious psychiatric deterioration.” N.J.S.A. 30:4-27.2(h).

What does “dangerous to others or property” mean?

“Dangerous to others or property” means that “by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person’s history, recent behavior and any recent act, threat or serious psychiatric deterioration.” N.J.S.A. 30:4-27.2(i).

Is there a different standard for the involuntary commitment of children?

Yes. Court rules define “childhood mental illness” as “a current substantial disturbance of thought, mood, perception, or orientation which differs from that which is typical of children of a similar developmental stage, and which significantly impairs judgment, behavior, or capacity to recognize reality when also compared with children of a similar developmental stage.” The adult definitions of dangerousness described above also apply to minors, except that for minors under 14 years of age “dangerous to self” also means that “there is a substantial likelihood that the failure to provide immediate, intensive, institutional, psychiatric therapy will create in the reasonably foreseeable future a genuine risk of irreversible or significant harm to the child arising from the interference with or arrest of the child’s growth and development and, ultimately, the child’s capacity to adapt and socialize as an adult.” In addition, a parent, with independent approval by a physician, may hospitalize his or her child for up to seven days for evaluation or a diagnosis of a childhood mental illness, without judicial approval. A minor over 14 years of age can also be admitted as a voluntary patient on his or her own, with prior court approval. New Jersey Court Rules 4:74-7A.

Can a person be admitted to a psychiatric hospital as a voluntary patient?

Yes. A person can be admitted as a voluntary patient if

the person has a mental illness; if the person presents a danger to self, others, or property, or the person's mental illness presents a substantial likelihood of rapid deterioration; and appropriate community services are not available in the community. N.J.S.A. 30:4-27.2(ee).

Can a voluntary patient leave the hospital whenever he or she wants?

No. A voluntary patient may request discharge at any time; however, the hospital may hold the patient for a short time to allow for an orderly discharge or to begin the involuntary commitment process. The hospital cannot detain a voluntary patient beyond 48 hours or the end of the next working day (whichever is longer), unless a court has issued a temporary order of involuntary commitment. N.J.S.A. 30:4-27.20.

Can a person be involuntarily detained prior to a court order?

A person can be involuntarily detained at a screening center for up to 24 hours while being evaluated, and can then be detained at a psychiatric hospital for up to 72 hours while court proceedings for involuntary commitment are being initiated. N.J.S.A. 30:4-27.5(a) and -27.9(c)

What is a screening center?

A screening center is a public or private ambulatory care center located in a hospital or a mental health center designated by the commissioner of the Department of Human Services (DHS). The screening centers provide mental health services including assessments and emergency and referral services for persons with mental illness. The location of county mental health screening centers can be found on the Division of Mental Health Services webpage: state.nj.us/humanservices/dmhs/news/publications/mhs/directory_by_program.html#6 or by calling the Division's information and referral number 800-382-6717.

If an individual is unable or unwilling to come to the screening center, mental health screeners will make outreach visits. N.J.S.A. 30:4-27.5(d). A law enforcement offi-

cer may take an individual to a screening center if there is reasonable cause to believe that the person is in need of involuntary commitment. N.J.S.A. 30:4-27.6.

What happens at the screening center?

At the screening center, a mental health screener, who is customarily a social worker, will determine if a person needs to be involuntarily committed. If the screener determines that the person needs involuntary commitment, a psychiatrist will evaluate him or her. If the psychiatrist agrees that the person is in need of involuntary commitment, the psychiatrist will complete a screening certificate that will be submitted to the court. If the mental health screener determines that the person does not need involuntary commitment, the individual will be referred to an appropriate community mental health or social service agency, mental health professional, or hospital. N.J.S.A. 30:4-27.5(b) and (c).

What is involuntary outpatient commitment?

Involuntary outpatient commitment is a community-based alternative to commitment to a psychiatric institution. If an individual is determined to be eligible for involuntary outpatient commitment, the individual is subject to a court-ordered course of treatment under the supervision of an outpatient treatment program.

In 2009, New Jersey's commitment laws were amended to allow involuntary outpatient commitment. P.L.2009, c.112. The definitions and procedures for outpatient and inpatient commitment are essentially the same. The 2009 law added the requirement that the screening center is to determine where the services needed by the individual may be most appropriately provided in the least restrictive environment. Inpatient treatment is designated if the individual "is immediately or imminently dangerous or if outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future." Involuntary outpatient treatment is designated when "outpatient treatment is deemed sufficient to render the person unlikely to

be dangerous to self, others or property within the reasonably foreseeable future.” N.J.S.A. 30:4-27.5(b).

In addition, the chief executive officer of a psychiatric facility or hospital may apply to the court for an order changing the placement of an individual from an inpatient setting to an outpatient setting. A court can enter an order authorizing the conversion of the involuntary commitment of the patient from inpatient to outpatient treatment if it finds, by clear and convincing evidence that the patient is in need of continued commitment to treatment and the least restrictive environment for the patient to receive clinically appropriate treatment is in an outpatient setting. N.J. Court Rule 4:64-7(f)(g).

How is a court proceeding for an involuntary commitment initiated?

If the commitment process is not initiated through a screening center, a psychiatric hospital may also begin court proceedings for involuntary commitment by submitting clinical certificates completed by two psychiatrists. If a court determines that there is probable cause for involuntary commitment, a temporary order for commitment is entered. The person will then be assigned to an involuntary outpatient treatment provider or admitted to an appropriate facility as soon as possible. A hearing will be held on the person’s continued need for involuntary commitment within 20 days of the person’s admission. N.J.S.A. 30:4-27.10 and -27.12.

What happens at the commitment hearing?

The state must prove that a person needs involuntary commitment and would present a danger to self, others or property, by clear and convincing evidence. If this cannot be shown, the patient must be discharged within 48 hours of the court’s verbal order, or by the end of the next working day (whichever is longer). If the court finds that the person is in need of involuntary commitment, periodic review hearings will be scheduled to determine whether the person continues to need involuntary commitment. N.J.S.A. 30:4-27.15 and -27.16.

What are the rights of persons who are being involuntarily committed to a psychiatric hospital?

Persons who are being involuntarily committed to a psychiatric hospital or outpatient treatment provider have a number of rights, including:

1. The right to receive a verbal explanation of the reasons for admission to the hospital;
2. The right to receive a copy of the temporary order of commitment and the screening certificates submitted to the court;
3. The right to have an attorney represent them at their commitment hearing;
4. The right to a private commitment hearing;
5. The right to be present at their hearing, to present evidence, and to cross examine witnesses; and,
6. The right to have services provided in the patient’s primary means of communication, including use of an interpreter. N.J.S.A. 30:4-27.11, -27.13(a) and -27.14.

Do patients at screening centers and psychiatric hospitals have any other rights?

Yes. The New Jersey Patients’ Bill of Rights guarantees that a patient shall not be deprived of any legal or civil right solely because he or she has received assessment or treatment for a mental illness. N.J.S.A. 30:4-27.11(c) and -24.2(a). In addition, the Bill of Rights guarantees to all patients the following:

1. The right to be free from unnecessary or excessive medication;
2. The right to be free from unnecessary physical restraint, seclusion and punishment;
3. The right to privacy and dignity;
4. The right to be confined in the least restrictive conditions necessary to achieve the purposes of treatment;
5. The right to receive visitors and to have reasonable access to telephone and writing materials;
6. The right to regular physical exercise and opportunities to be outdoors;
7. The right to receive prompt and adequate medical treatment for physical ailments; and,

8. The right to practice the religion of one's choice, or to refrain from religious practices.

Some of these rights can be denied if the treating psychiatrist feels that it is imperative to do so, and the patient and his or her attorney have been provided with a written explanation of the reason for the denial. N.J.S.A. 30:4-24.2, -27.11d, and -27.11e.

What if a patient thinks that his or her rights have been violated in connection with admission to, or treatment at a psychiatric hospital?

If a patient thinks that his or her rights may have been violated in connection with admission to, or treatment at a psychiatric hospital, or if a patient has a question about his or her rights, the patient should talk to the attorney who has been assigned to represent him or her at the

commitment hearing, the Division of Mental Health Advocacy in the Office of the Public Defender, 877-285-2844, or to Disability Rights New Jersey at 800-922-7233 (voice), or 609-633-7106 (TTY).

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Developmental Disabilities Services for Adults

What is DDD?

The Division of Developmental Disabilities (DDD) provides funding for services and supports that assist adults 21 and older with developmental disabilities. DDD services can include case management, residential services, adult day programs, vocational supports, family supports, and professional support services.

Who is eligible for DDD Services?

DDD determines who is eligible to receive services through an application process. The application can be completed by the individual's parent, guardian, or the individual him/herself. To receive DDD services, an individual must be *at least 21 years old, Medicaid eligible*, and meet the following functional criteria based on having a severe, chronic physical and/or mental impairment that:

1. manifests itself before age 22;
2. is likely to continue indefinitely;
3. As a result of the impairment the individual exhibits a substantial functional limitation in *three or more* of the following areas of major life activities:
 - a. self-care
 - b. receptive and expressive language
 - c. learning
 - d. mobility
 - e. self-direction and/or
 - f. capacity for independent living or
 - g. economic self-sufficiency

What if DDD finds someone ineligible?

If DDD finds a person ineligible, there is an appeal process to challenge the determination. The individual can also re-apply, at any time thereafter, if he/she has new information for DDD to consider.

Is there anything to use as a guide when filling out the application?

When applying to DDD, it is critical for parents/guardians to accurately describe the individual's limitations. Overemphasizing strengths and minimizing weaknesses may result in ineligibility. When asked about things the applicant can do "independently" the person answering the questions should consider the skills of a person who does not have a disability as a guide and answer the questions honestly. For instance, if the individual takes a shower only when reminded, requires prompting, or must be supervised, then they "require assistance" and are not "independent."

What type of non-residential supports does DDD provide?

The following are the types of support services that are available from DDD:

1. Supported Employment
2. Career Planning
3. Prevocational Services
4. Day Habilitation
5. Respite
6. Assistive Technology/Vehicle Modifications
7. Behavioral Supports
8. Community Based Supports
9. Physical, Occupational & Speech Therapies
10. Transportation
11. Support Coordination

What is the Supports Program—

The Comprehensive Medicaid Waiver (CMW)?

The Supports Program is a Medicaid waiver-funded program that supports non-residential habilitation services for individuals with developmental disabilities. All DDD-eligible adults receiving non-residential support will be placed on the Comprehensive Medicaid Waiver (CMW)

and receive need-based budgets to utilize for support services. As of this printing the Supports Program is being rolled out and once fully implemented, will fund Employment/Day Services (currently referred to as Self-Directed Day) as well as Family Support Services. All DDD clients not on the Community Care Waiver (CCW), discussed below, will have two separate need-based budgets in the Supports Program – one for Employment/Day Services and one for Individual and Family Supports. The Employment/Day Service budget will be assessed similarly to the current Self-Directed Day Program. The Individual and Family Support budget will be assessed at one of three “up to” levels of \$5,000, \$10,000, and \$15,000.

How are residential and intensive in-home supports funded?

The CCW is the funding source for DDD residential and intensive in-home supports. The funding levels under the CCW are more robust than those available under the Supports Program and can be used for residential placements or robust in-home services.

How does DDD decide who is placed on the CCW to receive residential and intensive in-home supports?

There is currently a long waiting list for the CCW. In order to be placed on the waiting list, individuals who are over 21 years of age and have been deemed eligible to receive services from DDD whose parents are both aged 55 or over can be placed on the waiting list. In addition, if there is a crisis in the home that DDD deems sufficient, they may place the individual on the waiting list before both parents reach age 55. In certain circumstances where a person is at risk of “imminent harm or homelessness,” they may be able to bypass the list and be placed directly on the CCW or granted an emergency residential placement.

What if the individual with a disability is not eligible for Medicaid?

All DDD-eligible adults must be enrolled in Medicaid in order to be placed on the CCW or the CMW in order to receive ANY services from DDD. If, at any time, an indi-

vidual receiving DDD services becomes ineligible for Medicaid, he/she will be *dis-enrolled* from ALL DDD-funded programs or services.

What about services for children with developmental disabilities under age 21?

As of January 1, 2013, DDD transferred all children served by DDD to the Children’s System of Care (CSOC), which is a part of the Department of Children and Families (DCF). Children that had been placed on the CCW prior to January 1, 2013, however, remained with DDD. All services for children, those with developmental as well as mental health disabilities, will be served by CSOC. CSOC offers a full range of services to children including intensive in-home and residential services. To contact CSOC call Perform Care at 1-877-652-7624. If Perform Care determines that there is an immediate crisis that endangers the child or the family, a mobile response team may be sent to the home.

What if employment assistance is needed?

The Division of Vocational & Rehabilitative Services (DVRS) services are limited to employment and employment-related training for adults with developmental disabilities. DVRS may provide the following services:

1. vocational evaluation
2. counseling
3. job-seeking skills training and selective job placement
4. job coaching, vocational, and on-the-job training

DVRS services are not intended to be long-term. They are intended to help the individual find and acclimate to a job and then to fade. More intensive job coaching services are accessed through DDD. However, due to an inter-agency agreement between DVRS and DDD, individuals may access both agencies for support.

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Education: Early Intervention Services

What laws apply to young children with disabilities?

The Individuals with Disabilities Education Improvement Act (IDEIA), 20 U.S.C. § 1400 *et seq.* Part C, governs early intervention services. State regulations concerning Early Intervention may be found at N.J.A.C. 8:17-1.1 *et seq.* The New Jersey State Department of Health is responsible for administering the program.

Who is eligible for Early Intervention Services?

Early intervention services (EIS) are available for all children from birth to age three who have a developmental delay (two standard deviations below the mean in one developmental area or one and one-half standard deviations below the mean in two or more developmental areas), or be diagnosed with a physical or mental disability that is highly likely to result in a developmental delay. Developmental areas include physical functioning (for example, walking, grasping objects), communication, learning/cognition, behavior (social-emotional), and self-help (for example, feeding).

How is a child referred for EIS?

Anyone may refer a child, including parents, doctors, daycare workers, and social service agencies. Written consent of the parent is not needed to refer a child; however, it is needed to conduct an initial evaluation. A referral is made by contacting the Regional Early Intervention Collaborative that covers the county in which the child resides or by calling 1-888-653-4463.

Once a child is identified, what happens?

Within 45 days of the date of referral, provided the parent gives written consent, the child will undergo a full multidisciplinary evaluation to assess the child's level of functioning. This evaluation will determine if the child is eligible for EIS. Federal and state regulations for EIS do not allow for children to be screened to determine whether an

evaluation is necessary. As long as a parent gives written consent to evaluate, the child must be evaluated.

What services may be offered?

Services include, but are not limited to, assistive technology, audiology services, family training and counseling, health/medical/nursing services, nutrition services, occupational and/or physical therapy, psychological services, service coordination, social work services, special instruction, speech/language pathology, and vision services.

Who determines what services the child receives?

The service coordinator, together with the parents and professionals who conducted the evaluations, develop a written individualized family service plan (IFSP) detailing the services the child needs, the service providers, and the goals for the child. The parent(s) may accept or reject each service offered. Parent(s) can only accept services by written consent.

Who pays for the services provided?

Evaluations, service coordination, and IFSP development and review are free of charge. EIS are free to families who fall below 300% of the federal poverty level. Families who fall above this level may pay for services using a sliding fee scale based on family income, size, and the number of service hours. Medicaid also may be used to pay for services. If a family has private health insurance that covers EIS and the family's income level requires it to pay a cost share, the private insurance may be used to offset the family cost share. In this instance, the family must pay the EIS cost share and then seek reimbursement from the insurance company.

Are services monitored?

Every six months, the service coordinator must meet with the parent(s) to review the child's progress and

amend the IFSP as needed. The child must be re-evaluated every year.

Are services ever suspended or terminated?

EIS may be suspended if the family, without notice, repeatedly fails to attend scheduled service sessions, or if the service provider reasonably believes that his/her safety is in jeopardy when providing services in the location specified by the family. EIS must give written notice of the suspension and suspension appeals must be made within 21 business days of receiving notice. If a family chooses not to appeal a suspension of EIS, the services will be terminated. EIS also may be terminated where a family does not pay the required cost share, a family harms the service provider or places the service provider in imminent danger of being harmed, a family engages in illegal or abusive conduct, or a child is found to be no longer eligible for EIS. Termination appeals must be filed within 21 business days of receiving notice of the termination.

What happens to the child at age three?

As a child's third birthday approaches, a decision must be made whether the child will stop receiving services

upon aging out of the EI system or the child will continue to receive services through the special education system. To assess a child for special education and assure a smooth transition from the EI system into the special education system, parents should contact, in writing, the local school district no fewer than 120 days and no more than nine months prior to the child's third birthday to request a transition meeting to plan for the child.

What if a dispute arises concerning EIS?

Parents may ask for a complaint investigation, mediation, or a due process hearing to resolve a dispute concerning referrals, evaluations, eligibility decisions, IFSPs, and the provision of EIS to a child and family. Information regarding the dispute resolution process may be found in the state EIS regulations or obtained from the EIS procedural safeguards office.

Jennifer Rosen Valverde, Esq.

Education: Post-Secondary Level

Which laws apply to post-secondary level students with disabilities?

Adults with disabilities are eligible for certain accommodations pursuant to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) as amended by the Americans with Disabilities Act Amendments Act of 2008, (effective January 1, 2009), and the New Jersey Law Against Discrimination (NJLAD).

How does the ADA affect post-secondary schools?

Title II of the ADA covers state-funded schools such as universities, community colleges, and vocational schools. Title III of the ADA covers private colleges and vocational schools. If a school receives federal dollars, regardless of whether it is private or public, it is also covered by the regulations of Section 504 of the Rehabilitation Act requiring schools to make their programs accessible to qualified students with disabilities.

How does the ADA and Section 504 affect admissions requirements?

The post-secondary program cannot have eligibility requirements that screen out people with physical or mental disabilities. Application forms cannot ask applicants if they have a history of mental illness or any other disability. Institutions may impose criteria that relate to safety risks, but these criteria must be based on actual risk and not on stereotypes or assumptions.

Must an applicant with a disability take SATs or other entrance exams?

It depends on the post-secondary program to which the student is applying. Where SATs and entrance exams are required, applicants with disabilities must be prepared to take them. However, every college, university and other entity administering tests is required to adapt the testing procedure to accommodate applicants with disabilities.

Therefore, it is necessary to call ahead and make the appropriate arrangements. The Educational Testing Service in Princeton must be contacted to make these arrangements with respect to the SAT or other College Board-sponsored tests.

What do post-secondary programs generally have to do for students with disabilities?

A school may not discriminate on the basis of disability. It must insure that the programs it offers, including extracurricular activities, are accessible to students with disabilities. Post-secondary schools can do this in a number of ways: by providing architectural access including accessible dorm rooms; by providing aids and services necessary for effective communication; and by modifying policies, practices, and procedures. There is no requirement for a post-secondary school to create a written 504 plan.

Will the student with a disability be expected to perform under the same academic standards as all of the other students?

Absolutely. While a college or university must provide “reasonable accommodations” to students with disabilities, they are not required to waive or modify academic standards.

What kinds of aids and services must post-secondary institutions provide to assure effective communication?

Qualified interpreters, assistive listening systems, captioning, TTYs, qualified readers, audio recordings, taped texts, Braille materials, materials on computer disk, and adapted computer terminals are examples of auxiliary aids and services that provide effective communication.

How would post-secondary programs modify their policies, practices, or procedures to make programs accessible?

The most challenging aspect of modifying classroom policies and practices for students with disabilities is that it requires thought and some prior preparation. The difficulty lies in the need to anticipate needs and be prepared in advance. The actual modifications themselves are rarely substantive or expensive. Some examples are rescheduling classes to an accessible location; providing students with disabilities with a syllabus prior to the beginning of class; clearly communicating course requirements, outlines or summaries of class lectures, or integrating this information into comments at the beginning or end of the class; and allowing students to use note-takers or tape record lectures and testing accommodations such as extended time and alternate test formats. Modifications will always vary based on the individual student's needs. Modifications of policies and practices are not required when it would fundamentally alter the nature of the service, program, or activity, or it results in a financial or administrative burden to the school.

Can a school charge me for the cost of providing an accommodation?

No.

Do I have to provide documentation of my disability to request accommodations?

Schools may request current documentation of a hidden disability, such as learning disabilities or chronic health impairment. For a person with an obvious physical disability, blindness or hearing impairment, no further documentation may be required. The request for documentation (such as evaluations, physicians' reports) is valid to establish the validity of the accommodation requested and to help identify required accommodations.

Are students with disabilities required to disclose their disability?

If you do not require any accommodations, you can choose to keep this information private. However, if you need accommodations because of your disability, you must disclose that information to receive those accommodations.

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(Prior Editions)**

Education: Special Education

Which laws govern special education in New Jersey?

Special education in New Jersey is governed by the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 *et seq.*, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, New Jersey's special education statute, N.J.S.A. 18A:46-1 *et seq.*; and New Jersey's special education regulations, N.J.A.C. 6A:14-1.1 *et seq.*

What is the difference between Section 504 and IDEA?

Section 504 of the Rehabilitation Act of 1974 is an anti-discrimination law, not an education law. Section 504 applies to anyone who can show that he or she: (1) has an impairment that substantially limits a major life activity (like learning), has a history of such an impairment or is regarded as having such an impairment, and (2) is being discriminated against by any program or activity receiving federal funds (like a public school or a public library).

While students with disabilities are entitled to education and related services under the Individuals with Disabilities Education Act (IDEA), the coverage under Section 504 is broader. A larger group of students may be covered under Section 504, because "disability" is defined broadly, unlike IDEA's list of qualifying disabilities. Section 504 also covers children who may require only "related" services, which can be viewed as accommodations and/or modifications, rather than special education.

Although the coverage is broader, the services under Section 504 are often more limited than those required by IDEA. Under Section 504, schools are only required to make sure that the student with a disability is getting the services that level the playing field in relation to students who do not have disabilities and are in the same situation. Thus, a child with a disability would only be entitled to preschool services under Section 504 if the district offers regular preschool services to all children. Preschool age children who qualify under IDEA must receive preschool special services, regardless of the existence of regular preschool programs.

Which children are entitled to special education services?

Every child in New Jersey from his or her third birthday until high school graduation or age 21 (whichever comes first), who is found to have a disability, is entitled to a free, appropriate public education (FAPE). Education for these children must be provided in the least restrictive environment. Supplementary aids and services must be implemented to ensure that, to the greatest extent possible, children with educational disabilities participate in the same programs, both academic and extracurricular, as children with no disabilities.

Do children with disabilities under age three have any special rights?

In conformance with Part C of the Individuals with Disabilities Education Act (IDEA) and New Jersey regulations, N.J.A.C. 8:17 *et seq.*, the New Jersey State Department of Health provides early intervention services for children with disabilities or developmental delays from birth up to their third birthday. There is a single point of entry for this program: Call 1-888-653-4463. You will be referred to your regional system point of entry (SPOE). See the Early Intervention section of this booklet for more information.

How is it determined that a child has an educational disability?

Each school district is required to evaluate any child when there is reason to believe the child may have a disability that may affect his or her ability to learn. The district must notify the child's parent(s) that an evaluation is planned, and state the reason for the evaluation. A parent has the right to request an evaluation. The request must be made in writing to the Director of Special Education of their school district. Written consent of the child's parent is required for all evaluations. "Parent" is defined as the natural, adoptive, foster parent, surrogate parent, legal

guardian or in the case of divorced or separated parents, the “custodial” parent, absent any contrary provision in a court order or settlement agreement. The initial evaluation includes professional observation and testing of the child to determine whether there is a need for special education and related services. In addition to basic testing, other evaluations may be required to complete identifying the child’s needs. There is no cost to the parent(s) for any/all evaluations conducted.

What are intervention and referral services?

A school district is required to provide intervention and referral services (I&RS) to children in regular education who are having learning, behavioral, or health difficulties in school. An intervention and referral services team (I&RS) team must identify children who need help and then create and implement a written plan. Parents must be involved in the development of the plan, and the I&RS team must provide support, guidance, and professional development to school staff working with the child. At a minimum, the plan must be reviewed annually. A child does not have to first receive I&RS to become eligible for special education. A parent has the right, at any time, to make a written request for evaluations for special education.

How is the child evaluated?

After the written evaluation referral from the parent, the school child study team (CST), comprised of a school psychologist, a learning disability teacher-consultant (LDTC), a school social worker, and sometimes a speech/language specialist, meets with the parent(s) to determine if the child needs an evaluation for a possible disability. If an evaluation is agreed upon, the CST and parent(s) determine the nature of the evaluation. There must be at least two areas of suspected disability tested. Usually there is a psychological and learning evaluation conducted. However, parents can also request additional testing, such as: speech/language, audiological, neurological, psychiatric, etc. All test results must be provided to

the parent(s) at least 10 days prior to the meeting, which will determine whether the child is eligible to be classified as needing special education and related services. If the child is so classified, a meeting will be scheduled with the individual education program (IEP) team to formulate a program and placement that will meet the established needs. A child has the right to receive at least one reevaluation (or more if necessary) every three years to make sure that all the services the child is receiving are appropriate. Reevaluations can occur sooner if necessary, such as if a child is not making progress or is regressing.

What happens after the evaluation?

According to IDEA, an IEP team, composed of the child’s parent(s); at least one special education teacher; one of the child’s regular education teachers; a representative of the local district who is qualified to provide or supervise specially designed instruction and is knowledgeable about the general curriculum and the availability of resources; an individual who can interpret the instructional implications of evaluation results; other individuals who may have evaluated the child; the case manager, and, when appropriate, the child, will meet after classification has been established. This IEP team determines what program and services the child needs. Special education is available to children who require services as a result of cognitive impairment, hearing impairments, speech and language impairments, visual impairments, emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments or specific learning disabilities.

How is it determined what services the eligible child will receive?

The individual education program, which is developed by the IEP team for each eligible student, is the cornerstone of the child’s right to services. The IEP specifies the programs, placement, and services the child will receive. It also includes a description of the child’s current educational status and a statement of objectives for the child’s

education that describes specific, measurable steps between a child's current status and ultimate goals. The IEP may also specify needed related services to which the child is entitled, including, but not limited to, transportation, occupational therapy, physical therapy, speech therapy and/or counseling, and extended school year. A school may not require a parent to use health insurance or otherwise pay for the evaluations or services. At an IEP meeting, the CST will present a proposed IEP to the parent in a language the parent can understand. The CST must ensure that the parent understands the contents of the IEP, the reasons for the services, and that consent may be revoked at any time. The initial IEP must be signed by a parent for it to be implemented. Subsequent IEPs do not require written consent to be implemented. Parents have 15 days to review, request changes, and object in writing to any provisions of the IEP. The IEP must be reviewed at least annually; however, if needed, a parent has a right to request an IEP meeting for review and possible revision at any time.

What types of programs are available?

Many options are available, depending upon the nature and severity of the child's disability and his or her educational needs. These options may include instruction in the regular school classroom that may be complemented with supports and/or services or replaced in part by special or supplemental instruction; full-time assignment to a special class in the local school district or in a neighboring school district; assignment to an educational program in a medical facility; vocational or technical classes; placement in an approved private school for students with severe disabilities that may be located inside or outside of New Jersey; placement in an approved residential school; or, as a last resort, individualized home instruction on a temporary basis or in the case of physically fragile children. The placement must be appropriate and in the least restrictive environment in order to minimize the child's isolation from the rest of the school population. School districts may be required to reimburse a parent for the tuition costs arising

out of a unilateral appropriate private-school placement when the school district did not provide FAPE or refused to classify a child for special education or related services.

What is inclusion?

Inclusion is a term commonly used to indicate the implementation of an IEP in a regular class in the local school district, with whatever supports and aids the child with a disability may need to receive an appropriate education. It is nothing more than the mandated appropriate public education in the least restrictive environment, as stated in both federal and state law.

Can state requirements for a high school diploma be waived for a child with a disability?

Sometimes. The High School Proficiency Assessment (HSPA), now required for the award of a high school diploma in New Jersey, may be modified or waived entirely for a child with severe disabilities. However, such modification must be specifically provided for in the child's IEP. The IEP must specify the skills and goals the child must attain to take the place of the HSPA, such as passing the Alternate High School Assessment (AHSA) and/or other state and local graduation requirements. A child who successfully completes his or her IEP graduation requirements will receive a high school diploma.

What if the family of a child with a disability moves to another school district?

When a student with a disability transfers to a New Jersey school district, that district's child study team must conduct an immediate review of the evaluation information and the IEP. The child's IEP will be implemented as written unless there is disagreement on the part of the child study team or the parent(s). In that case, services will be provided pursuant to an interim IEP that is consistent with the current IEP, and supplemental evaluations may be required. Should the records from the previous school be incomplete or unavailable, the student must receive services consistent with the available information.

The district must then complete evaluations, develop a new IEP, and implement an appropriate placement without delay.

What options are available if a dispute arises concerning the provisions of special education services to a child?

An adult student or a minor child's parent(s) can request an independent outside evaluation, at no cost to the parent. This evaluation must be reviewed by the local CST but does not have to be accepted. In addition, either of the parties can request either mediation or a due process hearing. The school district may also initiate either process.

What is mediation?

Mediation is an attempt to resolve a dispute informally, with a state Department of Special Education mediator who facilitates discussion between the parent(s) and the school district. Either party may request mediation, specifying the issue(s) in dispute and the relief sought, by writing to the Director, Office of Special Education Programs, Department of Education, P.O. Box 500, Trenton, N.J. 08625-0500. A copy of that request must be sent to the opposing party who must be willing to enter into mediation. A form for requesting mediation, while not required, is available from the Department of Education. The parties may or may not resolve the issues. The mediator cannot force a resolution.

What is a due process hearing?

In New Jersey, a due process hearing is a formal hearing before an administrative law judge (ALJ) in the Office of Administrative Law (OAL). The parent, adult student, or the school district may request a due process hearing by writing to the Director, Office of Special Education Programs, Department Education, with a copy to the opposing party. A form for requesting a hearing, while not required, is available from the Department of Education. Within seven days of receipt of the request, the Depart-

ment of Education will schedule a conference. At this conference, the issue(s) will be defined and the possibility of settlement through mediation may be initiated. If the matter cannot be resolved, it will be transmitted to the OAL for a hearing two weeks thereafter. The parties will be asked to state what evidence and what witnesses they intend to produce at the hearing. The ALJ has 45 days from the day of filing to reach a decision, which is final.

Are there any provisions for emergency relief?

Yes. Emergency relief can be requested in writing at the same time that a hearing is requested, or anytime thereafter, from the Office of Administrative Law. The request must be supported by an affidavit detailing the emergency relief requested and why emergency relief is needed. The probability of irreparable harm to the child's education must be demonstrated. A copy of the request and accompanying affidavit must be provided to the opposing party.

After the judge conducting the due process hearing reaches a decision, what avenues of appeal are available?

The decision of the ALJ, reached within 45 days of the hearing request, may be appealed in state or federal court. However, the decision will be implemented immediately, unless the judge grants a stay, which would delay implementation of the decision until the appeal is resolved.

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(Prior Editions)**

Estate Planning

What provisions should be made in a will for an individual with a disability?

Those who want to provide at their death for an individual with a disability should consider establishing a special needs trust (sometimes known as a supplemental needs trust) in his or her will. Properly drafted, such a trust not only will allow the trust funds to be managed for the person with a disability, but also will allow the trust funds to be available to that individual for his or her supplemental needs. This permits a person with a disability to remain eligible for government benefits such as Medicaid and Supplementary Security Income (SSI) that are available only to those with limited income and assets. A recipient of Social Security Disability and Medicare is not subject to income and asset limitations in order to continue receiving government benefits, but, depending upon the nature of the disability, the individual may benefit from the management aspect of the trust. The will must specify who will receive the trust funds remaining at the death of the person with a disability—for example, his or her children or siblings, or one or more charities.

Is a will the only document necessary in planning for an individual with a disability?

Sometimes other documents may be necessary. For example, a person making a will may have concerns that he or she may, in the future, be affected by a disability or cognitive impairment that would require long-term care. The long-term care needs, for example, of a parent or a grandparent could deplete assets that were intended for a beloved child or grandchild with a disability. Precautions can be taken to preserve one's assets. These precautions could include the purchase of long-term care insurance for the person making the will, or consulting with an attorney experienced in elder law who can give advice on how to make a plan so that government benefits can be

accessed at some future time to pay for their care, while having the bulk of the assets available for the person with a disability. In addition, Medicaid regulations presently provide that an individual entering a nursing home can create a trust in which the lion's share of his or her assets can be placed into a trust for a person with a disability under age 65, without creating any ineligibility for the person entering the nursing home. This trust is known as a "(d)(4)(A) payback trust," and must be created by the parent, grandparent, or guardian of the person with a disability, or the court, to be used for that person's sole benefit. The funds in the trust are available for the lifetime supplemental needs of the person with a disability, and upon that person's death, the trustee must repay Medicaid from the funds left in the trust, up to the amount that Medicaid paid on behalf of the person with a disability.

This "payback" trust also can be used on behalf of a person with a disability to protect funds he or she received from a personal injury lawsuit.

Another way of providing for the supplemental needs of a person with a disability is to create a trust funded with life insurance on, for example, a parent's life. Life insurance is relatively inexpensive if purchased when the parent is young, and such a trust ensures that the person with a disability will have funds in excess of the SSI or SSD check for his or her needs after the parent dies.

What happens to public benefits if an individual with a disability receives assets outright or in a trust that provides for his or her support, care, and maintenance?

An individual with a disability who receives assets outright from a decedent's will could become ineligible for Medicaid and SSI, both of which have rules on financial eligibility pertaining to income and assets. Similarly, an individual with a disability who is the beneficiary of a typical trust (rather than a supplemental needs trust) providing for his or her support, care, and maintenance will be

disqualified from receiving government benefits such as SSI and Medicaid (although not Medicare and SSD). In that case, the trustee would be required to use trust assets for that person's support, care, and maintenance until the trust funds are spent down to the maximum resource level for SSI and Medicaid. Only then can the person with a disability again receive SSI and Medicaid. Again, it would be prudent to take the necessary legal steps to transform that trust into a special needs trust.

I have two children. Should I leave all of my assets to the child who is not affected by a disability, to avoid the necessity of creating a special needs trust for the one who is?

No. Without such a trust, the child receiving the parent's assets would have absolutely no obligation to use any of those assets to benefit the sibling with a disability. Furthermore, that child could die prior to the child with a disability, without making any provision in his or her will for the sibling. If there is no special provision in the well child's will, assets would pass to the well child's surviving spouse and children, if any, and not to the sibling with a disability. Further, the child without a disability may be divorced, sued, or forced to enter bankruptcy—situations that could result in some or all the assets left by the parents being used for a purpose that does not benefit the child with a disability.

Is a special needs trust necessary if the parents own adequate assets to provide for the child with a disability?

This is a difficult question that can be answered only on an individual basis, with guidance from the parents' lawyer and financial advisor. An estate that can provide \$10,000,000 to a child with a disability is often more than sufficient without worrying about government benefits such as SSI and Medicaid. An estate valued at \$1,000,000 may not be sufficient, depending upon the degree of disability for the child and the resulting future care needs. An estate of \$25,000 certainly would not be sufficient to

provide for the care of a child with even a moderate disability. If a family realizes that their child's future care needs are large, and the parents do not believe they will have a large estate, they can purchase life insurance to create a suitable estate for their child.

A supplemental needs trust would preserve the parents' funds (or life insurance proceeds) for expenses relating to supplemental and special needs rather than day-to-day care and maintenance and still allow the child with a disability to receive government benefits such as Medicaid and SSI.

Who should be the trustee of a special needs trust for a child with a disability?

Most families wish to name a sibling or other close family member of the child with a disability as the trustee. Who should serve as trustee of a special needs trust is a decision to be reviewed carefully on an individual basis. The trustee sometimes may have to deny the demands of the person with a disability, either because granting the request would threaten the receipt of government benefits, or because the trustee believes the request is not in the person's best interests. The family must consider whether one sibling should be placed in the role of having to refuse another sibling's requests. Further, a sibling or other family member may not have sufficient expertise to manage the trust funds and/or to submit the proper tax returns and may not have sufficient time to identify and explore issues and resources, such as appropriate housing and programs for the child with a disability. One solution is that, rather than serving as sole trustee, a family member can be a co-trustee, with a professional serving as the other co-trustee. For example, a specialized agency or institution such as Planned Lifetime Assistance Network of New Jersey, "PLAN/NJ," could possibly serve as trustee or be hired by an individual trustee to assist with the care plan for a child with a disability and evaluate the appropriateness of distributions.

Should a supplemental needs trust be established for a child who is receiving Social Security Disability benefits and Medicare, which are not currently tied to any asset or income limitations?

Yes. While it is currently true that Social Security Disability and Medicare benefits are not income- and asset-tested, Social Security is a creature of the legislature, and Congress is free to change it at any time. Accordingly, it is prudent to establish a supplemental needs trust for an individual who is receiving these benefits, just as one would do for a recipient of SSI and Medicaid. Then, if the laws change in the future, the individual's benefits most likely will not be reduced, assuming the rules will not be more stringent than those that currently apply to SSI and Medicaid. In addition, the supplemental needs trust also provides management assistance for the individual with a disability of what may be substantial funds.

If a trust has already been created for the support, care, and maintenance of an individual with a disability who would otherwise be entitled to receive SSI and Medicaid, can anything be done to have the trust converted into a special needs trust?

Yes. New Jersey courts have been cooperative where it can be established that the intent of the person who created the trust was to ensure that the person with a dis-

ability would continue to receive government benefits. The trustee of the trust would have to apply to the Chancery Division of the Superior Court of New Jersey to amend the trust to a supplemental needs trust. Once the conversion is completed, the individual with a disability would qualify for SSI and Medicaid benefits, and there would no longer be a requirement to spend down the assets in the trust.

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Housing

Is there protection against discrimination on the basis of disability in housing?

Yes. The following discriminatory behavior is prohibited pursuant to the Fair Housing Amendments Act of 1988 (FHAA), 42 U.S.C. § 3601 *et seq.*:

- discrimination in the sale or rental of dwellings, or otherwise making unavailable or denying a dwelling;
- indicating that a dwelling is not available when the dwelling is, in fact, available;
- discrimination in the terms, conditions, or privileges of the sale or rental of a dwelling;
- discrimination in the provision of services or facilities in connection with the rental or sale of a dwelling;
- prompting a person to sell or rent by indicating that a person with a disability is entering or will enter the neighborhood;
- publishing any notice, statement, or advertisement with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination;
- refusing to permit a person to make reasonable modifications to a dwelling where such modifications are necessary to afford that person full enjoyment of the premises;
- refusing to make reasonable accommodations in rules, policies, practices, or services that would be necessary to afford a person with a disability equal opportunity to use and enjoy a dwelling; and,
- a landlord or seller asking about a tenant's or applicant's disability, unless the landlord or seller is providing housing designed for occupancy by persons with disabilities or for persons with a particular type of disability, and the questions relate to that applicant's eligibility for the housing.

The FHAA applies to all residential units, except a unit in an owner-occupied building with four or fewer units. Further, the sale or rental of a single-family house is not

covered by the FHAA if the owner owns three or fewer single-family dwellings, and does not advertise or use a broker to sell or rent the house.

Another federal law, Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, prohibits discrimination by recipients of federal funds, such as public housing agencies and the private owners of federally subsidized buildings. State law also prohibits housing discrimination on the basis of disability.

The New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 *et seq.*, the Municipal Land Use Law, N.J.S.A. 40:55D-66.1, the Handicapped Access Law, N.J.S.A. 52:32-4 *et seq.* and the Barrier-Free Sub Code, N.J.A.C. 5:23-7.1 *et seq.*, all contain important protections against housing discrimination for people with disabilities. The laws are similar, but not identical, to the federal FHAA. In some instances, state law may cover housing units not reached by the FHAA, or provide greater rights than federal law.

Are all persons with disabilities protected under anti-discrimination laws?

A person is protected under the anti-discrimination laws if he or she has a disability that meets the definition of "handicap." Handicap is defined as a physical or mental impairment that substantially limits one or more of a person's major life functions. The impairment can be episodic, like epilepsy, but cannot be temporary. A person with a history or record of a physical or mental impairment, or who is regarded as having such an impairment, is also considered to have a "handicap."

Discrimination based on a "handicap" is prohibited. However, a person with a "handicap" may not be protected if he or she constitutes a direct threat to the health or safety of others or if his or her tenancy would result in substantial physical damage to the property of others. (For a further explanation of this exception, see the question regarding reasonable accommodation, below in this section.) In addition, while the anti-discrimination laws

protect a person with a history of illegal drug use, one who is currently abusing illegal drugs is not protected.

Must all new housing be built to be accessible to persons with disabilities?

Much, but not all, new housing must be constructed to be accessible to people with disabilities. Barrier-free architectural design is required by both federal and state law in most newly constructed and, in certain cases, renovated multi-family housing. New housing covered by the Fair Housing Amendments Act (FHAA), 42 U.S.C. § 3601 *et seq.*, and the New Jersey Barrier-Free Sub Code, N.J.A.C. 5:23-7.1 *et seq.*, include units in buildings with four or more units.

The FHAA sets minimum federal standards that are, in certain respects, exceeded by the New Jersey Barrier-Free Sub Code. There are many technical design specifications and rules mandating how such units must be designed and constructed. Newly constructed housing must include accessible public spaces and routes of travel into the residential units. Such housing must also have individual units that have adaptable elements, such as kitchen counters, sinks, and grab bars, that can be readily modified for individual needs. (See the Architectural Barriers section of this booklet for further information.)

Can a tenant with a disability make changes to a unit to make it easier to live there?

Yes. A tenant with a disability can make changes, such as installing grab bars, handrails, or ramps, but the tenant will have to pay for the modifications, and have them removed at his or her own expense at move-out if the landlord requires it. The landlord cannot ask the tenant for a security deposit beyond what is normally required (not to exceed the equivalent of one and a half month's rent under New Jersey law). However, the landlord can negotiate an agreement for the tenant to make a monthly deposit into an interest-bearing escrow account if the removal of the interior modifications will be expensive. The amount of the deposit cannot be more than an esti-

mate of the reasonable cost of the removal.

How can anti-discrimination laws be used to protect a tenant with a disability from eviction?

The Fair Housing Amendments Act in part defines discrimination as the refusal by a landlord to make reasonable accommodations in rules, policies, practices, or services that would be necessary to afford a person with a disability an equal opportunity to use and enjoy a dwelling. This part of the law is particularly helpful for protecting persons with disabilities, including those who have a mental illness, from eviction based on allegations of disorderly conduct, damage to the landlord's property, breach of lease, late payment, or nonpayment of rent.

What is a reasonable accommodation?

A reasonable accommodation is a modification in the way a landlord normally does things that would allow the person with a disability to have an equal opportunity to use and enjoy his or her residence. It is a highly individualized determination that requires the tenant and landlord to work together to accommodate the tenant's needs without placing an undue financial or administrative burden on the landlord and without fundamentally altering the services provided by a landlord. If the landlord alleges that a tenant with a disability is breaching the lease, being disorderly, causing damage, or paying the rent late or not at all—and the conduct complained about is caused by the tenant's disability—then the tenant can request a reasonable modification in the landlord's rules or practices to avert the tenant's eviction. For example, a blind tenant with a seeing-eye dog could ask a landlord to make an exception in the landlord's no-pets provision in the tenant's lease so the tenant could keep the service animal without fearing eviction for breach of lease. A tenant with a mental health disability could ask for the same reasonable accommodation for a cat whose companionship the tenant's doctor can show improves the mental health of the tenant. Another example might be that of a senior citizen who loses the capacity to take care of his or her

personal affairs and falls behind on the rent. The landlord could agree to forego eviction so long as a trusted friend or family member ensures the senior citizen's income is used to catch up on the rent through a repayment agreement, and future payments are made in a timely manner.

A request by a tenant for a reasonable accommodation can be made to the landlord at the start of a tenancy or any time during that tenancy. The request can be made after a notice terminating tenancy is sent, or even after the filing of a court action for eviction. A tenant who is a direct threat to the health and safety of other people, or whose tenancy would result in substantial physical damage to property, is not protected from eviction. But reasonable accommodation must be explored first. Only if the tenant constitutes a threat to the safety of others after the landlord has made reasonable efforts to accommodate the tenant's handicap may the landlord refuse to offer the tenant continued housing.

What can individuals with disabilities do if they have been discriminated against in housing?

A person with a disability may file a complaint with office of the U.S. Department of Housing and Urban Development (HUD) online at www.hud.gov, or by calling 800-669-9777 (voice) or 800-927-9275 (TTY), or file a

lawsuit under federal or state laws. A HUD complaint must be filed within one year of the alleged discriminatory act, and a complaint in federal or state court under the FHAA must be filed within two years of the alleged discriminatory act. A person with a disability may also file a complaint online or by phone with the New Jersey Division on Civil Rights. The phone number for your local office is listed in the phone book or online at www.nj.gov/oag/dcr. Such a complaint must be filed within 180 days after the alleged act of discrimination. In addition, a person who believes he or she has been discriminated against based upon a disability may consult an attorney regarding any other legal remedies available.

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(Prior Editions)**

Law Against Discrimination (Overview)

What is the Law Against Discrimination?

The New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 to 49 (LAD), is the state civil rights statute that protects all individuals in New Jersey from discrimination by employers, housing providers, and places of public accommodation. The LAD is the oldest and most comprehensive state civil rights statute in the country.

Who is protected by the LAD?

Individuals with disabilities in the State of New Jersey are among the broad range of groups who are protected from discrimination by the LAD. Significantly, the LAD's coverage of people with disabilities is much broader than that of the federal ADA. Specifically, the LAD protects many individuals with disabilities who are not covered by the ADA because the LAD does not require that a covered disability substantially limit a major life activity. The LAD defines disability more expansively to include physical disabilities caused by illness, injury, infirmity, malformation, or disfigurement, including certain physical disabilities that are not permanent or long-term. The state law also covers mental, psychological, and developmental disabilities that impede any normal mental or bodily function, or that are shown to exist by accepted clinical or laboratory diagnostic techniques.

Similar to the ADA, the LAD protects individuals who have a history of a covered disability, or who are incorrectly perceived by others to have a disability. In the area of employment, the LAD covers many employees who are not protected by the ADA because the LAD applies to virtually all employers regardless of the number of individuals employed by the employer.

What is a place of public accommodation under the LAD?

The term "place of public accommodation" includes restaurants, movie theaters, stores, camps, schools, professional offices like doctors' and lawyers' offices, and

other places that offer goods and services to the public. The LAD also applies to services provided by the government. The LAD's public accommodations provision does not cover private clubs or schools operated or maintained by a *bona fide* religious or sectarian institution. However, a child-care or after school program that accepts state or federal funding is required to comply with anti-discrimination laws even if the program is operated or maintained by a *bona fide* religious or sectarian institution.

What protections are afforded under the LAD?

Under the LAD, a person with a disability has the right to most goods and services that are available to people without disabilities. This means, for example, that a person with a disability cannot be denied services simply because that person uses a wheelchair or relies on a properly trained guide dog or service animal. Also, a place of public accommodation that offers examinations or courses related to applications, licensing, or credentialing for education, professional, or trade purposes must ensure that such examinations or courses are administered in a way that reflects the skills or aptitude of a person with a disability rather than the person's impaired skills that are unrelated to those necessary for the credentialing. An exception to the LAD is that a place of public accommodation such as a sports organization open to the public may deny access or participation to a person with a disability if it is probable that serious harm will result to that person or others.

The LAD also requires places of public accommodation to take reasonable steps to ensure that a person with a disability has equal access to goods and services available to everyone else, unless to do so would create an undue hardship on the provider. Whether such a "reasonable accommodation" would pose an undue hardship generally turns on the size of the provider and the cost and nature of the reasonable accommodation. Required reasonable

accommodations could include making structural modifications like installing ramps, widening doors, rearranging furniture or equipment, or adding raised markers on elevator buttons; making alterations in restrooms by installing raised toilets and repositioning paper towel dispensers; and providing qualified, effective interpreters and Brailled materials where written materials or oral instructions are made generally available to the public.

How is the LAD enforced?

An individual who believes he or she is a victim of unlawful discrimination should call or visit the regional office of the New Jersey Division on Civil Rights (Division) closest to his or her home within 180 days of the alleged discriminatory act. A trained intake investigator will conduct a preliminary interview to determine whether the claim falls within the LAD's jurisdiction. If so, the Division will accept the complaint and conduct an investigation to determine if the LAD has been violated.

In the alternative, an aggrieved individual may file an LAD complaint directly in New Jersey Superior Court. Superior Court complaints must be filed within two years of the act of discrimination. For more information, please consult the Division's website, njcivilrights.org.

Gary LoCassio, Esq.

Medicaid

What is Medicaid?

Traditional Medicaid is an income- and asset-tested health benefits program funded and administered jointly by the federal government and the State of New Jersey. Traditional Medicaid is available primarily to needy families and pregnant women, as well as to those who are blind, have a disability, or are over the age of 65, and who otherwise meet the income and asset requirements.

Who is eligible for traditional Medicaid?

In New Jersey, individuals who are receiving Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF) are automatically eligible for Medicaid to cover their medical expenses. Individuals in the community who have a disability or are elderly, and who have resources (assets) at or below \$2,000 and monthly income of less than the Medicaid income cap (\$2,163 in 2014), may be entitled to receive Medicaid depending upon their medical condition. Individuals who are institutionalized may be entitled to receive Medicaid through either the Medicaid Only Program or the Medically Needy Program. For Medicaid Only, the individual's resources must not be greater than \$2,000 and their income must not be greater than the income cap for that year (\$2,163 in 2014). For Medically Needy Medicaid, the individual's resources must not be greater than \$4,000. In addition, although the individual's income may be above the Medicaid income cap (\$2,163 in 2014), if that income is not sufficient to cover certain of his or her medical expenses, the individual may be Medicaid eligible.

What is the difference between the Medicaid Only Program and the Medically Needy Program? What is a Qualified Income Trust?

The Medicaid Only Program is only available to those individuals whose income is at or below the income cap. The income cap is a figure set by the government annually

(again, \$2,163 in 2014). The Medically Needy Program has been available to those individuals whose income *exceeds* the income cap and/or who have resources greater than \$2,000 but less than \$4,000. In each case, the individual must be evaluated and be determined to be medically eligible as well.

The Medicaid Only Program covers Medicare Part B premiums, chiropractic visits, in-patient hospital services, nursing home costs and pharmaceuticals. Medicaid requires an annual review for this program.

The Medically Needy Program has not automatically covered Medicare Part B premiums, chiropractic visits, inpatient hospital services or pharmaceuticals received there, or services received outside a nursing home setting, but it does cover the costs of care in a nursing home, including pharmaceuticals received there.

Effective December 1, 2014, New Jersey will once again have Qualified Income Trusts, also sometimes known as Miller Trusts, which will allow individuals to qualify for Medicaid who meet the health and resource criteria for Medicaid, but whose income is over the income cap. Qualified Income Trusts will enable individuals otherwise medically and resource eligible, but with income above the income cap, to qualify for Medicaid if they are residing in their own homes or in an assisted living facility, as well as when they are living in an institutionalized setting.

If a patient requires Medicaid to cover his or her costs in a nursing home, what assets will the spouse who remains in the community be allowed to keep?

The spouse at home, called the Community Spouse, will be allowed to keep their residence, personal property (such as furniture and jewelry), and a car of any value. These assets are considered exempt. In addition, the Community Spouse can keep a minimum of \$23,448 (minimum for 2014) of the couple's countable assets, or one-half of the couple's countable assets. That one-half,

however, is subject to a maximum of \$117,240 (in 2014). These numbers are revised annually.

Can the Community Spouse be allowed to have any of the Medicaid recipient's income?

Medicaid calculates that the Community Spouse will need a sum known as the Minimum Monthly Maintenance Needs Allowance (MMMNA) (\$1,966 in 2014) each month, plus a sum known as the excess shelter allowance (ESA) for housing costs that exceed a given amount (\$589.88 in 2014) each month, but both the MMMNA and the excess shelter allowance cannot exceed a stated amount each month, as determined each year. The dollar amounts for the MMMNA and the ESA are determined each year as of July 1 of that year. If the Community Spouse's own income is less than the MMMNA, then a portion of the Medicaid recipient's income can go to the Community Spouse to bring his or her income up to the Medicaid approved level.

If someone needs nursing home care, is it still possible to qualify for Medicaid and preserve assets in addition to the Community Spouse Resource Allowance?

The ability of an individual to preserve assets is very fact sensitive. Some asset protection techniques are written into the Medicaid law. Other strategies have been developed by elder/disability law attorneys, carefully using annuities, for example, that comply with the requirements of federal and state laws. It is advisable to consult with an elder/disability law attorney to determine the maximum amount of assets that can be saved.

Does Medicaid cover home care services?

In New Jersey, Medicaid may provide home care services under a waiver program. The Global Options (GO) for Long Term Care provides assistance in the home for an individual who is a U.S. citizen or a qualified alien. To be eligible, an individual must be clinically and financially eligible for a Medicaid nursing facility level of care. To determine that, an individual has to be assessed by either a State Community Choice counselor or an Aging and Dis-

ability Resource Connection (ADRC) assessor. Applications for GO may be filed by individuals who are 65 years or older or by individuals between the ages of 21 and 64 who have been determined by the Social Security Administration or by the Division of Medical Assistance and Health Services, Disability Review Section to have a disability. (Individuals with a chronic mental illness or who have an intellectual or developmental disability require a service needs review conducted by a DHSS/DHS Service Review Team.) To be eligible for GO, there has to be an indication in the clinical assessment that the individual will require a level of care provided in a hospital, a nursing facility, or an intermediate care facility in the near future (within a month or less) unless that individual receives home and community based services. Individuals participating in GO work with a care manager to develop a plan of care that includes community-based services based upon the assessment of the individual's particular health-care needs. GO is designed to supplement—not replace—the assistance already being provided by family, friends, and neighbors. Under GO, qualified individuals known to the participant can be hired and paid. For an individual to be eligible for GO, their income and assets must be at the same levels as those for the Medicaid Only program.

How does a gift of income or assets affect Medicaid eligibility?

Gifts, also called asset transfers, may prevent an individual from receiving Medicaid. Medicaid regulations impose a period of ineligibility for uncompensated transfers of assets, such as gifts to children, made within five years of a Medicaid application. Certain transfers do not create periods of ineligibility, such as proper transfers of assets between spouses, to a caretaker child, or to a child with a disability. It is highly advisable that one obtains the advice of an elder/disability law attorney before an elderly person or a person with a disability divests himself or herself of funds.

What if an application for Medicaid benefits is denied or Medicaid benefits are terminated?

If an initial application for Medicaid is denied, Medicaid eligibility is terminated, or Medicaid refuses to pay a claim, the individual has a right to request a fair hearing before a New Jersey administrative law judge. The request for a fair hearing must be prompt. The individual has a right to be represented by a lawyer and to present evidence, including testimony, to support his or her case. The administrative law judge makes a recommendation to Medicaid regarding the case. Then, if Medicaid still denies the claim, the individual has the right to appeal the case to the Appellate Division of the Superior Court of New Jersey. If Medicaid advises that it intends to discontinue benefits, the individual may have a right to the continuation of benefits until the appeal has been decided.

Is an IRA, 401(k), or other tax-sheltered retirement account considered a resource for Medicaid purposes?

In a New Jersey Supreme Court decision, it was determined that tax-sheltered retirement accounts of a Medicaid applicant and the applicant's spouse, constitute available resources for Medicaid purposes and must be spent down to the allowable resource level before Medicaid eligibility is restored.

If someone has been determined in need of guardianship services by a court and a guardian has been appointed, can Medicaid planning be done for the individual receiving guardianship services and his or her spouse, if any, if the individual person needs nursing home care?

Yes. A New Jersey Supreme Court case and New Jersey statutes state clearly that it is appropriate for a guardian to engage in Medicaid planning to preserve assets for a ward (the person receiving guardianship services) and the natural objects of his or her bounty, unless the ward has indicated he or she does not want to do such planning.

What does Affordable Care Act Medicaid Expansion mean?

New Jersey opted to participate in the Medicaid Expansion program of the Affordable Care Act. Medicaid Expansion creates an entirely new group eligible for health insurance, effective January 1, 2014, which is comprised of adults aged 19 to 65 years of age, based solely on their income, which must be at or below 138 percent of the federal poverty level. *Unlike traditional Medicaid, there is no asset test for eligibility for this Medicaid program.*

How can I contact traditional Medicaid?

You can call New Jersey EASE toll free at 877-222-3737, which will put you in contact with Medicaid. Alternatively, the phone numbers for each county's Medicaid office can be found in the blue section of the telephone directory under county agencies.

How can I contact Expanded Medicaid?

New Jersey did not develop its own health care exchange, sometimes also known as a health insurance marketplace. To apply for the Medicaid Expansion program, visit the federal website located at HealthCare.gov or call 1-800-318-2596.

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Medicare

What is Medicare?

Medicare and Medicaid are government-administered programs that provide health insurance coverage in the United States. Entitlement to participate in Medicare is based upon a record of an individual's contributions paid to the Medicare fund, generally through the income tax structure. When enacted in 1965, the Medicare program was designed to provide health care only to persons age 65 and over, regardless of their income. In 1973, the program was expanded to include persons under the age of 65 who have been determined by the Social Security Administration to have a disability. Individuals who do not qualify for Medicare may qualify for Medicaid and should check with the Social Security Administration about their eligibility for that program.

Who is eligible for Medicare?

Medicare is available to persons age 65 and over who are entitled to Social Security or Railroad Retirement benefits, to persons with disabilities under age 65 who have been collecting Social Security Disability benefits for at least 24 months, persons under age 65 with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or transplant), and persons with ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease). Persons with ESRD and with ALS do not have to wait 24 months to be covered by Part A and Part B. Those with ALS will get Part A and Part B automatically the month their disability benefits begin. Those with ESRD who are on dialysis will get Part A and Part B coverage usually on the first day of the fourth month of their dialysis treatment. Under certain conditions, coverage for those with ESRD can begin as early as the first month of dialysis.

When should I enroll in Medicare?

When an individual becomes eligible for Medicare hospital insurance (Part A), he or she has a seven-month

period (known as the Initial Enrollment Period) in which to sign up for Medicare's medical insurance (Part B). Failure to enroll when first eligible may cause a delay in coverage and also result in penalties in the form of monthly premium surcharges. For those eligible at age 65, the initial enrollment period begins three months *before* their 65th birthday, includes the month the individual turns age 65, and ends three months *after* that birthday month. For individuals who fall into this category and are receiving Social Security benefits or benefits from the Railroad Retirement Board (RRB), enrollment in Part A and Part B is automatic unless the beneficiary *declines* Part B coverage at that time. Individuals not receiving Social Security or RRB benefits will need to contact Medicare to enroll at least three months before their 65th birthday.

For those eligible for Medicare based on disability or permanent kidney failure and who are under the age of 65, the Initial Enrollment Period depends on the date disability or treatment began. In general, individuals with disabilities under the age of 65 are eligible beginning the 25th month of disability benefit entitlement. Medicare generally notifies individuals several months in advance as to their upcoming eligibility. Persons with ESRD and those with ALS do not have a 24-month waiting period, as discussed in the above question "Who is Eligible?"

Not everyone who fails to enroll in Medicare when first eligible will experience penalties. Certain low-income beneficiaries will not be subject to a penalty. Further, persons who declined to enroll in Part B when first eligible because they were covered under an employer sponsored group health plan may be exempt from penalties and entitled to a Special Enrollment Period so coverage can begin right away. Note that COBRA coverage and retiree health plans are not considered coverage based on current employment and an individual is *not* eligible for a Special Enrollment Period when that coverage ends.

When will my coverage begin?

For beneficiaries who accept the automatic enrollment in Medicare, or who enroll in Medicare Part B during the first three months of their Initial Enrollment Period, coverage will start with the month they are first eligible. For beneficiaries enrolling during the last four months, coverage will start from one to three months after enrollment.

Individuals receiving disability benefits generally are not eligible for Part A and Part B until the 25th month that they are receiving those benefits. However, when a beneficiary enrolls in Medicare based on ESRD and is on dialysis, coverage usually starts the first day of the fourth month of dialysis treatment. It is possible that coverage can start earlier for individuals with special circumstances. An individual with ESRD should contact his or her local Social Security office right away to discuss enrollment options.

Individuals with ALS will get Part A and Part B coverage automatically with the first month that they begin receiving disability benefits.

Persons who did not sign up for Medicare Part B when first eligible can sign up during the General Enrollment Period. This period runs from January 1 through March 31 of each year, and coverage does not begin until the following July 1st. Individuals who did not sign up for Part A and/or Part B during the Initial Enrollment Period should contact Medicare to see if they qualify for enrollment under the Special Enrollment Period (SEP). Eligibility under the SEP is granted in limited circumstances and, if awarded, will eliminate the delay in coverage and any penalties.

How does Medicare differ from Medicaid?

Medicare is an exclusively federal program providing healthcare coverage to individuals who have contributed to the program, regardless of their present income or the value of their assets. Both rich and poor receive the same benefits. Eligibility for Medicaid, on the other hand, is based on an individual's income and the value of their assets. The program is administered by the federal and

state governments. Although each state has its own minor variations of the Medicaid rules, all Medicaid programs have strict financial guidelines. In most cases, a person cannot have more than \$2,000 in assets, and their income must be so low as to be unable to pay for their medical care. Medicare pays only for healthcare that is considered "medically necessary," while Medicaid will also pay for custodial care, including long term care, at home, in an assisted living facility, or in a nursing home. Medicaid will also pay for deterioration in vision and hearing as well as dental health, while Medicare will not cover these services.

What are the differences between Parts A and B of Medicare?

Medicare Part A is often referred to as "hospital insurance." Part A helps pay for inpatient care in a hospital or care in a skilled nursing facility (SNF) following a hospital stay where the patient has been admitted and has remained for at least three days for a related injury or illness. Skilled nursing care should not be confused with custodial or long term care in a nursing home or elsewhere, as Medicare does not cover those services. To receive skilled care in an SNF, a doctor must certify that one requires daily *specialized* care such as physical therapy or intravenous injections. In addition, Part A also helps pay for some home health services and hospice care.

Most people do not pay a monthly premium for Part A coverage because either the individual or the individual's spouse paid sufficient Medicare taxes while working to cover its cost. Medicare eligible persons not eligible for premium-free Part A coverage pay a premium, in 2014, of \$426 each month. *In most cases, if a person chooses to buy Part A, they must also buy Part B and pay monthly premiums for both.*

Enrollment in Part A for the majority of citizens is automatic. Persons receiving benefits from Social Security or the Railroad Retirement Board (RRB) get Part A starting the first day of the month he or she turns age 65, and generally, individuals under age 65 with a disability get Part A after getting disability benefits from Social Security or

certain disability benefits from the RRB for 24 months. There are enrollment exceptions for those with End Stage Renal Disease and ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), as discussed above.

Part B on the other hand is voluntary. Beneficiaries who are eligible for Part A and who wish to have Part B coverage would pay a premium of \$104.90 a month (in 2014). This amount is usually deducted from the beneficiary's monthly Social Security check. Part B coverage includes, among other things, services from doctors and other health care providers for "medically necessary" care, outpatient care, home health care, durable medical equipment, diagnostic tests, and ambulance services. Medicare also pays for some preventive care. Medicare covers mammography; PAP smears and pelvic examinations; colorectal cancer screening; diabetes monitoring; certain vaccinations; flu shots; prostate cancer screening; cardiovascular screening; and diabetes screening and monitoring.

How much does Medicare Part A pay?

It is important to understand that Medicare does not pay for the full cost of all services. Additionally, Medicare may not help pay for any services not deemed "medically necessary." The patient is responsible for deductibles and co-payments, often referred to as co-insurance.

Medicare measures a person's use of a hospital and a skilled nursing facility (SNF) by something called a "benefit period." A benefit period *begins* the day the person is admitted as an inpatient in a hospital or a SNF. The benefit period *ends* when the person hasn't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If a person goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. A person must pay the inpatient hospital deductible for *each* benefit period. There is no limit to the number of benefit periods.

In 2014, for each benefit period, Medicare Part A has a \$1,216 deductible. Medicare Part A will then pay 100 percent for covered services for the first 60 days in the hospital or SNF. For the 61st to the 90th day, Part A covers all

inpatient charges less a charge of \$304 per day, which is a co-payment that the beneficiary must pay. In the event the individual remains in the hospital beyond 90 consecutive days, Medicare Part A provides 60 lifetime reserve days of inpatient hospital coverage following a 90-day stay in the hospital. These lifetime reserve days can only be used once. For 2014, coverage of each lifetime reserve day, for days 91 to 150, is subject to a \$608 daily co-payment. However, not many people remain in a hospital for 150 consecutive days.

Part A can help pay up to 100 days per benefit period for care in a skilled nursing facility. Medicare may pay 100 percent for the first 20 days. For the 21st to the 100th day, the beneficiary must pay a co-payment of \$152 per day. There is no coverage beyond 100 days for a benefit period. Part A will also pay for most eligible home health services and most hospice care.

How much does Part B pay?

Medicare Part B has, in 2014, an annual deductible of \$147. Medicare will then pay 80 percent of the Medicare approved amount for each covered service from a qualified professional and for durable medical equipment. The patient is responsible for the remaining 20 percent of the Medicare approved amount. Medicare will also pay for 80 percent of the Medicare approved amount for visits to a doctor or other health care provider to diagnose a person's mental health condition or to monitor or change a person's prescriptions and 80 percent of the Medicare approved amount for outpatient treatment of the person's condition, such as individual or group psychotherapy or counseling. Medicare pays 100 percent of Medicare-approved clinical laboratory services and home health services. In 2014, there may be limits on physical therapy, occupational therapy, and speech language pathology services, as well as exceptions to the limits.

What is Medicare Part D?

Medicare offers prescription drug coverage, referred to as Part D, to anyone enrolled in Medicare. A beneficiary

seeking prescription drug coverage would have to join a plan administered by an insurance company approved by Medicare. The monthly premium varies by plan, and higher income consumers may pay more. A person can join, switch, or drop a Medicare drug plan from October 15 to December 7 each year. Information on the drug plans available in New Jersey can be found by calling 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 (TTY) or by visiting Medicare's website at medicare.gov. Further enrollment questions and assistance can be obtained by calling 1-800-792-8820.

The cost of the premium for participation in a prescription drug plan that an enrollee is charged depends upon the private plan that the enrollee chooses and his or her own income. Drug plans vary in what prescription drugs are covered, how much of a co-payment a beneficiary has to pay for the drugs, as well as which pharmacies a beneficiary can use.

Annual deductibles vary among Medicare drug plans. No Medicare drug plan may have an annual deductible of more than \$310 in 2014. Some Medicare drug plans don't have any deductible.

After the deductible amount has been reached, the beneficiary pays either a co-payment or co-insurance depending on the plan. When the individual's payments and the drug plan's payments of its share of each covered drug, plus the individual's deductible, total \$2,850 (for 2014), the individual has reached the coverage gap, also known as the "donut hole." Neither the monthly premiums, nor the cost of drugs not covered by the plan, count toward the \$2,850. After total drug costs reach \$2,850 (in 2014), the beneficiary pays 47.5 percent of the cost of brand-name prescription drugs and 79 percent of the cost of generic drugs, until the beneficiary has paid a total of \$4,550 (in 2014) in out-of-pocket costs. When the beneficiary spends more than \$4,550 (in 2014) out-of-pocket, the coverage gap ends and the drug plan pays most of the costs of covered drugs for the remainder of the year. This is known as catastrophic coverage. The beneficiary will be responsible for a small co-insurance or co-payment

for covered drugs for the rest of the year.

What if I have prescription drug coverage from an employer or union?

A Medicare beneficiary who has prescription drug coverage from an employer or union will get a notice from the employer or union when the beneficiary turns 65 that tells him or her if the plan covers as much or more than a Medicare prescription drug plan. If the employer or union plan covers as much as or more than a Medicare prescription drug plan, the beneficiary can keep the employer or union drug plan, and join a Medicare prescription drug plan later. Alternatively, the beneficiary can drop the employer or union drug plan and join a Medicare prescription drug plan, but the beneficiary may not be able to get the employer or union drug plan back.

If the employer or union plan covers less than a Medicare prescription drug plan, the beneficiary can keep the employer or union drug plan and join a Medicare prescription drug plan to give more complete prescription drug coverage. Under another possible scenario, the beneficiary can keep the employer or union drug plan, but if the beneficiary joins a Medicare prescription drug plan later, he or she will have to pay more for the monthly premium (a surcharge).

What if I already have prescription drug coverage from a Medigap (supplemental insurance) policy?

Beneficiaries who have a Medigap policy with drug coverage will get a detailed notice from his or her insurance company telling him or her whether the policy covers as much or more as a Medicare prescription drug plan. This notice will explain the beneficiary's rights and choices.

What is the relationship between Medicare and my physician?

Medicare classifies physicians into participating and non-participating physicians. Since 1990, however, all physicians, whether or not they participate in Medicare,

must submit claims to Medicare on behalf of their patients. A participating physician is said to take “assignment” and cannot charge more than what Medicare has established as the “reasonable and customary charge.” Medicare pays the physician who accepts assignment 80 percent of the charge, while the beneficiary or the beneficiary’s Medigap policy pays the 20 percent co-payment. If the physician does not accept assignment, Medicare sends the check to the beneficiary, who is then responsible for reimbursing the physician. Non-participating physicians are subject to what is called a “limiting charge.” Currently, a doctor may not charge a Medicare beneficiary more than 115 percent of what Medicare says is the “reasonable and customary fee.” The limiting charge applied only to certain Medicare-covered services and does not apply to some supplies and durable medical equipment.

What happens if Medicare declines to pay for a service?

A Medicare claim may be denied because the service was not considered reasonable or medically necessary or, in a claim for nursing home coverage, the service was considered custodial. A Medicare beneficiary has the right to appeal Medicare’s denial of service, or Medicare’s failure to pay for a service or item provided.

For beneficiaries in the original Medicare plan, the beneficiary follows the instructions for an appeal included with the Medicare Summary Notice (MSN), which describes the item or service that has been denied. For beneficiaries in other Medicare plans, including a prescription drug benefit plan, the beneficiary follows the appeal procedure described in the plan’s materials that the beneficiary received after enrolling in the plan.

What kind of financial assistance is available to low-income Medicare beneficiaries?

If a person has limited income and resources, he or she may be able to get help from New Jersey to pay for their Medicare costs if they meet certain conditions. There are several kinds of Medicare Savings Programs:

- (1) Qualified Medicare Beneficiary (QMB) Program which helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments.
- (2) Specified Low-Income Medicare Beneficiary (SLMB) Program which helps pay for Part B premiums only.
- (3) Qualifying Individual (QI) Program which helps pay Part B premiums only. An individual must apply each year for QI benefits and the applications are granted on a first-come, first-served basis.
- (4) Qualified Disabled and Working Individuals (ODWI) Program helps pay for the Part A premium. An individual may qualify if any of the following apply to them:
 - (a) The person is a working disabled person under age 65.
 - (b) The person lost his or her premium-free Part A when s/he went back to work.
 - (c) The person is not getting medical assistance from New Jersey.
 - (d) The person meets the income and resource limits required by New Jersey.

If a beneficiary’s income does not exceed (in 2014) \$993/month for an individual/\$1,331 for a couple and with bank accounts or other liquid resources that do not exceed **\$7,160 for an individual, \$10,750 for a couple**, that beneficiary may qualify for assistance as a qualified Medicare beneficiary (QMB). If a person does not qualify for the QMB program, has income (in 2014) of less than \$1,187/month for an individual and \$1,593/month combined income for a married couple, and has liquid assets not exceeding \$7,160 for a single person/\$10,750 for a married couple, that person may qualify as a specified low-income Medicare beneficiary (SLMB). If a person does not qualify for the QMB program, and has (in 2014) monthly income not exceeding \$1,333 for a single person and \$1,790 combined income for a married couple, with liquid assets of not more than \$7,160 for a single person and \$10,750 for a married couple, that person may qualify as a Qualifying Individual (QI). A person may qualify for the Qualified

Disabled and Working Individuals (QDWI) program if the individual, if otherwise eligible, has monthly income that does not exceed \$3,975, or \$5,329 for the combined income for a married couple, and has resources that do not exceed \$4,000 for a single individual, and \$6,000 for a married couple. Those who believe they may qualify should contact their county Medicaid office.

There is also Extra Help, which is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs. An individual can find out more about eligibility for Extra Help by calling Social Security at 1-800-772-1213 or visiting their local Social Security office.

Additionally, New Jersey offers prescription assistance through the Pharmaceutical Assistance to the Aged & Disabled (PAAD) and Senior Gold programs. To qualify for PAAD, the individual's annual income for 2014 must be less than \$26,139 for a single person or less than \$32,037 for a couple. To be eligible for Senior Gold, the individual's income for 2014 must be between \$26,130 to \$36,130 for a single individual and between \$32,037 and \$42,037 for a couple. It is important to note that **in order to receive benefits under PAAD or Senior Gold, the individual must enroll in a Medicare Part D prescription drug plan or be enrolled in a Medicare Advantage Plan (Part C) that provides prescription drug coverage.** The Part D plan and PAAD **will then pay any costs above the PAAD co-payment of \$5 for each covered generic drug or \$7 for each covered brand name drug, including premiums.** Those who qualify for Senior Gold are responsible for paying the monthly premium directly to Medicare Part D plan. They are also responsible for paying any late enrollment penalty imposed by Medicare for each month they were eligible to enroll in Medicare Part D but did not do so.

Be aware that the foregoing income and asset numbers can change each year.

What is Original Medicare?

Medicare beneficiaries have the option of choosing to receive Medicare coverage via two different avenues. The

first way is what is referred to as Original Medicare. Under Original Medicare, the government pays directly for the health care services an individual receives. Those enrolled in Original Medicare have the freedom of choice to use any hospital or doctor who accepts Medicare (and most do). Original Medicare is sometimes called "traditional" Medicare.

Individuals enrolled in Original Medicare have Part A and Part B and generally need to select a Part D prescription drug plan for pharmaceutical coverage. Because enrollment in Original Medicare can result in a significant amount of out-of-pocket costs, beneficiaries may consider purchasing a Medigap policy to cover these expenses.

What is a Medigap Policy?

Private insurance companies provide health insurance policies that can cover deductibles, co-payments, and other out-of-pocket costs, as well as services not paid for by Original Medicare. Such a policy is called Medigap insurance. Insurance companies offer 12 standardized Medigap policies labeled plans A through N with each plan covering specified expenses or services. This makes it easier for a beneficiary to comparison shop for a policy from different insurance companies. These plans must follow federal and state laws. It is important to note that all plans that are advertised are *not* approved Medigap plans. A Medigap policy must be clearly identified on the cover as "Medicare Supplement Insurance."

To obtain assistance with selecting a Medigap program, an individual may contact SHIP (State Health Insurance Program). To access SHIP for an individual's county, call the Division of Aging Services at 1-800-792-8820 and ask for the telephone number for your county.

What is a Medicare Advantage Plan?

If one does not choose the Original Medicare route to receive benefits, an individual may elect to enroll in a Medicare Advantage Plan (like an HMO or PPO). Receiving Medicare via a Medicare Advantage Plan is commonly

referred to as Medicare Part C. Medicare Advantage Plans (“Part C”) are run by private companies approved by and under contract with Medicare. There are rules that govern the basic coverage that has to be offered by all insurance companies offering Part C plans, but actual benefits may differ between companies.

Medicare Part C combines Part A and Part B, and most plans include a prescription drug benefit so enrollment in a separate Part D plan is not necessary. In addition, Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. However, it is important not to confuse Part C Medicare Advantage Plans with Medicare supplemental coverage such as a Medigap policy. Medigap is designed to assist with coverage gaps for those enrolled in Original Medicare whereas Part C is a separate avenue to receive one’s Medicare benefits and is thus an alternative to Original Medicare, not a supplement.

Plan C is often thought of as a cost saving alternative to the Original Medicare option because the out-of-pocket costs are lower. However, Part C plans often have networks, and you must use the doctors, hospitals, and suppliers that belong to those networks. Also, you may have to obtain pre-authorizations for certain procedures and referrals prior to receiving care by a specialist.

To obtain assistance with selecting a Part C Plan, an individual may contact SHIP (State Health Insurance Program). To access SHIP for an individual’s county, call the Division of Aging Services at 1-800-792-8820 and ask for the telephone number for your county. You may also contact Medicare at 1-800-633-4227.

What is a “Private Fee-for-Service Plan?”

Enrollees in a Private Fee-for-Service Plan purchase a private indemnity health insurance policy from a company that has contracted with Medicare to provide services under Parts A and B. The beneficiaries may not be able to go to any doctor or hospital, and the federal government will not limit the premiums that may be charged, nor regulate the fee schedule established by the insurance com-

pany for procedures and services. The plan will receive from Medicare a fixed amount of money for each beneficiary each month, and those providing services will be paid a separate fee, determined by the plan, for each service.

What is the State Health Insurance Program (SHIP)?

SHIP provides free, objective, confidential help to New Jersey Medicare beneficiaries who have problems with, or questions about, Medicare, Medigap, Medicare + Choice Plans, and long-term care insurance. SHIP is a statewide program, with a provider in each county, and is sponsored by the New Jersey Department of Human Services, Division of Aging Services, with major funding from the U.S. Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS). To locate a nearby provider, a Medicare beneficiary can call the Division of aging Services at 1-800-792-8820 and request the number for SHIP in their county.

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(Prior Editions)

Social Security

What kinds of disability benefits are available from the Social Security Administration?

The Social Security Administration (SSA) is responsible for two different types of monthly cash benefits for persons who are unable to work because of a disability. Social Security Disability Insurance benefits (also known as Title II benefits or SSDI) may be available to individuals with disabilities who have paid into the Social Security program through payroll taxes on their wages, or to individuals with disabilities who have been dependent on another person who has paid into the Social Security program. Supplemental Security Income (also known as Title XVI benefits or SSI) may be available to individuals with disabilities who have very little income and resources.

How does the Social Security Administration determine if an individual has a disability?

The Social Security Administration (SSA) uses a five-step sequential evaluation process to determine if an individual has a disability. If the SSA finds at any step that a person has a disability, the SSA will stop its inquiry.

First, the SSA will consider an individual's work activity. If a person is doing substantial gainful activity, that person will be found not disabled. Substantial gainful activity means work that: involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit.

If a person is not doing substantial gainful activity, the SSA will consider the medical severity of an individual's impairments: A person must have a severe medically determinable physical or mental impairment (or a combination of impairments) that has lasted, or is expected to last, for at least 12 months (the duration requirement) or is expected to result in death.

Next, the SSA will review a listing of recognized impairments to determine if an individual's impairment meets or equals one of the listed impairments and meets the

duration requirement or is expected to result in death. The listing of recognized impairments sets forth several categories of impairments, evidentiary requirements for proving the existence of a particular type of impairment, and specific criteria for finding that a particular impairment exists. A person's symptoms must meet or equal the criteria for a particular impairment. Medical evidence must substantiate a person's symptoms.

If a person's impairment, or combination of impairments, does not meet or equal one of the listed impairments, the SSA will consider a person's residual functional capacity and that person's past relevant work. An individual's impairment(s) and any related symptoms, such as pain, may cause physical and mental limitations that affect what a person can do in a work setting. An individual's residual functional capacity is the most a person can still do despite his or her limitations. If a person can still do his or her past relevant work, that person does not have a disability.

If a person cannot still do his or her past relevant work, the SSA will consider a person's residual functional capacity, age, education, and work experience. If a person can make an adjustment to other work, he or she is not disabled.

How severe must an individual's disability be to qualify for benefits from the Social Security Administration?

The SSA's definition of disability is very strict. An individual must have an impairment, or combination of impairments, that significantly limits that person's physical or mental ability to do basic work activities. It requires an inability to do any type of job that is generally available. In other words, even if a person is not able to perform his or her previous job, if there is some other job he or she could do, then that person is not eligible for disability benefits. Even if a person is not able to perform any type of job for some time, that person is not eligible for benefits unless he or she is unable to do any type of work

for at least 12 months, or unless the illness is expected to cause death.

If SSA finds that an individual's disability is based on blindness, the regulations are somewhat different. In that case, a period of disability may be established regardless of whether the individual is working. The law also differs for the individual with blindness in other respects. For some, even though they are working, it may be advantageous to establish a period of disability with SSA. When evaluating the work of an individual who is blind, higher monthly earnings are allowed by SSA before the work is regarded as "substantial gainful activity." In addition, there are more deductions from the gross earnings, which may be made in determining the income for substantial gainful activity purposes, as well as for counting income for SSI eligibility.

If a person meets the definition of disability, how much money will he or she receive?

The amount of monthly Social Security Disability Insurance (SSDI) benefits received depends on the amount of the individual's prior earnings. Some other types of income, such as workers' compensation benefits, may reduce the amount of the monthly check, but most other types of income will not affect SSDI benefits.

The amount of monthly Supplemental Security Income (SSI) benefits received depends on the person's living arrangement, that is whether the person is living independently or is being supported by someone, and any other income or resources he or she has. Most other types of income, except such benefits as food stamps or government rent subsidies, can reduce the amount of the SSI benefit.

Are there any health insurance benefits available with either SSI or SSDI?

The Social Security Disability Insurance (SSDI) program will qualify a recipient for Medicare insurance after he or she has been eligible for monthly SSDI benefits for two years. Medicaid is available to all Supplemental Security

Income recipients, usually beginning with the month in which the recipient applies for benefits. Some unpaid medical bills for up to three months prior to the application date also may be eligible for payment.

Once a person is found to be eligible for disability benefits, how long do benefits continue?

Technically, all disability benefits end at age 65. At that time, Social Security Disability Insurance (SSDI) benefits are converted to retirement benefits and Supplemental Security Income (SSI) benefits are converted to SSI's program for persons over 65. Until age 65, as long as an individual meets the eligibility requirements, there is no limit on the length of time that he or she can continue to receive disability benefits. However, the Social Security Administration (SSA) can require periodic submissions of evidence that an individual continues to meet the medical requirements for Social Security benefits. Everyone who receives SSDI or SSI benefits is required to notify SSA of any change in his or her living situation or income that may affect the monthly benefit.

Can a recipient try to go back to work and still receive disability benefits?

Both the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs have rules that will permit recipients to attempt to return to work without immediately risking the loss of monthly benefits and health insurance.

The SSDI program allows an individual to attempt to work for nine months (not necessarily consecutively) without jeopardizing his or her benefits. After those nine trial work months have been exhausted, there is a three-year period during which eligibility for monthly benefits depends on the amount of wages earned. Medical benefits can continue throughout this period.

The SSI program also permits recipients to work without jeopardizing eligibility for monthly benefits. However, the amount of the monthly benefit will depend on earnings. The Social Security Administration will deduct

approximately \$1 for every \$2 earned from an individual's monthly benefit. Medicaid benefits, however, can continue even if a person does not receive a monthly check because of his or her wages.

Almost everyone who is eligible for SSDI or SSI disability benefits is also eligible to receive a "ticket to work." The ticket can be used to obtain vocational rehabilitation and related services to foster the recipient's return to work. A person using the ticket has some additional protection against losing disability benefits while attempting a return to work.

Where does one apply for benefits?

Applications for either Social Security Disability Insurance or Supplemental Security Income can be made at the local Social Security Administration (SSA) office. If a person is unable to go to the local office, someone else may file the application, or the application process may be started over the telephone. SSA will usually require a face-to-face interview with one of its representatives, but a home visit can be scheduled.

Everyone has a right to file an application. Even if an SSA representative tells someone that he or she is not eligible for a program, that person should still be permitted to file an application, and to file an appeal if he or she is rejected.

What if benefits are denied, or if there is some other problem concerning benefits?

The Social Security Administration (SSA) has an extensive review process that permits an appeal of any decision it makes that adversely affects an application for benefits. If an applicant disagrees with an initial decision made by SSA, he or she can ask for reconsideration. If a person disagrees with the decision on reconsideration, he or she may ask for a hearing before an administrative law judge. In addition, the decision of an administrative law judge may be appealed to SSA's Appeals Council and, thereafter, may be pursued in federal court. SSA should fully explain the rights to appeal in any notice it sends to an applicant.

Special attention must be paid to any time limits that are stated, particularly because benefits may stop unless an appeal is filed within a short period of time.

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(Prior Editions)**

Surrogate Decision-Making

What is surrogate decision-making?

Surrogate decision-making is the delegation by one individual to another individual of some or all of his or her rights to make decisions concerning his or her person or property.

When might a surrogate decision-maker be needed?

When an individual is not able to manage part or all of his or her affairs, whether by reason of absence, age, incapacity, or physical or mental frailty, a surrogate decision-maker might be appropriate.

What if an individual can still manage all of his or her affairs but wants to be prepared in case a time comes when he or she is not able to do so?

It is possible, and often desirable, to arrange in advance for a surrogate decision-maker who would be empowered to act only if and when needed.

How does an individual arrange for a surrogate decision-maker?

There are a number of arrangements available. In order to decide which is best in a particular situation, an individual must first determine what task the surrogate will need to perform. Will there be many tasks to be handled? Are there many or few assets? Do the assets require much or little attention? Are the assets substantial or modest? Are the individual's affairs complex or simple? After having determined what the surrogate might be called upon to do, the next step is to choose an arrangement that will best serve that purpose.

What arrangements can be made regarding bank accounts?

Often the only difficulty a person with a disability experiences is paying bills and handling other financial transactions. In such a case, the problem can easily be resolved

by arranging for the surrogate and the person with a disability to sign a power-of-attorney card that banks provide to customers. This permits the surrogate to make withdrawals, deposits, and transfers and to sign checks. In addition, arrangements can be made for checks to be deposited by electronic fund transfer (direct deposit), which will eliminate the need to have the checks picked up, endorsed, and deposited. A feature that automatically pays recurring bills can also be of great assistance in reducing the duties of a surrogate.

Another option is for the person with a disability to have a joint bank account with a surrogate decision-maker. However, caution must be exercised in setting up the bank account so that if the person with a disability dies, any bank balance at death does not automatically become the property of the surviving joint account-holder, unless that is the intention of the person with a disability.

What are powers of attorney?

There are several ways a person can voluntarily delegate certain decisions to another person. Procedurally, the least complicated of these is the power of attorney. It is a flexible means of delegating authority without incurring court costs or excessively interfering with the independence of the individual with a disability. It is created by a competent adult (known as the principal) executing an appropriate document, and it may be revoked, if the person for whom the power of attorney is created is still competent, by giving written notice to the surrogate decision-maker (known as the attorney-in-fact). Generally speaking, everyone should execute a broad power of attorney to protect him or herself in the event of incapacity, which can occur unexpectedly.

What is a durable power of attorney?

N.J.S.A. 46:2B-8.2(b) defines a "durable power of attorney" as a power of attorney that contains the words, "this

power of attorney shall not be affected by subsequent disability or incapacity of the principal, or lapse of time,” or “this power of attorney shall become effective upon the disability or incapacity of the principal,” or similar words showing the intent of the principal to confer authority upon the attorney-in-fact in the event of the subsequent disability or incapacity of the principal. N.J.S.A. 46:2B-8.2(c) states that unless otherwise defined in the power of attorney document, disability occurs when a principal is unable to effectively manage his or her property and affairs. This document could eliminate the need for an onerous guardianship procedure.

It is wise to inquire of the companies or institutions holding an individual's assets whether the document will be acceptable to them and what wording or power should be included to make it acceptable. Some institutions may require a “third party exculpation” clause holding them harmless if they act in good-faith reliance on the document. Some may require specific provisions for when the document will “spring” into use, for example, when the principal is under a disability as certified by an appended affidavit of a treating physician.

Other requirements might be the specific listing of the particular power the agent is to have (for example: access to a safe deposit box); the signature of the surrogate to be compared with future signatures for identification; compliance with the statutes for recording deeds if real estate is to be transferred pursuant to the power; and an attestation clause for witnesses to the effect that the principal was competent to execute the instrument and wanted to do so.

What are the disadvantages of powers of attorney?

A power of attorney can vest authority in a person who may not be capable or trustworthy. There is no court oversight or protection for the individual with a disability when the power of attorney is in effect. There is no requirement for a bond or an accounting or any other type of reporting. It is extremely important, therefore, to select someone who is responsible and capable in order to gain the

many benefits a power of attorney can offer to someone with a disability.

What is an advance directive?

An advance directive, sometimes called a living will, is a document that plans for surrogate decision-making in medical treatment. A properly executed advance directive becomes effective when the individual is incapacitated and unable to make or express his or her own decisions regarding medical treatment.

The New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 *et seq.*, recognizes three different forms of an advance directive.

- A proxy directive is used to allow the individual to designate another person of his or her choosing to make medical treatment decisions, in the event that the individual becomes incapacitated.
- An instruction directive allows the individual to specify, in advance, the kinds of medical treatment and procedures that he or she wishes to have administered or withheld, in accordance with the individual's own values and choices.
- A combination directive contains both a proxy designation and an instruction directive to guide surrogate decision-making.

An advance directive does not become effective until the individual becomes incapacitated and unable to make and express decisions regarding medical treatment.

An advance directive can be modified or revoked at any time in writing, orally or by any action that indicates the individual no longer wants the directive to be in effect. It must be signed and dated by, or at the direction of the individual, in the presence of two adult witnesses who shall attest that the individual is of sound mind and free of duress and undue influence.

Alternatively, the advance directive shall be signed and dated by, or at the direction of the individual and be acknowledged by the individual before a notary public,

attorney at law or other person authorized to administer oaths. A designated healthcare representative shall not act as witness to the execution of an advance directive.

In 2005, New Jersey enacted the Advance Directives for Mental Health Care Act, N.J.S.A. 26:2H-102 to -125, which is substantially similar to the provision for a living will, except that it pertains to mental health treatment. Templates in English and Spanish are available on the websites for the Mental Health Association in New Jersey (mhanj.org), and Disability Rights New Jersey (drnj.org).

What is a standby guardianship?

A standby guardianship is a document or court proceeding that designates a future guardian for the minor children of a parent with a progressive, chronic condition or fatal illness. The standby guardian is standing by to immediately assume legal guardianship and provide for the care of the children should the parent die or become too debilitated to care for the children.

Standby guardianship is important to parents with severe disabilities who have custody of their children because it enables them to settle the future care and custody of their children before they become too ill to sign documents or participate in court proceedings. They can do this without giving up any of their parental rights or custody of the children, since the standby guardianship goes into effect only if they become unable to care for the children in the future.

The New Jersey Standby Guardianship Act, N.J.S.A. 3B:12-67 *et seq.*, is limited to use by parents and custodians who are suffering from a progressive, chronic condition or fatal illness, and the appointment pertains to minor children. However, occasionally when asked, the courts will appoint a standby guardian for an adult with a disability even when the guardian is not seriously ill.

Pursuant to the New Jersey Standby Guardianship Statute, a person may appoint a standby guardian in two ways: (1) by court petition, or (2) by a written document, called a designation.

When filing a court petition, notice of the petition must

be provided to the other parent, if alive, and/or any other legal custodian of the child. These parties have the right to object to the proposed arrangement. Often the petition is not contested, and the court will approve the standby guardianship with only a routine hearing. If the matter is disputed, a court hearing will be held to determine what will serve the best interests of the children.

A designation is a document in which the custodial parent with a disability appoints the person of his or her choice to be the standby guardian. No court petition is filed and no notice to the other parent is required at that time. However, the signing of a designation is of limited value. It can only be effective for a temporary period (six months maximum). Within that time, the standby guardian must petition the court to have the appointment continued. Even during the initial six months, a designation can be challenged in court.

What is a trust?

A trust is a legal document that allows a trustee to manage assets for the benefit of another. The trustee manages the assets in the trust. One or more people can be used, sometimes along with a trust company.

A specific type of trust, known as a “special needs trust,” is designed to preserve eligibility for government benefits. The funds in a special needs trust are used to supplement the government benefits received by a person with a disability. The monies in a special needs trust cannot be utilized for food, clothing, and/or shelter expenses, or eligibility for benefits such as SSI and Medicaid will be jeopardized. It is strongly advised that any special needs trust be prepared by an attorney well versed in this area of law.

There are three distinct types of special needs trusts. Each kind of trust is described as follows:

1. A pay-back trust or a d4a trust requires that any unused trust funds be paid back to Medicaid for services rendered to the beneficiary upon the beneficiary's death. Only a parent, grandparent, legal guardian, or a court can establish this kind of trust for the beneficiary

who must be under age 65 and have a disability. The beneficiary of the trust cannot establish this type of trust.

2. A third party trust is created by a family member or other person to benefit an individual with a disability. There is no requirement to repay Medicaid, and there is no age restriction, as compared with a payback trust.
3. A pooled trust is a trust in which a non-profit agency serves as trustee, and the assets of various beneficiaries are combined or “pooled” for purposes of investment. An advantage of a pooled trust is that the assets are managed by an organization that is knowledgeable about investments and the needs of persons with disabilities. A disadvantage is a pooled trust can be costly for the beneficiary in terms of maintenance fees and does not permit the beneficiary or his or her family members to make any decisions regarding investment or disbursement.

What is a conservatorship?

A conservatorship is a protective arrangement for estate management that is most useful when there is a need to ensure that the delegation of authority will be honored, or when the estate is large or complex. The individual who designates a conservator, known as the “conservatee,” must be competent, but due to age, illness, or physical infirmity, unable to care for or manage his or her own property or unable to financially provide for him or herself, or for his or her dependents. In New Jersey, a conservatorship cannot be imposed if the proposed conservatee objects to it. The individual or someone on his or her behalf can apply to have a conservator appointed to manage his or her property. Conservatees have more protection than individuals who delegate authority through a power of attorney. Conservators must file informal annual reports or accountings with both their conservatees and the court, and may also be required to file a bond and render formal accountings. A conservator may terminate the arrangement at any time by application to the court. N.J.S.A. 3B:13A-1 *et seq.*

What is a representative payee?

The Social Security Administration will appoint a representative payee to receive and administer benefits for recipients who are unable to receive and manage the benefits themselves due to mental or physical impairments. 20 C.F.R. §§ 404.2001(a) *et seq.* and 416.601(a) *et seq.* Representative payees may be appointed with or without the consent of the recipient, who may challenge the decision. Representative payees are required to use the benefits in the recipient’s best interests, and they are personally liable for misuse of the funds. However, there is no reliable oversight of these arrangements.

What is a guardian?

A guardian is a person appointed by a court to make financial and/or personal decisions for a person proven to be legally incapable of making his or her own decisions.

When is a guardian needed?

A guardian is needed when an individual lacks decision-making capacity as a result of a mental or physical disability or alcohol or drug addiction. The person for whom a guardian is appointed is called a ward.

What rights does a ward lose?

In a full or “plenary” guardianship, the ward loses the right to manage any of his or her own affairs independently. This includes the right to decide where to live, how to spend money and use property, and the capacity to appear in court or undergo medical treatment without the approval of his or her guardian. An unmarried ward also loses the right to marry. In practice, a ward with a significant disability may be able to retain the ability to participate in decision making so that the ward will not completely lose his or her independence. Of course, if the ward lacks the ability to make decisions, arguably plenary guardianship represents no loss at all but rather provides a way to exercise key rights through a guardian.

An important alternative to full guardianship is called “limited guardianship.” In a limited guardianship, the ward

retains the right to make those decisions that he or she is capable of making, while the guardian is limited to making only those decisions for which the ward lacks decision-making capacity. This recognizes that a person can lack decision-making capacity in some areas, but still retain the ability to make certain decisions (such as where to live). In a 1994 ruling, the New Jersey Supreme Court authorized trial courts to consider this option and to appoint limited guardians when appropriate. See, *Matter of M.R.*, 135 N.J. 155 (1994).

What happens if the ward regains the ability to manage his or her own affairs?

If an individual for whom a guardian has been appointed wishes to regain the legal right to make his or her own decisions, the individual must petition the court.

When is a guardian not needed?

Just because a person has a disability, it does not mean that he or she needs a guardian. A guardian is not needed for a person who has the mental capacity to understand and make decisions for him or herself and communicate these decisions to others. A guardian is not required for someone who has a physical disability but who can manage his or her affairs, and may not be needed for a person who merely has a problem managing money or property.

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(Prior Editions)**

Transportation Barriers

Must public transit buses be accessible to persons with disabilities?

Currently, the regulations implementing the Americans with Disabilities Act adopted by the United States Department of Transportation require all new buses to be accessible. Since this requirement was adopted in 1991, and buses have an expected life of 12 years, most, if not all, public transit buses should now be accessible.

How does the Americans with Disabilities Act affect rail transportation?

The ADA requires that:

1. All new rail vehicles ordered on or after August 26, 1990, must be accessible to persons with disabilities.
2. All new rail stations must be accessible and all alterations to existing stations must be accessible. When alterations are made to a “primary function” area, an accessible path to the altered area must also be made, unless the added cost of doing so would be disproportionate to the overall cost of the alterations.
3. Existing “key” commuter rail and subway stations were to be made accessible by July 26, 1993, unless an extension was secured. About two-thirds of key station retrofits were scheduled to be completed by this time. Existing inter-city rail stations (Amtrak) needed to be made accessible by July 26, 2010.
4. Existing rail systems must have one accessible car per train.

What is “paratransit”?

Paratransit is a system of public transportation for use by individuals where no bus or rail transportation exists or where individuals cannot appropriately access bus or rail transportation due, for example, to their disabilities. The former is known as “paratransit for the general public” while the latter is known as “complementary paratransit”

“Paratransit for the general public” must provide services to passengers with disabilities that are equivalent to services for other users.

Transit authorities may develop an eligibility process to determine who can receive complimentary service. However, if a passenger is unable to use mass transit, either because the system is not accessible or their disability prevents them from using even the accessible system, they must be found eligible. Complementary paratransit must also meet the following criteria:

1. Fares must be comparable to mass transit fares (no more than double);
2. Service must be available during the same times as the mass transit system operates;
3. Service must be provided in the same geographic area as the mass transit system;
4. There cannot be restrictions or priorities placed on trip purposes;
5. There must be next-day service (that is, if you call for service today, service must be provided any time tomorrow); and
6. There cannot be constraints on the capacity of paratransit service (for example, waiting lists, excessive waiting time or trip times).

Must bus and rail operators offer “complementary paratransit”?

Bus and rail operators must offer “complementary paratransit” to passengers with disabilities who cannot use mass transit.

How does the ADA affect private motor coach transportation?

Large, privately owned, fixed-route over-the-road bus companies (that is, those that use Greyhound-style buses) that acquire new buses must purchase or lease

only vehicles accessible to people with disabilities. By 2006, half of the fleet of a smaller company (those that gross less than \$5.3 million annually) should have been accessible. By 2012, all of the fleet must have been accessible. Until the fleet was accessible, but no later than 2012, over-the-road bus operators could have required 48-hours advance notice in order to ensure that an accessible bus is available.

Smaller companies providing fixed-route service were required to begin purchasing only accessible equipment in October 2001. Smaller companies must also provide boarding assistance and transport wheelchairs and scooters.

Charter bus operators do not need to purchase only accessible buses, but since 2001 they must be able to provide accessible service if they are given 48-hours advance notice.

Does the ADA cover airline and passenger vessel transportation?

Airline transportation accessibility requirements are under a separate statute, the Air Carrier Access Act, rather than the ADA.

Passenger vessels are subject to ADA coverage. At the end of 2013, the comment period was still open for the Passenger Vessels Accessibility Guidelines proposed by the United States Access Board.

Where can transportation-related complaints be brought under the ADA?

ADA complaints with respect to public bus and rail systems can be filed with the Department of Transportation. Complaints about motor coach companies or other private transportation companies should be filed with the Department of Justice. In addition, a lawsuit may be brought in court to enforce ADA requirements. Complaints about accessibility of airline service under the Air Carrier Access Act can be filed with the Department of Transportation.

Are there any other federal laws mandating accessible transportation?

Yes. The Architectural Barriers Act of 1968 requires that anything constructed or renovated with federal financial assistance be accessible to people with disabilities. Section 504 of the Rehabilitation Act also requires that facilities and services receiving federal financial assistance be accessible.

Who establishes federal standards for accessibility of vehicles and facilities?

Under the ADA and the Architectural Barriers Act, the Access Board establishes technical guidelines for the accessibility of facilities and vehicles (that is, describing in detail what an accessible facility or vehicle looks like). These guidelines are then incorporated as regulatory standards by the Departments of Justice and Transportation.

James Weisman, Esq.

Robert C. Ashby, Esq.
(Prior Editions)

Vocational Rehabilitation

What is the New Jersey Division of Vocational Rehabilitation Services?

The New Jersey Division of Vocational Rehabilitation Services (DVRS) is a state agency, established pursuant to the Rehabilitation Act of 1973, as amended (24 U.S.C. § 701 *et seq.*), which provides services to enable persons with disabilities to become or remain employed. A division of the New Jersey Department of Labor and Workforce Development, DVRS serves every county in the state through its network of offices.

Who is eligible for services?

An individual must have a physical or mental impairment that results in a substantial impediment to employment, and must be able to benefit from vocational rehabilitation services in terms of an employment outcome. The individual must require such services to prepare for, enter, engage in, or retain gainful employment.

What kinds of services might be provided to eligible persons?

1. Diagnostic evaluation to determine the extent of the disability, the presence of any other conditions, and the need for treatment. The client may choose his or her own physician for these examinations.
2. Individual vocational counseling and guidance to help select and work toward a suitable vocational objective. Together the client and counselor will plan the steps that lead to employment.
3. Job-seeking skills training and selective job placement in a job commensurate with the client's physical and mental abilities. This may include supported employment.
4. Follow-up services over a minimum of three months to ensure success. Job modification consultation may also be provided.
5. Post-employment services to enable a former client to

keep his or her present job.

6. Other goods and services, when they are essential to preparing the individual for employment.

Who decides what type of program and services will be provided?

The client and a counselor from the Division of Vocational Rehabilitation Services jointly work out an individualized plan for employment (IPE). The IPE contains a specific vocational goal to work toward and sets forth client and agency responsibilities and cost, if any.

What are the costs to eligible clients of DVRS?

Diagnostic evaluation, counseling and guidance, job placement, on-the-job training, and supported employment are provided at no cost to the client, regardless of the client's finances.

The purchase of other goods and services, when necessary to accomplish the vocational goal of the eligible consumer, are arranged for by the agency, and are provided subject to the client's financial eligibility. The financial criteria of the Division of Vocational Rehabilitation Services may be less restrictive than the criteria of other agencies.

Wherever possible, the counselor is required to utilize "similar benefit," that is, identical services or resources available from other sources. For example, those seeking training will also be required to apply for PELL and other educational grants.

Are DVRS clients assured that their confidentiality will be safeguarded?

Division of Vocational Rehabilitation Services' records are confidential, and no information will be revealed without a signed release from the client.

How does an individual apply for DVRS services?

Contact the nearest Division of Vocational Rehabilitation Services office and ask for an application or an appointment. To obtain the telephone number and the

address of the DVRS office nearest to the potential client, call 609-292-5987 (voice), 609-292-2919 (TTY), 1-866-VR1-STOP (toll free), or check the website at lwd.dol.state.nj.us and click on Vocational Rehabilitation.

Brian Fitzgibbons, MPA, CRC

Thomas G. Jennings and Alexander Kirk
(Prior Editions)

Workers' Compensation

What is workers' compensation?

Workers' compensation is a system designed by the New Jersey Legislature to pay benefits to employees and their dependents for work-related injuries, illnesses, or death.

What medical benefits does workers' compensation provide?

The injured worker's employer or the employer's insurance company must pay for all necessary and reasonable medical treatment, prescriptions, and hospitalization services connected to the work related injury or illness. The worker does not make any co-payments, nor are there any deductibles.

Are there guidelines to be followed in obtaining medical care?

The employer has a legal right to designate the authorized treating physician. Only in situations where the employer inappropriately refuses to provide medical treatment, or in emergencies, may the injured worker choose the treating physician. In such cases, the injured worker should notify the employer as soon as possible concerning the treatment. A letter from a physician, preferably a specialist, must be offered in support of the need for treatment.

What other benefits does workers' compensation provide?

An injured worker who is out of work for more than seven days will be eligible to receive temporary total benefits at a rate of 70 percent of his or her average weekly wage, subject to a maximum of \$843 per week in 2014. These benefits, which are tax free, are given as long as the injured worker is unable to work and is under active medical care. If a worker is out of work for less than eight days, the worker is not entitled to temporary total benefits.

How long can the worker receive these temporary total benefits?

Temporary total benefits usually end when the injured worker is released to return to work in light duty, or if he or she has reached maximum medical improvement (MMI). MMI is a term indicating additional treatment will no longer improve the injured worker's medical condition. A worker who has reached MMI is not necessarily totally cured of his or her injuries. Often, the worker is left with partial permanent injuries, but still is able to work.

Are benefits available for a worker left with partial permanent injuries?

Yes. When a job-related injury or illness results in a partial permanent disability, benefits are based upon a percentage of certain "scheduled" or "non-scheduled" losses. These benefits are accrued and paid weekly once temporary disability ends.

What happens to a worker who has been too severely injured to return to work in any capacity?

In such cases, the injured worker may be entitled to receive permanent total disability benefits. These weekly benefits, along with medical treatment, are provided initially for a period of 450 weeks. Then, if the injured worker is able to show that he or she remains unable to work, these benefits continue beyond the initial 450-week period. Wages earned after 450 weeks offset the weekly computation in proportion to the income at the time of the injury. Permanent total disability is 70 percent of a worker's gross wages, including overtime, up to a maximum, in 2014, of \$843 per week.

What criteria qualify an injured worker for permanent total disability?

An injured worker can automatically qualify for permanent total disability when he or she has lost two major

members or a combination of members of the body, such as eyes, arms, hands, legs, or feet. However, permanent total disability can also result from a combination of injuries that make the worker unemployable.

Are death benefits available under workers' compensation?

Yes. Dependents of a worker who dies of a work-related injury or illness may be eligible to receive death benefits totaling 70 percent of the deceased worker's weekly wage, not to exceed a maximum benefit amount—\$843 per week in 2014—established annually. The benefit amount is divided among the surviving dependents, as determined by a judge after a hearing on the extent of dependency.

What individuals would be considered dependents of the deceased worker?

The following are considered dependents:

1. A surviving spouse and natural children who were a part of decedent's household at the time of death are conclusively presumed to be dependents.
2. A surviving spouse and natural children who were not a part of decedent's household at the time of death, and all other alleged dependents (parents, grandparents, grandchildren, brothers, sisters, etc.) must prove actual dependency.
3. Children who are deemed to be dependents remain so until the age of 18 years, or until age 23, if full-time students.
4. A child who has a physical or mental disability may be eligible for further benefits.

Does workers' compensation provide for funeral expenses?

Yes. The employer or its insurance provider must pay up to \$3,500 in funeral expenses for a job-related death. These funds are payable to whoever is liable for the funeral bill, whether it is the estate or an individual.

What if my employer does not have workers' compensation insurance?

Workers' compensation insurance is mandatory in New Jersey. An employer must have workers' compensation insurance. If an employer does not have a workers' compensation insurance policy effective on the date of an employee's accident, the employee can make an application for benefits with the Uninsured Employee Fund (UEF), which provides temporary and medical benefits to an employee of an uninsured employer. The UEF can also impose fines and penalties on an employer who does not have workers' compensation insurance. There are also criminal charges that can be brought by the State of New Jersey against an employer who fails to maintain workers' compensation insurance.

Does an injured worker have to be a United States citizen or lawful permanent resident to be entitled to workers' compensation benefits?

No. Benefits under the New Jersey workers' compensation law are not dependent on legal status. The New Jersey workers' compensation law simply requires that the injured person prove that they were employed and injured during the course of their employment.

John M. Pinho, Esq.

**Craig Livingston, Esq. and Charles N. Miller, Esq.
(Prior Editions)**

Workplace

What laws protect the rights of persons with disabilities in the workplace?

Federal laws that provide protection in the workplace include the Americans with Disabilities Act (ADA) and the Rehabilitation Act. In New Jersey, since the New Jersey Law Against Discrimination (LAD) offers greater protections as compared to federal laws, this section focuses on the LAD.

What protections do persons with disabilities have in the workplace?

There are two types of protections for individuals with disabilities under the LAD: (1) the right to be free from disability-based discrimination, and (2) the right to reasonable accommodation of the job and the workplace so that the individual with a disability may effectively apply for the job, perform the essential functions of it, and enjoy the same privileges and benefits of the job that are offered to other employees.

What type of discrimination is prohibited?

The LAD prohibits discrimination in recruitment, hiring, promotion, training, pay, fringe benefits, leave, layoff, social activities, and other privileges of employment. It restricts questions that can be asked about an applicant's disability before a job offer is made, and it requires that employers make reasonable accommodation to the known physical and mental limitations of otherwise qualified individuals with disabilities, unless the accommodation would result in undue hardship to the employer.

An employer can neither refuse to hire nor fire an employee solely based on an individual's disability so long as the individual can perform the job's essential functions with or without reasonable accommodation. Also, an employer cannot deny an employee with a disability an assignment, transfer, or any other employment opportunity solely based on the employee's disability. However,

persons with disabilities are not entitled to a preference over more qualified applicants or employees.

An employer is not permitted to ask a job applicant about a disability or the nature or severity of a disability unless it first makes a job offer to the applicant, and only then if it makes medical inquiries of all persons offered a job. A job applicant may, however, be asked questions before a job is offered about his/her ability to perform specific job functions or to describe or demonstrate how she/he would perform specific functions which are essential to the job.

Employees with disabilities are not protected from negative employment actions, and therefore can be disciplined or terminated based on absenteeism caused by the disability. So long as an employee with a disability is held to the same attendance standards as employees who do not have disabilities, and the employee is not on a leave protected by the Family and Medical Leave Act (FMLA), an employee who is absent from work due to disability can be terminated from employment.

What are the essential functions of a job?

Essential functions of a job are duties central to the performance of the job. This is generally determined by reviewing the job description and the duties actually performed by all employees within the same job title.

What is reasonable accommodation?

Reasonable accommodation is a modification or adjustment to the work environment that will enable a qualified applicant or employee with a disability to perform the essential functions of the job and to enjoy all of the employment privileges available to other employees. Reasonable accommodation varies depending on the nature of the job and the disability as well as the makeup of the employing company. Even within the same work environment, reasonableness depends on the nature of

the particular job. For example, a janitor may be expected, as part of his job, to climb ladders in order to dust, replace light bulbs, or wash windows. An employee who could not climb ladders would be unable to perform the essential functions of cleaning and maintenance. Therefore, it would not be a reasonable accommodation for the employer to eliminate such aspects of the job. However, a secretarial employee who sits at a desk working on a computer and answering telephones might occasionally have to stand on a stepladder to obtain office supplies. In that situation, climbing the stepladder would be a “marginal function” of the job, not an essential function; therefore, a reasonable accommodation might be to have another employee climb the stepladder or to have the supplies kept on a lower shelf where the employee with a disability can reach them. At times, whether a reasonable accommodation can be made for a particular job is relatively obvious. Providing an interpreter for a deaf employee at a company sponsored awards dinner, purchasing an ergonomic chair for an employee with chronic back pain, and creating a reserved parking space specifically for an employee who is a wheelchair user are often apparent solutions to a need for reasonable accommodation. Other times, reasonable accommodation is determined through an “interactive process” between the employer and the employee.

What is the “interactive process?”

The “interactive process” is a dialogue between the employer and the employee concerning the nature of the employee’s disability, the essential functions of the job, and the possible accommodations needed to enable the employee to perform the job.

The employee has the initial obligation to approach the employer and request an accommodation. The employer may require medical documentation from a physician who supports the employee’s request and can require that the employee submit to an examination by the employer’s medical expert. The employer and employee then must engage in a dialogue concerning what, if any, accommo-

dation is appropriate. It should be noted that “reasonable accommodation” does not mean the “best” or “most reasonable” accommodation. If the employer offers the employee a reasonable accommodation the employee does not have the right to require a more reasonable accommodation. For example, if an employee with a medical condition that is negatively affected by heat is working at a company with both air-conditioned and non-air-conditioned facilities, the employee may have a right to an air-conditioned environment as a reasonable accommodation. However, the employer can choose to air-condition the office the employee currently works in or to move the employee to an air-conditioned facility. The employer determines which reasonable accommodation to provide.

All medical records and information obtained by an employer must be kept confidential and in medical files that are separate from employee files available to managers, supervisors, and clerical employees. Except on a need to know basis all medical information and files should generally be kept confidential by medical personnel.

What right does an employee with a disability have to take leave from work?

Under the federal Family and Medical Leave Act (FMLA), employers of 50 or more employees must allow employees to take up to 12 weeks of unpaid leave per year for their own personal illness. The law also allows the unpaid leave for such employees to care for a parent, spouse, or child with a serious health condition or is newly born or adopted by the employee. The employer is required during the unpaid leave to continue medical coverage of the employee.

How does an individual with a disability pursue a claim against an employer who has denied the employee his or her rights under the law?

If an individual with a disability believes he or she has not been hired due to a disability, or believes he or she has been terminated or denied some benefit of employ-

ment based upon his or her disability, the individual has a right to file a claim under the Law Against Discrimination (LAD).

The claim can be filed in one of two ways: (1) the individual can file a claim with the New Jersey Division on Civil Rights (DCR) within 180 days after the alleged negative employment action, or (2) the individual can file a claim in the Superior Court of New Jersey within two years of the alleged violation. Also, if an individual believes he or she has been denied his or her rights under the FMLA, a claim can be filed in federal court.

Is a lawyer needed to pursue these claims?

The DCR routinely handles claims from individuals who do not have attorneys, and the staff is accustomed to handling these claims. Also, an individual without a lawyer, known as *pro se*, can file claims in both state and federal court. However, an individual is generally better off in court with representation by a lawyer.

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**Nancy Oxfeld, Esq., Valerie A. Powers, Esq.
and Steven Weinstein, Esq.
(Prior Editions)**

Zoning

Have local zoning ordinances posed problems for persons with disabilities?

Local zoning ordinances specify what uses are permitted for each piece of land in the municipality and the size and location of any buildings that can be constructed. Local zoning ordinances can pose a problem if they prohibit physical modifications to housing that persons with disabilities need to live in the community, or if they prohibit or restrict the operation of community residences for persons with disabilities.

Do the civil rights laws give persons with disabilities the right to make physical modifications to housing that are prohibited by local zoning ordinances?

The federal Fair Housing Amendments Act (FHAA), 42 U.S.C. § 3601 *et seq.*, and the New Jersey Law Against Discrimination (NJLAD), N.J.S.A. 10:5-4.1, prohibit discrimination in housing on the basis of disability. These laws apply to municipalities as well as to private persons. 42 U.S.C. § 3610(g)(2)(c); N.J.S.A. 10:5-12.5. It is unlawful for a municipality to discriminate against persons with disabilities in the administration of its zoning ordinances. *Easter Seal Soc. of New Jersey, Inc. v. North Bergen*, 798 F. Supp. 228 (D.N.J. 1992). Under the FHAA, it is also unlawful discrimination for a municipality to refuse to make reasonable accommodations in its rules or policies that would be necessary to enable a person with a disability to obtain equal housing opportunities. The New Jersey Division on Civil Rights has also issued regulations under the disability discrimination provisions of the NJLAD that prohibit refusal to make reasonable accommodation in rules or policies. N.J.A.C. 13:13.3.4(e).

Where an occupant (or prospective occupant) with a disability seeks to make a physical modification that he or she needs, because of his or her disability, to live in a dwelling, the municipality must amend the zoning ordinance or grant a variance to permit that modification.

For example, if a person with a mobility impairment needs to construct a ramp that would extend closer to the property line than would be permitted by the local zoning ordinance, the municipality must amend the zoning ordinance or must grant a variance to permit construction of that ramp.

How can an individual with a disability enforce the right to reasonable accommodations in local zoning ordinances?

Ordinarily, an individual with a disability makes an application under N.J.S.A. 40:55D-70 (part of the Municipal Land Use Law (“MLUL”)) to a local zoning board of adjustment for a variance from the local zoning ordinance. The application process includes submission of background documentation, plans and drawings showing the proposed modifications, identifies the ordinance provisions from which the applicant seeks a variance, and explains why the requested accommodation is necessary, how it is related to the disability, and why it is reasonable, that is, why it does not cause excessive harm to the neighbors or surroundings or the municipal zoning plan. The applicant must give notice of the application to all of the neighbors within 200 feet of the property. The zoning board of adjustment will then hold a hearing and vote on the application.

The zoning board of adjustment is permitted to deny the variance only if it finds, as a matter of fact, that the variance is not necessary or is unreasonable. The mere fact that the municipality has never granted such a variance before, that the property will look different from nearby properties, that the requested variance is not itself directly related to the disability, or that the variance will have some impact on the neighbors unrelated to health or safety, are not sufficient grounds to deny the variance. A decision by the zoning board of adjustment to deny a variance can be appealed to the Law Division of Superior

Court or can be challenged in a lawsuit commenced in federal court.

Applying for a variance to obtain reasonable accommodations ordinarily requires the assistance of a builder, planner, architect, or civil engineer, and may also require the assistance of an attorney.

What are community residences?

The term community residence refers generally to specialized housing that enables persons with mental or physical disabilities to live in the community rather than in an institution. Community residences provide food, shelter, and personal guidance under supervision, as needed, for persons with mental or developmental disabilities. They include group homes, halfway houses, supervised apartments, family care homes, hostels, and other similar facilities. N.J.S.A. 30:11B-2, N.J.A.C. 10:44A-1.3, 10:39-1.2. Some forms of community residences are licensed and regulated by the state; others are not.

Can municipal zoning ordinances restrict or bar community residences?

No. The Fair Housing Amendments Act (FHAA) and New Jersey's Law Against Discrimination (NJLAD) prohibit discrimination by municipalities on the basis of disability. This includes ordinances and policies that intentionally treat housing for persons with disabilities differently and less favorably than other housing. For example, municipal ordinances may not establish quotas on the number of community residences in the municipality, and may not mandate that community residences be separated by a minimum distance from other community residences, or from schools or daycare centers. Similarly, the FHAA and NJLAD prohibit ordinances that require community residences for persons with disabilities to go through a local approval process that is more burdensome than what is required for other housing. *AAMH v. Elizabeth*, 876 F. Supp. 614 (D.N.J. 1994); *ARC of New Jersey v. New Jersey*, 950 F. Supp. 637 (D.N.J. 1996).

The FHAA and NJLAD also prohibit ordinances that,

even though facially neutral and not specifically intended to restrict housing for persons with disabilities, have the practical effect of placing greater restrictions on housing for persons with disabilities than housing for persons without disabilities. For example, ordinances that set a numerical limit on the number of unrelated persons who can live in a single-family house are prohibited. Although such an ordinance may not originally have been aimed at persons with disabilities, it has the practical effect of excluding group homes and other congregate housing that would be occupied by persons with disabilities. *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725 (1995).

In addition, under the FHAA and the regulations of the New Jersey Division on Civil Rights, N.J.A.C. 13:13-3.4(e), it is unlawful discrimination for a municipality to refuse to make reasonable accommodations in rules or policies affecting community residences that would be necessary to enable a person with a disability to obtain equal housing opportunities. *Hovsons v. Brick*, 89 F. 3d 1096 (3d Cir. 1996); *U.S. v. Philadelphia*, 838 F. Supp. 223 (E.D. Pa. 1993), *aff'd*, 30 F. 3d 1488 (3d Cir. 1994).

Are there other limitations on local zoning ordinances concerning community residences?

The MLUL was amended in 1997 to remove the authority from municipalities to impose certain types of zoning regulations on community residences. Municipalities no longer have the authority to place quotas on the total number of persons who can live in licensed community residences in the municipality or to require that licensed community residences be some minimum distance apart. Licensed community residences with up to 15 occupants are now permitted uses in all single-family housing zones. N.J.S.A. 40:55D-66.1 as amended by L.1997, c. 321, § 2. These provisions are limited to certain types of licensed community residences, including those for persons with mental illness, for persons with developmental disabilities, and for persons with head injuries (which also include residences for persons with Alzheimer's disease). N.J.S.A. 40:55D-66.2.

Are there restrictions on the operation of community residences other than local zoning ordinances?

Yes. The state has a complicated system of licensure that covers some but not all types of community residences. Depending on the specific population served by the community residence and the specific form of housing and additional services that are provided, the operator may need to satisfy the standards of, and obtain a license from, the New Jersey Departments of Health, Human Services, or Community Affairs. Some of these standards may themselves violate the Fair Housing Amendments Act. Municipalities may not establish their own separate licensure systems, except for residences classified as rooming houses or boarding houses. N.J.S.A. 40:52-9 *et seq.*

How can the prohibitions on discrimination on the basis of disability in municipal zoning be enforced?

Anyone harmed by discrimination on the basis of disability in municipal zoning ordinances may bring a lawsuit in state or federal court under the Fair Housing Amendments Act or New Jersey's Law Against Discrimination (NJLAD). A victim of discrimination may also complain to the U.S. Department of Housing and Urban Development (HUD). These cases are treated differently from other claims of housing discrimination. HUD refers these cases directly to the United States Department of Justice for investigation and remedial action. A victim of discriminatory municipal zoning may not file a complaint with the New Jersey Division on Civil Rights, which has no jurisdiction over claims that municipal zoning violates the NJLAD. Such claims can only be brought in court. Challenges to the MLUL may be filed in the Superior Court, Law Division.

Kathryn Razin, Esq.

**James W. Drake Jr., Esq., Stephen Eisdorfer, Esq.,
David Lazarus, Esq. and Susan R. Oxford, Esq.
(Prior Editions)**

Appendix: Resources

STATE AGENCIES

New Jersey Commission for the Blind and Visually Impaired

P.O. Box 47017
153 Halsey Street, 6th Floor
Newark, NJ 07101
Telephone: 877-685-8878;
973-648-3333
FAX: 973-648-3389
www.state.nj.us/humanservices/cbvi

New Jersey Council on Developmental Disabilities

P.O. Box 700
Trenton, NJ 08625-0700
Telephone (voice): 800-792-8858;
609-292-3745
TTY: 609-777-3238
FAX: 609-292-7114
www.njcdd.org

Department of Education, Office of Special Education Programs

P.O. Box 500
Trenton, NJ 08625-0500
Telephone: 877-900-6960;
609-292-0147
FAX: 609-984-8422
<http://www.state.nj.us/education/special/>

Division on Civil Rights

P.O. Box 090
Trenton, NJ 08625-0090
Telephone: 609-292-4605
TTY: 609-292-1785
FAX: 609-984-3812
www.nj.gov/oag/dcr/index.html

Division of the Deaf and Hard of Hearing

P.O. Box 074
Trenton, NJ 08625-0074
Telephone (Voice/TTY): 800-792-8339
FAX: 609-588-2528
www.state.nj.us/humanservices/ddh/home/index.html

Division of Developmental Disabilities

P.O. Box 726
Trenton, NJ 08625-0726
Telephone: 800-832-9173;
609-631-2200
FAX: 609-631-2217
www.state.nj.us/humanservices/ddd/home/index.html

Division of Disability Services

P.O. Box 705
Trenton, NJ 08625-0705
Telephone: 888-285-3036
TTY: 609-631-4366
FAX: 609-631-4365
www.state.nj.us/humanservices/dds

Division of Mental Health and Addiction Services

P.O. Box 727
Trenton, NJ 08625-0727
Telephone: 800-382-6717;
609-777-0702
FAX: 609-341-2302
www.state.nj.us/humanservices/divisions/dmhas/

Division of Vocational Rehabilitation Services

P.O. Box 398
Trenton, NJ 08625-0398
Telephone (voice): 609-292-5987
TTY: 609-292-2919
FAX: 609-292-8347
www.wnjp.in.state.nj.us

Governor's Council on Alcoholism and Substance Abuse

P.O. Box 345
Trenton, NJ 08625
Telephone: 609-777-0526
FAX: 609-777-0535
www.state.nj.us/treasury/gcada

FEDERAL AGENCIES

Department of Justice

Telephone (voice): 800-514-0301
TTY: 800-514-0383
www.ada.gov

Equal Employment Opportunity Commission

Telephone: 800-669-4000
TTY: 800-669-6820
www.eeoc.gov

Federal Communications Commission

Telephone (voice): 888-225-5322
TTY: 888-835-5322
www.fcc.gov/encyclopedia/telecommunications-relayservices-trs

Architectural and Transportation Barriers Compliance Board

Telephone (voice): 800-872-2253
TTY: 800-993-2822
www.access-board.gov

Department of Education, Office of Special Education and Rehabilitative Services

Telephone: 800-872-5327;
202-401-2000
www2.ed.gov/about/offices/list/oser/index.html

**Housing and Urban Development
Fair Housing Office**

Telephone: 800-496-4294:
212-542-7519

TTY: 212-264-0927

www.hud.gov/offices/fheo/aboutfheo/fhhubs.cfm

**DISABILITY-SPECIFIC
RESOURCES**

AIDS/HIV

Hyacinth AIDS Foundation

317 George Street, Suite 203
New Brunswick, NJ 08901

Telephone: 800-433-0254:
732-246-0204

FAX: 732-246-4137
www.hyacinth.org

**New Jersey Women
and AIDS Network**

4 North Broad Street, 4th Floor
Trenton, NJ 08608

Telephone: 800-747-1108:
609-695-1200

FAX: 609-695-1201
www.njwan.org

ALZHEIMER'S DISEASE

**Alzheimer's Association, Greater
New Jersey Chapter**

400 Morris Avenue, Suite 251
Denville, NJ 07834

Telephone: 800-272-3900:
973-586-4300

www.ALZ.org

**AMYOTROPHIC LATERAL
SCLEROSIS (ALS)**

**Neuromuscular and ALS Center
of Robert Wood Johnson
University Hospital**

125 Paterson Street, Suite 6100
New Brunswick, NJ 08901

Telephone: 732-235-7331

<http://web.rwjms.rutgers.edu/nmalsweb/>

ARTHRITIS/FIBROMYALGIA

**Arthritis Foundation—
New Jersey Chapter**

555 Route 1 South, Suite 320
Iselin, NJ 08830

Telephone: 888-467-3112:
732-283-4300

FAX: 732-283-4633
www.arthritis.org/new-jersey

AUTISM/ASPERGERS/ASD

**Asperger Syndrome Education
Network (ASPEN-)**

9 Aspen Circle

Edison, NJ 08820

Telephone: 732-321-0880

FAX: 732-744-1622

www.aspennj.org

**Autism Family Services
of New Jersey**

1 AAA Drive, Suite 203

Trenton, NJ 08691

Telephone: 877-237-4477

FAX: 609-392-5621

www.autismfamilyservicesnj.org

Autism New Jersey

500 Horizon Drive, Suite 530

Robbinsville, NJ 08691

Telephone: 800-4-AUTISM:
609-588-8200

FAX: 609-588-8858

www.autismnj.org

Parents of Autistic Children (POAC)

1989 Route 88 East

Brick, NJ 08724

Telephone: 732-785-1099

FAX: 732-785-1003

www.poac.net

BLINDNESS/VISUAL IMPAIRMENTS

**Friends of the New Jersey Library
for the Blind and Handicapped**

P.O. Box 434

Woodbridge NJ 07095-0434

Telephone: 609-895-1048

www.friendsnjlibraryfortheblind.org

National Federation of the Blind-NJ

254 Spruce Street

Bloomfield, NJ 07003

Telephone: 973-743-0075

www.nfbnj.org

**National Federation of the Blind,
Parents of Blind Children-NJ**

23 Alexander Ave.

Madison, NJ 07940

Telephone: 973-377-0976

www.blindchildren.org

New Jersey Council of the Blind

153 Franklin Corner Road

Lawrenceville, NJ 08648-2501

Telephone: 609-895-1048

FAX: 609-882-5416

www.njcounciloftheblind.org

**New Jersey Foundation
for the Blind**

230 Diamond Spring Road, Suite 100
Denville, NJ 07834
Telephone: 973-627-0055
FAX: 973-627-1622
www.njffb.org

CANCER

American Cancer Society—NJ

2600 US Highway 1
North Brunswick, NJ 08908
Telephone: 800-227-2345:
732-297-8000
FAX: 732-297-9043
www.cancer.org

CARDIAC/HEART DISEASE

American Heart Association

1 Union Street, Suite 301
Robbinsville, NJ 08691
Telephone: 800-242-8721:
609-208-0020
FAX: 609-208-2906
www.heart.org

CEREBRAL PALSY

Cerebral Palsy League

61 Myrtle St./75 Rod Smith Place
Cranford, NJ 07016
Telephone: 908-709-1800
www.thecplinc.org
Cerebral Palsy of North Jersey
220 South Orange Ave., Suite 300
Livingston, NJ 07039
Telephone: 973-763-9900 ext. 1100
FAX: 973-763-9905
www.cpnj.org

Ladacin Network

(Formerly Cerebral Palsy of
Monmouth and Ocean Counties)
1703 Kneeley Blvd.
Wanamassa, NJ 07712
Telephone: 732-493-5900
FAX: 732-493-5980
www.ladacin.org

CHRONIC FATIGUE SYNDROME

**New Jersey Chronic Fatigue
Syndrome Association, Inc.**

P.O. Box 477
Florham Park, NJ 07932
Help Desk: helpdesk@njcfsa.org
www.njcfsa.org

**COGNITIVE/INTELLECTUAL
DISABILITIES**

The ARC of New Jersey

985 Livingston Avenue
North Brunswick, NJ 08902
Telephone: 732-246-2525
FAX: 732-214-1834
www.arcnj.org

CROHN'S DISEASE

**Crohn's and Colitis Foundation of
America, New Jersey Chapter**

45 Wilson Avenue
Manalapan, NJ 07726
Telephone: 732-786-9960
FAX: 732-786-9964
www.ccfa.org

CROSS-DISABILITY

Advancing Opportunities

1005 Whitehead Road Extension,
Suite 1
Ewing, NJ 08638
Telephone (888-322-1918:
609-882-4182
TTY: 609-882-0620
FAX: 609-882-4054
www.advopps.org

**Alliance for the Betterment of
Citizens with Disabilities (ABCD-**

127 Route 206, Suite 18
Hamilton, NJ 08610
Telephone: 609-581-8375
FAX: 609-581-8512
www.abcdnj.org

Community Access Unlimited

80 West Grand Street
Elizabeth, NJ 07202
Telephone: 908-354-3040
TTY: 908-354-4629
FAX: 908-354-2665
www.caunj.org

Community Options, Inc.

16 Farber Road
Princeton, NJ 08540
Telephone: 609-951-9900
FAX: 609-951-9112
www.comop.org

Easter Seals New Jersey

25 Kennedy Boulevard, Suite 600
East Brunswick, NJ 08816
Telephone: 732-257-6662
FAX: 732-257-7373
www.easterseals.com/nj

Spectrum for Living

210 Rivervale Road, Suite 3
River Vale, NJ 07675
Telephone: 866-367-7732:
201-358-8000
FAX: 201-358-8089
www.spectrumforliving.org

CYSTIC FIBROSIS

Cystic Fibrosis Foundation, Greater New Jersey Chapter

1719 Route 10, Suite 229
Parsippany, NJ 07054
Telephone: 800-344-4823;
973-656-9200
www.cff.org

DEAFNESS/HEARING IMPAIRMENTS

Hearing Loss Association of America, New Jersey State Association

Telephone: 609-655-0090
www.hearingloss-nj.org

Association of Late-Deafened Adults—Garden State

www.alda-gs.org

New Jersey Association of the Deaf, Inc.

www.deafnjad.org

DEVELOPMENTAL DISABILITIES

The Boggs Center on Developmental Disabilities

Department of Pediatrics
Rutgers Robert Wood Johnson
Medical School
Library Plaza
335 George Street, 3rd Floor
P.O. Box 2688
New Brunswick, NJ 08903-2688
Telephone: 732-235-9300
FAX: 732-235-9330
www.rwjms.rutgers.edu/boggscenter

DIABETES

American Diabetes Association, New Jersey Chapter

Center Pointe II, Suite 103
1160 U.S. 22
Bridgewater, NJ 08807
Telephone: 888-DIABETES (342-2383);
732-469-7979
FAX: 908-722-4887
www.diabetes.org

DOWN SYNDROME

Bringing Up Down Syndrome (BUDS)

504 Centennial Boulevard, #1444
Voorhees, NJ 08043
Telephone: 856-985-5885
www.bringingupdownsyndrome.org

Down Syndrome Association of Central New Jersey

180 Ewingville Road
Ewing, NJ 08638
Telephone: 866-DOWN SYN:
866-369-6796
www.dsacnj.org

Down Syndrome Group of Northwest New Jersey

P.O. Box 212
Washington, NJ 07882
Telephone: 908-689-7525, Ext. 320
www.dsgnwnj.org/default.htm

Knowledge and Information About Individuals with Down Syndrome

www.kiids.info

DWARFISM

Little People of America

Telephone: 888-LPA-2001

www.lpadistrict2.org

EATING DISORDERS

Food Addicts Anonymous

Telephone: 732-244-4324
www.foodaddictsanonymous.org

EPILEPSY

Epilepsy Foundation of New Jersey

1 AAA Drive, Suite 203
Trenton, NJ 08691
Telephone: 800-336-5843;
609-392-4900
FAX: 609-392-5621
www.efnj.com

HEAD INJURY/TRAUMATIC BRAIN INJURY (TBI)

Brain Injury Alliance of New Jersey

825 Georges Road, Second Floor
North Brunswick, NJ 08902
Telephone: 800-669-4323;
732-745-0200
FAX: 732-745-0211
www.bianj.org

HUNTINGTON'S DISEASE

Huntington's Disease Society of America

P.O. Box 2103
Clifton, NJ 07015
Telephone: 888-HDSA-506
www.hdsanj.org

LEARNING DISABILITIES

International Dyslexia Association, New Jersey Branch

P.O. Box 32
Long Valley, NJ 07853
Telephone: 908-876-1179
www.njida.org

Learning Disabilities Association of America, New Jersey Chapter

P.O. Box 6282
East Brunswick, NJ 08816
Telephone: 732-645-2738
www.ldanj.org

LUPUS

Lupus Foundation of America, New Jersey Chapter

P.O. Box 1184
150 Morris Avenue, Suite 102
Springfield, NJ 07081
Telephone: 800-322-5816;
973-379-3226
FAX: 973-379-1053
www.lupusnj.org

MENTAL ILLNESS

Mental Health Association of New Jersey

88 Pompton Avenue
Verona, NJ 07044
Telephone: 800-367-8850;
973-571-4100
FAX: 973-857-1777
www.mhanj.org

New Jersey Disaster Mental Health Helpline Telephone: 877-294-HELP (4357)

TTY: 877-294-4356
www.mhanj.org/nj-disaster-mental-health-helpline

National Alliance on Mental Illness of New Jersey

1562 Route 130
North Brunswick, NJ 08902
Telephone: 732-940-0991
FAX: 732-940-0355
www.naminj.org

New Jersey Mental Health Cares

Telephone: 866-202-HELP (4357)
TTY: 877-294-HELP (4356)
www.njmentalhealthcares.org

MULTIPLE SCLEROSIS

Multiple Sclerosis Association of America

706 Haddonfield Road
Cherry Hill, NJ 08002
Telephone: 800-532-7667;
856-488-4500
FAX: 856-661-9797
www.mymsaa.org

National Multiple Sclerosis Society, New Jersey Metro Chapter

Aspen Corporate Park 1
1480 U.S. Highway 9 North, Suite 301
Woodbridge, NJ 07095
Telephone: 800-344-4867;
732-660-1005
FAX: 732-855-6984
www.nationalmssociety.org/Chapters/NJM

MUSCULAR DYSTROPHY

Muscular Dystrophy Association

25 East Spring Valley Avenue
Suite 210
Maywood, NJ 07607
Telephone: 800-572-1717;
201-843-4452
FAX: 201-843-2324
www.mda.org

PARKINSON'S DISEASE

American Parkinson Disease Association—New Jersey Chapter

P.O. Box 910
New Brunswick, NJ 08901
Telephone: 732-745-7520
FAX: 732-745-3114
www.njapda.org

POLIO

Polio Network of New Jersey

P.O. Box 537
Martinsville, NJ 08836
Telephone: 201-845-6860
FAX: 908-236-9388
www.njpolio.org

RESPIRATORY DISEASE

American Lung Association, New Jersey Chapter

1031 Route 22, Suite 203
Bridgewater, NJ 08807
Telephone: 908-685-8040
FAX: 908-685-8030
www.lung.org/associations/charters/mid-atlantic

SCLERODERMA

Scleroderma Foundation, Delaware Valley Chapter

385 Kings Highway North
Cherry Hill, NJ 08034
Telephone: 866-675-5545;
856-779-7225
www.scleroderma.org

SENSORY IMPAIRMENTS

Everas Community Services

(Formerly The New Jersey Association of the Deaf-Blind, Inc.)
24-K World's Fair Drive
Somerset, NJ 08873-1349
Telephone (Voice/TTY): 732-805-1912
FAX: 732-805-3088
www.everas.org

New Jersey Speech-Language-Hearing Association

174 Nassau Street, Suite 337
Princeton, NJ 08542
Telephone: 888-906-5742
FAX: 888-729-3489
www.njsha.org

SPINA BIFIDA

Spina Bifida Resource Network

(Formerly Spina Bifida Association-84 Park Avenue, Suite G-106
Flemington, NJ 08822
Telephone: 908-782-7475
FAX: 908-782-6102
www.thesbrn.org

SPINAL CORD INJURY

Central Jersey Spinal Cord Association

19 Jefferson Avenue
New Brunswick, NJ 08903
Telephone: 732-220-0870
www.cjsca.net.

Christopher & Dana Reeve Paralysis Resource Center

636 Morris Turnpike, Suite 3A
Short Hills, NJ 07078
Telephone: 800-539-7309
FAX: 973-467-9845
www.christopherreeve.org

STROKE

New Jersey Stroke Activity Center, Inc.

725 Joralemon Street, Suite 191
Belleville, NJ 07109
Telephone: 973-450-4114
FAX: 973-450-0805
www.njsac.org

TOURETTE SYNDROME

New Jersey Center for Tourette Syndrome

50 Division Street, Suite 205
Somerville, NJ 08876
Telephone: 908-575-7350
FAX: 908-575-8699
www.njcts.org

Tourette Syndrome Association of New Jersey, Inc.

P.O. Box 116
Somerville, NJ 08876
Telephone: 732-972-4459
FAX: 908-575-8699
www.tsanj.org

ADVOCACY RESOURCES

ADVOCACY—ASSISTIVE TECHNOLOGY

Richard West Assistive Technology Advocacy Center (ATAC) Disability Rights New Jersey

210 S. Broad Street, 3rd Floor
Trenton, NJ 08608
Telephone: 800-922-7233;
609-292-9742
TTY: 609-633-7106
FAX: 609-777-0187
www.drnj.org/atac

ADVOCACY—GENERAL

Advocates for Children of New Jersey (ACNJ)

35 Halsey Street, 2nd Floor
Newark, NJ 07102
Telephone: 973-643-3876
FAX: 973-643-9153
www.acnj.org

Association for Special Children and Families

P.O. Box 494
Hewitt, NJ 07421
Telephone: 973-728-8744
FAX: 973-728-5919
Help Line: 973-728-0999
www.ascfamily.org

New Jersey Self-Advocacy Project

985 Livingston Avenue
North Brunswick, NJ 08902
Telephone: 732-246-2525, x22
FAX: 732-214-1834
www.arcnj.org

Statewide Parent Advocacy Network (SPAN)

35 Halsey Street, 4th Floor
Newark, NJ 07102
Telephone: 800-654-7726;
973-642-8100
FAX: 973-642-8080
www.spannj.org

ADVOCACY—FAMILY SUPPORT

Family Support Center of New Jersey

35 Beaverson Boulevard, Building 11
Brick, NJ 08723
Telephone: 732-262-8020
FAX: 732-262-4373
www.fscnj.org

Family Resource Network

1 AAA Drive, Suite 203
Trenton, NJ 08691
Telephone: 800-336-5843;
609-392-4900
FAX: 609-392-5621
www.familyresourcenetwork.org

ADVOCACY—FUTURE PLANNING

**Planned Lifetime Assistance
Network of New Jersey (PLAN/NJ)**

P.O. Box 547
Somerville, NJ 08876-0547
Telephone: 908-575-8300
FAX: 908-927-9010
www.plannj.org

ADVOCACY—LEGAL

**American Civil Liberties Union of
New Jersey (ACLU-NJ)**

P.O. Box 32159
Newark, NJ 07102
Telephone: 973-642-2084
www.aclu-nj.org

**Community Health Law Project
(CHLP-**

185 Valley Street
South Orange, NJ 07079
Telephone: 973-275-1175
TTY: 973-275-1721
FAX: 973-275-5210
www.chlp.org

Community Justice Center

310 West State Street, 3rd Floor
Trenton, NJ 08618
Telephone: 609-218-5120
FAX: 609-218-5126
www.nj-communityjusticecenter.org

Disability Rights New Jersey

(Formerly New Jersey Protection
and Advocacy, Inc.)
210 South Broad Street, 3rd Floor
Trenton, NJ 08608
Telephone: 800-922-7233;
609-292-9742
TTY: 609-633-7106
FAX: 609-777-0187
www.drnj.org

Education Law Center

60 Park Place, Suite 300
Newark, NJ 07102
Telephone: 973-624-1815
TTY: 973-624-4618
FAX: 973-624-7339
www.edlawcenter.org

Legal Services of New Jersey

100 Metroplex Drive, Suite 402
P.O. Box 1357
Edison, NJ 08818
Telephone: 888-576-5529;
732-572-9100
www.lsnjlaw.org

About the Essex County Bar Association

The Essex County Bar Association is the professional association of the Essex County Bar founded in 1899. With 3,000 members, it is the largest county bar in New Jersey, and it is also the most diverse. Since its inception, the ECBA has enthusiastically implemented programs and aggressively embraced positions to meet the needs and concerns of the Essex County legal community and the community-at-large.

About the New Jersey State Bar Foundation

The New Jersey State Bar Foundation, founded in 1958, is the educational and philanthropic arm of the New Jersey State Bar Association. The Foundation is committed to providing free legal education programming for the public. Programs provided by the Foundation include seminars on disability law and health issues; mock trial programs for students in grades K to 12; and training sessions for teachers on the topics of conflict resolution, peer mediation and bullying prevention. In addition, the Foundation produces a legal newspaper for kids, *The Legal Eagle*, and a tolerance and diversity newsletter, *Respect*. Both are published three times a year. The Foundation also offers many publications including *Law Points for Senior Citizens (Third Edition)*, *Consumer's Guide to New Jersey Law*, *Legal Consequences of Substance Abuse*, *AIDS and the Law in New Jersey (Second Edition)*, *Domestic Violence: The Law and You (Third Edition)*, *Students' Rights Handbook*, cosponsored with ACLU-NJ, and *Residential Construction and Renovation: A Legal Guide for New Jersey Homeowners (Second Edition)*. Some publications are available in Spanish and all are available in alternative formats for persons with visual impairments. For more information or copies of program materials, visit the New Jersey State Bar Foundation online at njsbf.org, or call 1-800-FREE LAW.



New Jersey State Bar Foundation
One Constitution Square
New Brunswick, NJ 08901-1520
www.njsbf.org • 1-800 FREE LAW