



# DISABILITY LAW

## A LEGAL PRIMER

SEVENTH EDITION

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The information in *Disability Law: A Legal Primer (Seventh Edition)* 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 June 2024.

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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 active.

## **Who is protected by the ADA?**

To be covered under the Americans with Disabilities Act a person must have a disability themselves or have a relationship or association with someone who does. An individual with a disability is a person who has a physical or mental impairment that makes it difficult to do important everyday tasks. It can also include someone who used to have such an impairment or someone who others think has one. In response to the U.S. Supreme Court's decisions limiting who was protected by the ADA, Congress changed the law in 2008 to include more people with disabilities and give them stronger protections. According to the changes in the law, the effect of a person's impairment is considered while in an active state, or without any treatment. As a result, even if a person's impairment comes and goes or is manageable with help, they are still protected. The ADA does not list all included impairments.

## **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 when providing their services. When buying new vehicles, the ADA requirements for accessibility must be followed. Additionally, 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 making changes to main areas, accessible routes must be provided if the costs of doing so are not disproportionate compared to the overall changes being made. (This issue is discussed further in the Transportation Barriers 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 or at risk of institutionalization?**

In *Olmstead v. L.C.*, 526 U.S. 1037 (1999), the U.S. 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. See [eeoc.gov/field-office](http://eeoc.gov/field-office) for a list. 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.

# Architectural Barriers

## **What are architectural barriers?**

Architectural barriers are physical barriers in buildings, parks, transportation services or elsewhere that make access for 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 main 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 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. According to the Internal Revenue Code, 26 U.S.C. § 190, businesses can fully deduct the costs of removing barriers like steps, narrow doorways, and inaccessible parking spaces. They can deduct up to \$15,000 per year for these changes. However, comprehensive renovations or normal replacement of property that normally wears out 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 expenses made after November 5, 1990, to comply with the ADA. This credit covers things like 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,” which gives eligible small businesses 50% of the expenses for access changes between \$250 and \$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 places that anyone can use, even if built or owned by a private person, or company. 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.

The New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 et seq., also requires places of public accommodation to be made accessible to people with disabilities or to other-

wise make reasonable accommodations to ensure access to their goods and services.

### **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 architectural barrier codes.

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

Sometimes, when these buildings are remodeled, the law requires that they be accessible to everyone. 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 overseeing New Jersey's Fair Housing Act, made new rules. One of these rules, called N.J.A.C. 5:94-4.21(a), requires that 10% of all affordable townhouse units proposed in a town's fair share plan must be accessible to persons with disabilities.

### **Which laws affect accessibility of voting places?**

The Americans with Disabilities Act ensures that voting places are accessible 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 make sure 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 are no accessible alternative available. 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 to vote due to a disability or the U.S. attorney general may take legal action in the appropriate federal district court regarding inaccessible polling places.

# 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 themselves, others, or property; appropriate services for them 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 having serious problems with thinking, mood, perception, or understanding that greatly affect your ability to make good decisions, control your behavior, or see reality clearly. Mental illness does not include simple alcohol intoxication, a temporary reaction to drugs, organic brain syndrome, or having a developmental disability unless it's severe enough to cause the impairments described 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 due to a mental illness, a person has either threatened or attempted suicide, harmed themselves, or behaved in a way that shows they can't take care of themselves properly. This behavior indicates that they might seriously injure themselves or die soon. However, if the person can get help from others to meet their basic needs like food, medical care, or shelter, they might not be considered “dangerous to self.” In 2009, the law was updated to consider a person's history, recent behavior and any recent act, threat or serious psychiatric decline. N.J.S.A. 30:4-27.2(h).

## **What does “dangerous to others or property” mean?**

“Dangerous to others or property” means that because of a mental illness there is a strong chance the person will seriously hurt someone else or cause serious property damage within the reasonably foreseeable future. This determination should consider a person's history, recent behavior and any

recent act, threat or serious psychiatric decline. 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 serious disturbance in how a child thinks, feels, perceives things, or understands reality, which is different from what is typical for their age group, and significantly impairs their judgment, behavior, or capacity to recognize reality when compared with children of a similar developmental stage. The adult definitions of dangerousness described above also apply to minors. The difference is 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 is likely to get worse quickly; 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 the patient wants?**

No. If a patient has voluntarily admitted themselves to a hospital, they have the right to ask to leave whenever they

want. However, the hospital may hold the patient for a short time to make sure the discharge goes smoothly 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 held at a screening center for up to 24 hours for evaluation. Following recent legal updates, a psychiatric hospital, general hospital, or emergency department can now submit an urgent application to the court. This application allows for a temporary court order extending the involuntary hold for up to 144 hours while court proceedings for involuntary commitment are being initiated. N.J.S.A. 30:4-27.5(a), -27.9(c), and -27.9(a).

### **What is a screening center?**

A screening center is an 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. A list of designated screening services in New Jersey can be found on the New Jersey Department of Human Services' website. Here is a link to a PDF of the document: [nj.gov/humanservices/dmhas/home/hotlines/MH\\_Screening\\_Centers.pdf](http://nj.gov/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf)

The New Jersey Department of Human Services can also be reached at 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 officer may take an individual to a screening center if there is reasonable cause to believe that the person needs 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 needs involuntary commitment, they 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 changed its commitment laws to include 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 must decide 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 request a court order to transfer an individual from an inpatient setting to an outpatient setting. A court can grant an order authorizing the change from involuntary commitment of the patient from inpatient to outpatient treatment if it finds, by clear and convincing evidence that the patient needs 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 started through a screening center, a psychiatric hospital can begin court proceedings for involuntary commitment by submitting clinical certificates completed by two psychiatrists. If a court determines that there is enough reason 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, by clear and convincing evidence, that a person needs involuntary commitment and would present a danger to self, others or property. If this cannot be shown, the patient must be discharged within 48 hours of the court's decision being announced, or by the end of the next working day (whichever is longer). If the court finds the person needs involuntary commitment, periodic review hearings will be scheduled to determine if the person still needs it. 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 receiving mental health assessment or treatment does not deprive a patient of any legal or civil rights. 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. Freedom from unnecessary or excessive medication;
2. Freedom from unnecessary physical restraint, seclusion and punishment;
3. Privacy and dignity;
4. Confinement in the least restrictive conditions necessary to achieve the purposes of treatment;
5. Visitation rights and reasonable access to telephone and writing materials;
6. Opportunities for regular physical exercise and time outdoors;
7. Prompt and adequate medical care for physical health needs; and,
8. Freedom to practice or abstain from religious belief.

However, some of these rights can be denied if the treating psychiatrist believes it is necessary. In such cases, the patient and their attorney receive a written explanation for the denial of these rights. N.J.S.A. 30:4-24.2, -27.11d, and -27.11e.

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

If a patient believes their rights may have been violated during admission to, or treatment at a psychiatric hospital, or if they have questions about their rights, they should contact:

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

# Developmental Disabilities Services for Adults

## What is DDD?

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

## Who is eligible for DDD Services?

DDD decides who qualifies for their services through an application process. The application can be completed by the individual's parent, guardian, or the individual themselves. To receive DDD services, an individual must be at least 21 years old, Medicaid eligible, and meet specific functional criteria. This includes having a severe, chronic physical and/or mental impairment that:

1. manifests itself before age 22;
2. is likely to continue indefinitely;
3. and, as a result of the impairment, the individual shows serious 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
  - f. capacity for independent living
  - g. economic self-sufficiency

## What if DDD finds someone ineligible?

If DDD determines that a person is ineligible for their services, there is an appeal process to challenge the decision. The individual can also re-apply at any time if they have new information for DDD to review.

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

When applying to DDD services, 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," it is important to compare their abilities honestly with those of a person who does not have a disability. 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, funded through a Medicaid waiver, provides non-residential habilitation services for individuals with developmental disabilities. All adults eligible for DDD services receiving non-residential support will be placed on the Comprehensive Medicaid Waiver (CMW) and receive needs-based budgets to utilize for support services. The Supports Program funds Employment/Day Services and Family Support Services. Clients not on the Community Care Program (CCP), which is discussed below, will have two separate need-based budgets in the Supports Program—one for Employment/Day Services and another for Individual and Family Supports. The Employment/Day Service budget will be evaluated similarly to the current Self-Directed Day

Program. The Individual and Family Support budget will be assessed at one of three levels up to \$5,000, \$10,000, and \$15,000, depending on the individual's needs.

### **How are residential and intensive in-home supports funded?**

The CCP is the funding source for DDD residential and intensive in-home supports. Compared to the Supports Program, the CCP offers higher funding levels that can be used for residential placements or more robust in-home services.

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

There is currently a long waiting list for the CCP. To be placed on the waiting list, individuals who are over 21 years of age and eligible to receive services from DDD whose parents are both aged 55 or over can be placed on the priority waiting list. In addition, if there is a crisis in the home that DDD deems sufficient, they may place the individual on the priority waiting list before both parents reach age 55. Under certain circumstances, such as when a person is at risk of "imminent harm or homelessness," they may be able to bypass the list and be placed directly on the CCP 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 CCP or the Supports Program in order to receive ANY services from DDD. If, at any time, an individual receiving DDD services becomes ineligible for Medicaid, they 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 under their care to the Children's System of Care (CSOC), which is a part of the Department of Children and Families (DCF). Children placed on the CCW before January 1, 2013,

however, remained with DDD. All services for children, those with developmental and 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 designed to assist individuals in finding and adjusting to a job, with the goal of eventually reducing their involvement as they become more independent at work. For more intensive job coaching services, individuals typically turn to DDD. However, due to an interagency agreement between DVRS and DDD, individuals may access both agencies for support.

# Education: Early Intervention Services

Early Intervention Services are available to children ages zero through three years of age to address any delay in a young child's development as early as possible.

## 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 are 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, day-care 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 and an initial individualized family service plan (IFSP) meeting will be held. The multidisciplinary 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. Services can be provided at the child's home, childcare, a center or hospital. The location for services is to be designated in the IFSP.

## 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 350% of the federal poverty level. Families who are at or above 350% of the federal poverty 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 their 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. Appeals must be submitted in writing to the Early Intervention Procedural Safeguards Office at P.O. Box 364, Trenton, NJ 08625-0364. The Procedural Safeguards Office shall review appeals of terminations and make a decision within 30 calendar days of the date of receipt of the appeal. A family will receive a written determination and copies will be provided to all relevant parties.

**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 90 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.

# 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 the individual: (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.

To receive services under Section 504, the student would need a 504 Plan in place. A parent or a school staff member can make the referral. A variety of sources can be considered

when determining eligibility for a 504 Plan. Sources can be formal, like an evaluation by a professional, or informal, like examples of the student's work. If the student is denied a 504 Plan, the student may file for due process to have a hearing in front of an administrative law judge.

## **Which children are entitled to special education services?**

Every child in New Jersey from their 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 (LRE). 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.

Special education is available to children who require services as a result of cognitive impairment, hearing impairments, speech or language impairments, visual impairments, emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning 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?**

Under Child Find, each school district has an affirmative obligation 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 evaluations that the school district conducts.

### **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. The most common evaluations are a psychological and learning evaluation. However, parents can

also request additional testing, such as: speech/language, audiological, neurological, psychiatric, functional behavioral assessment, 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. This entire process must be completed within 90 calendar days after receiving parental consent to evaluate.

After determining that a student is eligible for special education services and implementing an IEP, a school district must conduct a multi-disciplinary reevaluation once every three years to redetermine eligibility for special education services. The student's parent and school district can agree to waive those reevaluations if they both agree they are not necessary. Alternatively, as long as it has been longer than a year since the last set of evaluations were conducted, reevaluations can be requested if conditions warrant it.

If a parent has concerns with an evaluation that was conducted, they may request an independent evaluation at no cost to the parent, which is explained in more detail later in this section.

### **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.

### **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 calendar days to review, request changes, and object in writing to any provisions of the IEP. To properly object in writing and prevent the IEP from going into effect, the parents must file for mediation or due process within 15 calendar days of the IEP being proposed. 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. An IEP meeting can be held in the summertime since the Child Study Team works year-round.

### **What types of programs are available?**

Many options are available, depending upon the nature and severity of the child's disability and 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.

### **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 are transition services?**

Students with disabilities are entitled to a coordinated set of activities that are focused on improving the academic and functional achievement of the student with a disability to facilitate the student's movement from school to post-school activities, such as, employment, independent living, or post-secondary education. Beginning the school year the student turns age 16, the IEP should have a transition statement in the IEP outlining the goals. Transition services could include instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, if appropriate, acquisition of daily living skills.

### **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 and, without delay, shall provide a comparable program. The district shall take reasonable steps to obtain the student's

records, including the current IEP and supporting documentation from the previous district. 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).

**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 independent evaluation must be reviewed by the local CST but does not have to be accepted. A parent or adult student should submit the request for an independent evaluation in writing to the CST director. A school district must take steps to provide that independent evaluation without delay, or the district must file for due process no later than 20 calendar days after receipt of the request for the independent evaluation in order to reject the request.

**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. The Department of Education has a form on their website that can be used as the written request for the due process hearing.

After filing the request, the school district may hold a resolution session with the parent/adult student to try to resolve

the issues, or mediation may be requested, as discussed above. If the matter cannot be resolved, it will be transmitted to the OAL for a hearing. The parties will be asked to state what evidence and what witnesses they intend to produce at the hearing. The ALJ has 45 days after the resolution period to issue a final decision. Requests to adjourn the due process hearing must be made in writing on the OAL's Extension/Adjournment Form to make sure that the case does not take too long to resolve.

**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.

If a proposed IEP has a significant change to the student's programing and/or placement, the student may be entitled to "stay put" if the IEP was not signed and the parent filed for due process in a timely manner. Stay put can be requested via emergency relief.

**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 after the resolution period has expired, 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.

# 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. Requests for an accommodation can take time for approval, so the requests must be made well before the test date. Most schools have an SSD (services for students with disabilities) coordinator

that can assist the student and families with applying for an accommodation. However, students and families can make the request on their own by using the SSD Student Eligibility Form on the College Board's website. A student only has to make the request once to be applied to any of the College Board's 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 ensure that the programs it offers, including extracurricular activities, are accessible to students with disabilities. Post-secondary schools can do this in several ways: by providing architectural access including accessible buildings, facilities, dorm rooms, etc.; 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. Additionally, the Individuals with Disabilities Education Act (IDEA) does not apply to post-secondary programs.

## **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, 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 pol-

icies 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 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.

# Estate Planning

## **Can a person with disabilities have estate planning documents prepared for them?**

All people over 18 who have legal capacity can have estate planning documents prepared. A diagnosis alone does not preclude an individual from being able to execute estate planning documents. Instead, whether an individual has legal capacity to execute estate planning documents is a legal determination made based on the individual. However, a person who has been determined incapacitated in a guardianship proceeding is not able to execute estate planning documents without further court order.

In general, there are three (3) basic estate planning documents that all adults, with capacity, should have:

- 1) Last Will and Testament
- 2) Durable Power of Attorney
- 3) Advance Directive for Healthcare

### **What is a Last Will and Testament?**

A Last Will and Testament, commonly called a “Will,” is a document, executed in accordance with state law, which directs how some or all of an individual’s property is distributed at death. An executor is designated in the Will and it is their responsibility to collect the assets, pay the debts and taxes, and distribute the remaining estate in accordance with the terms of the Will.

### **What is a Durable Power of Attorney?**

A Durable Power of Attorney (POA) is a document in which the creator, commonly called the “Principal,” can appoint an agent to manage their financial affairs. The agent is commonly called an “attorney-in-fact.” The agent can be anyone, a spouse, parent, child over 18, friend, etc. The Principal can appoint multiple people as co-attorneys-in-fact and appoint successor attorneys-in-fact if the first person they pick can no longer serve. Importantly, the POA can be revoked or changed at any time as long as the Principal continues to have the requisite capacity.

A general POA grants the attorney-in-fact broad powers over finances, including the ability to write checks, to move

money between bank accounts, to make investments, to buy or sell the Principal’s house or other real property, to enter into contracts, to file a lawsuit, to apply for government benefits, to create a trust, etc.

A POA is important because it allows the person with disabilities to exercise autonomy in choosing who they wish to help them rather than allowing a court to make this determination for them in a guardianship proceeding.

A POA is only valid while the Principal is alive. When the Principal passes away, the power of attorney ceases. After the Principal passes away, their property would generally be governed under their will.

### **What is an Advance Directive for Healthcare?**

An Advance Directive for Healthcare is a document in which an individual can set forth instructions regarding their medical care (called an instruction directive or living will), and an individual can designate a healthcare representative to make decisions regarding medical care if the individual is unable to make those decisions (called a proxy directive or medical power of attorney).

This document is important because an individual should have a voice in their own medical care. Healthcare choices, and in particular end of life care choices, are some of the most personal decisions we can make in life. This document lets the individual set forth instructions in advance, in case the individual cannot express their wishes or does not have the wherewithal to make decisions. In addition, without this document, others may not be able to get important medical information for the individual due to patient privacy laws.

The Advance Directive should be provided to the individual’s attending physician or other medical institution. The Advance Directive will be used when the attending physician determines the individual lacks the capacity to make medical decisions.

### **What if someone wants to leave an inheritance to a person with disabilities?**

Those who want to provide at their death for a person with disabilities should consider establishing a third-party special

needs trust (sometimes known as a supplemental benefits trust) in their Will. Properly drafted, such a trust not only will allow the trust funds to be managed for the person with disabilities, but also will allow the trust funds to be available to that individual for their supplemental needs. This permits a person with disabilities to remain eligible for government benefits such as Medicaid and Supplemental Security Income (SSI) that are available only to those with limited income and assets. The Will specifies who will receive the trust funds remaining at the death of the person with disabilities—for example, their children or siblings, or one or more charities. Importantly, the individual must ensure that their beneficiary designations are coordinated with their estate plan. For example, instead of designating the person with disabilities as a beneficiary, the individual would list the supplemental benefits trust as the designated beneficiary. It is recommended that an attorney be obtained to draft such a 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 a trust for the benefit of the person with disabilities, the other beneficiaries have absolutely no obligation to use any of those assets to benefit the person with disabilities. Furthermore, the person receiving the funds could die prior to the person with disabilities without making any provision in their Will for the person with disabilities. At that point, the assets would pass to the person's heirs who also are not obligated to use the funds for the person with disabilities. Further, the person receiving the inheritance 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 person with disabilities. In other words, it is extremely risky that such a plan will not result in the funds being used to provide for the needs of the person with disabilities.

**What happens to public benefits if an individual with a disability receives assets outright?**

A person with disabilities who receives assets outright from a friend or family member's Will or because they were listed as a designated beneficiary could become ineligible for Medicaid and/or SSI if their assets exceed the allowable

limits for the program(s).

If a person with disabilities receives an inheritance outright, or if they receive other funds which disqualify the individual from Medicaid and/or SSI such as a personal injury settlement, the person may be able to establish a first-party special needs trust (commonly called a d4A trust). The special needs trust can be established by the person with disabilities, provided they have capacity, a parent, grandparent, guardian, or court. Again, it is recommended that an attorney draft the trust. The trustee can use the funds for the sole benefit of the person with disabilities. The special needs trust can only be established and funded prior to the age of 65. Any funds remaining upon the death of the person with disabilities must be used to pay Medicaid for any benefits paid on behalf of the person with disabilities during his or her entire lifetime. This is commonly called the payback provision.

**Who should be the trustee of a supplemental benefits trust or special needs trust for a person with disabilities?**

Most individuals wish to name a sibling or other close family member of the person with disabilities. 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 person with disabilities. 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 or simply having a professional trustee serve as sole 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.

# 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 they have 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 the person constitutes a direct threat to the health or safety of others or if the person's 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 architec-

tural 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 reasonable modifications if the modification is necessary to afford the tenant with a disability the same use and enjoyment of the property as other tenants. Reasonable modifications may include, but are not limited to installing grab bars, handrails, or ramps, but the tenant will have to pay for the modifications, and have them removed at their 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 estimate 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 arising from incidents that are a result of their disability.

In addition to anti-discrimination laws, tenants also have the protection of New Jersey's Anti-Eviction Act, N.J.S.A. 2A:18-61.1, *et seq.* This law establishes the good cause grounds that a tenant who is protected by the law can be evicted for.

### **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 their 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, or paying the rent late—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 visually impaired 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. Or a tenant with a hoarding disorder could request a reasonable accommodation to give them time to clean up the home and seek mental health treatment to address the underlying issue to prevent a clutter from occurring again.

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 has resulted in substantial physical damage to property, is not protected from eviction.

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

A person with a disability may file a complaint with the U.S. Department of Housing and Urban Development (HUD) online at [hud.gov/fairhousing/fileacomplaint](http://hud.gov/fairhousing/fileacomplaint) , or by calling 800-669-9777 (voice) or 800-927-9275 (TTY), or file a law-

suit 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 (DCR). A bias investigation with DCR can be filed online at [bias.njcivilrights.gov/en-US/](http://bias.njcivilrights.gov/en-US/) or by phone at 833-653-2748. Such a complaint must be filed within 180 days after the alleged act of discrimination. In addition, a person who believes they have been discriminated against based upon a disability may consult an attorney regarding any other legal remedies available.

# 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. It has an impact in a variety of different areas and has been mentioned in various sections throughout this primer.

The New Jersey Division on Civil Rights (DCR) is the leading agency in educating people on their rights under the LAD. They offer a comprehensive breakdown about LAD, in the publication “Know the Law,” available on the New Jersey Office of Attorney General’s website ([njoag.gov](http://njoag.gov)). In that publication, DCR provides more specific information about the LAD in the areas of:

- Employment Discrimination
- Housing Discrimination
- Public Accommodation Discrimination

## 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 they are a victim of unlawful discrimination should contact the New Jersey Division on Civil Rights within 180 days of the alleged discriminatory act. A person must first submit an intake form with DCR’s NJ Bias Investigation Access System (NJBIAS) by calling 1-866-NJDCR4U and speaking with someone to fill out the NJBIAS form. Or, the NJBIAS form can be completed online through the NJ DCR Portal ([njcivilrights.gov](http://njcivilrights.gov)). Once the form is submitted, 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 a LAD complaint directly in New Jersey Superior Court. Superior Court complaints must be filed within two years of the act of discrimination.

# Medicaid

## What is Medicaid?

There are currently a number of Medicaid programs in New Jersey, each with its own eligibility guidelines and covered services. These programs are designed to provide health-care coverage to people who are poor, disabled, or elderly. Importantly, all Medicaid eligibility groups provide Personal Care Assistance (PCA) as one of its covered services.

Given the number of Medicaid eligibility groups, it would be impossible to review the eligibility criteria and services for each program. Instead, we are providing a snapshot of some of the programs that are most commonly utilized by individuals with disabilities. You should contact your county board of social services or an attorney to determine whether or not you are eligible for any of the Medicaid programs.

## Affordable Care Act or MAGI Medicaid

Affordable Care Act Medicaid (also commonly referred to as Modified Adjusted Gross Income (MAGI) Medicaid), is a program for individuals between the ages of 18-64 who earn less than \$1,732 (2024) per month for a household of one (1) and who do not have Medicare coverage.

## Supplemental Security Income

If you are approved for Supplemental Security Income (SSI), you are automatically entitled to receive Medicaid.

## Workability

Workability under N.J.S.A. 30:4D-3(18) was recently legislatively amended which significantly expanded the eligibility rules. The modifications were implemented in phases with the last phase taking effect February 1, 2024. The following are the new eligibility criteria for workability:

- 1) 16 years or older
- 2) Permanently disabled (as defined by the Social Security Administration)
- 3) Working (including self-employed individuals earning at least \$400 per year); and
- 4) Pays the Medicaid premium based on his or her income.

You will notice that there are no income, resource, or age limits. Additionally, a provision was added which allows an individual to maintain eligibility for up to one year after a job loss through no fault of their own.

While the expansion of this program gives people with disabilities the flexibility to maintain their benefits while working, some caution should be added. First, where an individual is receiving Social Security Disability benefits, they should be aware they may lose their disability benefits if they earn over the Substantial Gainful Activity threshold, presently \$1,550 (2024), for too long. Second, an individual receiving Supplemental Security Income (SSI) may also be at risk of losing their SSI benefits if their income (after deductions) exceeds the SSI limit. Finally, since there is no longer an age limit for Workability, but there remains an age 65 limit for funding a first-party special needs trust, it would be beneficial for the recipient to have their situation reviewed prior to attaining age 65 to determine if further action should be taken to ensure continued eligibility for a different Medicaid program once the individual is no longer working. For example, in some cases, the individual may elect to fund the special needs trust prior to turning age 65 even though their assets are not disqualifying them from Workability but may disqualify them from other programs in the future.

## MLTSS

An important Medicaid program is Managed Long Term Services and Supports (MLTSS). This is the Medicaid program that covers long term care in a nursing facility or assisted living facility and provides a special package of benefits to individuals at home including private duty nursing, home delivered meals, and a personal emergency response system.

A person in need of long-term care must meet both clinical and financial eligibility in order to qualify for MLTSS. To be financially eligible, there is both a resource or asset test and an income test. For resources, a single person must have \$2,000 or less in assets which includes real estate (unless they are currently living there), retirement accounts, checking accounts, the cash value of life insurance, etc. For married

couples, anything belonging to either spouse counts toward resource eligibility but there are rules to prevent spousal impoverishment. First, the primary residence is exempt if the well spouse (known as a community spouse) resides there. Second, the community spouse can keep one-half (½) of their non-exempt resources up to a maximum of \$154,140 (2024). If one-half (½) of their resources is less than the minimum of \$30,828 (2024) they get to keep the minimum amount. Anything over these limits, must be spent on allowable expenses before the person can be Medicaid eligible.

With respect to the income test, the person seeking Medicaid eligibility must have gross income (i.e. before any deductions), including Social Security or pensions, below \$2,829 (2024). The income of the community spouse is not counted, and they get to keep their entire income. Beginning December 1, 2014, individuals whose income exceeds the income limit may still be eligible for MLTSS if they establish a Qualified Income Trust (QIT). Income that goes into the QIT is not counted for eligibility purposes but must still go toward the person's cost of care. The rules for QITs are complicated and if it is not done correctly, Medicaid eligibility will be denied, so an attorney's guidance is highly recommended. If the Medicaid applicant's gross income exceeds \$2,829 (2024), they will not be eligible without a QIT. If you may need a QIT, you likely should speak with an elder law attorney.

When considering an application for Medicaid, one should bear in mind that the rules are fairly complicated, and that transfers of assets to third parties (such as gifts to children), whether done in order to become eligible for the program or not, can result in a penalty period being imposed during which payments by the state will not be made for long-term care.

OBRA-93 (Omnibus Budget Reconciliation Act of 1993), which is federal legislation effective October 1, 1993, made significant changes to Medicaid. Transfers of assets made within 60 months of an application for Medicaid are penalized. This is commonly referred to as the five-year lookback. The penalty period is a number of days of ineligibility for Medicaid, determined by dividing the value of the assets transferred by the average cost of a nursing home in New Jersey which is \$440.10 (2024) per day. States must apportion the period of ineligibility between spouses so that only one penalty applies. In the case of joint assets, a withdrawal by one party is considered a transfer. The law also subjects transfers of income to a period of ineligibility. Transfer penalties can

be avoided by returning all of the assets that were transferred.

When applying for MLTSS, agency workers will review your financial records for the past five years and require proof of where deposits came from and where withdrawals were spent. For that reason, if you are considering applying for MLTSS in the future, it's important to keep good records of your finances, and pay for things in a way that establishes records of where funds were spent (i.e. do not use cash).

In addition to the complicated financial criteria, an individual must be found clinically eligible in order to qualify for MLTSS. The Office of Community Choice Options (OCCO) is tasked with the responsibility of determining if an individual meets clinical eligibility for MLTSS. If the applicant is in a nursing facility or assisted living facility at the time of their application, the facility will file a request for the nursing assessment from OCCO. Individuals who are home have the extra burden of making the request themselves. To do that, the Medicaid applicant or family member most familiar with their medical condition, would call the local Area Agency on Aging or Aging and Disability Resources Center (AAA/ADRC) and request to be screened for eligibility for home-based Medicaid. The AAA/ADRC will then complete a series of pre-screening questions. If their screening yields that the individual may be clinically eligible, they will refer the case to OCCO for a full nursing assessment.

States are mandated to recover payments from the estates of Medicaid recipients. All benefits paid from the age of 55+ must be repaid to Medicaid from the estate of the Medicaid recipient. Many Medicaid recipients do not have an estate at the time of their death, so estate recovery does not affect them. However, if the Medicaid recipient was home, they may still own their house which Medicaid will put a lien on in order to be repaid.

If your application for Medicaid benefits is denied, if your Medicaid eligibility is terminated, or if Medicaid refuses to pay a claim, you have a right to a fair hearing before a New Jersey Administrative Law Judge. At that hearing you have a right to be represented by counsel and to present evidence, including testimony, to support your case. The judge makes a recommendation to Medicaid regarding your case. Then, if Medicaid still denies your claim, you have a right to appeal to the Appellate Division of the Superior Court of New Jersey. In a situation where Medicaid has advised you that it intends to discontinue the payment of benefits, you may have

a right to have benefits continued until your appeal has been decided but you must file your appeal within the time limits listed on the notice to receive this benefit.

Medicaid is constantly changing through regulations, statutes, and case law; as such, it is important to consult with an elder law attorney if you or someone you know may need long term care in the future. There may be steps you can take to protect assets from the cost of long-term care with proper advance planning. Non-attorney Medicaid advisors often tout their services with respect to Medicaid and Medicaid planning, but the New Jersey Division of Consumer Affairs recommends against utilizing these services. See this fact sheet on the issue: <https://www.njconsumeraffairs.gov/News/Consumer%20Briefs/medicaid-advisors-application-assistors.pdf>. Be sure the person you choose to assist you have experience in Medicaid planning.

### Additional Support Programs

There are also a number of other programs that are similar to Medicaid in that they assist in affording you access to medical care or services. For information on subsidized programs in New Jersey, please contact your county Office on Aging (or Area Agency on Aging). A partial list of programs appears below:

NJ Save is an online application to help low-income seniors and individuals with disabilities save money on Medicare premiums, prescription drug costs, and other living expenses. The application can be accessed online at <https://njdoas-ua.force.com/njsave/quickstart>. A paper application can be printed at <https://www.nj.gov/humanservices/doas/forms/NJSaveApp.pdf>. This single application determines eligibility for the following programs:

- **PAAD (Pharmaceutical Assistance to the Aged and Disabled)** helps eligible New Jersey residents pay for most prescription drugs, testing materials and supplies. Eligibility requirements for PAAD are based on the residents' income, covering insurances and marital status.
- **Senior Gold Prescription Plan** provides pharmaceutical assistance to New Jersey residents whose income is too high for PAAD, but is not enough to adequately cover their prescription expenses each year.
- **Lifeline (Utility Assistance Program)** offers \$225 to persons who meet the PAAD eligibility requirements.

This includes utility customers as well as tenants whose utility bills are included in their rent. Only one tenant in a household is entitled to this assistance. You are eligible for the Lifeline benefit if you are a recipient of PAAD.

- **SLMB (Specified Low Income Medicare Beneficiaries)** is a program that covers Medicare Part B premiums. Eligibility is based on income, resources, and being ineligible for full Medicaid.
- **Medicare Part D Low Income Subsidy (LIS also known as Extra Help)** is a program that reduces Medicare Part D premiums, deductibles, and copays.
- **HAAAD (Hearing Aid Assistance to the Aged and Disabled)** provides a \$100 reimbursement to eligible persons who purchase a hearing aid.

Additionally, the NJ Save application screens applicants and forwards their information to the appropriate eligibility determining agency for the following programs:

- **Universal Service Fund (USF)** is a program that helps make energy bills more affordable for low income customers. If eligible, USF may be able to lower the amount you have to pay for natural gas and electricity.
- **Low-Income Heating and Energy Assistance Program (LIHEAP)** is a program that helps very low-income residents with their heating and cooling bills, and makes provisions for emergency heating system services and emergency fuel assistance.
- **Supplemental Nutrition Assistance Program (SNAP)** is a program that provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency.

JACC (Jersey Assistance for Community Caregiving) provides a broad array of in-home services and supports that enable an individual who would otherwise qualify for placement in a nursing facility to remain in his or her community home. By providing a uniquely designed package of supports for the individual, JACC is intended to supplement and strengthen the capacity of caregivers, as well as to delay or prevent placement in a nursing facility. JACC serves individuals who are not eligible for Medicaid, and participants will share in the cost of their services.

# Medicare

## What is Medicare?

Medicare is a federal program of health insurance. Medicare insurance helps pay for acute illness situations and not for long-term or custodial care.

Many private health insurance companies sell Medicare supplemental insurance that will help cover a number of the gaps in Medicare insurance. The United States Congress has regulated this field so that now all companies must offer policies with 10 levels of coverage. It is important to understand what each level of coverage does and does not include.

Read each explanation of Medicare benefits that you receive regarding every claim that is submitted. This will be listed on your Medicare Summary Notice (MSN). If Medicare refuses to pay for a claim, you have the right to appeal the decision. If you wish to appeal, you must do so within 120 days of receipt of the MSN. You can complete the redetermination request form and send it to the Medicare contractor listed on the MSN to appeal. Medicare will then review your appeal and send you its decision.

For both Part A and B appeals, if the amount at issue is \$180 (2024 amount) or more, you have the right to a hearing before a United States administrative law judge after you have exhausted the lower level appeals. At that hearing you can be represented by an attorney and may present evidence, including sworn testimony to support your case. If the amount at issue is \$1,840 (2024 amount) or more, you will also have the right to take your case to federal court.

## Who is eligible for Medicare?

Medicare is available to persons age 65 and over who have paid into the Social Security system, typically through payroll deductions, while they were employed for at least 40 quarters. Medicare is also available 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.

Importantly, an individual who is determined to have a disability that started prior to the age of 22 can collect Social Security Disability, and Medicare, under a parent's work record provided the parent is retired or disabled and collecting Social Security or has passed away.

## When should I enroll in Medicare?

When an individual becomes eligible for Medicare hospital insurance (Part A), the individual 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.

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.

The late enrollment penalty for late enrollment in Medicare Part B is 10% for each 12 month period. The penalty is permanent and will be paid for the duration of the person's life-

time. Once the individual has Medicare Part B, they have a 6 month open enrollment to purchase a Medicare Supplement Policy with a guaranteed issue. After this one time open enrollment period, Medicare Supplement policies are not a guaranteed issue and may be declined or have higher premiums.

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 above.

### **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 of the initial enrollment period, 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 25<sup>th</sup> month that they are receiving those benefits (commonly referred to as the 24-month waiting period). 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 their 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 Spe-

cial 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 a federal program providing healthcare coverage to individuals who have contributed to the program, regardless of their present income or the value of their assets. Eligibility for Medicaid, on the other hand, is means tested, meaning they may look at an individual's income and/or assets, depending on the Medicaid eligibility group. Medicaid is administered by the federal and state governments. Although each state has its own variations of the Medicaid rules, all Medicaid programs have strict financial guidelines. Medicare is primary and pays for healthcare that is considered "medically necessary," while Medicaid is "the payor of last resort" and will pay what is not covered by Medicare including custodial care, such as long-term care, at home, in an assisted living facility, or in a nursing facility. Medicaid will also pay for deterioration in vision and hearing as well as dental health, while Medicare will not cover these services.

### **What is Medicare Part A?**

Part A Medicare is primarily hospital insurance. When a hospitalization occurs, the patient is required to pay a deductible of \$1,632 (2024). After that, Medicare will pay for most of the patient's expenses up until the 60th day of the hospitalization. After 60 days in the hospital, the patient is required to pay \$408 (2024) per day toward expenses. Part A Medicare will also help pay for stays in skilled nursing facilities, home health care, and hospice care if the patient qualifies. There is usually no premium for Part A.

Medicare Part A may also pay for limited days in a skilled nursing facility (SNF). Medicare Part A will cover up to 100 days in a skilled nursing facility provided the requirements are met. The individual must have had a three day hospital admittance (not observation) followed by an admission to a SNF within 60 days after discharge and is receiving rehabilitative services for the reason they were admitted to the hospital. Medicare coverage can terminate prior to 100 days.

Medicare Part A will cover the first 20 days in full, days 21-100 have a co-pay of \$204 (2024) per day. Some Medicare Supplement policies will cover the co-pay.

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.

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 2024, of \$505 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 they turn age 65, and generally, individuals under age 65 with a disability get Part A after getting disability benefits from Social Security 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.

### **What is Medicare Part B?**

Part B Medicare is physician services insurance. It will help pay for medical services, durable medical equipment, diagnostic tests, X-rays, and physical and speech therapies that are considered medically necessary. After the patient pays the first \$240 (2024) for Medicare-approved services, Medicare will pay 80 percent of the amount approved by Medicare for the service. The patient is responsible for the 20 percent that Medicare does not pay. Also, the patient may have to pay the difference between what the doctor billed and

Medicare approved unless the doctor accepts "assignment." If assignment is accepted, the physician agrees to accept as the full fee the amount Medicare approves for the service. If you enroll for Part B, you must pay a monthly premium. For most people the premium is \$174.70 for 2024 but high income earners will have a higher premium as a result of the Income Related Monthly Adjustment (IRMA). However, the State will cover the Medicare Part B premium for anyone who is Medicaid eligible.

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.

### **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. Each Medicare Part D plan has a "formulary" which lists the prescriptions covered under that particular plan. Accordingly, a plan should be selected based on the prescriptions needed by the individual.

The monthly premium varies by plan, and higher income consumers may pay more. Moreover, there is a penalty for late enrollment after your initial enrollment period. The penalty is 1% of the national base premium multiplied by the number of months the individual did not have coverage. The initial enrollment period is a seven-month period, three months before your 65th birthday, the month of your birthday, and three months after.

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](https://www.medicare.gov). Further enrollment questions and assistance can be obtained by calling 1-800-792-8820 for the free State Health Insurance Assistance Program.

The Medicare Part D coverage has four phases:

1. **The Deductible Phase**—In this phase, the individual pays 100% of the prescription drug costs up to the annual deductible which can be no higher than \$545 (2024). Some Medicare Part D plans do not have a deductible.
2. **The Initial Coverage Phase**—In this phase, the individual pays up to 25% of total drug costs and the plan pays 75% up to a combined total of \$5,030 (2024). Most Medicare Part D plans do not charge a flat 25% for all drugs, they charge a mix of copayments and coinsurances.
3. **The Coverage Gap Phase**—In this phase, the individual pays 25% of the total drug cost (brand name and generic) and the Medicare Part D plan pays 75% for generic drugs and 5% for brand name drugs. They are able to do this because the drug manufacturers provide a 70% discount on brand name drugs in this phase.
4. **The Catastrophic Phase**—An individual reaches this phase if the costs total \$8,000 (2024). The costs that apply to this threshold include what the individual spends, what the Medicare Part D plan spends, and the Manufacturer discount. Accordingly, enrollees only need to spend about \$3,300 before reaching the catastrophic limit. Once reached, an individual receiving “extra-help” will have no costs. An individual who does not receive extra-help is limited to 5%. Medicare will pay 80% and the Medicare Part D plan will pay 15%.

NOTE: Beginning in 2025, the coverage gap (or “donut hole”) phase will be eliminated.

### **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, this is known as “creditable coverage” and the beneficiary can keep the employer or union drug plan, and join a Medicare prescription drug plan later without penalty. 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. Moreover, the Medicare premiums may be higher since they are working.

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, they will have to pay more for the monthly premium (a penalty).

### **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% of the charge, while the beneficiary or the beneficiary’s Medicare Supplement policy pays the 20% 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. The appeal must be filed within 60 days of the date of the notice. 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, they 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.

QMB, SLMB, and QI all have the same resource limit: \$9,430 (2024) for an individual, \$14,130 (2024) for a couple.

If income does not exceed \$1,255 (2024) per month for an individual or \$1,704 (2024) for a couple and their resources are below the limit, that individual/couple may qualify for assistance as a qualified Medicare beneficiary (QMB).

If a person does not qualify for the QMB program, has income of less than \$1,506 (2024) per month for an individual and \$2,044(2024) per month combined for a married couple, and has liquid assets not exceeding \$7,160 for a single person/\$10,750 for a married couple, and their resources are

below the limits, that person may qualify as a specified low-income Medicare beneficiary (SLMB).

If a person does not qualify for the QMB, or SLMB and whose income does not exceed \$1,695 (2024) for a single person and \$2,300 (2024) combined income for a married couple, with assets under the limits, that person may qualify as a Qualifying Individual (QI).

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 automatically qualifies for Extra-Help if they are Medicaid eligible or eligible for any of the above listed Medicare Savings Plans.

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 must be less than \$52,142 (2024) for a single person or less than \$59,209 for a couple. There is no resource limit. If you qualify for PAAD, your out of pocket costs are limited to \$5 for generic drugs and \$7 for name brand drugs. PAAD will also pay your Medicare Part D premium (including any late enrollment penalties).

To be eligible for Senior Gold, the individual's income must be between \$52,142 to \$62,142 (2024) for a single individual and between \$59,209 and \$69,209 (2024) for a couple. Again, there is no resource test. If you qualify for Senior Gold, your out of pocket costs are limited to \$15 plus 50% of the remaining costs; however, there is a catastrophic limit of \$2,000 for a single person and \$3,000 for a couple. If the catastrophic limit is met, the cost is \$15 per drug. Senior Gold does not pay the Medicare Part D premium. 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.**

### **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 hos-

pital or doctor who accepts Medicare (and most do). Original Medicare is sometimes called “traditional” Medicare.

Individuals enrolled in Original Medicare have Part A, Part B, a Part D prescription drug plan, and a Medicare Supplement (or Medigap) policy.

### **What is a Medicare Supplement or 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 Medicare Supplement or Medigap insurance. Insurance companies offer 10 standardized Medigap policies labeled plans A through N with each plan covering specified expenses or services. Note, Plans C and F are only available to those who turned 65 prior to January 1, 2020. 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.

To obtain assistance with selecting a Medicare Supplement or Medigap policy, an individual may contact SHIP (State Health Insurance Program). 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.

### **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 (which is an HMO or PPO). Receiving Medicare via a Medicare Advantage Plan is commonly referred to as Medicare Part C. Medicare Advantage Plans are run by private insurance 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.

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.

### **Can I keep Medicare if I go back to work?**

With the expansion of Workability, many people with disabilities may elect to work above the Substantial Gainful Activity earnings limit. While the individual may not be permitted to continue to collect Social Security after their trial work period ends, they are permitted to continue to receive Medicare for a period of 93 months provided the individual continues to have a disabling impairment.

# 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 are eligible to collect under another person's work record who has paid into the Social Security program such as a Disabled Adult Child (DAC). Supplemental Security Income (also known as Title XVI benefits or SSI) may be available to individuals with disabilities who did not pay into the Social Security system, are not eligible for a derivative benefit under another person's record, whose income is below the Federal Benefit Rate, presently \$943 (2024) per month, after deductions, and whose countable resources are below \$2,000. The purpose of SSI is to provide a minimum income to low-income people who are 65 or older, blind or disabled.

## **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 does not have a disability, the SSA will stop its inquiry.

First, the SSA will consider an individual's work activity. If a person is engaging in Substantial Gainful Activity (SGA), that person will be found not disabled. SGA means work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit. The SGA limit is \$1,550 (2024) per month for non-blind individuals and \$2,590 (2024) for individuals who are blind.

If a person is not doing SGA, 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 their limitations. If a person can still do their past relevant work, that person does not have a disability.

If a person cannot still do 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, they are not disabled. In other words, even if a person is not able to perform a previous job, if there is some other job the individual could do, then that person is not eligible for disability benefits.

## **If a person meets the definition of disability, how much money will they receive collecting SSDI?**

When you apply for SSDI, Social Security will check your Social Security record, which shows all of your earnings covered by Social Security. Social Security will then figure your exact benefit rate. Your rate will depend on the amount of earnings reported for you. Unlike early retirement, where there is a reduction of benefits, an individual collecting SSDI will not have a reduction of benefits.

For an individual who has a benefit below the SSI rate, they may collect both SSDI and SSI.

### **How much is the SSI benefit?**

The basic SSI benefits are monthly cash benefits. These rates change annually. For 2024 the federal single rate is \$943 and the rate for a couple is \$1,415. However, some factors reduce benefits, e.g., living arrangements, monetary assistance from friends or family, earned income, or unearned income.

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

The SSDI program will qualify a recipient for Medicare insurance after the recipient has been eligible for monthly SSDI benefits for 24 months. In New Jersey, an individual who is SSI eligible (regardless of the monthly amount) is automatically Medicaid eligible. 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, SSDI benefits are converted to retirement benefits and SSI benefits for a person with disabilities are converted to SSI for a person over 65. Until age 65, as long as an individual meets the eligibility requirements, there is no limit on the length of time that they 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 their 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 Social Security Administration publishes a

detailed guide to work incentive programs: Red Book 2023 ([ssa.gov](https://www.ssa.gov)).

The SSDI program allows a Trial Work Period in which an individual can attempt to work for nine months (not necessarily consecutively) without jeopardizing his or her benefits. There is no earning limit during the Trial Work Period but you must continue to have a disabling impairment. Additionally, after the Trial Work Period has been exhausted, there is a 36-month “re-entitlement period” during which you can receive SSDI for any month your earnings are below SGA. The re-entitlement period is followed by a five-year period in which benefits can be restarted without a new application. Medical benefits can continue throughout this period.

The SSI program also permits recipients to work without jeopardizing eligibility for monthly benefits. There are several important deductions. First there is a \$20 general income exclusion which applies first to unearned income. Second, there is an earned income deduction which deducts the first \$65, followed by one-half of the remaining amount. For example, if an individual has \$0 of unearned income and \$500 of earned income, only \$207.50 is counted as earned income ( $\$500 - \$20 - \$65 = \$415/2 = \$207.50$ ). The countable income is then deducted from the Federal Benefit Rate to determine the SSI benefit. In this example, \$207.50 would be deducted from \$943 (2024) for a benefit amount of \$735.50. In this case, the total income is  $\$735.50 + 500 = \$1,235.50$

### **Where does one apply for benefits?**

Applications for either Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) can be made at the local Social Security Administration (SSA) office or online at [ssa.gov](https://www.ssa.gov).

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

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

An attorney can be extremely helpful in assisting with

Social Security appeals. If you have limited income, you may be eligible for free legal assistance from your local Legal Services office. If you are not eligible for free help from the Legal Services office, you should seek guidance from your county office on aging or from a private attorney. If the attorney wins the case for you, the attorney's fee will be taken from the Social Security award. The lawyer's fee will be set by the Social Security Administration and will be paid directly from the amount awarded.

The first step in the appeals process is a request for reconsideration, which must be filed within 60 days of receiving the notice of the denial. During the reconsideration stage, the applicant has the right to present new evidence.

If the application is again denied, the applicant has 60 days in which to request a hearing before an administrative law judge. At the hearing, the person appealing can have an attorney represent him or her.

Evidence can be presented, witnesses can testify (the judge can order witnesses to appear and testify), and Social Security Administration experts can be challenged by means of cross-examination.

The third stage involves a review by the appeals council that must be filed within 60 days of the decision by the administrative law judge.

The last step in the appeals process involves a lawsuit in federal court.

# 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 their rights to make decisions concerning their person or property.

## When might a surrogate decision-maker be needed?

When an individual is not able to manage part or all of their 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 their affairs but wants to be prepared in case a time comes when they are unable 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. As discussed in detail under the Estate Planning section in this booklet, one option is to execute a Power of Attorney for financial affairs and an Advance Directive for medical affairs provided the individual has the required capacity to execute the documents.

## What is a standby guardian?

A standby guardian is a document that designates a future guardian for the minor children of a parent with a progressive, chronic condition or fatal illness. This is only available to appoint a guardian for an individual's minor child, not an adult child with disabilities. As such, the functionality of this document is limited. The standby guardian is standing by to immediately assume legal guardianship and provide for the care of the minor 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 their 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 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 their own property or unable to financially provide for themselves, or for their dependents. In New Jersey, a conservatorship cannot be imposed if the proposed conservatee objects to it. The individual or someone on their behalf can

apply to have a conservator appointed to manage their 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?**

If you receive Social Security, the law permits a person designated by the Social Security Administration to receive and use your benefits for your necessities. This person is known as a “representative payee.” The Social Security Administration is not required to honor a power of attorney. Instead, they have their own process for designating a third party (such as a guardian, spouse, friend, public or non-profit agency, or a private institution licensed under State law) as the representative payee. Any third party may apply to become a “representative payee” but the Social Security Administration has discretion over who they appoint. To apply, a doctor must certify on form SSA 787 that the Social Security recipient is not capable of managing their own benefits. As of 2018, the law allows competent, adult Social Security recipients to make an “Advance Designation of Representative Payee.” A Social Security recipient may designate up to three individuals who may serve as their representative payee should the need arise. You can make this designation online on your “My Social Security” account, by telephone, in person, or in writing. Additionally, provided you have capacity, you can change your designations at any time via the same methods.

No hearing is required for a representative payee to be appointed. The only notice is a letter to you that if you do not object within 10 days, the third party will be named as your representative payee. Your future checks will be made out in the name of your representative payee for your benefit. A law effective as of 1991 requires that the Social Security Administration conduct a face-to-face interview, if practicable, and obtain the prospective representative payee’s Social Security

number to determine if that person has ever previously misused funds as a payee.

### **What is a guardian?**

A guardian is a person appointed by a court to make legal, financial, and medical 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 does not have the necessary estate planning documents, i.e. a Power of Attorney and Advance Directive for Healthcare, and lacks decision-making capacity as a result of a mental illness, developmental disability, physical illness or disability, substance use disorder. The person for whom a guardian is appointed is called a ward or incapacitated person.

### **What rights does an adjudicated incapacitated person lose?**

In a full or “plenary” guardianship, the incapacitated person loses the right to manage any of their 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 their guardian. An unmarried incapacitated person also loses the right to marry.

An important alternative to full guardianship is called “limited guardianship.” In a limited guardianship, the incapacitated person retains the right to make those decisions that they are capable of making, while the guardian is limited to making only those decisions for which the incapacitated person 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). Importantly, the Court is required to consider the least restrictive alternative before imposing a Guardianship.

**What happens if the incapacitated person regains the ability to manage their own affairs?**

If an individual for whom a guardian has been appointed wishes to regain the legal right to make their own decisions, the individual must petition the court for a “return to competency.”

**When is a guardian not needed?**

Just because a person has a disability, does not mean that they need a guardian. A guardian is not needed for a person who has the capacity to understand and make decisions for themselves and communicate those decisions to others. A guardian is not required for someone who has a disability but who can manage their affairs.

**What is Supported Decision-Making?**

Supported decision-making means that someone relies on help of other people to manage their own affairs. Unlike guardianship, it does not involve removing someone’s fundamental right to self-determination. Support might be informal and used only as needed. It can also be formalized with a written plan about the supports someone uses to make different kinds of decisions. Supporters include only people chosen by the person. They help with some or all types of

decisions. Someone might rely on the advice of friends, family or even paid supports like hired attorneys, social workers, or accountants to help them make decisions in areas that they could not understand on their own.

Many adults, regardless of disability, use supported decision-making without knowing it. For example, many people with no disability hire lawyers to plan their estates because estate planning laws are complicated and difficult to understand. The lawyers’ job in this example is not to make decisions for their clients, but rather to help them understand the choices available and to help the client reach a decision. The lawyer also probably helps the client to communicate their decision by drafting the appropriate documents that will effectively carry out the client’s wishes. At no point does the client lose the right to decide on their own, even if they need lots of help to understand their choices.

With enough support, many people with cognitive disabilities can manage their affairs and do not need a guardian appointed. Unlike other states, New Jersey does not have a supported decision-making statute mandating any particular form of arrangement or providing any safe harbor for a third-party relying on the existence of a SDM arrangement to conduct business with someone who has a disability.

# Transportation Barriers

## **Must public transit buses be accessible to persons with disabilities?**

The Americans with Disabilities Act adopted by the United States Department of Transportation require that all new buses be accessible. This requirement was adopted in 1991. Considering that buses typically have a life of 12 years, most, if not all, public transit buses should be accessible to people with disabilities.

## **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 public transportation system designed for individuals in areas without bus or rail services, or for those who cannot use these services due to disabilities. The former is known as “paratransit for the general public” while the latter is known as “complementary paratransit.”

**Paratransit for the general public:** This provides services to individuals with disabilities that are equal to those provided for other users.

**Complementary paratransit:** This is specifically for indi-

viduals whose disabilities prevent them from using regular transit, even if it is accessible. Transit authorities may develop eligibility criteria for this service. However, if a passenger cannot use mass transit because the system is not accessible or due to their disability, they must be found eligible for complementary paratransit. Complementary paratransit must also meet the following criteria:

- Fares must be comparable to mass transit fares (no more than double);
- Service must be available during the same times as the mass transit system operates;
- Service must be provided in the same geographic area as the mass transit system;
- There cannot be restrictions or priorities placed on trip purposes;
- There must be next-day service (that is, if you call for service today, service must be provided any time tomorrow); and
- 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 bus companies that operate fixed routes using buses (like Greyhound) must acquire new buses that are 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 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 to ensure an accessible bus is available.

Starting in October 2001, smaller companies providing fixed-route service were required to begin purchasing only accessible equipment. They must also offer boarding assistance and transport wheelchairs and scooters.

Charter bus operators are not mandated to purchase only accessible buses. However, since 2001, they must be capable of providing 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 any construction or renovation funded with federal money must be accessible to people with disabilities. Similarly, Section 504 of the Rehabilitation Act requires that facilities and services receiving federal financial assistance must also 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.

# Vocational Rehabilitation

The Division of Vocational Rehabilitation Services (DVRS) and the Commission for the Blind and Visually Impaired (CBVI) administer New Jersey's vocational rehabilitation system, required under the Rehabilitation Act and Workforce Innovation and Opportunity Act.

Disability Rights NJ publishes a comprehensive guide to New Jersey's vocational rehabilitation system for people with disabilities, titled, "Navigating Your Rights to Vocational Rehabilitation Services: A Self-Advocacy Guide." The guide covers everything about the vocational rehabilitation agencies in New Jersey, from application, eligibility, available services, to appeals. It can be downloaded from Disability Rights NJ's website ([disabilityrightsny.org](http://disabilityrightsny.org)) or use this link: [disabilityrightsny.org/navigating-your-rights-to-vr-services-a-self-advocacy-guide/](http://disabilityrightsny.org/navigating-your-rights-to-vr-services-a-self-advocacy-guide/)

## **What if I need help accessing services from DVRS or CBVI?**

Disability Rights New Jersey's Client Assistance Program (CAP) helps people with disabilities understand their rights and access vocational rehabilitation services. CAP provides important information about benefits, advocates for needed services, represents clients in appeals, and resolves issues with vocational rehabilitation counselors or agencies.

*NOTE: Contact information for Disability Rights NJ can be found in the Resource Section of this guide under Advocacy Resources.*

# 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 their average weekly wage, subject to a maximum benefit that is established annually. 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 they have 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 their 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 they remain 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 benefit that is established annually.

## **What criteria qualify an injured worker for permanent total disability?**

An injured worker can automatically qualify for permanent total disability when they have 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, which is 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.

*For more information on workers' compensation issues, visit [nj.gov/labor](http://nj.gov/labor)*

# 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?**

Under the LAD, individuals with disabilities are entitled to: (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 their ability to perform specific job functions or to describe or demonstrate how the applicant 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 an adjustment to the work environment that allows a qualified applicant or employee with a disability to perform essential job functions and enjoy the employment benefits as other workers. The type of accommodation needed depends on the specific job and disability, as well as the employer's structure.

For instance, a janitor may be expected, as part of the job, to climb ladders 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, accommodation 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 they have not been hired due to a disability, or believes they have been terminated or denied some benefit of employment based upon their 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 they have 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.

# 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 is needed, because of a 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 per-

sonal 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 hous-

ing 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.

# 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  
Phone: 877-685-8878;  
973-648-3333  
Email: askcbvi@dhs.nj.gov  
[state.nj.us/humanservices/cbvi](http://state.nj.us/humanservices/cbvi)

### **New Jersey Council on Developmental Disabilities**

P.O. Box 700  
Trenton, NJ 08625-0700  
Phone: 800-792-8858  
609-292-3745  
TDD: 609-777-3238  
FAX: 609-292-7114  
Email: njcdd@njcdd.org  
[njcdd.org](http://njcdd.org)

### **Department of Education, Office of Special Education**

P.O. Box 500  
Trenton, NJ 08625-0500  
Phone: 609-292-0147  
[state.nj.us/education/specialed/](http://state.nj.us/education/specialed/)

### **Office of Special Education Complaint Investigation**

609-376-9060  
OSEinfo@doe.nj.gov

### **Division on Civil Rights**

P.O. Box 090  
Trenton, NJ 08625-0090  
Phone: 609-292-4605  
833-653-3748  
Email: NJDCR4U@njcivilrights.gov  
[nj.gov/oag/dcr](http://nj.gov/oag/dcr)

### **Division of the Deaf and Hard of Hearing**

P.O. Box 074  
Trenton, NJ 08625-0074  
Phone (Voice/TTY): 800-792-8339  
609-588-2648  
Videophone: 609-503-4862  
FAX: 609-588-2528  
Email: DDHH.communications2@dhs.nj.gov  
[nj.gov/humanservices/ddhh](http://nj.gov/humanservices/ddhh)

### **Division of Developmental Disabilities**

P.O. Box 726  
222 South Warren Street  
Trenton, NJ 08625-0726  
Phone: 800-832-9173  
609-633-7482  
[state.nj.us/humanservices/ddd](http://state.nj.us/humanservices/ddd)

### **Division of Disability Services**

P.O. Box 705  
Trenton, NJ 08625-0705  
Phone: 888-285-3036  
FAX: 609-631-4365  
[state.nj.us/humanservices/dds](http://state.nj.us/humanservices/dds)

### **Division of Mental Health and Addiction Services**

P.O. Box 727  
Trenton, NJ 08625-0727  
[state.nj.us/humanservices/divisions/dmhas/](http://state.nj.us/humanservices/divisions/dmhas/)

### **DMHAS Ombudsman**

609-438-4321  
dmhas.ombudsman@dhs.nj.gov

### **Division of Vocational Rehabilitation Services**

P.O. Box 398  
1 John Fitch Plaza  
Trenton, NJ 08625-0398  
Phone: 866-871-7867  
609-292-5987  
FAX: 609-292-8347  
[nj.gov/labor/career-services/special-services/individuals-with-disabilities/](http://nj.gov/labor/career-services/special-services/individuals-with-disabilities/)

### **Governor's Council on Substance Use Disorder**

P.O. Box 345  
Trenton, NJ 08625-0345  
Phone: 609-588-4466  
FAX: 609-588-2222  
[nj.gov/treasury/gcada](http://nj.gov/treasury/gcada)

## FEDERAL AGENCIES

### **Department of Justice**

Phone: 800-514-0301  
TTY: 833-610-1264  
[ada.gov](http://ada.gov)

### **Equal Employment Opportunity Commission**

Phone: 800-669-4000  
TTY: 800-669-6820  
[eoc.gov](http://eoc.gov)

**Federal Communications Commission**

Phone: 888-225-5322  
ASL Video Call: 844-432-2275  
[fcc.gov](http://fcc.gov)

**United States Access Board**

Phone: 202-272-0080  
Fax: 202-272-0081  
Email: [info@access-board.gov](mailto:info@access-board.gov)  
[access-board.gov](http://access-board.gov)

**Department of Education, Office of Special Education and Rehabilitative Services**

Phone: 800-872-5327  
202-401-2000  
[www2.ed.gov/about/offices/list/osers/index.html](http://www2.ed.gov/about/offices/list/osers/index.html)

**Housing and Urban Development Fair Housing Office**

Phone: 202-708-1112  
212-542-7519  
TTY: 202-708-1455  
[hud.gov](http://hud.gov)

**DISABILITY-SPECIFIC RESOURCES****AIDS/HIV****Hyacinth AIDS Foundation**

317 George Street, Suite 203  
New Brunswick, NJ 08901  
Phone: 732-246-0204  
[hyacinth.org](http://hyacinth.org)

**ALZHEIMER'S DISEASE****Alzheimer's Association, Greater New Jersey Chapter**

23 Vreeland Road, #105  
Florham Park, NJ 07932  
Phone: 800-272-3900  
[ALZ.org](http://ALZ.org)

**Alzheimer's New Jersey**

425 Eagle Rock Avenue, #203  
Roseland, NJ 07068  
Phone: 888-280-6055  
973-586-4300  
[alznj.org](http://alznj.org)

**AMYOTROPHIC LATERAL SCLEROSIS (ALS)****Neuromuscular and ALS Center of Robert Wood Johnson University Hospital**

125 Paterson Street, Suite 6100  
New Brunswick, NJ 08901  
Phone: 732-235-7733

**ARTHRITIS/FIBROMYALGIA****Arthritis Foundation—New Jersey Chapter**

555 Route 1 South, Suite 320  
Iselin, NJ 08830  
Phone: 732-283-4300  
[arthritis.org/new-jersey](http://arthritis.org/new-jersey)

**AUTISM/ASPERGERS/ASD****Autism Family Services of New Jersey**

50 Millstone Road  
Building 300, Suite 201  
East Windsor, NJ 08520  
Phone: 800-372-6510  
FAX: 609-392-5621  
[autismfamilyservicesnj.org](http://autismfamilyservicesnj.org)

**Autism New Jersey**

500 Horizon Drive, Suite 530  
Robbinsville, NJ 08691  
Phone: 800-4-AUTISM:  
609-588-8200  
FAX: 609-588-8858  
[autismnj.org](http://autismnj.org)

**Parents of Autistic Children (POAC)**

1989 Route 88 East  
Brick, NJ 08724  
Phone: 732-785-1099  
Email: [info@poac.net](mailto:info@poac.net)  
[poac.net](http://poac.net)

**BLINDNESS/VISUAL IMPAIRMENTS****Friends of the New Jersey Library for the Blind and Handicapped**

P.O. Box 434  
Woodbridge NJ 07095-0434  
Phone: 609-888-5459  
Email: [friendsnjlbhweb@gmail.com](mailto:friendsnjlbhweb@gmail.com)  
[friendsnjlibraryfortheblind.org](http://friendsnjlibraryfortheblind.org)

**National Federation of the Blind-NJ**

P.O. Box 2202  
Vincentown, NJ 08088  
Phone: 908-590-1747  
Email: [info@nfbnj.org](mailto:info@nfbnj.org)  
[nfbnj.org](http://nfbnj.org)

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

23 Alexander Ave.  
Madison, NJ 07940  
Phone: 973-377-0976  
Email: [blindchildren@verizon.net](mailto:blindchildren@verizon.net)  
[blindchildren.org](http://blindchildren.org)

### **New Jersey Council of the Blind**

P.O. Box 434  
Woodbridge, NJ 07095  
Phone: 609-672-7059  
Email: njcounciloftheblind@gmail.com  
[njcounciloftheblind.org](http://njcounciloftheblind.org)

### **Vision Loss Alliance of New Jersey**

155 Morris Avenue, Suite 2  
Denville, NJ 07834  
Phone: 973-627-0055  
FAX: 973-627-1622  
Email: info@vlanj.org  
[vlanj.org](http://vlanj.org)

## **CANCER**

### **American Cancer Society—NJ**

2600 US Highway 1  
North Brunswick, NJ 08908  
Phone: 800-227-2345  
732-297-8000  
FAX: 732-297-9043  
[cancer.org](http://cancer.org)

## **CARDIAC/HEART DISEASE**

### **American Heart Association**

1 Union Street, Suite 301  
Robbinsville, NJ 08691  
Phone: 609-208-0020  
[heart.org](http://heart.org)

## **CEREBRAL PALSY**

### **Cerebral Palsy League**

61 Myrtle St./75 Rod Smith Place  
Cranford, NJ 07016  
Phone: 908-709-1800  
Email: cplinfo@theclinc.org  
[theclinc.org](http://theclinc.org)

### **Pillar Care Continuum (formerly Cerebral Palsy of North Jersey)**

120 Eagle Rock Avenue, Suite 290  
East Hanover, NJ 07936  
Phone: 973-763-9900  
Email: cdemarco@pillarnj.org  
[pillarnj.org](http://pillarnj.org)

### **Ladacin Network**

(Formerly Cerebral Palsy of Monmouth and Ocean Counties)  
1703 Kneelely Blvd.  
Wanamassa, NJ 07712  
Phone: 732-493-5900  
FAX: 732-493-5980  
[ladacin.org](http://ladacin.org)

## **CHRONIC FATIGUE SYNDROME**

### **New Jersey Myalgic Encephalomyelitis Chronic Fatigue Syndrome Association, Inc.**

P.O. Box 477  
Florham Park, NJ 07932  
Help Desk: helpdesk@njcfssa.org  
[njmecfssa.org](http://njmecfssa.org)

## **COGNITIVE/INTELLECTUAL DISABILITIES**

### **The ARC of New Jersey**

985 Livingston Avenue  
North Brunswick, NJ 08902  
Phone: 732-246-2525  
FAX: 732-214-1834  
[arcnj.org](http://arcnj.org)

## **CROHN'S DISEASE**

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

766 Shrewsbury Avenue  
Suite 404, East Building  
Tinton Falls, NJ 07724  
Phone: 732-786-9960  
FAX: 732-786-9964  
[crohnscolitisfoundation.org](http://crohnscolitisfoundation.org)

## **CROSS-DISABILITY**

### **Advancing Opportunities**

610 Beverly Rancocas Road  
Willingboro, NJ 080476  
Phone: 888-695-0845  
609-882-4182  
FAX: 609-882-4054  
[advopps.org](http://advopps.org)

### **Alliance for the Betterment of Citizens with Disabilities (ABCD)**

127 Route 206, Suite 26  
Hamilton, NJ 08610  
Phone: 609-581-8375  
Email: admin@abcdnj.org  
[abcdnj.org](http://abcdnj.org)

### **Community Access Unlimited**

80 West Grand Street  
Elizabeth, NJ 07202  
Phone: 908-354-3040  
TTY: 908-354-4629  
FAX: 908-354-2665  
Email: info@caunj.org  
[caunj.org](http://caunj.org)

**Community Options, Inc.**

16 Farber Road  
Princeton, NJ 08540  
Phone: 609-951-9900  
FAX: 609-951-9112  
Email: [moreinfo@comop.org](mailto:moreinfo@comop.org)  
[comop.org](http://comop.org)

**Easter Seals New Jersey**

241 Forsgate Drive, Suite 200  
Phone: 732-257-6662  
FAX: 732-257-7373  
[easterseals.com/nj](http://easterseals.com/nj)

**Spectrum for Living**

210 Rivervale Road, Suite 3  
River Vale, NJ 07675  
Phone: 866-367-7732  
201-358-8000  
FAX: 201-358-8089  
[spectrumforliving.org](http://spectrumforliving.org)

200 Spectrum Drive  
Edison, NJ 08817  
Phone: 732-287-1104  
FAX: 732-650-0137

**CYSTIC FIBROSIS**

**Cystic Fibrosis Foundation,  
Greater New Jersey Chapter**  
290 West Mount Pleasant Avenue  
Suite 2240  
Livingston, NJ 07039  
Phone: 973-656-9200  
Email: [newjersey@cff.org](mailto:newjersey@cff.org)  
[cff.org](http://cff.org)

**DEAFNESS/HEARING IMPAIRMENTS**

**Hearing Loss Association of America,  
New Jersey State Association**  
Phone: 973-705-9215  
[hearingloss-nj.org](http://hearingloss-nj.org)

**New Jersey Association of the Deaf, Inc.**  
[deafnjad.org](http://deafnjad.org)

**DEVELOPMENTAL DISABILITIES****The Boggs Center on Disability and  
Human Development**

Department of Pediatrics  
Rutgers Robert Wood Johnson Medical School  
Liberty Plaza  
335 George Street, 3rd Floor  
New Brunswick, NJ 08901  
Phone: 732-235-9300  
[rwjms.rutgers.edu/boggscenter](http://rwjms.rutgers.edu/boggscenter)

**DIABETES****American Diabetes Association, New Jersey Chapter**

Center Pointe II, Suite 103  
1160 U.S. Route 22 East  
Bridgewater, NJ 08807  
Phone: 732-469-7979  
FAX: 908-722-4887  
[diabetes.org](http://diabetes.org)

**DOWN SYNDROME****Bringing Up Down Syndrome (BUDS)**

504 Centennial Boulevard, #1444  
Voorhees, NJ 08043  
Phone: 856-985-5885  
Email: [information@bringingupdownsyndrome.org](mailto:information@bringingupdownsyndrome.org)  
[bringingupdownsyndrome.org](http://bringingupdownsyndrome.org)

**Down Syndrome Association of Central New Jersey**

25 Scotch Road, Suite H  
Ewing, NJ 08628  
Phone: 609-535-3696  
Email: [dsacnj@dsacnj.org](mailto:dsacnj@dsacnj.org)  
[dsacnj.org](http://dsacnj.org)

**Down Syndrome Association of Southern New Jersey  
(formerly known as KIIDS)**

P.O. Box 1546  
Bellmawr, NJ 08099  
[dsasnj.com](http://dsasnj.com)

**DWARFISM****Little People of America**

Phone: 888-LPA-2001  
[lpadistrict2.org](http://lpadistrict2.org)

**EATING DISORDERS****Food Addicts Anonymous**

Phone: 772-878-9657  
Email: [faawso@faacanhhelp.org](mailto:faawso@faacanhhelp.org)  
[faacanhhelp.org](http://faacanhhelp.org)

## **EPILEPSY**

### **Epilepsy Services of New Jersey**

50 Millstone Road  
Building 300, Suite 201  
East Windsor, NJ 08520  
Phone: 800-372-6510  
FAX: 609-392-5621  
[epilepsyservicesnj.org](http://epilepsyservicesnj.org)

## **HEAD INJURY/TRAUMATIC BRAIN INJURY (TBI)**

### **Brain Injury Alliance of New Jersey**

825 Georges Road, Second Floor  
North Brunswick, NJ 08902  
Phone: 800-669-4323  
FAX: 732-745-0211  
Email: [info@bianj.org](mailto:info@bianj.org)  
[bianj.org](http://bianj.org)

## **HUNTINGTON'S DISEASE**

### **Huntington's Disease Society of America— New Jersey Chapter**

P.O. Box 268  
Ridgewood, NJ 07451  
Phone: 888-HDSA-506  
[newjersey.hdsanj.org](http://newjersey.hdsanj.org)

## **LEARNING DISABILITIES**

### **International Dyslexia Association, New Jersey Branch**

P.O. Box 32  
Long Valley, NJ 07853  
Phone: 908-876-1179  
FAX: 908-876-0092  
Email: [njida@msn.com](mailto:njida@msn.com)  
[nj-dyslexiaida.org](http://nj-dyslexiaida.org)

### **Learning Disabilities Association**

of America, New Jersey Chapter  
614 Cranbury Road, Unit 6268  
East Brunswick, NJ 08816  
Phone: 732-645-2738  
Email: [info@ldanj.org](mailto:info@ldanj.org)  
[ldanj.org](http://ldanj.org)

## **MENTAL ILLNESS**

### **Mental Health Association in New Jersey, Inc.**

673 Morris Avenue, Suite 100  
Springfield, NJ 07081  
Phone: 800-367-8850  
[mhanj.org](http://mhanj.org)

### **New Jersey Disaster Mental Health**

Helpline Telephone: 877-294-HELP (4357)  
TTY: 877-294-4356

### **National Alliance on Mental Illness of New Jersey**

1562 Route 130  
North Brunswick, NJ 08902  
Phone: 866-626-4664  
732-940-0991  
[naminj.org](http://naminj.org)

### **New Jersey Mental Health Cares**

Phone: 866-202-HELP (4357)  
TTY: 877-294-HELP (4356)  
[njmentalhealthcares.org](http://njmentalhealthcares.org)

## **MULTIPLE SCLEROSIS**

### **Multiple Sclerosis Association of America**

375 Kings Highway North  
Suite b  
Cherry Hill, NJ 08034  
Phone: 800-532-7667  
856-488-4500  
FAX: 856-661-9797  
[mymsaa.org](http://mymsaa.org)

### **National Multiple Sclerosis Society, New Jersey Metro Chapter**

246 Monmouth Road  
Oakhurst, NJ 07755  
Phone: 800-344-4867  
732-660-1005  
FAX: 732-855-6984  
[nationalmssociety.org](http://nationalmssociety.org)

## **MUSCULAR DYSTROPHY**

### **Muscular Dystrophy Association**

25 East Spring Valley Avenue  
Suite 210  
Maywood, NJ 07607  
Phone: -800-572-1717:  
201-843-4452  
[mda.org](http://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  
Email: [apdanj@apdaparkison.org](mailto:apdanj@apdaparkison.org)  
[apdaparkison.org](http://apdaparkison.org)

## RESPIRATORY DISEASE

### **American Lung Association, New Jersey Chapter**

1031 U.S. Highway Route 22, Suite 203

Bridgewater, NJ 08807

Phone: 908-685-8040

FAX: 908-685-8030

[lung.org](http://lung.org)

## SCLERODERMA

### **Scleroderma Foundation, Delaware Valley Chapter**

385 Kings Highway North

Cherry Hill, NJ 08034

Telephone: -866-675-5545:

856-779-7225

[www.scleroderma.org](http://www.scleroderma.org)

## SENSORY IMPAIRMENTS

### **Everas Community Services, Inc.**

24K World's Fair Drive

Somerset, NJ 08873

Phone (Voice/TTY): 732-805-1912

FAX: 732-805-3088

[everas.org](http://everas.org)

### **New Jersey Speech-Language-Hearing Association**

174 Nassau Street, Suite 337

Princeton, NJ 08542

Phone: 888-906-5742

FAX: 888-729-3489

Email: [info@njsha.org](mailto:info@njsha.org)

[njsha.org](http://njsha.org)

## SPINA BIFIDA

### **Spina Bifida Resource Network**

84 Park Avenue, Suite G-106

Flemington, NJ 08822

Phone: 908-782-7475

FAX: 908-782-6102

Email: [info@thebrn.org](mailto:info@thebrn.org)

[thesbrn.org](http://thesbrn.org)

## SPINAL CORD INJURY

### **Central Jersey Spinal Cord Association**

P.O. Box 74

New Brunswick, NJ 08903

Phone: 732-828-5418

[cjsca.net](http://cjsca.net)

### **Christopher & Dana Reeve Paralysis Resource Center**

636 Morris Turnpike, Suite 3A

Short Hills, NJ 07078

Phone: 800-225-0292

[christopherreeve.org](http://christopherreeve.org)

## STROKE

### **New Jersey Stroke Activity Center, Inc.**

725 Joralemon Street, Suite 191

Belleville, NJ 07109

Phone: -973-450-4114

FAX: 973-450-0805

## TOURETTE SYNDROME

### **New Jersey Center for Tourette Syndrome**

50 Division Street, Suite 205

Somerville, NJ 08876

Phone: 908-575-7350

FAX: 908-575-8699

Email: [info@njcts.org](mailto:info@njcts.org)

[njcts.org](http://njcts.org)

# ADVOCACY RESOURCES

## ASSISTIVE TECHNOLOGY

**Richard West Assistive Technology Advocacy Center (ATAC)**  
**Disability Rights New Jersey**  
210 S. Broad Street, 3rd Floor  
Trenton, NJ 08608  
Phone: 800-922-7233  
609-292-9742  
TTY: 609-633-7106  
FAX: 609-777-0187  
Email: ATAC@disabilityrightsnj.org  
[disabilityrightsnj.org](http://disabilityrightsnj.org)

## GENERAL

**Advocates for Children of New Jersey (ACNJ)**  
35 Halsey Street, 2nd Floor  
Newark, NJ 07102  
Phone: 973-643-3876  
Email: advocates@acnj.org  
[acnj.org](http://acnj.org)

**Association for Special Children and Families**  
P.O. Box 494  
Hewitt, NJ 07421  
Phone: 973-728-8744  
FAX: 973-728-5919  
Help Line: 973-728-0999  
Email: ascfamily@hotmail.com  
[ascfamily.org](http://ascfamily.org)

**New Jersey Self-Advocacy Project**  
985 Livingston Avenue  
North Brunswick, NJ 08902  
Phone: 732-246-2525, x22  
FAX: 732-214-1834  
Email: NJSAP@ArcNJ.org  
[arcnj.org](http://arcnj.org)

**Statewide Parent Advocacy Network (SPAN)**  
570 Broad Street, Suite 702  
Phone: 800-654-7726  
973-642-8100  
FAX: 973-642-8080  
Email: info@spanadvocacy.org  
[spanadvocacy.org](http://spanadvocacy.org)

## FAMILY SUPPORT

**Family Resource Network**  
50 Millstone Road  
Building 300, Suite 201  
East Windsor, NJ 08520  
Phone: 800-372-6510  
FAX: 609-392-5621  
[familyresourcenetwork.org](http://familyresourcenetwork.org)

## FUTURE PLANNING

**Planned Lifetime Assistance Network of New Jersey (PLAN/NJ)**  
P.O. Box 547  
Somerville, NJ 08876-0547  
Phone: 908-575-8300  
FAX: 908-927-9010  
Email: info@plannj.org  
[plannj.org](http://plannj.org)

## LEGAL

**American Civil Liberties Union of New Jersey (ACLU-NJ)**  
P.O. Box 32159  
Newark, NJ 07102  
Phone: 973-642-2084  
[aclu-nj.org](http://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  
Email: chlpinfo@chlp.org  
[chlp.org](http://chlp.org)

**Community Justice Center**  
310 West State Street, 3rd Floor  
Trenton, NJ 08618  
Phone: 609-218-5120  
FAX: 609-218-5126  
[nj-communityjusticecenter.org](http://nj-communityjusticecenter.org)

**Disability Rights New Jersey**  
210 South Broad Street, 3rd Floor  
Trenton, NJ 08608  
Phone: 800-922-7233:  
609-292-9742  
TTY: 609-633-7106  
FAX: 609-777-0187  
[disabilityrightsnj.org](http://disabilityrightsnj.org)

**Education Law Center**  
60 Park Place, Suite 300  
Newark, NJ 07102  
Phone: 973-624-1815  
TTY: 973-624-4618  
FAX: 973-624-7339  
Email: elc@edlawcenter.org  
[edlawcenter.org](http://edlawcenter.org)

**Legal Services of New Jersey**  
P.O. Box 1357  
Edison, NJ 08818  
Phone: 888-576-5529  
[lsnjlaw.org](http://lsnjlaw.org)

# 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 believes that **informed citizens are better citizens** and is committed to providing free legal education programming for educators and the public. Programs provided by the Foundation include mock trial competitions for students in grades 3 to 12 and training sessions for educators on the topics of anti-bullying, anti-bias, conflict resolution, peer mediation, social emotional character development, and much more.

Publications geared for the public include *Domestic Violence: The Law and You (Fifth Edition)*, *Consumer's Guide to New Jersey Law*, *Avoiding Notario Fraud in New Jersey*, and *Your Guide to Municipal Court*. School-based publications available through the Bar Foundation include *The Bill of Rights Up Close*, *Beyond the Bill of Rights*, as well as our subscription-based publications—*The Legal Eagle*, a legal newspaper for kids, and *Respect*, a diversity and inclusion newsletter. Some publications are available in Spanish, and all are available in alternative formats for the visually impaired. Visit [publications.njsbf.org](http://publications.njsbf.org) to order or download.

For more information on programs and publications, visit the New Jersey State Bar Foundation online at [njsbf.org](http://njsbf.org). Please follow the Bar Foundation on social media and invite your friends to like and follow us as well. @NJStateBarFdn can be found on Facebook and Instagram. The New Jersey State Bar Foundation can also be found on LinkedIn and YouTube.





**New Jersey State Bar Foundation**  
**One Constitution Square**  
**New Brunswick, NJ 08901-1520**  
**732-249-5000**  
[njsbf.org](http://njsbf.org)

