TRUSTED

THE SURPLUS SOLUTION

JOINDER AGREEMENT

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29TRUST
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trustedsurplus.org

TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST

Joinder Agreement / Beneficiary Profile Sheet

This is a legal document. It is an agreement pertaining to a supplemental needs trust created pursuant to 42 United States Code §1396. You are encouraged to seek independent, professional advice before signing this agreement. The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST, dated February 13, 2023. The Trust is Irrevocable.

NOTE: All questions must be answered or your application will be delayed.

SPONSOR/BENEFICIARY INFORMATION

The Beneficiary and Donor must always be the same person. Only funds belonging to the Beneficiary may be contributed to the Trust.

Legal Name: First:_____ Middle:_____ Last: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Gender: _____

SSN: _____ - _____ - _____ Date of Birth: _____ /_____ /_____

Citizen: ☐ Yes ☐ No Tel: Home_____ Cell: _____

Place of Birth: _____

Address:_____ Apt#: _____

City:_____ State:_____ County:_____ Zip: _____

Email: _____

Spouses Name if Married: _____

(First / Last Name)

Please mail all trust documents to:
Trusted Surplus Solution
PO Box 297-050
Brooklyn, NY 11229

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PURPOSE OF ENROLLMENT

Indicate reason for establishing an account.

☐ Shelter Monthly Excess Income ☐ Shelter Excess Resources

HOUSEHOLD INCOME INFORMATION (please include proof of income)

Is Spouse Deceased? ☐ Yes ☐ No

Is Applicant & Spouse Applying Together? ☐ Yes ☐ No If Yes, Fill in Spouse's Income.

SPOUSE INFORMATION:

Name: First:_____ Last:_____

Spouse applied for Medicaid with beneficiary? ☐ Yes ☐ No

Type of Benefit	**Applicant** Monthly Amount	**Spouse** Monthly Amount
Supplement Security Income (SSI)	$	$
Social Security Disability Income (SSDI)	$	$
Social Security Retirement Income (SSA)	$	$
VA Benefits	$	$
Employment Benefits	$	$
Survivor Benefits	$	$
IRA Distribution	$	$
Pensions / Annuities	$	$
Interest / Dividends	$	$
Reparations	$	$
Other	$	$

Please Note: All disbursements must be for sole benefit of the account beneficiary.
A spouse is not a beneficiary for the account.

MEDICAID INFORMATION - Please Attach MAP / LDSS Notice of Decision

	Applicant	**Spouse**
Application Status Does the beneficiary receive Medicaid?	☐ **Yes** ☐ **No** ☐ **Pending**	☐ **Yes** ☐ **No** ☐ **Pending**
CIN Number/medicaid Number		
Monthly Spend Down $		

If the Beneficiary receives other benefits, such as Food Stamps, HUD Section 8, etc. list these benefits and monthly amounts: _____

FOR ANY APPLICABLE ITEMS BELOW, PLEASE ATTACH THE NECCESARY PROOF.

HEALTHCARE PREMIUMS

Please attach current statement and proof of payment.

Medicare part B Supplement: Plan Name: _____

Premium $:_____ Frequency:_____

Medicare Part D Plan: Plan Name:_____ Premium $:_____

FUNERAL ARRANGEMENT

Please attach pre-need funeral agreement.

Name of Funeral Home: _____

Address:_____ City: _____

State:_____ Zip:_____ Telephone: _____

BURIAL PLOT

Please attach a copy of plot deed.

Name of Cemetery:_____

Address:_____ City: _____

State:_____ Zip:_____ Telephone: _____

LIFE INSURANCE

Please attach a copy of policy.

Name of Insured:_____ Name of Owner: _____

Name of Insurance Company:_____ Policy #:_____

Type of Policy: ☐ Term _____ ☐ Life_____ Cash Surrender Value $ _____

Upon the death of the Beneficiary, amounts remaining in the Beneficiary's sub- account shall be retained in the Trust solely for the benefit of individuals who are disabled as defined in Soc. Sec. Law Section 1614(a) (3) [42 USC 1382c(a) (3)] and any subsequent definitions that are enacted into law.

QUALIFYING DISABILITIES

1. _____ 2. _____ 3. _____

LIVING ARRANGEMENTS (indicate the living arrangement of the Beneficiary)

☐ Independently ☐ With Spouse ☐ With Parents/other family ☐ Assisted Living Facility

☐ Family Care Program ☐ Nursing Home ☐ CR/IRA/ICF (supervised) ☐ CR/IRA (supportive)

☐ Other - Explain: _____

POWER OF ATTORNEY

Please attach a copy of Power of Attorney

Name: First: _____ Middle: _____ Last: _____

Address: _____ Apt#: _____

City: _____ State: _____ County: _____ Zip: _____

Tel. Home: _____ Cell: _____ Email: _____

Is this person the sole POA? ☐ Yes ☐ No

If No, are the agents authorized to act separately? ☐ Yes ☐ No

GUARDIANSHIP

Please attach a copy of Decree or Letter of guardianship.

Guardian appointed for the: ☐ Person ☐ Property ☐ Both

Name: First: _____ Middle: _____ Last: _____

Address: _____ Apt#: _____

City: _____ State: _____ County: _____ Zip: _____

Tel: _____ Email: _____

BENEFICIARY SERVICES

List other services that the Beneficiary receives (include day services, service coordination, employment programs, etc.):

Service: _____ Name of Provider: _____

_____ _____

_____ _____

AUTHORIZED REPRESENTATIVE: # 1

The following individual will be authorized to communicate with Trusted Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____ Middle:_____ Last: _____

Address:_____ Apt#: _____

City:_____ State:_____ County:_____ Zip: _____

Tel. Home: _____ Cell: _____

Email:_____ Relationship to Beneficiary:_____

Would you like this representative to be the primary contact? ☐ Yes ☐ No

AUTHORIZED REPRESENTATIVE: # 2

The following individual will be authorized to communicate with Trusted Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____ Middle:_____ Last: _____

Address:_____ Apt#: _____

City:_____ State:_____ County:_____ Zip: _____

Tel. Home: _____ Cell: _____

Email:_____ Relationship to Beneficiary:_____

Would you like this representative to be the primary contact? ☐ Yes ☐ No

REFERRING SOURCE

Name of Agency:_____ Name Of Contact: _____

Address:_____ Apt#: _____

City: _____ State: _____ County: _____ Zip: _____

Tel:_____ Email: _____

I Authorize any applicable documents necessary for reporting to Government Agencies to be sent to the referring source above. ☐ **Yes** ☐ **No**

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INFORMATION AND DISCLOSURES:

Death of Beneficiary:
The Beneficiary's sub-trust account terminates upon his or her death. If, upon the death of the Beneficiary, funds remain in his or her sub-trust account, such funds shall be deemed to be property of the Trust and all funds that are remaining in the Beneficiary's separate sub-trust account shall be retained by TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST to further the purposes of that Trust. However, to the extent that amounts remaining in the individual's subtrust account upon the death of the individual are not in fact retained by the Trust, the Trust shall pay to the State(s) from such remaining amounts in the sub-trust account an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan (s). To the extent that the trust does not retain the funds in the account, the State(s) shall be the first payee(s) of any such funds and the State(s) shall have priority over payment of other debts and administrative expenses except as listed in POMS SI 01120.203E.

Funeral expenses will only be paid pursuant to a Medicaid eligible pre-need funeral arrangement established and funded prior to the Beneficiary's death. Funeral expenses will not be paid after the Beneficiary's death.

Contributions/Deposits:
All contributions made to the sub-trust account will be held and administered pursuant to the provisions of the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST which are incorporated by reference herein.

The Trustees shall have the sole and absolute right to accept or refuse additional deposits to the sub-trust account.

In the event that a Beneficiary has a zero ($0) sub-trust account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary's sub-trust account. Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming from the prior sub-trust account. Additionally, the Beneficiary shall be required to pay a new enrollment fee when re-opening a sub-trust account.

Disbursements:
All disbursement requests shall be reviewed and approved on an individual basis.
Disbursements for expenses incurred more than 90 days prior to submission of a disbursement request form shall not be paid.

The Trustees, in their discretion, have determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol, tobacco, items relating to illegal activity, bail, or restitution.

All disbursements shall be made at the sole and absolute discretion of the Trustee. No disbursements will be made after the death of the beneficiary, even for expenses incurred or due prior to death.

Disability Determination:
In the event that a determination of disability is required for Medicaid purposes, please be advised that administrative fees shall be incurred while the determination of disability is being made.

The Donor acknowledges that contributions to the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST are not tax deductible as charitable gifts, or otherwise.

Sub-trust account income may be taxable to the Beneficiary.

Disclosure of Potential Conflict of Interest:
There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the sub-trust account at the time of death of the Beneficiary. Funds remaining in the Trust may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST.

The Donor executing this Joinder Agreement is aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with SCF Charitable Organization or with any Beneficiary or constituent agencies and/or Chapters.

Situs:
The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be administered by SCF Charitable Organization Inc. and a financial institution in the State of New York. The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New York. The situs of this Trust for administrative, account and legal purposes shall be in the County of Kings, the County where the majority of meetings concerning establishment of the Trust occurred.

Invalidity of any Provision:
Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

By signing below, you affirm that you understand and agree to the following:
I have received and read a copy of the applicable Master Trust prior to the signing of this Joinder Agreement and acknowledge that I understand the contents thereof. I also understand that said document may be amended from time to time. I have been provided with the applicable fee schedule and acknowledge that I understand the contents thereof. I also understand there may be changes from time to time.

I am entering into this Joinder Agreement voluntarily and acting on my own free accord.

The Donor acknowledges that the Beneficiary is disabled as defined in Social Security Law Section 1614(a)(3) [42 USC 1382c(a) (3)].

Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.

The TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST is authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept a donor's property pursuant to this Joinder Agreement, TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST, Inc. agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation. It is the sole responsibility of the donor and/or the donor's representative to determine whether the donor is "disabled" as that term is defined under federal law, to determine whether they have the legal authority to transfer property to fund the trust, and the impact that a transfer of property to the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST will have on the donor's continuing eligibility for government benefit programs.

SCF Charitable Organization is not assuming any responsibility as counsel for the donor or Beneficiary, or providing any legal advice as it relates to the consequences of a transfer of property to the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST.

The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account. The cost of which may be charged to the sub-trust account.

The party authorized to speak with us on your behalf or the intermediary must notify TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST, Inc. immediately upon your death and will be required to provide us with a certified death certificate. An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.

This Joinder Agreement and the participation of the Beneficiary in the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST is an important legal decision that may have significant and lasting consequences for the Beneficiary and as a result you may want to consider obtaining advice from an attorney or another professional adviser before entering into this Agreement. By signing this Agreement you are acknowledging that you have had a full and complete opportunity to confer with an attorney or other adviser and that no employee of SCF Charitable Organization has provided you (or the Beneficiary, if different from the person signing this Agreement) with any legal advice in connection with this Joinder Agreement, the participation by the Beneficiary in the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST or the suitability of such participation by the Beneficiary in the TRUSTED SURPLUS SOLUTIONS DISABILITY POOLED TRUST based upon the particular circumstances of the Beneficiary.

SIGNATURE

I certify that the above Information is accurate and completed to the best of my knowledge.

SIGNATURE _____ DATE _____

PRINT _____ RELATIONSHIP _____

SIGNATURE OF NOTARY

STATE OF New York) SS:
COUNTY OF: _____)

On_____ , 20_____ Before me the undersigned, a Notary Public in and for said State, personally appeared_____personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledge to me that he/she/they executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed this instrument.

NOTARY PUBLIC _____

(New York Residents Only)
Or in lieu of Notarization, the following two witness signatures are provided:

WITNESS 1 : _____ WITNESS 2 : _____

SIGNATURE: _____ SIGNATURE: _____

PLEASE PRINT FULL NAME: _____ PLEASE PRINT FULL NAME: _____

FULL ADDRESS: _____ FULL ADDRESS: _____

FOR OFFICE USE ONLY

Accepted by Trustee or Designated Representative of the Trustees, Trusted Supplemental Needs Trust.

SIGNATURE _____ DATE APPROVED _____

TITLE _____

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TRUSTED
THE SURPLUS SOLUTION

FOR OFFICE USE ONLY:	
Member ID #:	
Effective Date:	

DIRECT DEBIT REQUEST FORM

Donor/Beneficiary: _____

Representative: _____

Bank Name: _____ City: _____ State _____

Bank Routing Number: _____ Account Number: _____

Account Name: _____ Account Type: ☐ Checking ☐ Savings

PLEASE SUBMIT A VOID CHECK ALONG WITH YOUR FORM.

I authorize and request Trusted Pooled Trust to initiate debit entries to my account at the depository financial institution indicated above. This authorization is to remain in full force and affect until Trusted has written notification from me of its termination in such time and manner as to afford Trusted and depository financial institution a reasonable opportunity to act on it.

Beneficiary/ Representative Signature: _____

FOR OFFICE USE:					
Account #:		Member ID #:		Processed By	
Monthly Debit Amount: $ _____					
Monthly dates for direct debit are as follows: 1, 3, 7, 14, 21, 28 (debit will occur on or around the date selected)					
Date of Monthly Debit: _____ First Debit Month: _____					

If any direct debits are returned for insufficient funds, a $53 charge will apply

A $100 annual - renewal fee will be charged on the anniversary of the account