TRUSTED

THE SURPLUS SOLUTION

JOINDER AGREEMENT

TF : 877-298-7878
29TRUST
Tel : 718-970-7878
Fax : 646-904-8963
info@trustedsurplus.org
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: Talha Refferal Middle: 4iOaOVs7de Last: Rana

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

SSN: 1231232 Date of birth: 2023-10-13

Citizen: ☐ Yes ☐ No Tel: Home 33FRNlumky Cell: (923) 116-9023

Place of birth j5iIAQa38X

Address: C-5 Staff Colony Apt# 123

State Alaska City Sahiwal Country United States of America Zip Code 57000

Spouses Name if Married: WycQ6UdQom

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:

First Name w5sNOsUQan Last Name ZhEOV2SMLq

Spouse Applied for Medicaid with beneficiary? ☐ Yes ☐ No

Type of Benefit	Application Monthly Amount	Spouse Monthly Amount
Supplement Security Income(SSI)	$ YCpnMZkYnH	$ ISVes1Hajr
Supplement Security Disability Income(SSDI)	$ 2rINXA4apA	$ 420a53MesO
Supplement Security Retirement Income(SSA)	$ VEvytWm0nY	$ jDeNq2j9EV
VA Benefits	$ qMTLqmnzlU	$ mNoQVInmpZ
Employment Benefits	$ K6lteWwsox	$ DWD1SjAAYU
Survivor Benefits	$ d1rCxJDDOc	$ fEwkaO3RNO
IRA Distribution	$ OgqBzbYCKn	$ BluTdZxidu
Pension / Annuities	$ 0c27DkamXb	$ z6deSZldyz
Interest / Dividends	$ fcWtEzzxGZ	$ ZkHo5XEb7r
Reparations	$ Wl22msmDsB	$ 4WVtlJLu9I
Other	$ IfyOVHbORt	$ XMCLQU8dkw

Please note: All disbursements must be for sole benefit of the country 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	0911019051	4410825664
Monthly Spend Down $	PX6eRVL1b3	fd3SrhBTQQ

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 NECESSARY PROOF.

HEALTH CARE PREMIUM

Please attach current statement and proof of payment.
Medicare part B Supplement Plan Name: PX6eRVL1b3
Premium $: 0Uf2qYgjIU Frequency: rt95HQtYUE
Medicare Part D Plan Plan Name: VLvk8MQfAT Premium $: fxvHXfxC2X

FUNERAL ARRANGEMENT

Please attach pre-need funeral agreement.
Name of Funeral Home: tTNtKPumbk
Address 8yeDwLKf9d City W7tzf1HotA
State xtgWJeYhjJ Zip: c7RpPt4vgt Telephone 8149627381

BURIAL PLOT

Please attach a copy of plot deed.
Name of Cemetery: AffLnCqSyc
Address PQWfSRudYZ City rL9qVZeccx
State 66xuXfPfFG Zip: VhdzwKG4rs Telephone 4349888392

LIFE INSURANCE

Please attach a copy of policy
Name of Insured: nmK3DAWnI8 Name of Owner gJYS15l0wn
Name of insurance company WLtp1qakgN Policy #: 4669132579
Term of policy ☐ Term clKz4gAzxf ☐ Life TeMclwpcMO Cash Surrender Value $ xdpZmfWvkw

Upon the death of the Beneficiary, amounts remaining in the Beneficiary's sub-account shall be reined 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 yZP7X6q1vt 2. D6U6G59mi0 3. W0DMC5OjVn

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 u6OZ2n0X6V

POWER OF ATTORNEY

Name: First sJHrTMG0bs Middle JARPkSJmqh Last QKP9M31OoT

Address bqG5G2TfxD Apt#: OFifnYwVCB

City y4kBu8E7Ba State SaPCMVs4Wh Country Ph3JtLcaTh Zip NemrSdLSEr

Tel. Home: HAVbiXfggk Cell Nt1lWb3pVl Email kMUSad0pFE

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 FZnutYZ2H1 Middle FHz2QjJ0B4 Last F7WaVG6VeJ

Address qVnkZXiqOP Apt#: WDLPj5IB59

City JCTKiiQEcx State 63KQcNvCwS Country EHSlMTqG9Y Zip dRDqxH7F9E

Telephone 2442006842 Email IEi1fK3fOA

BENEFICIARY SERVICES

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

Service	Name of Provider
zr45exd9OE	o46ble3BL0
OVnZ7WlT1D	KgYYFBfm7E
9xvCLQh5Oj	nfxtGJgNWV

AUTHORIZED PREVENTATIVE: #1

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

Name: First Cdr605NIRs Middle A0texQJ9rB Last 9iKZ2wGket

Address 4g0lFeXG45 Apt#: DOdDRIMYvh

City nDt4YKkP7H State ABOXeKhLXE Country Y0IZwAIMb3 Zip rmB9x1fzZZ

Telephone MU2FKgfbJw Cell R7d43oHHem

Email ZNmnJYXACQ Relationship to Beneficiary SoHfjXI63F

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

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AUTHORIZED PREVENTATIVE: #2

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

Name: First lxRr29dszH Middle sC91V0jJGu Last RpUptJRMqv

Address C4IsdkT3vW Apt#: m8U4DvI7nb

City 8C9DT4VC91 State uvagpDma5U Country 4kGqMeh3jO Zip EDk7MS2slH

Telephone PXSv1vx83I Cell p2eNfE8oib

Email H4hF24Id7A Relationship to Beneficiary hGZO0Cokyd

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

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REFERRING SOURCE

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

Name of Agency 5ASIWjLZgb Name of Contact 4379866319

Address IJyBPUhGqD Apt#: Pk7NyIWmOt

City Glioq81kyi State nW2W0y1h31 Country RqSvot5Fbo Zip OhkousWLgM

Telephone 8XjlMxGyaY Email 3Xj7hFqjKN

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

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 sub-trust 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.
br 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 the completed to the best of my knowledge.

2023-11-18

DATE

F37GutEqnx

PRINT

flKfizJTIr

RELATIONSHIP

SIGNATURE OF NOTARY

STATE OF New York GPsKPBnAHY SS:

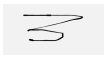
COUNTY OF wJyFlwXzE3)

ON 2023-11-22 ,20 qiqC2xMKEw

Before me the undersigned. aNotary Public in and for said State, personally appeared 6VbDPCz3F9 personally known to me or proved to me on the basis of satisfactory evidence to me 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.

y7CSxO1Qcr

NOTARY PUBLIC

facERYKXlR	nt4QBXjKLS
WITNESS 1	WITNESS 2
	
Witness 1 Signature	Witness 2 Signature
HkkYGCvwWN	Ei2uZ4SsLL
FULL NAME	FULL NAME
2h9ZDx71nn	rPZoGIUHk0
FULL ADDRESS	FULL ADDRESS

FOR OFFICE USE ONLY

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

2023-11-22

DATE APPROVED

SIGNATURE

HWk0NtXgdw

TITLE

FOR OFFICE USE ONLY	
Member ID#:	SsSOTs2NQj
Effective Date:	2023-11-01

TRUSTED
THE SURPLUS SOLUTION

DIRECT DEBIT REQUEST FORM

Donor/Beneficiary:
2023-11-01

Representative:
eNodlz6XxC

Bank Name: GZIC1KHTK8 City: bhgx6CY8za State: hHzQj00gVm

Bank Routing Number: 63QGYaLqY6 Account Number: 2271783820

Account Name: 2lyOOiD9es 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#:	8804486119	MemberID#:	nmgpsNR9Ou	Processed By:	MmK40PAmKF
Monthly Debit Amount: $ eFClApyaf7					
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: eFClApyaf7 First Debit Month:: JADVQXDVmU					

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

TRUSTED