

SPECIAL NEEDS TRUST FOUNDATION THIRD-PARTY MASTER TRUST JOINDER AGREEMENT

UPON EXECUTION BY DONOR AND UPON ACCEPTANCE AND EXECUTION BY THE SPECIAL NEEDS TRUST FOUNDATION, THIS WILL BE A BINDING LEGAL DOCUMENT. YOU ARE ENCOURAGED TO SEEK INDEPENDENT PROFESSIONAL ADVICE BEFORE SIGNING.

The undersigned hereby enrolls in and adopts the "Special Needs Trust Foundation Master Trust Agreement" dated January 17, 1992, which is incorporated herein by reference and a copy of which has been delivered to the Donor.

A. All property transferred to the Trustee pursuant to this Joinder Agreement shall be held in a sub-account and administered and distributed as provided herein and in the Master Trust Agreement.

B. Trust sub-account number: _____
(Assigned by Trust Company)

C. **DONOR INFORMATION**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (day): _____ (evening): _____

Date of Birth: ___/___/___ (mm/dd/yyyy) **Social Security number** ___ - ___ - ___

Relationship to person with special needs: _____

Family Attorney: _____

Attorney's Address: _____

Attorney's Phone #: _____

D. PERSON WITH SPECIAL NEEDS INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (day): _____ (evening): _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Social Security number ____ - ____ - ____

Place of Birth: _____ Citizenship (country): _____

Is Person With Special Needs Conserved? Yes: ____ No: ____

If yes, please attach documentation.

Name of Conservator: _____ Phone: _____

Address: _____

1. Does the Beneficiary receive **Supplemental Security Income (SSI)**?

Yes: ____ No: ____ If so, how much per month? \$ _____

2. Does the Beneficiary receive **Social Security Disability Insurance (SSDI)**?

Yes: ____ No: ____ If so, how much per month? \$ _____

3. Does the Beneficiary receive **Social Security Survivor's Benefits**?

Yes: ____ No: ____ If so, how much per month? \$ _____

4. Does the beneficiary receive **Social Security Benefits**?

Yes: ____ No: ____ If so, how much per month? \$ _____

If "yes" to any of the above, who is **Beneficiary's representative payee**?

Name: _____ Phone: _____

Address: _____

5. Does the Beneficiary receive **Medi-Cal**?

Yes: ____ No: ____

If "yes" what is the Beneficiary's Medicaid card number? _____

If "Yes" what is the name, ID Number, address and telephone number of the Beneficiary's Medicaid Caseworker?

Name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

6. Does the Beneficiary receive a **Medicaid Waiver**:

Yes: _____ No: _____

If "yes" specify the waiver program(s) under which the Beneficiary receives benefits:

If "yes" what is the Beneficiary's Medicaid card number? _____

7. If the Beneficiary receives **other Government Assistance***, such as **Food Stamps, SILP, AFA, Supported Living, CHOICE, ARCH, Section 8 Housing**, etc., please **list these benefits and the case worker and/or contact person's name and address here**:

*"Government Assistance" means those services or financial assistance paid for or otherwise provided by a local, state, or federal government or agency or department thereof, to, or on behalf of eligible beneficiaries.

8. Does the Beneficiary receive services from the **San Diego Regional Center**?

Yes: _____ No: _____

If "Yes" what is the name, ID Number, address and telephone number of the Beneficiary's Regional Center Caseworker?

Name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

9. Does the Beneficiary receive services from the **Department of Rehabilitation, the Department of Mental Health, the Department of Social Services, and/or Department of Developmental Services (i.e. Regional Center)**?

Yes: _____ No: _____

If "Yes" what is the name, ID Number, address and telephone number of the Beneficiary's Caseworker?

Name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

10. Does the Beneficiary have an **additional source of income**?

Yes: _____ No: _____ Source of additional funding _____ Amount \$ _____

E. KEY PERSON:

A "Key Person" is an individual who knows the Beneficiary, whom the Beneficiary trusts, and who can act as a prudent and responsible "advisor" to The Special Needs Trust Foundation (SNTF). Essentially, a "key person" acts as a liaison between the Beneficiary and SNTF. The key person communicates the Beneficiary's needs and desires to the SNTF and makes actual disbursement request to be considered by the SNTF, key people are valuable to both the Beneficiary and the SNTF because they provide insight into how a Beneficiary's trust account can best be used to provide him or her with the best possible material quality of life. A Beneficiary can have more than one key person.

List the key person or key people below:

1. Name: _____ Phone: _____
Relationship to Beneficiary: _____
Address: _____
City: _____ State: _____ Zip: _____

2. Name: _____ Phone: _____
Relationship to Beneficiary: _____
Address: _____
City: _____ State: _____ Zip: _____

3. Name: _____ Phone: _____
Relationship to Beneficiary: _____
Address: _____
City: _____ State: _____ Zip: _____

G. DISTRIBUTIONS FOLLOWING THE DEATH OF THE PERSON WITH SPECIAL NEEDS:

1. At the time of death of the person with special needs, if there are assets remaining in his or her separate trust sub-account, a minimum of at least twenty-five (25%) of the remaining property shall be distributed to the Special Needs Trust Foundation (SNTF) **and** a minimum of at least twenty-five (25%) of the remaining property shall be distributed to one of the participating member charitable organization(s) serving persons with special needs as designated by the Donor*. These organizations include only those which are members of the SNTF Board and SNTF. A current list of such organizations may be obtained from the SNTF office.

Distributions shall be in the following percentages and to the following organizations and/or persons:

	Percentage	Donor's Initials
Special Needs Trust Foundation (at least 25%)	_____	_____
Address: P. O. Box 1890		
City: Lakeside State: CA Zip: 92040 Phone: 619-201-2672		
Member Charity (at least 25%) _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
Beneficiary Name _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
Beneficiary Name _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
	TOTAL 100%	

***Note: A Donor may not be listed as a beneficiary.**

2. The share for a remainderman named in (F)(1) who does not survive the beneficiary shall lapse and be distributed prorated to the remaindermen stated on page 3 or as otherwise stated as follows:

3. Article Three, section (b) of the Special Needs Trust Foundation, Master Trust Agreement states in part: "Upon receipt and acceptance by the Trustee, such contributions shall be irrevocable." Pursuant to this provision, the designations of distributees made in F.1., 2. above are irrevocable with respect to funds which have been given to the Trust. For example, a Donor may fund the trust during the Donor's lifetime with a gift of \$5,000. The designations above are irrevocable upon the receipt of the \$5,000 with respect to the \$5,000. However, the designations can be amended by the Donor with respect to future funding.

SPECIAL NEEDS TRUST FOUNDATION

Information Sheet

Obtain document from C:/SNTF/SNTF Material/Joinder Info Sheet.xls.

DISABILITY(S) & EQUIPMENT

Name _____

TYPE	EQUIPMENT AND/OR USE		FUNDING SOURCE	
	YES	NO	YES	NO
VISUAL				
BLIND				
IMPAIRED				
HEARING				
DEAF				
IMPAIRED				
RETARDATION				
MILD				
SEVERE				
PROFOUND				
PSYCHIATRIC DISORDER				
SCHIZOPHRENIA				
MANIC DEPRESSION				
OTHER				
PHYSICAL				
CEREBRAL PALSY				
HEAD INJURED				
OTHER				

Please write below some suggested guidelines for use of this Special Needs Trust. What hopes and dreams for the person with special needs do you see being fulfilled with this money?

LETTER OF INTENT

The following guide is to direct the Special Needs Trust Foundation Board in carrying out your wishes when we make future financial decisions. It is important that you sit down with your family and come to a consensus about what you want for the future. The outline below can be used as a guide in your decision. **List 4 or 5 preferences under each heading.** (Example: Residential: 1st Choice - Live in an apartment with assistance. 2nd Choice – Live in a group home.)

Residence: *If something should happen to you tomorrow, where will your son or daughter live:*
___ Group Home _____
___ Apartment with Assistance _____
___ Family Member's Home _____
___ Other _____

Education: *You have a lifelong perspective of your son or daughter's capabilities. Share it!*

Employment: *What has your son or daughter enjoyed? Consider his or her goals, aspirations, limitations, etc.*
___ Group Employment _____
___ Individual Employment _____
___ Community Employment _____
___ Light Industrial Workshop _____
___ Day Activity Center _____
___ Other _____

Medical Care: *What has and has not worked with your son or daughter? What should future caregivers know?*

Social: *What activities make life meaningful for your son or daughter?*
___ Favorite Activities _____
___ Community Recreation Organization _____
___ Travel _____
___ Other _____

Religious: *Is there a special church or synagogue or person your son or daughter prefers for fellowship?*

It is also very important that the Board know whom you have designated to be an advocate or guardian for your son or daughter. If you don't have family or anyone you can designate, please indicate that you'd like some of the money used to purchase private fiduciary services.

After you complete all of the life planning areas, **sign and date this important document.** This letter will be kept with your trust documents to provide the Board instructions for future disbursement. This letter can be amended any time in the future.

Donor's Name (please print) _____

Person with special needs _____

Signature _____ Date _____