JOINDER AGREEMENT
SPECIAL NEEDS TRUST FOUNDATION
SELF-SETTLED MASTER TRUST

THIS IS A LEGAL DOCUMENT. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING.

The undersigning hereby enrolls in and adopts Special Needs Trust Foundation (SNTF) Self-Settled Master Trust dated March 17, 2006 which is incorporated herein by reference.

A. Trust sub-account number(Assigned by Trustee): ____

B. Beneficiary's Information:

Name: ____

Address: ____

City: ______________________ State: ______________________ Zip: ________

Phone (day): _______________________ (evening): _________________________________

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

Disability/Diagnosis: ____

Is the beneficiary conserved? Yes: _____ No: _____ If yes, please attach documentation.

Name of Conservator: __________________________ Phone: ____________________________

Address: ____

City: ______________________ State: ______________________ Zip: ________

C. Benefits Received:

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: ____

City: ______________________________ State: _______________ Zip: ________

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 $__________

D. **The amount at which the sub-account has been funded is: $** ____________________

Source of original funding: ________________________________

Additional funding: $ __________ Frequency: __________________

Source of additional funding: ______________________________

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: ____
   Relationship to Beneficiary: ____________________________
   Address: ____
   City: ________________ State: __________ Zip: ________
   Phone: ______________________________

2. Name: ____
   Relationship to Beneficiary: ____________________________
   Address: ____
   City: ________________ State: __________ Zip: ________
   Phone: ______________________________

3. Name: ____
   Relationship to Beneficiary: ____________________________
   Address: ____
   City: ________________ State: __________ Zip: ________
   Phone: ______________________________

F. Distributions upon the Beneficiary's death:

If this trust account is funded with the Beneficiary's own money, federal law requires that all unspent money in the account remaining at the time of the Beneficiary's death be used to reimburse the State(s) for medical services received up to the total amount that the State(s) has spent on medical services for the Beneficiary throughout the Beneficiary's lifetime. If a balance remains after the State(s) has been reimbursed (which is highly unlikely, unless the Beneficiary has drawn Medicaid benefits for only a short period of time), said balance shall be disbursed as follows:

If the Beneficiary is a minor or is incompetent, the remainder shall be that individual's "heirs at law" as determined by the California Probate Code.

1. Name:________________________________ **Percentage:** ______________________
   Relationship to Beneficiary: ____
   Address: ____
   City: ___________________________ State: _______________ Zip: _________
   Phone: ____

2. Name:________________________________ **Percentage:** ______________________
   Relationship to Beneficiary: ____
   Address: ____
   City: ___________________________ State: _______________ Zip: _________
   Phone: ____

3. Name:________________________________ **Percentage:** ______________________
   Relationship to Beneficiary: ____
   Address: ____
   City: ___________________________ State: _______________ Zip: _________
   Phone: ____

TOTAL 100%

If the Beneficiary's residence changes from California to another state, distributions may cease until appropriate arrangements can be made within the sole discretion of the Trustee. If appropriate arrangements cannot be made, the Beneficiary's trust sub-account will be terminated by the Trustee with the remaining sub-account property distributed according to Section F, above.

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:

____

____

____

G. Fee:

An enrollment fee of $1,000.00 will be paid when this subtrust is funded.

An annual Trustee fee shall be assessed on funded trusts. This fee shall be determined according to the attached Schedule of Fees.

If the Beneficiary is subject to any additional fees, a listing of these fees shall be attached to this Joinder Agreement.

H. Miscellaneous:

The provisions of this Joinder Agreement may be amended as the Beneficiary and the Trustee may jointly agree, provided that such amendment is consistent with the SNTF Self-Settled Master Trust.

This Joinder Agreement and SNTF Self-Settled Master Trust may be terminated by the Trustee upon nonpayment of any required fee.

I. Taxes:

1. The Beneficiary (or his legal representative and/or Key person) acknowledges that contributions to SNTF Self-Settled Master Trust are not deductible as charitable gifts, or otherwise.

2. Trust sub-account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. The Beneficiary (or his legal representative and/or Key Person) is encouraged to obtain advice from a qualified tax professional

IN WITNESS WHEREOF, the undersigned Beneficiary or his/her legal representatives or designees has reviewed and signed this Joinder Agreement, understands it, and agrees to be bound by its terms, and the Trustee has accepted and signed this Joinder Agreement this _______ day of _______________, 20____.

______________________________________ ______________________________________

BENEFICIARY

BENEFICIARY'S LEGAL REP., TITLE
ATTACH SUPPORTING DOCUMENTATION

Approved and accepted:

____ ______________________________

TRUSTEE/SNTF Corporate Officer DATE

I have advised the special needs trust beneficiary or his/her representative regarding the alternatives to the establishment of a special needs trust. In addition, I will report the establishment of this special needs trust to any governmental agencies which require notice.

____ ______________________________

ATTORNEY DATE

Address:____

City:_____________________________ State: ____________________ Zip: ________

Telephone: ____