Special Needs Trust Foundation

353 E. Park Ave., Suite 101 ◆ El Cajon, CA 92020 ◆ (619) 790-4810

SECTION 2

JOINDER AGREEMENT
For the FIRST PARTY MASTER TRUST II

Special Needs Trust Foundation

353 E. Park Avenue, Suite 101 ◆ El Cajon, CA 92020 ◆ (619) 790-4810

JOINDER AGREEMENT
FIRST PARTY MASTER TRUST II

THIS IS A LEGAL DOCUMENT. YOU MUST BE REPRESENTED BY AN ATTORNEY.

The undersigning hereby enrolls in and adopts the Special Needs Trust Foundation (SNTF) First Party Master Trust II, which is incorporated herein by reference.

A. **Trust sub-account numbers (Assigned by Trustee): EIN** _____ **Case #** _____

B. **Beneficiary's Information:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Facility/Residence: _____

Does the Beneficiary anticipate any changes in his/her living situation in the next year?

_____

Phone (day):_____ (evening): _____

Email: _____

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

Disability/Diagnosis/Medications: _____

_____

Is the beneficiary conserved? Yes:_____No:_____If yes, please attach documentation.

Name of Conservator:_____Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

C. **Grantor:**

Name: _____

Established by: ___ Self ____Guardian ____Court ____Parent ____Grandparent

D. **Benefits Received:** Attach benefit letters for all applicable.

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 Disability Benefits as an Adult Disabled Child (DAC)**?
   Yes:_____No:_____ If so, how much per month? $_____

4. Does the Beneficiary receive **Retirement Social Security Benefits**?
   Yes:_____No:_____ If so, how much per month? $_____

If "yes" to any of the above, who is **Beneficiary's Representative Payee** if any?

Name:_____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

5. Does the Beneficiary receive **Medi-Cal**?
   Yes:_____ No:_____

6. Does the Beneficiary receive a **Medicaid Waiver**:
   Yes:_____No:_____

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

7. Does the Beneficiary receive Section 8 Housing benefits?
   Yes:_____No:_____

   If "yes," then regular distributions may increase your rent, whereas irregular distributions should not.

8. If the Beneficiary receives other Government Assistance*, such as **Food Stamps,** etc. Please **list these benefits**:

_____

_____

9. Does the Beneficiary receive services from the **San Diego Regional Center**?
Yes:_____No:_____

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

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____Email: _____

10. Does the Beneficiary have an additional source of income?
Yes:____No:_____Source of additional income:_____Amount $_____

11. Benefits Pending:
Does the Beneficiary have a pending benefits application? _____

If yes, which type of benefits? _____

What was the application date? _____

E. **<u>The amount at which the sub-account will be funded is</u>:** $ _____

Source of original funding: _____

Additional funding: $_____ Frequency: _____

Source of additional funding: _____
If additional funding is from an annuity or structured settlement, please attach documentation.

Additional background information (summary of events leading to establishment of SNT):

_____

_____

_____

F. **<u>Beneficiary Advocate:</u>**

A "Beneficiary Advocate" 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 "beneficiary advocate" acts as a liaison between the Beneficiary and SNTF. The beneficiary advocate communicates the Beneficiary's needs and

desires to the SNTF and makes actual disbursement request to be considered by the SNTF, beneficiary advocates 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 beneficiary advocate serving at a time, and may provide for successor beneficiary advocates to serve when the initial beneficiary advocate(s) is(are) unable or unwilling to serve. A competent Beneficiary may serve as their own beneficiary advocate, but should name at least one additional beneficiary advocate.

List the beneficiary advocate(s) below:

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

   Phone:_____ Email: _____

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

   Phone:_____ Email: _____

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

   Phone:_____ Email: _____

G. Distributions upon the Beneficiary's death:

Because 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 ("Medi-Cal Payback"), to the extent that the State(s) is entitled, excepting amounts retained by the Trust ("Trust Remainder Share").

1. Trust Remainder Share

The Beneficiary may designate the amount to be retained by the Trust. The designation may be for an amount up to 70% of the funds remaining. Specify the percentage to be retained by the trust below:

In the event that the Medi-Cal Payback amount exceeds the funds remaining in the trust account at the time of the Beneficiary's death, _____% of the funds remaining upon the Beneficiary's death after payment of allowable expenses are to be retained by the Trust.

In the event that the Medi-Cal Payback amount is less then the funds remaining in the trust account at the time of the Beneficiary's death,_____% of the funds remaining upon the Beneficiary's death after payment of allowable expenses are to be retained by the Trust.

If a balance remains after the State(s) has been reimbursed said balance shall be disbursed as follows:

2. Remainder Beneficiary(ies)

(a) IF THE BENEFICIARY IS A MINOR OR IS INCOMPETENT, THE REMAINDER BENEFICIARY(IES) SHALL BE THAT INDIVIDUAL'S "HEIRS AT LAW" AS DETERMINED BY THE CALIFORNIA PROBATE CODE. OTHERWISE, THE REMAINDER BENEFICIARY(IES) SHALL BE AS NAMED BELOW:

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

Phone:_____ Email: _____

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

Phone:_____ Email: _____

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

Phone: _____ Email: _____

TOTAL 100%

If the Beneficiary prefers not to designate remainder beneficiary's, distributions will be made to the Beneficiary's Heirs at Law.

(b) If any Remainder Beneficiary is deceased at the time of distribution, the funds that would have been distributed to that beneficiary will instead be distributed to his or her descendants, by right of representation. If a Remainder Beneficiary does not have descendants, then his or her share shall lapse, and be distributed prorated to the remaindermen who survive the deceased remaindermen.

(c) If any Remainder Beneficiary is deceased at the time of distribution, any specific instructions written below shall take precedence over the provisions of subsection (b) above, and final distribution should be made according to this subsection (c):

_____

_____

_____

H. Outstanding Obligations:

List any outstanding loans, bills, liens, etc. (including unmet medical needs) that need to be paid:

_____ $_____ $_____
_____ $_____ $_____
_____ $_____ $_____

I. Expected Trust Distributions:

What are the beneficiary's expected trust distributions over the next 12 months?

_____ $_____ $_____
_____ $_____ $_____
_____ $_____ $_____

J. Fees:

1. Enrollment fee is $1,000 per 1st party trust established, billed to the trust when funded.

2. Annual administration fees are as follows:
   - Accounts with a balance of $10,000 or less will have zero fees, other than a $25 transaction fee for each check written over three checks per month. (If the account is frozen or closing, that fee will not be charged.)
   - Accounts with a balance of $10,000 - $120,000 will be charged a fee of $100 per month.
   - Accounts over $120,000 will be charged a fee of 1% per year.

Administrative fees will be billed to each trust on a quarterly basis. The fee covers record keeping, the cost of disbursing funds, post-funding reporting to Social Security and the Department of Health Care Services as required by State Law, communications with the beneficiary or their advocate as needed, and other general services.

3. Bank investment fees for each trust will be a minimum .67% annual fee, billed at the first of each month at the rate of 1/12 of .67%. The fee is subject to change from time to time. There will be no bank investment fees if Option 1 is chosen for Asset Allocation as defined in the Investment Policy Statement.

4. Termination fee of 5% of the remainder in the sub-account is due upon termination of the sub-account. This fee covers the administrative functions of the SNTF in relation to terminating the sub-account.

K. Amendment:

The provisions of this Joinder Agreement may be amended as the Beneficiary or their Beneficiary Advocate and the Trustee may jointly agree, provided that such amendment is consistent with the SNTF First Party Master Trust II.

L. **Taxes:**

1. The Beneficiary (or his legal representative and/or Beneficiary Advocate) acknowledges that contributions to SNTF First Party Master Trust II 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 Beneficiary Advocate) is encouraged to obtain advice from a qualified tax professional. Annual tax returns, if required, will be prepared by a certified public accountant. Preparation fee and any related tax liability will be billed to the trust.

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: _____

Attached are copies of the Beneficiary's:

- ☐ Benefit Eligibility Letters
- ☐ Benefit Eligibility Cards
- ☐ State Driver's License/ID Card
- ☐ Social Security Card
- ☐ Birth Certificate and/or Passport
- ☐ Any other pertinent benefit or identification documentation
- ☐ Copy of Annuity or Structured Settlement if Applicable

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SECTION 3

LIMITATIONS DISCLOSURE

Special Needs Trust Foundation

353 E. Park Ave., Ste. 101 ◆ El Cajon, CA 92020 ◆ (619) 790-4810

First Party Special Needs Trust
Limitations Disclosure

I have been informed of, and understand the nature of the following:

_____The fees associated with this trust as outlined in the Joinder Agreement.

_____I have been advised that the trust account is to maintain a minimum balance of no less than $5,000 to be used towards any final fees, taxes, filing fees, etc. for a reasonable period of time before final distribution can be made on my behalf.

_____I have been advised to seek professional advice on the tax consequences of trust sub-account income and/or gain.

_____I have been advised that the Master Pooled Trust is a supplemental trust and that it cannot disburse cash, nor funds for food or shelter expenses, without it potentially affecting my government benefits. The funds are budgeted for supplemental items which, in the trustee's discretion, are deemed appropriate to the sub-account beneficiary's needs.

_____I have been advised that if the funds are disbursed for food or shelter that I must be willing to take a reduction in SSI, and that it is my responsibility, or that of my legal representative, to report the funds received to Medi-Cal and SSI.

_____To the best of my knowledge, there are no liens or claims against the trust sub-account funds.

_____To the best of my knowledge, I meet the definition of having a disability according to the Social Security Administration.

_____I have been advised that I may join the Special Needs Trust Foundation and that my money will be put into a pooled account. I have chosen this option freely.

_____I have been advised that my Special Needs Trust with the Special Needs Trust Foundation is an irrevocable trust, and that the trust may only be terminated in accordance with the provisions of this Declaration of Trust. I have further been advised that terminating the trust may result in a reimbursement up to an amount equal to the total amount of medical assistance paid on my behalf by the Medicaid program.

_____I have been advised that the Special Needs Trust Foundation as Trustee may, at its sole discretion, disburse trust income or principal to purchase property or services for me, consistent with the purpose and objective of this Trust. Disbursements shall be made according to my interests and needs, taking into account the services and financial resources available to me from any sources.

_____I have been advised that the Special Needs Trust Foundation has the right to refuse the Joinder Agreement.

_____I acknowledge that I have received, read, understood and completed the First Party Master Trust II, Joinder Agreement, and Investment Policy Statement.

_____I have been advised that trust account balances under $10,000 will not be invested and will be held in a cash account.

For Spanish speaking only:

_____I acknowledge receipt of a copy of an unexecuted Spanish language translation of the 3rd Party Master Trust, Joinder Agreement, and Investment Policy Statement, prior to signing a completely filled in copy of these documents in English.

_____ _____

Beneficiary Signature **Date**

Or Beneficiary's Legal Representative_____

State Relationship _____