

Senior Life Care

JOINDER AGREEMENT

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SLC SUPPLEMENTAL NEEDS 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 §1396p(d)(4). 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 SLC Supplemental Needs Trust, dated December 24, 2017.

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

BENEFICIARY INFORMATION

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

Name:

First *Middle* *Last*

Marital Status Married Widowed Single **Gender** _____

_____-_____-_____
Social Security Number *Date of Birth* *Citizenship*

Contact Information:

Home Phone *Cell Phone*

Preferred Phone Cell Home

Email

Address:

Address *Apt #* *City* *State* *Zip*

Qualifying Disabilities:

1. _____ 2. _____ 3. _____

Please mail all trust documents to:

SLC Supplemental Needs Trust
5014-16th Ave, Suite 489
Brooklyn, NY 11204

AUTHORIZED REPRESENTATIVES:

Who will be your primary contact? Beneficiary Auth. Rep. 1 Auth. Rep. 2

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

Authorized Representative #1

First _____ *Last*

Contact Information

Home Phone _____ *Cell Phone* _____ Preferred Phone Cell Home

Email _____ Relationship to Beneficiary _____

Address

Address _____ *Apt #* _____ *City* _____ *State* _____ *Zip* _____

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

Authorized Representative #2

First _____ *Last*

Contact Information

Home Phone _____ *Cell Phone* _____ Preferred Phone Cell Home

Email _____ Relationship to Beneficiary _____

Address

Address _____ *Apt #* _____ *City* _____ *State* _____ *Zip* _____

REFERRING SOURCE

Name of Agency

Name of Contract

Home

Email

Address _____ *Apt #* _____ *City* _____ *State* _____ *Zip* _____

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

PURPOSE OF ENROLLMENT

Indicate reason for establishing an account.

Shelter Monthly Excess Income Shelter Excess Resources

MEDICAID INFORMATION

Please Attach MAP / LDSS Notice of Decision	Applicant	Spouse
Application Status Does the beneficiary receive Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 _____

HOUSEHOLD INCOME

Spouse 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.

Name: First _____ Last _____

Spouse applied for Medicaid with beneficiary? Yes No

TYPE OF BENEFIT MONTHLY AMOUNT	Applicant	Spouse
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.

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

HEALTHCARE PREMIUMS

Medicare Part: B D

Does the applicant have a supplemental policy? Yes No

If yes, what is the monthly premium? \$ _____ Plan Name? _____

FUNERAL INFORMATION

Does the Beneficiary have any funeral provisions in place? Yes No

If you answered yes, please attach funeral provision documents.

LIFE INSURANCE INFORMATION

Is there a life insurance policy in place for the Beneficiary? Yes No

If you answered yes, please attach funeral provision documents.

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.

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 - _____

LIVING ARRANGEMENTS

Please attach a copy of the guardianship order with this Joinder Agreement.

Does the Beneficiary have a court appointed Guardian? Yes No

If you answered yes, continue to fill out below:

Guardian of the: Person Property Both

Court Appointed Guardian Information

First

Last

Primary Phone

Email

POWER OF ATTORNEY

Power of Attorney *Please attach a copy of Power of Attorney*

First

Last

Primary Phone

Email

Address

Apt #

City

State

Zip

Is this person the sole POA? Yes No

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

Power of Attorney - Second Agent *Please attach a copy of Power of Attorney*

First

Last

Primary Phone

Email

Address

Apt #

City

State

Zip

Is this person the sole POA? Yes No

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

GUARDIAN INFORMATION

Please attach a copy of Decree or Letter of guardianship.

Does the Beneficiary have a court appointed Guardian? Yes No

If you answered yes, continue to fill out below:

Guardian of the: Person Property Both

Court Appointed Guardian Information

First

Last

Primary Phone

Email

BENEFICIARY SERVICE

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

Service _____

Name of Provider _____

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 SLC Supplemental Needs 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 SLC Supplemental Needs 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 SLC Supplemental Needs 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 SLC Supplemental Needs 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 a liations with Senior Lifecare Corp 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 Senior Lifecare Corp 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 SLC Supplemental Needs 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, SLC Supplemental Needs Trust 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 SLC Supplemental Needs Trust will have on the donor's continuing eligibility for government benefit programs.

Senior Lifecare Corp 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 SLC Supplemental Needs 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 SLC Supplemental Needs Trust 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 SLC Supplemental Needs 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 Senior Lifecare Corp 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 SLC Supplemental Needs Trust or the suitability of such participation by the Beneficiary in the SLC Supplemental Needs Trust based upon the particular circumstances of the Beneficiary.

AGREEMENT SIGNATURE

Who is signing this Joinder Agreement? Beneficiary Power of Attorney Guardian

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

Sign Here

Print

____/____/____
Date

SIGNATURE OF NOTARY

STATE OF _____

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

OR SIGNATURE OF TWO WITNESSES

(New York Residents Only)

Or in lieu of Notarization, the following two witness signatures are provided:

Witness 1

Date

Sign Here

Print Full Name

Full Address

Witness 2

Date

Sign Here

Print Full Name

Full Address

FOR OFFICE USE ONLY

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

Sign Here

____/____/____
DATE

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 SLC Supplemental Needs Trust, dated December 24, 2017 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 SLC Supplemental Needs Trust has written notification from me of its termination in such time and manner as to afford SLC Supplemental Needs Trust and depository financial institution a reasonable opportunity to act on it.

Beneficiary/ Representative Sign Here _____

FOR OFFICE USE:

Account #: _____ Member #: _____

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 \$150 annual - renewal fee will be charged on the anniversary of the account*

