CCT
Commonwealth Community Trust

Security for People with Special Needs since 1990

office | 804.740.6930 toll free | 888.241.6039 fax | 804.740.6065
address | PO Box 29408, Richmond, VA 23242-0408

First-Party Pooled Special Needs Trust Joinder Agreement With Medicare Set-Aside Account

IRREVOCABLE TRUST ADOPTION INSTRUMENT TAX IDENTIFICATION NUMBER 54-6440812

The undersigned Grantor(s) hereby irrevocably establish(es) a trust fund (sub account) with a Medicare Set-Aside Account (MSA) under Commonwealth Community Trust Endowment Fund ("CCT") Pooled Special Needs Master Trust Agreement, established by CCT, a non-profit, non-stock Virginia Corporation. The terms of the Grantor's trust fund are set forth in this Joinder Agreement (Joinder) and the applicable provisions of the CCT Pooled Special Needs Master Trust Agreement (MTA), dated December 8, 1994, as amended and restated, which is hereby adopted and incorporated herein by reference hereto. The terms of this Joinder may be revised in accordance with any revisions to the MTA and such revisions shall relate back to the date hereof.

This is a binding legal document. You are advised to seek professional advice before signing.

1. **Grantor(s) Information:** The Grantor(s) must be either the Beneficiary, the Beneficiary's parent(s), grandparent(s) or Guardian(s), or the Court. **If Guardian(s) or the Court, please provide legal documentation.**

A. Grantor 1:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

B. Grantor 2 (if applicable):

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

2. **Beneficiary Information:**

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Residence: (*e.g. private residence, group home)* _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

3. **Beneficiary Date of Birth:** _____

4. **Beneficiary Social Security Number*:** _____

*A copy is requested, if available.

5. **Description of Beneficiary's Disability:**
(Please enclose written documentation from a medical professional, if available).

_____

_____

6. **Has the beneficiary ever been declared to be incapacitated or incompetent by a Court of law?**
☐ Yes ☐ No

7. **Designation of Advocate:** The Advocate(s) is the person(s) responsible (*e.g., parent, sibling, relative, Guardian, Representative Payee, Power of Attorney, Beneficiary, Caseworker, Conservator, or other) for requesting disbursements and communicating information about the Beneficiary and the Trust.

PLEASE IDENTIFY PRIMARY ADVOCATE(S).

A. Primary Advocate: This person or person(s) will receive financial account information, tax documents and official correspondence from CCT and signs disbursement requests.

1.) Primary Advocate 1:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

*Relationship to Beneficiary: _____

Indicate account access preference: ☐Online / Internet ☐Mail

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

2.) Primary Advocate 2:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

*Relationship to Beneficiary: _____

Indicate account access preference: ☐Online / Internet ☐Mail

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

PLEASE IDENTIFY AT LEAST ONE SECONDARY ADVOCATE IF ONLY ONE PRIMARY ADVOCATE IS NAMED.

The Secondary Advocate will be contacted if the Primary Advocate cannot be reached or to obtain additional information.

B. Secondary Advocate: This person or person(s) can receive financial account information, can sign disbursement requests and will be contacted by CCT when needed.

1.) Secondary Advocate 1:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

*Relationship to Beneficiary: _____

Permission to receive financial account information?

a) Immediately upon funding? ☐ YES ☐ NO

b) If requested in the future? ☐ YES ☐ NO

If YES to a) or b), indicate account access preference:

☐Online / Internet ☐Mail

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

2.) Secondary Advocate 2:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

*Relationship to Beneficiary: _____

Permission to receive financial account information?

a) Immediately upon funding? ☐ YES ☐ NO

b) If requested in the future? ☐ YES ☐ NO

If YES to a) or b), indicate account access preference:

☐Online / Internet ☐Mail

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

C. Additional Contacts: In addition to the Primary and Secondary Advocates, permission is granted to contact and share information with the following should the need arise (optional):

1.) Additional Contact 1:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

2.) Additional Contact 2:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

8. Beneficiary's Funeral or Burial Arrangements:

A. Have pre-need funeral arrangements been made/paid for the Beneficiary? ☐ Yes ☐ No

B. If yes, provide the following information, if available.

Insurer/Other: _____

Name of Contact: _____

Policy #: _____

Phone: _____

Email Address: _____

C. If not, do you anticipate using funds from the trust to pay for pre-need arrangements? ☐ Yes ☐ No

Note: Any arrangements must be paid pre-need. Upon death of the Beneficiary, any remaining funds will be distributed according to *Section 10 Distributions of the Remainder Funds Upon the Death of the Beneficiary* of this Agreement.

9. Funding Information:

A. Describe the source of the funds (e.g. personal injury award, inheritance, Social Security back payment, other):

_____

_____

_____

_____

B. Amount to be deposited into the trust (estimate if not certain): $ _____

C. Will there be a structured settlement?

☐ Yes ☐ No

If yes, please provide a copy of the structured settlement.

D. Will there be a Court ordered settlement?

☐ Yes ☐ No

If yes, please provide a copy of the proposed order, and the entered order after the hearing.

E. Will qualification of the Trustee before the Clerk of Court and/or annual filings with the Commissioner of Accounts be required by the Court?

☐ Yes ☐ No

If yes, please provide a copy of the order.

F. Amount to be deposited into the Medicare Set-Aside Account (MSA): $ _____

G. Will any future payments be made to the MSA?

☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

_____

_____

H. Grantor selects the following company as the Administrator of the MSA:

☐ Affiance

☐ Medivest

☐ MSA Meds

☐ Other: _____

10. Distributions of the Remainder Funds Upon the Death of the Beneficiary:

Upon the death of the Beneficiary, no further payment requests will be fulfilled.

CCT shall direct the Trustee to first distribute to the state or agency of the state, in accordance with the valid regulations enacted by the state, the remaining assets of the Beneficiary's account up to an amount equal to the total medical assistance paid on behalf of the Beneficiary under the state plan for medical assistance ("Reimbursement"). Such Reimbursement shall not exceed the amount of medical assistance payments which have been made on behalf of the Beneficiary and which have not otherwise been reimbursed as of his or her death. To the extent necessary to qualify this Trust as exempt under 42 U.S.C. 1396p(d)(4)(C), if the Beneficiary has resided in more than one state, reimbursement from the Trust shall be made to each state in which the Beneficiary received Medicaid, based on the states' proportionate share of the total amount of Medicaid benefits paid by all of the states on behalf of the Beneficiary.

List all States from which the Beneficiary has ever received Medicaid benefits*:
***The Advocate has the obligation to immediately inform CCT of any future Medicaid benefits received from any state(s).**

After such Reimbursement and subject to federal and state(s) Medicaid Reimbursement policy, the remaining assets shall be distributed to the Successor Beneficiaries in the proportions which are specified in this Joinder, or any Amendment to the Joinder Agreement Form. If the Joinder does not name Successor Beneficiaries, or in the event that the Reimbursement exceeds the value of the remaining assets in the Beneficiary's account, then the assets shall be deemed to be surplus property and shall be retained by CCT and, in its sole discretion, used to further the mission of CCT, to the extent permitted under 42 U.S.C. 1396p.

This reimbursement provision shall be made in accordance with all applicable federal and state laws and regulations, and may change from time to time as such laws and regulations are amended, as is stated in the Commonwealth Community Trust First-Party Pooled Trust Master Trust Agreement.

Instructions for Naming Successor Beneficiaries and Contingent Beneficiaries

It is required that at least one Successor Beneficiary be named (See Section 10A). If a Successor Beneficiary is no longer living at the death of the Beneficiary, his or her share shall be distributed to the named Contingent Beneficiary (ies). Additional Successor Beneficiaries and Contingent Beneficiaries can be added (See Section 10B and Section 10C). An individual or charity can be named as a Successor Beneficiary and/or Contingent Beneficiary. Naming CCT as a Successor Beneficiary and/or Contingent Beneficiary, supports the organization's mission to serve people with disabilities.

If an individual Successor Beneficiary predeceases the Beneficiary, or an entity named as a Successor Beneficiary is no longer in existence, and there is no Contingent Beneficiary named, the distribution to that individual or entity lapses and will be divided among the remaining Successor Beneficiaries who are then living or in existence. If an individual Contingent Beneficiary predeceases the Beneficiary, or an entity named as a Contingent Beneficiary is no longer in existence, the distribution to that individual or entity lapses and will be divided among the remaining Contingent Beneficiaries to that Successor Beneficiary who are then living or in existence. If there are no Contingent Beneficiaries then living or in existence, such remaining funds shall be distributed to Commonwealth Community Trust.

***Important**:* The Grantor is required to list any Primary Beneficiaries and Contingent Beneficiaries (and their contact information) and agrees that CCT's liability for payment under this Section 10 is limited to the beneficiaries known to CCT based upon the information noted in this Joinder Agreement and the Grantor(s) agree to otherwise hold CCT harmless with respect to payment hereunder. The determinations of CCT regarding payment under this Section 10 shall be final and binding on all parties. The Grantor can complete the Amendment to the Joinder Agreement Form to change Successor Beneficiaries and/or Contingent Beneficiaries (must be completed, signed, and notarized).

A. *Successor Beneficiary A (Required):**

Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Percentage A (required) _____ **%** *If more than one Successor Beneficiary is named, the total of all Successor Beneficiaries must equal 100%. (See Page 9, Section 10D.)*

If *Successor Beneficiary A* is no longer living at the death of the Beneficiary, his or her share shall be distributed to the following *Contingent Beneficiary (ies).

Example: A1: 25% + A2: 25% + A3: 50% = 100%

A1. Contingent Beneficiary to Successor Beneficiary A:

Name _____ SSN _____ **Percentage A1** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

A2. Contingent Beneficiary to Successor Beneficiary A:

Name _____ SSN _____ **Percentage A2** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

A3. Contingent Beneficiary to Successor Beneficiary A:

Name _____ SSN _____ **Percentage A3** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Total Percentage for ALL *Contingent Beneficiary(ies) to Successor Beneficiary A*

(must total 100%) **%**

Provide an attachment with additional Successor Beneficiaries and Contingent Beneficiaries, if desired.

B. *Successor Beneficiary B:**

Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Percentage B _____ **%** *If more than one Successor Beneficiary is named, the total of all Successor Beneficiaries must equal 100%. (See Page 9, Section 10D.)*

If *Successor Beneficiary B* is no longer living at the death of the Beneficiary, his or her share shall be distributed to the following *Contingent Beneficiary (ies).

Example: B1: 25% + B2: 25% + B3: 50% = 100%

B1. Contingent Beneficiary to Successor Beneficiary B:

Name _____ SSN _____ **Percentage B1** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

B2. Contingent Beneficiary to Successor Beneficiary B:

Name _____ SSN _____ **Percentage B2** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

B3. Contingent Beneficiary to Successor Beneficiary B:

Name _____ SSN _____ **Percentage B3** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Total Percentage for ALL *Contingent Beneficiary(ies) to Successor Beneficiary B*

(must total 100%) **%**

Provide an attachment with additional Successor Beneficiaries and Contingent Beneficiaries, if desired.

C. *Successor Beneficiary C:**

Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Percentage C _____ **%** *If more than one Successor Beneficiary is named, the total of all Successor Beneficiaries must equal 100%. (See Page 9, Section 10D.)*

If *Successor Beneficiary C* is no longer living at the death of the Beneficiary, his or her share shall be distributed to the following *Contingent Beneficiary (ies):
Example: C1: 50% + C2: 50% = 100%

C1. Contingent Beneficiary to Successor Beneficiary C:

Name _____ SSN _____ **Percentage C1** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

C2. Contingent Beneficiary to Successor Beneficiary C:

Name _____ SSN _____ **Percentage C2** _____ **%**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Total Percentage for ALL *Contingent Beneficiary(ies) to Successor Beneficiary C*	
(must total 100%)	**%**

Provide an attachment with additional Successor Beneficiaries and Contingent Beneficiaries, if desired.

D. Summary (required if more than once Successor Beneficiary is named):

Name of Successor Beneficiary A:		**Percentage A**	**%**
Name of Successor Beneficiary B:		**Percentage B**	**%**
Name of Successor Beneficiary C:		**Percentage C**	**%**
Total Percentage for ALL Successor Beneficiaries (must total 100%)			**%**

11. Government Assistance the Beneficiary Receives: CCT will provide information to local government agencies for SSI, Medicaid, subsidized housing and food stamps recipients.

A. Social Security Information:

Does Beneficiary receive ***Supplemental Security Income (SSI)***? ☐ Yes ☐ No ☐ In the Process of Applying

If yes, or in process of applying, complete the following contact information for the local SSA Office:

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Phone Ext: _____

Email Address: _____

Supplemental Security Disability Insurance (SSDI): ☐ Yes ☐ No

Other: _____

B. Medical Information:

Does Beneficiary receive ***Medicaid*** benefits? ☐ Yes ☐ No ☐ In the Process of Applying

Does Beneficiary receive ***Medicaid Waiver*** benefits? ☐ Yes ☐ No ☐ In the Process of Applying

If yes, or in process of applying, complete the following information for local Medicaid office:

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Phone Ext: _____

Email Address: _____

Does Beneficiary receive ***Medicare*** benefits? ☐ Yes ☐ No

Does Beneficiary receive any other medical benefits? ☐ Yes ☐ No

If yes, please describe: _____

C. Section 8 or Subsidized Housing: ☐ Yes ☐ No

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

D. Case Management or Other Support Services: Provide the following information, if applicable.

Agency/Provider: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Main Phone Number: _____ Cell Number: _____

Email Address: _____

Description of Service: _____

E. Other Public Assistance (e.g. food stamps): ☐ Yes ☐ No

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Description of services: _____

F. Other Public Assistance: ☐ Yes ☐ No

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Description of services: _____

12. Please read the following:

(a) In order to facilitate pooling of the assets in all sub accounts, it is required that all deposits must be made in cash. The trust does not hold non-cash assets or real estate property.

(b) Income and principal will be distributed for the Beneficiary at the sole discretion of CCT.

(c) The provisions of this Joinder Agreement may be amended as determined reasonably necessary by CCT so long as any such amendment is consistent with the Master Trust Agreement or is deemed necessary to conform to any changes required by the law.

(d) It is understood and agreed upon that the trust is for the sole benefit of the Beneficiary.

(e) It is understood and agreed upon that the trust is irrevocable.

(f) Trustee and other fees shall be charged in accordance with the Fee Schedule as amended from time to time.

NOTE: CCT may, from time to time and at its discretion, hire additional professionals to serve as a liaison between CCT and the Beneficiary, or to assess the financial or custodial care arrangements of the Beneficiary and provide reports to CCT (e.g. accountants, attorneys, health care professionals, social workers, life care planners, care managers). CCT reserves the right to charge this expense to the Beneficiary's trust sub account.

(g) Taxes
  (1) The Grantor acknowledges that there have been no representations made to the Grantor regarding the deductibility of the contributions to the trust as charitable gifts or otherwise.
  (2) Trust fund (sub account) income, whether paid in cash or distribution in other property may be taxable to the Beneficiary, subject to applicable exemptions and deductions. Professional tax advice is recommended.
  (3) Income of the trust fund (sub account) may be taxable to the trust and when this occurs, such taxes shall be payable from the trust fund (sub account) of the Beneficiary.

(h) This trust administered by CCT is a pooled trust, governed by the laws of Virginia, in conformity with the provisions of 42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993. To the extent there is conflict between the terms of the Trust Agreement and/or this Instrument, and the governing law as from time to time as amended, the law and regulations shall control.

(i) The decision to fund the MSA is solely the choice of the Grantor and not that of the Trustee or Commonwealth Community Trust.

(j) The Grantor understands that neither CCT nor the Trustee have advised the Grantor regarding the need for or allocation of settlement proceeds to the MSA.

(k) The Grantor has been fully advised by his or her counsel concerning the need for, and rules governing distribution from the MSA.

(l) The MSA shall be separately invested in an interest bearing account as administered by the MSA Administrator.

(m) The Grantor has fully read and understands paragraphs M through T of Article One of the First-Party Special Needs Trust Master Trust Agreement.

(n) The Grantor understands that, if required by law, and upon the advice of legal counsel, the Trustee may transfer funds from the sub account to the MSA or may transfer funds from the MSA to the sub account.

(o) The Grantor understands that the Administrator may be changed at the Beneficiary's request, and that some fees may apply.

(p) The Grantor understands that upon the death of the Beneficiary and the termination of the MSA, any funds remaining in the MSA will be transferred to the sub account to be disbursed according to the terms of this Joinder and the Master Trust Agreement.

13. Professional Representation – Grantor(s) has/have been represented with regard to CCT by:

Name: _____

Firm: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

THIS JOINDER AGREEMENT NEEDS TO BE SIGNED IN FRONT OF A NOTARY.

14. **In Witness Whereof** – The undersigned Grantor(s) has/have signed this agreement and understand(s) same and agree(s) to be bound by the terms thereof this _____ day of _____, 20_____.

_____ _____

Grantor's Signature Grantor's Signature

STATE OF_____ CITY/COUNTY OF_____

TO-WIT: The foregoing Joinder Agreement, dated _____ was acknowledged before me by _____ and _____, Grantor(s), this _____ day of _____, 20_____.

_____ My commission expires: _____

Notary Public

TO BE COMPLETED BY COMMONWEALTH COMMUNITY TRUST (CCT):

Commonwealth Community Trust hereby accepts the terms of this Joinder Agreement on this _____ day of _____, 20____.

By _____ Title: _____

STATE OF VIRGINIA, COUNTY OF HENRICO

TO-WIT: The foregoing Joinder Agreement, dated _____ was acknowledged before me by _____ and _____ on behalf of CCT, this ____ day of_____ , 20 ____ .

_____ My commission expires: _____

Notary Public