

**WESTERN NEW YORK COALITION POOLED TRUST TWO
Over 65 TRUST**

(A Trust for Persons with Disabilities)

JOINDER AGREEMENT

The undersigned hereby establishes a Trust Account under the WESTERN NEW YORK COALITION POOLED TRUST TWO dated this _____ day of _____, 20____, in the initial sum of \$_____.

1. Name of Donor/Beneficiary: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Telephone Number: _____

2. Name of Donor/Beneficiary's Legal Representative, if any:

Date of Birth: _____ Social Security Number: _____

Relationship to Designated Beneficiary: _____
(POA, HCP, Friend, Family Member)

Address: _____

Phone Number: _____

3. Name of Donor/Beneficiary's Attorney: _____

Telephone Number: _____

4. Upon the death of the Designated Beneficiary, amounts remaining in the Designated Beneficiary's account shall be retained in the Trust solely for the benefit of individuals who are disabled as defined in Social Security Law § 1614 (a)(3) [42 USC 1382c (a)(3)] and any subsequent definitions that are enacted into law.

5. Estimated payment dates for funding of Trust Account:

	<u>Amount</u>
Upon Acceptance of Joinder Agreement by Trustees	\$ _____
Date of Additional Contribution	\$ _____
Date of Additional Contribution	\$ _____
Date of Additional Contribution	\$ _____
Date of Additional Contribution	\$ _____
Date of Additional Contribution	\$ _____
(If no contributions are anticipated other than the initial contribution upon acceptance of the Joinder Agreement by the Trustee, enter NA)	
Total Amount	\$ _____

The undersigned Beneficiary, or his/her legal representative on behalf of the Beneficiary, if this Joinder Agreement is being executed by the Beneficiary's guardian, attorney-in-fact or other duly authorized legal representative, hereby acknowledges and agrees:

A. That the signing of this document constitutes a legal agreement and contributions to the Trust Account may have tax consequences or impact my benefits that I currently receive or may in the future. I have been advised to consult with my attorney and tax advisor before signing this Joinder Agreement, and have done so to the extent I felt necessary to knowingly enter into this Joinder Agreement. I did not receive any legal advice from the Trust or Trustees and waive any and all claims against them in the event my involvement with this Trust results in any loss or cost to me. I am solely responsible for advising the Trust of any changes to the information set forth above and to any changes in benefits I receive. I grant the Trust and the Trustees the right to communicate with any individual or entity, including, but not limited to, Medicaid, SSI, HUD and all other public benefits programs, concerning my involvement in the Trust and to provide information to the extent deemed necessary by the Trust or Trustees. I will be solely responsible to settle any Social Services, Medicaid or Medicare liens prior to entry of funds into the Trust and I will hold the Trust and Trustees harmless for any loss I suffer or any amounts due to the liener for failing to resolve any such liens.

- B. That all contributions made to the Trust Account will be held and administered pursuant to the provisions of the Western New York Coalition Pooled Trust Two dated the 24th day of July, 2009, including any amendments to the Trust made after the date of this Joinder Agreement. The provisions of the Western New York Coalition Pooled Trust Two are incorporated herein by reference. I have received and reviewed a copy of the Western New York Coalition Pooled Trust Two and the current fee schedule prior to signing the Joinder Agreement and I understand it may change from time to time.
- C. That a potential conflict of interest exists in the administration of the Western New York Coalition Pooled Trust Two. People Inc. and Center for Elder Law & Justice (the “agency trustees”), may have an interest in retaining funds in the Trust accounts for the benefit of other disabled individuals. In the administration of the Trust, the Trustees are permitted to disburse Trust funds to the agency trustees on behalf of the designated beneficiaries. I am aware of the existence of this potential conflict of interest and expressly waive any and all claims against the Trust or the Trustees on account of self-dealing, conflict of interest, or any other act.
- D. I understand that, since this is an Over-65 Supplemental Needs Trust, and, as such, that the local and state departments who administer the Medicaid Program may determine that my transfer into the Trust is a transfer of assets, and contributions to the Trust may result in periods of ineligibility for Medicaid payment of skilled nursing care if I need to go into a nursing home in the future. I acknowledge it is my responsibility to notify the Trust and determine any impacts I may face if I go into a nursing home or other skilled medical facility.
- E. I understand that, since this is an Over-65 Supplemental Needs Trust, I cannot utilize the Trust if I am on SSI without a reduction in my SSI benefits. I acknowledge it is my responsibility to notify the Trust and determine any impacts I may face if I am over 65 and receive SSI.
- F. I understand if I reside in subsidized housing regular disbursements from a SNT on my behalf may be seen by the federal housing authority as “income” and could result in an increase in the beneficiary’s share of the rent. Therefore, it is recommended that individuals in federally subsidized housing programs only request sporadic and infrequent disbursements from their trust accounts. However, it is not the responsibility of the trustees to monitor the frequency of beneficiary requests and, if we make payments as requested by the beneficiary, we are not responsible for any subsequent increase in rental payments.
- G. I understand that while the Trustees may provide numerous forms of services, entry into the Trust does not make me eligible for any service by the Trust or Trustees aside from Trust services and I am responsible for arranging any outside services I may require. Additionally, I acknowledge the Trust and Trustees have no obligation to and do not monitor my well-being or any other condition I may face or provide me any assistance. However, the Trust or Trustees may, but are not obligated to, contact appropriate authorities, such as law enforcement, protective services or other agencies if circumstances are brought to their attention, which in their sole discretion warrants such contact and I consent to any such contact and disclosure of information to such agencies.

Beneficiary / Legal Representative

Date

State of New York)
County of Erie) ss.:

On the _____ day of _____ in the year 20____ before me, the undersigned, a notary public in and for said state, personally appeared _____ personally known to me or proved to me on a basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity as Donor, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

Beneficiary's Attorney

Date

Accepted by the Trustees of the Western New York Coalition Pooled Trust Two:

Trustee

Trustee

Trustee

State of New York)
County of Erie) ss.:

On the _____ day of _____ in the year 20__ before me, the undersigned, a notary public in and for said state, personally appeared _____, personally known to me or proved to me on a basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity as Trustee, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

State of New York)
County of Erie) ss.:

On the _____ day of _____ in the year 20__ before me, the undersigned, a notary public in and for said state, personally appeared _____ personally known to me or proved to me on a basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity as Trustee, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

State of Ohio)
County of Cuyahoga) ss.:

On the _____ day of _____ in the year 20__ before me, the undersigned, came _____, to me known, who, being by me duly sworn, did depose and say that he/she resides in _____ of _____; and the he/she is the _____ of **KEY BANK TRUST COMPANY**, the corporation described in and which executed the above instrument, and that he/she signed his/her name thereto by authority of the Board of Directors of said corporation.

Signature and Office of Individual taking
Acknowledgment (affix stamp)