WESTERN NEW YORK COALITION POOLED TRUST TWO
Over 65 TRUST
(An irrevocable supplemental needs trust for persons with disabilities over the age of 65)

JOINDER AGREEMENT

This is a legal document pertaining to a pooled SNT created pursuant to 42 USC 1396 and you are encouraged to seek independent and professional legal advice before signing.

The undersigned hereby establishes a Trust Account under the WESTERN NEW YORK COALITION POOLED TRUST TWO dated as of the date of execution hereof.

Pre-screening questions:

1. Do you receive SSI benefits? _____ Yes or_____ No
2. Do you reside in a Long Term Health Facility i.e. a nursing home? _____ Yes or_____ No

If the answer to either question is yes, please contact us.

1. NAME OF BENEFICIARY (same as Donor): _____

Sex: Male: _____ Female: _____

Marital status: _____ Maiden Name: _____
(S = Single, M= Married, W= Widowed, D= Divorced)

Date of Birth: _____ Social Security Number: _____

Address: _____

_____
City County State Zip

Home phone Number: _____ Cell phone number: _____

Do you want to communicate with us via Text Messaging? _____Yes or _____ No

E-mail Address: _____
You may receive information about your trust account via email

Ethnicity: _____ Native American ____ Indian ____ Asian
_____ Black or African American ____Hispanic or Latino
_____ White, non – Hispanic ____White, Hispanic
_____ Other

Number of People in Household _____

Number of People in Household _____

Do you reside in Public/section 8 housing? _____Yes or _____ No

Specify:_____

Do you have a Guardian? _____ Yes or_____ No (if yes please list below and provide copies of the court papers) If yes, the Joinder Agreement will need to signed by the guardian.

Is this trust being set up pursuant to a Court order? _____ Yes or_____ No (if yes please provide copies of the court papers)

2. RESPONSIBLE PERSONS, EMERGENCY and AUTHORIZED CONTACTS

List individuals below authorized to contact us on behalf of the Beneficiary starting with primary contact.
(check all that apply)

	Communicate	Receive Statements	Submit Disbursements
Name: _____	☐	☐	☐

Address: _____

_____

Telephone No.: _____

Email Address: _____

Relationship: _____

(POA, Guardian, HCP, Friend, Family Member) If Guardian or POA please include paperwork

	Communicate	Receive Statements	Submit Disbursements
Name: _____	☐	☐	☐

Address: _____

_____

Telephone No.: _____

Email Address: _____

Relationship: _____

(POA, Guardian, HCP, Friend, Family Member) If Guardian or POA please include paperwork

Name of Donor/Beneficiary's Attorney or other professional assisting with this trust**:**

_____

Telephone Number: _____

3. MEDICAL and SERVICES INFORMATION

Nature and onset of your disability:

_____

_____

_____

Do you have home care? Yes __ No __ If yes, how often? _____

Do you have a case manager? Yes __ No __

What agencies are involved with your care? (include contact info for any care manager)

_____

_____

MEDICARE #: _____

MEDICAID CASE # _____

4. INCOME INFORMATION

Do you receive any of the following? Indicate if received money from:

		Amount
• Supplemental Security Income (SSI) Benefits	Yes __ No __	_____
• Social Security Disability Benefits	Yes __ No __	_____
• Social Security Dependent Benefits	Yes __ No __	_____
• Social Security Survivor's Benefits	Yes __ No __	_____
• Social Security Retirement Benefits	Yes __ No __	_____
• NYS Disability	Yes __ No __	_____

How do you see the trust money being spent?

_____

_____

Referral Source: Name_____ email: _____

5. REQUIRED DOCUMENTATION

Please include the following paperwork if it applies to your application:

- Any award letters for Social Security Disability and/or SSI benefits.
- Any disability determinations received from NYS after age 65.
- Any Medicaid spenddown letters.
- Any POA papers where the POA signs the Joinder Agreement.
- If you have a Guardian: Guardianship papers (referred to as Decree and Letters in Art 17A or Order and Commission is Art 81)
- If the joinder was executed utilizing a supported decision-making process as delineated in Art 82 of the Mental Hygiene Law provide a copy of the agreement and attestation, as provided in MHL 82.10 (d)(3).
- Any court orders directing the establishment of the trust and any structure settlement orders.

6. PRINCIPLE

What money will be placed in the Trust and how often? Circle all that apply:

(Lump Sum) (Monthly Income/Spenddown) (Periodic Payments) (Court ordered) (structured settlement). If structured settlement, please include settlement order.

Estimated payment dates for funding of Trust Account:

	Amount
Upon Acceptance of Joinder Agreement by Trustees	$ _____
Date of Additional Contribution (circle if monthly)	$ _____
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	$ _____

7. REPRESENTATIONS

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. I have been advised to consult with my attorney, tax advisor or other professional before signing this Joinder Agreement, and have done so to the extent I felt necessary to knowingly enter into this Joinder Agreement. 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 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 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. I will remain solely responsible to notify and provide necessary documentation to Medicaid, SSA, HUD and all other public benefits programs, from which I receive benefits from at any time necessary now and in the future.

I grant the Trust and the Trustees the right, but not the obligation, to communicate with any individual or entity, including, but not limited to, Medicaid, SSA, 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**.**

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. I understand that the fees and other terms and conditions of the trust may change from time to time and I agree to abide to any such amendments

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 or payment of administrative costs. 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 or conflict of interest.

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 SSA 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. 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. Upon the death of the Designated Beneficiary, amounts remaining in the Designated Beneficiary's account shall be retained in the Trust solely for use as allowed under applicable regulations currently including the benefit of individuals (including administration fees of the trust) 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.

H. I understand that payments cannot be made on my behalf following my death. I have been advised to pre fund and arrange all funeral related matters.

I. 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. 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.

J. This Joinder Agreement is subject and interpreted according to the Laws of NYS and any issues requiring litigation shall be venued in Erie County.

K. This Agreement may be executed in counterparts (signed or unsigned copies of original), each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of Electronic Transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

_____ _____
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

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

_____
Trustee

_____
Trustee

_____
Trustee

Notaries on next page

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)