CENTER FOR DISABILITY RIGHTS, INC.
COMMUNITY SUPPLEMENTAL NEEDS TRUST

(A Trust for Persons with Disabilities)

BENEFICIARY PROFILE SHEET AND

COMMUNITY SUPPLEMENTAL NEEDS TRUST

AMENDED AND RESTATED JOINDER AGREEMENT

Center for Disability Rights, Inc.
497 State Street
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Beneficiary Profile Sheet

1. Name of Donor (Generally same as Beneficiary): ______________________________

   Social Security No. of Donor:______________________________

   Address of Donor: ______________________________

   Telephone Number of Donor (day): ____________________(evening): ______________

   Email: ______________________________

2. Name of Disabled Beneficiary (In-Kind Beneficiary):______________________________

   Disabled Beneficiary's Social Security Number: ______________________________

   Address: ______________________________

   Telephone Number of Beneficiary (day): ________________(evening):______________

   Email: ______________________________

3. County of Residence: ____________________

   Date of Birth: ____________________

   Gender: ____________________

4. Is the purpose of establishing this account to shelter monthly income? Yes ____ No _____

   Indicate estimated monthly deposit. ______________________________

   (Note: This is supplemental information for Center for Disability Rights, Inc. purposes only. This amount may be changed at any time with no effect on the Joinder Agreement.)

5. Beneficiary Income:

   Does the Beneficiary receive Supplemental Security Income (SSI)? Yes ____ No ____

   Does the Beneficiary receive Social Security Disability Income (SSDI)? Yes ____ No ____

   Does the Beneficiary receive Social Security Retirement Income (SSA)? Yes ____ No ____

Does the Beneficiary receive any other income? Yes ____ No ____

If yes, please provide detail: ____

____

____

____

Does the Beneficiary receive Medicaid? Yes _________No ___________ Pending _________

If yes, list Medicaid card number: ____

If the Beneficiary receives other benefits or entitlements, such as Food Stamps, HUD Sec. 8, etc. list these benefits and monthly amounts: ____

____

6. Indicate the living arrangement of the Beneficiary:

Lives Independently _________________ Lives with parents or other family _________

Family Care Program ________________ CR/IRA/ICF (supervised) ________________

CR/IRA (supportive) ________________ Nursing Home _________________________

Assisted Living Facility ______________ Other (explain) _________________________

Does the Beneficiary receive a personal allowance as part of residential care? Yes ____ No ____

If yes, how much is it and how often received? ____

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

Service	Name of Provider
______________________	____
______________________	____
______________________	____
______________________	____

8. a. Is there a court appointed Guardian for the Beneficiary? Yes ____ No _____

If yes, attach copy of Decree or Letters of Guardianship and complete the following:

If yes, for the Person________________, Property________________, Both_____________

If specific powers/authority is granted please list:

(Include dental and medical) ____

If specific powers/authority is exempted please list:

(Include dental and medical) ____

Please list name(s) and addresses of Guardian(s). ___________________________________

____

____

b. Are Standby Guardian(s) appointed? Yes ______ No_______

If yes, for the Person________________, Property________________, Both_____________

Please list name(s) and addresses of Standby Guardian(s).____________________________

____

____

c. Are Alternate Standby Guardian(s) appointed? Yes _____ No _____

If yes, for the Person_____________, Property________________, Both_____________

Please list name(s) and addresses of Alternate Standby Guardian(s).____________________

____

____

9. Relationship of Donor to Beneficiary? ____

10. Who is authorized to speak with us on behalf of the Donor and Beneficiary? (Please include address and phone number)

For Donor:

Agency/Individual	Address/Phone #	Relationship
________________	________________________________	___________________
________________	________________________________	___________________
________________	________________________________	___________________
________________	________________________________	___________________

For Beneficiary:

Agency/Individual	Address/Phone #	Relationship
________________	________________________________	___________________
________________	________________________________	___________________
________________	________________________________	___________________
________________	________________________________	___________________

If you would like monthly statements and tax information sent to above person(s), rather than Donor and Beneficiary, check here ____. (Indicate who if more than one contact is listed).

____

Is this person authorized to make disbursement requests on behalf of Donor and Beneficiary?

Yes _____ No _____

11. Who will be submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on behalf of the Beneficiary?

Name:______________________________ Phone #: ______________________________

Agency/Firm, etc.____

12. If this is a Medicaid trust, please list who the trust documents should be sent to:

Name:______________________________ Phone #: ______________________________

Agency/Firm, etc.____

13. Does the Beneficiary have funeral provisions in place (pre-paid funeral, burial plot, etc.?)
Yes _____ No _____

If yes, briefly describe and list contact information ___________________________________

____

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

    If yes, provide the name and address of the life insurance beneficiary and the insurance company and policy number: ____

    ____

15. What is the beneficiary's primary disability? ____________________________________

    ____

    Please list all secondary disabilities ____

    ____

I certify that the information provided above is accurate and complete to the best of my knowledge and that I choose an Independent Living Plan of Personal Resource Management.

____________________________________ ______________________

Beneficiary Signature Date

____________________________________ ______________________

Donor Signature (if different from Beneficiary) Date

THE CENTER FOR DISABILITY RIGHTS, INC.
COMMUNITY SUPPLEMENTAL NEEDS TRUST
(A TRUST FOR PERSONS WITH DISABILITIES)

Amended and Restated Joinder Agreement

NOTE: THIS IS A LEGAL DOCUMENT. IT IS AN AGREEMENT PERTAINING TO A SUPPLEMENTAL NEEDS TRUST CREATED PURSUANT TO 42 UNITED STATES CODE §1396. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING THIS AGREEMENT. ADDITIONALLY, THE CENTER FOR DISABILITY RIGHTS, INC. MAY NOT ACCEPT THIS JOINDER AGREEMENT UNLESS YOU HAVE A LEGAL REPRESENTATIVE.

The undersigned hereby adopts and enrolls in and establishes a Trust Account under the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST** originally dated, June 5, 2008, as amended and restated on June 26, 2013, this Trust being incorporated herein by reference. **THIS TRUST IS IRREVOCABLE**.

1. Name of Donor (Generally same as Beneficiary):______________________________________

   Social Security No. of Donor: ____

   Date of Birth:____

   Address of Donor: ____

   Telephone Number of Donor (day):________________________ (evening): ________________

   Email: ____

2. Name of Disabled Beneficiary (In-Kind Beneficiary):__________________________________

   Disabled Beneficiary's Social Security Number:______________________________________

   Date of Birth:______________________________

   Address of Beneficiary:____

   Telephone Number of Beneficiary (day): __________________(evening): ________________

   Email: ____

3. Fees shall be paid in accordance with the fee schedule, published by the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as it may be amended from time to time.

4. To the extent that amounts remaining in a Beneficiary's account upon the death of the Beneficiary are not retained by the trust and credited to the Remainder Sub-Trust Account, to be used in furtherance of the purpose of the Trust, the Trust shall pay to the States from such deceased Beneficiary's account any remaining amounts equal to the total amount of medical assistance paid on behalf of the Beneficiary under the respective States' plans pursuant to 42 U.S.C. §§ 1396 *et seq*., with reimbursements to the States to be made in proportion to the amounts of medical assistance each provided to the Beneficiary.

5. Contributions/Deposits:

   a. All contributions made to the Trust Account will be held and administered pursuant to the provisions of the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, originally dated June 5, 2008, as amended and restated on June 26, 2013. The provisions of the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as amended and restated, are incorporated herein by reference.

   b. The Trustee shall have the sole and absolute right to accept or refuse additional deposits to the Trust Account.

   c. In the event that a Beneficiary has a zero ($0) 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 may, in the Trustee's sole and absolute discretion, be required to pay a new enrollment fee when re-opening a Sub-Trust account.

6. Disbursements:

   a. All disbursement requests shall be reviewed and approved by the Trustee on an individual basis.

   b. Disbursements for expenses incurred prior to 90 days of a submission of a disbursement request form shall not be paid.

   c. The Trustee, in its discretion, has determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol, tobacco, items relating to illegal activity, bail, or restitution.

   d. All disbursements shall be made at the sole and absolute discretion of the Trustee.

7. Disability Determination:

   In the event that a disability determination is required for Medicaid purposes, please note that administrative fees shall be incurred until a determination of disability is made.

8. Miscellaneous:

Amendments:
Provisions of this Joinder Agreement may be amended by the parties hereto in writing, so long as any such amendment is consistent with the Master Trust, as amended.

Taxes:

a. The Donor acknowledges that contributions to the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as amended are not tax deductible as charitable gifts, or otherwise.

b. Sub-Trust account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice may be needed.

9. 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 **Center for Disability Rights, Inc**.

The Donor(s) executing this Joinder Agreement is/are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to the Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **Center for Disability Rights, Inc.** or with any Beneficiary.

10. Situs: The Sub-Trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be initially administered by **Center for Disability Rights, Inc.** 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, accounting and legal purposes shall be in the County of Monroe, the County where the majority of meetings concerning establishment of the Trust have occurred.

11. 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.

I have received and reviewed a copy of the Community Supplemental Needs Trust Master Trust, as amended and restated, prior to the signing of this Amended and Restated Joinder Agreement**.** I acknowledge that I understand the contents of all of the trust documents. I also understand that said trust documents may be amended from time to time.

By signing below, the Donor acknowledges that the Beneficiary is disabled as defined in Section 1614(a)(3) of the Social Security Act [42 U.S.C. § 1382c(a)(3)].

Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.

By signing below, you agree and understand that the Community Supplemental Needs Trust, as amended, is a trust 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, Center for Disability Rights, Inc. agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement, as amended, 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, and to determine the impact that a transfer of property to the Center for Disability Rights, Inc. Community Supplemental Needs Trust, as amended, will have on the Beneficiary's continuing eligibility for government benefit programs. By your signature below, you agree and understand that Center for Disability Rights, Inc. 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 Community Supplemental Needs Trust, as amended.

______________________________	______________________________	____________
SIGNATURE OF DONOR/GUARDIAN	RELATIONSHIP TO BENEFICIARY	DATE

State of New York)s
County of__________________)

On this ______________ day of _____________ , 201 _____, 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 within the instrument and acknowledged to me that he/she 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 the instrument.

____
Notary Public

FOR OFFICE USE ONLY

____	____________________
CENTER FOR DISABILITY RIGHTS, INC., as Trustee	DATE

Date Received: ____________

Date Accepted: ____________

Initial Funding: ____________