

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.
INTEGRATION, INDEPENDENCE, CIVIL RIGHTS

Center for Disability Rights, Inc.

497 State Street
Rochester, NY 14608
Telephone: 585-546-7560
Facsimile: 585-546-7567
Website: cdrnys.org
E-mail: Pooledtrust@cdrnys.org

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.):

<u>Service</u>	<u>Name of Provider</u>
_____	_____
_____	_____
_____	_____
_____	_____

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:

<u>Agency/Individual</u>	<u>Address/Phone #</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Beneficiary:

<u>Agency/Individual</u>	<u>Address/Phone #</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____