POOLED TRUST

SERVICES

JOINDER AGREEMENT

P: (718) 971- 2509 F: (844) 623-0481 E: info@scspooledtrust.org

www.scspooledtrust.org

SENIOR COMMUNITY SERVICES
SUPPLEMENTAL NEEDS TRUST
JOINDER AGREEMENT

The undersigned hereby establishes a Trust Account under the Senior Community Services Supplemental Needs Trust dated January 5, 2015 and as amended and restated thereafter in the initial sum of $250.00

Sponsor Information

Name: First:_____ **Middle:**_____ **Last:**_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:**_____

SSN: _____ - _____ - _____ **Date of Birth:** _____/_____/_____

Citizen: _____ **Tel: Home**_____ **Cell:**_____

Address:_____ **Apt#:**_____

City:_____ **State:**_____ **County:**_____ **Zip:**_____

Email:_____

Beneficiary Information

☐ Same as Sponsor

Name: First:_____ **Middle:**_____ **Last:**_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:**_____

SSN: _____ - _____ - _____ **Date of Birth:** _____/_____/_____

Citizen: _____ **Tel: Home**_____ **Cell:**_____

Address:_____ **Apt#:**_____

City:_____ **State:**_____ **County:**_____ **Zip:**_____

Email:_____

Relationship To Beneficiary:_____

Purpose of Enrollment- Indicate reason for establishing an account.

☐ **Shelter Monthly Excess Income** ☐ **Shelter Excess Resources**

Household Income Information

Is Spouse Deceased? ☐ **Yes** ☐ **No**

Is Applicant & Spouse applying together? ☐ **Yes** ☐ **No If Yes, Fill in Spouse's Income.**

TYPE OF BENEFIT	Applicant Monthly Amount	Spouse Monthly Amount
Supplement Security Income (SSI)	$	$
Social Security Disability Income (SSDI)	$	$
Social Security Retirement Income (SSA)	$	$
VA Benefits	$	$
Employment Benefits	$	$
Survivor Benefits	$	$
IRA Distribution	$	$
Pensions / Annuities	$	$
Interest / Dividends	$	$
Reparations	$	$
Other	$	$

Please Note: All disbursements must be for sole benefit of the account beneficiary. A spouse is not a beneficiary for the account.

Medicaid Information- Please Attach MAP / LDSS Notice of Decision

	Applicant	Spouse
Application Status	☐ Pending ☐ Accepted	☐ Pending ☐ Accepted
CIN NUMBER		
MONTHLY SPEND DOWN $		

FOR ANY APPLICABLE ITEMS BELOW, PLEASE ATTACH THE NECCESARY PROOF.

Healthcare Premiums-Please attach current statement and proof of payment.

Medicare part B Supplement: Plan Name:_____

Premium $:_____ **Frequency:**_____

Medicare Part D Plan: Plan Name:_____ **Premium $:**_____

Funeral Arrangement- Please attach pre-need funeral agreement.

Name of Funeral Home:_____

Address:_____ **City:**_____

State:_____ **Zip:**_____

Telephone:_____

Burial Plot- Please attach a copy of plot deed.

Name of Cemetery:_____

Address:_____ **City:**_____

State:_____ **Zip:**_____

Telephone:_____

Life Insurance:- Please attach a copy of policy.

Name of Insured:_____ **Name of Owner:**_____

Name of Insurance Company:_____ **Policy #:**_____

Type of Policy: Term: _____ Life:_____ Cash Surrender Value $:_____

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

Qualifying Disabilities

1._____

2._____

3._____

Living Arrangements:

At Home Independently:____ At Home with Assistance:____ Assisted Living Facility:___

Resides with parents or other family:___ Other- Explain:_____

Power Of Attorney- Please attach a copy of Power of Attorney

Name: First:_____Middle:_____ Last:_____

Address:_____ Apt#:_____ City:_____

State:_____ County:_____ Zip:_____ Tel: Home:_____

Cell:_____ Email:_____

Is this person the sole POA? _____ Yes _____ No

If No, are the agents authorized to act separately? _____ Yes _____ No

Guardianship- Please attach a copy of Decree or Letter of guardianship.

Guardian appointed for the: _____ Person _____ Property _____Both

Name: First:_____ Middle:_____Last:_____

Address:_____Apt#:_____City:_____

State:_____ County:_____ Zip:_____

Telephone:_____

Email:_____

Authorized Representative: # 1

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____ Middle:_____ Last:_____

Address:_____ Apt#:_____ City:_____

State:_____ County:_____ Zip:_____ Tel: Home:_____

Cell:_____ Email:_____

Relationship to Beneficiary:_____

Would you like this representative to be the primary contact? ____ Yes _____ No

Authorized Representative: # 2

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____ Middle:_____ Last:_____

Address:_____ Apt#:_____ City:_____

State:_____ County:_____ Zip:_____ Tel: Home:_____

Cell:_____ Email:_____

Relationship to Beneficiary:_____

Would you like this representative to be the primary contact? ____ Yes _____ No

Referring Source:

Name of Agency:_____ Name Of Contact:_____

Address:_____ Apt#:_____ City:_____

State:_____ County:_____ Zip:_____ Phone:_____

Email:_____

I Authorize any applicable documents necessary for reporting to Government Agencies to be sent to the referring source above. _____Yes _____ No

The Undersigned Sponsor Hereby Acknowledges

1. That signing of this document constitutes a legal agreement and contributions to the Trust Account may have tax consequences. I have been advised to consult with my attorney and tax advisor before signing this Joinder Agreement.

2. That I am obligated to make a minimum contribution to the Trust Account in the amount of $250.00 (unless otherwise determined / approved by the Trustees of the Senior Community Services Supplement Needs Trust).

3. That I agree to the attached fee schedule and understand that fees may be adjusted from time to time by the Trustees of Senior Community Services Supplement Needs Trusts.

4. That all contributions made to the Trust account will be held and administered pursuant to the provisions of the Senior Community Services Supplement Needs Trust dated January 5, 2015 including any amendments to the Trust made after the date of this Joinder Agreement. The provisions of the Senior Community Services Supplement Needs Trust are incorporated herein by reference. I have received and reviewed a copy of the Senior Community services Supplemental Needs Trust, prior to signing this Joinder Agreement. **I UNDERSTAND THAT THIS AGREEMENT IS IRREVOCABLE.**

5. That the Designated Beneficiary is disabled or has medical condition that renders him or her unable to sustain employment.

6. THAT A POTENTIAL CONFLICT OF INTEREST EXISTS IN THE ADMINISTRATION OF THE SENIOR COMMUNITY SERVICES SUPPLEMENTAL NEEDS TRUST. THE TRUSTEES ARE APPOINTED BY THE BOARD OF THE SENIOR COMMUNITY SERVICES, INC. WHICH MAY HAVE A REMAINDER INTEREST IN THE TRUST ACCOUNTS. IN THE ADMINISTRATION OF THE TRUST, THE TRUSTEES ARE PERMITTED TO DISBURSE TRUST FUNDS TO SENIOR COMMUNITY SERVICES, INC., AND/OR BENEFICIARY, AFFILIATE OR CONSTITUENT AGENCIES OF SENIOR COMMUNITY SERVICES, INC. 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 TRUSTEES ON ACCOUNT OF SELF-DEALING, CONFLICT OF INTEREST OR ANY OTHER ACT.

Please mail all Trust documents to:
SCS POOLED TRUST
100 Boulevard of the Americas, Lakewood, NJ 08701

Signature

I certify that the above Information is accurate and completed to the best of my knowledge.

_____ _____

SIGNATURE **DATE**

_____ _____

PRINT **RELATIONSHIP**

SIGNATURE OF NOTARY

STATE OF New York) **SS:**

COUNTY OF: _____)

On _____ , 20___ 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 the within instrument and acknowledge to me that he/she/they 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 this instrument.

_____

Notary Public

FOR OFFICE USE ONLY

Accepted by Trustee or Designated Representative of the Trustees, Senior Community Services Supplemental Needs Trust.

_____ _____

SIGNATURE **DATE APPROVED**

_____

TITLE