1st Party

Joinder Agreement

Enrollment application for Sub-trust accounts being funded with assets or income belonging to the Beneficiary.

INSTRUCTIONS

- Please read the entire Joinder Agreement including all attachments (**Master Trust Document** and **Fee Schedule**). For additional information, please review the Getting Started Guide available on our website at www.OregonSNT.org.
- This is a binding legal document. The Arc Oregon can assist with any questions you may have about completing the application but cannot provide legal advice. You are encouraged to seek independent, professional legal advice before entering into this Agreement.
- Enclose the following documents:
  - ❑ Signed and Notarized Joinder Agreement
  - ❑ A check for the $750 enrollment fee, payable to *The Arc Oregon* **and/or**
  - ❑ A check for the initial deposit, payable to *The Arc Oregon FBO [Beneficiary's Name]*
  - ❑ Copy of photo identification or birth certificate **AND** Social Security Card of the Beneficiary
  - ❑ Proof of authority to establish and fund the sub-account, if not being done by the Beneficiary (must specifically authorize you to establish AND fund the sub-account)
  - ❑ Verification of any and all government assistance being received by the Beneficiary
  - ❑ Any other documentation as may be indicated in the **Application Checklist**
- Return the complete enrollment package to:

  The Arc Oregon
  Oregon Special Needs Trust
  2405 Front Street NE #120
  Salem OR 97301

- Upon approval and acceptance of the sub-account, the Primary Authorized Representative will receive a Welcome Binder containing a copy of the fully executed Agreement, information on how to access the sub-trust account, forms needed for disbursements and changes to account information, and an opening statement.
- Please allow 2 to 4 weeks for processing.
- ***The Arc Oregon reserves the right refuse or decline an application for any reason. If an application is rejected, the enrollment fee will be returned.***

***** This is a binding legal document. *****
You are encouraged to seek independent, professional legal advice before signing.

OREGON SPECIAL NEEDS TRUST JOINDER AGREEMENT

Please answer every question completely. If the document is incomplete or completed incorrectly, processing may be delayed.

A. DEFINITIONS

Primary Representative: The primary person authorized to access the Sub-trust account and/or communicate with Trust staff on behalf of the Beneficiary.

Beneficiary: The person on whose behalf the Sub-trust account is established.

First-Party Trust: A Sub-trust account funded with the beneficiary's own assets. Also known as Self-Settled.

Government Assistance: Services or financial assistance paid for or otherwise provided by a local, state, or federal government agency or department thereof, to, for, or on behalf of eligible beneficiaries.

Grantor: The person authorized to establish and transfer funds into a Sub-trust account on behalf of the Beneficiary. For a self-settled trust, Grantor may also be the beneficiary.

Trustee: The person or entity holding the trust assets.

Trustor: The person or entity holding establishing the Trust and directing the Trustee on certain matters.

B. ESTABLISHMENT OF TRUST

The undersigned (the "Grantor"), on behalf of the below named Beneficiary, hereby adopts and enrolls in the Oregon Special Needs Trust Master Trust Agreement (the "Trust"), established November 25, 2015, as amended from time to time, executed by The Arc Oregon (the "Trustor") and Key Bank National Association (the "Trustee"), and incorporated herein by reference.

The effect of joining the Trust through this Agreement is to establish a pooled sub-trust account separately maintained with the Trust for the sole and exclusive use of the Beneficiary. This agreement, and such pooled sub-trust account, shall be irrevocable.

The Sub-trust account established through this Agreement, together with the Master Trust Agreement, is a Pooled Trust created pursuant to 42 U.S.C. § 1396p (d)(4)(C), amended August 10, 1993, by the Omnibus Budget Reconciliation Act of 1993. Accordingly, the Sub-trust account has been specifically established to be an exempt trust and to comply with the controlling state and federal authorities in maintaining eligibility for means-tested government assistance. It is the mutual intent of the Grantor, the Trustor, and the Trustee that the Sub-trust account be managed and administered so as to maintain such compliance in all respects and not adversely affect the Beneficiary's ability to receive certain Government Assistance. To the extent there is conflict between the terms of this Trust and the governing law, the law shall control.

GRANTOR INITIALS _____

C. AUTHORITY TO SIGN JOINDER AGREEMENT

Under federal law, a self-settled pooled sub-trust account may only be established by a competent Beneficiary or by his or her parent, grandparent, guardian, or the court. The person establishing the account must also have legal authority to act with regard to the assets of the Beneficiary.

If a court order is issued, the person specifically authorized by the court shall be the Grantor for purposes of executing this Agreement. Oregon law states that if the Beneficiary is financially incapable, as defined in Oregon Revised Statute, ORS 125.005(3), a court order is required before a sub-trust account may be opened or funded with the Beneficiary's assets by a court appointed conservator.

D. TRUST PARTIES

1. ***Trustee***. The Trustee is Key Bank National Association. The Trustor is The Arc Oregon as detailed in the Master Trust Agreement.

2. ***Grantor***. This is the person authorized to sign this Agreement if not the beneficiary.

   ☐ Check here if the Beneficiary is signing the form and skip to Section D(3).

   Name: _____

   Address: _____

   City, State, Zip: _____

   Home Phone: _____ Cell Phone: _____

   Email: _____

   Relationship to Beneficiary: *Must provide proof of authority to establish and fund this sub-account on behalf of the Beneficiary.*

   ☐ Parent ☐ Guardian/Conservator ☐ Power of Attorney
   ☐ Grandparent ☐ Court Appointed Grantor

3. ***Beneficiary***. The Sub-trust account is established for the benefit of:

   Name: _____

   Address: _____

   City, State, Zip: _____

   Home Phone: _____ Cell Phone: _____

   Email: _____

   Date of Birth: _____ Social Security No: _____ Gender: ☐ M ☐ F

   Description of Beneficiary's disability: _____

   Beneficiary's living arrangements: _____
   (Independent, with family, treatment facility, group home, etc)

GRANTOR INITIALS _____

E. DESIGNATION OF AUTHORIZED PERSONS

Person(s) responsible *(e.g., parent, sibling, relative, Guardian, Representative Payee, Power of Attorney, Beneficiary, Caseworker, Conservator, or other*)* for requesting disbursements, receiving financial statements and communicating information about the Beneficiary and the Trust. ***Please identify one Primary Authorized Person and one Alternate Authorized Person:***

1. ***Primary Representative:***

☐ Check here if the Grantor will act as the Primary Representative

☐ The following person, not the Grantor, will act as the Primary Representative:

Name: _____
Organization: _____
Address: _____
City, State, Zip: _____
Phone:
Cell _____ Work: _____
Home _____
Email: _____
Relationship to Beneficiary*: _____

☐ Check here if the Beneficiary is not the Primary Authorized Person but may request disbursements.

2. ***Alternate Representative:***

In the event that the Primary Representative is not able to serve in that capacity, the following person will serve as successor Primary Representative:

Name: _____
Organization: _____
Address: _____
City, State, Zip: _____
Phone:
Cell _____ Work: _____
Home _____
Email: _____
Relationship to Beneficiary*: _____

3. ***Future Representative:***

In the event that neither the Primary nor Alternate Representatives is able to serve, how should the Trustor select another Primary Representative *(e.g. Appoint current guardian, representative payee, conservator, foster parent, family member or other)*?

_____

GRANTOR INITIALS _____

4. **ADDITIONAL CONTACTS:**

In addition to the Primary and Alternate Representatives, permission is granted to contact and share information with the following individuals should the need arise (optional):

Name: ____________________
Organization: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: __________ Work Phone: __________
Cell Phone: __________
Email: ____________________
Relationship to Beneficiary*: ____________________

Please indicate level of access granted:

☐ Verbal Communication
☐ Online Account Access
☐ Request Benefit Recertification Documents

Name: ____________________
Organization: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: __________ Work Phone: __________
Cell Phone: __________
Email: ____________________
Relationship to Beneficiary*: ____________________

Please indicate level of access granted:

☐ Verbal Communication
☐ Online Account Access
☐ Request Benefit Recertification Documents

Name: ____________________
Organization: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: __________ Work Phone: __________
Cell Phone: __________
Email: ____________________
Relationship to Beneficiary*: ____________________

Please indicate level of access granted:

☐ Verbal Communication
☐ Online Account Access
☐ Request Benefit Recertification Documents

Name: ____________________
Organization: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: __________ Work Phone: __________
Cell Phone: __________
Email: ____________________
Relationship to Beneficiary*: ____________________

Please indicate level of access granted:

☐ Verbal Communication
☐ Online Account Access
☐ Request Benefit Recertification Documents

GRANTOR INITIALS __________

F. SOURCE OF FUNDS

1. The Grantor acknowledges that upon signing this Agreement and funding the Beneficiary's Sub-trust account that the sub-account is funded with only the assets and/or income of the Beneficiary. The source of the Beneficiary's assets is:

   ☐ Inheritance payable to the Beneficiary ☐ Excess income or resources
   ☐ Injury or other legal settlement award ☐ Social Security back payment
   ☐ Other _____

2. In order to facilitate pooling of the assets in all sub-accounts, it is required that all deposits must be made from cash assets. The Trust does not hold non-cash assets or real estate property.
3. Additional assets of the Beneficiary may be deposited into the Beneficiary's Sub-trust account at any time.
4. All deposits become the irrevocable property of the Trust.

G. DISTRIBUTIONS FROM TRUST

Distributions from the Beneficiary's Sub-trust account may be made during the life of the Beneficiary in accordance with the provisions of the Trust and as follows:

1. Distributions shall be made for the sole benefit of the Beneficiary but never directly payable to the Beneficiary.
2. Disbursements will be reviewed and approved on an individual basis, and in accordance with the guidelines set forth in the Welcome Handbook, as amended from time to time.
3. The Grantor recognizes that all distributions are made by the Trustee in accordance with directions from the Trustor, in its sole discretion. With this in mind, the Grantor may express desires as to how assets might be used on behalf of the Beneficiary in the Trust Plan (Section H). The Trustor will also consider any Individual Support Plan or Treatment Plan that may be in place for the Beneficiary when reviewing a distribution request.
4. If the Beneficiary's residence changes from Oregon to another state, distributions may cease until appropriate arrangements can be made, within the sole discretion of the Trustor, including, but not limited to:
   a) The in-kind transfer of the sub-account property directly to a comparable 501(c)(3) tax-exempt pooled trust serving the geographic location to which the Beneficiary has moved.
   b) The continued administration of the Beneficiary's sub-account by the Trustor and the Trustee in accordance with the applicable laws of the state to which the Beneficiary moves.
5. No disbursements may be made after the death of a Beneficiary, including funeral or cremation expenses. Beneficiaries are encouraged to prearrange for these services and may use Trust funds for that purpose.

GRANTOR INITIALS _____

H. TRUST PLAN

1. ***Addressing Needs***
Within the parameters of Trust Distributions as described above in Section G, in addressing the needs of the beneficiary, the Grantor hereby expresses the following desires as to how the Beneficiary's trust fund might be used:

☐ Check here to indicate that you would like the Trustor to attempt to address needs as they arise and not necessarily attempt to have the funds last throughout the beneficiary's lifetime.

OR

☐ Check here to indicate that you would like the Trustor to attempt to have the funds last throughout the Beneficiary's lifetime. (IMPORTANT NOTE: While the Trustor will attempt to take the Grantor's desires into consideration, it is possible, in any event, that the funds may be exhausted prior to the Beneficiary's lifetime if the Trustor determines that it is in the Beneficiary's best interest.)

2. ***Funeral Arrangements***
Have pre-need funeral arrangements been made/paid for the Beneficiary? ☐ Yes ☐ No

If not, do you anticipate using funds from the trust to pay for pre-need arrangements? ☐ Yes ☐ No

Note: Any arrangements must be paid pre-need. Upon death of the Beneficiary, any remaining funds will be distributed according to Section J of this Agreement.

3. ***Objectives***
Please tell us what your objectives are for the Trust. Please include information regarding the Beneficiary's interests and hobbies that will guide us in using the Trust to enhance quality of life, as well as any specific needs that may be anticipated for the future. Keep in mind that the Trust will not pay for any services that are otherwise available from public assistance for which the Beneficiary is eligible to receive.

_____

_____

I. FEES

Trust fees will be assessed in accordance with the Fee Schedule that is attached hereto and that may be amended from time to time.

GRANTOR INITIALS _____

J. DISTRIBUTIONS UPON DEATH OF THE BENEFICIARY

1. Upon the death of the Beneficiary, 50% of any funds remaining in the Sub-trust account will be retained by the Trust pursuant to the current contractual agreement with the State of Oregon.
2. In accordance with state and federal law, any surplus funds that are not retained by the Trust will be subject to recovery by the State up to the amount of medical benefits paid on behalf of the Beneficiary. Any amounts not retained by the Trust, shall be used to satisfy any claims by the State.
3. If there are funds remaining in the Beneficiary's Sub-trust account after retention by the Trust and payment of the State's claim, then any such amounts are available for distribution to Remainder Beneficiaries of the Grantor's choosing as follows:

a) ***Primary Remainder Beneficiary(ies):***

☐ Check here for the Oregon Special Needs Trust to receive the following percentage of remaining assets:

☐ 100% or ☐ _____%

☐ Check here for named Remainder Beneficiaries to receive the following share of assets:

1). Name/Organization: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Date of Birth: _____ Social Security No: _____
This person shall receive the following percentage of assets: _____ %

2). Name/Organization: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Date of Birth: _____ Social Security No: _____
This person shall receive the following percentage of assets: _____ %

Add additional Primary Remainder Beneficiaries on a separate paper.

GRANTOR INITIALS _____

b) ***Secondary Remainder Beneficiary(ies):***

☐ Check here for the Oregon Special Needs Trust to receive the following percentage of remaining assets:

☐ 100% or ☐ _____%

☐ Check here for your named Remainder Beneficiaries to receive the following percentage of assets:

1). Name/Organization: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Social Security No: _____

This person shall receive the following percentage of assets: _____ %

2). Name/Organization: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Social Security No: _____

This person shall receive the following percentage of assets: _____ %

Add additional Secondary Remainder Beneficiaries on a separate paper.

c) If a Primary Remainder Beneficiary is deceased, and there are no descendants entitled to his or her share, that share will be distributed to the other listed beneficiary(ies), if any, and then if none to Secondary Remainder Beneficiaries. If a Secondary Remainder Beneficiary is deceased, and there are no descendants entitled to his or her share, that share will be distributed to the other listed beneficiary(ies), if any, and then if none to the Oregon Special Needs Trust as set forth in the Master Trust Agreement.

GRANTOR INITIALS _____

K. GOVERNMENT ASSISTANCE

The Trustor will provide information to local government agencies for SSI, Medicaid, food stamps and subsidized housing recipients as requested for benefit verification and/or recertification.

1. ***Social Security Administration***

Does Beneficiary receive Supplemental Security Income (SSI)?
Yes ☐ No ☐ In process of applying ☐ Amount: $ _____ /month

Does Beneficiary receive Supplemental Security Disability Income (SSDI)?
Yes ☐ No ☐ In process of applying ☐ Amount: $ _____ /month

Does Beneficiary receive Social Security Retirement?
Yes ☐ No ☐ In process of applying ☐ Amount: $ _____ /month

2. ***Veterans Benefit***

Does Beneficiary receive Veteran's Benefits?
Yes ☐ No ☐ In process of applying ☐ Amount: $ _____ /month

3. ***Medical / Medicaid Waiver Information***

Does Beneficiary receive Medicaid Benefits (OHP)?
Yes ☐ No ☐ In process of applying ☐ ID #: _____

Does Beneficiary receive Medicare Benefits (A, B, C or D)?
Yes ☐ No ☐ In process of applying ☐ ID #: _____

Does Beneficiary receive Brokerage Services?
Yes ☐ No ☐ In process of applying ☐

Brokerage: _____
Personal Agent: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____

Does Beneficiary receive Comprehensive Services?
Yes ☐ No ☐ In process of applying ☐

Provider: _____
Contact Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____

GRANTOR INITIALS _____

4. ***Housing***
Does Beneficiary receive any housing assistance? ☐ None ☐ HUD ☐ Section 8 ☐ Other ☐ Applying
Housing Authority/Provider: _____
Case Manager/Contact Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____
Amount Received: _____

5. ***Residential Care***
Does Beneficiary live in residential care (group home, foster care, assisted living, nursing home, etc)?
☐ Yes ☐ No ☐ In process of applying
Type of Residence: _____
Residential Provider: _____
Contact Name: _____
Corporate Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____

6. ***Food Stamps or Other Assistance***
Does Beneficiary receive any other assistance? ☐ Yes ☐ No ☐ In process of applying
Type of Assistance: _____
Agency & Contact Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____
Amount Received: _____

7. ***Health Insurance Policy***
Does Beneficiary have private health insurance? ☐ Yes ☐ No
Insurance Provider: _____
Contact Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Email Address: _____

GRANTOR INITIALS _____

8. ***EPD Program***
Does Beneficiary participate in the Employed Persons with Disabilities program? ☐ Yes ☐ No

Employer: _____

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Email Address: _____

Average Monthly Wages: _____

L. MISCELLANEOUS

1. ***Notice of Government Assistance***

a) The Beneficiary, or the Beneficiary's primary authorized representative, must notify the Trustor in writing whenever there is a change in government assistance being received by the Beneficiary.

b) The Trustor and Trustee shall not be held liable for making disbursements which result in a reduction of, or ineligibility for, government assistance when such Trustor or Trustee did not have actual notice of such government assistance at the time such disbursements were requested or made.

c) The Grantor recognizes and acknowledges the uncertainty and changing nature of laws, regulations, policies and procedures relating to government assistance and neither the Trustor nor Trustee will in any event be held liable for loss of benefits as long as it acted in good faith.

2. ***Amendments***

a) The information provided by the Grantor may be amended as the Grantor, the Trustor, and, to the extent required, the Trustee may jointly agree, provided any such amendment is consistent with the Master Trust Agreement and any then-applicable law.

b) The Trustor may make any unilateral amendments as may be necessary to comply with any changes in the law and/or agency policy for the proper and efficient administration of the Trust.

c) No amendment shall be made that might diminish or defeat the purpose and intent of this Agreement.

3. ***Taxes***

a) The Grantor acknowledges that contributions to the Oregon Special Needs Trust are not deductible as charitable gifts or otherwise.

GRANTOR INITIALS _____

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 is recommended.

c) Sub-trust account income may be taxable to the Oregon Special Needs Trust and when this is the case, such taxes shall be payable from the sub-trust account.

4. ***Entire Agreement***

a) This Agreement, with its noted attachments, constitutes the entire agreement between the parties. No promises, agreements or representations, expressed or implied, have been made, except those contained in this writing, and all corrections and additions hereto shall be in writing, specifically designated as an amendment to this Agreement, and signed by the parties.

b) If any provision of this Agreement shall be deemed invalid, illegal or unenforceable, the remaining provisions shall remain operative.

This Joinder Agreement needs to be signed in front of a Notary Public.

IN WITNESS WHEREOF, the undersigned Grantor has had full and adequate opportunity to seek independent, professional legal advice; has reviewed this agreement and understands its terms; agrees to be bound by its terms; and has accepted and signed this agreement.

GRANTOR:

_____ _____

Signature Date

STATE OF OREGON)
) ss
County of _____)

Signed before me on the _____ day of _____, 20____ by the following person:
_____, who [ ] is personally known to me or who [ ] produced _____ as evidence of identification.

Notary Public: _____ My Commission Expires: _____

GRANTOR INITIALS _____

This agreement will only become effective upon acceptance by the Trustor of the agreement and of the initial funding of the Sub-trust account.

ACCEPTANCE

THE TRUSTOR HEREBY ACCEPTS THE ABOVE-NOMINATED BENEFICIARY OF THE TRUST AND AGREES TO OPEN A SUB-ACCOUNT FOR THE BENEFICIARY'S BENEFIT UPON RECEIPT OF THE INITIAL CASH CONTRIBUTION TO THE TRUSTEE.

Dated this the _____ day of _____, 20_____,

TRUSTOR:
The Arc Oregon

_____ _____
By: Signature

The Arc Oregon
2405 Front Street NE, Suite 120
Salem OR 97301
503.581.2726

_____
Sub-trust account number *(office use only)*

☐ Enrollment application is REJECTED

Date: _____

Reason: _____

The Arc Oregon

_____ _____
By: Signature

GRANTOR INITIALS _____