

## Self-Funded Pooled Disability Trust Joinder Agreement

Trust Adoption Instrument  
Tax Identification Number 54-6440812

The undersigned Grantor(s) hereby establish(es) a trust fund (sub account) under the Commonwealth Community Trust Endowment Fund Pooled Trust Master Trust Agreement, established by the Commonwealth Community Trust Endowment Fund, a non-profit, non-stock Virginia Corporation. The terms of the Grantor's trust fund are set forth in this Joinder Agreement (Trust Adoption Instrument) and the applicable provisions of the Commonwealth Community Trust Endowment Fund Pooled Trust Master Trust Agreement (dated December 8, 1994, as amended and restated June 1, 1998), which is hereby adopted and incorporated herein by reference hereto.

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

- 1. Name(s) of Grantor(s)** – The Grantor(s) must be either the Beneficiary of the trust fund, parent(s), grandparent(s), Guardian or Court\*:

Mr. Mrs. Ms. _____	Mr. Mrs. Ms. _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone No: _____	Home Phone No: _____
Work Phone No: _____	Work Phone No: _____
Cell Phone No: _____	Cell Phone No: _____
E-mail Address: _____	E-mail Address: _____
*Relationship to Beneficiary: _____	*Relationship to Beneficiary: _____

- 2. Name of Beneficiary** – the person whose funds are being placed in the trust, if other than the Grantor:

Mr. Mrs. Ms. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

- 3. Beneficiary's Date of Birth:** \_\_\_\_\_

- 4. Beneficiary's Social Security Number:** \_\_\_\_\_

5. Nature of Disability: \_\_\_\_\_

6. Designation of Advocate – 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 his or her interest in the Pooled Disability Trust:

**A. Primary Advocate:**

Mr. Mrs. Ms. _____	Mr. Mrs. Ms. _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone No: _____	Home Phone No: _____
Work Phone No: _____	Work Phone No: _____
Cell Phone No: _____	Cell Phone No: _____
E-mail Address: _____	E-mail Address: _____
Please indicate your contact preferences: home phone <input type="checkbox"/> cell phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail <input type="checkbox"/> mail <input type="checkbox"/>	Please indicate your contact preferences: home phone <input type="checkbox"/> cell phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail <input type="checkbox"/> mail <input type="checkbox"/>
*Relationship to Beneficiary: _____	*Relationship to Beneficiary: _____

Please provide Commonwealth Community Trust (CCT) with legal documentation for Guardianship, Power of Attorney, and Conservator.

**B. Secondary Advocate:**

Mr. Mrs. Ms. _____	Mr. Mrs. Ms. _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone No: _____	Home Phone No: _____
Work Phone No: _____	Work Phone No: _____
Cell Phone No: _____	Cell Phone No: _____
E-mail Address: _____	E-mail Address: _____
Please indicate your contact preferences: home phone <input type="checkbox"/> cell phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail <input type="checkbox"/> mail <input type="checkbox"/>	Please indicate your contact preferences: home phone <input type="checkbox"/> cell phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail <input type="checkbox"/> mail <input type="checkbox"/>
*Relationship to Beneficiary: _____	*Relationship to Beneficiary: _____

Please provide CCT with legal documentation for Guardianship, Power of Attorney, and Conservator.

**C. Additional Contacts** – In addition to the Primary and Secondary Advocates, permission is granted to contact and share information with the following should the need arise (optional):

**1.) Name:**

Mr. Mrs. Ms. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**2.) Name:**

Mr. Mrs. Ms. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**3.) Name:**

Mr. Mrs. Ms. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**7. Funding Information:**

(a) Describe the source of the funds (e.g., a personal injury award, inheritance, Social Security back payment, other): \_\_\_\_\_

(b) Amount to be deposited into the trust (can be an estimate): \$ \_\_\_\_\_

(c) Will there be a Structured Settlement? Yes \_\_\_ No \_\_\_ If yes, provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(d) Will annual court filings be required? Yes \_\_\_ No \_\_\_ If yes, provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(e) Will the Trust Company of Virginia have to go to court to qualify? Yes \_\_\_ No \_\_\_ If yes, provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8. Income and Principal Distribution –** Income and principal will be distributed for the Beneficiary at the Trustee’s discretion:

While realizing that all distributions are at the Trustee’s sole discretion, the Grantor hereby expresses the following desires as to how the Beneficiary’s trust fund might be used:

\_\_\_\_\_ Initial here to indicate that you would like the Trustee to attempt to address needs as they arise and not necessarily attempt to have the funds last throughout the beneficiary’s lifetime.

\_\_\_\_\_ Initial here to indicate that you would like the Trustee to attempt to have the funds last throughout the Beneficiary’s lifetime.

**IMPORTANT NOTE:** While the Trustee will attempt to take your desires into consideration, it is possible, in any event, that the funds may be exhausted prior to the Beneficiary’s lifetime if the Trustee determines that it is in the Beneficiary’s best interest.

**9. Distributions upon the death of the Beneficiary:**

Upon the actual death of the Beneficiary, the trust will be restricted. Any assets remaining in his/her separate trust fund (sub account), the Trustees will (i) pay to the State or States of \_\_\_\_\_ and any other states such remaining assets in an amount equal to the total amount of Medicaid assistance paid on behalf of the Beneficiary under the State or States Medicaid Assistance Plan; and (ii) distribute the remaining assets to the following individual(s) or other entities listed below.

In the event that either no individual(s) or entities are listed below, or in the sole and absolute discretion of the Trustee, if the total amount of Medicaid assistance paid on behalf of the Beneficiary under the State Medicaid Assistance Plan exceeds the remaining assets in the sub-account, any assets remaining in the Beneficiary's separate trust fund (sub account) shall be deemed to be surplus trust property and shall be retained by the Trustees and used, in their sole discretion in the furtherance of the charitable purposes of the Commonwealth Community Trust Endowment Fund, in accordance with the provisions of the Trust Agreement and applicable law.

**A. Primary Successor Beneficiaries** – If a Primary Beneficiary is deceased without named living descendants to be substituted, the assets will be paid to the remaining Primary Beneficiaries *pro rata*:

**1.) Name:** \_\_\_\_\_ Address: \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Percentage: \_\_\_\_\_

**2.) Name:** \_\_\_\_\_ Address: \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Percentage: \_\_\_\_\_

**3.) Name:** \_\_\_\_\_ Address: \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Percentage: \_\_\_\_\_

**Total Percentage (must total 100%)** \_\_\_\_\_

Add additional Primary Beneficiaries or substitute descendants on a separate page.

Note: If a Primary Successor Beneficiary predeceases the Beneficiary leaving no descendants entitled to his or her share, the distribution lapses and will be divided among the remaining Primary Successor Beneficiaries.

**A. Contingent Successor Beneficiaries** – To be paid if none of the Primary Successor Beneficiaries or their substitute descendants, if applicable, are then living:

**1.) Name:** \_\_\_\_\_ Address: \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Percentage: \_\_\_\_\_

**2.) Name:** \_\_\_\_\_ Address: \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Percentage: \_\_\_\_\_  
**Total Percentage (must total 100%)** \_\_\_\_\_

Add additional Contingent Beneficiaries on a separate page.

Note: If a Contingent Successor Beneficiary predeceases the Beneficiary leaving no descendants entitled to his or her share, the distribution lapses and will be divided among the remaining Primary Successor Beneficiaries.

If there are no Primary or Contingent Beneficiaries named above who are then living, and no entities named above which are then in existence, such remaining funds shall be retained by the Commonwealth Community Trust.

CCT accepts donations that will support the mission to serve people with disabilities.

**10. Government Assistance the Beneficiary Receives** – CCT will provide information to local government agencies for SSI, Medicaid, food stamps and subsidized housing recipients:

**A. Social Security Information:**

Supplemental Security Income (SSI): Yes  No  In the Process of Applying

Address, telephone and contact information for the Social Security Administration (for SSI recipients only):

Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Supplemental Security Disability Insurance (SSDI): Yes  No

Other: \_\_\_\_\_

**B. Medical Information:**

Medicaid: Yes  No  In the Process of Applying

Address, telephone and contact information for the Department of Social Services (for Medicaid recipients only):

Name of Case Manager: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Medicare: Yes  No

**C. Section 8 or Subsidized Housing:**

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**D. Other Public Assistance (e.g., food stamps):**

Please specify agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**11. Health Insurance Policy – Provide the following information if applicable:**

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**12. Beneficiary's Funeral or Burial Plan** – Provide the following information if available:

Insurer/Other: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Contact: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**13. Preference for Trust Account Information (select one):**

- Internet access to daily account information and annual statements
- Printed statements that are mailed: quarterly  annually

**14. Please read the following:**

- (a) In order to facilitate pooling the assets in all sub accounts, it is requested that all deposits be made in cash.
- (b) The provisions of this Joinder Agreement may be amended as determined reasonably necessary by the Trustees so long as any such amendment is consistent with the Master Trust Agreement and is deemed necessary to conform with any changes required by the law.
- (c) It is understood and agreed upon that the trust is for the sole benefit of the Beneficiary.
- (d) Trustee and other fees shall be charged in accordance with the Fee Schedule attached hereto and as amended from time to time.
- (e) Taxes
  - (1) The Grantor acknowledges that there have been no representations made to the Grantor regarding the deductibility of the contributions to the trust as charitable gifts or otherwise.
  - (2) Trust fund (sub account) income, whether paid in cash or distribution in other property may be taxable to the Beneficiary, subject to applicable exemptions and deductions. Professional tax advice is recommended.
  - (3) Income of the trust fund (sub account) may be taxable to the trust and when this occurs, such taxes shall be payable from the trust fund (sub account) of the Beneficiary.
- (f) This trust administered by the Commonwealth Community Trust Endowment Fund is a pooled trust, governed by the laws of Virginia, in conformity with the provisions of 42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993. To the extent there is conflict between the terms of the Trust Agreement and/or this Instrument, and the governing law as from time to time as amended, the law and regulations shall control.

**15. Professional Representation** – Grantor has been represented with regard to the Commonwealth Community Trust Endowment Fund Pooled Trust Master Trust by:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**This Joinder Agreement needs to be signed in front of a notary.**

**16. In Witness Whereof** – The undersigned Grantor(s) has/have signed this Trust Adoption Agreement and understand(s) same and agree(s) to be bound by the terms thereof and the Commonwealth Community Trust hereby accepts this trust this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. The Grantor(s) confirm(s) that simultaneously with the execution of this instrument or prior thereto the assets set forth are or were transferred to the Trustees hereunder.

\_\_\_\_\_  
Grantor's Signature

\_\_\_\_\_  
Grantor's Signature

STATE OF \_\_\_\_\_ CITY/COUNTY OF \_\_\_\_\_

TO-WIT: The foregoing Joinder Agreement, dated \_\_\_\_\_ was acknowledged before me by \_\_\_\_\_ and \_\_\_\_\_, Grantor(s), this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

**TO BE COMPLETED BY COMMONWEALTH COMMUNITY TRUST (CCT):**

By \_\_\_\_\_ Title: \_\_\_\_\_

STATE OF VIRGINIA, CITY/COUNTY OF HENRICO

TO-WIT: The foregoing Joinder Agreement, dated \_\_\_\_\_ was acknowledged before me by \_\_\_\_\_ and \_\_\_\_\_ on behalf of CCT, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_