

## Third Party Special Needs Trust Joinder Agreement

Trust Adoption Instrument  
Tax Identification Number 54-6302655

The undersigned Grantor(s) hereby establish(es) a trust fund under the Commonwealth Community Trust's Master Trust Agreement. 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's Master Trust Agreement dated October 9, 1990, as amended and restated as of 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):

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. Beneficiary Information:

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

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

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

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

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

3. Date of Birth: \_\_\_\_\_

4. 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 the Special Needs 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  cell phone  work phone  e-mail  mail

Please indicate your contact preferences:

home phone  cell phone  work phone  e-mail  mail

\*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  cell phone  work phone  e-mail  mail

Please indicate your contact preferences:

home phone  cell phone  work phone  e-mail  mail

\*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. 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.

**8. The Grantor(s) agrees to the current published fee schedule as may be amended from time to time.**

**9. Revocability of Trust (Choose one alternative and initial):**

(a) The trust fund cannot be revoked. \_\_\_\_\_

(b) The trust fund can be revoked so long as individual Grantor lives. \_\_\_\_\_

(c) The trust fund can be revoked so long as any Grantor lives  
(where there is more than one Grantor). \_\_\_\_\_

(d) The trust fund cannot be revoked after the death of any one Grantor  
(where there is more than one Grantor). \_\_\_\_\_

Note: Any revocation must be made by all living Grantors, in writing, properly notarized, and in a form acceptable to the Trustee.

**10. Distributions Upon the Death of the Beneficiary** – Upon the actual death of the Beneficiary, the trust will be restricted and any remaining and unpaid funds shall be distributed to the following individuals who are then living or entities which are then in existence:

**A. Primary Successor Beneficiaries:**

**1.) Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ %UUP: \_\_\_\_\_ Percentage: \_\_\_\_\_  
Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

**2.) Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ %UUP: \_\_\_\_\_ Percentage: \_\_\_\_\_  
Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

**3.) Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
Mr. Mrs. Ms. \_\_\_\_\_  
Home Phone No: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ %UUP: \_\_\_\_\_ Percentage: \_\_\_\_\_  
Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

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

Add additional Primary Beneficiaries on separate paper.

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.

**B. Contingent Successor Beneficiaries – To be paid if none of the Primary Beneficiaries are then living:**

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

G/o ckl' Cf ft guu <aaaaaaaaaaaaaaaaaaaaaaaaaaaaa "UUP <aaaaaaaaaaaaaaaaaaaaa "Rgtegpwi g<aaaaaaa"

Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

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

G/o ckl' Cf ft guu <aaaaaaaaaaaaaaaaaaaaaaaaaaaaa "UUP <aaaaaaaaaaaaaaaaaaaaa "Rgtegpwi g<aaaaaaa"

Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

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

G/o ckl' Cf ft guu <aaaaaaaaaaaaaaaaaaaaaaaaaaaaa "UUP <aaaaaaaaaaaaaaaaaaaaa "Rgtegpwi g<aaaaaaa"

Substitute descendants, *per stirpes*, for individuals who are not then living? Yes/No/N/A \_\_\_\_\_

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

Add additional Contingent Beneficiaries on separate paper.

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 Beneficiaries named above who are then living, and no entities named above which are then in existence, such remaining funds shall be distributed to the person or persons who would inherit the Beneficiary's personal estate under the laws of Virginia then in effect if the Beneficiary had then died without a will, unmarried, and owning the assets.

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

**11. 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 Address: \_\_\_\_\_

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: \_\_\_\_\_

**12. Funding Information:**

(a) Amount to be deposited into the trust (estimate if not certain): \$ \_\_\_\_\_

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

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

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(d) This Provision is Part of the Grantor's Will? Yes  No

(e) In order to facilitate pooling of the assets in all sub accounts, it is requested that all deposits must be made in cash. The trust does not hold real estate property.

**13. Preference for trust account financial information (select one):**

Daily electronic access to account information and annual statements

Written statements that are mailed: quarterly    annually

**14. Professional Representation – Grantor(s) has/have been represented with regard to the Commonwealth Community Trust by:**

Name: \_\_\_\_\_

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

\_\_\_\_\_

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

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

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

**15. In Witness Whereof** – The undersigned Grantor(s) has/have signed this 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 on the attached schedule 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: \_\_\_\_\_