SPECIAL NEEDS TRUST FOUNDATION
THIRD-PARTY MASTER TRUST
JOINDER AGREEMENT

UPON EXECUTION BY DONOR AND UPON ACCEPTANCE AND EXECUTION BY THE SPECIAL NEEDS TRUST FOUNDATION, THIS WILL BE A BINDING LEGAL DOCUMENT. YOU ARE ENCOURAGED TO SEEK INDEPENDENT PROFESSIONAL ADVICE BEFORE SIGNING.

The undersigned hereby enrolls in and adopts the "Special Needs Trust Foundation Third Party Master Trust Agreement" dated January 17, 1992, as amended and restated on January 1, 2013 which is incorporated herein by reference and a copy of which has been delivered to the Donor.

A. All property transferred to the Trustee pursuant to this Joinder Agreement shall be held in a sub-account and administered and distributed as provided herein and in the Master Trust Agreement.

B. **Trust sub-account number: EIN _____ Case #_____**
(Assigned by Trust Company)

C. **DONOR INFORMATION:**

Name: _____

Address: _____

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

Phone (day):_____**(evening):** _____

Date of Birth: ____/____/_____ (mm/dd/yyyy**)** **Social Security number** _____-_____-_____

Relationship to person with special needs: _____

Family Attorney: _____

Attorney's Address: _____

_____

Attorney's Phone #: _____

D. BENEFICIARY WITH SPECIAL NEEDS INFORMATION:

Name: _____

Address: _____

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

Phone (day):_____**(evening):** _____

Date of Birth: ____/____/_____ (mm/dd/yyyy**)** **Social Security number** _____-_____-_____

Is Beneficiary With Special Needs Conserved? Yes: _____ No: _____ If yes, please attach documentation.

Name of Conservator:_____**Phone:** _____

Address: _____

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

1. Does the Beneficiary receive **Supplemental Security Income (SSI)?**
   Yes: _____ No:____ If so, how much per month? $_____

2. Does the Beneficiary receive **Social Security Disability Insurance (SSDI**)?
   Yes: _____ No:____ If so, how much per month? $_____

3. Does the Beneficiary receive **Social Security Survivor's Disability Benefits as an Adult Disabled Child (DAC)**?
   Yes: _____ No:____ If so, how much per month? $_____

4. Does the beneficiary receive Retirement **Social Security Benefits**?
   Yes: _____ No:____ If so, how much per month? $_____

   If "yes" to any of the above, please attach a copy of the most recent benefits award letter(s)

   If "yes" to any of the above, who is **Beneficiary's representative payee?**

   Name of Rep Payee:_____**Phone:** _____

   Address: _____

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

5. Does the Beneficiary receive **Medi-Cal**?
   Yes: _____ No:____

6. Does the Beneficiary receive **Medicare**?
   Yes: _____ No:____

   If "yes" to any of the above, please attach a copy of the Medi-Cal and/or Medicare card.

7. Does the Beneficiary receive a **Medicaid Waiver: (Please attach copy of the waiver)**
   Yes: _____ No:____

   If "yes" specify the waiver program(s) under which the Beneficiary receives benefits:
   _____
   _____

8. If the Beneficiary receives **other Government Assistance***, such as **Food Stamps, Section 8 Housing**, etc., **Please list these benefits.**
   _____
   _____
   _____

9. Does the Beneficiary receive services from the **San Diego Regional Center**?
Yes: _____ No:_____

If "Yes" what is the name, ID Number, address and telephone number of the Beneficiary's Regional Center Caseworker?

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Email: _____

10. Does the Beneficiary receive services from the **Department of Rehabilitation, the Department of Mental Health, the Department of Social Services, and/or Department of Developmental Services (i.e. Regional Center)**?
Yes: _____ No:____

If "Yes" what is the name, address and telephone number of the Beneficiary's Caseworker?

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Email: _____

11. Does the Beneficiary have an **additional source of income**?
Yes: _____ No:____ Source of additional income: _____ Amount $_____

12. Benefits Pending:
Does the Beneficiary have a pending benefits application? _____

If yes, which type of benefits? _____

What was the application date? _____

E. BENEFICIARY ADVOCATE:

A "Beneficiary Advocate" is an individual who knows the Beneficiary, whom the Beneficiary trusts, and who can act as a prudent and responsible "advisor" to The Special Needs Trust Foundation (SNTF). Essentially, a "beneficiary advocate" acts as a liaison between the Beneficiary and SNTF. The beneficiary advocate communicates the Beneficiary's needs and desires to the SNTF and makes actual disbursement request to be considered by the SNTF, beneficiary advocates are valuable to both the Beneficiary and the SNTF because they provide insight into how a Beneficiary's trust account can best be used to provide him or her with the best possible material quality of life. A Beneficiary can have more than one beneficiary advocate.

List the beneficiary advocate below:

1. Name: _____ Phone: _____
   Relationship to Beneficiary: _____
   Address: _____
   City: _____ State: _____ Zip: _____

2. Name: _____ Phone: _____
   Relationship to Beneficiary: _____
   Address: _____
   City: _____ State: _____ Zip: _____

3. Name: _____ Phone: _____
   Relationship to Beneficiary: _____
   Address: _____
   City: _____ State: _____ Zip: _____

F. METHOD OR SOURCE OF FUNDING

		List Amount and Initial if Applicable	
		Amount	**Donor's Initials**
1.	**Current Funding:**		
	(a) The trust sub-account is being funded concurrently with the execution of this Joinder Agreement with assets described in Attachment "A".	$ _____	_____
2.	**Future Funding:**		
	(a) The trust sub-account is to be funded under the Donor's:		
	Will	$ _____	_____
	Living Trust	$ _____	_____
	(b) The trust sub-account is to be funded through life insurance or otherwise, and the Special Needs Trust Foundation Master Trust will be designated as primary beneficiary.	$ _____	_____

(c) Any proposed or designated future funding shall be revocable by the Donor during the Donor's life. The Donor shall notify the Trustee of any such revocation promptly.

(d) The owner of each policy made payable to the Trustee has reserved all rights, options, and privileges conferred upon the owner by the terms of the policies. Sickness, disability or other benefits and all dividends accruing on the policies during the insured's life may be paid by the insurer to the owner.

(e) Upon receipt of proof of death of an insured, or upon maturity prior to an insured's death, and upon receiving possession of the policies, the Trustee shall use reasonable efforts to collect all sums payable on them, which sums upon receipt shall become principal of the trust sub-account, except interest paid by

the insurer, which shall be income. The Trustee may, if it elects, exercise any settlement options under any policy. The Trustee may compromise, arbitrate or otherwise adjust claims upon any of the policies. The receipt of the Trustee to the insurer shall be a full discharge, and the insurer is not required to see to the application of the proceeds.

(f) The Trustee shall not be responsible for any acts or omissions of the Donor owner in connection with or relating to any policy, and shall not be required to prosecute any action to collect any insurance or to defend any action relating to any policy unless indemnified in manner and amount satisfactory to it.

(g) Upon the death of an insured Donor, the Trustee shall collect all life insurance policy proceeds payable to the Trustee as beneficiary, as the result of said Donor's death. The Trustee shall not, however, collect from the said Donor's estate or from any other person any repayment on any loan secured by any insurance policies. The Trustee shall have the power to execute and deliver receipts and other instruments, to compromise or adjust disputed claims in such manner as in its sole discretion seems just, and to take such steps as in its discretion are necessary and proper for collection of any insurance proceeds and to pay the expenses of collection out of the trust sub-account. However, if payment on any policy is contested or refused, the Trustee shall not be obligated to take any action for collection unless and until it shall have been indemnified to its reasonable satisfaction against any loss, liability or expense, including reasonable attorneys' fees.

G. DISTRIBUTIONS FOLLOWING THE DEATH OF THE PERSON WITH SPECIAL NEEDS:

1. At the time of death of the person with special needs, if there are assets remaining in his or her separate trust sub-account, a minimum of at least twenty-five (25%) of the remaining property shall be distributed to the Special Needs Trust Foundation (SNTF) **and** a minimum of at least twenty-five (25%) of the remaining property shall be distributed to one of the participating member charitable organization(s) serving persons with special needs as designated by the Donor*. These organizations include only those which are members of the SNTF Board and SNTF. A current list of such organizations may be obtained from the SNTF office.* **Note: A Donor may not be listed as a beneficiary.**

Distributions shall be in the following percentages and to the following organizations and/or persons:

	Percentage	**Donor's Initials**
Special Needs Trust Foundation (at least 25%)	_____	_____
Member Charity (at least 25%) _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
Beneficiary Name _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
Beneficiary Name _____	_____	_____
Address _____		
City _____ State _____ Zip _____ Phone _____		
	TOTAL 100%	

2. The share for a remainderman named in (G)(1) who does not survive the beneficiary shall lapse and be distributed prorated to the remaindermen stated on page 5 or as otherwise stated as follows:

_____

_____

3. Article Three, section (b) of the Special Needs Trust Foundation, Master Trust Agreement states in part: "Upon receipt and acceptance by the Trustee, such contributions shall be irrevocable." Pursuant to this provision, the designations of distributees made in F.1., 2. above are irrevocable with repsect to funds which have been given to the Trust. For example, a Donor may fund the trust during the Donor's lifetime with a gift of $5,000. The designations above are irrevocable upon the receipt of the $5,000 with respect to the $5,000. However, the designations can be amended by the Donor with respect to future funding.

H. DISTRIBUTION TO THE BENEFICIARY

The Donor recognizes that all distributions are at the discretion of the Special Needs Trust Foundation, and shall be made consistent with the provisions of the Special Needs Trust Foundation Master Trust Agreement and this Joinder Agreement as follows (*Check one*):

____ Discretionary income distributed; no principal distributed

____ Both discretionary income and principal distributed

I. Fees:

1. Enrollment fee is $100.00 per 3rd party trust established. To be billed to the trust when trust is accepted.

2. Distribution check administration fee: no fee for the first three (3) checks issued per month and a fee of $25 per check issued over the 3-check limit per month.

3. Bank investment fees for each trust will be a minimum .72% annual fee, which may vary with current fees, billed at the first of each month at the rate of 1/12 of .72%. There will be no bank investment fees if Option 1 is chosen for Asset Allocation as defined in the Investment Policy Statement.

J. MISCELLANEOUS

1. Except as set forth in F.2., the provisions of this Joinder Agreement may be amended by the Donor so long as any such amendment is consistent with the Master Trust Agreement. Any such amendment shall be effective upon receipt by the Trustee and approval by the Special Needs Trust Foundation, which approval shall not be unreasonably delayed or withheld.

2. The Donor may terminate his or her Joinder Agreement if the trust sub-account has not yet been funded, in which case the Special Needs Trust Foundation Master Trust and this Joinder Agreement shall then become null and void as to the Donor, the person with special needs and the Special Needs Trust Foundation.

3. Taxes: The Donor acknowledges that:

a. Contributions to the Special Needs Trust Foundation Master Trust under this Joinder Agreement are not deductible as charitable contributions or gifts and may not be otherwise deductible for tax purposes.

b. Trust sub-account income may be taxable to the person with special needs for whose benefit the sub-account is maintained.

c. Trust sub-account income may be taxable to the Trust, in which case such taxes shall be payable from the trust sub-account.

d. The Donor has been advised to seek professional tax advice regarding any income or gift tax consequences of these gifts.

4. The Donor acknowledges receipt of copies of the Master Trust Agreement and this Joinder Agreement, and that the Donor has read and understood both. The Donor agrees to be bound by their terms.

This Joinder Agreement is executed on _____ _____, 20 _____

at _____, _____

_____ _____

DONOR DONOR

Approved and accepted:

_____ _____

TRUSTEE/SNTF Corporate Officer DATE

Attached are copies of the Beneficiary's:

- ☐ Benefit Eligibility Letters
- ☐ Benefit Eligibility Cards
- ☐ State Drivers' License/ID Card
- ☐ Social Security Card
- ☐ Birth Certificate and/or Passport
- ☐ Any other Pertinent benefit or identification documents

SPECIAL NEEDS TRUST FOUNDATION

Information Sheet

Person with Special Needs:

Name	SSAN:
Residence Address	Tel #
City State	Zip

Residential Provider:

Name:	Tel#:

Resident Type		Comments
	Group Home	
	Board & Care	
	Residential/Nursing Home	
	Independent Living	
	With Family or Relative	Who?
	Other Describe	
Date entered this residence	YRS	

Special Needs Trust Foundation Contact

	Named in Joinder Agreement
Access To Independence	
Arc San Diego	
Community Catalysts	
Developmental Services Continuum	
Home of Guiding Hands	
Mt. Shadows Support Group	
NAMI San Diego	
Options for All	
Partnerships With Industry	
Sharp Healthcare Foundation	
St. Madeleine Sohpie's Center	
Stein Education Center	
United Cerebral Palsy Assoc. SD	
Unyeway	

Who else knows the person with Special Needs?

Name

Relationship Tel#

Personal Data on Person with Special Needs

Birthday		Age	Sex
Single	Married	Divorced	Other
Legally Competent		Yes	No
Eligible for Medicare		Yes	No

Medical Insurance Type/Name Tel#

Dental Insurance Type/Name Tel#

Other Insurance Coverage Type/Name Tel#

SSI/SSA Income (Describe)

Trust and/or Other Income (Describe)

Name of Social Security Rep/Payee Tel#

Name of Regional Center (if Eligible): Tel#

Case Manager and Unit Assigned

Other Agencies providing services Tel#

Type of Services and Contact Person

DISABILITY/DIAGNOSIS Seizures Yes No

(Use Additional Sheet(s) if necessary)

Personal Physician(s)	Specialty	Tel#

Hospital Preferred	Address	Tel#

Method(s) or Source(s) of Funding (list all that apply) Est. Value $

1. Current Funding $
   (Assets described in Attachment "A")
2. Future Funding via Donors:
   - Will $
   - Living Trust $
   - Life Insurance $
   - Other $

Revised 11/04/2005

Assigned to (Agency) Date

DISABILITY(S) & EQUIPMENT

Name _____

TYPE	YES	NO	EQUIPMENT AND/OR USE	YES	NO	FUNDING SOURCE
VISUAL			GLASSES			
BLIND			WHITE CANE			
IMPAIRED			HEARING AID			
HEARING			WALKING CANE(S)			
DEAF			WALKER			
IMPAIRED			CRUTCHES			
RETARDATION			ELECTRIC WHEELCHAIR			
MILD			MANUAL WHEELCHAIR			
SEVERE			HELMET			
PROFOUND			COMMUNICATION BOARD			
PSYCHIATRIC DISORDER			COMMUNICATION DEVICE			
SCHIZOPHRENIA			OTHER			
MANIC DEPRESSION						
OTHER						
PHYSICAL						
CEREBRAL PALSY						
HEAD INJURED						
OTHER						

Please write below some suggested guidelines for use of this Special Needs Trust. What hopes and dreams for the person with special needs do you see being fulfilled with this money?

_____

_

_____

_

LETTER OF INTENT

The following guide is to direct the Special Needs Trust Foundation Board in carrying out your wishes when we make future financial decisions. It is important that you sit down with your family and come to a consensus about what you want for the future. The outline below can be used as a guide in your decision. **List 4 or 5 preferences under each heading.** (Example: Residential: 1st Choice - Live in an apartment with assistance. 2nd Choice – Live in a group home.)

Residence: *If something should happen to you tomorrow, where will your son or daughter live:*

____ Group Home _____
____ Apartment with Assistance _____
____ Family Member's Home _____
____ Other _____

Education: *You have a lifelong perspective of your son or daughter's capabilities. Share it!*

_____
_____
_____

Employment: *What has your son or daughter enjoyed? Consider his or her goals, aspirations, limitations, etc.*

____ Group Employment _____
____ Individual Employment _____
____ Community Employment _____
____ Light Industrial Workshop _____
____ Day Activity Center _____
____ Other _____

Medical Care: *What has and has not worked with your son or daughter? What should future caregivers know?*

_____
_____
_____
_____

Social: *What activities make life meaningful for your son or daughter?*

____ Favorite Activities _____
____ Community Recreation Organization _____
____ Travel _____
____ Other _____

Religious: *Is there a special church or synagogue or person your son or daughter prefers for fellowship?*

_____
_____
_____

It is also very important that the Board know whom you have designated to be an advocate or guardian for your son or daughter. If you don't have family or anyone you can designate, please indicate that you'd like some of the money used to purchase private fiduciary services.

_____
_____
_____

After you complete all of the life planning areas, **sign and date this important document**. This letter will be kept with your trust documents to provide the Board instructions for future disbursement. This letter can be amended any time in the future.

Donor's Name (please print) _____

Person with special needs _____

Signature _____ Date _____