

**JOINDER AGREEMENT
SPECIAL NEEDS TRUST FOUNDATION
SELF-SETTLED MASTER TRUST**

THIS IS A LEGAL DOCUMENT. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING.

The undersigning hereby enrolls in and adopts Special Needs Trust Foundation (SNTF) Self-Settled Master Trust dated March 17, 2006 which is incorporated herein by reference.

Sponsoring Organization: _____

A. Trust sub-account number(Assigned by Trustee): _____

B. Beneficiary's Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (day): _____ (evening): _____

Date of Birth: ___/___/___ (mm/dd/yyyy) Social Security number ___-___-___

Disability/Diagnosis: _____

Is the beneficiary conserved? Yes: ___ No: ___ If yes, please attach documentation.

Name of Conservator: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

C. Benefits Received:

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 Benefits?

Yes: ___ No: ___ If so, how much per month? \$ _____

4. Does the Beneficiary receive Medi-Cal?

Yes: ___ No: ___

If "yes" what is the Beneficiary's Medicaid card number? _____

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

Name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

5. Does the Beneficiary receive a **Medicaid Waiver**:

Yes: _____ No: _____

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

If "yes" what is the Beneficiary's Medicaid card number? _____

6. If the Beneficiary receives other Government Assistance*, such as Food Stamps, SILP, AFA, Supported Living, CHOICE, ARCH, Section 8 Housing, etc., please **list these benefits and the case worker and/or contact person's name and address here**:

*"Government Assistance" means those services or financial assistance paid for or otherwise provided by a local, state, or federal government or agency or department thereof, to, or on behalf of eligible beneficiaries.

7. 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: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

8. 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, ID Number, address and telephone number of the Beneficiary's Caseworker?

Name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

D. The amount at which the sub-account has been funded is: \$ _____

E. Key Person:

A "Key Person" 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 "key person" acts as a liaison between the Beneficiary and SNTF. The key person communicates the Beneficiary's needs and desires to the SNTF and makes actual disbursement request to be considered by the SNTF, key people 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 key person.

List the key person or key people below:

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

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

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

F. Distributions upon the Beneficiary's death:

If this trust account is funded with the Beneficiary's own money, federal law requires that all unspent money in the account remaining at the time of the Beneficiary's death be used to reimburse the State(s) for medical services received up to the total amount that the State(s) has spent on medical services for the Beneficiary throughout the Beneficiary's lifetime. If a balance remains after the State(s) has been reimbursed (which is highly unlikely, unless the Beneficiary has drawn Medicaid benefits for only a short period of time), said balance shall be disbursed as follows:

If the Beneficiary is a minor or is incompetent, the remainder shall be that individual's "heirs at law" as determined by the California Probate Code.

1. Name: _____ Percentage: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

2. Name: _____ Percentage: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

3. Name: _____ Percentage: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

If the Beneficiary's residence changes from California to another state, distributions may cease until appropriate arrangements can be made within the sole discretion of the Trustee. If appropriate arrangements cannot be made, the Beneficiary's trust sub-account will be terminated by the Trustee with the remaining sub-account property distributed according to Section F, above.

Any remainder shares for a remainderman named in Section F who does not survive the Beneficiary shall lapse and be distributed in equal shares to all other remaindermen.

G. Fee:

An enrollment fee of \$ _____ will be paid when this subtrust is funded.

An annual Trustee fee shall be assessed on funded trusts. This fee shall be determined according to the attached Schedule of Fees.

If the Beneficiary is subject to any additional fees, a listing of these fees shall be attached to this Joinder Agreement.

H. Miscellaneous:

The provisions of this Joinder Agreement may be amended as the Beneficiary and the Trustee may jointly agree, provided that such amendment is consistent with the SNTF Self-Settled Master Trust.

This Joinder Agreement and SNTF Self-Settled Master Trust may be terminated by the Trustee upon nonpayment of any required fee.

I. Taxes:

1. The Beneficiary (or his legal representative and/or Key person) acknowledges that contributions to SNTF Self-Settled Master Trust are not deductible as charitable gifts, or otherwise.
2. Trust sub-account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. The Beneficiary (or his legal representative and/or Key Person) is encouraged to obtain advice from a qualified tax professional

IN WITNESS WHEREOF, the undersigned Beneficiary or his/her legal representatives or designees has reviewed and signed this Joinder Agreement, understands it, and agrees to be bound by its terms, and the Trustee has accepted and signed this Joinder Agreement this _____ day of _____, 20____.

BENEFICIARY (or Beneficiary's legal representative)

Approved and accepted:

TRUSTEE/SNTF Corporate Officer

DATE

I have advised the special needs trust beneficiary or his/her representative regarding the alternatives to the establishment of a special needs trust. In addition, I will report the establishment of this special needs trust to any governmental agencies which require notice.

ATTORNEY

DATE

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____