



SENIORCOMMUNITY
SERVICES

JOINDER AGREEMENT

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**SENIOR COMMUNITY SERVICES
SUPPLEMENTAL NEEDS TRUST
JOINDER AGREEMENT**

The undersigned hereby establishes a Trust Account under the Senior Community Services Supplemental Needs Trust dated January 5, 2015 and as amended and restated thereafter in the initial sum of \$250.00

Sponsor Information

Name: First: _____ Middle: _____ Last: _____

Marital Status: Married Widowed Single Gender: _____

SSN: _____ - _____ - _____ Date of Birth: ____/____/____

Citizen: _____ Tel: Home _____ Cell: _____

Address: _____ Apt#: _____

City: _____ State: _____ County: _____ Zip: _____

Email: _____

Beneficiary Information

Same as Sponsor

Name: First: _____ Middle: _____ Last: _____

Marital Status: Married Widowed Single Gender: _____

SSN: _____ - _____ - _____ Date of Birth: ____/____/____

Citizen: _____ Tel: Home _____ Cell: _____

Address: _____ Apt#: _____

City: _____ State: _____ County: _____ Zip: _____

Email: _____

Relationship To Beneficiary: _____

Household Income Information

Is Spouse Deceased? Yes No

Is Applicant & Spouse applying together? Yes No If Yes, Fill in Spouse's Income.

	<u>Applicant</u>	<u>Spouse</u>
TYPE OF BENEFIT	Monthly Amount	Monthly Amount
Supplement Security Income (SSI)	\$	\$
Social Security Disability Income (SSDI)	\$	\$
Social Security Retirement Income (SSA)	\$	\$
VA Benefits	\$	\$
Employment Benefits	\$	\$
Survivor Benefits	\$	\$
IRA Distribution	\$	\$
Pensions / Annuities	\$	\$
Interest / Dividends	\$	\$
Reparations	\$	\$
Other	\$	\$

Please Note: All disbursements must be for sole benefit of the account beneficiary. A spouse is not a beneficiary for the account.

Medicaid Information- Please Attach MAP / LDSS Notice of Decision

	Applicant	Spouse
Application Status	<input type="checkbox"/> Pending <input type="checkbox"/> Accepted	<input type="checkbox"/> Pending <input type="checkbox"/> Accepted
CIN NUMBER		
MONTHLY SPEND DOWN \$		

**FOR ANY APPLICABLE ITEMS BELOW, PLEASE ATTACH THE
NECCESARY PROOF.**

Healthcare Premiums-Please attach current statement and proof of payment.

Medicare part B Supplement: Plan Name: _____

Premium \$: _____ **Frequency:** _____

Medicare Part D Plan: Plan Name: _____ **Premium \$:** _____

Funeral Arrangement- Please attach pre-need funeral agreement.

Name of Funeral Home: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Telephone: _____

Burial Plot- Please attach a copy of plot deed.

Name of Cemetery: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Telephone: _____

Life Insurance:- Please attach a copy of policy.

Name of Insured: _____ **Name of Owner:** _____

Name of Insurance Company: _____ **Policy #:** _____

Type of Policy: Term: _____ **Life:** _____ **Cash Surrender Value \$:** _____

Upon the death of the Beneficiary, amounts remaining in the Beneficiary's sub- account shall be retained in the Trust solely for the benefit of individuals who are disabled as defined in Soc. Sec. Law Section 1614(a) (3) [42 USC 1382c(a) (3)] and any subsequent definitions that are enacted into law.

Qualifying Disabilities

- 1. _____
- 2. _____
- 3. _____

Living Arrangements:

At Home Independently:____ **At Home with Assistance:**____ **Assisted Living Facility:**____

Resides with parents or other family:____ **Other- Explain:**_____

Power Of Attorney- Please attach a copy of Power of Attorney

Name: First:_____ **Middle:**_____ **Last:**_____

Address:_____ **Apt#:**_____ **City:**_____

State:_____ **County:**_____ **Zip:**_____ **Tel: Home:**_____

Cell:_____ **Email:**_____

Is this person the sole POA? _____ **Yes** _____ **No**

If No, are the agents authorized to act separately? _____ **Yes** _____ **No**

Guardianship- Please attach a copy of Decree or Letter of guardianship.

Guardian appointed for the: _____ **Person** _____ **Property** _____ **Both**

Name: First:_____ **Middle:**_____ **Last:**_____

Address:_____ **Apt#:**_____ **City:**_____

State:_____ **County:**_____ **Zip:**_____

Telephone:_____

Email:_____

Authorized Representative: # 1

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First: _____ Middle: _____ Last: _____

Address: _____ Apt#: _____ City: _____

State: _____ County: _____ Zip: _____ Tel: Home: _____

Cell: _____ Email: _____

Relationship to Beneficiary: _____

Would you like this representative to be the primary contact? ____ Yes ____ No

Authorized Representative: # 2

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First: _____ Middle: _____ Last: _____

Address: _____ Apt#: _____ City: _____

State: _____ County: _____ Zip: _____ Tel: Home: _____

Cell: _____ Email: _____

Relationship to Beneficiary: _____

Would you like this representative to be the primary contact? ____ Yes ____ No

Referring Source:

Name of Agency: _____ Name Of Contact: _____

Address: _____ Apt#: _____ City: _____

State: _____ County: _____ Zip: _____ Phone: _____

Email: _____

I Authorize any applicable documents necessary for reporting to Government Agencies to be sent to the referring source above. ____ Yes ____ No

The Undersigned Sponsor Hereby Acknowledges

1. That signing of this document constitutes a legal agreement and contributions to the Trust Account may have tax consequences. I have been advised to consult with my attorney and tax advisor before signing this Joinder Agreement.
2. That I am obligated to make a minimum contribution to the Trust Account in the amount of \$250.00 (unless otherwise determined / approved by the Trustees of the Senior Community Services Supplement Needs Trust).
3. That I agree to the attached fee schedule and understand that fees may be adjusted from time to time by the Trustees of Senior Community Services Supplement Needs Trusts.
4. That all contributions made to the Trust account will be held and administered pursuant to the provisions of the Senior Community Services Supplement Needs Trust dated January 5, 2015 including any amendments to the Trust made after the date of this Joinder Agreement. The provisions of the Senior Community Services Supplement Needs Trust are incorporated herein by reference. I have received and reviewed a copy of the Senior Community services Supplemental Needs Trust, prior to signing this Joinder Agreement. **I UNDERSTAND THAT THIS AGREEMENT IS IRREVOCABLE.**
5. That the Designated Beneficiary is disabled or has medical condition that renders him or her unable to sustain employment.
6. THAT A POTENTIAL CONFLICT OF INTEREST EXISTS IN THE ADMINISTRATION OF THE SENIOR COMMUNITY SERVICES SUPPLEMENTAL NEEDS TRUST. THE TRUSTEES ARE APPOINTED BY THE BOARD OF THE SENIOR COMMUNITY SERVICES, INC. WHICH MAY HAVE A REMAINDER INTEREST IN THE TRUST ACCOUNTS. IN THE ADMINISTRATION OF THE TRUST, THE TRUSTEES ARE PERMITTED TO DISBURSE TRUST FUNDS TO SENIOR COMMUNITY SERVICES, INC., AND/OR BENEFICIARY, AFFILIATE OR CONSTITUENT AGENCIES OF SENIOR COMMUNITY SERVICES, INC. ON BEHALF OF THE DESIGNATED BENEFICIARIES. I AM AWARE OF THE EXISTENCE OF THIS POTENTIAL CONFLICT OF INTEREST AND EXPRESSLY WAIVE ANY AND ALL CLAIMS AGAINST THE TRUSTEES ON ACCOUNT OF SELF-DEALING, CONFLICT OF INTEREST OR ANY OTHER ACT.

**Please mail all Trust documents to:
SCS POOLED TRUST
7 RANDOLPH RD, HOWELL, NJ 07731**

Signature

I certify that the above Information is accurate and completed to the best of my knowledge.

SIGNATURE

DATE

PRINT

RELATIONSHIP

SIGNATURE OF NOTARY

STATE OF New York) SS:

COUNTY OF: _____)

On _____, 20____ Before me the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledge to me that he/she/they executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed this instrument.

Notary Public

FOR OFFICE USE ONLY

Accepted by Trustee or Designated Representative of the Trustees, Senior Community Services Supplemental Needs Trust.

SIGNATURE

DATE APPROVED

TITLE