Wellness for All POOLED TRUST

(A Trust for Persons with Disabilities)

BENEFICIARY PROFILE SHEET AND JOINDER AGREEMENT

NOTE: All questions must be answered or your application will be delayed.

Beneficiary Profile Sheet

1. Name of Donor (Generally same as Beneficiary): _____
(First Name, Middle Name, Last Name)

Social Security No. of Donor: _____

Address of Donor: _____

_____

Telephone Number of Donor: _____

2. Name of Disabled Beneficiary (In-Kind Beneficiary): _____
(First Name, Middle Name, Last Name)

Social Security No. of Disabled Beneficiary: _____

Address: _____

_____

Telephone Number (Day): _____ (Evening): _____

3. County of Residence: _____

Place of Birth: _____

Citizenship: _____

Date of Birth: _____ Gender: _____

Please list qualifying disabilities: _____

_____

_____

4. Is the purpose of establishing this trust the result of a Court Order? Yes ☐ No ☐
(If yes, please include a copy of Court Order)

5. Is the purpose of establishing this account to shelter monthly income? Yes ☐ No ☐

Indicate estimated monthly deposit: $_____
(Note: This is supplemental information for Wellness for All Pooled Trust purposes only. This amount may be changed at any time with no effect on the Joinder Agreement.)

6. Beneficiary Income: *If you receive any form of Social Security benefit,* ***if possible*** *please submit a copy of your "proof of income" letter.*

Does the Beneficiary receive Supplemental Security Income (SSI)?

Yes ☐ No ☐ If yes, how much? Amount $_____

Does the Beneficiary receive Social Security Disability Income (SSDI)?

Yes ☐ No ☐ If yes, how much? Amount $ _____

Does the Beneficiary receive Social Security Retirement Income (SSA)?

Yes ☐ No ☐ If yes, how much? Amount $ _____

Does the Beneficiary receive Survivor Benefits?

Yes ☐ No ☐ If yes, how much? Amount $ _____

Does the Beneficiary receive other income? Yes ☐ No ☐

(If yes, please provide detail)

_____

_____

Does the Beneficiary receive Medicaid? Yes ☐ No ☐ Pending ☐

If yes, list Medicaid card number _____

If the Beneficiary receives other benefits or entitlements, such as Food Stamps, HUD Sec. 8, etc. list these benefits and monthly amounts:

_____

_____

7. (a) Indicate the living arrangement of the Beneficiary:

Lives Independently	☐	Lives with parents or other family	☐
Family Care Program	☐	CR/IRA/ICF (supervised)	☐
CR/IRA (supportive)	☐	Nursing Home	☐
Assisted Living Facility	☐	Other (explain) _____	

(b) Does the Beneficiary receive community funds as part of residential care?

Yes ☐ No ☐ If yes, how much is it and how often received? _____

8. List other services that the Beneficiary receives (include day services, service coordination, employment programs, etc.):

Service	Name of Provider

9. (a) Is there a court appointed Guardian for the Beneficiary? Yes ☐ No ☐

If yes, attach copy of Decree or Letters of Guardianship and complete the following:

Guardian of the: ☐Person ☐Property ☐Both

If specific powers/authority is granted please list:

(Include dental and medical)_____

_____

If specific powers/authority is exempted please list:

(Include dental and medical)_____

_____

Please list name(s) and addresses of Guardian(s): _____

_____

_____

(b) Are Standby Guardian(s) appointed? Yes _____ No _____

If yes, for the: ☐Person ☐Property ☐Both

Please list name(s) and addresses of Standby Guardian(s).

_____

_____

(c) Are Alternate Standby Guardian(s) appointed? Yes ☐ No ☐

If yes, for the: ☐Person ☐Property ☐Both

Please list name(s) and addresses of Alternate Standby Guardian(s).

_____

_____

10. Relationship of Donor to Beneficiary _____

11. Would anyone like to receive an e-mail copy of monthly statements? Yes ☐ No ☐

12. List the individual to receive the "Beneficiary Binder" _____

(**Please note: One individual will receive a "Beneficiary Binder". This may be sent to the beneficiary or an alternate authorized individual. The binder contains a copy of the acceptance letter, executed Joinder Agreement, disbursement request forms, deposit slips, etc.**)

AUTHORIZED CONTACTS: Please note that Wellness for All Pooled Trust requires the Beneficiary to have an authorized contact to speak to us on your behalf. Please note that the Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account.

List individuals below authorized to contact us on behalf of the Beneficiary *(check all that apply)*

		Communicate	Submit Disbursements
Name:	_____	☐	☐
Address:	_____		
	_____		
Telephone No.:	_____		
Relationship:	_____		
E-mail:	_____		

Person to contact in case of Emergency
(REQUIRED IF NO ONE IS LISTED ABOVE):
(This individual will only be contacted if we are unable to reach you)

Name: _____

Address: _____

_____

Telephone No.: _____

Relationship: _____

13. List an individual who will be submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on your behalf: *(must be knowledgeable in Medicaid Law, i.e., Attorney, Social Worker, Elder Care Consultant, etc.)* ***Please note: The individual listed below will receive a copy of the acceptance letter in addition to a copy of the executed Joinder Agreement.***

Name: Jeff Brown Telephone No.: 7162592341

Agency/Firm, etc. WFA Pooled Trust E-mail: _____

Address: _____

14. Does the Beneficiary have funeral provisions in place? Yes ☐ No ☐

If yes, please include a copy of the funeral arrangements and provide as much detail as possible.

Please provide name, address and phone number of the Funeral Home, submit a copy of the funeral agreement and indicate status of funding:

_____

15. Is there a life insurance policy in place for the Beneficiary? Yes ☐ No ☐

If yes, provide the name and address of the insurance company and the policy number:

_____

_____

_____

CERTIFICATION:

I certify that the above information is accurate and complete to the best of my knowledge.

_____ _____

Donor/Beneficiary Signature Date

WELLNESS FOR ALL POOLED TRUST

Joinder Agreement

NOTE: THIS IS A LEGAL DOCUMENT. IT IS AN AGREEMENT PERTAINING TO A SUPPLEMENTAL NEEDS TRUST CREATED PURSUANT TO 42 UNITED STATES CODE §1396. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING THIS AGREEMENT. ADDITIONALLY, THE WELLNESS FOR ALL POOLED TRUST MAY NOT ACCEPT THIS JOINDER AGREEMENT UNLESS YOU HAVE A LEGAL REPRESENTATIVE OR ARE CAPABLE OF REPRESENTING YOURSELF.

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **WELLNESS FOR ALL POOLED TRUST**, this Trust being incorporated herein by reference. **THIS TRUST IS IRREVOCABLE.**

1. Name of Donor (Generally same as Beneficiary): _____

   Social Security No. of Donor: _____

   Date of Birth: _____

   Address of Donor: _____

   _____

   Telephone Number of Donor: _____

2. Name of Disabled Beneficiary (In-Kind Beneficiary): _____

   Disabled Beneficiary's Social Security Number: _____

   Date of Birth: _____

   Address: _____

   _____

   Telephone Number (Day): _____ (Evening): _____

3. Fees shall be paid in accordance with the published fee schedule.

4. Death of Beneficiary

a. **The Beneficiary's sub-trust account terminates upon his or her death**. If, upon the death of the Beneficiary, funds remain in his or her sub-trust account, such funds shall be deemed to be property of the Trust and all funds that are remaining in the Beneficiary's separate sub-trust account shall be retained by the **WELLNESS FOR ALL POOLED TRUST** to further the purposes of the Trust.

b. All final disbursement requests must be submitted within ninety (90) days of the Beneficiary's death and upon submission of the death certificate. Only expenses incurred prior to the Beneficiary's death will be considered.

c. Funeral expenses will only be paid pursuant to a Medicaid eligible pre-need funeral agreement established prior to the Beneficiary's death. **Funeral expenses will not be paid after the Beneficiary's death.**

5. Contributions/Deposits:

a. All contributions made to the Trust Account will be held and administered pursuant to the provisions of the **WELLNESS FOR ALL POOLED TRUST**. The provisions of the **WELLNESS FOR ALL POOLED TRUST** are incorporated herein by reference.

b. The Trustees shall have the sole and absolute right to accept or refuse additional deposits to the Sub-trust account.

c. In the event that a Beneficiary has a zero ($0) sub-trust account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary's sub-trust account. Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming from the prior sub-trust account. Additionally, the Beneficiary shall be required to pay a new enrollment fee when re-opening a sub-trust account.

6. Disbursements:

a. All disbursement requests shall be reviewed and approved on an individual basis.

b. Disbursements for expenses incurred prior to 90 days of submission of a disbursement request form shall not be paid.

c. The Trustees, in their discretion, have determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol, tobacco, items relating to illegal activity, bail, or restitution.

d. All disbursements shall be made at the sole and absolute discretion of the Trustees.

7. Disability Determination:

In the event that a disability determination is required for Medicaid purposes, please be advised that administrative fees shall be incurred while the determination of disability is being made.

8. Miscellaneous: Amendments:

Provisions of this Joinder Agreement may be amended by the parties hereto in writing, so long as any such amendment is consistent with the Master Trust.

Taxes:

The Donor acknowledges that contributions to the **WELLNESS FOR ALL POOLED TRUST** are not tax deductible as charitable gifts, or otherwise.

9. Disclosure of Potential Conflict of Interest:

There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the sub-trust account at the time of death of the Beneficiary. Funds remaining in the Trust may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by **WELLNESS FOR ALL POOLED TRUST**.

The Donor(s) executing this Joinder Agreement is/are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to the Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **WELLNESS FOR ALL POOLED TRUST** or with any Beneficiary or constituent agencies.

10. Situs: The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be initially administered by the current Trustees of **WELLNESS FOR ALL POOLED TRUST**. The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New York. The situs of this Trust for administrative, accounting and legal purposes shall be in the County of ERIE, the County where the majority of meetings concerning establishment of the Trust have occurred.

11. Invalidity of any Provision: Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

I have received and reviewed a copy of the WELLNESS FOR ALL POOLED TRUST Declaration of Master Trust, prior to the signing of this ***Joinder Agreement***. I have also read the Information and Procedures and acknowledge that I understand the contents of all of the trust documents. I also understand that said documents may be amended from time to time.

By signing below, the Donor acknowledges that the Beneficiary is disabled as defined in Social Security Law Section 1614 (a) (3) [42 USC 13822(c) (a) (3)]

Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.

By signing below, you agree to the following:

The WELLNESS FOR ALL POOLED TRUST is a trust authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept a donor's property pursuant to this Joinder Agreement, WELLNESS FOR ALL POOLED TRUST, agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation. It is the sole responsibility of the donor and/o r the donor's representative to determine whether the donor is "disabled" as that term is defined under federal law, to determine whether they have the legal authority to transfer property to fund the trust, and the impact that a transfer of property to the WELLNESS FOR ALL POOLED TRUST will have on the donor's continuing eligibility for government benefit programs.

WELLNESS FOR ALL POOLED TRUST is not assuming any responsibility as counsel for the donor or Beneficiary, or providing any legal advice as it relates to the consequences of a transfer of property to the WELLNESS FOR ALL POOLED TRUST.

The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account, the cost of which would be charged to that Beneficiary's sub-trust account.

The party authorized to speak with us on your behalf or the intermediary must notify WELLNESS FOR ALL POOLED TRUST, immediately upon your death and will be required to provide us with a certified death certificate.

An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.

This Joinder Agreement and the participation of the Beneficiary in the WELLNESS FOR ALL POOLED TRUST is an important legal decision that will have significant and lasting consequences for the Beneficiary and as a result you may want to consider obtaining advice from an attorney or another trusted professional adviser before entering into this Agreement. By signing this Agreement you are acknowledging that you have had a full and complete opportunity to confer with an attorney or other adviser and that no employee of WELLNESS FOR ALL POOLED TRUST has provided you (or the Beneficiary, if different from the person signing this Agreement) with any legal advice in connection with this Joinder Agreement, the participation by the Beneficiary in the WELLNESS FOR ALL POOLED TRUST or the suitability of such participation by the Beneficiary in the WELLNESS FOR ALL POOLED TRUST based upon the particular circumstances of the Beneficiary.

If applicable, this document was translated from Latin American Spanish to English by:

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_____	_____	_____
SIGNATURE OF DONOR/GUARDIAN	RELATIONSHIP TO BENEFICIARY	DATE

State of New York)
County of _____) ss.

On this _____ day of _____, 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 within the instrument and acknowledged to me that he/she 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 the instrument.

_____
Notary Public

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FOR OFFICE USE ONLY

_____	_____/_____/_____
WELLNESS FOR ALL POOLED TRUST, as Trustee	DATE

Date Complete:_____/_____/_____
Date Accepted:_____/_____/_____
Initial Funding: $_____