ICS COMMUNITY TRUST

JOINDER AGREEMENT

(COMMUNITY TRUSTS I & II)

Telephone: 718.208.1743 | Email: trustdept@icstrustservices.org

ICS Community Trust Joinder Agreement

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 guidance before signing this agreement

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **ICS Community Trust I** dated, July 25, 2018 and as amended and restated thereafter OR under the **ICS Community Trust II** dated, July 25, 2018 and as amended and restated thereafter, both trusts incorporated herein by reference. **These Trusts are Irrevocable**.

1. Donor: (Generally same as Beneficiary)

Name: First, Middle: _____ Last: _____

Date of Birth: _____/____/_____ SSN: _____ - _____ - _____ Gender: □ Male □ Female

2. Disabled Beneficiary: (In-Kind Beneficiary)

Name: First, Middle: _____ Last: _____

Date of Birth: _____/____/_____ SSN: _____ - _____ - _____ Gender: □ Male □ Female

Address: _____ Apt#: _____

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

Tel: Home: _____ Cell: _____ Email: _____

Relationship of Donor to Beneficiary: _____

3. Marital Status: Indicate Beneficiary's marital status

☐ Married Name of Spouse: _____

☐ Widowed Name of Deceased Spouse: _____

☐ Single If Divorced, Name of Spouse: _____

4. Medical Conditions: List diagnoses or nature of impairments

1. _____

2. _____

3. _____

5. Reason for Establishing Trust: Indicate all that are applicable

☐ Excess Income (Monthly Spend Down) ☐ Excess Resources/Savings ☐ Inheritance

☐ Settlement ☐ Other (explain): _____

6. Person Establishing Trust (Signing the Agreement):

☐ Self ☐ Authorized Agent (POA) ☐ Legal Guardian ☐ Parent ☐ Grandparent

7. Living Arrangements: Specify the current living arrangement of Beneficiary

☐ Independently ☐ With Spouse ☐ With Parents ☐ With Other Family

☐ Assisted Living Facility ☐ Medicaid Assisted Living Program ☐ Nursing & Rehab Center

Other (explain): _____

8. Beneficiary's Income: Provide proof of income

Is Beneficiary's spouse also applying for Medicaid? □ Yes □ No If Yes, please fill in income

Source of Income	Applicant Monthly Amount	Spouse Monthly Amount
Supplemental Security Income (SSI)	$	$
Social Security Disability Income (SSDI)	$	$
Social Security Retirement Income (SSA)	$	$
VA Benefits	$	$
IRA Distributions	$	$
Pensions / Annuities	$	$
Interest / Dividends	$	$
Other: _____	$	$

9. Healthcare Premiums: Provide proof of medical premium □ None

Plan Type	Plan Name	Amount / Frequency
Medicare Part B Supplement		$ □ Monthly □ Quarterly
Medicare Part D Plan		$ □ Monthly □ Quarterly
Other		$ _____

10. Medicaid Information: Provide a copy of the Medicaid Notice of Acceptance

Application Status: ☐ Pending ☐ Accepted Medicaid ID Number (if accepted): _____

Monthly Surplus Amount: $ _____ ☐ Determined By Medicaid ☐ Estimated

11. Benefits: Indicate all that are applicable ☐ **None**

☐ SNAP (Food Stamps) ☐ HUD Section 8 ☐ SCRIE/DRIE

12. Funeral Provisions: Indicate all that are applicable ☐ **None**

☐ Prepaid Funeral Contract ☐ Burial Plot ☐ Other _____

13. Life Insurance: List all policies owned by Beneficiary ☐ **None**

Insurance Company: _____ Face Value: $ _____

Insurance Company: _____ Face Value: $ _____

Insurance Company: _____ Face Value: $ _____

14. Guardianship: Provide proof of Guardianship ☐ **No Guardians Appointed**

Guardian appointed for the: ☐ Person ☐ Property ☐ Person & Property

Name: First, Middle: _____ Last: _____

Address: _____ Apt#: _____

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

Tel: Home: _____ Cell: _____ Email: _____

15. Authorized Contacts: One contact is required

Primary Contact:

My Contact may;
□ Communicate/Obtain Information □ Authorize Deposits □ Request Disbursements

Name: First, Middle: _____ Last: _____

Address: _____ Apt#: _____

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

Tel: Home: _____ Cell: _____ Email: _____

Relationship to Beneficiary: _____

Preferred Method of Communication: □ Email □ Phone

Additional Contact:

My Contact may;
□ Communicate/Obtain Information □ Authorize Deposits □ Request Disbursements

Name: First, Middle: _____ Last: _____

Address: _____ Apt#: _____

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

Tel: Home: _____ Cell: _____ Email: _____

Relationship to Beneficiary: _____

Preferred Method of Communication: □ Email □ Phone

16. Referral Source: ☐ **N/A**

Name: First, Middle: _____ Last: _____

☐ Senior Consultant ☐ Elder Law Attorney ☐ Social Worker ☐ MLTC/LHCSA

Direct Number: _____ Email: _____

Agency/Firm, etc.: _____Telephone: _____

Address: _____ Apt#: _____

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

Information and Disclosures

Trust Fees
The Donor hereby agrees to pay all fees of the Trustee in accordance with the applicable Fee Schedule, as well as any amendments to such Fee Schedule as may be made by Trustee from time to time.

Contributions/Deposits
The Donor acknowledges that all contributions made to the sub-trust account will be held and administered pursuant to the provisions of the applicable ICS Community Trust I or II, including any amendments made after the date of this Joinder Agreement. The provisions of the ICS Community Trusts are incorporated herein by reference.

Disbursements
Disbursement requests shall be made in writing by beneficiary or authorized contact on a pre supplied ICS disbursement request form or through approved electronic methods, and shall be accompanied by the necessary supporting documentation. All disbursement requests shall be reviewed and approved on an individual basis, all in accordance with the written policies and procedures as adopted by the Trustee.

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

No disbursements will be made after the death of the Beneficiary, even for expenses incurred or due prior to death.

Taxes:
The Donor acknowledges that contributions to the ICS Community Trusts are not tax deductible as charitable gifts, or otherwise. Additionally, sub-trust account income may be taxable to the beneficiary. Professional tax advice is recommended

Death of Beneficiary
Upon the death of the Beneficiary, the sub-trust account terminates and the remaining balance may be retained by the applicable ICS Community Trust to further the purposes of that Trust.

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

The party authorized to communicate on Beneficiary's behalf must notify **Innovative Care Solutions, Inc.** immediately upon Beneficiary's death and provide a copy of the death certificate.

Account Suspension/Reinstatement
The Trustee reserves the right to suspend the Beneficiary's sub-trust account if a zero ($0) balance is maintained for sixty (60) or more consecutive days. The Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its suspension. If the Beneficiary wishes to reinstate the sub-trust account, the Beneficiary will be required to pay a reinstatement fee and any outstanding administrative fees.

Disclosure of Potential Conflict of Interest
There may be a potential conflict of interest in the administration of the Trust since, pursuant to the terms of the Trust, any remaining funds in the sub-trust account at the time of beneficiary's death, may be retained by the Trust to further the purposes of the Trust. By executing and delivering this Agreement to Trustee, the Donor acknowledges that such a potential conflict of interest may arise.

Applicable Law
This Trust shall be construed in accordance with and governed by the laws of the State of New York. The situs of this Trust for administrative and accounting purposes shall be in the County of Kings, which is the primary location of **Innovative Care Solutions, Inc.** and where the majority of meetings concerning the administration of the Trust take place.

Invalidity of any Provision
In the event that any one or more of the provisions contained in this Agreement shall for any reason be held invalid or unenforceable in any respect, such invalidity or unenforceability shall not affect any other provision of this Agreement.

I, the undersigned, hereby acknowledge and affirm the following;

I have received a true and correct copy of the applicable Master Trust prior to the signing of this Joinder Agreement. I acknowledge that I understand the contents thereof and that said document may be amended from time to time.

I have received a true and correct copy of the applicable Fee Schedule and the Policy & Procedures prior to the signing of this Joinder Agreement. I acknowledge that I understand the contents thereof and that said document may be amended from time to time.

I am entering into this Joinder Agreement of my own free will. Innovative Care Solutions, Inc. has not exerted any undue pressure or influence on me in this regard. I have had reasonable time to determine whether entering into this agreement is in my best interest.

Beneficiary is disabled as defined in Social Security Law Section 1614(a)(3)[42 USC 1382c(a)(3)]

I acknowledge that Innovative Care Solutions, Inc. is not assuming any responsibility as counsel for the Donor or Beneficiary or providing any legal advice regarding the suitability of participation by the Beneficiary in the Community Trust as it may apply to the particular circumstances of the Beneficiary.

_____ _____ _____/____/_____
Signature of Donor or POA/Guardian Relationship to Beneficiary Date

_____
Print Name

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 this instrument.

_____
Notary Public

FOR OFFICE USE ONLY

_____ _____/____/_____
Signature of Trustee Date

Date Received: _____/____/_____

Date Accepted: _____/____/_____

Initial Funding: $_____

Assigned Trust: Community Trust I □ Community Trust II □ Acct. #: _____