Protect Your Family

PEACE OF MIND YOU CAN TRUST

Pooled Trust I
Monthly Spend Down Trust for Persons with Disabilities

Beneficiary Background
and
Joinder Agreement

303 Merrick Road
Suite 505
Lynbrook, NY 11563
(516) 837-3737
www.pyftrust.org
info@pyftrust.org

BENEFICIARY BACKGROUND

1. **Beneficiary:**

Name of Beneficiary:____

☐Male ☐ Female

Address: ____
Street

____
City State Zip

Home Phone: (______)________________________ Cell Phone: (______)_______________________

Email Address: ____

Date of Birth: ______/_________/________

Social Security #: __________ - ___________ - __________

2. **Authorized Contact**:

Please list all persons or agencies authorized to speak with PYF regarding the Beneficiary's trust. PYF will not speak with anyone not listed here.

a. Name of Contact 1: ____

☐Male ☐ Female

Relationship: ____

Address: ____
Street

____
City State Zip

Home Phone: (______)____________________Cell Phone: (______)______________________

Email Address: ____

Authorized to submit bills and disbursement requests for payment: (*must check one)*

☐Yes ☐No

b. Name of Authorized Contact 2: ____

☐Male ☐ Female

Relationship: ____

Address: ____
Street

____
City State Zip

Home Phone: (______)____________________Cell Phone: (______)______________________

Email Address: ____

Authorized to submit bills and disbursement requests for payment: (*must check one)*

☐Yes ☐No

c. Name of Authorized Contact 3: ____

☐Male ☐ Female

Relationship: ____

Address: ____
Street

____
City State Zip

Home Phone: (______)____________________ Cell Phone: (______)______________________

Email Address: ____

Authorized to submit bills and disbursement requests for payment: (*must check one)*

☐Yes ☐No

3. **<u>Disability</u>**:

Please describe Beneficiary's disability? ____

____

____

4. **Income:**

What is the estimated *monthly surplus amount* that will be deposited into Beneficiary's trust account? (*Please note: this is only an estimate for PYF, this amount may change with no effect on the Joinder Agreement*) $ ______________________

Sources of Income: (*Please check all that apply)*

- ☐ Supplemental Security Income (SSI) Monthly Amount: $ ____________
- ☐ Social Security Disability Income (SSDI) Monthly Amount: $ ____________
- ☐ Social Security Retirement Income (SSA) Monthly Amount: $ ____________
- ☐ Food Stamps Monthly Amount: $ ____________
- ☐ Section 8 Housing
- ☐ Other (please describe) ____

____

Does Beneficiary receive Medicaid:

- ☐ Yes Medicaid Card Number: ______________________________
  (*please provide a copy of card*)
- ☐ No
- ☐ Pending

5. **Power of Attorney**:

Is there a Power of Attorney: (*must check one)*

- ☐ Yes (*please provide a copy of Power of Attorney Paperwork)*
- ☐ No

Name of Power of Attorney: ____

Address: ____
Street

____
City State Zip

6. **Guardian**:

Is there a Court appointed Guardian: (*must check one)*

- ☐ Yes (*please provide a copy of Decree or Letter of Guardianship)*
- ☐ No

Is the Guardianship of:

☐ Person ☐ Property ☐ Both

If specific power(s)/authority is granted please list (includes dental and medical): ____

____

If specific power(s)/authority is exempted please list (includes dental and medical): ____

____

Name of Guardian: ____

Address: ____
Street

____
City State Zip

7. **List the Individual who will receive the Monthly statement and other PYF Mailings:**

Name: ____

Address: ____
Street

____
City State Zip

Home Phone: (______)______________________ Cell Phone: (______)______________________

Email Address: ____

8. **List the individual or agency who will be submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on your behalf:** *(please note: individual or agency listed below will receive a copy of the acceptance letter, Verification of Deposit and executed Joinder Agreement.)*

Name of Individual/Agency: ____

Address: ____
Street

____
City State Zip

Home Phone: (______)______________________ Cell Phone: (______)______________________

Email Address: ____

9. **<u>Does the Beneficiary have funeral provisions in place?</u>** *(must check one)*
   - ☐ Yes (*please include a copy of funeral arrangements*)
   - ☐ No

10. **<u>Does the Beneficiary have a life insurance policy in place?</u>** *(must check one)*
    - ☐ Yes *(please include a copy of life insurance policy)*
    - ☐ No

==

FOR OFFICE USE ONLY

Date Accepted: ________/ ________/ __________

Initial Funding: $ _____________________

Account #: ____________________________

JOINDER AGREEMENT

This Trust Joinder Agreement (" Agreement") is entered into by Life Family Center, Inc. d/b/a Protect Your Family ("Trustee"), having an office at 303 Merrick Road, Suite 505, Lynbrook, NY 11563 and the "Grantor" as set forth below:

1. **Defined Terms.** All capitalized terms used in this Agreement, which are not defined in this Agreement, shall have the meanings ascribed to them in the Master Pooled Trust Agreement (the "Trust") dated as of March 31, 2016 by and among Life Family Center, Inc., as Settlor and as Trustee of the Trust.

2. **Name of Grantor.** The name and address of the Grantor (Generally same as beneficiary) to the Trust is:
   Name:____("Grantor")
   Address: ____

3. **Establishment of Trust.** (a) The purpose of this Trust is to create an irrevocable pooled trust for the sole benefit of the disabled (as such term is defined in the Social Security Act and more fully set forth in the Trust) Grantor for the needs of such Grantor during their lifetime. Because this is an irrevocable trust, Grantor may not revoke this Agreement or access any of the trust property that has been put into the Trust. (b) With the full execution of this Agreement, as well as pursuant to all of the terms, provisions and covenants of the Trust, Grantor has hereby delivered to Trustee the minimum amount of trust property (as such term is defined in the Trust) in order to establish a sub-account under the Trust. (c) By executing this Trust Joinder Agreement, Grantor agrees to be bound by all of the terms, covenants and conditions of the Trust and any and all amendments thereto.

4. **Trust Fees**. Grantor hereby agrees to pay all of the fees of Trustee in accordance with the Fee Schedule, previously provided to Grantor, as well as any amendments to such Fee Schedule as may be made by Trustee from time to time.

5. **Contributions to the Trust.** (a) Grantor shall be required to make monthly contributions as are required by Medicaid. In the event that the Grantor's sub-account has a zero ($0) 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 may be required to pay a new enrollment fee when re-opening a sub-trust account. (b) Any additional contributions to the sub-account by Grantor or any other party shall be deemed to be Trust property and shall be used solely for the benefit of the Grantor pursuant to the terms of the irrevocable Trust.

6. **Disbursements.** Disbursement requests made to the Trustee shall be in writing or via approved electronic means by authorized contact. All disbursement requests shall be reviewed

and approved on an individual basis, all in accordance with the written policies and procedures as established by Trustee. Such expenses must have occurred from the date of establishment of trust forward and must have occurred within 90 days of submission. No disbursements will be made after the death of the beneficiary, even for expenses incurred or due prior to death.

7. **Disclosure of Conflict of Interest/Waiver.** Grantor, or any person legally executing a Sub-Trust Joinder Agreement on behalf of Grantor, hereby acknowledges a potential conflict of interest in the Trust administration since, pursuant to the terms and conditions of the Trust, any remaining funds in the Grantor's sub-account shall remain with the Trust to be used as herein set forth. By executing and delivering this Agreement to Trustee, Grantor or any party claiming through Grantor, hereby waives any and all claims against the Settlor, Trust or any Trustee for self-dealing or conflicts of interest arising out of the terms and conditions of this Agreement.

8. **Governing Laws.** (a) This Trust shall be governed by the laws of the State of New York. All accounting and administrative services shall be done in Nassau County, New York, the corporate home of Life Family Center, Inc. Federal law may also be applicable in the event of a conflict of laws. (b) Invalidity of Provisions. Should any provision of this Agreement be deemed illegal, invalid or otherwise unenforceable, the remainder of this Agreement shall remain in full force and effect and fully enforceable thereunder. (c) Counterparts. This Agreement may be signed in any number of counterparts all of which, when taken together, shall constitute a fully executed agreement.

9. **Acknowledgement of Grantor.** The undersigned Grantor hereby acknowledges that by executing this Trust Joinder Agreement, Grantor is entering into a trust with Trustee pursuant to the terms and conditions of the Master Pooled Trust Agreement entitled Protect Your Family Pooled Trust I. Grantor has received and read a copy of the applicable Master Trust and understands the contents thereof and that said document may be amended from time to time. Grantor has been provided the fee schedule and the Policy and Procedures and understands the contents thereof and that said document may be amended from time to time.

10. **Affirmation:** Grantor is entering into this Joinder Agreement voluntarily and acting on their own free accord. Beneficiary is disabled as defined by Social Security Law Section 1614(a)(3) [42 USC 1382c(a) (3)]. Under penalty of perjury, all statements made in this document are true and accurate to the best of Grantor's knowledge. By agreeing to accept Grantor's property pursuant to this Joinder Agreement, Life Family Center, Inc., 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 Grantor and/or the Grantor's representative to determine whether the beneficiary 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 Protect Your Family Trust I will have on the Grantor's continuing eligibility for government benefit programs. Life Family Center, Inc. is not assuming any responsibility as counsel for the Grantor, or providing any legal advice as it relates to the consequences of a transfer of property to the Protect Your Family Trust I.

This Agreement is hereby executed as of _________________________, __________, 20__________, which is the date that this Agreement is fully executed by *both* parties. Grantor and Trustee. *(Please do NOT fill in the date. For trust office use ONLY.)*

GRANTOR:

Sign Here: _____________________________________ Print Name: ______________________________

STATE OF NEW YORK)
) ss.:
COUNTY OF)

On the _____ day of _________________ in the year 20_____ before me, the undersigned, a Notary Public in and said State, personally appeared ________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____
Notary Public

TRUSTEE: LIFE FAMILY CENTER, INC. d/b/a PROTECT YOUR FAMILY

Sign Here: ___________________________________ Print Name: ______________________________

STATE OF NEW YORK)
) ss.:
COUNTY OF)

On the _____ day of _________________ in the year 20_____ before me, the undersigned, a Notary Public in and said State, personally appeared ________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____
Notary Public