Protect Your Family

PEACE OF MIND YOU CAN TRUST

Pooled Trust II
Asset Trust for Persons with Disabilities

Beneficiary Background
and
Joinder Agreement

303 Merrick Road
Suite 508
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. **Disability**:

Please describe Beneficiary's disability? _____

_____

_____

4. **Asset:**

What is the estimated amount of assets 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*) $ _____

Source of Assets: _____

_____

5. **Benefits:**

Does Beneficiary receive Medicaid:

☐ Yes Medicaid Card Number: _____
(*please provide a copy of card*)

☐ No

☐ Pending

6. **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

7. **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

8. **List the Individual who will receive the Monthly statement and other PYF Mailings:**
*(Please provide **email** for **PYF Online Account access.** Documents will only be mailed when requested, otherwise its online)*

Name: _____

Address: _____
Street

_____
City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____

9. **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: _____

10. **Does the Beneficiary have funeral provisions in place?** *(must check one)*

- ☐ Yes (*please include a copy of funeral arrangements*)
- ☐ No

11. **Does the Beneficiary have a life insurance policy in place?** *(must check one)*

- ☐ Yes *(please include a copy of life insurance policy)*
- ☐ No

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FOR OFFICE USE ONLY

Date Accepted: _____/ _____/ _____

Initial Funding: $ _____

Account #: _____