United Community Services
Disability Pooled Trust

BENEFICIARY PROFILE SHEET & JOINDER AGREEMENT

A Trust For Persons With Disabilities

Beneficiary Profile Sheet

Please print clearly in blue or black ink. All sections must be completed.

A Donor Information - Generally Same as Beneficiary

LEGAL NAME: FIRST	MIDDLE	LAST	
GENDER ☐ Male ☐ Female	MARITAL STATUS ☐ Married ☐ Widowed ☐ Single		
SSN - -	DATE OF BIRTH / /	CITIZEN ☐ Yes ☐ No	
TEL: PRIMARY ☐ Home ☐ Cell			
TEL: SECONDARY ☐ Home ☐ Cell			
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
EMAIL			

B Beneficiary Information - In Kind Beneficiary

☐ **Same as Above**

LEGAL NAME: FIRST	MIDDLE	LAST	
GENDER ☐ Male ☐ Female	MARITAL STATUS ☐ Married ☐ Widowed ☐ Single		
SSN - -	DATE OF BIRTH / /	CITIZEN ☐ Yes ☐ No	
TEL: PRIMARY ☐ Home ☐ Cell			
TEL: SECONDARY ☐ Home ☐ Cell			
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
EMAIL			

RELATIONSHIP OF DONOR TO BENEFICIARY

C Qualifying Disabilities - List diagnosis or specific nature of disability.

1.

2.

3.

D Purpose of Enrollment - Indicate reason for establishing an account.

☐ Shelter monthly excess income ☐ Shelter excess resources

E Beneficiary Monthly Income

Indicate type of current benefits and unearned income for beneficiary. List amount before deductions (gross).

1. Current Benefits - 📎 Attach a copy of the social security benefit letter and proof of other benefits

TYPE OF BENEFIT		MONTHLY AMOUNT
Supplemental Security Income (SSI)	☐ Yes ☐ No	$
Social Security Disability Income (SSDI)	☐ Yes ☐ No	$
Social Security Retirement Income (SSA)	☐ Yes ☐ No	$
VA Benefits	☐ Yes ☐ No	$
Employment Benefits	☐ Yes ☐ No	$
Survivor Benefits	☐ Yes ☐ No	$

2. Current Unearned Income - 📎 Attach a recent statement or letter from the financial institution

TYPE OF INCOME		MONTHLY AMOUNT
IRA Distribution	☐ Yes ☐ No	$
Pension / Annuities	☐ Yes ☐ No	$
Interest / Dividends / Royalties	☐ Yes ☐ No	$
Other	☐ Yes ☐ No	$

F Spouse Information

Please note: Spouse is not a Beneficiary of sub-trust account. All disbursements must be for the sole benefit of the above listed beneficiary.

NAME OF SPOUSE: FIRST	MIDDLE	LAST

If Spouse deceased, check here ☐ Continue to Section G

1. Current Benefits - Indicate type of current benefits for spouse. List amount before deductions (gross).

TYPE OF BENEFIT		MONTHLY AMOUNT
Supplemental Security Income (SSI)	☐ Yes ☐ No	$
Social Security Disability Income (SSDI)	☐ Yes ☐ No	$
Social Security Retirement Income (SSA)	☐ Yes ☐ No	$
VA Benefits	☐ Yes ☐ No	$
Employment Benefits	☐ Yes ☐ No	$
Survivor Benefits	☐ Yes ☐ No	$

2. Current Unearned Income - Indicate type of current unearned income for spouse. List amount before deductions (gross).

TYPE OF INCOME		MONTHLY AMOUNT
IRA Distribution	☐ Yes ☐ No	$
Pension / Annuities	☐ Yes ☐ No	$
Interest / Dividends / Royalties	☐ Yes ☐ No	$
Other	☐ Yes ☐ No	$

3. Medicaid Information

Spouse applied for Medicaid with beneficiary? ☐ Yes ☐ No

Spouse monthly income included in Medicaid application? ☐ Yes ☐ No

G Health Care Premiums - Indicate premium amount beneficiary pays for other medical insurance.

Attach a current statement or invoice containing the premium amount.

Medicare part B Supplement	☐ Yes ☐ No	NAME OF PLAN
PREMIUM $	☐ Monthly ☐ Quarterly ☐ Other - Specify	
Medicare part D Plan	☐ Yes ☐ No	NAME OF PLAN
PREMIUM $	☐ Monthly ☐ Quarterly ☐ Other - Specify	
Other	☐ Yes ☐ No	NAME OF PLAN
PREMIUM $	☐ Monthly ☐ Quarterly ☐ Other - Specify	

H Medicaid Information - Indicate status of Medicaid application. Provide estimated/determined amount of monthly spend down.

Attach MAP/LDSS (Medicaid) Notice of Acceptance /Decision and Budget Explanation

Application Status	☐ N/A ☐ Pending (Filed) ☐ Accepted
CIN NUMBER	☐ Unavailable
MONTHLY SPEND DOWN / SURPLUS $	☐ Estimated ☐ Determined by Medicaid

I Government Assistance / Entitlements - Identify all forms of assistance/entitlements beneficiary currently receives.

TYPE OF ASSISTANCE / ENTITLEMENTS		MONTHLY ALLOTMENT / SUBSIDY
SNAP / Food Stamps	☐ Yes ☐ No	$
SCRIE	☐ Yes ☐ No	$
HUD Sec 8	☐ Yes ☐ No	$

J Living Arrangements - Indicate current living arrangements of Beneficiary.

☐ At Home Independently	☐ At Home with Assistance	☐ Resides with parents or other family
☐ Assisted Living Facility	☐ Family Care Program	☐ CR/IRA/ICF (Supervised)
☐ CR/IRA (Supportive)	☐ Nursing Home	☐ Other - explain

K Community Services - Indicate services beneficiary currently receives. List frequency for each service.

TYPE OF SERVICE		FREQUENCY / DURATION OF SERVICE	PROVIDER
Home Health Aide	☐ Yes ☐ No		
LPN	☐ Yes ☐ No		
Adult Day Care	☐ Yes ☐ No		
Daily Meals	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

L Funeral Arrangements - Complete if beneficiary has funeral provisions in place.

Attach a copy of the Pre-need funeral agreement and a current account summary statement

NAME OF FUNERAL HOME

ADDRESS

CITY	STATE	ZIP

TELEPHONE

M Burial Plot - Complete if beneficiary has a burial plot in place.

Attach a copy of the burial plot deed

NAME OF CEMETERY

ADDRESS

CITY	STATE	ZIP

TELEPHONE

N Life Insurance - Complete if beneficiary has a life insurance policy.

Attach a copy of the policy statement

NAME OF INSURED	NAME OF OWNER

NAME OF INSURANCE COMPANY	POLICY NUMBER

Type of Policy: ☐ Term ☐ Whole Life	CASH SURRENDER VALUE $	☐ N/A

O Guardianship - List all court appointed guardians for the beneficiary.

If no guardians appointed, check here ☐

📎 Attach a copy of Decree or Letter of Guardianship

1. Guardian appointed for the ☐ Person ☐ Property ☐ Both

List below specific powers / authority granted / exempted (include dental and medical)

GRANTED

EXEMPTED

List below contact information of guardian

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
TEL: PRIMARY		TEL: SECONDARY	
EMAIL			

2. Standby Guardian(s) appointed for the ☐ Person ☐ Property ☐ Both

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
TEL: PRIMARY		TEL: SECONDARY	
EMAIL			

3. Alternate Standby Guardian(s) appointed for the ☐ Person ☐ Property ☐ Both

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
TEL: PRIMARY		TEL: SECONDARY	
EMAIL			

P Authorized Representatives

Please Note: Beneficiary must authorize at least one individual to communicate with UCS.

1. The following individual will be authorized to communicate and receive notices and correspondence from UCS. Additionally, this individual will be authorized to:

☐ View account online ☐ Request disbursements ☐ Transfer funds (monthly surplus deposit) electronically

Primary

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
PHONE		CELL	
EMAIL			
RELATIONSHIP OF REPRESENTATIVE TO BENEFICIARY			

Preferred method of communication ☐ Email ☐ Phone

2. The following individual will be authorized to communicate and receive notices and correspondence from UCS. Additionally, this individual will be authorized to:

☐ View account online ☐ Request disbursements ☐ Transfer funds (monthly surplus deposit) electronically

Secondary

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
PHONE		CELL	
EMAIL			
RELATIONSHIP OF REPRESENTATIVE TO BENEFICIARY			

Preferred method of communication ☐ Email ☐ Phone

Q Additional Contacts (Optional)

The following individuals will be authorized to communicate with UCS.

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
PHONE		CELL	
EMAIL			
RELATIONSHIP OF REPRESENTATIVE TO BENEFICIARY			

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
PHONE		CELL	
EMAIL			
RELATIONSHIP OF REPRESENTATIVE TO BENEFICIARY			

LEGAL NAME: FIRST	MIDDLE	LAST	
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
PHONE		CELL	
EMAIL			
RELATIONSHIP OF REPRESENTATIVE TO BENEFICIARY			

R Referral Agency / Firm - List the Agency / Firm that assisted with Trust application.

Please note: A copy of the Acceptance Letter, signed Joinder Agreement and verification of deposits will be forwarded to the "contact" listed below.

NAME OF AGENCY / FIRM

NAME OF CONTACT

TITLE ☐ Attorney ☐ Consultant ☐ Social Worker ☐ Other - Specify

ADDRESS			APT#
CITY	STATE	COUNTY	ZIP

PHONE

EMAIL

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

SIGNATURE OF DONOR / BENEFICIARY OR POA / GUARDIAN

DATE / /

PRINT NAME

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.

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the UNITED COMMUNITY SERVICES DISABILITY POOLED TRUST (the "UCS Disability Pooled Trust") dated, June 19, 2009 and as restated, this Trust and its definitions being incorporated herein by reference. **THIS TRUST IS IRREVOCABLE.**

1. Donor Information - Generally Same as Beneficiary

LEGAL NAME: FIRST	MIDDLE	LAST	
SSN - -		DATE OF BIRTH / /	
TEL: PRIMARY			☐ Home ☐ Cell
TEL: SECONDARY			☐ Home ☐ Cell
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
EMAIL			

2. Beneficiary Information - In Kind Beneficiary

☐ **Same as Above**

LEGAL NAME: FIRST	MIDDLE	LAST	
SSN - -		DATE OF BIRTH / /	
TEL: PRIMARY			☐ Home ☐ Cell
TEL: SECONDARY			☐ Home ☐ Cell
ADDRESS			APT#
CITY	STATE	COUNTY	ZIP
EMAIL			
RELATIONSHIP OF DONOR TO BENEFICIARY			

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/or United Community services of Boro Park a New York not-for-profit corporation having its principal place of business at 1575 50th Street, 3rd Floor, Brooklyn, NY 11219, and all funds that are remaining in the Beneficiary's separate sub-trust account shall be retained by the UCS Disability 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 UCS Disability Pooled Trust dated June 19, 2009 and as restated. The provisions of the UCS Disability 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 Trustees shall retain the right to close the Beneficiary's sub-trust account. Please be advised that the Trustees 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 a 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:

A. 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.

B. Taxes:
(i) The Donor acknowledges that contributions to the UCS Disability Pooled Trust are not tax deductible as charitable gifts, or otherwise.

(ii) Sub-trust account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice may be needed.

C. Policies
Additional policies, schedules and guidelines of the UCS Disability Pooled Trust are on file with the Trustees and are available upon request.

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 UCS Disability 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 UCS Disability Pooled Trust or the United Community Services of Boro Park or with any Beneficiary or constituent agencies and/or Chapters.

10. Situs:

The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York. 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 Kings, State of New York, 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 Declaration of Trust (The 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)

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:

UCS Disability 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, UCS Disability 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/or the Donor's representative to determine whether the Donor is "disabled" as that term is defined under federal law, and to determine the impact that a transfer of property to the UCS Disability Pooled Trust will have on the Donor's continuing eligibility for government benefit programs.

UCS Disability Pooled Trust or The United Community Services of Boro Park 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 UCS Disability Pooled Trust. The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account.

The party authorized to speak with us on your behalf or the intermediary must notify UCS Disability 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.

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

Print Name

[If signed by a Power of Attorny or Guardian attach a copy of the POA/Guardianship documents.]

State of New York)ss:.
County of)
On this____day of_____, 201___, 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

FOR OFFICE USE ONL Y

TRUSTEE	DATE / /
DATE RECEIVED / /	
DATE COMPLETE / /	
DATE ACCEPTED / /	
INITIAL FUNDING $	