Joinder Agreement

(Pennsylvania Trust)

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SENIOR COMMUNITY SERVICES
SUPPLEMENTAL NEEDS POOLED
TRUST_PENNSYLVANIA
JOINDER AGREEMENT

The undersigned hereby establishes a Trust Account under the Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania dated February 7, 2024 and as amended and restated thereafter.

Sponsor Information

Name: First:_____ **Middle:**_____ **Last:**_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:**_____

SSN:_____-_____-_____ **Date of Birth:**_____/_____/_____

Citizen:_____ **Tel: Home**_____ **Cell:**_____

Address:_____ **Apt#:**_____

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

Email:_____

Relationship To Beneficiary:_____

Beneficiary Information

☐ **Same as Sponsor**

Name: First:_____ **Middle:**_____ **Last:**_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:**_____

SSN:_____-_____-_____ **Date of Birth:**_____/_____/_____

Citizen:_____ **Tel: Home**_____ **Cell:**_____

Address:_____ **Apt#:**_____

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

Email:_____

Remainder Beneficiary

Will Funds Remain in Trust After the Designated Beneficiary's Death: _____

If Not, Remainder Beneficiaries AFTER Medicaid Payback Requirements shall be:

Name: First:_____Middle:_____Last:_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:_____**

SSN:_____-_____-_____ **Date of Birth:_____/_____/_____**

Citizen:_____Tel: Home_____Cell:_____

Address:_____Apt#:_____

City:_____State:_____County:_____Zip:_____

Email:_____

Name: First:_____Middle:_____Last:_____

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Single** **Gender:_____**

SSN:_____-_____-_____ **Date of Birth:_____/_____/_____**

Citizen:_____Tel: Home_____Cell:_____

Address:_____Apt#:_____

City:_____State:_____County:_____Zip:_____

Email:_____

Household Income Information

Is Spouse Deceased ☐ **Yes** ☐ **No**

Is Applicant & Spouse applying together? ☐ **Yes** ☐ **No If Yes, Fill in Spouse's Income.**

TYPE OF BENEFIT	Applicant Monthly Amount	Spouse Monthly Amount
Supplement Security Income (SSI)	$	$
Social Security Disability Income (SSDI)	$	$
Social Security Retirement Income (SSA)	$	$
VA Benefits	$	$
Employment Benefits	$	$
Survivor Benefits	$	$
IRA Distribution	$	$
Pensions / Annuities	$	$
Interest / Dividends	$	$
Reparations	$	$
Other	$	$

Please Note: All disbursements must be for the sole benefit of the Designated Beneficiary. A spouse is not a Designated Beneficiary for the Trust Account held for the benefit of their spouse.

Medicaid Information– Please Attach MAP / LDSS Notice of Decision

	Applicant	Spouse
Application Status	☐ Pending ☐ Accepted	☐ Pending ☐ Accepted
MEDICAID NUMBER		
MONTHLY SPEND DOWN $ *(For Income Accounts Only)*		

FOR ANY APPLICABLE ITEMS BELOW, PLEASE ATTACH THE NECCESARY PROOF.

Healthcare Premiums- Please attach a copy of the front and back of your insurance cards and a current statement and proof of payment.

Insurance/Medicare Part B Supplement/Medicare Part C Advantage:

Plan Name:_____

Premium $:_____ **Frequency:**_____

Medicare Part D Plan: Plan Name:_____ **Premium $:**_____

Funeral Arrangement- Please attach pre-need funeral agreement.

Name of Funeral Home:_____

Address:_____ **City:**_____

State:_____ **Zip:**_____

Telephone:_____

Burial Plot- Please attach a copy of plot deed.

Number of Plots:_____ **Location of Plots:**_____

Name of Cemetery:_____

Address:_____ **City:**_____

State:_____ **Zip:**_____

Telephone:_____

Life Insurance:- Please attach a copy of each policy.

Name of Insured:_____ **Name of Owner:**_____

Name of the Beneficiary[i]: _____

Name of Insurance Company:_____ **Policy #:**_____

Type of Policy: Term:_____ **Life:**_____ **Cash Surrender Value $:**_____

Name of Insured:_____ **Name of Owner:**_____

Name of Insurance Company:_____ **Policy #:**_____

Type of Policy: Term:_____ **Life:**_____ **Cash Surrender Value $:**_____

Qualifying Disabilities

1._____

2._____

3._____

Living Arrangements:

At Home Independently:_____ **At Home with Assistance:**_____ **Assisted Living Facility:**_____

Skilled or Memory Care Facility:_____

Please Select if Applicable:

☐ Power of Attorney ☐ Guardianship ☐ Care Manager ☐ VA Fiduciary ☐ SSA Representative Payee

***Please attach supporting documentation of the appointment selected above.**

Name: First:_____ **Middle:**_____ **Last:**_____

Address:_____ **Apt#:**_____ **City:**_____

State:_____ **County:**_____ **Zip:**_____ **Tel: Home:**_____

Cell:_____ **Email:**_____

Authorized Representative: # 1

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____Middle:_____Last:_____

Address:_____Apt#:_____City:_____

State:_____County:_____Zip:_____Tel: Home:_____

Cell:_____Email:_____

Relationship to Beneficiary:_____

Would you like this representative to be the primary contact?_____Yes_____No

Authorized Representative: # 2

The following individual will be authorized to communicate with SCS Pooled Trust. I authorize this individual to: Make Deposits, Request Statements and Request Disbursements.

Name: First:_____Middle:_____Last:_____

Address:_____Apt#:_____City:_____

State:_____County:_____Zip:_____Tel: Home:_____

Cell:_____Email:_____

Relationship to Beneficiary:_____

Would you like this representative to be the primary contact?_____Yes_____No

Referring Source:

Name of Agency:_____Name Of Contact:_____

Address:_____Apt#:_____City:_____

State:_____County:_____Zip:_____Phone:_____

Email:_____

I Authorize any applicable documents necessary for reporting to Government Agencies to be sent to the referring source above. _____Yes_____No

The Undersigned Sponsor Hereby Acknowledges

1. That signing of this document constitutes a legal agreement and contributions to the Trust Account may have tax consequences. I have been advised to consult with my attorney and tax advisor before signing this Joinder Agreement.

2. That I am obligated to make a minimum contribution to the Trust Account (unless otherwise determined / approved by the Trustees of the Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania). **See fee schedule*

3. That I agree to the attached fee schedule and understand that fees may be adjusted from time to time by the Trustees of Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania.

4. That all contributions made to the Trust account will be held and administered pursuant to the provisions of the Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania dated February 7, 2024 including any amendments to the Trust made after the date of this Joinder Agreement. The provisions of the Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania are incorporated herein by reference. I have received and reviewed a copy of the Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania, prior to signing this Joinder Agreement. **I UNDERSTAND THAT THIS AGREEMENT IS IRREVOCABLE.**

5. That the Designated Beneficiary is disabled or has medical condition that renders him or her unable to sustain employment.

6. That by signing this document I agree that myself or anyone listed as my representative may receive text messages regarding my account. You may call your case manager to opt out anytime.

7. That upon the death of the Beneficiary, amounts remaining in the Beneficiary's Trust Account shall be retained in the Trust solely for the benefit of individuals who are disabled as defined in Soc. Sec. Law Section 1614(a) (3) [42 USC 1382c(a) (3)] and any subsequent definitions that are enacted into law.

8. THAT A POTENTIAL CONFLICT OF INTEREST EXISTS IN THE ADMINISTRATION OF THE SENIOR COMMUNITY SERVICES SUPPLEMENTAL NEEDS POOLED TRUST_PENNSYLVANIA. THE TRUSTEES ARE APPOINTED BY THE BOARD OF SENIOR COMMUNITY SERVICES, INC., WHICH MAY HAVE A REMAINDER INTEREST IN THE TRUST ACCOUNTS. IN THE ADMINISTRATION OF THE TRUST, THE TRUSTEES ARE PERMITTED TO DISBURSE TRUST FUNDS TO SENIOR COMMUNITY SERVICES, INC., AND/OR BENEFICIARY, AFFILIATE OR CONSTITUENT AGENCIES OF SENIOR COMMUNITY SERVICES, INC. ON BEHALF OF THE DESIGNATED BENEFICIARIES. I AM AWARE OF THE EXISTENCE OF THIS POTENTIAL CONFLICT OF INTEREST AND EXPRESSLY WAIVE ANY AND ALL CLAIMS AGAINST THE TRUSTEES ON ACCOUNT OF SELF-DEALING, CONFLICT OF INTEREST OR ANY OTHER ACT.

9. Important Information About Procedures for Opening a New Account: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Please mail all Trust documents to:
SCS POOLED TRUST
100 Boulevard of the Americas, Lakewood, NJ 08701

Signature

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

SIGNATURE	**DATE**
PRINT	**RELATIONSHIP**

NOTARY OF SIGNATURE

STATE OF _____

ss:

COUNTY OF _____

On_____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 the within instrument and acknowledge to me that he/she/they 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.

_____

(Signature and office of person taking acknowledgment)

OR TWO WITNESSES

WITNESS 1	WITNESS 2
_____	_____
(Print Name)	(Print Name)
_____	_____
(Signature)	(Signature)
_____	_____
Date	Date

FOR OFFICE USE ONLY

Accepted by Trustee or Designated Representative of the Trustees, Senior Community Services Supplemental Needs Pooled Trust_Pennsylvania.

_____	_____
(Signature)	Date
_____	
(Printed Name)	