CCT
Commonwealth Community Trust

Security for People with Disabilities since 1990

office | 804.740.6930 toll free | 888.241.6039 fax | 804.740.6065
address | PO Box 29408, Richmond, VA 23242-0408

Third-Party Special Needs Trust Joinder Agreement

Trust Adoption Instrument
Tax Identification Number 54-6302655

The undersigned Grantor(s) hereby establish(es) a trust fund under Commonwealth Community Trust's ("CCT") Master Trust Agreement. The terms of the Grantor's trust fund are set forth in this Joinder Agreement (Trust Adoption Instrument) and the applicable provisions of CCT's Master Trust Agreement dated October 9, 1990, as amended and restated, which is hereby adopted and incorporated herein by reference hereto.

This is a binding legal document. You are advised to seek professional advice before signing.

1. Grantor(s) Information:

Mr. Mrs. Ms. _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Relationship to Beneficiary: _____

Mr. Mrs. Ms. _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Relationship to Beneficiary: _____

2. Beneficiary Information:

Mr. Mrs. Ms. _____
Address: _____
City: _____ State: _____ Zip: _____
Type of Residence: (*e.g. private residence, group home, assisted living facility)* _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

3. Beneficiary Date of Birth: _____

4. Beneficiary Social Security Number*: _____

*A copy of the Beneficiary's Social Security Card is requested.

5. Description of Beneficiary's Disability: _____

_____

_____

6. **Designation of Advocate –** Once the trust is funded, the Advocate is the person(s) responsible (*e.g., parent, sibling, relative, Guardian, Representative Payee, Power of Attorney, Beneficiary, Caseworker, Conservator, or other) for requesting disbursements and communicating information about the Beneficiary and the Trust.

PLEASE IDENTIFY AT LEAST ONE PRIMARY ADVOCATE AND ONE SECONDARY ADVOCATE.

A. Primary Advocate – will receive financial account information, tax documents and official correspondence from CCT and signs disbursement requests.

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Indicate account access preference:

☐Online / Internet ☐Mail

*Relationship to Beneficiary: _____

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Indicate account access preference:

☐Online / Internet ☐Mail

*Relationship to Beneficiary: _____

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

B. Secondary Advocate- can receive financial account information, can sign disbursement requests and will be contacted by CCT when needed.

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Permission to receive financial account information?

i. Immediately upon funding? ☐YES ☐NO
ii. If requested in the future? ☐YES ☐NO

If YES to i. or ii., indicate account access preference:

☐Online / Internet ☐Mail

*Relationship to Beneficiary: _____

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Permission to receive financial account information?

i. Immediately upon funding? ☐YES ☐NO
ii. If requested in the future? ☐YES ☐NO

If YES to i. or ii., indicate account access preference:

☐Online / Internet ☐Mail

*Relationship to Beneficiary: _____

Provide CCT with legal documentation for Guardianship, Power of Attorney, and/or Conservator.

C. Additional Contacts – In addition to the Primary and Secondary Advocates, permission is granted to contact and share information with the following should the need arise (optional):

1.) Name:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

2.) Name:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

3.) Name:

Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Relationship to Beneficiary: _____

7. Beneficiary's Funeral or Burial Arrangements:

Have pre-need funeral arrangements been made/paid for the Beneficiary? ☐ Yes ☐ No

If not, do you anticipate using funds from the trust to pay for pre-need arrangements? ☐ Yes ☐ No

Note: Any arrangements must be paid pre-need. Upon death of the Beneficiary, any remaining funds will be distributed according to Section 11 (Distributions Upon the Death of the Beneficiary) of this Agreement.

8. **The Grantor(s) agrees to the current published fee schedule as may be amended from time to time.** IMPORTANT NOTE: CCT may, from time to time and at its discretion, hire additional professionals to serve as a liaison between CCT and the Beneficiary, or to assess the financial or custodial care arrangements of the Beneficiary and provide reports to CCT (e.g. accountants, attorneys, health care professionals, social workers, life care planners, and care managers). CCT reserves the right to charge this expense to the Beneficiary's trust account.

9. **Revocability of Trust (check one of the following options):**

☐ (a) The trust fund cannot be revoked.

☐ (b) The trust fund can be revoked so long as individual Grantor lives.*

☐ (c) The trust fund can be revoked so long as any Grantor lives (where there is more than one Grantor).*

☐ (d) The trust fund cannot be revoked after the death of any one Grantor (where there is more than one Grantor).*

Note: Any revocation must be made by all living Grantors, in writing, properly notarized, and in a form acceptable to the Trustee.

*Notwithstanding the foregoing, in the event that the trust fund receives any assets prior to the death(s) of the Grantor(s), the trust fund shall become irrevocable to the extent funded and the Grantor(s) and/or any donors to the trust fund shall not have the right to alter, amend, revoke or terminate the trust fund with respect to the donated funds. In such an event, the Grantor(s)' election above with respect to the revocability of the trust fund shall continue in force with respect to all other aspects of the trust fund and this Joinder Agreement and the Grantor(s) and third parties shall be entitled to add additional property to the Trust Fund .

10. **Government Assistance the Beneficiary Receives –** CCT will provide information to local government agencies for SSI, Medicaid, food stamps and subsidized housing recipients.

A. Social Security Information:

Does Beneficiary receive ***Supplemental Security Income (SSI)***? ☐ Yes ☐ No ☐ In the Process of Applying

If yes or in process of applying, include contact information for local Social Security Administration Office:

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Phone Ext: _____

Email Address: _____

Supplemental Security Disability Insurance (SSDI): ☐ Yes ☐ No

Other: _____

B. Medical Information:

Does Beneficiary receive ***Medicaid*** benefits? ☐ Yes ☐ No ☐ In the Process of Applying

Does Beneficiary receive ***Medicaid Waiver*** benefits? ☐ Yes ☐ No ☐ In the Process of Applying

If yes or in process of applying, include contact information for local Medicaid (DSS) Office:

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Phone Ext: _____

Email Address: _____

Does Beneficiary receive ***Medicare*** benefits? ☐ Yes ☐ No

Does Beneficiary receive any other medical benefits? ☐ Yes ☐ No

If Yes, please describe: _____

C. Case Management or Other Support Services: Provide the following information if applicable:

Agency/Provider: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Main Phone Number: _____ Cell Number: _____

Email Address: _____

Description of Service: _____

D. Section 8 or Subsidized Housing: ☐ Yes ☐ No

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

E. Other Public Assistance (e.g., food stamps): _____

Agency: _____

Contact Name (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

11. Distributions Upon the Death of the Beneficiary – Upon the actual death of the Beneficiary, the trust will be restricted and any remaining and unpaid funds shall be distributed to the following individuals who are then living or entities which are then in existence:

A. Primary Successor Beneficiaries:

1.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

2.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

3.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Total Percentage (must total 100%) _____ %

Add additional Primary Beneficiaries on separate paper.

Note: If an individual Primary Successor Beneficiary predeceases the Beneficiary, or an entity named as a Primary Successor Beneficiary is no longer in existence, the distribution to that individual or entity lapses and will be divided among the remaining Primary Successor Beneficiaries who are then living or in existence.

B. Contingent Successor Beneficiaries – To be paid if none of the Primary Beneficiaries are then living:

1.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

2.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

3.) Name: _____ SSN: _____ **Percentage:** _____ **%**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Total Percentage (must total 100%) _____ %

Add additional Contingent Beneficiaries on separate paper.

Note: If an individual Contingent Successor Beneficiary predeceases the Beneficiary, or an entity named as a Contingent Successor Beneficiary is no longer in existence, the distribution to that individual or entity lapses and will be divided among the remaining Contingent Successor Beneficiaries who are then living or in existence.

If there are no Contingent Successor Beneficiaries then living or in existence, such remaining funds shall be distributed to Commonwealth Community Trust.

Important: The Grantor is required to list any Primary Successor Beneficiaries and Contingent Successor Beneficiaries (and their contact information) and agrees that CCT's liability for payment under this Section 11 (Distributions Upon the Death of the Beneficiary) is limited to the beneficiaries known to CCT based upon the information noted in this Joinder Agreement and the Grantor(s) agree to otherwise hold CCT harmless with respect to payment hereunder. The determinations of CCT regarding payment under this Section 11 (Distributions Upon the Death of the Beneficiary) shall be final and binding on all parties.

CCT accepts donations that will support the mission to serve people with disabilities.

12. Funding Information:

IMPORTANT NOTE: All assets intended for the Beneficiary must be third-party assets, typically belonging to the Grantor, family member, or friend at the time of transfer.

A. How will this sub-account be funded? (please check any that apply)

- ☐ Lifetime contribution(s) by Grantor(s) or others
- ☐ Transfer from an existing special needs trust - **Please provide copy of trust.**
- ☐ Last will and testament of the Grantor(s) - **Please provide copy of will.**
- ☐ Life Insurance Policy of the Grantor(s) - **Please provide copy of the policy.**
- ☐ Other: (please explain) _____

B. Amount to be deposited into the trust (estimate if not certain): $ _____

C. Will annual court filings be required? ☐ Yes ☐ No If yes, please provide details: _____

_____

D. Will the Trust Company of Virginia have to go to court to qualify? ☐ Yes ☐ No If yes, please provide details: _____

_____

13. Please read the following:

(a) In order to facilitate pooling of the assets in all sub accounts, it is required that all deposits must be made in cash. The trust does not hold non-cash assets or real estate property.

(b) Income and principal will be distributed for the Beneficiary at the sole discretion of CCT.

(c) The provisions of this Joinder Agreement may be amended as determined reasonably necessary by the CCT so long as any such amendment is consistent with the Master Trust Agreement or is deemed necessary to conform to any changes required by the law.

(d) It is understood and agreed upon that the trust is for the sole benefit of the Beneficiary.

(e) Trustee and other fees shall be charged in accordance with the Fee Schedule attached hereto and as amended from time to time.

NOTE: CCT may, from time to time and at its discretion, hire additional professionals to serve as a liaison between CCT and the Beneficiary, or to assess the financial or custodial care arrangements of the Beneficiary and provide reports to CCT (e.g. accountants, attorneys, health care professionals, social workers, life care planners, care managers). CCT reserves the right to charge this expense to the Beneficiary's trust sub-account.

(f) Taxes
(1) The Grantor acknowledges that there have been no representations made to the Grantor regarding the deductibility of the contributions to the trust as charitable gifts or otherwise.
(2) Trust fund (sub account) income, whether paid in cash or distribution in other property may be taxable to the Beneficiary, subject to applicable exemptions and deductions. Professional tax advice is recommended.
(3) Income of the trust fund (sub account) may be taxable to the trust and when this occurs, such taxes shall be payable from the trust fund (sub account) of the Beneficiary.

(g) This trust administered by CCT is a pooled trust, governed by the laws of Virginia, in conformity with the provisions of 42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993. To the extent there is conflict between the terms of the Trust Agreement and/or this Instrument, and the governing law as from time to time as amended, the law and regulations shall control.

14. Professional Representation – Grantor(s) has/have been represented with regard to CCT by:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

THIS JOINDNER AGREEMENT NEEDS TO BE SIGNED IN FRONT OF A NOTARY.

15. In Witness Whereof – The undersigned Grantor(s) has/have signed this agreement and understand(s) same and agree(s) to be bound by the terms thereof and the Commonwealth Community Trust hereby accepts this trust this _____ day of _____, 20_____. The Grantor(s) confirm(s) that simultaneously with the execution of this instrument or prior thereto the assets set forth on the attached schedule are or were transferred to the Trustees hereunder.

_____ _____

Grantor's Signature Grantor's Signature

STATE OF_____ CITY/COUNTY OF_____

TO-WIT: The foregoing Joinder Agreement, dated _____ was acknowledged before me by _____ and _____, Grantor(s), this _____ day of _____ , 20_____ .

_____ My commission expires: _____

Notary Public

TO BE COMPLETED BY COMMONWEALTH COMMUNITY TRUST (CCT):

By _____ Title: _____

STATE OF VIRGINIA, COUNTY OF HENRICO

TO-WIT: The foregoing Joinder Agreement, dated _____ was acknowledged before me by _____ and _____ on behalf of CCT, this ____ day of_____ , 20 ____ .

_____ My commission expires: _____

Notary Public