COMMUNITY TRUST ENROLLMENT APPLICATION (JOINDER)

This is a legal document and agreement pertaining to a supplemental needs trust created pursuant to 42 United States Code §1396. We encourage you to seek independent, professional advice before signing.

The undersigned hereby adopts, enrolls in and establishes an account under the Coordinated Care Alliance NY, Inc., Master Trust dated May 2024. This Trust is Irrevocable.

This paperwork pertains to the Trust Services only. It is the responsibility of the beneficiary or their authorized representative to submit any required documents to Medicaid or any of the other appropriate governmental agencies related to benefit eligibility.

***Note: All questions must be answered, or your application will be delayed*

Disabled Beneficiary/Donor: _____

(First, Middle, Last Name)

Social Security Number: _____-_____-_____ **Date of Birth:** _____/_____/_____

Street Address: _____

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

Birthplace: _____ **Citizenship:** _____

Home Phone: (_____) _____ -_____ **Mobile:** (_____) _____ -_____

Email Address: _____

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

If Married, Maiden Name:_____ **Spouse's Name:**_____

Does the Beneficiary have a Guardian? ☐ Yes ☐ No *(if yes, please include documents)*

If yes, Name: _____ Phone: (_____) _____ - _____

Address: _____

Email: _____

Guardian of: ☐ Person ☐ Property ☐ Both

Are Standby and/or Alternate Standby Guardians appointed? ☐ Yes ☐ No

If yes, Name: _____ Phone: (_____) _____ - _____

Address: _____

Email: _____

Guardian of: ☐ Person ☐ Property ☐ Both

Does the Beneficiary have a Power of Attorney? ☐ Yes ☐ No

(if yes, please include POA documents)

Name: _____ Phone: (_____) _____ - _____

Address: _____

Email: _____ Relationship: _____

Is the Trust being established per a Court Order? ☐ Yes ☐ No

(If yes, please include a copy of the Order)

Does the Beneficiary have a Representative Payee? ☐ Yes ☐ No

Name: _____ Phone: (_____) _____ - _____

Address: _____

Email: _____ Relationship: _____

Beneficiary's Qualifying Disability(ies): _____

_____

Beneficiary's Living Arrangement:

☐ Independently ☐ CR/IRA/ICF (supervised) ☐ Family Care Program

☐ With Spouse ☐ CR/IRA (supportive) ☐ Nursing Home

☐ With Family ☐ Assisted Living Facility

Other: _____

- If an OPWDD residential program, does the Beneficiary receive community funds?

☐ Yes ☐ No If yes, amount $_____ How often? _____

- If at home, is there home care?

☐ Yes ☐ No If yes, how often? _____

- Please list any services received and agencies involved in your care (day services, employment services, service coordination, etc.)

Service	Name of Provider
_____	_____
_____	_____
_____	_____

Does the Beneficiary have a Care Manager? ☐ Yes ☐ No

If yes, Name:_____ Phone: (____) _____-_____

Email:_____

Organization:_____

Funding of Trust (Indicate all that apply):

☐ Lump Sum ☐ Structured Settlement (please provide settlement order)

Other _____

_____

Beneficiary's Income Information (please complete all that apply):

Supplemental Security Income (SSI) ☐ Yes ☐ No Amount $_____

Social Security Disability Income (SSDI) ☐ Yes ☐ No Amount $_____

Social Security Retirement Income (SSA) ☐ Yes ☐ No Amount $_____

Social Security Survivor/Dependent Benefits ☐ Yes ☐ No Amount $_____

*Please provide a copy of your Social Security Award letter indicating your claim number.

Other income? ☐ Yes ☐ No If yes, Amount $_____

Frequency _____ Source_____

Does the Beneficiary receive Medicaid? ☐ Yes ☐ No ☐ Pending

If yes, Medicaid case #:_____

Please list other monthly benefits that the Beneficiary may receive (food stamps, HUD, section 8, etc.):

_____

_____

Does the Beneficiary have Funeral Provisions in place? ☐ Yes ☐ No

If yes, please provide details:

Funeral Home Name:_____

Contact Name:_____Phone: (____) _____-_____

Email:_____

Details:_____

_____

_____

Authorized Contacts:

*Anyone listed as an authorized contact will have authorization to speak with Trustees and Trust staff regarding the Trust of the Beneficiary including, but not limited to, account activity, legal documents and forms. However, only those specifically indicated below to receive statements and/or submit withdrawal requests will be permitted to do so.

***Please indicate one party to receive annual tax information*

Name: ______________________________ Phone: (____) __________ - __________

Address: ____

Email: ______________________________ Relationship: ______________________

Receive Statements: ☐ Yes ☐ No Submit Withdrawal Requests: ☐ Yes ☐ No

Send Annual Tax Info.: ☐ Yes ☐ No

Name: ______________________________ Phone: (____) __________ - __________

Address: ____

Email: ______________________________ Relationship: ______________________

Receive Statements: ☐ Yes ☐ No Submit Withdrawal Requests: ☐ Yes ☐ No

Send Annual Tax Info.: ☐ Yes ☐ No

Name: ______________________________ Phone: (____) __________ - __________

Address: ____

Email: ______________________________ Relationship: ______________________

Receive Statements: ☐ Yes ☐ No Submit Withdrawal Requests: ☐ Yes ☐ No

Send Annual Tax Info.: ☐ Yes ☐ No

Please indicate the name of the party responsible for submitting Trust Documents to Medicaid, Social Security Administration, or other government agency on behalf of the Beneficiary:

Name: ______________________________ Phone: (____) __________ - __________

Address: ____

Email: ______________________________ Relationship: ______________________

How did you hear about us?

Name: _____Phone: (_____) _____ - _____

Agency:_____

Address: _____

Email:_____Relationship:_____

Required Documentation:

If any of the following applies to your Trust application, please include it with this Joinder Agreement:

- Award letters for Social Security Disability and/or SSI benefits (if applicable).
- Disability determinations through NYS Medicaid or the Social Security Administration.
- Any determinations from NYS Medicaid.
- Power of Attorney documents.
- Guardianship papers, Decrees, Letters in Article 17A or Order and Commission in Article 81.
- Any court orders directing the establishment of a trust along with any structure settlement orders.
- If the joinder was executed utilizing a supported decision-making process as delineated in Article 82 of the Mental Hygiene Law, please provide a copy of the agreement and attestation, as provided in MHL 82.10 (d)(3).

Situs:

The Trust instruments and administration of the account created by this Joinder Agreement shall be governed by the State of New York; and administered by CCANY, Inc. and a financial institution in the State of New York. If applicable, the Federal law shall govern any matters between the Trust and the government benefits for which a designated Beneficiary may be eligible. The Situs of this Trust shall be the County of Oneida, the County where the majority of meetings concerning the establishment of the Trust occurred.

Deposits:

Should an account have a zero ($0) account balance for 60 or more consecutive days, The Trustee has the right to close the account at their discretion. Any applicable administrative or management fees may be charged to the account prior to closing. Should the beneficiary wish to reopen said account, the donor will be responsible for settling any prior outstanding balance as well as any new enrollment fees related to the reopening of the account.

Withdrawals:

All withdrawal requests will be reviewed by the Trustee and approved at their discretion, on an individual basis. Requests for withdrawals to pay for the following items will not be approved: Medicaid eligible expenses incurred after the establishment of the Trust, gifts, charitable donations, Medicaid surplus premium invoices, rent agreements between spouses, any payments to financial institutions, items related to illegal activities, or any items that may jeopardize government benefits.

No withdrawals will be made after the death of a Beneficiary.

Death of Beneficiary:

The Beneficiary's account will terminate upon death. If there are remaining funds in the account, such funds will be deemed property of the Trust and/or CCANY, Inc. to further the purpose of the Trust for use as allowed under applicable regulations including for the benefit of individuals with disabilities defined in Social Security Law Section 1614 (a) (3) [42 USC 1382c(a) (3)].

Funeral expenses will only be paid prior to the Beneficiary's death, pursuant to an approved Medicaid eligible, irrevocable, pre-need funeral arrangement.

Disclosure of Potential Conflict of Interest:

I understand that a potential conflict of interest may exist in the administration of the Trust, since the remaining funds in the sub-account upon the passing of a beneficiary will be retained and used for the benefit of other individuals with disabilities, for whom services may be rendered by CCANY, Inc.

And understand the Trustee shall not be liable to the Donor or any party for any and all claims against the trustees on account of self-dealing, conflict of interest, or any other act resulting from their affiliations with CCANY, Inc.

The undersigned Beneficiary and/or their authorized representative hereby acknowledges and agrees:

- The signing of this document constitutes a legal agreement. I have been advised to consult with an attorney or tax professional regarding potential tax consequences or any other lasting impact related to the establishment of an account. Contributions to the trust are not tax deductible as charitable gifts or otherwise.
- CCANY, Inc. will not be held responsible for legal advice or counsel to the donor or Beneficiary regarding transfer of property to the Community Trust.
- I am solely responsible for advising the Trust of any changes in my situation or address.
- I have received the applicable Fee Schedule, Master Trust, and Information and Procedures documents. I acknowledge understanding of the contents thereof, and that they may be amended and adjusted in the future by the Board of Trustees.
- Anyone requesting and receiving withdrawals in violation of the Master Trust Agreement and this Joinder Agreement, will be required to refund the amount disbursed.
- The Beneficiary is disabled as defined in Social Security Law Section 1614(a)(3) [42 USC 1382c(a) (3)].
- I am entering into this Joinder Agreement voluntarily. All statements made in this document are accurate to the best of my knowledge.
- By agreeing to accept the transfer of assets pursuant to this Joinder Agreement, CCCANY, Inc. agrees to manage the trust funds only in accordance with the terms of the Master Trust Agreement, compliant with all related and applicable State and Federal law and regulation.
- Should an intermediary be necessary at an point to assist in the administration of this account, the Beneficiary will be responsibility for expenses incurred. The chosen party authorized to speak on the Beneficiary's behalf will be responsible for notifying CCANY, Inc. immediately upon the death of the beneficiary, and will also be required to promptly supply CCANY, Inc. with a certified death certificate.

Signature of Donor/Guardian	Relationship to Beneficiary	Date

State of New York)
County of _____) ss.:

On this _____ day of _____ , 20_____ 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 this instrument.

_____
Notary Public

State of New York)
County of _____) ss.:

On this _____ day of _____ , 20_____ 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 this instrument.

_____
Notary Public