

**JOINDER AGREEMENT  
FOR THE ARC OF INDIANA MASTER TRUST II  
A POOLED SPECIAL NEEDS TRUST**

THIS IS A LEGAL DOCUMENT. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING.

**PLEASE USE BLACK OR BLUE INK AND ANSWER EVERY QUESTION COMPLETELY.**

**PLEASE NOTE IF THIS DOCUMENT IS NOT COMPLETELY FILLED OUT IT CAN RESULT IN A DELAY IN PROCESSING.**

The undersigned hereby enrolls in and adopts The Arc of Indiana Master Trust II dated January 9, 1995, which is incorporated herein by reference.

**A. Trust sub-account number (Arc Trust use only):** \_\_\_\_\_

**B. The source of the funds for this trust sub-account:**

1. Social Security Back Payment \_\_\_\_\_
2. Inheritance \_\_\_\_\_
3. Beneficiary's Social Security money \_\_\_\_\_
4. Beneficiary's wages \_\_\_\_\_
5. Money set aside by parents or others for the Beneficiary \_\_\_\_\_
6. Beneficiary's savings or investments \_\_\_\_\_
7. Other (Please explain) \_\_\_\_\_

**C. The amount the Beneficiary is depositing to this trust sub-account is:** \_\_\_\_\_. **(Arc Trust Use Only)**

**D. Beneficiary's name:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Does beneficiary live: Alone \_\_\_\_ With Roommate \_\_\_\_ In a Group Home \_\_\_\_ With Family \_\_\_\_\_

If beneficiary lives with roommate or family, how many people reside in home? \_\_\_\_\_

Beneficiary's Social Security Number: \_\_\_\_\_

Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_ (cell): \_\_\_\_\_

E-mail: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: M \_\_\_\_ F \_\_\_\_

Disability/Diagnosis: \_\_\_\_\_

Was the onset of the disability at birth? Yes: \_\_\_\_ No: \_\_\_\_ If no, when: \_\_\_\_\_

Does the beneficiary have a guardian? Yes: \_\_\_\_ No: \_\_\_\_\_

If yes, what type of guardianship? Person: \_\_\_\_ Estate \_\_\_\_\_ Both \_\_\_\_\_

Does the beneficiary have a Power Of Attorney? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**\*Please note that any legal paperwork showing guardianship or a POA (power of attorney) must be on file with The Arc of Indiana at the time the trust is established.**

**E. Benefits Received:**

1. Does the Beneficiary receive **Supplemental Security Income (SSI)**? Yes: \_\_\_\_ No: \_\_\_\_

If yes, amount received per month: \$ \_\_\_\_\_

Address and phone number of SSI office:

\_\_\_\_\_  
\_\_\_\_\_

2. Does the Beneficiary receive any other **Social Security benefit (SSDI or Survivor's Benefits)**?

Yes: \_\_\_\_ No: \_\_\_\_

If yes, amount received per month: \$ \_\_\_\_\_

3. Does the Beneficiary receive **Medicaid**? Yes: \_\_\_\_ No: \_\_\_\_

If yes then:

Medicaid card number: \_\_\_\_\_

Medicaid case number: \_\_\_\_\_

4. Does the Beneficiary receive a **Medicaid Waiver**? Yes: \_\_\_\_ No: \_\_\_\_

If yes, please specify the waiver program(s) under which the Beneficiary receives benefits:

\_\_\_\_\_

5. Does the Beneficiary have **HUD housing assistance (Section 8)**? Yes: \_\_\_\_ No: \_\_\_\_

If yes, the ID #: \_\_\_\_\_

Name, address and phone number of contact person:

\_\_\_\_\_  
\_\_\_\_\_

6. If the Beneficiary receives other government assistance such as **Food Stamps, Medicare, VA Benefits, etc.** list these benefits here:

\_\_\_\_\_

\_\_\_\_\_

Has the Beneficiary ever received Medicaid assistance of any kind from any other state at any time during their lifetime? If so, please list all state Medicaid agencies from whom Medicaid assistance of any kind have been paid, and the approximate dates between which they were received such assistance:

| <u>State:</u> | <u>Date From:</u> | <u>Date To:</u> |
|---------------|-------------------|-----------------|
| _____         | _____             | _____           |
| _____         | _____             | _____           |
| _____         | _____             | _____           |

**F. Key people:**

A “key person” is someone who the Beneficiary knows and trusts, and who can act as a prudent and responsible key contact for The Arc Trust. Essentially, a key person acts as a liaison between the Beneficiary and The Arc Trust, communicating the Beneficiary’s needs and desires to The Arc Trust and making disbursement requests on his or her behalf. Although The Arc Trust ultimately decides whether a disbursement will or will not be made, key people are valuable to both the Beneficiary and The Arc Trust, because they provide insight into how a Beneficiary’s trust account can best be used to provide him or her with the best possible material quality of life. A Beneficiary can have more than one key person.

**Please list the primary contact first and only one key person should receive the annual mailing to keep the account information updated**

|                                     | <b>This Key Person is Responsible for...</b>     |
|-------------------------------------|--|
| 1. Name: _____                      | _____  |
| Company: _____                      | ___ Receive Mailing to Keep Account Info Updated |
| Address: _____<br>_____             | ___ Receive Statement of Account                 |
|                                     | ___ On-Line                                      |
|                                     | ___ Annual Mail                                  |
|                                     | ___ Quarterly Mail                               |
| Phone (day): _____ (evening): _____ | ___ Bi-Monthly Mail                              |
|                                     | ___ Monthly Mail                                 |

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

2. Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**This Key Person is Responsible for...**

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- Receive Mailing to Keep Account Info Updated
- Receive Statement of Account
  - On-Line
  - Annual Mail
  - Quarterly Mail
  - Bi-Monthly Mail
  - Monthly Mail

3. Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**This Key Person is Responsible for...**

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- Receive Mailing to Keep Account Info Updated
- Receive Statement of Account
  - On-Line
  - Annual Mail
  - Quarterly Mail
  - Bi-Monthly Mail
  - Monthly Mail

Relationship to Beneficiary: \_\_\_\_\_

4. Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**This Key Person is  
Responsible for...**

\_\_\_ Receive Mailing to  
Keep Account Info  
Updated

\_\_\_ Receive Statement  
of Account

\_\_\_ On-Line

\_\_\_ Annual Mail

\_\_\_ Quarterly Mail

\_\_\_ Bi-Monthly Mail

\_\_\_ Monthly Mail

**G. Distributions upon the Beneficiary's death:**

Since this trust account is funded with the Beneficiary's own assets, federal law requires that to the extent that amounts remaining in the individual's account upon the death of the individual are not retained by the trust, the trust pays to the State(s) from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s). To the extent that the trust does not retain the funds in the account, the State(s) must be listed as the first payee(s) and have priority over payment of other debts and administrative expenses except:

- a. Taxes due from the trust to the State(s) or Federal government because the death of the beneficiary:
- b. Reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions as associated with termination and wrapping up of the trust:

Medicaid payback may also not be limited to any particular period of time, i.e., payback cannot be limited to the period after establishment of the trust. Pursuant to applicable law, 42 U.S.C. § 1396p(d)(4)(C)(iv), The Arc of Indiana will retain 50% of any trust assets remaining upon the death of the Beneficiary. The remaining 50% shall be distributed to the appropriate Medicaid agency, up to the amount the agency has expended on behalf of the Beneficiary, of each state that has provided medical assistance to the Beneficiary during the Beneficiary's lifetime, pro-rata, with each state receiving a percentage of the remainder that is commensurate with the proportionate share that it has expended on behalf of the Beneficiary during the Beneficiary's lifetime respective to all other state Medicaid agencies that also have expended money on behalf of the Beneficiary during the Beneficiary's lifetime. If a balance remains after The Arc of Indiana has retained 50% of the remainder, and the state(s) have been reimbursed, said balance shall be disbursed as follows. These people or organizations shall hereafter be known as remaindermen.

**THIS AREA IS REQUIRED.**

a) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Relationship to Beneficiary: \_\_\_\_\_  
This person listed above should receive \_\_\_\_\_%

b) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Relationship to Beneficiary: \_\_\_\_\_  
This person listed above should receive \_\_\_\_\_%

c) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Relationship to Beneficiary: \_\_\_\_\_  
This person listed above should receive \_\_\_\_\_%

**H. MISCELLANEOUS**

1. If the Beneficiary's residence changes from Indiana to another state, distributions may cease until appropriate arrangements can be made within the sole discretion of the Trustee – including:
  - a. the in-kind transfer of the sub-account property directly to a comparable 501(c)(3) tax-exempt pooled special needs trust serving the geographic location to which the Beneficiary has moved;
  - b. the continued administration of the Beneficiary's sub-account by the Trustee in accordance with the applicable laws of the state to which the Beneficiary moves.

However, in no event shall the Beneficiary's move from the state of Indiana to another state render the Beneficiary's sub-account revocable or otherwise available to the Beneficiary or any other person in any way; and in no event shall the Beneficiary's move from the state of Indiana to another state terminate the Beneficiary's sub-account.

2. All Arc of Indiana Master Trust II Joinder Agreements executed prior to this current revision shall hereby incorporate the above language, as if fully set forth verbatim therein, and the pre-existing language found

in Section F.1. of all Arc of Indiana Master Trust II Joinder Agreements, executed prior to this current revision shall be rendered null and void *ab initio*, as if it were never drafted and incorporated in the original Joinder Agreement for The Arc of Indiana Master Trust II (1995) or any revision thereafter (8/2000; 4/2002, 3/2004, 2/2006, 5/2007, 10/2007 and 9/2014)

3. The provisions of this Joinder Agreement may be amended as the Beneficiary and the Trustee may jointly agree, provided that such amendment is consistent with the Master Trust II.
4. Any remainder amount for a remainderman named in Section G who does not survive the Beneficiary shall lapse and be distributed in equal share to all other remaindermen.

**I. Fees:**

1. An enrollment fee of \$\_\_\_\_\_, (**Arc Trust use only**) was paid when the Joinder Agreement was executed.
2. An annual Trustee's fee shall be addressed. This fee shall be determined according to Article Seven of the Declaration of Trust for The Arc of Indiana Master Trust II.
3. If the Beneficiary is subject to any additional fees, a listing of these fees shall be attached to this Joinder Agreement.

**J. Taxes:**

1. The Beneficiary (or his or her legal representative and/or Key Person) acknowledges that contributions to The Arc of Indiana Master Trust II are not deductible as charitable gifts, or otherwise.
2. Trust sub-account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. The Beneficiary (or his or her legal representative and/or Key Person) is encouraged to obtain advice from a qualified tax professional

**IN WITNESS WHEREOF**, the undersigned Beneficiary and his or her legal representatives or designees have reviewed and signed this Joinder Agreement, understand it, and agree to be bound by its terms, and the Trustee has accepted and signed this Joinder Agreement on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
BENEFICIARY, PARENT, OR GUARDIAN OF ESTATE ONLY

\_\_\_\_\_  
THE ARC OF INDIANA, INC. as TRUSTEE