

**JOINDER AGREEMENT
FOR THE ARC OF INDIANA MASTER TRUST II**

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

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. Beneficiary's name: _____

Address: _____

Beneficiary's Social Security Number: _____

Phone (day): _____ (evening): _____ (cell): _____

E-mail: _____

Birth date: _____ Gender: M ___ F ___

Disability/Diagnosis: _____

Does the beneficiary have a guardian? Yes: ___ No: ___

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

Does the beneficiary have a POA? 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.**

C. 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 **Social Security Disability Benefits (SSDI)**? Yes: ___ No: ___

If yes, amount received per month: \$ _____

3. Does the Beneficiary receive **Social Security Dependent Survivor's Benefits**? Yes: ___ No: ___

If yes, amount received per month: \$ _____

4. Does the Beneficiary receive **Medicaid**? Yes: ____ No: ____

If yes, the Medicaid card number: _____

Name, ID#, address, and phone number of caseworker:

5. Does the Beneficiary receive a **Medicaid Waiver**? Yes: ____ No: ____

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

6. Does the Beneficiary have **HUD housing assistance (Section 8)**? Yes: ____ No: ____

If yes, the ID #: _____

Name, address and phone number of contact person:

7. If the Beneficiary receives other government assistance such as **Food Stamps, Supported Living, RLA**, list these benefits here:

7. Have you ever received Medicaid benefits of any kind from any other state at any time during your lifetime? If so, please list all state Medicaid agencies from whom you received Medicaid benefits of any kind, and the approximate dates between which you received such benefits:

State:

Date From:

Date To:

D. Please indicate the source of the funds for this account:

The amount at which the sub-account has been funded is: _____ . (Arc Trust Use Only)

E. Key people:

A “key person” is someone whom 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.

List the Key people below (please list primary contact first):

	This Key Person is Responsible for...
1. Name: _____	
Company: _____	<input type="checkbox"/> Verify Account Information
Address: _____ _____	<input type="checkbox"/> Receive Statement of Account
Phone (day): _____ (evening): _____	<input type="checkbox"/> On-Line
Cell Phone: _____	<input type="checkbox"/> Annual Mail
E-mail: _____	<input type="checkbox"/> Quarterly Mail
Relationship to Beneficiary: _____	<input type="checkbox"/> Bi-Monthly Mail
	<input type="checkbox"/> Monthly Mail
	<input type="checkbox"/> Receive Arc Trust Annual Report
2. Name: _____	This Key Person is Responsible for...
Company: _____	<input type="checkbox"/> Verify Account Information
Address: _____ _____	<input type="checkbox"/> Receive Statement of Account
Phone (day): _____ (evening): _____	<input type="checkbox"/> On-Line
Cell Phone: _____	<input type="checkbox"/> Annual Mail
E-mail: _____	<input type="checkbox"/> Quarterly Mail
Relationship to Beneficiary: _____	<input type="checkbox"/> Bi-Monthly Mail
	<input type="checkbox"/> Monthly Mail
	<input type="checkbox"/> Receive Arc Trust Annual Report
3. Name: _____	This Key Person is Responsible for...
Company: _____	<input type="checkbox"/> Verify Account

Address: _____

Phone (day): _____ (evening): _____

Cell Phone: _____

E-mail: _____

Relationship to Beneficiary: _____

4. Name: _____

Company: _____

Address: _____

Phone (day): _____ (evening): _____

Cell Phone: _____

E-mail: _____

Relationship to Beneficiary: _____

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- Information
____ Receive Statement
of Account

____ On-Line
____ Annual Mail
____ Quarterly Mail
____ Bi-Monthly Mail
____ Monthly Mail
____ Receive Arc Trust
Annual Report

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

-
- ____ Verify Account
Information
____ Receive Statement
of Account
____ On-Line
____ Annual Mail
____ Quarterly Mail
____ Bi-Monthly Mail
____ Monthly Mail

____ Receive Arc Trust
Annual Report

F. Distributions upon the Beneficiary's death.

1. If this trust account is funded with the Beneficiary's own money, federal law requires that all unspent money in the account remaining at the time of the Beneficiary's death be used to reimburse the state for medical services received up to the total amount that the state has spent on medical services for the Beneficiary throughout the Beneficiary's lifetime, unless such amounts are retained by the Trust administrator. Pursuant to applicable law, 42 U.S.C Section 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 of each state that has provided benefits 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 has been reimbursed (which is highly unlikely, unless the Beneficiary has drawn Medicaid benefits for only a short period of time), said balance shall be disbursed as follows. These people will be after here known as remaindermen. **Please list below.**

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 _____ %

2. 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, but not necessarily limited to:
- a. the in-kind transfer of the sub-account property directly to a comparable 501(c)(3) tax-exempt pooled trust serving the geographic location to which the Beneficiary has moved
 - b. the establishment by the Beneficiary of a properly-drafted private special needs trust
 - c. 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.

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 (2/5/01; 4/23/02; 12/27/05; 5/3/07; 9/21/07; 2/15/08)

3. Any remainder amount for a remainderman named in Section F who does not survive the Beneficiary shall lapse and be distributed in equal share to all other remaindermen.

G. 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.

H. Miscellaneous:

1. 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.
2. This Joinder Agreement and The Arc of Indiana Master Trust II may be terminated by the Trustee upon nonpayment of any required fee.

I. 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 (or Beneficiary's legal representative)

THE ARC OF INDIANA, INC. as TRUSTEE