

CFMF Agreement Number: _____

5. BENEFICIARY INFORMATION:

Name of Beneficiary: _____

Title: Mr. Mrs. Ms. Miss Dr. Other: _____

Address: _____

City, State, ZIP: _____

County: _____ Email: _____

Phone: _____

Date of Birth: _____ Social Security Number: _____

(Please contact CFMF’s Administrative Office prior to submitting this Joinder if the Beneficiary is age 65 or older.)

Beneficiary’s Disability (check all that apply):

_____ ID (Intellectual Disability) _____ MH (Mental Health)
_____ DD (Developmental Disability) _____ Other: _____

The following state(s) have provided or may provide Medicaid-covered services to the Beneficiary (check one):

_____ Ohio only
_____ The Beneficiary has not yet applied for Medicaid, but we expect Ohio to be the only state
_____ Ohio and the following states: _____

6. DESIGNATED ADVOCATE

The Designated Advocate is responsible for providing current and correct information about the Beneficiary and the government benefits applied for and/or received. The Designated Advocate is also responsible for requesting funds from the Trust and for providing supporting information for the requested funds. The Designated Advocate shall also serve as the Beneficiary Surrogate defined in R.C. 5801.01(D) for purposes of receiving notices as required by R.C. 5808.13. The person establishing the Trust Sub-Account may change the Designated Advocate(s) at any time, subject to prior approval by CFMF.

ANY INDIVIDUAL OR ORGANIZATION MAY SERVE AS THE DESIGNATED ADVOCATE. MANY PEOPLE CONSIDER NAMING A FAMILY MEMBER AS A DESIGNATED ADVOCATE. HOWEVER, BECAUSE OF POSSIBLE CONFLICT OF INTEREST, EXPERIENCE INDICATES THAT THIS MAY NOT BE A GOOD IDEA, PARTICULARLY WHEN THE DESIGNATED ADVOCATE, OR HIS OR HER FAMILY, IS THE ULTIMATE RECIPIENT OF REMAINING TRUST ASSETS AFTER THE DEATH OF THE BENEFICIARY.

Name of Designated Advocate: _____

Type: Individual Organization / Contact Name: _____

Title: Mr. Mrs. Ms. Miss Dr. Other: _____

Address: _____

City, State, ZIP: _____

County: _____ Email: _____

Phone: _____

Relationship to Beneficiary: _____

CFMF Agreement Number: _____

If the Designated Advocate is unable to serve, the person establishing the Trust Sub-Account appoints the following individuals in the order named to serve as Successor Designated Advocate. CFMF strongly recommends naming at least one Successor. If none of the Designated Advocates are able to serve, the last acting Designated Advocate may designate a successor in writing delivered to CFMF. If no successor is so designated, the Trust Advisor may consult with the Person Establishing the Trust, the Beneficiary, the Guardian of the Beneficiary, the Beneficiary's caseworker, and/or any interested family member of the Beneficiary to identify a successor Designated Advocate. [Please attach additional pages if more than two successors are named.]

Name of First Successor Designated Advocate: _____

Type: Individual Organization / Contact Name: _____

Title: Mr. Mrs. Ms. Miss Dr. Other: _____

Address: _____

City, State, ZIP: _____

County: _____ Email: _____

Phone: _____

Relationship to Beneficiary: _____

Name of Second Successor Designated Advocate: _____

Type: Individual Organization / Contact Name: _____

Title: Mr. Mrs. Ms. Miss Dr. Other: _____

Address: _____

City, State, ZIP: _____

County: _____ Email: _____

Phone: _____

Relationship to Beneficiary: _____

7. FEES

Fees are based on a published schedule. CFMF and the Trustee reserve the right to modify the published fee schedule.

8. DISTRIBUTIONS TO THE BENEFICIARY

Income and principal shall be distributed by the Trustee in cash or in kind at the direction of the Trust Advisor for the benefit of the Beneficiary during his or her life or until the termination of the Trust Sub-Account for his or her benefit, whichever occurs sooner.

(Remainder of Page Intentionally Left Blank)

CFMF Agreement Number: _____

9. DISTRIBUTIONS UPON DEATH OF BENEFICIARY

Upon the death of the Beneficiary, distribution shall be made to the following individuals or entities: (**initial one option**):

(1) _____	OPTION 1: Allow CFMF to retain all monies remaining in the Trust Sub-Account under the terms of the Trust Agreement. If OPTION 1 is selected, the assets will be used by CFMF to further its charitable and educational purposes, and may be used to reduce CFMF administration costs.*
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OR

(2) _____	<p>OPTION 2: Payment of claim made by state(s) for reimbursement of medical assistance expenditures made on behalf of the Beneficiary. If OPTION 2 is selected, Federal law, 42 U.S.C. 1396p(d)(4)(C), and Social Security Administration regulations require that, to the extent that funds are not retained by the Trust, the Trustee must pay to the state(s) from such remaining amounts in the Trust Sub-Account an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary under any state Medicaid plan. The Trustee must make an appropriate, proportionate payment from the Trust Sub-Account in payment of any claim for reimbursement from a state that has paid for medical assistance on behalf of the Beneficiary under a state plan pursuant to 42 U.S.C. 1396, <i>et seq.</i></p> <p>If monies are remaining in the Trust Sub-Account after payment in full of the claim made by state(s) for reimbursement of medical assistance expenditures made on behalf of the Beneficiary, the remaining monies shall be distributed as follows (attach additional sheets and instructions if necessary):</p> <p>Primary Distributee(s) After Repayment to the State(s):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Percentage</th> <th style="text-align: center;">Name**</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">_____ %</td> <td>_____</td> </tr> <tr> <td style="text-align: center;">_____ %</td> <td>_____</td> </tr> <tr> <td style="text-align: center;">_____ %</td> <td>_____</td> </tr> <tr> <td style="text-align: center;">_____ %</td> <td>_____</td> </tr> <tr> <td style="text-align: center;">_____ %</td> <td>Community Fund Management Foundation*</td> </tr> <tr> <td style="text-align: center;">100%</td> <td>TOTAL</td> </tr> </tbody> </table>	Percentage	Name**	_____ %	_____	_____ %	_____	_____ %	_____	_____ %	_____	_____ %	Community Fund Management Foundation*	100%	TOTAL
Percentage	Name**														
_____ %	_____														
_____ %	_____														
_____ %	_____														
_____ %	_____														
_____ %	Community Fund Management Foundation*														
100%	TOTAL														

*Please consider distributing a portion of the Trust Estate to CFMF upon the death of the Beneficiary. CFMF is a 501(c)(3) and utilizes these funds to approve grants for individuals with disabilities and nonprofits that serve individuals with disabilities. CFMF may also use the funds to help defray the cost to educate and communicate to the public about the opportunities and desirability of using trusts for individuals with disabilities and reduce the cost of administering this sub-account and other similar sub-accounts.

**If a guardian is establishing the Trust, the guardian must name the ward’s estate as the remainder distributee after repayment to the state(s) unless the guardian provides a court order authorizing the guardian to designate a distributee other than the ward’s estate.

10. IRREVOCABILITY OF TRUST

This Joinder Agreement shall be irrevocable.

11. PROPERTY TRANSFERRED TO TRUSTEE

All property transferred to Trustee by the person establishing the trust or others for administration hereunder, shall be listed on the attached Asset Transfer and Beneficiary Designation Record. The Trustee will accept only intangible assets; no real property will be held.

CFMF Agreement Number: _____

12. APPLICATION OF PERSON ESTABLISHING TRUST

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING AN 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.

When you apply to open a CFMF trust account, you will be asked to and you must provide your name, address, date of birth, driver license, or other identifying information that will allow the Trustee, Equity Trust Company, and Trust Advisor to identify you.

The undersigned hereby applies for admission to establish a Trust Sub-Account in the COMMUNITY FUND MANAGEMENT FOUNDATION POOLED MEDICAID PAYBACK TRUST, Equity Trust Company, as Trustee, and Community Fund Management Foundation as Trust Advisor. The undersigned understands the terms of the Pooled Medicaid Payback Trust Agreement and this Joinder Agreement and adopts said Agreement and agrees to be bound by the terms thereof.

DISCLAIMER: INVESTMENT PRODUCTS, INCLUDING SHARES OF MUTUAL FUNDS, ARE NOT DEPOSITS OR OBLIGATIONS OF, OR GUARANTEED BY, EQUITY TRUST COMPANY OR ANY OF ITS AFFILIATES, NOR ARE THEY INSURED BY THE FEDERAL DEPOSIT INSURANCE CORPORATION, OR ANY OTHER GOVERNMENT AGENCY. AN INVESTMENT IN SUCH PRODUCTS INVOLVES INVESTMENT RISK, INCLUDING POSSIBLE LOSS OF PRINCIPAL.
THE TRUSTEE’S INVESTMENT POLICY SHALL BE AVAILABLE UPON REQUEST.

THE TERMS OF THE TRUST ARE INTENDED TO COMPLY WITH ALL APPLICABLE LAWS AND REGULATIONS, BUT WITH THE EVER-CHANGING AGENCY INTERPRETATIONS IN THIS AREA, NEITHER CFMF NOR THE TRUSTEE CAN SERVE AS GUARANTOR FOR RECEIVING OR CONTINUING BENEFITS.

Date: _____
_____ Person Establishing Trust Sub-Account

13. CERTIFICATION OF PERSON ESTABLISHING TRUST SUB-ACCOUNT

Under penalties of perjury, the Person establishing the Trust certifies that:

- a. The social security number listed under section 5 of this Joinder Agreement is the beneficiary’s correct taxpayer identification number, and
- b. The beneficiary is not subject to backup withholding because (i) he/she is exempt from backup withholding, or (ii) he/she has not been notified by the Internal Revenue Service (IRS) that he/she am subject to backup withholding as a result of a failure to report all interest or dividends, or (iii) the IRS has notified him/her that he/she is no longer subject to backup withholding, and
- c. The beneficiary is a U.S. person (including a U.S. resident alien).

You must cross out item b above if you have been notified by the IRS that the Beneficiary is currently subject to backup withholding because he/she has failed to report all interest and dividends on his/her tax return.

Date: _____
_____ Person Establishing Trust Sub-Account

CFMF Agreement Number: _____

14. WITNESS OR NOTARY DECLARATION

[This Joinder Agreement and Application for Admission to Establish Trust Sub-Account will not be accepted unless it is either signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]

ON THE DATE INDICATED BELOW, _____ declared to us, the undersigned, that he/she was applying for admission to establish a Trust Sub-Account in the Community Fund Management Foundation Pooled Medicaid Payback Trust with Equity Trust Company, as Trustee and Community Fund Management Foundation as Trust Advisor. He/she thereupon signed this Joinder Agreement and Application for Admission as the person establishing the trust, in our presence, all of us being present at the same time. We now, at his/her request, in his/her presence and in the presence of each other, subscribe our names as witnesses.

At this time, the person establishing the Trust Sub-Account and each of us are over eighteen (18) years of age and each of us believe _____ understands the provisions of this Trust and is not acting under duress, menace, fraud, misrepresentation or undue influence.

Date: _____

Witness

Date: _____

Witness

OR

NOTARY ACKNOWLEDGMENT

State of Ohio

County of _____ ss.

Before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Joinder Agreement and Application for Admission to Establish Trust Sub-Account as Person Establishing Trust Sub-Account, and who has acknowledged that he/she executed the same for the purposes expressed therein. I attest that the Person Establishing Trust Sub-Account appears to be of sound mind and not under or subject to duress, fraud or undue influence.

Date: _____

Notary Public

CFMF Agreement Number: _____

15. **ATTORNEY’S DECLARATION – NEITHER CFMF NOR THE TRUSTEE IS AUTHORIZED TO PRACTICE LAW AND CANNOT PROVIDE ANY LEGAL ADVICE. THIS DOCUMENT MUST BE DISCUSSED WITH THE PERSON’S ATTORNEY.**

I am a licensed attorney and represent the person establishing this Trust Sub-Account with respect to his or her adoption of the Community Fund Management Foundation Pooled Medicaid Payback Trust and approve the Trust Agreement and this Joinder Agreement as to form and content. I acknowledge that I have informed the person establishing this Trust Sub-Account that this Trust may be created only for the benefit of a beneficiary who is a person with a disability (as defined in 42 U.S.C. 1382c(a)(3)).

Date: _____ Attorney’s Signature: _____
Print Name: _____
Firm: _____
Address: _____
City, State, ZIP: _____
County: _____
Phone: _____
Fax: _____
Email: _____

16. **TRUST ADVISOR’S APPROVAL**

Application for admission to establish this Trust Sub-Account is hereby approved.

Date: _____ **COMMUNITY FUND MANAGEMENT FOUNDATION**
an Ohio Non-Profit Corporation, Trust Advisor

By: _____

(Remainder of Page Intentionally Left Blank)

CFMF Agreement Number: _____

17. TRUSTEE'S APPROVAL

Application for admission to establish this Trust Sub-Account is hereby approved and the Asset Transfer and Beneficiary Designation Record is hereby accepted.

Date: _____ EQUITY TRUST COMPANY, Trustee

By: _____

(Remainder of Page Intentionally Left Blank)

CFMF Agreement Number: _____

COMMUNITY FUND MANAGEMENT FOUNDATION POOLED MEDICAID PAYBACK TRUST

ASSET TRANSFER AND BENEFICIARY DESIGNATION RECORD

1. HOW WILL THIS TRUST ACCOUNT BE FUNDED?

_____ CASH OR CHECK

_____ ANNUITY PAYMENTS OR STRUCTURED SETTLEMENT (Please provide copy of contract)

_____ OTHER, SPECIFY _____

2. ASSETS OWNED BY THE BENEFICIARY?

_____ YES

_____ NO. If No, who owns? _____

3. LIST ALL CHECKS INCLUDED WITH THIS APPLICATION. Note: If assets listed total less than \$5,000, the person establishing the trust must initial part 5 below.

CHECK NO.	CHECK AMOUNT
_____	_____
_____	_____
_____	_____
_____	_____

4. IS A SEPARATE CHECK PROVIDED FOR THE CFMF SETUP FEE? _____ YES _____ NO
IF NO, THE CFMF SETUP FEE WILL BE DEDUCTED FROM THE ASSETS FOR TRANSFER TO THE TRUST ACCOUNT IDENTIFIED IN PART 3 ABOVE.

5. IF THE ASSETS FOR TRANSFER TO THE TRUST ARE LESS THAN \$5,000, THE FOLLOWING MUST BE INITIALED:

Initials of person
establishing trust

This is a Roll-in Pooled Medicaid Payback Trust. I understand that distributions will not be made from the trust until the trust balance reaches \$5,000.00.