THE ARC OF OHIO INC. ACCOUNT
OF THE
COMMUNITY FUND MANAGEMENT FOUNDATION POOLED MEDICAID PAYBACK TRUST
POOLED MEDICAID PAYBACK SUB-ACCOUNT

JOINDER AGREEMENT AND APPLICATION FOR
ADMISSION TO ESTABLISH POOLED MEDICAID PAYBACK TRUST SUB-ACCOUNT

TO BE ADMINISTERED IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE COMMUNITY FUND MANAGEMENT FOUNDATION POOLED MEDICAID PAYBACK TRUST AGREEMENT, 42 U.S.C. 1396p(d)(4)(C), R.C. 5163.21(F)(3)(a), 42 U.S.C. 1382b(e), AND THE COLLECTIVE INVESTMENT FUND LAW, SECTION 9.18(c)(4), AS ANY MAY BE AMENDED FROM TIME TO TIME. IN THE EVENT THERE IS A CONFLICT BETWEEN A JOINDER AGREEMENT AND ANY TERM OF THE POOLED MEDICAID PAYBACK TRUST AGREEMENT, THEN THE TERMS OF THE POOLED MEDICAID PAYBACK TRUST AGREEMENT SHALL GOVERN. THE POOLED MEDICAID PAYBACK TRUST AGREEMENT AND/OR THE JOINDER AGREEMENT MAY BE AMENDED AND/OR RESTATED FROM TIME TO TIME IN ORDER TO COMPLY WITH FEDERAL AND STATE LAWS. ANY SUCH AMENDMENT OR RESTATEMENT SHALL BE APPLICABLE RETROACTIVELY TO ALL JOINDER AGREEMENTS.

THIS JOINDER AGREEMENT IS ENTERED INTO PURSUANT TO AND IS EXEMPT UNDER 42 U.S.C. 1396p(d)(4)(C), AS AMENDED EFFECTIVE OCTOBER 1, 1993, AND OHIO ADM.CODE 5160:1-3-05.2, AND THEREFORE THE ASSETS DIRECTED TO THIS TRUST SHOULD NOT BE DEEMED TO BE AVAILABLE TO THE BENEFICIARY.

1. AGREEMENT NUMBER:_____

2. TRUSTEE: EQUITY TRUST COMPANY of Westlake, Ohio

3. TRUST ADVISOR: COMMUNITY FUND MANAGEMENT FOUNDATION (CFMF), an Ohio Non-Profit, tax-exempt Corporation

4. PERSON ESTABLISHING TRUST SUB-ACCOUNT (check **one** option):

_____PARENT
_____GUARDIAN (provide Letters of Guardianship)
_____COURT (provide Court Order)
_____BENEFICIARY (provide power of attorney if applicable)
_____GRANDPARENT

Name of Person Establishing Trust: _____

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

Address: _____

City, State, ZIP: _____

County: _____ Email: _____

Phone: _____

Date of Birth: _____ Social Security Number: _____

IF GUARDIAN OR COURT IS ESTABLISHING TRUST (check **all** that apply):

_____The Court will release jurisdiction once the Trust is established; no further court monitoring
_____The Court requires the filing of a trust accounting
_____The Court requires prior approval of all expenditures
_____The Court requires prior approval of trustee fees
_____The Court requires prior approval of attorney fees

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

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. Upon the death of the Beneficiary, assets remaining in the sub-account shall be retained by the Pooled Medicaid Payback Trust in the The Arc of Ohio Inc. Sub-Account to provide for the supplemental needs of individuals with disabilities who lack financial support.

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.

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 THE ARC OF OHIO INC. ACCOUNT OF 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, THE ARC OF OHIO INC., NOR THE TRUSTEE CAN SERVE AS GUARANTOR FOR RECEIVING OR CONTINUING BENEFITS.

Date: _____ _____

Person Establishing Trust Sub-Account

CFMF Agreement Number: _____

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

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 The Arc of Ohio Inc. Account of 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

CFMF Agreement Number: _____

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

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:_____

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: _____

THE THE ARC OF OHIO INC. ACCOUNT OF THE
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.