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 (please mark all that apply):

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:

State:	Date From:	Date To:
_____	_____	_____
_____	_____	_____
_____	_____	_____

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, ley 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

1. Name: _____

Company: _____

Address: _____

_____

Phone (day): _____ (evening): _____

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

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...

___ 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...

___ 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 remainderme n.

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