THE HATTIE LARLHAM ACCOUNT OF THE
COMMUNITY FUND MANAGEMENT FOUNDATION
POOLED MEDICAID PAYBACK TRUST

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 USC 1396p(d)(4)(C), RC 5163.21(F)(3)(a), 42 USC 1382b(e), and the Collective Investment Fund, Section 9.18(c)(4), as any may be amended from time to time. In the event there is a conflict between the Pooled Medicaid Payback Trust Agreement and Joinder Agreement, 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, and any such amendment or restatement shall be retroactively applicable to all Joinder Agreements. This Joinder Agreement is entered into pursuant to, and is exempt under, 42 USC 1396p(d)(4)(C), RC 5163.21(F)(3)(a), and Ohio Adm. Code 5160:1-3-05.2. The assets deposited and held in this Trust Sub-Account shall not be deemed to be available to the Beneficiary.

1. **Agreement Number:** _____ (Assigned by Trust Advisor upon approval)
2. **Trustee:** The Huntington National Bank
3. **Trust Advisor:** Community Fund Management Foundation, an Ohio Non-Profit Corp.

4.a. Person Establishing Trust Sub-Account (check only **one** of the five options)

☐ Parent (skip Section 4.b.)

☐ Grandparent (skip Section 4.b.)

☐ Guardian (attach a copy of the Letters of Guardianship and complete Section 4.b.)

☐ Court (attach a copy of the court order and complete Section 4.b.)

☐ Beneficiary (skip Section 4.b.)
If the Joinder Agreement is signed by the Beneficiary's agent pursuant to a financial power of attorney, please complete Section 4.a. using the Beneficiary/principal's information and attach a copy of the power of attorney. All initials and signatures on this Joinder Agreement must clearly designate that the signer is signing as agent, POA, attorney-in-fact, or words of similar effect.

Name of Person/Entity Establishing Trust Sub-Account: _____

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

Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

4.b. Court Supervision

If a guardian or court is establishing the Trust Sub-Account as identified in Section 4.a., please complete this section. If a parent, grandparent, or the Beneficiary is establishing the Trust Sub-Account, please skip to Section 5.

Please check only **one** of the two options:

☐ **Option 1:** The Court does not require ongoing court monitoring of this trust; **or**

☐ **Option 2:** The Court is retaining supervision of this trust in the following county and case number:

_____

If Option 2 is checked and the Court is retaining supervision, please check **all** that apply:

☐ The Court requires the **trustee** to file a **trust** accounting.

☐ The Court requires the **trustee** to seek prior approval of all trust distributions.

☐ The Court requires the **trustee** to seek prior approval of trustee fees.

☐ The Court requires the **trustee** to seek prior approval of attorney fees.

☐ The Court requires the **guardian** to seek prior approval of trust distributions and/or file an account that includes the trust, but the trustee is not responsible for doing so.

5. Beneficiary Information

5.a. Beneficiary's Name: _____

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

Name and Address of Current Nursing Home, Long-Term Care Facility, or Assisted Living Facility if different than home address: _____

_____

Home Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

Date of Birth: _____ SSN: _____

5.b. Beneficiary's Disability: (check **all** that apply)

☐ Intellectual Disability ☐ Developmental Disability

☐ Mental Health ☐ Other: _____

5.c. The Beneficiary has received Medicaid in the following state(s): (check only **one** of the three options)

☐ The Beneficiary has not yet applied for Medicaid, but we expect Ohio to be the only state

☐ Ohio only

☐ Ohio and the following states: _____

6. Designated Advocate

6.a. The Designated Advocate (DA) is responsible for providing information about the Beneficiary and the government benefits received by the Beneficiary to the Trust Advisor. The DA is the only party who may submit a distribution request and supporting documentation. The DA shall also serve as the Beneficiary Surrogate as defined in RC 5801.01(D) for purposes of receiving notices as required by RC 5808.13. The Person Establishing Trust Sub-Account may change the DA, subject to approval of the Trust Advisor and pursuant to the Trust Advisor's policies. A DA may be an individual or an organization.

Primary Designated Advocate (check either Organization DA or Individual DA):

☐ Organization DA Name: _____

The name of the contact at the Organization DA is: _____

If an organization is nominated, a contact person must be identified. The organization will continue as DA even if the contact person is no longer with the organization. The organization's leadership may change the contact person pursuant to the Trust Advisor's policies.

☐ Individual DA Name: _____

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

Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

Relationship to the Beneficiary: _____

6.b. If the DA is unable to serve, the Person Establishing Trust Sub-Account appoints the following individuals in the order named to serve as Successor DA. *The Trust Advisor strongly recommends naming at least one Successor DA.* If none of the appointees can serve, the last-acting DA may designate a successor pursuant to the Trust Advisor's policies. If no successor is designated, the Trust Advisor may consult with the person who established the Trust Sub-Account, the Beneficiary if a competent adult, the guardian of the Beneficiary, if any, the Beneficiary's service provider, and/or any interested family member of the Beneficiary to appoint a Successor DA.

First Successor Designated Advocate (check either Organization DA or Individual DA):

☐ Organization DA Name: _____

The name of the contact at the Organization DA is: _____

☐ Individual DA Name: _____

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

Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

Relationship to the Beneficiary: _____

Second Successor Designated Advocate (check either Organization DA or Individual DA):

☐ Organization DA Name: _____

The name of the contact at the Organization DA is: _____

☐ Individual DA Name: _____

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

Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

Relationship to the Beneficiary: _____

Third Successor Designated Advocate (check either Organization DA or Individual DA):

☐ Organization DA Name: _____

The name of the contact at the Organization DA is: _____

☐ Individual DA Name: _____

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

Address: _____

City, State ZIP: _____

County: _____ Email: _____

Phone Number(s): _____

Relationship to the Beneficiary: _____

Please attach additional pages if needed to appoint additional successor Designated Advocates.

7. Fees

Fees are based on a published fee schedule. It is available on the Trust Advisor's website. The Trustee and Trust Advisor reserve the right to modify the fee schedule.

8. Distributions for 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.

9. Distributions Upon the Death of the Beneficiary

Federal law, 42 USC 1396p(d)(4)(C), and the 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 Hattie Larlham Sub-Account, to provide for the supplemental needs of individuals with disabilities who lack financial support.

10. Irrevocability of the Trust

This Joinder Agreement shall be irrevocable.

11. Property Transferred to the Trustee

The initial deposit(s) shall be listed on the attached Asset Transfer and Beneficiary Designation Record for the convenience of the Trustee and Trust Advisor.

12. Application of Person Establishing Trust Sub-Account

The undersigned, who is eighteen years of age or older, hereby applies for admission to establish a Trust Sub-Account in the Hattie Larlham Account of the Community Fund Management Foundation Pooled Medicaid Payback Trust with The Huntington National Bank 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, adopts said Agreements, and agrees to be bound by the terms thereof.

The undersigned understands that this Trust Sub-Account will be pooled for investment purposes and that investment products, including shares of mutual funds, are not deposits or obligations of, or guaranteed by, the Trustee, Trust Advisor, or any of its affiliates, nor are the accounts insured by FDIC or any other government agency. The undersigned understands that this Trust Sub-Account involves investment risk, including the possible loss of principal. The Trustee's investment policy shall be available upon request.

The undersigned agrees to provide information necessary to establish this Trust Sub-Account that will allow the Trustee and Trust Advisor to meet their respective requirements under federal and state law, as well as the internal policies of each organization.

The undersigned also understands that the terms of the Trust are intended to comply with all applicable laws and regulations currently in existence, but agency interpretations and laws may change at any time without notice. Neither the Trustee nor the Trust Advisor can guarantee the Beneficiary will receive or continue to receive government benefits.

Date	Signature of Person Establishing Trust Sub-Account

[The remainder of this page is intentionally left blank.]

13. Certification of Person Establishing Trust Sub-Account

This Section must be signed **or** a Department of the Treasury Internal Revenue Service Form W-9 completed on behalf of the Beneficiary must be submitted with this Joinder Agreement. Under penalties of perjury, the Person Establishing Trust Sub-Account certifies that:

1. The Social Security Number identified in Section 5.a. of this Joinder Agreement is the Beneficiary's correct taxpayer identification number; and
2. The Beneficiary is not subject to backup withholding because: (a) the Beneficiary is exempt from backup withholding, or (b) the Beneficiary has not been notified by the Internal Revenue Service (IRS) that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified the Beneficiary that he/she is no longer subject to backup withholding; and
3. The Beneficiary is a U.S. citizen or other U.S. person (defined in Form W-9); and
4. FATCA reporting does not apply to the Beneficiary (described in Form W-9).

You must cross out item 2 above if the Beneficiary has been notified by the IRS that the Beneficiary is currently subject to backup withholding because he/she failed to report all interest and dividends on his/her tax return.

Date	Signature of Person Establishing Trust Sub-Account

[The remainder of this page is intentionally left blank.]

14. Witness or Notary Declaration

This Joinder Agreement and Application for Admission to Establish Trust Sub-Account must be signed by two disinterested witnesses who are present when the Joinder Agreement is signed, or it must be acknowledged by a Notary Public.

On the date indicated below, _____, the Person Establishing Trust Sub-Account, declared to the undersigned that he/she was applying for admission to establish a Trust Sub-Account in the Hattie Larlham Account of the Community Fund Management Foundation Pooled Medicaid Payback Trust. He/she signed this Joinder Agreement and Application for Admission to Establish Pooled Medicaid Payback Trust Sub-Account in our presence with all of us being present at the same time. We now, at his/her request, and in his/her presence and in the presence of each other, subscribe our names as witnesses. We are both eighteen years of age or older. We believe the Person Establishing Trust Sub-Account understands the provisions of the Trust and this Joinder Agreement and is not acting under duress, menace, fraud, misrepresentation, or undue influence.

Date	Signature of Witness #1
	Printed Name of Witness #1
Date	Signature of Witness #2
	Printed Name of Witness #2

OR

Notary Acknowledgment

State of Ohio
County of _____ ss.

Before me, the undersigned Notary Public, personally appeared _____, the Person Establishing Trust Sub-Account, 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, 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

15.a. Neither the Trustee nor the Trust Advisor is authorized to practice law and cannot provide any legal advice. This Joinder Agreement and Application for Admission to Establish Trust Sub-Account must be entered into with the advice of legal counsel. The attorney identified below confirms that he/she is a licensed attorney and represents the Person Establishing Trust Sub-Account with respect to his/her application to the Hattie Larlham Account of the Community Fund Management Foundation Pooled Medicaid Payback Trust. The attorney acknowledges that he/she has informed the Person Establishing Trust Sub-Account that this Trust Sub-Account may only be created for a beneficiary who is a person with a disability as defined in 42 USC 1382c(a)(3). By signing below, the attorney further confirms that he/she has not altered or amended this document in any way.

Date	Attorney's Signature
Phone	Attorney's Printed Name
Fax	Law Firm
Email	Address
	City, State Zip
	County

15.b. Optional Authorization: The Trustee and Trust Advisor will not release information to the above-referenced attorney once the Sub-Account is established unless this Section is signed and dated. If the Designated Advocate identified in Section 6.a. signs and dates this optional Section 15.b., the Trust Advisor will release information when requested to the attorney identified above. The Designated Advocate may revoke this Authorization at any time by notifying the Trust Advisor in writing. In the alternative, the Designated Advocate may sign a separate authorization form provided by the Trust Advisor or may choose not to grant such authority to the attorney.

Date	Signature of Primary Designated Advocate
	Printed Name of Primary Designated Advocate

16. Trust Advisor's Approval

	Community Fund Management Foundation
Date	
	By:

17. Trustee's Approval

The Huntington National Bank, Trustee

Date

By: _____

Trust Sub-Account EIN Assigned by the Trustee
(For Trustee Use Only)

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THE HATTIE LARLHAM ACCOUNT OF THE COMMUNITY FUND MANAGEMENT FOUNDATION POOLED MEDICAID PAYBACK TRUST SUB-ACCOUNT

Asset Transfer and Beneficiary Designation Record

1. **How will this Trust Sub-Account be funded?** Please check **all** that apply.

   □ Check

   □ Annuity (attach a copy of the contract including payment frequency)

   □ Structured Settlement (attach a copy of the contract including payment frequency)

   □ Other: _____

2. **Are the assets funding this Trust Sub-Account owned by or available to the Beneficiary?**

   □ Yes

   □ No. If no, who owns the assets? _____
   Caution: Assets not owned by or available to the Beneficiary may not require Medicaid payback. Please consult your attorney to determine if a Master Trust may be a more appropriate option.

3. **List all checks submitted with this Joinder Agreement and Application for Admission to Establish Pooled Medicaid Payback Trust Sub-Account:**

Check Number	Check Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. **Is a separate check provided for the Trust Advisor's Setup Fee?**

   □ Yes

   □ No. If no, the Trust Advisor Setup Fee will be deducted from the assets for transfer to the Trust Sub-Account identified in Section 3 above.

5. **If the assets initially funding this Trust Sub-Account have a total value of less than $5,000.00, the following statement must be initialed by the Person Establishing Trust Sub-Account:**

_____
Initials

I understand that a Pooled Medicaid Payback Trust Sub-Account initially funded with less than $5,000.00 is called a "Roll-In" Pooled Medicaid Payback Trust. I understand that while a balance of $5,000.00 is not required to be maintained, distributions for the Beneficiary will not be made from the Trust Sub-Account until the cumulative value of the "Roll-In" Pooled Medicaid Payback Trust contributions reaches $5,000.00 or more at least once. The Trustee and/or Trust Advisor may deduct their respective fees as determined by each organization's policies even if the balance has not reached $5,000.00.