NYSARC, INC.
COMMUNITY TRUST III

JOINDER AGREEMENT

IMPORTANT - PLEASE READ CAREFULLY

🚫 **DO NOT** mail deposit checks with this application.
To avoid delays, follow these steps:

Submit application, documents, and E-Deposit form to:
intake@nysarc.org, fax (518) 439-2670, or PO Box 1531 Latham, NY 12110

Mail deposit checks (with a ***New Account Deposit Slip*** **ONLY**) **to:**
PO Box 1788 Albany, NY 12201

Checks or documents sent to the wrong address will delay this application

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Revised January 2026

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P: (518) 439-8323
F: (518) 439-2670

PO Box 1531
Latham, NY 12110

NYSARC, Inc. Community Trust III Joinder Agreement

This is a legal document. It is an agreement pertaining to a supplemental needs trust created pursuant to 42 United States Code §1396. You are encouraged to seek independent, professional advice before signing this agreement.

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **NYSARC, INC. COMMUNITY TRUST III ("CT III")** dated October 23, 2003 and as amended. **This Trust is Irrevocable.**

NOTE: All questions must be answered or your application will be delayed.

1. **Disabled Beneficiary/Donor**: ____

(First Name, Middle Name, Last Name)

Social Security Number: _____-_____-_______

Date of Birth: ____/____/______ (mm/dd/yyyy)

Address: ____

City/State/Zip: ____

Telephone Number of Donor: (_____)_____-_______(Home) (_____)_____-_______(Mobile)

Email Address: ____

County of Residence: _______________________ Place of Birth: _____________________

Gender: _________ Citizenship: _________

Marital Status: ___________ Spouse's name if married: _______________________________

(First Name/Last Name)

2. **Beneficiary's Qualifying Disability(ies)**: ______________________________

3. **Court Order**:

Is the Trust being established as the result of a Court Order? Yes ☐ No ☐

If yes, please include a copy of the Court Order.

4. **Funding: (indicate all that are applicable):**

☐ Surplus monthly income/NAMI deposits

Indicate monthly deposit amount: _______________

☐ Lump Sum

☐ Structured settlement payment (Please provide settlement order.)

☐ Other (e.g. occasional resource deposits)

Describe: ________________________________

Note: This is supplemental information for NYSARC, Inc. purposes only. This amount may be changed at any time with no effect on the Joinder Agreement.

5. **Beneficiary's Income:**

Indicate what sources of income the Beneficiary receives:

Social Security (Indicate Benefit Type)*:

Social Security Retirement Income (SSA)? Yes ☐ No ☐

Social Security Disability Insurance (SSDI)? Yes ☐ No ☐

Supplemental Security Income (SSI)? Yes ☐ No ☐

Social Security Survivor/Dependent Benefits? Yes ☐ No ☐

Provide *copy of Social Security Award letter, indicating your claim number.

Other income? Yes ☐ No ☐

If yes, please provide source, amount and frequency.

____

6. **Benefits:**

Does the Beneficiary receive Medicaid? Yes ☐ No ☐ Pending ☐

If yes, list Medicaid Case #: ______________________________

Please list other monthly benefits that the Beneficiary receives, such as Food Stamps, HUD Section 8, etc.: ____

____

7. **Living Arrangements**: (indicate the living arrangement of the Beneficiary):

Independently (Lives Alone)	☐	CR/IRA/ICF (supervised OPWDD)	☐
With Spouse	☐	CR/IRA (supportive OPWDD)	☐
With Family/Parents	☐	Family Care Program	☐
Assisted Living Facility	☐	Nursing Home	☐
Transitional housing (OMH)	☐	Permanent Supported Housing (OMH)	☐
Inpatient	☐	Subsidized Housing (HUD/Section 8)	☐

Other (explain) ____

If in an OPWDD residential program, does the Beneficiary receive community funds (clothing allowance, personal needs allowance)?

Yes ☐ No ☐ If yes, how much and how often received? ____________________

8. **Beneficiary Services**:

List other services that the Beneficiary receives (include day services, service coordination, employment programs, etc.):

Service	Name of Provider
____________________________	____
____________________________	____

If the Beneficiary has a Representative Payee, please list their name and contact information. ***Note: By listing a rep payee, you authorize NYSARC to communicate with this person regarding your trust account***.

____

____

9. **Guardianship**:

Is there a court appointed Guardian for the Beneficiary? Yes ☐ No ☐

If yes, attach copy of Decree and Letters of Guardianship (Art. 17A) OR Guardianship Order and Commission (Art. 81) and complete the following:

Guardian of the: ☐Person ☐Property ☐Both

Please list name(s) and address(es) of Guardian(s):

____

Are Standby and/or Alternate Standby Guardian(s) appointed? Yes ☐ No ☐

If yes, for the: ☐Person ☐Property ☐Both

Please list name(s) and address(es) of Standby and/or Alternate Standby Guardian(s):

____

10. Representative:

List the individual/firm who is responsible for submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on the Beneficiary's behalf.

Note: The individual listed below will receive a copy of the acceptance letter and a copy of the executed Joinder Agreement.

Name:____________________________________ Phone: (_____) _____-________

Agency/Firm, etc.: ____

Address:____

Email Address: ____

Would you like to add this representative as an authorized contact? Yes ☐ No ☐

Indicate designated permissions: (for authorized contacts only)	Receive Monthly Statements?	Submit Disbursement Requests?	Allow Online Portal Access?
	☐	☐	☐

11. Submit Documents to Medicaid/Agency:

If you would like NYSARC to also send the Trust documents, attach the beneficiary's Medicaid Notice of Decision and/or provide the agency's contact details. You or your representative are responsible for confirming receipt with Medicaid or the relevant agency.

Send to ATTN: ____

Agency: ____

Fax # to: ____

Email to:____

Mail to: ____

12. Authorized Contacts:

Note: You must list at least one authorized contact who can submit requests.

Name: ____________________________________
Address: ____________________________________
City/State/Zip: ________________________________
Home Phone: (______) _______-________________
Cell Phone: (______) _______-________________
Email Address: ________________________________
Relationship: _________________________________

Receive Monthly Statements?	Submit Disbursement Requests?	Allow Online Portal Access?
☐	☐	☐

Name: ____________________________________
Address: ____________________________________
City/State/Zip: ________________________________
Home Phone: (______) _______-________________
Cell Phone: (______) _______-________________
Email Address: ________________________________
Relationship: _________________________________

Receive Monthly Statements?	Submit Disbursement Requests?	Allow Online Portal Access?
☐	☐	☐

Name: ____________________________________
Address: ____________________________________
City/State/Zip: ________________________________
Home Phone: (______) _______-________________
Cell Phone: (______) _______-________________
Email Address: ________________________________
Relationship: _________________________________

Receive Monthly Statements?	Submit Disbursement Requests?	Allow Online Portal Access?
☐	☐	☐

Need to add more contacts? Include an additional page or letter with the same details.

13. **Supplemental Information:**

List one contact to receive the Beneficiary Welcome Packet: ________________________

List one contact to receive the annual tax information: _____________________________

Note: Must be the Beneficiary or an authorized contact listed above.

14. **Monthly Statements:**

Should the Beneficiary receive a copy of the monthly statement? Yes ☐ No ☐

15. **Funeral Provisions:**

Does the Beneficiary have funeral provisions in place? Yes ☐ No ☐

If yes, please provide details (e.g. funeral home, plot location, etc.)

____

Information and Disclosures:

Death of Beneficiary:

Upon the death of the Beneficiary, amounts remaining in the Beneficiary's sub-trust account shall be distributed or retained pursuant to the following:

a. Upon the death of the Beneficiary, the Trustee shall request from the State the dollar amount of any uncompromised/unreduced Medicaid lien which is or would be imposed against the deceased Beneficiary's assets, without regard to the existence of and the Beneficiary's participation in the Trust. The Trustee retains the authority to agree to a compromised/reduce lien amount with the State but shall be under no obligation to do so.

b. Funeral expenses will only be paid pursuant to a Medicaid eligible pre-need funeral arrangement established and funded prior to the Beneficiary's death. **Funeral expenses will not be paid after the Beneficiary's death.**

c. The Trustee shall prepare an accounting and obtain an order for a court of competent jurisdiction fixing the amount of the Medicaid lien pursuant to Section 8.3 of the Master Trust. The cost of the proceeding and preparation of the accounting shall be paid from the sub-trust account.

d. After the information in (a) above is received by the Trust from the State, any remaining balance in the deceased Beneficiary's sub-trust account will be distributed or retained as follows:

    a) If the balance in the deceased Beneficiary's sub-trust account is less than the amount of the money that would be due Medicaid, determined as if this Trust were a 1396(p)(d)(4)(A) self-settled OBRA payback Trust, then all remaining amounts in the deceased Beneficiary's sub-trust account will remain with the Trust and credited to the Trust's "Remainder Sub-Trust Account" to be used in furtherance of the purposes of the Trust.

    b) If the balance in the deceased Beneficiary's sub-trust account is greater than the amount of money that would be due Medicaid, determined as if this Trust were a 1396(p)(d)(4)(A) self-settled OBRA payback Trust, then any remaining amounts in the deceased Beneficiary's sub-trust account will be distributed as follows and in the following order:

        i. First, the trust shall pay to the State(s) from the 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) shall be the first payee(s) of any such funds and the State(s) shall have priority over payment of other debts and administrative expenses except as listed in the POMS SI 01120.203.E.

ii. Second, NYSARC, Inc. will be paid an amount equal to twenty-five percent (25%) of the remaining balance after subtraction of the amount due the state in (i) above.

iii. Third, the balance to be distributed in accordance with the executed Joinder Agreement.

In the event that at my death funds remain in my sub-trust account in an amount sufficient to reimburse Medicaid for all monies, due and owing, and to pay NYSARC, Inc. 25% of any remaining balance after Medicaid is reimbursed, I instruct, the Trustee to disburse the remaining amount to the following named Beneficiaries as follows:

Name and Relationship	Address	Percent
______________________	____________________________	_______
______________________	____________________________	_______
______________________	____________________________	_______
	Percentage Must Total 100%	_______

____

Signature of Trust Participant/Beneficiary[1]

In the event that the Trust Participant/Beneficiary fails to name any Remainder Beneficiary, any amounts remaining in the sub-trust account after payment to the State and NYSARC will be paid to the Trust Participant/Beneficiary's Estate.

Contributions/Deposits:

a. All contributions made to the sub-trust account will be held and administered pursuant to the provisions of the **NYSARC, Inc. Community Trust III** which are incorporated by reference herein.

b. The Trustee shall have the sole and absolute right to accept or refuse additional deposits to the sub-trust account.

c. In the event that a Beneficiary has a zero ($0) sub-trust account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary's sub-trust account.

[1] **Only the Trust Participant/Beneficiary or person who is establishing the trust account on his/her behalf may designate who will receive the balance in his/her sub-trust account.** If the Beneficiary is unable to name a Beneficiary due to medical or any other reason, any remaining balance in the sub-trust account will be paid to the Beneficiary's Estate.

Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming from the prior sub-trust account. Additionally, the Beneficiary shall be required to pay a new enrollment fee when re-opening a sub-trust account.

Disbursements:

a. All disbursement requests shall be reviewed and approved on an individual basis.

b. Disbursements for expenses incurred more than 90 days prior to submission of a disbursement request form shall not be paid.

c. The Trustee, in their discretion, have determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol, tobacco, items relating to illegal activity, bail, or restitution.

d. All disbursements shall be made at the sole and absolute discretion of the Trustee.

e. No disbursements will be made after the death of the beneficiary, even for expenses incurred or due prior to death.

Disability Determination:

In the event that a determination of disability is required for Medicaid purposes, please be advised that administrative fees shall be incurred while the determination of disability is being made.

Taxes:

a. The Donor acknowledges that contributions to the **NYSARC, Inc. Community Trust III** are not tax deductible as charitable gifts, or otherwise.

b. Sub-trust account income may be taxable to the Beneficiary.

Disclosure of Potential Conflict of Interest:

There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the sub-trust account at the time of death of the Beneficiary. Funds remaining in the Trust may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by a **Chapter of NYSARC, Inc.** or by **NYSARC, Inc.** itself.

The Donor(s) acknowledge(s) that under certain circumstances, NYSARC, Inc., in addition to its annual Trustee fee may receive 25% of the funds remaining in the Beneficiary's sub-trust account upon the death of the Beneficiary as a contingent remainderman.

The Donor(s) executing this Joinder Agreement is/are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **NYSARC, Inc.** or with any Beneficiary or constituent agencies and/or Chapters.

Situs:

The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be administered by **NYSARC, Inc.** and a financial institution in the State of New York. The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New York. The situs of this Trust for administrative, account and legal purposes shall be in the County of Albany, the County where the majority of meetings concerning establishment of the Trust occurred.

Invalidity of any Provision:

Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

By signing below, you affirm that you understand and agree to the following:

I have received and read a copy of the Community Trust III Master Trust prior to the signing of this *Joinder Agreement* and acknowledge that I understand the contents thereof. I also understand that said document may be amended from time to time. I have been provided with the applicable fee schedule and the Information & Procedures narrative and acknowledge that I understand the contents thereof. I also understand there may be changes from time to time.

I am entering into this Joinder Agreement voluntarily and acting on my own free accord.

The Donor acknowledges that the Beneficiary is disabled as defined in Social Security Law Section 1614(a)(3) [42 USC 1382c(a) (3)].

Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.

The NYSARC, Inc. Community Trust III is a trust authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept a donor's property pursuant to this Joinder Agreement, NYSARC, Inc. agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation. It is the sole responsibility of the donor and/or the donor's representative to determine whether the donor is "disabled" as that term is defined under federal law, to determine whether they have the legal authority to transfer property to fund the trust, and the impact that a transfer of property to the NYSARC, Inc. Community Trust III will have on the donor's continuing eligibility for government benefit programs.

NYSARC, Inc. is not assuming any responsibility as counsel for the donor or Beneficiary, or providing any legal advice as it relates to the consequences of a transfer of property to the NYSARC, Inc. Community Trust III.

The Trustee in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account. The cost of which may be charged to the sub-trust account.

The party authorized to speak with us on your behalf or the intermediary must notify NYSARC, Inc. immediately upon your death and will be required to provide us with a certified death certificate.

An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.

This Joinder Agreement and the participation of the Beneficiary in the NYSARC Community Trust III is an important legal decision that may have significant and lasting consequences for the Beneficiary and as a result you may want to consider obtaining advice from an attorney or another professional adviser before entering into this Agreement. By signing this Agreement you are acknowledging that you have had a full and complete opportunity to confer with an attorney or other adviser and that no employee of NYSARC, Inc. has provided you (or the Beneficiary, if different from the person signing this Agreement) with any legal advice in connection with this Joinder Agreement, the participation by the Beneficiary in the Community Trust III or the suitability of such participation by the Beneficiary in the Community Trust III based upon the particular circumstances of the Beneficiary.

Who is signing this Joinder Agreement? (Select only one)

☐ Beneficiary ☐ Agent (Power of Attorney) ☐ Legal Guardian ☐ Parent/Grandparent ☐ Court Order

__________________________________ ________________
Signature Date

State of New York)
County of __________________) ss.

On this ____ day of ___________________, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared,

____,
personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within the instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed this instrument.

____
Notary Public

Submit to:
intake@nysarc.org, (518) 439-2670, or PO Box 1531 Latham, NY 12110

*****_Checks must be mailed separately with a **New Account Deposit Slip** to:_
PO Box 1788 Albany, NY 12201

If applicable, this document was translated by:

______________________________ ______________________________
Print Name Sign