

**JOINDER AGREEMENT FOR  
THE FULL LIFE CENTER POOLED SPECIAL NEEDS TRUST**

I, the undersigned, in consideration of the covenants, promises, and representations contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, do hereby adopt The Full Life Center Pooled Special Needs Trust (“Trust”) executed on \_\_\_\_\_, 2023.

I understand that by signing this Joinder Agreement for The Full Life Center Pooled Special Needs Trust, a Trust Sub-Account will be established by me and will be referred to as:

“The Full Life Center Pooled Special Needs Trust f/b/o \_\_\_\_\_.”  
Name of Beneficiary

To be administered in accordance with the terms of The Full Life Center [TFLC] Pooled Special Needs Trust under Agreement dated \_\_\_\_\_, 2023, as amended or restated from time to time, and in compliance with the following laws and regulations: 42 U.S.C. §1396p(d)(4)(C), 42 U.S.C. §1382b(e), R.C. 5163.21(F)(3)(a), and O.A.C. 5160:1-3-05.2(C)(3)(c), as amended from time to time. The nature of the Trust, and compliance with those laws and regulations, are intended to make possible the transfer of assets to this Sub-Account without Medicaid penalty, and to render assets held in the Sub-Account unavailable for certain means-tested public benefit programs.

**1. GRANTOR (Person Establishing the Trust)**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship to the Beneficiary: \_\_\_\_\_

**2. BENEFICIARY**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Date of Birth; \_\_\_\_\_  
Social Security Number (last 4) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Type of Living Situation:** \_\_\_\_\_ Private Residence \_\_\_\_\_ Group Home  
\_\_\_\_\_ Apartment \_\_\_\_\_ Other \_\_\_\_\_

**Current Benefits:** \_\_\_\_\_ Medicaid \_\_\_\_\_ Food Assistance  
(Check all that apply) \_\_\_\_\_ SSI \_\_\_\_\_ Other: \_\_\_\_\_

Please describe the nature of the Beneficiary's disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

U.S. Citizen: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed

**3. BENEFICIARY ADVOCATE**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to the Beneficiary: \_\_\_\_\_

Online access to view statements & activity (Email address is required) \_\_\_\_\_ Yes \_\_\_\_\_ No

**4. FIRST SUCCESSOR BENEFICIARY ADVOCATE**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship to the Beneficiary: \_\_\_\_\_  
Online access to view statements & activity (Email address is required) \_\_\_\_\_ Yes \_\_\_\_\_ No

**5. SECOND SUCCESSOR BENEFICIARY ADVOCATE**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship to the Beneficiary: \_\_\_\_\_  
Online access to view statements & activity (Email address is required) \_\_\_\_\_ Yes \_\_\_\_\_ No

In the event that none of the Beneficiary Advocates are able to serve, the last acting Beneficiary Advocate may appoint a successor in writing. If no successor is designated, the Trust Advisor may nominate a successor Beneficiary Advocate and may consult with the Grantor, Beneficiary, Guardian of the Beneficiary, caseworker and/or any other interested party in order to nominate a successor.

**6. DISTRIBUTIONS DURING THE LIFE OF THE BENEFICIARY**

The income and principal shall be distributed by the Trustee, at the discretion and direction of the Trust Advisor.

**7. DISTRIBUTIONS AT THE DEATH OF THE BENEFICIARY**

Please select either Option A or Option B below for how remaining assets should be distributed at the death of the beneficiary. Place your initials in the box indicating your selection:

	<b>Full Name</b>	<b>Address</b>	<b>Percentage</b>	<b>Grantor Initials</b>
<b>Option A</b>	The Full Life Center, Inc.	349 E. High Avenue New Philadelphia, OH 44663	<b>100%</b>	_____
<b>OR</b>				
<b>Option B</b>	Medicaid reimbursement to any state that paid Medicaid benefits for the Beneficiary.	--	<b>Up to full amount of liability owed</b>	_____

List **Beneficiary** information below for any funds that remain after Medicaid is paid back.  
**Percentages should add up to 100%.**

	<b>Full Name</b>	<b>Address</b>	<b>Primary Percentage</b>	<b>Per Stirpes</b>	<b>Secondary Percentage</b>
Primary Beneficiary			_____%		
Secondary Beneficiaries					_____%
					_____%
Primary Beneficiary			_____%		
Secondary Beneficiaries					_____%
					_____%
Primary Beneficiary			_____%		
Secondary Beneficiaries					_____%
					_____%
Primary Beneficiary	The Full Life Center, Inc.	349 E. High Avenue New Philadelphia, OH 44663	_____%		

**Please Note: It is FLC's policy to retain funds if there are no identifiable, living Beneficiaries.**

**8. IRREVOCABILITY**

This Joinder Agreement shall be irrevocable. It may be amended by the Grantor or Beneficiary, with the approval of the Trust Advisor, to either change or add a Beneficiary Advocate in Paragraph 5.

**9. TRUSTEE IS NOT A GUARANTOR OF BENEFITS**

The terms of the Trust are intended to comply with all current applicable laws and regulations. However, the laws in this area are continually changing as well as the interpretation of those laws. A Trustee cannot guarantee the receipt or continuation of benefits.

**10. DOCUMENTATION**

The Trust Advisor and Trustee retain the right to request documentation such as birth certificates, Letters of Guardianship and proof of identification.

**11. LEGAL ADVICE**

**The Trustee, Trustee Advisor, their employees and/or agents are not permitted to provide legal advice regarding the Joinder Agreement, Declaration of Trust or any other documentation relating to The Full Life Center Pooled Special Needs Trust. The Grantor must seek independent legal counsel to evaluate the suitability of The Full Life Center Pooled Special Needs Trust. Attorney named below acknowledges and confirms that he or she has advised the Grantor regarding the suitability and requirements of establishing such a Trust, including any reporting requirements to agencies which provide government benefits to the Beneficiary.**

\_\_\_\_\_  
Date Attorney's Signature

\_\_\_\_\_  
Phone Attorney's Printed Name

\_\_\_\_\_  
Email Law Firm

\_\_\_\_\_  
Address



Application for admission to establish this Trust sub-account is hereby approved.

**TRUST ADVISOR'S APPROVAL**

The Full Life Center, Inc.

Date: \_\_\_\_\_

By: \_\_\_\_\_

**TRUSTEE'S APPROVAL**

Huntington National Bank

Date: \_\_\_\_\_

By: \_\_\_\_\_