USING A POOLED INCOME TRUST TO ELIMINATE A MEDICAID SPEND-DOWN MARCH 2015

APPENDIX

by

VALERIE J. BOGART, Esq.

Director, Evelyn Frank Legal Resources Program
New York Legal Assistance Group
New York City

NEW YORK LEGAL ASSISTANCE GROUP

USING A POOLED INCOME TRUST TO ELIMINATE A MEDICAID SPEND-DOWN
MARCH 2015

APPENDIX

| 7 HANOVER SQ, 18TH FL NEW YORK NY 10004-4027 |
| TEL: (212) 613 7310 | FAX: (212) 967 0725 | EFLRP@NYLAG.ORG | WWW.NYLAG.ORG |

NEW YORK LEGAL ASSISTANCE GROUP

Pooled Income Trust Home Visit Document Checklist

For your file:

☐ **Retainer**

For the Medicaid application:

☐ **DOH-4220- signed by client**

☐ **DOH-4495a- signed by client**

☐ **MAP-751D- signed by client**

For the Pooled Income Trust application:

☐ **Beneficiary Profile Sheet- signed by client**

☐ **Joinder Agreement- signed by client AND notarized**

☐ **$240 enrollment funds, minimum- check or money order made out to Center for Disability Rights- client can also send to CDR directly**

☐ **ACH/Direct Deposit Request Form- signed by client (if client want auto-withdrawals from their bank account)- client can also send to CDR directly**

☐ **Disbursement Request Form(s)- signed by client, with proof amount is due attached- client can also send to CDR directly**

For submitting the Pooled Income Trust to Medicaid:

☐ **LDSS-486T- to be left with the client for their doctor(s) to fill out and attach 12 months of client's medical records- client sends back to you**

☐ **LDSS-1151- to be left with the client to fill out themselves or with the help of another- client sends back to you**

☐ **3 originals of OCA Form 960- signed AND initialed by client AND provider info left blank**

To give to client for their reference:

☐ **Center for Disability Rights "Frequently Asked Questions"**

☐ **Center for Disability Rights Administrative Fee Schedule**

☐ **Center for Disability Rights Disbursement Information Sheet**

MEDICAL ASSISTANCE PROGRAM
MANAGED LONG TERM CARE(CASA)
785 ATLANTIC AVENUE, 7TH FLOOR
BROOKLYN, NY 11238

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

PROGRAM CODE = 5H9

NOTICE NUMBER:	DATE:	CASE NUMBER:
[redacted]	September 18, 2014	[redacted]

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
5H9		[redacted]	MANAGED LONG TERM CARE-CASA	888-692-6116

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-557-1399
OR Agency Conference	718-637-2426
Fair Hearing information and assistance	718-637-2426
Record Access	718-637-2425
Child/Teen Health Plan	718-557-1399

CASE NAME / AND ADDRESS

[redacted]

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

MEDICAL ASSISTANCE

We have accepted your application dated June 18, 2014 for Medicaid with a spenddown requirement effective June 1, 2014 for:

Name	Client I.D. #
[redacted]	[redacted]

This is because your net income (gross income less Medicaid deductions) of $1,548.23 is over the allowable Medicaid income limit of $809.00. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $739.23. Please look at the budget calculation section to see how your excess income was determined, and read the Sections: "Explanation of the Excess Income Program" and "Optional Pay-In Program.".

Because you have or are expected to have 120 days of community based long term care services, you are required to enroll in a Managed Long Term Care (MLTC) plan. Once enrolled in a MLTC plan, you will have to pay your excess income amount to the plan each month to receive MLTC and Medicaid covered services. These monthly payments must be made as long as you remain enrolled in the MLTC plan, unless you are notified of a change in your Medicaid eligibility. For more information about enrolling in a MLTC health plan, please contact NY Medicaid Choice at 1-888-401-6582.

You have been determined Medicaid eligible for community coverage with community-based long-term care.

Your eligibility for the following services has **not** been determined:

- o Nursing home care, other than short-term rehabilitation
- o Nursing home care provided in a hospital
- o Hospice in a nursing home
- o Managed long-term care in a nursing home

How we figured your Medical Assistance Budget.

Check the information below and let us know if there is anything wrong. If there is a mistake it could mean that the decision we made about your benefit is not correct.

The income amounts should show the actual verified income Amount(s). Because of your Budget Type, all expenses you have may not be used in figuring your budget.

General monthly disregards from income are:

- Non-SSI Budget Types receive a $90.00 disregard from earned income.
- SSI Related Budget Types receive a $65.00 and 1/2 remainder deduction from earned income.
- SSI Related Budget Types receive a $20.00 disregard from income.
- All amounts are counted on a monthly basis. To figure your monthly income we multiply your average weekly income by 4 1/3, or your average bi-weekly income by 2 1/6, etc. The Period used in your budget determines which method was used.

MA NOTICE BUDGET

Date: 06/01/14 TO 05/31/15

Version: 1

Case Name	Case No.	Budget Type	Number in Case
[redacted]	[redacted]	SSI Related	1

EARNED INCOME

Income Source 1	Period	Amount
		0.00

Expenses From Earned Income Source 1

Insurance	Support	Work Expense	Impairment Related Expense	Allowable Child Care
0.00	0.00	0.00	0.00	0.00

Income Source 2	Period	Amount
		0.00

Expenses From Earned Income Source 2

Insurance	Support	Work Expense	Impairment Related Expense	Allowable Child Care
0.00	0.00	0.00	0.00	0.00

UNEARNED INCOME

Source	Period	Amount	Exemption	Amount	Exemption	Amount
S.S. Retirement Benefit	Mnthly	1594.90	Medicare	104.90		0.00
Retirement Benefits	Mnthly	78.23		0.00		0.00

RESOURCES

Resource	Value	Resource	Value
Bank Accounts	6459.92		0.00
Straight Life	4336.11		0.00

CONTINUED ON THE NEXT PAGE ...

Human Resources Administration
Department of Social Services

MAP-2060 (E-S).....Rev. 05/09/08

BUDGET EXPLANATION

CASE NAME: _____ **CIN:** _____

We computed your Medical budget for the period beginning _____ as follows:

GROSS INCOME	AMOUNT
Employment	$
Interest Income	$
Social Security	$
Child Support	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL MONTHLY GROSS INCOME	$
☐ Allowance for disabled, aged or blind persons	$
☐ Work Related Expenses	$
☐ Family Care Expenses	$
☐ Health Care Expenses	$
☐ Child Support Exemption	$
☐ Other (specify):	$
TOTAL MONTHLY DEDUCTIONS ALLOWED TO YOU:	$
Net Monthly Income (gross income minus deductions)	$
☐ The monthly Medicaid allowance for your household is:	$
☐ The monthly FHP allowance for your household is:	$
☐ The monthly FPBP allowance for your household is:	$
☐ The monthly Public Assistance Standard of Need for your household is:	$
☐ The monthly Public Assistance Standard of Need for your household is: (185%)	$

After subtracting the appropriate monthly allowance from your net monthly income, we have determined that your income exceeds this allowance by: $_____

RESOURCES (exempt resources such as money held in a burial fund are not shown below)

Bank Accounts	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL RESOURCES	$
☐ Medicaid Resource Allowance	$
☐ Public Assistance Resource Allowance	$

After subtracting the appropriate resource allowance from your countable resources, we have determined that your resources exceed this allowance by: $_____

(Vea al dorso para ver esta notificación en Español)

MEDICAL ASSISTANCE PROGRAM
STATEN ISLAND MEDICAID OFFICE (R07)
215 BAY STREET
STATEN ISLAND, NY 10301

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

PROGRAM CODE = 531

NOTICE NUMBER: [redacted]	DATE: September 25, 2014	CASE NUMBER: [redacted]		
OFFICE 531	UNIT	WORKER [redacted]	UNIT OR WORKER NAME STATEN ISLAND MEDICAID OFF	TELEPHONE NO. 888-692-6116

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-557-1399
OR Agency Conference	718-637-2426
Fair Hearing information and assistance	718-637-2426
Record Access	718-637-2425
Child/Teen Health Plan	718-557-1399

CASE NAME / AND ADDRESS

[redacted]

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

MEDICAL ASSISTANCE

We have denied your application for Medicaid dated September 12, 2014 for:

Name	Client I.D. #
[redacted]	[redacted]

This is because your net income (gross income less Medicaid deductions) of $1,487.00 is over the allowable Medicaid income limit of $809.00. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $678.00. Also, you do not have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income amount. To qualify for spenddown, you must tell us the amount of your resources if you have not already done so.

This applies to Medicaid recipients who are 65 years of age or older, certified blind or certified disabled.

Please look at the budget calculation section to see how we figured your excess income.

If you incur medical bills in the amount of your excess income, you may reapply.

Please read the Sections: "Explanation of the Excess Income Program" and "Optional Pay-In Program".

This decision is based on Regulation 18 NYCRR 360-4.8.

If your income is too high for Medicaid coverage, you may still be able to get health care coverage.

IMPORTANT INFORMATION - If you applied for Medicaid coverage before January 1,

CONTINUED ON THE NEXT PAGE ...

How we figured your Medical Assistance Budget.

Check the information below and let us know if there is anything wrong. If there is a mistake it could mean that the decision we made about your benefit is not correct.

The income amounts should show the actual verified income Amount(s). Because of your Budget Type, all expenses you have may not be used in figuring your budget.

General monthly disregards from income are:

- Non-SSI Budget Types receive a $90.00 disregard from earned income.
- SSI Related Budget Types receive a $65.00 and 1/2 remainder deduction from earned income.
- SSI Related Budget Types receive a $20.00 disregard from income.
- All amounts are counted on a monthly basis. To figure your monthly income we multiply your average weekly income by 4 1/3, or your average bi-weekly income by 2 1/6, etc. The Period used in your budget determines which method was used.

MA NOTICE BUDGET

Date: 08/01/14 TO 07/31/15

Version: 1

Case Name	Case No.	Budget Type	Number in Case
[redacted]	[redacted]	SSI Related	1

EARNED INCOME

Income Source 1	Period	Amount
		0.00

Expenses From Earned Income Source 1

Insurance	Support	Work Expense	Impairment Related Expense	Allowable Child Care
0.00	0.00	0.00	0.00	0.00

Income Source 2	Period	Amount
		0.00

Expenses From Earned Income Source 2

Insurance	Support	Work Expense	Impairment Related Expense	Allowable Child Care
0.00	0.00	0.00	0.00	0.00

UNEARNED INCOME

Source	Period	Amount	Exemption	Amount	Exemption	Amount
S.S. Retirement Benefit	Mnthly	1611.90	Medicare	104.90		0.00

RESOURCES

Resource	Value	Resource	Value

CONTINUED ON THE NEXT PAGE ...

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION/RECERTIFICATION
(Home Care Services/Managed Long Term Care)

NYC Human Resources Administration
Department of Social Services
MAP-259p (E) 10/16/2012

[redacted]

DATE: 10/3/14.

CASE NUMBER: [redacted]

If you have any questions, call HRA Infoline at 718-557-1399

CHECK PROGRAM AREA
☐ Home Care Services Program
☑ Managed Long Term Care Program

Dear Consumer:

We are sending you this notice to tell you that the Medical Assistance Program will:

☐ **ACCEPT** your Medicaid application/recertification for **full** Medicaid coverage from: _____

For the following person(s): _____

☑ **ACCEPT** your Medicaid application/recertification with a **spenddown** (excess/ surplus income) from: 10.01.14

For the following person(s): [redacted]

We have certified that you have a continuing need for Home Care/Managed Long Term Care Services.

WE HAVE DETERMINED YOUR SPENDDOWN AS FOLLOWS:

A. Total monthly income	$ 2733.35
B. Total monthly deductions	$ 385.90
C. Net Medicaid income (line A minus line B)	$ 2347.45
D. Medicaid level for your household size	$ 809.00
E. Monthly Excess Income (line C minus line D)	$ 1538.45

THIS IS NOT A BILL. DO NOT SEND ANY MONEY TO MEDICAID. YOU WILL RECEIVE A BILL SHORTLY. FOLLOW INSTRUCTIONS ON THE BILL.

You are required to pay your full excess (surplus) income or spenddown in the amount of $ 1538.45 each month to the agency providing your Home Care/Managed Long Term Care services. You will receive your first bill shortly. This bill will be retroactive to the date indicated above and may be for more than one month's service.

This decision is based on Social Services Law or Regulation: 360-4.8(c)

WORKER [redacted]	TITLE CSII	SECTION MLTC

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements, or address.

BE SURE TO READ THE ENCLOSED FORM MAP-2086B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION

BUDGET EXPLANATION

NYC Human Resources Administration
Department of Social Services

MAP-2060 (E) 05/28/2013

CASE NAME: [redacted] **CIN:** [redacted]

We calculated your Medical budget for the period beginning 10.01.14 as follows:

MONTHLY GROSS INCOME	AMOUNT
Employment	$
Interest Income	$
Social Security	$ 941.90
Child Support	$ 9.89
Other (specify): PENSION	$ 1100.84
Other (specify):	$ 31.24
Other (specify):	$ 42.48
TOTAL MONTHLY GROSS INCOME:	$ 2133.35

MONTHLY DEDUCTIONS	AMOUNT
Allowance for disabled, aged or blind persons	$ 20.00
Work Related Expenses	$
Family Care Expenses	$
Health Care Expenses	$ 261.00
Child Support Exemption	$
Other (specify):	$ 104.90
TOTAL MONTHLY DEDUCTIONS:	$ 385.90
TOTAL MONTHLY NET INCOME (gross income minus deductions)	$ 2347.45

MONTHLY ALLOWANCES	AMOUNT
The monthly Medicaid allowance for your household is:	$ 809.00
The monthly Medicare Savings Program allowance for your household is:	$
The monthly Family Health Plus allowance for your household is:	$
The monthly Family Planning Benefit Program allowance for your household is:	$
The monthly Public Assistance Standard of Need for your household is:	$

After subtracting the appropriate monthly allowance from your monthly net income, we have determined that your income exceeds this allowance by: $ 1538.45

(See back of page for resource details, if applicable)

RESOURCES (exempt resources such as money held in a burial fund are not shown below)	AMOUNT
Bank Accounts:	$ 5607.25
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL RESOURCES:	$ 5607.25

RESOURCE ALLOWANCE	AMOUNT
Medicaid Resource Allowance	$ 14,550.00
Public Assistance Resource Allowance	$

After subtracting the appropriate resource allowance from your non-exempt resources, we have determined that your resources exceed this allowance by: $ 0

WORKER (Print) [redacted]	WORKER (Sign) [redacted]	SECTION MCTC
SUPERVISOR (Print) [redacted]	SUPERVISOR (Sign) [redacted]	DATE 10/3/14

Center for Disability Rights, Inc.
Community Supplemental Needs Trust
497 State Street
Rochester New York 14608
Phone: (585) 546-7560
Toll Free: (877) 237-2230
Fax: (585) 546-7567
Email: pooledtrust@cdrnys.org
Website: www.cdrnys.org/pooledtrust

Frequently Asked Questions about the Trust:

What is the Center for Disability Rights Community Supplemental Needs Trust?
Individuals who have too much money to qualify for Medicaid can put the extra money into a special bank account called a Supplemental Needs "Pooled" Trust. The money put into this account is not counted against the person when applying for Medicaid and can be used for other supplemental needs above and beyond what is covered by Medicaid. The Center for Disability Rights, Inc. (CDR), a non-profit organization, has set up such a bank account, maintained by Canandaigua National Bank & Trust, allowing individuals with disabilities to "pool" their money together for investment purposes. Although the funds are pooled together CDR will maintain individual sub-accounts for each person in the trust.

Are trusts legal?
Yes, trusts are used by many people as a tool to reduce assets so that they may apply for public assistance. Supplemental Needs Trusts have been used for years. In 1993, The Congress created an exception under the amendments to the Omnibus Budget and Reconciliation Act (OBRA-93) which specifically authorized the use of Supplemental Needs Trusts for the benefit of individuals who are under the age of 65 and disabled according to Social Security standards. This allows people who would not normally qualify for public benefits, the opportunity to participate in Medicaid funded programs. While Individual Supplemental Needs Trusts are only available to those under the age of 65, CDR's Community Supplemental Needs "Pooled" Trust, authorized by 42 U.S.C. § 1396p (d)(4)(C), is available for people with disabilities of any age.

Who is my point of Contact when I call looking to Speak with Someone from the Pooled Trust?
When calling the Pooled Trust Department we have a direct line which is (585) 546-7560 and you will reach the Customer Service Representatives who will direct your call as appropriate. Please note when using the toll free number listed in the heading of this document, it will take you to the general receptionist who will transfer you to the Pooled Trust Department. Please note all calls are answered in the order they were received and during the first 10 days of the month it may take several days for someone to return your call. During this period please be patient and above all do not call several times per day your call is important therefore shall be returned in a timely fashion! If the Customer Service Representative ever asks if

they can "ticket your call" this means they are sending an electronic message to the necessary individual related to your concern.

When Can the Trust Start Paying Bills & What is the Process?
Once the first deposit is made, allow 10 business days to process any check disbursements. You must submit each request in writing using our Disbursement/Withdrawal Form. CDR's Pooled Trust Sub-Committee will review and approve all your requests for payment. Once approved, you can expect payment within 10 business days. If the bill is a regular recurring monthly expense, to cut down on your paperwork, you can arrange for the bill to be sent directly to CDR. Payment of any bill submitted is always contingent upon availability of sufficient funds in your individual sub-account. Please remember, we cannot give any money from the trust account to the consumer directly. We pay third parties on the consumer's behalf.

Where do I send my bills that I want paid?
You have to send full whole bills with a disbursement form. You can send bills to us by email, fax, regular mail, or if it is more convenient and you live nearby, you can drop them off at the reception desk. You can also change your billing address with your creditors and have the bills come directly to our address. If you select your creditors to send the bill directly to our office, it is important the consumer's name to who it regards must be on the bill(s). Any disbursement form you fill out for a bill is good for one (1) year. When filling out disbursement forms for bills to be paid keep the following tips in mind:
You must fill out one disbursement form for each bill. Question #1 is the consumer who is in the trust. If you would like for us to pay this bill every month please answer yes. You will just have to fill out the disbursement form **once a year if we are paying your bill every month.**
For rents/Mortgages:
The majority of consumers in the trust have their rent/mortgage paid. Most rental/mortgage agencies have no problem with receiving the rent/mortgage a few days past the 1st being that most social security checks arrive after the 1st of every month. We do checks every Tuesdays and Thursdays. Please see your calendar days. Each month will vary.
Please send us a full copy of your updated lease including a disbursement form.

What are Your Fees in Order for Me to Use this Trust?
There is a one-time fee of $200 to join the trust, which is deducted from your initial deposit. There is a $20 monthly maintenance fee, which includes up to four (4) withdrawals per month. If you require more than four (4) withdrawals for a given month, it will cost an additional $10 for all additional withdrawals for the month. Annually in January, CDR will deduct a flat fee of $50 from your trust sub-account to cover our independent audit and tax return filing fees

What documentation is required to open the trust?
- Proof of disability from Social Security or the Department of Social Services.
- The proof of your spend down amount from the Department of Social Services.

- The Beneficiary Profile sheet/Joinder Agreement signed and notarized.
- The deposit into the trust of $240 or the equivalent amount of your spend down.

How do I apply to join the trust?
Please contact CDR's Pooled Trust Department at (585) 546-7560 and a staff member will explain how the trust works and answer any questions you may have. Once you have decided that the trust is right for you or your loved one, you will be asked to complete a Beneficiary Profile Sheet and Joinder Agreement. The Joinder agreement must be notarized. For your convenience, we have a Notary Public who can perform this service with you free of charge. Deliver or mail original completed Profiles / Joinder Agreements, the required documentation and your deposit to:

Center for Disability Rights, Inc.
Pooled Trust Department
497 State Street
Rochester, New York 14608

What happens after the application is received?
A Confirmation letter is sent to the consumer explaining the amount due for deposit together with the Joinder agreement and check disbursement forms for use.

How will I know I have been accepted?
The New Member Specialist of CDR's Pooled Trust Department will notify you in writing of your acceptance into the trust. We will also provide you with a confirmation letter detailing how much your initial deposit should be, including all fees. Upon acceptance, you will receive a fee schedule, Disbursement/Withdrawal Forms and a signed copy of your Joinder Agreement.

Will CDR notify Medicaid and the Department of Social Services when I am accepted?
Yes, we will send a letter to your Medicaid worker confirming your acceptance into the trust. Be sure to include your worker's name and phone number on your Beneficiary Profile Sheet. It is very important that these documents are received and processed by your Medicaid caseworker so that your participation in the trust is recognized. We recommend that you call your Medicaid worker to make sure they got the paperwork. If your worker's contact information changes, be sure to notify CDR's Pooled Trust Department so we can notify the right person.

Can the Trust withdraw money directly from my bank account?
Yes, the Trust has contracted with a third party software allowing us to automatically withdraw funds which can include your spend down amount directly from your bank account via the Direct Deposit form. All that is needed is to fill out an ACH Form with your bank account information, the amount you want us to withdraw, and the day to withdraw it on.

After I am enrolled in the trust, how do I make a deposit?

We encourage direct deposit from your personal bank account; it's very simple check with your bank for electronic funds transfer (EFT). You can also use personal checks, money orders, cashier's checks or certified bank checks drawn on the beneficiary's account, and make payable to CDR's Community Supplemental Needs Trust to make a deposit. **Please don't send cash.**

When can I start requesting payments (distributions) from the trust?
You must submit each request in writing using our Disbursement/Withdrawal Form. You will be provided with these forms upon your acceptance into the trust. CDR's Pooled Trust Sub-Committee will review and must approve all your requests for payment. If approved, you can expect payment within ten business days. If the bill is a regular recurring monthly expense, to cut down on your paperwork, you can arrange for the bill to be sent directly to CDR. Sub-Committee pre-approved recurring expenses will be paid by the due date indicated on the bill. Payment of any bill submitted is always contingent upon availability of sufficient funds in your individual sub-account and your timely submission of the bill for payment. CDR will not be held liable for any late charges or penalties assessed to your accounts. Please allow ten business days to assure time for Sub-Committee review and processing. You will be notified if any expenses you submit cannot be processed for any reason. Please remember, we cannot give any money from the trust account to you directly. We pay third parties on your behalf. Please submit original invoices or receipts with the name of the beneficiary on them along with your Disbursement/Withdrawal Form. Other examples of documentation that would be acceptable for payment include: signed price quotes, copy of a current signed lease agreement which indicates that the beneficiary is a tenant, or a utility bill with the beneficiary's name on it. If you have any questions regarding whether a bill would be reimbursable from the trust feel free to call us.

Can the Trust pay a higher amount than what the bill is for?
No, the Trust can only pay up to the amount that the bill says you owe. We do this to ensure that there is not a possibility that you can go to the company we paid a bill to and ask for a refund. This would result in you having a higher allowable income for Medicaid than stated and could result in you having to repay medical expenses covered by Medicaid that month.

What can my trust funds be used for?
The trust can be used for almost anything that enhances the beneficiary's quality of life without impacting Medicaid or public benefits. You can pay your rent or mortgage, utilities such as electric, gas, heating oil, telephone, and cable or satellite service. The trust can be used for clothing, food, or obtaining additional personal care or services not covered by Medicaid. Money in your trust can even be used to go on vacation. Items the Trust will not in any circumstance pay for are Alcohol, Tabaco, Fire arms, anything related to Illegal activities, or bale. All expenses paid by the trust must be for the sole benefit of the person named as the beneficiary of the trust. To make this process as easy as possible for you, we suggest that you identify a few recurring expenses that can be pre-approved. CDR can pay those regular expenses on your behalf out of the trust. Please remember, once you join the trust and decide what bills you would like the trust to pay,

fill out the Disbursement/Withdrawal Form and attach your bill or invoice. We will work with you if you have questions regarding how to maximize your participation in the trust. CDR's Pooled Trust Sub-Committee will review and approve each withdrawal request on an individual basis. This Sub-Committee has absolute discretion to approve or deny withdrawal requests. Again, those are the Government's rules. Your Master Trust Agreement details the responsibilities and authority of the Trustee. We can work with you to figure out how you can avoid denials and best get your needs met while still working within the rules of the trust.

What is the benefit of having a Community Supplemental Needs "Pooled" Trust?
Some individuals may be able to set up an Individual Supplemental Needs Trust, but there are benefits to using a pooled trust:

- Cost: The start-up fees to join CDR's pooled trust are substantially lower than the cost of setting up an individual trust. CDR has a $200 initial fee to join the trust and a monthly maintenance fee of $20 per month. The maintenance fee includes up to four withdrawals each month. If you make additional withdrawals during a month they will cost an additional $10 per withdrawal. Every January, CDR deducts a flat fee of $50 to cover our independent audit and tax return filing fees. These costs are much lower than setting up your own individual trust with an attorney. **The minimum deposit needed to open the trust is $240 or spend down amount if it is more than $240.**
- Reporting requirements: A Supplemental Needs Trust requires someone other than the individual to manage it. This person is called the trustee. When you set up a trust, the trustee is responsible for handling all of the reporting requirements. As part of CDR's trust, we do all of that work because we are the trustee. When you enroll, CDR sends a letter to your Medicaid worker confirming your participation in the trust. We also send an annual summary of all deposit and withdrawal activity in your sub-account to your Medicaid worker at the time of your Medicaid recertification. If you are eligible for a trust but don't have someone who will be able to serve as the trustee, CDR's pooled trust is a good option.
- Age: An individual Supplemental Needs Trust requires that you be under the age of 65. After you turn 65 you can no longer contribute to the trust. There are no age requirements to join our pooled trust. This is the only type of trust that people over age 65 can use. CDR's pooled trust may make sense for you if you are nearing age 65 or want a trust that you'll be able to use when you get older.

How do I qualify to participate in the trust?
You can have any type of qualifying disability as long as your doctor has evaluated your condition and determined that you are disabled. If you were born with a disability you may already receive Supplemental Security Income (SSI) or Social Security Disability (SSD) benefits. If you are over age 65 and have only received Social Security Retirement Benefits, you may not have gone through the disability determination process. If you have not been previously determined to be disabled and you are applying for the first time you must bring the Determination of Disability Application and the Disability

Interview Form to your doctor. Your doctor will use them to identify and document your disability. CDR can provide you with these forms if you do not have access to a computer or you may come in to our offices and use our public computers. After these forms are completed, you will take them to your Medicaid worker who will submit your application for public benefits. These forms can be intimidating, especially if you are navigating through the process for the first time. If you need guidance with this process, the CDR Independent Living Department can help who can be contacted at (585) 546-7510 and ask to speak to the on-call staff for the Independent Living Department

Who could benefit by joining the trust?

Several different groups of people could benefit from joining this trust:

- People who "spend down" to qualify for Medicaid. Some people "spend down" to get Medicaid services such as home care or other community-based long term care services because their monthly income or assets are over the limits established by the Government to get public assistance. Each month, these individuals need to pay for some of their own medical expenses and submit receipts or give the county a check for the difference. Instead, these individuals could put that money into CDR's Community Supplemental Needs "Pooled" Trust. Once the money is in the trust, it becomes exempt which means that it is not counted by Medicaid. The person becomes eligible for Medicaid benefits and services while still being able to use the money put into the trust for their personal benefit.
- Families caring for a child with a developmental disability can use the trust for estate planning purposes. They can put money in the trust and use it for their child's future expenses. These resources will not prevent the child from qualifying for Medicaid.
- People over the age of 65 can use this trust instead of paying a Medicaid "spend down." A Pooled trust is the only trust option for disabled persons over the age of 65 who have income or assets which are above the established Medicaid limits. It is an ideal solution for seniors who need long term care services, but wouldn't be able to maintain their home with the money Medicaid would allow them to keep. The trust allows them to do both!
- People with HIV/AIDS or other medical conditions that may have high medical expenses may benefit by joining our pooled trust. They can put money in the trust and use it for their future expenses. These resources will not prevent them from qualifying for Medicaid.

I heard that only people with developmental disabilities can use a trust. Is that true?

No, Supplemental Needs Trusts have been much more widely publicized within the developmental disabilities community as a tool to assist parents with getting public assistance benefits for their developmentally disabled children. You can have any type of qualifying disability as long as your doctor has evaluated your condition and determined that you are disabled and you follow the Determination of Disability process outlined above (if necessary).

Do I need an attorney to join the trust?
If you believe that joining this trust may be a good idea, an attorney can help you make that decision. The trust is a legal contract therefore we recommend you seek legal advice before signing the Joinder Agreement.

Can I pay a yearly fee of $240.00 and receive 48 checks for the entire year instead of $20.00 a month for 4 checks?
This is not currently an option for Trust members. We have looked into making this a possibility; however it is in the consumer's better interest not to do so. If we were to offer such an option, it would require additional work making it necessary to hire more staff in order to manage this information properly. This additional position would cause us to raise our fees which we do not want to do. Additionally, this would lead to people asking us to roll over the remaining disbursements from year to year creating a liability adding additional work onto the staff members that make CDR's annual statement.

It doesn't seem like CDR gets a lot of fees for doing this, so what does CDR get out of providing the trust?
CDR's mission is to work for the full integration, independence, and civil rights of people with disabilities. One of the most compelling reasons we decided to do this was some people have ended up in nursing homes because they didn't have enough money to keep their housing after they qualified for Medicaid. There wasn't a pooled trust available locally and by making it available, this addresses the problem and provides a way to help seniors and people with disabilities stay in their homes.

Does my account earn interest?
The Canandaigua National Bank & Trust is the co-trustee with CDR. The sub-accounts themselves do not earn interest. All the funds are pooled together in a master account at the bank which earns more interest annually than any individual sub-account would. The interest earned on the main account is then divided between the sub-accounts based on individual balances, so every participant gets a proportionate share of the interest.

It seems foolish that I need to open a trust account and send you money to pay my bills. Can't I just pay my bills directly?
It may seem unnecessary, but those are the rules that the Government set up for these trusts. If you didn't use the trust, those funds would have to pay for medical expenses for you to qualify for Medicaid. By putting this money in the trust, you get to use it for your personal benefit and still qualify for Medicaid.

If the Trust can pay bills at different places, does CDR set up accounts for me?
No, although you can request that CDR's Pooled Trust pay specific bills, CDR does not set up either corporate or personal accounts on your behalf. For example, the Pooled Trust may be used to pay your RG&E bill. The RG&E account is not set up by CDR for you. Instead, you set up your own account and forward the bills to CDR for payment. CDR does not set up individual accounts for you because we are not authorized to make transactions on your behalf. A guardian or Representative Payee might do this, but they are legally empowered to do this whereas CDR is not. You control where the funds go

using the Disbursement Form. CDR does not set up corporate accounts because we cannot assume liability for your transactions. CDR can make payments for you based on the funds you have available in the account, but is not legally responsible for any debts you may incur. You can access the funds from the CDR Pooled Trust, but just like with a bank account, you need to set up your own arrangements with individual vendors.

Can I withdraw money from my account to use as cash?
No, payments cannot be issued directly to you as the beneficiary. If we gave you cash that money would be counted as income for the purposes of qualifying for Medicaid and you would have to give it to the Department of Social Services. All payments must be made to third parties or vendors such as department stores, grocery stores or pharmacies. For example, if you wish to purchase a reclining lift chair for your home from a medical supply shop, we could pay the medical supply shop for you through your account, using the invoice you provide with our Disbursement/Withdrawal Form.

Can I buy holiday gifts for my children or grandchildren or give a check to a family member as a gift from my trust account?
No, the trust can only be used for the benefit of the beneficiary. However, you can do whatever you want with the money that you keep to live on each month. Instead of using the trust to purchase holiday gifts, we would encourage you to pay allowable large monthly bills, like utilities, with the money available in the trust. Then you could use your own money to buy gifts. If you are concerned about having enough money during the holidays you could open a "Holiday Club" account with your bank or set aside money in your savings account to use for gifts for your family and friends.

Can I use the trust account to go on vacation?
Yes, you can use the trust to pay for vacation expenses for the beneficiary, including hotel, food, transportation, airfare, admission to events, parks, etc. If it is medically necessary, you can even use the trust to pay for personal assistance services while on vacation if Medicaid will not pay for them.

Can the trust be used to buy gift cards for stores or restaurants?
No, gift cards cannot be purchased with trust funds. The trust can be used to pay for lay-away orders at department and grocery stores or pharmacies as long as the purchase is for the beneficiary's use and it is not payable by Medicaid. Keep in mind the trust is best utilized by paying larger recurring monthly expenses, due to the administrative costs associated with making more than four withdrawals in a month.

My mortgage is paid. Can I pay my property taxes with the trust?
Yes, the trust can be used to pay property taxes.

What can't the trust pay for?
Your trust is designed to enhance the quality of your life and allows you to pay for things that Medicaid does not cover. So, activities which are not usually associated with a healthy lifestyle or which are illegal cannot be paid for with funds from the trust. Expenses which cannot be approved from the trust include payment for the purchase of

firearms, alcohol, tobacco, illegal drugs or drug paraphernalia. The trust also cannot pay legal fees related to illegal activities, restitution or bail. The trust is set up for the beneficiary so the trust cannot pay for expenses or products for anyone other than the beneficiary. The trust also cannot pay for pre-existing credit card debt, fees associated with overdrawn bank accounts, debit card charges, or cash advances taken on credit cards. Feel free to call us with questions if you are not sure if an expense would be payable.

What kind of statements will I receive?
You will receive monthly statements 30 days after the end of each month. Your statement will include a summary of all the activity in your sub-account for the month. You may need these statements for your annual recertification for Medicaid, please keep them in a safe place. You can direct us to send a copy to someone you designate who could hold them for you if you prefer. We will also send a summary of all deposits to your Medicaid worker at the time of your recertification.

What happens if I decide to leave the trust?
You may stop contributing to the trust account at any time. If the beneficiary has a zero ($0) balance for sixty (60) or more consecutive days, we reserve the right to close the sub-account. We must immediately report to your Medicaid worker that you are no longer participating in the trust as this may affect your eligibility for some Medicaid programs. If you decide to re-open the account, you may be required to pay any outstanding administrative fees stemming from the prior sub-account and you may also be required to pay a new enrollment fee.

What if I move out of state?
This is complicated because every state has different laws regarding administration of public benefits. If you move out of state, you won't be able to make withdrawals from the trust until appropriate arrangements can be made. If you are planning to move, let us know so we can help you make the necessary arrangements early.

What if I move into a nursing home?
If you are over 65, receive community-based Medicaid and participate in this trust, New York State has confirmed there will be no transfer penalty if you later enter a nursing home. Transfer penalties have been a concern for persons over the age of 65 who placed their excess income into a trust and later entered a nursing home. This is described in General Information System 2008 MA/020: Transfers to Pooled Trusts by Disabled Individuals Age 65 and Over, but in a nutshell, all the monthly deposits made into the trust were combined into a big penalty amount, which would disqualify the person from having Medicaid pay for nursing home care for a period of time. The period of time was determined by the total amount of the deposits compared to the cost of nursing home care. This period of disqualification was called the penalty period. This means that trust participants over age 65 who entered a nursing home would have been responsible to pay for the cost of their nursing home care for the entire length of this penalty period, until now! The State Medicaid Program has confirmed that the use of pooled trusts by people over 65 will not automatically trigger the transfer penalty if they later enter a nursing

home. Please remember that in order to avoid any other penalties you must ensure that the money you place in the trust is spent on your monthly expenses. Do not save large amounts of money in the trust or these unused amounts will be subject to a penalty if you later enter a nursing home. For example: You place your $500 monthly spend-down into the trust for two years. Your deposits total $12,000 and your total withdrawals from the trust each month for rent and utilities equal $450 per month totaling $10,800. The difference between your deposits and the total withdrawals made on your behalf is $1200. If you entered a nursing home, this $1200 would be subject to the transfer penalty. To avoid the penalty, assure that the money you deposit each month is spent on your behalf and do not allow it to accumulate.
Once you enter a nursing home, you must stop making deposits into the trust. You may continue to request withdrawals from the remaining money in the trust until the account is exhausted. Once the balance is spent, your trust account will be closed.

What happens to my trust funds when I die?
Any money left in the trust at the time of your death will be used to further the purposes of the trust as indicated in your Joinder agreement. This means that no more withdrawals can be made after your death for any reason. You can plan ahead for death and burial expenses and we can assist you with making some of these arrangements in advance, as the trust can be used to pre-pay or fund a burial account.

Does This Trust Have Anyone Who Can Assist when I have Social Services Office Issues?
Yes, there is the Pooled Trust Advocate who assists the consumers with filing Fair Hearings in their county or contacting their county Department of Social Services (DSS) to inquire further information related to the situation.

Are there any other advantages to being in this Pooled Trust?
Yes, as a member of the Pooled Trust the consumer is eligible to enroll in the Medicare Savings Program (MSP). This program assists the eligible consumer with paying for Medicare premiums, co-insurance, and deductibles. It is to the consumer's best interest to enroll in a MSP because it saves them a monthly amount of $104.90 increasing their income which allows for payment for additional approved items.

Is there someone in the Trust I can contact to help stay out of a Nursing Home?
Yes, there is a Pooled Trust staff member dedicated to helping consumers facing this issue. This staff member will aid in providing the necessary resources available to the consumer to prevent this from occurring.

What if I have more questions?
Call the Pooled Trust Department at (585) 546-7560 and we will answer any questions you have about the pooled trust.
Revised: September 2014

Center for Disability Rights, Inc.

Community Supplemental Needs Trust
Schedule of Administrative Fees

Note: All fees will be automatically deducted from each Trust Sub-Account

Enrollment Fee to set up Trust Sub-Account **(Fee deducted on date when first deposit is credited)**	**$200.00**
Monthly Trust Sub-Account Maintenance Fee (includes up to Four withdrawals from account each month) **(Initial fee deducted on the date when first deposit is credited and then deducted on the 1st day of each month)**	**$20.00**
Fee for each Additional Monthly Withdrawal (four are included with Monthly Maintenance Fee) **(Fee deducted on last day of each month)**	**$10.00**
Fee for each Additional Copy of Monthly Statement (one is included in the Monthly Maintenance Fee) **(Fee deducted on date when the statement is mailed, emailed, or faxed out)**	**$5.00**
Annual CDR Trust Audit and Tax Return Filing Fee **(Deducted from each Trust Sub-Account on January 15)**	**$50.00**
Returned Check or ACH	**$40.00**
Stop Payment	**$40.00**
Copy of Cancelled Check	**$10.00**

Reminders:
A $20.00 minimum balance must be maintained in each sub account.

It a Trust Sub-Account has a zero balance for sixty or more consecutive days, the trustee shall retain the right to permanently close the Beneficiary's Trust Sub-Account.

Effective 1/1/2014 – 12/31/2014

Rochester Office 497 State Street Rochester, New York 14608 (585) 546-7560 V/TTY (585) 546-7567 FAX
Edgerton Community Center 41 Backus Street Rochester, New York 14613 (585) 546-7510 V/TTY (585) 458-8046 FAX
Albany Office 99 Washington Avenue, Suite 806B Albany, New York 12210 (518) 320-7100 V/TTY (518) 320-7122 FAX
Geneva Office 34 Castle Street Geneva, New York 14456 (315) 789-1800 V/TTY (315) 789-2100 FAX
Corning Office 23 West Market Street, Suite 103 Corning, New York 14830 (607) 654-0030 V/TTY (607) 936-1258 FAX

CENTER FOR DISABILITY RIGHTS, INC.
COMMUNITY SUPPLEMENTAL NEEDS TRUST

(A Trust for Persons with Disabilities)

BENEFICIARY PROFILE SHEET AND

COMMUNITY SUPPLEMENTAL NEEDS TRUST

AMENDED AND RESTATED JOINDER AGREEMENT

Center for Disability Rights, Inc.
497 State Street
Rochester, NY 14608
Telephone: 585-546-7560
Facsimile: 585-546-7567
E-mail: Matthew Albright malbright@cdrnys.org

{1767139:}

Beneficiary Profile Sheet

1. Name of Donor (Generally same as Beneficiary): SALLY GALYN

   Social Security No. of Donor: 123-45-6789

   Address of Donor: 7 HANOVER SQUARE, NY, NY 10004

   Telephone Number of Donor (day): 212-123-4567 (evening): SAME

   Email: N/A

2. Name of Disabled Beneficiary (In-Kind Beneficiary): SALLY GALYN

   Disabled Beneficiary's Social Security Number: 123-45-6789

   Address: 7 HANOVER SQUARE, NY, NY 10004

   Telephone Number of Beneficiary (day): 212-123-4567 (evening): SAME

   Email: N/A

3. County of Residence: NEW YORK

   Date of Birth: JANUARY 1, 1920

   Gender: FEMALE

4. Is the purpose of establishing this account to shelter monthly income? Yes ✓ No ____

   Indicate estimated monthly deposit. $1352

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

5. Beneficiary Income:

   Does the Beneficiary receive Supplemental Security Income (SSI)? Yes ____ No ✓

   Does the Beneficiary receive Social Security Disability Income (SSDI)? Yes ____ No ✓

   Does the Beneficiary receive Social Security Retirement Income (SSA)? Yes ✓ No ____

Does the Beneficiary receive any other income? Yes ✓ No ____

If yes, please provide detail: PENSION #300/MONTH

Does the Beneficiary receive Medicaid? Yes _____ No _____ Pending ✓

If yes, list Medicaid card number: _____

If the Beneficiary receives other benefits or entitlements, such as Food Stamps, HUD Sec. 8, etc. list these benefits and monthly amounts: FOOD STAMPS #75/MONTH, SCRIE

6. Indicate the living arrangement of the Beneficiary:

Lives Independently ✓	Lives with parents or other family _____
Family Care Program _____	CR/IRA/ICF (supervised) _____
CR/IRA (supportive) _____	Nursing Home _____
Assisted Living Facility _____	Other (explain) _____

Does the Beneficiary receive a personal allowance as part of residential care? Yes ____ No ✓

If yes, how much is it and how often received? _____

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

Service	Name of Provider
NONE	

8. a. Is there a court appointed Guardian for the Beneficiary? Yes ____ No ✓

If yes, attach copy of Decree or Letters of Guardianship and complete the following:

If yes, for the Person_____, Property_____, Both_____

If specific powers/authority is granted please list:

(Include dental and medical) _____

If specific powers/authority is exempted please list:

(Include dental and medical) _____

Please list name(s) and addresses of Guardian(s). _____

_____

_____

b. Are Standby Guardian(s) appointed? Yes _____ No ✓

If yes, for the Person_____, Property_____, Both_____

Please list name(s) and addresses of Standby Guardian(s).

_____

_____

c. Are Alternate Standby Guardian(s) appointed? Yes _____ No _____

If yes, for the Person_____, Property_____, Both_____

Please list name(s) and addresses of Alternate Standby Guardian(s).

_____

_____

9. Relationship of Donor to Beneficiary? SELF

{1767139:}

10. Who is authorized to speak with us on behalf of the Donor and Beneficiary? (Please include address and phone number)

For Donor:

Agency/Individual	Address/Phone #	Relationship
JOHN GALYN	SAME AS DONOR/BEN.	SPOUSE
JOE LAWYER	123 LAW FIRM WAY NY, NY 10004 (212) 567-8912	ATTORNEY, BROWN & WILLIAMS LLP

For Beneficiary:

Agency/Individual	Address/Phone #	Relationship
SAME AS ABOVE		

If you would like monthly statements and tax information sent to above person(s), rather than Donor and Beneficiary, check here ✓. (Indicate who if more than one contact is listed).

Is this person authorized to make disbursement requests on behalf of Donor and Beneficiary?

Yes ✓ No ____ JOHN GALYN ONLY

11. Who will be submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on behalf of the Beneficiary?

Name: JOE LAWYER Phone #: (212) 567-8912

Agency/Firm, etc. BROWN & WILLIAMS LLP

12. If this is a Medicaid trust, please list who the trust documents should be sent to:

Name: JOE LAWYER Phone #: (212) 567-8912

Agency/Firm, etc. BROWN & WILLIAMS LLP

13. Does the Beneficiary have funeral provisions in place (pre-paid funeral, burial plot, etc.?)

Yes ✓ No ____

If yes, briefly describe and list contact information PRE PAID FUNERAL AGREEMENT & BURIAL PLOT

14. Is there a life insurance policy in place for the Beneficiary? Yes ✓ No ____

If yes, provide the name and address of the life insurance beneficiary and the insurance company and policy number: JOHN GALYN - BENEFICIARY - ADDRESS SAME AS SALLY, PRUDENTIAL #30313233

15. What is the beneficiary's primary disability? CONGESTIVE HEART FAILURE

Please list all secondary disabilities SPINAL STENOSIS, DIABETES, OSTEOPOROSIS, ARTHRITIS

I certify that the information provided above is accurate and complete to the best of my knowledge and that I choose an Independent Living Plan of Personal Resource Management.

Sally Galyn — Beneficiary Signature

10/10/2014 — Date

Donor Signature (if different from Beneficiary)

Date

THE CENTER FOR DISABILITY RIGHTS, INC.
COMMUNITY SUPPLEMENTAL NEEDS TRUST
(A TRUST FOR PERSONS WITH DISABILITIES)

Amended and Restated Joinder Agreement

NOTE: 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. ADDITIONALLY, THE CENTER FOR DISABILITY RIGHTS, INC. MAY NOT ACCEPT THIS JOINDER AGREEMENT UNLESS YOU HAVE A LEGAL REPRESENTATIVE.

The undersigned hereby adopts and enrolls in and establishes a Trust Account under the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST** originally dated, June 5, 2008, as amended and restated on June 26, 2013, this Trust being incorporated herein by reference. **THIS TRUST IS IRREVOCABLE.**

1. Name of Donor (Generally same as Beneficiary): SALLY GALYN

   Social Security No. of Donor: 123-45-6789

   Date of Birth: JANUARY 1, 1920

   Address of Donor: 7 HANOVER SQUARE, NY, NY 10004

   Telephone Number of Donor (day): 212-123-4567 (evening): SAME

   Email: N/A

2. Name of Disabled Beneficiary (In-Kind Beneficiary): SALLY GALYN

   Disabled Beneficiary's Social Security Number: 123-45-6789

   Date of Birth: JANUARY 1, 1920

   Address of Beneficiary: 7 HANOVER SQUARE, NY, NY 10004

   Telephone Number of Beneficiary (day): 212-123-4567 (evening): SAME

   Email: N/A

3. Fees shall be paid in accordance with the fee schedule, published by the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as it may be amended from time to time.

4. To the extent that amounts remaining in a Beneficiary's account upon the death of the Beneficiary are not retained by the trust and credited to the Remainder Sub-Trust Account, to be used in furtherance of the purpose of the Trust, the Trust shall pay to the States from such deceased Beneficiary's account any remaining amounts equal to the total amount of medical assistance paid on behalf of the Beneficiary under the respective States' plans pursuant to 42 U.S.C. §§ 1396 *et seq.*, with reimbursements to the States to be made in proportion to the amounts of medical assistance each provided to the Beneficiary.

5. Contributions/Deposits:

   a. All contributions made to the Trust Account will be held and administered pursuant to the provisions of the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, originally dated June 5, 2008, as amended and restated on June 26, 2013. The provisions of the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as amended and restated, are incorporated herein by reference.

   b. The Trustee shall have the sole and absolute right to accept or refuse additional deposits to the Trust Account.

   c. In the event that a Beneficiary has a zero ($0) account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary's Sub-Trust account. 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 may, in the Trustee's sole and absolute discretion, be required to pay a new enrollment fee when re-opening a Sub-Trust account.

6. Disbursements:

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

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

   c. The Trustee, in its discretion, has 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.

7. Disability Determination:

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

8. Miscellaneous:

Amendments:
Provisions of this Joinder Agreement may be amended by the parties hereto in writing, so long as any such amendment is consistent with the Master Trust, as amended.

Taxes:

a. The Donor acknowledges that contributions to the **CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**, as amended are not tax deductible as charitable gifts, or otherwise.

b. Sub-Trust account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice may be needed.

9. 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 **Center for Disability Rights, Inc**.

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 the Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **Center for Disability Rights, Inc.** or with any Beneficiary.

10. Situs: The Sub-Trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be initially administered by **Center for Disability Rights, 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, accounting and legal purposes shall be in the County of Monroe, the County where the majority of meetings concerning establishment of the Trust have occurred.

11. 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.

I have received and reviewed a copy of the Community Supplemental Needs Trust Master Trust, as amended and restated, prior to the signing of this Amended and Restated Joinder Agreement. I acknowledge that I understand the contents of all of the trust documents. I also understand that said trust documents may be amended from time to time.

By signing below, the Donor acknowledges that the Beneficiary is disabled as defined in Section 1614(a)(3) of the Social Security Act [42 U.S.C. § 1382c(a)(3)].

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

By signing below, you agree and understand that the Community Supplemental Needs Trust, as amended, 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, Center for Disability Rights, Inc. agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement, as amended, 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, and to determine the impact that a transfer of property to the Center for Disability Rights, Inc. Community Supplemental Needs Trust, as amended, will have on the Beneficiary's continuing eligibility for government benefit programs. By your signature below, you agree and understand that Center for Disability Rights, 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 Community Supplemental Needs Trust, as amended.

Sally Galyn — SIGNATURE OF DONOR/GUARDIAN

SELF — RELATIONSHIP TO BENEFICIARY

10/10/2014 — DATE

State of New York)s
County of NEW YORK)

On this 10th day of OCTOBER, 2014, before me, the undersigned, a Notary Public in and for said State, personally appeared, SALLY GALYN 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 the instrument.

Joe Lawyer
Notary Public

FOR OFFICE USE ONLY

CENTER FOR DISABILITY RIGHTS, INC., as Trustee

DATE

Date Received: _____

Date Accepted: _____

Initial Funding: _____

Center for Disability Rights, Inc.

Community Supplemental Needs Trust
ACH request Form

1. Name and address of the beneficiary:
   SALLY GALYN
   7 HANOVER SQUARE, APT 7
   NY, NY 10004
2. Email Address (*optional*): N/A
3. Do you want CDR to pull this amount [ ] **Immediately** and/or [✓] **Each Month**
   *-If you selected **Immediately** CDR will pull the funds from your account when we receive the form*
4. If you selected **Each Month** above what day of the month: 4th
5. What month do you want to start it in: NOVEMBER
6. Amount Requested: $ 1352.00
7. Bank Routing Number (*9 digits*): 000000001
8. Bank Account Number: 1234567891011

Sally Galyn — Signature of beneficiary or legally responsible person

10/10/2014 — Date

By signing this form, I attest that I agree to have the Center for Disability Rights withdraw the amount stated immediately or on the date I indicated each month. I understand that it could take up to 3 days for the ACH to fully process and that I will only have access to the funds after the funds have fully cleared. I also agree to pay any fee that might result from a NSF or an ACH Revoke/Unauthorized Fee.

Supplemental Needs Trust Fax Number: 585-546-7567.

Center for Disability Rights, Inc.

Community Supplemental Needs Trust
Disbursement/Withdrawal Form

1. Name and address of the beneficiary (**Person who's name is on trust account**):

   SALLY GALYN
   7 HANOVER SQUARE, APT 7
   NY, NY 10004

2. Amount requested: $1000.00

3. Do you want CDR to pay this bill every month? [✓] Yes [ ] No
   You must send a bill in each month if you want it paid. If we have a lease or rental agreement on file then a bill is not needed for rent only.

4. Describe what the request is for: RENT
   (Examples: Utilities, Phone, Rent, Clothing, Food)

5. If this request is for rent please state the month to be paid NOVEMBER

6. Name and Address of the business or person to whom the check should be made out:

   SUE LANDLORD
   7 HANOVER SQUARE, APT 1, NY, NY 10004

Sally Galyn — Signature of beneficiary or legally responsible person
10/10/2014 — Date

By signing this form, I attest that payment from the trust is being used for the benefit of the trust beneficiary identified on this form and no other individual. I further attest that the funds are not paying for:

- an expense that Medicaid would cover;
- the purchase of firearms, alcohol, tobacco, illegal drugs, or drug paraphernalia; or
- legal fees relating to illegal activities, restitution, bail, credit card debt prior to enrollment in the trust, fees associated with overdrawn bank accounts, debit card charges, or cash advances taken on credit cards.

For Trustee Use
Date approved by Board of Trustees: _____
Approval by trustees of payment to this vendor for this type of purchase will be valid for one year.

Rochester Office 497 State Street Rochester, New York 14608 (585) 546-7560 V/TTY (585) 546-7567 FAX
Edgerton Community Center 41 Backus Street Rochester, New York 14613 (585) 546-7510 V/TTY ((585) 546-7567 FAX
Albany Office 99 Washington Avenue, Suite 806B Albany, New York 12210 (518) 320-7100 V/TTY (585) 546-7567 FAX
Geneva Office 34 Castle Street Geneva, New York 14456 (315) 789-1800 V/TTY (585) 546-7567 FAX
Corning Office 23 West Market Street Suite 103 Corning, New York 14830 (607) 654-0030 V/TTY (585) 546-7567 FAX

Revised 6/13

Disbursements Information Sheet

ALL DISBURSEMENTS MUST BE FOR THE BENEFIT OF THE PARTICIPANT IN THE TRUST AND THEY MUST BE PAID TO THIRD PARTIES.

In order to pay any disbursement we must have on file:

1) **Disbursement form-** *completed and signed.* Please use the disbursement form that you can find on the CDR website at cdrnys.org\pooledtrust.
2) **Complete invoice with remittance stub or other documentation-** *see below*
3) **Available funds –***funds that have already been deposited into the trust.* **Reminder your account needs to have a $20 balance at all times.**

If one of these is not available, the disbursement request will NOT be processed.

Disbursement Type	**Proper Documentation**
Rent	Lease or rental agreement if you do not have a rental agreement you can find one online at cdrnys.org\pooledtrust
Utilities and all monthly bills	**Monthly bills – this means each month the bill will need to be forwarded to CDR**
Payments with a coupon booklet	Coupon Booklet must be submitted to CDR.
Credit Card – the trust WILL NOT pay for a Debit Card	Complete Credit card invoice sent each month with detail of purchases, including a remittance stub.
Third Party Reimbursement	If paid with cash- attach receipts for items to be reimbursed to third party. If paid with credit card- attach full credit card invoice including items to be reimbursed.
Company for Services	An invoice that should include your name and what the service is.
Individuals for Services	An invoice that should include your name and what the service is.
Pre-payment	Invoice or Agreement outlining what will be done including costs. Generally used for pre needs funeral plans.

Recurring Expenses

- For recurring expenses, you can fill out one disbursement form and check that it is recurring. In this case, you will not have to fill out a new form each month as the disbursement form is good for one year.

- If the amount of the bill changes per month, write "will vary per month" on the amount requested line.

- **PLEASE NOTE THAT EVEN IF YOU HAVE A DISBURSEMENT FORM MARKED RECURRING, WITHOUT THE INVOICE BEING SENT IN EACH MONTH AND THE FUNDS IN YOUR ACCOUNT TO PAY IT THEN IT WILL NOT AUTOMATICALLY BE PAID.**

Disbursement Limit

- You are allowed 4 disbursements per month. After that there will be a $10 fee for each additional withdrawal.

- To cut back on disbursements, you can use a credit card to pay for most of your bills and have the trust pay the credit card. This is counted as only one disbursement no matter how many bills are on it.

Processing Time

- Please be aware that there is a 7-10 day processing time allowance for disbursements. Once all documentation is provided and all funds are available, the trust has 10 business days to process the requests.

- To speed up this process you can have your bills sent directly to CDR. You can also speed up the process by changing the way you fund the account. Funding the account one month ahead of time is the most efficient way to ensure that there will be no late payments.

Illegal Payments

- Even with the proper documentation, the trust cannot pay for gifts (or gift cards), alcohol, tobacco, firearms, illegal drugs or drug paraphernalia, legal fees relating to illegal activities, restitution, or bail.

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Disbursement requests can be addressed to:
CDR Community Supplemental Needs Trust Dept.
497 State St. Rochester, NY 14608
OR
Fax: (585) 546-7567

Questions? Call CDR at (585) 546-7560

CENTER FOR DISABILITY RIGHTS, INC.
COMMUNITY SUPPLEMENTAL NEEDS TRUST

(A Trust for Persons with Disabilities)

AMENDED AND RESTATED
MASTER TRUST AGREEMENT

Center for Disability Rights, Inc.
497 State Street
Rochester, NY 14608
585-546-7510
E-mail: Matthew Albright malbright@cdrnys.org

CENTER FOR DISABILITY RIGHTS, INC.

COMMUNITY SUPPLEMENTAL NEEDS TRUST

(A Trust for Persons with Disabilities)

MASTER TRUST

THIS TRUST AGREEMENT is made and entered into this 26th day of June, 2013, by and between Center for Disability Rights, Inc., a New York not-for-profit corporation, with principal offices at 497 State Street, Rochester, New York, as Settlor; and Center for Disability Rights, Inc., a New York not-for-profit corporation, with principal offices at 497 State Street, Rochester, New York, and a financial institution as selected in Article V Section 5.1 as co-trustees (hereinafter referred to collectively as "Trustee").

WITNESSETH:

WHEREAS, the Settlor established a Trust (the "**CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST**" herein also referred to as the "Trust") on June 5, 2008, with CENTER FOR DISABILITY RIGHTS, INC. AND MANUFACTURERS AND TRADERS TRUST COMPANY as Co-Trustees, solely to provide a broad range of benefits for persons with disabilities as set forth herein; and

WHEREAS, the Board of Trustees of the CENTER FOR DISABILITY RIGHTS, INC. has the power pursuant to Article 8.1. of the Trust to amend the provisions of the Trust, with such amendment becoming effective immediately upon approval by the requisite number of the Board of Trustees; and

WHEREAS, Article 5.1. of the Trust provides CENTER FOR DISABILITY RIGHTS, INC. with the ability to appoint a financial institution to serve as new Co-Trustee with Center for

Disability Rights, Inc.; and

WHEREAS, CENTER FOR DISABILITY RIGHTS, INC., pursuant to its power in Article 5.1., hereby appoints GENESEE VALLEY TRUST COMPANY to serve as Co-Trustee in accordance with Article 5.1; and **NOW, THEREFORE, IT IS AGREED** that the Trust shall be amended and restated in whole, and the Trustee shall administer and dispose of the Trust property as more specifically set forth hereinafter:

ARTICLE ONE

1.0 NAME OF TRUST AND DEFINITIONS

1.1 Name of Trust:

CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST

1.2 Definitions:

For all purposes under this instrument:

a. "CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST": shall mean a Supplemental Needs Trust (SNT) that is created pursuant to the federal and state laws under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

b. "OBRA '93": authorizes the establishment of trusts containing the assets of persons with disabilities so long as the assets are managed by not-for-profit associations.

c. "Settlor": the not-for-profit association establishing a Supplemental Needs

Trust.

d. "Donor": shall mean the person who is donating property.

e. "Trustee": shall mean CENTER FOR DISABILITY RIGHTS, INC. and a financial institution which holds legal title to property "in trust" for the benefit of another person.

f. "CENTER FOR DISABILITY RIGHTS, INC.": is a not-for-profit corporation created under the laws of the State of New York.

g. "Beneficiary, Disabled Beneficiary or in-kind-Beneficiary": shall mean those persons with mental retardation or other disability as determined by the Trustee in accordance with the Joinder Agreement who may receive the benefits of the Trust property.

h. "Distribute": shall mean to pay over, convey, deliver, transfer, and assign absolutely and in fee simple forever, free of all trusts created hereunder.

i. "Trust Account": shall mean the pooled Sub-Trust accounts which shall consist of contributions from Donors of both income and principal.

j. "Sub-Trust account": shall mean a separate account maintained for each Beneficiary of the Trust by CENTER FOR DISABILITY RIGHTS, INC. as Trustee, consisting primarily of cash and its equivalent.

k. "Joinder Agreement": shall mean the instrument that is executed by the Settlor for purposes of establishing a separate Sub-Trust account for the benefit of a person with a disability.

l. "Remainderman": the individual or entity receiving proceeds upon

termination of the Sub-Trust account.

m. "Remainder Sub-Trust account": shall mean the separate account maintained by CENTER FOR DISABILITY RIGHTS, INC. as Trustee to which may be credited any and all amounts remaining in a Beneficiary's Sub-Trust account upon the death of said Beneficiary.

ARTICLE TWO

2.0 TRUST PURPOSE, ELIGIBILITY AND ACCEPTANCE

2.1 Trust Purpose:

The express purpose of this Trust is to provide for the collective management and distribution of the Trust Estate on behalf of eligible Beneficiaries (the "Disabled Beneficiary" referred to in the "Joinder Agreement") who are disabled as defined in Section 1614(a)(3) of the Social Security Act [42 U.S.C. § 1382c(a)(3)] for whom trust accounts (hereinafter called "Sub-Trust account") are established and upon the death of the Beneficiary, the funds that are received by the Trust may be retained by the CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST and administered by the Trustee to further the express purpose of the Trust as more fully stated below. This Trust is intended to provide, in the sole and absolute discretion of the Trustee, extra and supplemental services and benefits for the care, support, comfort, education and training of the Beneficiaries in addition to and over and above benefits they already receive, are entitled to receive or may receive or be entitled to receive in the future as a result of their present or future mental

retardation or physical, psychological or developmental disabilities from any federal, state or local government program, agency or department.

Except as Donor's intent is otherwise expressed in the Joinder Agreement, Donor declares that in creating the Trust account provided for the Beneficiary, the Donor's primary purpose is to benefit the Beneficiary for all reasonable expenditures, as to both income and principal and not to preserve the principal for the benefit of any remainderman. Donor directs that this purpose be carried out in determining any questions which may arise between the interests of the Beneficiary and the remainderman. The Trustee retains the full discretion to determine the appropriateness of said expenditures.

Center for Disability Rights, Inc. as Trustee shall be responsible for maintaining a Sub-Trust account in the name of, and showing the property contributed for, each Beneficiary. Genesee Valley Trust Company, or any other financial institution serving as Co-Trustee under this Agreement, shall be responsible solely as custodian and money manager of the Trust Account. Any provision in this Agreement which refers to the duties of the Trustee shall be interpreted in accordance with this division of responsibilities. The investment objective for a Sub-Trust account shall consist primarily of cash and its equivalent. However, the Center for Disability Rights, Inc. as Trustee, and the financial institution serving as Co-Trustee under this Agreement, may agree to invest some portion of these funds in non-cash investments as permitted by EPTL §11-2.1 or any other law applicable to fiduciaries.

Any and all amounts remaining in the Trust upon the death of any Beneficiary may be credited to the "Remainder Sub-Trust Account" which amounts may be used for the purpose of providing direct supplemental needs assistance to any individual who is

disabled, as determined by the Trustee, pursuant to Section 1614(a)(3) of the Social Security Act [42 U.S.C. § 1382c(a)(3)], whether or not such individual is a current Beneficiary of the Trust. Amounts in the "Remainder Sub-Trust Account" shall also be available to the Trustee for the purpose of providing indirect supplemental needs assistance to or on behalf of individuals with disabilities. Such indirect expenditure(s) may consist of, but are not limited to, education, training, advocacy and such other incidental services or products which meet the need(s) of any current or potential Beneficiary of the Trust or have the effect of heightening the awareness of the general community to the special needs of individuals with disabilities. Amounts in the "Remainder Sub-Trust Account" shall also be available to the Trustee to meet any administrative and/or operating expenses incurred by the Trust.

To the extent that amounts remaining in a Beneficiary's account upon the death of the Beneficiary are not retained by the trust and credited to the Remainder Sub-Trust Account, to be used in furtherance of the purpose of the Trust, the Trust shall pay to the States from such deceased Beneficiary's account any remaining amounts equal to the total amount of medical assistance paid on behalf of the Beneficiary under the respective States' plans pursuant to 42 U.S.C. §§ 1396 *et seq.*, with reimbursements to the States to be made in proportion to the amounts of medical assistance each provided to the Beneficiary.

2.1.1 Compliance with Federal and State Law: This Trust is established pursuant to, and is intended to comply with the provisions of 42 U.S.C. § 1396(p)(d)(4) (commonly known as OBRA '93), New York Social Services Law § 366(2)(b)(2)(iii)(B), and the New York State Department of Health and rules and regulations promulgated

thereunder, and it shall be construed accordingly. The Trustee shall provide to the New York State Department of Health and/or the appropriate social services district of the State of New York such notices as are required by statute and regulation.

2.2 Eligibility

a. Eligible Beneficiaries: This Trust is open to individuals who, by reason of their being disabled as defined in Section 1614(a)(3) of the Social Security Act [42 U.S.C. § 1382c(a)(3)], shall be eligible Beneficiaries of this Trust.

b. Funding Trust Accounts: The Trust is established as of the day and year first above written. It shall be effective as to any Beneficiary upon execution of a Joinder Agreement, after proper certification by the Trustee. A sample Joinder Agreement is attached hereto. Upon delivery to and acceptance by the Trustee of cash, its equivalent, or then marketable securities, the Trust, as to the Beneficiary, shall be irrevocable and said property shall be non-refundable.

Deposits, in not less than $100 increments, to fund the Sub-Trust account shall be accepted at any time during the year. Said contributions are to be administered in accordance with the Joinder Agreement, subject to proper certification by the Trustee.

The Beneficiary for whom a Sub-Trust account shall have been set apart under this Agreement may not alienate, dispose of or in any manner encumber his or her benefits under this Agreement, and any purported alienation, disposition or encumbrance by or on behalf of the Beneficiary shall be null and void. The interest of the Beneficiary and the income under the Sub-Trust account created under this Agreement shall be free from the control or interference of any creditor of the

Beneficiary, and shall not be subject to attachment or susceptible to anticipation or alienation.

2.3 Acceptance

The Settlor hereby establishes a Master Trust for the convenience of individuals and families. If a Joinder Agreement is executed incorporating the provisions of this Trust by reference, and the Joinder Agreement has been approved by the Trustee, the Trustee agrees to hold, administer, and distribute the income and principal of the Trust in accordance with the terms and provisions hereinafter set forth.

ARTICLE THREE

3.0 EXPENDITURES:

3.1 The Trustee may, at its discretion, disburse trust income or principal to purchase property or services for each Beneficiary, consistent with the purposes and objectives as referred to in this instrument. Disbursements shall be made according to the interests and location of each Beneficiary, taking into account the services and financial resources legally available to him or her from any sources. Any net income not so disbursed shall be accumulated and added to the principal on an annual basis.

3.2 Notwithstanding the above, it is the further intent of the Settlor that no distribution be ordered in contravention of the intent of the Trust and of 42 U.S.C. § 1396p(d)(4)(C), Social Services Law § 366(2)(b)(2)(iii)(B) and New York Estates, Powers and Trusts Law (E.P.T.L.) § 7-1.12. This provision is intended to negate and eliminate any discretion granted to any Court by E.P.T.L. § 7-1.6. The Settlor intends that the funds provided by any third party be utilized for the "supplemental needs" of the Beneficiary. The Settlor intends that if the Trustee receives

any contributions from the Beneficiary, whether as an outright gift or pursuant to a Court Order, these Trust assets are to be protected by the terms of this Supplemental Needs Trust.

Notwithstanding the provisions above, the Trustee in consultation with the Beneficiary's legal guardian, if any, or family members of the Beneficiary, may make distributions to meet the Beneficiary's need for food, clothing, shelter or health care even if such distribution may result in an impairment or diminution of the Beneficiary's receipt or eligibility for government benefits or assistance, but only if the Trustee determines (i) that the Beneficiary's basic needs cannot be met adequately without such expenditure, and (ii) that it is in the Beneficiary's best interest to suffer the consequent effect, if any, on the Beneficiary's eligibility for or receipt of government benefits or assistance; provided, however, that if the mere existence of the Trustee's authority to make distributions pursuant to this subparagraph shall result in the Beneficiary's loss of government benefits or assistance, regardless of whether such authority is actually exercised, this subparagraph shall be null and void and the Trustee's authority to make such distributions shall cease and shall be limited as otherwise provided herein to supplement and not supplant any government entitlement.

3.3 If the Beneficiary's residence changes from the State of New York to another state, distributions may cease until appropriate arrangements for the distribution of funds can be made.

ARTICLE FOUR

4.0 TRUSTEE FEES

4.1 The Trustee shall be entitled to an annual fee from each Sub-Trust account. The annual fee

shall be calculated based upon the Sub-Trust account's status and in accordance with the published fee schedule then in effect which is subject to and may change from time to time.

ARTICLE FIVE

5.0 ADMINISTRATIVE PROVISIONS

5.1 Selection of Co-Trustee: Genesee Valley Trust Company shall serve as Co-Trustee for an initial term of one (1) year from the date of this agreement previously set forth; and Center for Disability Rights, Inc. shall, on an annual basis, evaluate the performance of the financial institution which is serving as Co-Trustee and either reappoint the same or appoint a new Co-Trustee provided that said Co-Trustee shall be another trust company or bank qualified to act as a Trustee in New York.

5.2. Management Board: Center for Disability Rights, Inc. shall appoint a management board to carry out its duties as Trustee. The Finance Committee of the Center for Disability Rights, Inc. shall recommend, nominate, appoint and remove members of this management board (the "Board of Trustees").

5.3 Accountings: For accounting purposes, the Trust shall be operated on a calendar year basis. Center for Disability Rights, Inc. as Trustee, or its authorized agent, shall maintain records for each Trust Sub-Trust account in the name of, and showing the property contributed for, each Beneficiary. Periodic accounts not less often than annually shall be sent to each Beneficiary and/or the appropriate representatives or designees of each Beneficiary, showing additions to and disbursements from the funds held on account in Trust for that Beneficiary during the preceding calendar year. At least as often as annually, the books and records of the Trustee shall be audited by a certified public accounting firm.

5.4 Trustee Powers: The Trustee shall have full power and authority in its absolute discretion, without recourse to any court or any notice whatsoever, to do all acts and things necessary to accomplish the purposes of this Trust, and to perform the Trustee's duties as such and to receive, hold, manage, and control all the income arising from such Trust and the corpus thereof and do such other acts and things concerning the Trust as may be advisable, including, but not limited to, all powers conferred upon fiduciaries by the E.P.T.L., as of the date of the execution of this Master Trust, and the powers conferred upon the Trustee by said statute are hereby incorporated into this Trust by reference.

No Trustee named in this Agreement or named pursuant to the power granted in this Agreement shall be required to furnish any bond or other security in any jurisdiction for the faithful performance of its duties as Trustee.

5.5 No money or property of the Trust shall be pledged, assigned, transferred, sold in any manner anticipated, charged or encumbered by any Beneficiary, remainderman or other Beneficiary hereunder, except by operation of law, or be in any manner liable while in the possession of the Trustee for his/her or their debts, contracts, obligations, or engagements, voluntary or involuntary, or for any claims, legal or equitable, against such remainderman, Beneficiary, or Beneficiaries. No Trust property shall be available to any Beneficiary, remainderman, or any other Beneficiary until actually delivered to or for the benefit of him or her.

ARTICLE SIX

6.0 INDEMNIFICATION

6.1 The Trustee shall not be liable for any error of judgment, or for any loss arising out of any act or omission in the management of this Trust, so long as it acts prudently

with due care, good faith and diligence.

6.2 The Trustee shall be fully protected in acting upon any instrument, certificate or paper believed by it to be genuine and to be signed or presented by the proper person or persons, and the Trustee shall be under no duty to make any investigation or inquiry as to any statement contained in any such writing, but may accept the same as conclusive evidence of the truth and accuracy of the statements therein contained.

6.3 All persons dealing with the Trustee are released from inquiry into the decision or authority of the Trustee and to the application of any monies, securities, or other property paid or delivered to the Trustee.

6.4 The Trustee and each of its agents and employees, as well as its agents' and employees' heirs and legal and personal representatives, shall be and are hereby indemnified by the Trust and the Trust property against all claims, liabilities, fines, or penalties and against all costs and expenses, including attorneys' fees and disbursements and the cost of reasonable settlements imposed upon, asserted against, or reasonably incurred thereby in connection with or arising out of any claim, action, suit or proceeding in which he, she, or it may be involved by reason of being or having been a Trustee, whether or not he, she or it shall have continued to serve as such at the time of incurring such claim, liabilities, fines, penalties, costs or expenses or at the time of being subjected to the same. However, said persons and entities, or their heirs or legal representatives shall not be so indemnified with respect to matters as to which he, she or it shall be finally determined to have been guilty of willful misconduct in the performance of any duty as such, by a court of competent jurisdiction. This right of indemnification shall not be exclusive of, or prejudicial to, other rights to which any such person or entity may be entitled as a matter of law or otherwise.

ARTICLE SEVEN

7.0 APPOINTMENT OF SUCCESSORS

7.1 This Trustee may resign at any time: In the event a Trustee resigns, the successor shall be selected and appointed by Center for Disability Rights, Inc. If Center for Disability Rights, Inc. does not appoint a successor within thirty (30) days of its resignation, its successor shall be selected and appointed by a court of appropriate jurisdiction in Monroe County, New York. Upon resignation, the Trustee shall prepare a final accounting which shall be approved by the Board of Trustees of the Center for Disability Rights, Inc. and the successor Trustee, if required, shall seek approval by a court of appropriate jurisdiction in Monroe County, New York.

7.2 Rights and Powers of Successor Trustees: Every successor Trustee or additional Trustee appointed to and accepting a Trusteeship hereunder shall have all the rights, title, powers, duties, exemptions and limitations of the original Trustee; but no successor Trustee shall in any way be liable or responsible for anything done or omitted in the administration of the Trust prior to the date of becoming successor Trustee. The Trustee shall promptly notify the Board of Trustees of the Center for Disability Rights, Inc. and the Beneficiaries and/or their representatives by first class mail upon the happening of any change in the personnel of Trusteeship.

ARTICLE EIGHT

8.0 AMENDMENT AND TERMINATION OF TRUST

8.1 Amendment: The Board of Trustees of the Center for Disability Rights, Inc. shall have the right and power to amend the provisions of this Trust and the Joinder Agreement, and such amendment shall become effective immediately upon approval of the requisite number of the Board of Trustees without action or approval of any court having jurisdiction over the trust, provided, however, that any such amendment shall not:

a. alter the purpose or objective of the Trust;

b. make gifts revocable that are otherwise irrevocable under this Trust or the Joinder Agreement;

c. adversely affect a prior executed joinder agreement.

8.2 Death Of Beneficiary

Upon the death of the Beneficiary, amounts remaining in the Beneficiary's Sub-Trust account may be retained by the Center for Disability Rights, Inc. Community Supplemental Needs Trust to further the purposes of the Trust.

8.3 Center for Disability Rights, Inc. is a corporation organized and existing under the Not-For-Profit Corporation Law of the State of New York. Center for Disability Rights, Inc. is recognized as a qualified charitable organization under Section 501 (c) (3) of the Internal Revenue Code. Upon the death of the Beneficiary, the funds that are received by the Trust may be retained by the CENTER FOR DISABILITY RIGHTS, INC. COMMUNITY SUPPLEMENTAL NEEDS TRUST and administered by the Trustee to further the purposes of the Trust. If the funds are not retained by the Trust upon the death of

the Beneficiary, the Trust shall pay to the States from such deceased Beneficiary's account any remaining amounts equal to the total amount of medical assistance paid on behalf of the Beneficiary under the respective States' plans pursuant to 42 U.S.C. §§ 1396 *et seq.*, with reimbursements to the States to be made in proportion to the amounts of medical assistance each provided to the Beneficiary.

ARTICLE NINE

9.0 DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

9.1 There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the Trust 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 which services may be rendered by Center for Disability Rights, Inc.

The Donors executing the Joinder Agreements are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. Any Donor executing a Joinder Agreement to this Master Trust hereby waives any and all claims against the Trustee on account of self-dealing, conflict of interest or any other act. The Trustee shall not be liable to the Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with Center for Disability Rights, Inc. or with any Beneficiary.

ARTICLE TEN

10.0 SITUS:

10.1 The Trust created by this Agreement has been accepted by the Trustee in the State of New

York and will be initially administered by Center for Disability Rights, Inc. 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 and accounting purposes shall be in the County of Monroe, the County where the majority of meetings concerning establishment of the Trust have occurred.

10.2 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.

IN WITNESS WHEREOF, the undersigned hereby subscribe to this **AMENDED AND RESTATED MASTER TRUST,** consisting of sixteen (16) pages, including this page, on the date first above written.

CENTER FOR DISABILITY RIGHTS, INC., as Settlor and Trustee

BY: _____
Bruce Darling, Chief Executive Officer

BY: _____
Chris Hilderbrant, Chief Operating Officer, Member of the Board of Trustees

BY: _____
Jennifer Smouse, Director of Finance, Member of the Board of Trustees

BY: _____
Marsha Sweet, Assistant Director of Independent Living, Member of the Board of Trustees

BY: _____
Diane Coleman, Member of the Board of Trustees

BY: _____
Murray Stahl, Treasurer of the Board of Trustees

MARY M. WILLOUGHBY
REG #01WI5013556
COUNTY OF MONROE
COMMISSION EXPIRES_____

GENESEE VALLEY TRUST COMPANY, as Co-Trustee

BY:_____
Joy Ryen Plotnik, Senior Vice President
and Chief Operating Officer

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 26th day of June, 2013, before me personally came Bruce Darling, to me known, did depose and say that he resides at Hilton NY; and that he is the Chief Executive Officer of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that he signed his name thereto by authority of the Board of Directors of said corporation.

MARY M. WILLOUGHBY
REG #01WI5013556
COUNTY OF MONROE
COMMISSION EXPIRES 7-15-2013

Mary M Willoughby
Notary Public

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 13th day of June, 2013, before me personally came Chris Hilderbrant, to me known, did depose and say that he resides at Rochester NY; and that he is the Chief Operating Officer of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that he signed his name thereto by authority of the Board of Directors of said corporation.

MARY M. WILLOUGHBY
REG #01WI5013556
COUNTY OF MONROE
COMMISSION EXPIRES 7-15-2013

Mary M Willoughby
Notary Public

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 13 day of June, 2013, before me personally came Jennifer Smouse, to me known, did depose and say that she resides at 497 State St.; and that she is the Director of Finance of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that she signed her name thereto by authority of the Board of Directors of said corporation.

Susan Stahl
Notary Public

SUSAN STAHL
NOTARY PUBLIC, STATE OF NEW YORK
No. 01ST6097414
QUALIFIED IN MONROE COUNTY
MY COMMISON EXPIRES AUG. 18, 2015

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 11th day of June, 2013, before me personally came Marsha Sweet, to me known, did depose and say that she resides at Rochester, NY; and that she is the Assistant Director of Independent Living of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that she signed her name thereto by authority of the Board of Directors of said corporation.

Notary Public

Jane D. Chase
Notary Public
State Of NY, Monroe Co.
Commission Exp. Jan. 31 2014

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 26th day of June, 2013, before me personally came Diane Coleman, to me known, did depose and say that she resides at Rochester NY; and that she is a Member of the Board of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that she signed her name thereto by authority of the Board of Directors of said corporation.

Notary Public

MARY M. WILLOUGHBY
REG #01WI5013556
COUNTY OF MONROE
COMMISSION EXPIRES 7-15-2013

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 26th day of June, 2013, before me personally came Murray Stahl, to me known, did depose and say that he resides at Rochester NY; and that he is the Treasurer of CENTER FOR DISABILITY RIGHTS, INC., the corporation described herein and which executed the foregoing instrument, and that he signed his name thereto by authority of the Board of Directors of said corporation.

Notary Public

MARY M. WILLOUGHBY
REG #01WI5013556
COUNTY OF MONROE
COMMISSION EXPIRES 7-15-2013

STATE OF NEW YORK)
COUNTY OF MONROE) ss.:

On this 13th day of June, 2013, before me personally came Joy Ryen Plotnik, to me known, did depose and say that she resides at Pittsford New York; and that she is the Senior Vice-President and Chief Operating Officer of GENESEE VALLEY TRUST COMPANY, the corporation described herein and which executed the foregoing instrument, and that she signed her name thereto by authority of the Board of Directors of said corporation.

Notary Public

JAMES GUIDO
Notary Public in the State of New York
MONROE COUNTY
Commission Expires January 10, 20 14

Center for Disability Rights, Inc.

October 2, 2014

New York City HRA
Attn: To whom it may concern

Re: Center for Disability Rights Community Supplemental Needs Trust
Recipients name: [redacted]
SS# [redacted]

To whom it may concern:

I am writing to inform you that the above-referenced individual is now the beneficiary of a Pooled supplemental needs trust. A deposit of $1965.00 in the month of September 2014 was made towards the spend down. This trust is a Medicaid exception trust as described in 96ADM 8, and Section 1917 (d) (4) (C) (i) of the Social Security Act.

The trust is maintained by the Center for Disability Rights, a nonprofit organization. The account is established by the individual with a disability or a parent, grandparent, legal guardian or Court. Accounts are established solely for the benefit of the disabled individual.

Enclosed please find a copy of the Master Trust Agreement as well as a copy of the signed Joinder Agreement. We are requesting that [redacted] budget be adjusted to reflect her participation in this trust.

Should you require additional documentation or verification of the funding of the trust, please contact me or my staff at (585) 546-7560.

Sincerely,

Stephanie Ibarrondo
Pooled Trust New Member Specialist

Encl: 2
Cc: file

Heidi Cornelius
Pooled Trust Customer Service Representative

CDR/RCIL WebOffice

Finance » Trust Transactions

Search Options

Select [redacted]
Consumer:

☑ Display Deposits only

Start Date: End Date: Search

Search Results

[redacted]

Legal Address	**Mailing Address**
[redacted]	[redacted]

Power of Attorney/Representatives

[redacted] New York, NY
New York, NY [redacted]

Transaction Ledger

Date	Type	Ref #	Amount	To/Memo
09/09/2014	Deposit		596.00	*No Payee Data* ACH
08/07/2014	Deposit		596.00	*No Payee Data* ACH
08/05/2014	Deposit		6.79	*No Payee Data* check 1426
07/09/2014	Deposit		6.81	*No Payee Data* CHECK 124
07/07/2014	Deposit		588.39	*No Payee Data* ACH
06/06/2014	Deposit		588.39	*No Payee Data* ACH
06/03/2014	Deposit		240.00	*No Payee Data* Check 123

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

May 3, 2011

Expansion of Attestation of Income, Resources, and Residence for SSI-Related (DAB) Renewals

The purpose of this Medicaid Alert is to advise Client Representatives, Hospitals, Community Based Organizations and Facilitated Enrollers of the provisions of Chapter 58 of the Laws of 2010, which expand attestation of income, resources and a change of residence at renewal for Medicaid recipients who are receiving Community Coverage with Community-Based Long-Term Care (SSI-Related category). This Alert also advises of changes to Social Services Law (SSL) that allow attestation of interest income at application for Family Health Plus (FHPlus) and certain Medicaid applicants.

Effective for renewals received on or after March 1, 2011, SSI-related individuals who are in receipt of Community Coverage with Community–Based Long-Term Care will be allowed to attest to income, resources and a change in residency at the time of renewal. These individuals will continue to be required to document income and resources at the time of **initial application** and when an increase in coverage is requested for Medicaid payment of nursing facility services.

SSI-related individuals will also be required to document income and resources when a change in coverage is required in the community (e.g., moving from Community Coverage **without** Community-Based Long-Term Care to Community Coverage **with** Community-Based Long-Term Care).

If an SSI-related individual is institutionalized and in receipt of nursing facility services, the individual continues to be required to document income and resources at renewal. Additionally, since recipients receiving Community Coverage with Community-Based Long-Term Care will no longer be documenting resources at each renewal, should such individual become institutionalized and require Medicaid coverage for nursing facility services, resource documentation for the full transfer of assets look-back period (up to 60 months) will be required.

- continued on the reverse -

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 330 West 34th Street, New York, NY 10001
Robert Doar, ***Administrator/Commissioner*** **♦ Mary Harper,** ***Executive Deputy Commissioner*** **♦Maria Ortiz-Quezada,** *Director of EIS*

Documentation of health insurance premiums will continue to be required for SSI-related recipients. If a recipient does not provide proof of a health insurance premium but the district has previously documented the available insurance, eligibility will be determined without deducting the amount of the premium. If the recipient needs this deduction to remain eligible for his/her current coverage, send a follow-up request for documentation of health insurance premiums to the recipient. If no documentation is received subsequent to the request, the case will be re-budgeted without the premium amount as a deduction.

Although SSI-related recipients who are in receipt of Medicaid coverage of community-based long-term care services are no longer required to document income at renewal, individuals who are participating in the Medicaid Buy-In Program for Working People with Disabilities must still document that they are employed.

Attestation of Interest Income at Application for Certain Medicaid Individuals

Effective for all applications filed on or after March 1, 2011, FH Plus and Medicaid applicants with no resource test can attest to their **resource generated** interest income. If the amount of reported interest income is questionable and the inconsistent amount could affect eligibility for Medicaid benefits, the applicant may be required to provide follow-up documentation to determine eligibility.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

INFORMATIONAL LETTER

TRANSMITTAL: 05 OMM/INF-1

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: April 19, 2005

SUBJECT: Pooled Trusts and Disability Determinations for Individuals 65 Years of Age and Over

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Staff Development Coordinators

CONTACT PERSON: Upstate: Local District Liaison (518) 474-8216
NYC: (212) 417-4500

ATTACHMENTS: Attachment I – Transmittal Sheet – Disability Determination Request form (DSS-654 Rev. 1/05)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref
96 ADM-8			SSL 366(2)(b)(2)(iii)		

The purpose of this Office of Medicaid Management/Informational Letter (OMM/INF) is to inform local departments of social services (LDSS) of new procedures for determining disability for individuals age 65 and over when the disability determination is needed to determine whether to exempt an Applicant/Recipient's (A/R's) funds placed in a pooled trust.

A pooled trust is a trust which meets the criteria set forth in Section 1917(d)(4)(C) of the Social Security Act (the Act) and Section 366(2)(b)(2)(iii) of the Social Services Law. It contains the assets of a number of disabled individuals and is managed by a nonprofit organization that maintains separate accounts for each such individual. The principal and income of a pooled trust account are not counted in determining Medicaid eligibility.

The federal Medicaid statute does not require that a pooled trust be established with the funds of a disabled individual under age 65 (as is the case with the other type of exception trust exempted under the statute). Therefore, a properly constituted pooled trust must be exempted even if it is established by a disabled individual over age 65. Please note, however, that the transfer-of-assets statute only provides an exception for assets transferred to trusts for the benefit of disabled individuals under age 65. Assets transferred to a pooled trust on or after the disabled individual's 65th birthday are subject to a transfer penalty.

An increasing number of senior citizens are establishing pooled trusts. Many of these individuals are not in receipt of Social Security Disability Insurance (SSDI) benefits and, therefore, require a separate disability determination. Social Security Administration Ruling SSR 03-3p, Evaluation of Disability and Blindness in Initial Claims for Individuals Aged 65 or Older, prescribes the method used to determine disability for individuals age 65 or over.

Individuals age 65 and over may have Medicare coverage as a result of their age rather than the result of a disability determination and receipt of SSDI benefits. This means that in verifying disability, a Medicare card must not be used as proof of disability unless it is accompanied by a Social Security Administration SSDI award letter.

Effective immediately, disability determinations for individuals who are age 65 or over who are establishing a pooled trust, must be performed by the State Disability Review Team in Albany. The following instructions must be followed by all local districts in submitting a disability packet.

The submission process for an individual age 65 or over is much the same as submission of a disability determination packet for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD). The submission process is as follows:

- Have the applicant sign the appropriate release of medical documentation forms.

- Complete and sign the DSS-1151, "Disability Interview" form during the face-to-face interview.

- Send the appropriate release of medical evidence form and appropriate sections of the "Medical Report for Determination of Disability" (DSS-486T) form to treating sources to obtain medical evidence covering a period up to 12 months prior to the date of application. Each provider who receives any portion of the LDSS-486T must also receive pages 1 and 2, along with the specific body part section of the form. It is important to gather medical evidence that covers the timeframe for which the disability determination is being sought.

- As medical evidence is received, a disability package is created consisting of the completed LDSS-1151 "Interview form", appropriate portions of the LDSS-486T, signed by a medical doctor or a qualified psychologist (as applicable) and all requested supporting medical evidence, such as hospital records, office notes and treatment records, etc. It is important that the Medical Report forms be signed by a medical doctor, psychiatrist or qualified psychologist, as appropriate. If forms are received that are unsigned or otherwise incomplete, you must return it to the provider for completion prior to submitting it to the Disability Review Team in Albany.

  Note: An M11Q, "Medical Request for Home Care" form cannot be used as a substitute for the disability packet.

- Complete the Transmittal Sheet, "Disability Determination Request" form (see attached LDSS-654, Revised 2/05) and place two copies on the front of the disability packet.

  Note: The revised LDSS-654 Transmittal Sheet attached to this INF must be used for any disability determination packet sent to the State Disability Review Team in Albany. The form has been revised to accommodate all of the types of cases that may be submitted for disability determination, including Medicaid Only, Temporary Assistance Only, Audit cases, MBI-WPD cases, and Individuals 65 Years of Age and Over. This means that local districts that have the State Disability Review Team perform all of their disability determinations must begin using this transmittal form for all submissions. Please replace the previous LDSS-654 with the revised form immediately and batch submissions according to case type as described on the revised form. Remember to attach two copies of the transmittal sheet to each batch of cases submitted.

- Mail the complete disability packet to:

  New York State Disability Review Team
  Division of Consumer and Local District Relations
  NYS Department of Health
  Office of Medicaid Management
  One Commerce Plaza, Room 826
  Albany, New York 12260

The State Disability Review Team will perform the disability determination and send the completed "Disability Review Team Certificate" (LDSS-639) to the district with the submitted medical evidence package. If the individual is determined disabled, any of the disabled individual's income placed in his or her pooled trust account must be disregarded in determining the disabled individual's eligibility for Medicaid. It should be noted that this disregard does not apply under chronic care budgeting. Additionally, if a disabled individual transfers assets to a pooled trust after he/she turns age 65, that transfer of assets is subject to the appropriate period for medical coverage of nursing facility services.

An applicant seeking to have a pooled trust account exempted is, by virtue of the application, claiming a disability. As with any Medicaid eligibility determination, the local district must require proof of disability if it exists, as previously discussed in this INF, or initiate the disability determination process described above. The LDSS, in conjunction with the State Disability Review Team, has 90 days from the date of application to make the disability determination. Applicants, who establish a pooled trust for the purposes of exempting income, must have a disability determination prior to an eligibility determination.

If you have any questions about pooled trusts for individuals over 65 years of age, please contact Wendy Butz at (518) 473-0955. If you have questions regarding the submission of a packet for disability determination, please contact Peggy Williams at (518) 473-0891.

_____

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

Attachment I

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

NEW YORK STATE DEPARTMENT OF HEALTH

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS:	**PATIENT'S NAME** ***(Last, First, Middle):***	**CASE NUMBER:**	
	PATIENT'S ADDRESS ***(Street, City, State & Zip Code):***	**SOCIAL SECURITY NUMBER:**	
		SEX: ☐ MALE ☐ FEMALE	**DATE OF BIRTH:**

SECTION II – MEDICAL REPORT – NOTICE TO PHYSICIAN

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above.

Diagnosis(es):	**Date of last exam:** _____
	Height: ____ **ft.** ____ **in.**
	Weight: _____ **lbs.**

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting:	**Carrying:**	**Standing:**	**Walking:**	**Sitting:**	**Pushing:**	**Pulling:**
☐ < 10 lbs. ☐ Max. 10 lbs. ☐ Max. 20 lbs./freq. 10 lbs. ☐ Max. 50 lbs./freq. 25 lbs. ☐ > 50 lbs.	☐ < 10 lbs. ☐ Max. 10 lbs. ☐ Max. 20 lbs./freq. 10 lbs. ☐ Max. 50 lbs./freq. 25 lbs. ☐ > 50 lbs.	☐ < 2 hrs./day ☐ 2 hrs./day ☐ 6 hrs./day	☐ < 2 hrs./day ☐ 2 hrs./day ☐ 6 hrs./day	☐ < 6 hrs./day ☐ 6 hrs./day	☐ Using R arm ☐ Using L arm ☐ Using R leg ☐ Using L leg	☐ Using R arm ☐ Using L arm

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory: ☐ No Limitations
☐ Seeing
☐ Hearing
☐ Speaking

Postural: ☐ No Limitations
☐ Stooping/Bending
☐ Crouching/Squatting
☐ Climbing

Manipulative: ☐ No Limitations
☐ R Upper Extremity
☐ L Upper Extremity

Environmental: ☐ No Limitations
☐ Tolerating dust, fumes, extremes of temperature
☐ Tolerating exposure to heights or machinery
☐ Operating a motor vehicle

Mental: ☐ No Limitations
☐ Understanding, carrying out, remembering instructions
☐ Making simple work-related decisions
☐ Responding appropriately to supervision, co-workers, work situations
☐ Dealing with changes in a routine work setting

Signature of Physician:	**(Print Name):**	**Date Signed:**
Specialty:	**Office Address:**	**Office Phone Number:**

LDSS-1151(Revised 6/2012)

Attachment II

AGENCY/ADDRESS:

DISABILITY QUESTIONNAIRE

NEW YORK STATE **DEPARTMENT OF HEALTH**

Name (Last, First, Middle)	TO BE COMPLETED BY LOCAL AGENCY:
SALLY GALYN	Case Number: _____
	Client Identification Number: _____
	Medicaid application date: _____
	Ineligible without disability review? ☐ Yes ☐ No
Social Security Number (last 4 digits) 6789	Family Health Plus eligible? ☐ Yes ☐ No
Date of Birth: 01/01/1920	Medicaid Waiver? ☐ Yes ☐ No
Telephone No.: 212/123/4567	Waiver type: _____

Have you ever applied to the Social Security Administration (SSA) for disability benefits? ☐ Yes ☒ No

If "Yes", when? (month/year) _____ SSA decision date: (month/year) _____

What was the decision?

If denied for benefits, what was the reason (medical or non-medical)?

Did you appeal the decision? ☐ Yes ☐ No If "Yes", when? (month/year) _____

PART I – INFORMATION ABOUT YOUR MEDICAL CONDITIONS

A. Please list all of your medical conditions (diagnoses):

SPINAL STENOSIS
DIABETES
OSTEOPOROSIS
CONGESTIVE HEART FAILURE
ARTHRITIS

B. How do your medical conditions affect your ability to function? (Please include any limitations in your ability to perform activities of daily living and work-related activities.)

I CANNOT WALK WITHOUT A WALKER. I CANNOT PERFORM ACTIVITIES OF DAILY LIVING SUCH AS BATHING, GROOMING, PREPARING MEALS, & HOUSEKEEPING WITHOUT ASSISTANCE. I HAVE POOR BALANCE & CANNOT LIFT ITEMS MORE THAN A FEW POUNDS.

C. Please list your medications (or attach a list).

GLIMEPIRIDE 5mg once a day
LOSARTAN 10mg " "
ALENDRONATE 15mg twice a day
METFORMIN 20mg once a day

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

A. Do you have a primary care provider? ☒ Yes ☐ No
(If "Yes", please provide name, address, phone number.)

DR. SAM PHYSICIAN
1 MAIN STREET, NY, NY 10004 212-456-7891

Date of last visit (month/year): 9/9/2014

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☒ No
(If "Yes", please complete the section below.)

Please list the name, address, and phone number of all medical providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.). (Continuation sheets are available.)

NAME	ADDRESS	PHONE NO.	REASON FOR SEEING:

C. Have you received medical care in a hospital or other health care facility within the past 12 months? ☐ Yes ☒ No
(If "Yes", please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months. (Continuation sheets are available.)

Hospital/Facility	Address	Reason:

D. Have you received services from any agencies to assist you with your impairment(s) within the past 12 months?
☐ Yes *(If "Yes", please complete the section below.)*
☒ No

Please list the name and address of any other agencies that you have seen for assistance with your medical conditions in the past 12 months (for example, vocational rehabilitation agencies, supported employment or housing agencies, case management agencies, etc.).

Name	Address	Reason:

PART III – INFORMATION ABOUT YOUR EDUCATION, LITERACY AND ABILITY TO COMMUNICATE IN ENGLISH *(Complete ONLY if you are an adult, age 18 or over.)*

If a disability determination cannot be made based on your medical conditions alone, the factors of education, literacy, ability to communicate in English, and work history will be used to determine disability.

A. What is the highest grade level of schooling that you have completed? HIGH SCHOOL - 12th

B. Were (are) you involved in Special Education classes in school? ☐ Yes ☒ No

C. Did (do) you receive any special help or accommodations in school? ☐ Yes ☒ No
(If "Yes", please describe.)

D. Have you received any vocational training or additional education within the past 12 months? ☐ Yes ☒ No
(If "Yes", please describe.)

E. Can you read a simple message in English (such as simple instructions, or a list of items)? ☒ Yes ☐ No

F. Can you write a simple message in English? ☒ Yes ☐ No

G. If English is not your primary language, please answer the next 3 questions: N/A

1. Can you understand a simple message spoken in English?

2. Can you speak a simple message in English?

3. Was assistance or an interpreter necessary to complete this application?
(If "Yes", please describe.)

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

In as much detail as possible, please list jobs (up to 5) that you performed in the past 15 years, starting with your most recent job. Be sure to complete all portions to the best of your ability.

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____

Describe your basic duties:

N/A - RETIRED MORE THAN 15 yrs AGO DUE TO AGE AND HEALTH CONDITION

During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____

How much did you frequently lift? _____ pounds

Reason for leaving:

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____

Describe your basic duties:

During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____

How much did you frequently lift? _____ pounds

Reason for leaving:

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____

Describe your basic duties:

During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____

How much did you frequently lift? _____ pounds

Reason for leaving:

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

PART V – AGENCY COMMENTS

Name of Agency Worker reviewing this form:	Date:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
SALLY GALYN	1/1/1920	123-45-6789
Patient Address: 7 HANOVER SQUARE, APT 7, NY, NY 10004		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☒ By initialing here SG (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Sally Galyn
Signature of patient or representative authorized by law.

Date: 10/10/2014

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

[date]

Center for Disability Rights
Pooled Trust Department
497 State Street
Rochester, NY 14608

Via Certified Mail [receipt #]

To Whom It May Concern:

On behalf of my client [client name], I am submitting an executed Beneficiary Profile Sheet and Joinder Agreement for your Community Supplemental Needs Trust.

I have enclosed a check/money order in the amount of $240.00 to cover the enrollment fees.

Please let me know if you need additional information or documentation to begin the processing of this application.

Sincerely,

[attorney name and contact info]

Enclosures:
Beneficiary Profile Sheet
Joinder Agreement
$240

[date]

Human Resources Administration
HCSP Central Medicaid Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238

BY CERTIFIED MAIL # [XXXX]

RE: Pooled Trust of [CLIENT NAME] (SSN: [SSN])

Dear Medicaid Eligibility Worker,

I am writing on behalf of my client, [CLIENT NAME] ("the Applicant"), regarding his/her application for Medical Assistance.

The Applicant is a beneficiary of a Pooled Supplemental Needs Trust (SNT) maintained by [TRUSTEE ORGANIZATION]. Because he/she is disabled, the income contributed monthly to this trust should be deducted from countable income. Please forward the enclosed disability forms to the State Disability Review Team in Albany for a disability determination. See GIS 12 MA/027; 05 OMM/INF-1.

The Applicant has gross income of $0.00/mo. However, since [START DATE], the Applicant has been contributing $0.00 each month to his/her SNT. Accordingly, the Applicant's countable income is only $0.00/mo. (after the $20 disregard for unearned income and health insurance premiums), making him/her eligible for Medicaid with a spend-down of $0.00. In addition, this brings the Applicant's income below the limit for the Medicare Savings Program.

I. APPLICANT IS DISABLED

The Applicant suffers from multiple, severe, permanent, medically-determinable physical impairments which, in light of his/her age, education and experience, render him/her incapable of performing any substantial gainful activity. Accordingly, the Applicant is disabled as defined by section 1614(a)(3)(A) of the Social Security Act (42 U.S.C. § 1382c).

The enclosed forms – DSS-486T, LDSS-1151, and accompanying medical records – establish that the Applicant meets the Social Security standards for disability, and is therefore eligible to use a Supplemental Needs Trust to shelter excess income and/or resources.[1]

[1] See N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: MEDICAL EVIDENCE GATHERING FOR DISABILITY DETERMINATIONS – ADULT CASES, GIS 12 MA/027 (October 12, 2012); NYC HRA, MEDICAID ALERT: MEDICAL EVIDENCE GATHERING FOR ADULT DISABILITY DETERMINATIONS (January 24, 2013); NYC HRA, MEDICAID

II. POOLED INCOME SUPPLEMENTAL NEEDS TRUST

The Applicant was accepted to the [NAME OF TRUST] on [START DATE]. See Acceptance Letter and Joinder Agreement. He/she has contributed $0.00 to his/her pooled trust account in every month since then, and intends to continue this monthly contribution. See Verification of Deposits. The [NAME OF TRUST] is a valid pooled supplemental needs trust pursuant to section 1917(d)(4)(C) of the Social Security Act and section 366(2)(b)(2)(iii) of the New York Social Services Law. See Master Trust.

Accordingly, the Applicant's monthly contributions of income to the pooled trust account should be deducted from countable income. Please budget the Applicant's Medicaid case with a spend-down of $0.00 effective [START DATE].

In addition, the deduction of the Applicant's contributions to the pooled trust make him/her eligible for the Medicare Savings Program. Accordingly, please enroll the Applicant in the Medicare Savings Program retroactively to [START DATE].

Please do not hesitate to contact me at [PHONE] with any questions regarding this request. Thank you for your prompt attention to this matter.

Very Truly Yours,

[ADVOCATE'S NAME]

Enclosures: Documentation relating to Pooled Income SNT:

- Acceptance Letter
- Joinder Agreement
- Master Trust
- Verification of Deposits

Documentation relating to disability:

- DSS-486T – Medical Report for Determination of Disability
- LDSS-1151 – Disability Interview
- Medical Records from provider(s)

OCA Form 960 – Authorization for Release of Health Information Pursuant to HIPAA

MAP-751D – Authorization for Disclosure of Individual Health Information

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ALERT: DISABILITY DETERMINATIONS FOR INDIVIDUALS WITH A POOLED TRUST (July 7, 2005); N.Y. Dep't of Health, INFORMATIONAL LETTER: POOLED TRUSTS & DISABILITY DETERMINATIONS FOR INDIVIDUALS 65 YEARS OF AGE & OLDER, 05 OMM/INF-1 (April 19, 2005); Social Security Administration, EVALUATION OF DISABILITY AND BLINDNESS IN INITIAL CLAIMS FOR INDIVIDUALS AGED 65 OR OLDER, SSR 03-3p (November 10, 2003).

[date]

Attn: [name of healthcare provider, home care agency]

To Whom It May Concern:

My client, [name] (DOB: 00/00/0000), was accepted into the Center for Disability Rights Supplemental Needs Trust on [date]. As of [month] 2014, [Mr./Ms. name] has been contributing the full amount of [his/her] Medicaid spend-down to the trust. This means that effective [month] 2014, [Mr./Ms. name] will no longer have a Medicaid spend-down.

My office has submitted proof of [Mr./Ms. name]'s trust enrollment to Medicaid so that Medicaid will re-budget [his/her] case to have no spend-down. In my experience, while Medicaid will re-budget [Mr./Ms. name] retroactively to [month] 2014, it can take them a few months to do so. My office will continue to follow up with Medicaid to ensure that the re-budgeting takes place.

I ask that you cease billing [Mr./Ms. name] for the monthly spend-down amount until [he/she] has been notified by Medicaid that [his/her] case has been re-budgeted. At that time your office will be able to bill Medicaid for the monthly spend-down amount multiplied by the number of months between [month] and the month that the re-budgeting takes place.

Please contact me at [attorney phone number] if you need to discuss this matter further.

Sincerely,

[attorney name and contact info]

[date]

[client name and contact info]

Dear [Mr./Ms. name]:

I hope you have been doing well. I am writing to follow up on the work we did together to enroll you in the Center for Disability Rights Pooled Income Trust and submit your enrollment in the Trust to Medicaid for approval. As you know, your use of the Trust has been approved by Medicaid, and you no longer have a Medicaid spend-down going back to [month] 2014. [You have also been enrolled in the Medicare Savings Program retroactively to x date.]

Going forward, you must continue to send [amount you agreed upon] to the Center for Disability Rights every month. If you fail to do so, your Trust account might close, and you will have a Medicaid spend-down again.

Now that Medicaid has approved your use of the Trust, your medical bills should be covered in full by Medicaid going back to [month] 2014. If you have any medical bills from those months that you want Medicaid to pay for, you can tell your healthcare provider to submit the bills to Medicaid- as long as that provider accepts Medicaid. If you receive home care from a Medicaid managed long term care plan, send the plan a copy of your new Medicaid budget letter. That way the plan will know to bill Medicaid for your care since [month] and going forward.

Please remember that you must recertify your Medicaid every year. When you receive your recertification papers from Medicaid, you must return them with proof from the Center for Disability Rights of the deposits you made since your last recertification. You can obtain this proof by calling the Center for Disability Rights at (585) 546-7560 and asking for a statement showing your deposits only. If you send this information to Medicaid, your Medicaid spend-down should remain at zero after your recertification is processed.

As there is no further action for [law firm] to take with regard to this matter, we will be closing your file at this time. If you have any further questions about your Medicaid, please contact [law firm intake phone #].

It was a pleasure working with you, and we wish you all the best.

Sincerely,

[attorney name and contact info]