Exhibit "A"

Grantor and Beneficiary Information

Please be as thorough as possible in completing this section. This information is necessary for administering the Trust for the Beneficiary's best possible interest.

Grantor Information

(This is the person who will sign the Joinder Agreement)

Name: ____________________

Address: ____________________

____

Telephone: Home: ____________ Work: ____________

Cell Phone: ____________ Fax: ____________

Email Address: ____________________

Birth Date: ____________________

SS Number: ____________________

Driver's License Number: ____________________
(provide copy of front & back)

Relationship to Beneficiary: ____________________

Source of Deposit Funds: ____________________

Initial Amount of Deposit Funds: ____________________

Additional Deposits: ____________________

Expected Fund Activity – please check appropriate box:

- ☐ 1-5 checks per month
- ☐ 6-10 checks per month
- ☐ 11-15 checks per month
- ☐ more than 16 checks per month

Advisors – Attorney: ____________________ Phone # ____________

CPA: ____________________ Phone # ____________

____ ____________________

Other: ____Phone # ____________________

Beneficiary Information

(This is the person who will be a beneficiary of the Pooled Trust)

Name: ______________________________

Address: ______________________________

____

Telephone: Home: ______________ Work: ______________

Email Address: ______________________________

Birth Date: ______________________________

SS#: ______________________________

Medicare #: ______________________________

Medicaid #: ______________________________

Other Insurance Info: ______________________________

Driver's License #: ______________________________

Blood Type ________ Transfusions Allowed? ____yes ____no

Religious Affiliation: ______________________________

Priest/Rabbi/Bishop: ______________________________

Telephone: ______________________________

Hospital Preference: ______________________________

Address ______________________________

Emergency Contact

Primary ______________________________

Telephone Home ______________ Work ______________

Secondary ______________________________

Telephone Home ______________ Work ______________

If Beneficiary is a Minor, Please Provide:

Mother's Name: ____________________

SS#: ____________________

Address: ____________________

____

Telephone: Home: __________ Work: __________

Cell Phone: __________ Fax: __________

Email Address: ____________________

Father's Name: ____________________

SS#: ____________________

Address: ____________________

____

Telephone: Home: __________ Work: __________

Cell Phone: __________ Fax: __________

Email Address: ____________________

Beneficiary's Siblings:

Name: ____________________ age __________

Address: ____________________

____

Telephone: Home: __________ Work: __________

Email Address: ____________________

Name: ____ age __________

Address: ____

____

Telephone: Home: _______________________ Work: ___________________________

Email Address: ____

Name: ____ age __________

Address: ____

____

Telephone: Home: _______________________ Work: ___________________________

Email Address: ____

Does the Beneficiary have a legal representative? ____yes ____no
If yes, please provide the representative's name, address, telephone number, and check the box indicating the relationship to the Beneficiary.

Name: ____

Address: ____

____

Telephone: Home: _______________________ Work: ___________________________

Email Address: ____

Please check the description that best describes the correct legal relationship:

- ☐ Legal Guardian
- ☐ Conservator
- ☐ Representative Payee
- ☐ Power of Attorney – Financial
- ☐ Power of Attorney – Medical
- ☐ Parent of Minor Child
- ☐ Other ______________________

Primary Representative:

Unless the Grantor requests otherwise and until the Grantor is no longer able to serve as such, the Grantor shall be the Beneficiary's Primary Representative. When the Grantor is no longer able to act as the Beneficiary's Primary Representative, the Guardian or legal representative listed above shall be the Primary Representative (with a court-appointed Guardian, if any, taking precedence). If the legal representative listed above ceases to serve, please list below, in order, the persons that you would like to be successor Primary Representatives:

First Alternate:

Name: ______________________________

Address: ______________________________

____

Telephone: Days: ______________ Evening: ______________

Relationship: ______________________________

Second Alternate:

Name: ______________________________

Address: ______________________________

____

Telephone: Days: ______________ Evening: ______________

Relationship: ______________________________

No Alternates Remaining:

If none of the named Primary Representatives or successors are able to serve, how would you like for the Manager to select another Primary Representative?

____

____

What is the specific nature of the Beneficiary's disability? Also, if the Beneficiary's condition has been medically diagnosed, what is the diagnosis?

____

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____

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____

What is the Beneficiary's current prognosis?

____

____

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____

Beneficiary's Educational History:

Elementary School ____

Grade Completed ____

Jr./Sr. High School ____

Grade Completed ____________________________ Graduated? ____yes ____no

Higher Education ____

Other Education ____

Beneficiary's Work Experience:

Employer ____

Dates Worked ____________________ Why Left? ____________________

Employer ____

Dates Worked ____________________ Why Left? ____________________

Employer ____

Dates Worked ____________________ Why Left? ____________________

Beneficiary's Medical Care Professionals:

Name: ____

Specialty: ____

Clinic Name: ____

Address: ____

____

Telephone: ____________________ Fax: ____________________

Last Seen: ____

Name: ____

Specialty: ____

Clinic Name: ____

Address: ____

____

Telephone: ______________________ Fax: ______________________

Last Seen: ____

Name: ____

Specialty: ____

Clinic Name: ____

Address: ____

____

Telephone: ______________________ Fax: ______________________

Last Seen: ____

Name: ____

Specialty: ____

Clinic Name: ____

Address: ____

____

Telephone: ______________________ Fax: ______________________

Last Seen: ____

Beneficiary's Pets

Name: ____

Dog ____________ Cat ____________ Other ____________

Name: ______________________________

Dog ____________ Cat ____________ Other ____________

Name: ______________________________

Dog ____________ Cat ____________ Other ____________

____

Veterinarian: ______________________________

Address: ______________________________

Telephone: Office ____________ ER #: ____________

Beneficiary's Professional Care Providers:

Name: ______________________________

Agency: ______________________________

Telephone: ______________________________

Type of Care Provided ______________________________

Name: ______________________________

Agency: ______________________________

Telephone: ______________________________

Type of Care Provided ______________________________

Name: ______________________________

Agency: ______________________________

Telephone: ______________________________

Type of Care
Provided ______________________________

Government Assistance

Please indicate all forms of government assistance that the Beneficiary receives.

Social Security	____yes	____no	____not sure
Supplemental Security Income (SSI)	____yes	____no	____not sure
Medicaid	____yes	____no	____not sure
VA Pension	____yes	____no	____not sure
VA Survivor Pension	____yes	____no	____not sure
Home or Community Based Waiver Program	____yes	____no	____not sure
Food Stamps	____yes	____no	____not sure
Other __________________	____yes	____no	____not sure
Other __________________	____yes	____no	____not sure

List all forms of government assistance that have been denied and/or discontinued to the Beneficiary, including the approximate dates of denial/discontinuation.

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Insurance Information

If the Beneficiary is covered under any health care insurance, please complete the following

Name: ____

Address: ____

____

Telephone: Home: ______________________ Work: ______________________

Cell Phone: ______________________ Fax: ______________________

SS#: ____

Policy #: ____

Group #: ____

Employer: ____

Type: ____Medical ____Dental ____Eye ____Mental Health

If the Beneficiary is covered under any life insurance policy, please complete the following

Company Name: ____

Address: ____

____

Telephone: ____

Fax: ____

Policy #: ____

Owner of Policy: ____

Beneficiary: At Insured's Death ____

Face Amount: ________________ Term Policy?______________ Whole Life?__________

If the Beneficiary is covered under any prepaid funeral plan or burial insurance,
please provide the following:

Company Name: ____

Address: ____

____

Local Agent Name: ____

Telephone: ____

Fax: ____

Policy #: ____

If the Beneficiary is covered under any Long-Term Care insurance plan,
please provide the following:

Company Name: ____

Address: ____

____

Local Agent Name: ____

Telephone: ____

Fax: ____

Policy #: ____

Beneficiary's Adaptive Equipment

Eye Glasses	Safety Bars
Hearing Aids	Emergency Response System
Wheel Chair	Other ____________________
Cane	Other ____________________
Walker	Other ____________________
Toilet Lift	Other ____________________

Beneficiary's Current Financial Cash Flow

Income:

Source & Amount: ____

Source & Amount: ____

Source & Amount: ____

Expenses:

Housing: ____

Utilities: ____

Food: ____

Personal Needs: ____

Medications: ____

Other Outstanding Debts:

_______________ ____

_______________ ____

_______________ ____

Tax Preparation:

Does the client file personal income taxes? ____yes ____no

Who prepares the tax filings?

Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Please provide copies of the last three years tax returns.

Other Information Regarding the Needs of the Beneficiary

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____

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____

____

Distributions of Remainder of Sub-Account upon Beneficiary's death

Upon the death of a beneficiary the following provisions apply to the distribution of funds remaining in the Sub-Account. Funds from the beneficiary's assets must be either retained by the Trust or used to reimburse Medicaid for amounts advanced by Medicaid for the benefit of the beneficiary.

Distributions of Self-Funded Sub-Accounts

Self-funded Sub-Accounts will be distributed as follows:

(1) Funds to be repaid to Medicaid:

The lesser of Medicaid funds advanced or 50% of the funds remaining in the Sub-Account.

(2) Funds retained by the Trust:

All funds remaining in the account after Medicaid reimbursement.

Early Termination of the Sub-Account

In the event that it becomes impossible or impractical to carry out the purposes of the Trust the Manager or Trustee shall have the authority to terminate the Trust Sub-Account and distribute the remaining funds. In the case of a self-funded Sub-Account the funds will be distributed to the beneficiary or his or her legal representative. This distribution may have an effect on the Beneficiary's Medicaid qualifications. The Beneficiary or legal representative should consult the Beneficiary's Medicaid caseworker for further advice.