2014 OHIO COMMUNITY POOLED FLEXIBLE-SPENDING TRUST ACCOUNT AGREEMENT

This is an Application by the Qualified Donor identified below to establish an Account within the Ohio Community Pooled Flexible-Spending Trust (the "Trust"), to provide benefits for the Individual with Disabilities identified below. The Account so established will be administered in accordance with the terms of the Trust, as amended from time to time. The Qualified Donor understands and acknowledges that, once accepted, the funds placed in this Account may not be withdrawn, except in accordance with the terms of the Trust. Capitalized and other terms used in this Account Agreement shall have the same meaning as in the Agreement of Trust of the Ohio Community Pooled Flexible-Spending Trust.

1. TRUSTEE: KEY BANK, N.A.

2. DISTRIBUTION TRUSTEE: THE DISABILITY FOUNDATION, INC.

3. QUALIFIED DONOR:

Name of First Grantor: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Social Security Number: _____
Relationship to Individual with Disabilities: _____

4. INDIVIDUAL WITH DISABILITIES:

Name: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Date of Birth: _____
Social Security Number: _____

You must complete a Beneficiary Profile with information regarding this Individual with Disabilities. It is the duty of the Personal Representative to regularly review the Beneficiary Profile, and promptly notify the Disability Foundation, Inc. of any changes as they occur.

5. PERSONAL REPRESENTATIVE:

The Personal Representative is responsible for providing information and updates about the Individual with Disabilities. The Personal Representative is also responsible for asking the Trust to expend funds for the Individual with Disabilities, and providing supporting information.

INITIAL PERSONAL REPRESENTATIVE

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email: _____

Relationship to Individual with Disabilities: _____

In case the Personal Representative named above is unable or unwilling to serve or to continue to serve in that capacity, the Qualified Donor names the following **Successor Personal Representatives** to serve (in the order listed):

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email: _____

Relationship to Individual with Disabilities: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email: _____

Relationship to Individual with Disabilities: _____

6. PROPERTY TRANSFERRED BY THE QUALIFIED DONOR:

_____

_____

7. USE OF FUNDS AFTER DEATH OF INDIVIDUAL WITH DISABILITIES:

Upon the death of the Individual with Disabilities, the Qualified Donor acknowledges and agrees that **twenty-five percent (25%)** of any funds remaining in the Account will be retained by the Disability Foundation, Inc., to be used for the funding of Disability Programs and

Services. The Qualified Donor directs that the remaining funds in the Account, beyond the amount retained by the Disability Foundation, Inc., shall be distributed as follows (*choose one*):

A: If the Qualified Donor wishes for all funds to remain with the Disability Foundation, Inc., then no funds will be used to repay Medicaid and no funds will go to any other person. – *Select Option A below for this result.*

B: If the Qualified Donor wishes to name beneficiaries beyond the Disability Foundation, Inc., then Medicaid *must* be paid back *first* for all recoverable benefits paid to the Individual with Disabilities. If funds are leftover after Medicaid is paid back, then the funds will be distributed as indicated in the chart below. – *Select Option B below for this result.*

Option *(choose one)*	**Full Name**	**Relationship to Individual with Disabilities**	**Current Address**	**Percentage**	**Qualified Donor Initials** *(initial row for selected Option only)*
☐ **A** *(if selected, STOP here. Proceed to next page.)*	The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	**100%**	_____
☐ **B**	Ohio Department of Medicaid *(repayment of benefits provided to Individual with Disabilities)*	--	--	**Up to full amount of liability owed**	_____
	*List **PRIMARY Beneficiary** information below for any funds that might remain after Medicaid is paid back. (Percents should add up to 100%)*				**If Deceased…** *(complete if beneficiary below is a person)*
				_____ **%**	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
				_____ **%**	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
	The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	_____ **%**	
	*List **SECONDARY Beneficiary** information below for any funds that might remain after Medicaid is paid back. (Percents should add up to 100%)*				**If Deceased…** *(complete if beneficiary below is a person)*
				_____ **%**	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
				_____ **%**	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
	The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	_____ **%**	--

Please attach additional pages if more space is required to list Primary and Secondary Beneficiary information.

8. APPLICATION:

The Qualified Donor acknowledges and agrees to all fees that will be assessed on the Account. Fees are based on a published fee schedule maintained by the Distribution Trustee. Qualified Donor acknowledges and agrees that the Distribution Trustee and Trustee reserve the right to modify the fee schedule from time to time, in their discretion. The Qualified Donor hereby applies to establish an Account in the Trust for the Individual with Disabilities identified above, this ____ day of _____, 20____. **NOTE:** (this agreement must be signed before 2 witnesses **or** a notary, unless signed in our office)

_____
Signature of Qualified Donor

_____ _____
Printed Name of Witness Signature of Witness

_____ _____
Printed Name of Witness Signature of Witness

OR

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned notary public, personally appeared _____, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary

. APPROVAL BY THE DISTRIBUTION TRUSTEE:

The application to establish this Account with the Trust is hereby approved.

THE DISABILITY FOUNDATION, INC.

_____ By: _____
Date

Its: _____