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 The Qualified Donor understands and acknowledges that, once accepted, the funds placed in this Account may not be withdrawn, except in accordance with the terms of the Trust.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: U.S. BANK, N.A.

2. DISTRIBUTION TRUSTEE: THE DISABILITY FOUNDATION, INC.

3. QUALIFIED DONOR:

Name: ____________________

Address: ____________________

____

Telephone: ____________________

Cell/Mobile: ____________________

Work Phone: ____________________

Relationship to Individual with Disabilities: ____________________

Social Security Number: ____________________

4. INDIVIDUAL WITH DISABILITIES:

Name: ____________________

Address: ____________________

____

Telephone: ____________________

Cell/Mobile: ____________________

Work Phone: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Receiving: ☐ Medicaid ☐ Supplemental Security Income (SSI)

5. PERSONAL REPRESENTATIVE

The Personal Representative is responsible for providing information and updates about the Individual with Disabilities, including his/her address, telephone, and benefits and services (s)he is receiving. The Personal Representative is also responsible for asking the Trust to purchase items for the Supplemental Needs of the Individual with Disabilities, and providing supporting information.

PERSONAL REPRESENTATIVE:

Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Cell/Mobile: ______________________________

Work Phone: ______________________________

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: ______________________________

____

Telephone: ______________________________

Cell/Mobile: ______________________________

Work Phone: ______________________________

Relationship to Individual with Disabilities: ______________________________

Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Cell/Mobile: ______________________________

Work Phone: ______________________________

Relationship to Individual with Disabilities: ______________________________

6. PROPERTY TRANSFERRED BY THE QUALIFIED DONOR:

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

It is acknowledged and agreed that twenty-five percent of any funds remaining in the Account of the Individual with Disabilities after his/her death will be retained by The Disability Foundation, Inc., for Disability Programs and Services. The Qualified Donor requests, by indicating below, that any funds remaining in the Account be used as follows:

_______ % to re-pay Medicaid, as reimbursement for benefits

_______ % to be retained by the Trust, for Disability Programs and Services

7. APPLICATION

The Qualified Donor hereby applies to establish an Account in the Trust for the Individual with Disabilities identified above, this _____ day of ________________ , 2006.

____
Individual Named in the Trust

8. APPROVAL BY THE DISTRIBUTION TRUSTEE

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

THE DISABILITY FOUNDATION, INC.

By: ______________________________________