Letter of Intent

(Instructions for Caregiving)

Please complete the following form to communicate to future caregivers and trustees what you think they need to know to care for you or your loved one. Regardless of where the person with a disability lives – in a group home, a parent's or family member's home, or his or her own home, you or the parent (spouse or other family caregiver) should indicate what you know best based upon a lifetime of your care. You can pass on the information to succeeding caregivers. These instructions should be given to successor caregivers (and trustees) after they have agreed to serve as well as kept in the special needs trust attorney's file. Sharing the instructions is best done though a meeting to review the Letter after it is completed.

This letter of intent is designed to give successor caregivers and trustees the realistic information they need to carry on effectively as caregivers after parents (or other family members) no longer can provide the care themselves. This practical information could also alleviate concerns that caregivers and trustees might have about how they best can fulfill expected family obligations.

If you run out of space, please attach additional sheets of paper as needed

For: _____

Name of person with disability

Prepared by: _____

Date: _____

Signature: _____

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I.

II. IDENTIFYING INFORMATION

A. Person with Disability

FIRST NAME, MIDDLE INITIAL, LAST NAME | SOCIAL SECURITY NUMBER | BIRTH DATE

HOME ADDRESS | CITY, STATE | ZIP

PHONE NUMBER

B. Parents

MOTHER'S NAME | DOB | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

FATHER'S NAME | DOB | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

C. Guardian

NAME | RELATIONSHIP TO CLIENT | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

D. Trustees

TRUSTEE'S NAME | RELATIONSHIP TO CLIENT | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

NAME OF 1ST SUCCESSOR | RELATIONSHIP TO CLIENT | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

NAME OF 2ND SUCCESSOR | RELATIONSHIP TO CLIENT | PHONE NUMBER

HOME ADDRESS | CITY, STATE | ZIP

E. Contacts:

Other than the person's physician and medical treatment providers, please identify any individuals, organizations, professional groups, government agencies, or other important contacts providing or coordinating services for the person with a disability:

Organization Name | Address

Person to Contact | Phone Number

Services provided or reason to be contacted

Organization Name | Address

Person to Contact | Phone Number

Services provided or reason to be contacted

Organization Name | Address

Person to Contact | Phone Number

Services provided or reason to be contacted

Organization Name | Address

Person to Contact | Phone Number

Services provided or reason to be contacted

F. Involved Family Members

NAME _____ RELATIONSHIP TO CLIENT _____ PHONE NUMBER _____

HOME ADDRESS _____ CITY, STATE _____ ZIP _____

NAME _____ RELATIONSHIP TO CLIENT _____ PHONE NUMBER _____

HOME ADDRESS _____ CITY, STATE _____ ZIP _____

NAME _____ RELATIONSHIP TO CLIENT _____ PHONE NUMBER _____

HOME ADDRESS _____ CITY, STATE _____ ZIP _____

G. Pets

Name of first pet _____ Type _____

Describe how person relates to pet _____

_____

_____

Who cares for pet? _____

_____

Name of second pet _____ Type _____

Describe how person relates to pet _____

_____

Who cares for pet? _____

G. Friends

FIRST FRIEND'S NAME _____ TYPE (e.g., best friend, girl/boy friend) _____ PHONE NUMBER _____

_____ _____ _____

HOME ADDRESS CITY, STATE ZIP

_____ _____ _____

NAME TYPE (e.g., best friend, girl/boy friend) PHONE NUMBER

_____ _____ _____

HOME ADDRESS CITY, STATE ZIP

_____ _____ _____

NAME TYPE (e.g., best friend, girl/boy friend) PHONE NUMBER

_____ _____ _____

HOME ADDRESS CITY, STATE ZIP

II. MEDICAL INFORMATION

A.Please identify the person's current physicians, therapists, and specialists:

Name: _____ Name: _____
Address: _____ Address: _____
Address: _____ Address: _____
City/State:_____ City/State: _____
Phone:_____ Phone:_____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Address: _____ Address: _____
Address: _____ Address: _____
City/State: _____ City/State: _____
Phone:_____ Phone: _____
Specialty: _____ Specialty: _____

A.Does the person have any healthcare coverage? _____ If so, please complete all questions that apply:

1. Medicare: Give claim number _____. Does the person have Medicare coverage under parts A and B. If no, please explain _____.

_____

_____

2. Health insurance: Identify the company _____, type of coverage _____, group number if appropriate, _____, Medicare Supplement Plan (A through J) _____, and identification number _____. Is insurance on parent's or guardian's account? _____ What are plans for continuing after death of parent or guardian?

_____

_____

3. Medicaid: Give the Medicaid identification number _____

4. Any dental or vision coverage? If so, identify the company _____, type of coverage _____, group number, if appropriate, _____, and identification number _____.

C. Identify the hospital and the pharmacy that the person uses: _____
_____
_____
_____

D. What medications does the person use, and what are the purposes? Who prescribed the medications?

Medication & Purpose	Doctor's Name
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E. What non-prescription medications or vitamins does the person (indicate the purposes) take? _____
_____
_____

F. How is payment made for health insurance, dental care, medical care, and medications?
_____
_____

G. Identify any treatments or special care that the person must receive at home or in a medical setting:
_____
_____
_____
_____
_____
_____

H. Is the disabled person allergic to any medications, insect bites, chemicals, or any other item? If yes, please list and explain type of reaction and treatment required: _____
_____
_____
_____
_____
_____

I. Provide any special instructions or procedures to follow when taking the person to a doctor or dentist: _____
_____(Instru
ctions for doctor or dentist continued) _____
_____
_____
_____.

J. Please share additional comments or instructions about medical and dental care:
_____
_____
_____

K. In the event of an emergency, are there any special instructions _____
_____
_____
_____

III. PERSONALITY TRAITS & PREFERENCES:

A. Describe in general terms what living with the person is like.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

A. Describe the person's basic characteristics and personality: _____
_____
_____
_____

_____
_____
_____
_____
_____
_____
_____

B. What are the person's preferences? _____
_____
_____
_____
_____
_____
_____

(Persons preferences continued)_____
_____
_____
_____
_____
_____

D. What does the person dislike? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

E. What are the person's special interests? _____
_____
_____
_____
_____

F. Does the person prefer a male or female attendant? If yes, please explain:
_____
_____
_____

G. Please list the person's favorite type of clothes _____
_____
_____

_____
_____

H. Does the person have favorite places he or she likes to go? _____
_____
_____
_____

I. Provide the person's shoe and clothing sizes: Shoes _____ Pants _____ Shirt or Blouse _____ Skirt or Dress _____ Coat _____ Gloves _____ Underwear _____ Belt _____ Other _____

J. What is the person's height? _____; weight _____.

IV. PERSONAL CARE:

A. Does the individual need any assistance with personal care? If yes, please explain what assistance is needed:

B. Does the person need assistance with taking Medicine (for example, you must give insulin shots or put certain pills in applesauce):_____

C. What assistance does the person need with dressing (for example, you must help the person button clothes or tie shoes):

D. What assistance is needed for the following personal care activities?
Bathing:_
Caring for hair:
Shaving:
Using the toilet:
Other personal hygiene:

E. Does the individual need any special reminders to do his or her personal care needs to include taking medicine? If yes, please explain:

F. Are there any special instructions regarding any personal care items (for example, can the person select own clothes or must assistance be provided):

V. MEALS:

A. Does the individual prepare meals? If yes, please explain:

1. What foods are prepared (for example, sandwiches or frozen dinners)?
   _____
2. Which meals or snacks are prepared

B. Does the individual need assistance in preparing meals? If yes, what help is needed?

C. Is the individual allergic to any foods? If yes, please identify:

D. Please list foods that the individual does not like or will not eat (for example, broccoli or fried foods):

E. Is the person unable to feed self, or needs limited help at meals (for example, person cannot cut up his or her food or lift eating utensils)? If yes, please explain what help is needed:

F. Please share comments or additional information about meals, food preparation, or eating habits:

VI. ACTIVITIES:

A. Does the individual assist with or do any house or yard work: If yes, please explain:

1. List the chores the person does (for example dusting, folding clothes, or raking leaves):

2. What assistance does the person need to do the house or yard work?

3. What chores does the person like to do best?
4. How often does he or she help with chores?
5. How long can the person do the chore(s)?

6. Provide any additional comments or instructions about house and yard work:

B. Does she or he have any hobbies, favorite entertainment, or recreation? If yes, please identify and explain what help or assistance is needed for the person to do the hobby, entertainment, or recreation (for example, person loves game shows on television but needs help to turn on television and select channel):

C. Describe the person's daily routine (for example, gets up at 7AM, drinks coffee until 7:30AM, eats breakfast at 8AM & watches television).

1. Morning:

1. Noon time:

1. Evening:

1. Bedtime:

D. Does the person like to go to places such as churches, sports events, shopping malls, grocery stores, or theaters?

1. If yes, please explain

2. Does the person require assistance or supervision? Please explain:

3. Provide any further comments or instructions about activities.

E. Does the person work (for example, Sheltered Workshop or competitive employment)? If so, specify employer, type of work, work schedule, how person gets to work, and any other information or instructions needed:

F. Does the person attend a school or day care/program facility? If yes, identify school or day care facility and provide any instructions regarding person's attendance and participation at the school or day care/program facility:

VII. ABILITIES & DISABILITIES:

A. Please circle and explain any of the following that the person has extraordinary powers or limitations:

☐ Hearing ☐ Seeing ☐ Speaking ☐ Walking ☐ Memory

☐ Concentrating ☐ Understanding ☐ Standing ☐ Coordination

☐ Communicating ☐ Making change ☐ Other_____

Explanation(s):

A. Does the person need medical or adaptive equipment/supplies? If so, mark appropriate box, and describe in comment section what assistance the person will need with each item (for example, the person needs help to put on his or her braces):

Glasses Yes ☐ No ☐ Dentures, Yes ☐ No ☐
Braces, Yes ☐ No ☐ Hearing Aids, Yes ☐ No ☐
Walker, Yes ☐ No ☐ Cane, Yes ☐ No ☐
Wheelchair, Yes ☐ No ☐ Service Dog Yes ☐ No ☐
Other: _____

Comments:

C. What limitations does the person have because of one or more medical problems (for example, the person must rest after waking a short distance or cannot see without glasses), and what assistance must be provided:

D. Does the person get along with family, friends, authority figures (such as teachers or police), and strangers? If no, please explain and provide recommendation on how to handle situation:

E. If the person has problems in coping with stress, please explain problems and provide instructions on how to handle them:

F. Do changes in routine affect the person? If so, please explain and give instructions on how to handle the changes:

VIII. END-OF-LIFE ISSUES

A. Does the person have an advance directive or a durable power of attorney for healthcare? _____ If so, please attach a copy of the document. If not, indicate your end of life preferences, if any, for the person:

B. What arrangements been made to take care of the person's body at death? Pre-need or pre-arranged contract? _____. If so, with what business or agency are the arrangements made?
If no arrangements have been made, do you have a preference of a funeral home where you want arrangements to be made?

C. What are the person's plans for anatomical gifts? _____
_____

D. Is a certain family member to be consulted regarding final service arrangements, if any? _____. If so, who? .

E. Where is body to be interred (or if it is to be cremated, what is to be done with the ashes)?

F. What is to be placed on the marker or tombstone, if applicable?

.

G. What are preferences for a memorial service?

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IX. INCOME

A. Does the person receive Supplemental Security Income ("SSI")? _____
If so, how much per month? _____

B. Does the person receive Social Security Disability Insurance ("SSDI" or "DIB")? _____. If so, how much per month? _____. Does the person receive the SSDI on own account or on a parent's account as an Adult Disabled Child ("DAC") since before age 22 (called "Childhood Disability Benefit" or "CDB").
_____
_____

C. Does the person have any earned income from employment? _____ If so, how much average monthly income does the person receive from earnings? _____. Is this income from a sheltered workshop or part of a trial work period? If so, which_____

D. Does the person receive Veteran's Benefits? _____. If so, how much per month _____?

E. Is the person receiving any income from a workers compensation matter, personal injury claim, or other legal or insurance compensation claim or judgment? _____ If so, how much and what terms _____
_____

F. Does the person receive a disability or retirement pension? _____ If so, how much per month? _____.

G. Does the person receive any income from a trust? _____. If so, how much per month or year? _____

H. Does the person receive any income (or regular gifts) from a parent or family member? _____ If so, how much per month? _____.

I. Does the person receive any other income? _____. If so how much and what is source? _____

X. GENERAL INFORMATION

A. Describe any hopes that you have for the person in the future:

B. What actions do you think would help the person in the future?

C. What additional information would you like to share about the person?

XI. DIAGNOSIS AND OTHER INFORMATION

Please write in your own words what your understanding is of the person's disability? For example, what is the diagnosis? What do you think the person needs in the way of treatment, training, habilitation, or rehabilitation?

(Diagnosis and other information continued)

_____
_____
_____
_____

XII. ADDITIONAL INSTRUCTIONS:

Please indicate anything else that you have learned in working with and caring for the person and that you think the caregivers and/or trustees should know about the person (for example, does the person like back rubbed at bedtime? Or what calms the person down when upset and frustrated? Add sheets of paper as necessary.)