

Completing the following form can aid in communicating what the present caregiver needs to tell future caregivers.

**LETTER OF INTENT
(CARE PLAN)**

All parents or family members caring for disabled children (adults or minors) should write down what any successor caregivers (or trustees) would need to know about the child and what the parents' (or family member's) wishes are for the disabled child's care.

Regardless of whether the person lives in a group home, a parent or family member's home, or his or her own home, the parent (or family caregiver) should indicate what the parent knows best and pass on the information. The plan can be kept in the attorney's file, as well as given to the successor caregivers after they have agreed to serve (best done in a meeting).

This letter of intent will give successor caregivers and trustees the practical information they need to carry on as expected caregivers by the parents. This can alleviate practical concerns they might have about how to fulfill a family obligation. Please attach additional sheets of paper if you need to add comments.

For: _____
Name of Disabled Child

Prepared by: _____

Date: _____

Signature: _____

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LETTER OF INTENT INFORMATION

Section One: Personal Information

Name: _____

Address: _____

Phone: _____

Driver's License Number: _____

Social Security Number: _____

State of Arizona ID: _____ Yes _____ No

Parents

Mother's Name: _____

D.O.B.: _____

Address: _____

Phone: _____

Father's Name: _____

D.O.B.: _____

Address: _____

Phone: _____

Guardian

Name: _____

Relationship to Client: _____ Phone: _____

Address: _____

Trustees

Name of 1st Successor: _____

Relationship to Client: _____ Phone: _____

Address: _____

Name of 2nd Successor: _____

Relationship to Client: _____ Phone: _____

Address: _____

Name of 3rd Successor: _____

Relationship to Client: _____ Phone: _____

Address: _____

Contacts:

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: _____

Person to Contact: _____ Phone: _____

Address: _____

Services Provided or Reason to be Contacted: _____

Organization Name: _____

Person to Contact: _____ Phone: _____

Address: _____

Services Provided or Reason to be Contacted: _____

Organization Name: _____

Person to Contact: _____ Phone: _____

Address: _____

Services Provided or Reason to be Contacted: _____

Organization Name: _____

Person to Contact: _____ Phone: _____

Address: _____

Services Provided or Reason to be Contacted: _____

Involved Family Members

Name: _____

Relationship to Client: _____ Phone: _____

Address: _____

Name: _____

Relationship to Client: _____ Phone: _____

Address: _____

Name: _____

Relationship to Client: _____ Phone: _____

Address: _____

Section Two: Current Living Situation

Currently, _____ lives . . .

Important information about current living situation:

Section Three: Future Living Situation

After I (we) are gone, I (we) would like _____ to live . . .

_____ would like to live with:

_____ would like to live in (City, State, general location)

_____ would like any potential staff to assist him/her with the following household tasks:

_____ can do the following household tasks for himself/herself:

Important information when considering future living situation for _____:

Section Four: Estate/Legal Plans

Special Needs Trust

I (we) have developed a special needs trust for _____. Yes No

The Trustee of his/her trust is: _____

The Advisor to the trust is: _____

The Personal Agent to the trust is: _____

_____’s Attorney is: _____

Important information regarding _____’s special needs trust:

Power of Attorney/Guardianship

I (we) current have Power of Attorney for _____. Yes No

I (we) current have Patient Advocate for _____. Yes No

I (we) current have Guardianship for _____. Yes No

I (we) have named the following people as successor Power of Attorney (name and contact information):

I (we) have named the following people as successor Patient Advocate (name and contract information):

I (we) have named the following people as successor Guardian (name and contract information):

I (we) have authorized _____ to receive medical information through a Stand Alone HIPAA Waiver (name and contact information):

Section Five: Financial Information

SSI _____ Current Amount: _____ Medicaid: _____

SSDI _____ Current Amount: _____ Medicare: _____

Adult Home Help: _____ Current Amount: _____

ALTCS Caseworker: _____
(Name and contact information)

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, B and/or D? Yes or No. 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 _____.

3) Medicaid: Give the Medicaid identification number and program contractor name _____.

Other Health Insurance: _____

ID number: _____

Contact Person: _____

Banking

Bank/Credit Union Name: _____

Address: _____

Contact Person/Phone: _____

Savings Account Number: _____

Checking Account Number: _____

Special Information: _____

Retirement Plans/IRA: _____

A copy of the Summary Plan Description has been provided: _____ Yes _____ No

Paychecks

_____ works at:

Contact Information: _____

Amount of paychecks _____

Uses paychecks for: _____

Does own banking: _____ Yes _____ No

Needs assistance with banking: _____ Yes _____ No

Specific assistance needed: _____

Home _____

Tax information _____

Accountant Name: _____

Contact Information: _____

Can do own taxes: _____ Yes _____ No

Needs assistance with taxes: _____ Yes _____ No

Section Six: Community Mental Health Assistance

Case Management Agency: _____

Contact Information: _____

Supports Coordinator: _____

Phone Number: _____

Case Number: _____

_____ receives the following services (i.e. supported employment, respite, sheltered employment, counseling, housing, etc).

Include agency and contact information:

Section Seven: Medical/Emergency Information

Current Doctors (Include name, address and phone number(s))

Dentist:

Specialists:

Allergies:

Vision:

Hearing:

Seizures:

Seizure Medications:

Therapist/Counselor/Psychologist/Psychiatrist:

Medications: (include what the diagnosis is, who prescribed the medication, dosage, times, side effects, and how medication is given)

Past Operations/ Conditions:

Other Important Medical Information:

I (we) would like _____ to continue with his/her current doctors _____ Yes _____ No

Comments:

Section Eight: School Information

School Name: _____

Address: _____

Phone: _____

Teacher: _____

_____ will remain in Special Education until he/she reaches the age of 26.

_____ Yes _____ No, he/she can graduate when ready

_____ has a current IEP: _____ Yes _____ NO

Important information regarding educational planning for _____:

_____ currently has a transition plan:

_____ Yes _____ No

Important information regarding transition planning for _____:

Section Nine: Employment

I (we) would like _____ to seek out community employment at some point in the future.

_____ Yes _____ No

Important information regarding future community employment opportunities:

Section Ten: Personal Possessions

_____ owns the following items: (i.e. home, care, collections, TV, VCR, stereo, CDs, tapes, etc)

Section Eleven: Personal Care

_____ appreciates assistance with the following personal care tasks:

_____ is able to do the following personal care tasks alone:

_____ is used to the following personal care items (i.e. brands of shampoo, soap, toothpaste, razor, etc)

_____ is used to the following personal care routine:

Section Twelve: Food and Eating

_____ appreciates assistance with the following food preparation and clean-up:

_____ is able to do the following food preparation and clean up:

_____ likes the following foods:

_____ dislikes the following foods:

Special information regarding food and _____:

Section Thirteen: Leisure and Recreation

_____ likes the following leisure/recreation activities:

_____ dislikes the following leisure/recreation activities:

Favorite activities/places to go:

Favorite friends to go with: (include phone number)

Vacations:

Fitness/exercise programs or activities:

Section Fourteen: Special Interests/Abilities

Section Fifteen: Religion

Church: (include address, phone, pastor, how often he/she attends)

Funeral Arrangements:

Special information regarding religion:

Section Sixteen: Family Culture

Our family is: _____close _____not close

Our family celebrates the following events: (i.e. birthdays, holidays, anniversaries, etc)

Our family celebrates events by . . .

Other important cultural/ethnic information:

Section Seventeen: Community Participation

_____ participates in the following community functions:

Voting _____ absentee ballot _____ in person _____)

Library: _____

Clubs (i.e. Knights of Columbus, Moose Club, VFW, etc.):

Health Clubs (YWCA, YMCA, etc.)

Volunteer:

Section Eighteen: Habits/Routines

_____ is used to the following routines:

_____ has the following habits:

Section Nineteen: Disposition

_____’s disposition is generally: (i.e. happy, playful, quiet, withdrawn, assertive, passive, easily influenced, etc)

_____ might become upset/violent if . . .

This is how we calm/comfort him/her:

Section Twenty: Communication:

_____ uses speech to communicate. _____ Yes _____ No

Special information about _____’s speech

Date Updated

How _____ Communicates with Me (us)

When this is happening	And _____ does	We think it means	And we should
<p>(EXAMPLE)</p> <p>Tim is walking with support</p>	<p>Sits down</p>	<p>Tim doesn't want to go where you are taking him</p> <p>Tim is afraid of falling</p> <p>Tim is tired or his back hurts</p>	<p>Ask him to show you where he wants to go</p> <p>Hold him more securely under his arms</p> <p>Sit down with him for a rest</p>

How I (we) Communicates with _____

I want to let _____ know	To do this I	And then support/encourage ____ to
(EXAMPLE) It's time to get up (if not already awake)	Knock on his bedroom door and then open it.	Continue his morning routine.

