

APPENDIX 5-11¹

LETTER OF INTENT

Name of Disabled Person _____

Prepared By _____

Date _____

INDEX

1. THE PLAYERS
 - 1.1. Person with Disability*
 - 1.2. Parents
 - 1.3. Guardian
 - 1.4. Trustees
 - 1.5. Important Contacts
 - 1.6. Involved Family Members
 - 1.7. Friends
 - 1.8. Pets
2. MEDICAL INFORMATION
3. PUBLIC BENEFITS
4. ABILITIES/DISABILITIES
5. PERSONAL CHARACTERISTICS
6. ACTIVITIES
7. PERSONAL CARE
8. MEALS
9. HOPES AND EXPECTATIONS
10. ADDITIONAL INSTRUCTIONS

1. THE PLAYERS

1.1. Person with Disability

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

¹ From Special Needs Trusts, Begley & Canellos, Wolters Kluwer, 2009

E-mail address _____ Cell No. _____
Birth Date _____ Social Security No. _____

1.2. Parents

Name of Father _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Birth Date _____
Name of Mother _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Birth Date _____

1.3. Guardian

Name of Guardian _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Relationship to Person with Disability _____

1.4. Trustee

Name of Trustee _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Name of Contact Person (if corporate trustee) _____
Name of First Successor Trustee _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____
Name of Contact Person (if corporate trustee) _____
Name of Second Successor Trustee _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Name of Contact Person (if corporate trustee) _____

1.5. Contacts

Please list those organizations providing or coordinating services for the person with the disability.

Name of Organization _____
Name of Contact Person _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Services provided _____

Name of Organization _____
Name of Contact Person _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Services provided _____

Name of Organization _____
Name of Contact Person _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Services provided _____

1.6. Involved Family Members

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Relationship to Person with Disability _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Relationship to Person with Disability _____

1.7. Pets

Name of Pet _____ Type _____

Describe how person relates to pet _____

Who cares for pet? _____

Name of Veterinarian _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Name of Pet _____ Type _____

Describe how person relates to pet _____

Who cares for pet? _____

Name of Veterinarian _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

1.8. Friends

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

2. MEDICAL INFORMATION

2.1. Please identify the child's current physicians, therapists, and specialists.

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Speciality _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Speciality _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Speciality _____

Full Name _____

Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____
Specialty _____

2.2. Medical Coverage

Please indicate the medical coverage available to the child with disabilities.

2.2.1. Private Medical Insurance

Name of Company _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____
Type of Coverage _____
Policy No. _____

2.2.2. Medicare: _____ Yes _____ No

If yes, Medicare No. _____

2.2.3. Medicaid: _____ Yes _____ No

If yes, Medicaid No. _____

2.2.4. Dental Coverage: _____ Yes _____ No

If yes, Name of Company _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____
Policy No. _____

2.2.5. Vision Coverage: _____ Yes _____ No

If yes, Name of Company _____
Street Address _____

City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____
Policy No. _____

2.2.6. Prescription Coverage

Does the person with disabilities have a prescription plan? _____ Yes _____
No

If yes, Name _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____
Policy No. _____

2.3. Hospital

Name _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____

2.4. Pharmacy

Name _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail address _____

2.5. Medications

2.5.1. List of all prescriptions used by the person with disabilities, including the name, dosage, frequency, purpose and name of prescribing physician on Exhibit 1.

2.5.2. List the non-prescription medications or vitamins used by the person with disabilities on Exhibit 2.

2.6. Treatments or Special Care

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

2.7. Allergies

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.

2.8. Emergency

In the event of an emergency, are there any special instructions?

2.9. Assistance

Does the person need assistance with taking medicine (for example, you must give insulin shots or put certain pills in apple sauce)?

3. PUBLIC BENEFITS

Is the person with disabilities receiving any public benefits? _____ Yes _____ No

If yes, he/she is receiving:

- _____ SSI
- _____ Medicaid
- _____ SSD
- _____ Medicare
- _____ Section 8 Housing
- _____ Group Home
- _____ Special Education
- _____ Vocational Training
- _____ Other _____

4. ABILITIES/DISABILITIES

4.1. Limitations

Please indicate whether the person with disabilities has limitations with respect to any of the following:

- _____ Hearing
- _____ Seeing
- _____ Speaking
- _____ Walking
- _____ Memory
- _____ Concentrating
- _____ Understanding
- _____ Standing

_____ Coordination

_____ Communicating

_____ Making change

_____ Other

Explanation _____

4.2. Extraordinary Powers

Please indicate whether the person with disabilities has extraordinary powers with respect to any of the following:

_____ Hearing

_____ Seeing

_____ Speaking

_____ Walking

_____ Memory

_____ Concentrating

_____ Understanding

_____ Standing

_____ Coordination

_____ Communicating

_____ Making change

_____ Other _____

Explanation _____

4.3. Medical or Adaptive Equipment/Supplies

Please indicate whether the person with disabilities needs any of the following adaptive equipment:

_____ Glasses

_____ Dentures

_____ Braces

_____ Hearing Aids

_____ Walker

_____ Cane

_____ Wheelchair

_____ Service Dog

_____ Other _____

Comments _____

4.4. Interaction with Others

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

4.5. Stress

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

4.6. Change

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

5. PERSONAL CHARACTERISTICS

5.1. General

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

5.2. Personality

Describe the person's basic characteristics and personality.

5.3. Preferences

What are the person's preferences?

5.4. Dislikes

What does the person dislike?

5.5. Interests

What are the person's special interests?

5.6. Male/Female

Does the person prefer a male or female attendant? Please explain.

5.7. Clothing

Please list the person's favorite type of clothes.

5.8. Favorite Places

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

5.9. Sizes

Shoes	_____
Pants	_____
Shirt or Blouse	_____
Skirt or Dress	_____
Coat	_____
Gloves	_____
Underwear	_____
Belt	_____
Other _____	_____

6. ACTIVITIES

6.1. Housework

6.1.1. Chores

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

6.1.2. Required Assistance

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

6.1.3. Likes

What chores does the person like to do best?

6.1.4. Frequency

How often does he or she help with chores?

6.1.5. Endurance

How long can the person do the chore?

6.1.6. Additional Comments

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

6.2. Recreation

Does he or she have any hobbies, favorite entertainment, or recreation?

_____ Yes _____ No

If yes, please identify and explain what help or assistance is needed for the person to do the hobby, entertainment, recreation (for example, person loves game shows on television, but needs help to turn on television and select channel).

6.3. Daily Routine

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

Morning

Noon time

Evening

Bedtime

6.4. Visitation

6.4.1. Does the person like to go to places such as churches, sports events, shopping malls, grocery stores, or theaters? _____ Yes _____ No

If yes, please explain.

6.4.2. Does the person require assistance or supervision? _____ Yes _____ No

If yes, please explain.

6.4.3. Provide any further comments or instructions about activities.

6.5. Work Experience

Does the person work (for example, Sheltered Workshop or competitive employment)?
_____ Yes _____ No

If yes, specify employer, type of work, work schedule, how person gets to work, and any other information or instructions needed.

6.6. School

Does the person attend a school or day care/program facility? _____ Yes _____ No

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.

7. PERSONAL CARE

7.1. Assistance

Does the individual need any assistance with personal care? _____ Yes _____ No

If yes, please explain what assistance is needed.

7.2. Dressing

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

7.3. Bathing

What assistance is needed for bathing?

7.4. Hair Care

What assistance is needed for hair care?

7.5. Shaving

What assistance is needed for shaving?

7.6. Using the Toilet

What assistance is needed for using the toilet?

7.7. Other Personal Hygiene

What assistance is needed for other personal hygiene?

7.8. Special Reminders

Does the individual need any special reminders to do his or her personal care needs to include taking medicine? _____ Yes _____ No

If yes, please explain.

7.9. Special Instructions

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

8. MEALS

8.1. Preparation

Does the individual prepare meals? _____ Yes _____ No

If yes, please explain.

8.2. Preparation Assistance

Does the individual need assistance in preparing meals? _____ Yes _____ No

If yes, what help is needed?

8.3. Food Allergies

Is the individual allergic to any foods? _____ Yes _____ No

If yes, please identify.

8.4. Dislikes

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

8.5. Eating Assistance

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)? _____ Yes _____ No

If yes, please explain what help is needed.

8.6. Additional Comments

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

9. HOPES AND EXPECTATIONS

9.1. Hopes

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

9.2. Necessary Actions

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

9.3. Additional Information

What additional information would you like to share about this person?

10. ADDITIONAL INSTRUCTIONS

What else would you like to share with the future caregivers and trustees for your disabled child?

EXHIBIT 1 Prescriptions

Name Dosage Frequency Purpose Name of Prescribing Physician

EXHIBIT 2 Non-Prescription Medications and Vitamins

Name Dosage Frequency Purpose Name of Prescribing Physician