



*Protecting Benefits.
Promoting Independence.
Providing Peace of Mind.*

Beneficiary History and Preferences

Letter of Intent 2018 – 1st Party

This Letter of Intent is a written document that provides vital information and instructions as well as passing along personal desires that fall outside the boundaries of a will. It is **not a legal document**. It should be updated annually to reflect the changing needs, desires and interests of the beneficiary. beneficiary.

This should be considered a roadmap for current and future caregivers and caseworkers and a place where and a place where both important factual information about the beneficiary's care can be recorded. If the beneficiary has limited communication ability, this is where If the beneficiary has limited communication ability, this where intentions and preferences can also be recorded to ensure a continuation of care that is as smooth as possible if a change in caregivers is needed. The intention is both for the beneficiary (the person with the disability) and the beneficiary advocate (the parent or sibling caregiver, or Conservator of the person) with the disability to contribute where appropriate to this document's completion. This also allows both the beneficiary and beneficiary advocate a chance to reflect on family member's hopes, dreams and fears and provide a direction for the care of his/herself or from the beneficiary advocate in a change of circumstance.

There are three sections to this document:

I. **Factual Information** regarding the beneficiary's background, abilities, and family support. This section is mandatory and should be reviewed for accuracy once a year. Although there is some overlap with our Joinder document, please keep in mind that this document may be used for "stand-alone" purposes by social workers, Regional Centers, etc. Although there is some overlap with our Joinder document, please keep in mind that this document may be used for "stand-alone" purposes by social workers, Regional Centers, etc.

II. **Beneficiary's Preferences** on a wide range of items as specified both by the beneficiary and by his/her advocate as relevant. For this section, we ask that you answer the sections most relevant to you.

III. **Medical Information** including Medical Providers, Insurance Information and other relevant medical information. This section is required to fill out and should be updated as soon as any changes are known. Please note, this should be filled out in a separate document for HIPAA compliance purposes.

Name of Beneficiary: _____ Today's Date: _____

Name of Beneficiary Advocate (if appropriate): _____ Relationship: _____

Please Note: If the beneficiary is over 18 and not under a conservatorship, please sign below as a waiver to allow the beneficiary advocate to see the beneficiary's responses:

Signature of Beneficiary: _____ Today's Date: _____

Section I – Factual Information

A. Background Information

*Name of Beneficiary: _____ Birthdate: _____

Phone (*circle one* H / W / C): _____ Email: _____

Address: _____

Height: _____ Weight: _____ Color Eyes: _____

U.S. Citizen: Yes No

Is beneficiary a verbal communicator? Yes No If no, please indicate other modes of communication:

*Beneficiary Advocate: _____ Age Today: _____

Phone (H / W / C): _____ Email: _____

Address: _____

Relationship to Beneficiary: _____

List any health concerns and/or medical conditions of beneficiary advocate, along with parents or other close relatives:

B. Family / Support Relationships

Is there a conservatorship in place? Yes No If yes, name of conservator: _____

Is there a Power of Attorney / Durable Health Care Directive? Yes No If yes, please provide name _____

List any living Parents / Step Parents:

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

List any living Grandparents:

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

List any living Siblings and indicate whether they have expressed interest in helping:

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes / Interested in Helping: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes / Interested in Helping: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes / Interested in Helping: _____

List any Extended Family or Close Family Friends who have expressed interest in helping and/or in Beneficiary's life:

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Interested in Helping: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Interested in Helping: _____

C. Professional Agency / Support Information

Is the beneficiary a current Regional Center client? Yes No If yes: _____

Name of RC: _____ Name of Service Coordinator: _____

Phone: _____ Email: _____

Current Professional Service Providers (e.g. home/residential, employment, respite, personal care attendant)

*Name: _____ Agency: _____

Address: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Notes: _____

*Name: _____ Agency: _____

Address: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Notes: _____

(For Beneficiary Advocates only:) List any **individuals who may jeopardize the beneficiary's health and safety**, including persons who you are concerned about taking advantage of the beneficiary financially:

*Name: _____ Relationship: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes: _____

*Name: _____ Relationship: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes: _____

D. Legal / Financial Information

Does the beneficiary have a **Representative Payee** for their SSI or SSDI? Yes No If yes:

Name: _____ Company (if applicable): _____

Address: _____

Phone: _____ Email: _____

Do you have an **Estate Attorney**? Yes No

Do you have a **Financial Planner**? Yes No

Is there an additional **Special Needs Trust besides JLA Trust** besides JLA Trust established for the beneficiary? Yes No

If yes, please attach a copy of the trust document and fill out:

Is there a blocked account? Yes No

Is it court-supervised? Yes No If yes, Case Number: _____

Name of Trust: _____ Trustee: _____

Type of Trust: _____ Phone: _____

Address: _____

Is there a **Bank / ABLE Account** established for the beneficiary? Yes No If yes:

Name of Bank: _____ Account Number: _____

State Issued: _____ Account Balance: _____

Have the parents of the beneficiary purchased **Life Insurance**? Yes No If yes:

Name of Agent: _____ Company: _____

Address: _____

Phone: _____ Email: _____

Amount of Life Insurance: _____ Type of Policy: _____

E. Upon Death

Are any funeral / burial arrangements in place for the beneficiary? If so, please provide a copy of the receipt.

Section II – Beneficiary’s Preferences

F. Personality Characteristics of Beneficiary

*What activities does the beneficiary enjoy the most? _____

*Does the beneficiary enjoy organized group activities? _____

G. Abilities

1. Beneficiary enjoy reading? _____

2. Abilities and skills with money and budgeting? _____

3. Abilities and skills with household chores such as laundry, cleaning up, taking out the trash, etc. _____

H. Life / Work Preferences

1. Preferred residential setting/environment (for example Quiet/Lively, City/Suburb, Small/Large) _____

3. Does the beneficiary have and use (*Check all that apply*):

- Cellphone
- iPad / Tablet
- Laptop or Desktop Computer
- Email use on a regular basis

4. Does the beneficiary engage in social media (*Check all that apply*)?

- Facebook
- Twitter
- Instagram

Other: _____

6. List any work history, including volunteer work: _____

7. Career/employment goals, short-term and long-term: _____

8. Current and Future Educational Plans: _____

I. Social / Recreational

1. Sports / Recreational Activities that the beneficiary has enjoyed in the past: _____

2. Sports / Recreational Activities that the beneficiary has expressed an interest in doing in the future: _____

J. Religion / Spiritual

1. Is the beneficiary practicing in a particular faith / religion? Yes No If yes, which one: _____

2. Does the beneficiary attend a synagogue/church or other place of worship? Yes No

K. Physical Abilities

Please indicate if there are any issues / concerns in the following areas:

Physical Mobility: _____

Small Motor Abilities / Challenges: _____

Hearing Ability: _____

Eyesight: _____

Responsiveness to Questions: _____

Ability to Initiate Self-Care: _____

Special Equipment: _____

L. Eating / Meals / Dietary Concerns

Is he/she (check all that apply):

Tube-fed

Gluten-Free

Kosher

Vegetarian

Vegan

Low-sodium diet

Low-carb diet

Other special diet: _____

1. Grocery Shopping: No Assistance Needed Minimum Assistance Maximum Assistance N/A

2. Meal Prep: No Assistance Needed Minimum Assistance Maximum Assistance N/A
3. Eating: No Assistance Needed Minimum Assistance Maximum Assistance N/A
4. Clean Up: No Assistance Needed Minimum Assistance Maximum Assistance N/A

M. Any Additional Information you would like to share, including your hopes for the future:

Section III – Medical Information

N. Medical Information, Providers and Insurance

Beneficiary Disability: List all, with primary diagnosis first.

1. _____ Age at Onset: _____

2. _____ Age at Onset: _____

3. _____ Age at Onset: _____

Any serious chronic health conditions (such as asthma, diabetes, severe allergies etc.):

1. _____ 3. _____

2. _____ 4. _____

Current Insurance Provider:

Insurer Company: _____ Policy Number: _____

Primary Person Insured: _____

Phone: _____ Address: _____

Name of Primary Care Physician: _____

Phone (H / W / C): _____ Email: _____

Address: _____

Notes: _____

How is the provider paid? Covered through insurance Private Pay

Phone (H / W / C): _____ Email: _____

Address: _____

Current Medications / Dosages – Prescription Drugs (This is vital information that must be updated whenever there are relevant changes)

Other current medical conditions / issues (including digestive/bowel habits) you would like to share:

O. Allergies / Bad Reactions

Food Allergies:

Name of Food: _____ What Happened: _____

Environmental Allergies: _____

Medication Allergies (either prescription or over-the-counter):

Name of Medication: _____ What Happened: _____

Any Additional Medical Information you would like to share: _____