

PRUDENTIAL  
**SPECIAL NEEDS  
SOLUTIONS**  
FOR ALL AGES®



**Letter of Intent**

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We understand that, as a parent or person responsible for a loved one with special needs, you sometimes face difficult tasks that may make you uncomfortable, but their importance compels you to take action. Creating a Letter of Intent for your loved one with special needs is one such task—emotional and difficult—yet tremendously important.

The personal, financial and medical information that is detailed in a Letter of Intent will help your child's or loved one's guardians, caregivers, relatives or friends—the people who will be critical to your loved one's physical, emotional, and financial well-being—care for him or her in the way that you would when you are no longer able to do so. Your hopes and desires are put into writing so that others will know your wishes for the future and be able to carry them out. This is very personal information, unlikely to be found in a will or trust.

It is important to update your Letter of Intent on a regular basis and also when information changes. The Letter of Intent is not a legal document, but it should be signed and dated upon completion. Any updates should also be signed and dated. Once complete, please share your Letter of Intent with the people who are most likely to provide care and have responsibility for your family member with special needs.

We hope that you find the attached sample Letter of Intent to be helpful as you prepare yours.

*This sample Letter of Intent is provided courtesy of The Prudential Insurance Company of America ("Prudential") and its financial professionals. It is intended to assist you and your professional advisors in understanding the issues involved in planning for the future of loved ones with special needs. It is not a legal document.*

*Neither Prudential nor its financial professionals render tax or legal advice. For guidance regarding your particular circumstances, you should consult your personal legal and tax advisors.*

## SAMPLE LETTER OF INTENT

This is a sample letter that you can use as a starting point for writing your own personalized letter to those individuals who will be involved in the care of your loved one.

Dear \_\_\_\_\_:

I am writing this letter to you because of the crucial role you will play in [loved one's name]'s life when [I am/we are] no longer here. [I/We] know that the transition period can be very challenging and [I/we] hope that this information will help make it easier for both you and [loved one's name]. [I/We] want you to know as much as possible about [loved one], our family, and [my/our] hopes and dreams for [him/her] so that you will be able to provide the care and support that [I/we] would if [I/we] could. Thank you.

This Letter of Intent is not a legal document, but it has been signed and dated. You can see that this content provides important information that is not necessarily included in [my/our] [will/trust].

Thank you again for what you are doing for [me/us] and, more importantly, thank you for what you will be doing for [loved one's name]. Your willingness to take on this important responsibility means more than we could possibly ever express.

Very sincerely yours,

[Your [and your spouse's/partner's] name]

(CONTINUED)

# Letter of Intent



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LETTER OF INTENT REGARDING:

---

PREPARED BY:

---

DATE:

---

PHONE:

---

ADDRESS:

---

---

This Letter of Intent contains personal medical, financial and other information about [Name], who has special needs. Please note:

- [Name] is a minor (under the legal age of majority for his/her state of residence). Initials: \_\_\_\_\_
- [Name] is of the age of majority (at or over the legal age of majority for his/her state of residence) but, due to his/her disability, is not legally able to give consent to the provision of the information in this Letter of Intent. [I/we] retain a copy of the [proof of guardianship] [power of attorney]. Initials: \_\_\_\_\_
- [Name] is of the age of majority and consents to disclosure of the medical, financial and other information in this Letter of Intent, as indicated by his/her signature below. Initials: \_\_\_\_\_

---

Signature:

---

Date:





**2** [Name]'s

**INFORMATION**



Full name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Social Security number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Information below as of: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Work phone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe size: \_\_\_\_\_ Clothing sizes: \_\_\_\_\_

Gender:  Male  Female Race: \_\_\_\_\_

Fluent languages: \_\_\_\_\_ Religion: \_\_\_\_\_

Country of citizenship: \_\_\_\_\_

If married:

Spouse's name: \_\_\_\_\_

Spouse's date of birth: \_\_\_\_\_

Children's name(s) and date of birth: \_\_\_\_\_

**3 BIRTH INFORMATION**

Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Obstetrician name and address: \_\_\_\_\_

City and State where born: \_\_\_\_\_

Hospital name and address: \_\_\_\_\_

Information about the delivery: \_\_\_\_\_

**4 FATHER'S INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Social Security number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Birth date: \_\_\_\_\_ City and State where born: \_\_\_\_\_

Religion: \_\_\_\_\_ Race: \_\_\_\_\_

Blood type: \_\_\_\_\_ U.S. citizen:  Yes  No

Marital status and date: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

(CONTINUED)

**4 FATHER'S INFORMATION** *continued...*

[Name]'s

Aunt(s) and Uncle(s):

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

**5 MOTHER'S INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Social Security number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Birth date: \_\_\_\_\_ City and State where born: \_\_\_\_\_

Religion: \_\_\_\_\_ Race: \_\_\_\_\_

Blood type: \_\_\_\_\_ U.S. citizen:  Yes  No

Marital status and date: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

[Name]'s

Aunt(s) and Uncle(s):

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

Name and age: \_\_\_\_\_

Address, phone, and e-mail address: \_\_\_\_\_

\_\_\_\_\_

(CONTINUED)

## 6 SIBLINGS

Sibling name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Sibling name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

## 7 OTHER RELATIONSHIPS

[Name of friend] \_\_\_\_\_ is closest to [Name] \_\_\_\_\_ .

Friends or relatives who are special to [Name] \_\_\_\_\_ :

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relationship to [Name] \_\_\_\_\_ : \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relationship to [Name] \_\_\_\_\_ : \_\_\_\_\_

## 8 CURRENT LEGAL GUARDIAN

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

[Name] \_\_\_\_\_ has \_\_\_ has not \_\_\_ been declared incompetent.

Relationship: \_\_\_\_\_

A copy of the guardianship papers is \_\_\_ is not \_\_\_ attached.

(CONTINUED)

## 9 SUCCESSOR/ALTERNATE GUARDIAN

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

## 10 TRUST INFORMATION

Name of trust: \_\_\_\_\_

Date of trust: \_\_\_\_\_

Current trustees:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

## 11 REPRESENTATIVE PAYEE INFORMATION

The Representative Payee was appointed by the Social Security Administration to receive Social Security and/or Supplemental Security Income benefits for [Name]. The Representative Payee's main responsibility is to use the benefits to pay for current and foreseeable needs of [Name] and properly save any benefits not needed to meet current needs.

A copy of the Representative Payee's appointment is \_\_\_ is not \_\_\_ attached.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

## 12 POWER OF ATTORNEY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Date Power of Attorney was granted: \_\_\_\_\_

A copy of the Power of Attorney is \_\_\_ is not \_\_\_ attached.

(CONTINUED)

## 13 FINAL ARRANGEMENTS

Final arrangements have \_\_\_\_ have not \_\_\_\_ been made.

If they have been made:

Name of funeral home: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Contact person: \_\_\_\_\_

Name of cemetery: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Contact person: \_\_\_\_\_

Payments have \_\_\_\_ have not \_\_\_\_ been made.

[I/We] would \_\_\_\_ would not \_\_\_\_ like a service.

[I/We] would \_\_\_\_ would not \_\_\_\_ like a monument to be created.

[I/We] would like [Name] to be buried \_\_\_\_ cremated \_\_\_\_.

[I/We] wish that final arrangements include \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 14 MEDICAL HISTORY AND CARE

Diagnoses: \_\_\_\_\_

\_\_\_\_\_

Diagnostic and genetic tests performed, including dates, doctor/laboratory performing tests and results: \_\_\_\_\_

\_\_\_\_\_

Intellectual functioning level: \_\_\_\_\_

Vision level: \_\_\_\_\_

Contact lenses or glasses: \_\_\_\_\_

If contacts, brand and prescription: \_\_\_\_\_

Vision prescription: \_\_\_\_\_ Hearing aid:  Yes  No

Speech and communication: \_\_\_\_\_ Seizures:  Yes  No

Blood type and conditions: \_\_\_\_\_

(CONTINUED)

Doctors—including medical and psychological:

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(CONTINUED)

Immunizations:

Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_  
Immunization: \_\_\_\_\_ Date: \_\_\_\_\_

Diseases:

Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_  
Disease: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Allergies:

Allergic to: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Testing: \_\_\_\_\_  
Date: \_\_\_\_\_  
  
Allergic to: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Testing: \_\_\_\_\_  
Date: \_\_\_\_\_  
  
Allergic to: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Testing: \_\_\_\_\_  
Date: \_\_\_\_\_

(CONTINUED)

**14** MEDICAL HISTORY AND CARE *continued...*

Previous medical doctors:

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

[Name] no longer sees this doctor because \_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

[Name] no longer sees this doctor because \_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

[Name] no longer sees this doctor because \_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

[Name] no longer sees this doctor because \_\_\_\_\_

\_\_\_\_\_

(CONTINUED)

Dentist:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Important background information and findings to note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Orthodontist:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Important background information and findings to note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nursing care:

[Name] requires nursing care because \_\_\_\_\_  
\_\_\_\_\_

Care is given at home unless noted below.

Name of firm or facility: \_\_\_\_\_  
Primary contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Important background information and findings to note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapy:

Therapy type: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Name of therapist: \_\_\_\_\_  
Frequency and duration: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Important background information and findings to note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(CONTINUED)

Therapy type: \_\_\_\_\_

Specialty: \_\_\_\_\_

Name of therapist: \_\_\_\_\_

Frequency and duration: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

Therapy type: \_\_\_\_\_

Specialty: \_\_\_\_\_

Name of therapist: \_\_\_\_\_

Frequency and duration: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Important background information and findings to note: \_\_\_\_\_

\_\_\_\_\_

**Surgery:**

Procedure: \_\_\_\_\_ Date: \_\_\_\_\_

Where it was performed: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Hospitalizations:**

Doctor: \_\_\_\_\_

Reason: \_\_\_\_\_

Date: \_\_\_\_\_

Hospital name and address: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

(CONTINUED)

[Name] uses \_\_\_\_\_ as a method of birth control.

[Name] is \_\_\_\_ is not \_\_\_\_ ambulatory.

Medical equipment and assistive devices:

[Name] uses the following: \_\_\_\_\_ (e.g. wheelchair, adaptive cutlery, glasses, contact lenses, hearing aids, hand splints, orthotics, shower chair, accessible van, augmentative speech device, etc.)

Prescription Medication:

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Past prescription medication:

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescribing doctor: \_\_\_\_\_

Was discontinued because \_\_\_\_\_

(CONTINUED)

**14** MEDICAL HISTORY AND CARE *continued...*

Over-the-counter medications and items:

[Name] does \_\_\_ does not \_\_\_ need help to take his/her medicine. [Name of helper] helps [Name] to take his /her medicine at this time.

[Name] picks-up/buys [Name]'s medicine.

[Name] can \_\_\_ cannot \_\_\_ swallow pills.

The best way to get [Name] to take medicine is \_\_\_\_\_

[Name]'s diet is restricted as follows (e.g, no sugar, no salt, no foods that would present a choking hazard such as nuts or chewing gum, etc.): \_\_\_\_\_

\_\_\_\_\_

Other:

Please be aware of these additional medical needs and conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**15** HOUSING

Current living arrangements: \_\_\_\_\_

Past living arrangements: \_\_\_\_\_

\_\_\_\_\_

[I/We] feel that the best living situation for [Name] is (e.g., living with relatives, living with friends, living in a group home or institution in a shared room or a single room, etc.):

First choice: \_\_\_\_\_

Second choice: \_\_\_\_\_

Third choice: \_\_\_\_\_

(CONTINUED)

## 16 DAILY LIVING AND DAILY LIVING SKILLS

[Name]'s weekday schedule includes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[Name]'s weekend schedule includes \_\_\_\_\_

\_\_\_\_\_

[Name] usually awakens around \_\_\_\_ AM

[Name] usually goes to sleep around \_\_\_\_ PM

[Name]'s morning routine is \_\_\_\_\_

[Name]'s nighttime routine is \_\_\_\_\_

[Name]'s primary method of ambulation is \_\_\_\_\_

[Name]'s primary method of communication is \_\_\_\_\_

[Name]'s primary signs include \_\_\_\_\_

[Name] needs help with (eating, drinking, brushing teeth, brushing hair, dressing bathing, toileting, etc.) \_\_\_\_\_

[Name] uses the following incontinence supplies: \_\_\_\_\_

[Name] can \_\_\_\_ cannot \_\_\_\_ drive a car.

[Name]'s daily transportation needs are \_\_\_\_\_

## 17 PERSONAL BANKING AND FINANCIAL INFORMATION

[Name] needs \_\_\_\_ does not need \_\_\_\_ help with banking.

[Name] has a banking account at \_\_\_\_\_

The account is in the name of [account holder] for the benefit of [Name].

The account number is \_\_\_\_\_

[Name] can \_\_\_\_ cannot \_\_\_\_ pay bills and stick to a budget.

[Name]'s finances are managed on a day-to-day basis by \_\_\_\_\_

The person who is best able to help [Name] with his/her personal finances is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

E-mail address: \_\_\_\_\_

[Name] does \_\_\_\_ does not \_\_\_\_ receive an allowance.

[Name]'s allowance, in the amount of \$\_\_\_\_\_ is paid on a [frequency] basis by [name of payee].

(CONTINUED)

**18 EDUCATION**

[Name] currently attends [level of school and type of school] .

Contact person: \_\_\_\_\_

School name: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Ages attended: \_\_\_\_\_ Grade level completed: \_\_\_\_\_

[Name]'s Individual Education Plan (IEP) is \_\_\_ is not \_\_\_ attached.

[Name] also attends the program(s) below:

Program: \_\_\_\_\_ Length of program: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Program: \_\_\_\_\_ Length of program: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

[Name] previously attended:

School/program: \_\_\_\_\_ Length of program: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

School/program: \_\_\_\_\_ Length of program: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

E-mail address: \_\_\_\_\_

[Name]'s special academic abilities include \_\_\_\_\_

In the future, [I/we] hope that [Name]'s educational plans include \_\_\_\_\_

[Name] is/was \_\_\_ is not/was not \_\_\_ integrated into regular classes during his/her education.

(CONTINUED)

## 19 DAY PROGRAM OR WORK

[Name] currently attends a day program \_\_\_\_ job \_\_\_\_.

Describe: \_\_\_\_\_

Location: \_\_\_\_\_

Past programs or jobs that were not appropriate were \_\_\_\_\_

[I/We] feel that the best day program or job for [Name] would be \_\_\_\_\_

A copy of [Name]'s Individual Habitation Plan is \_\_\_\_\_ is not \_\_\_\_\_ attached.

## 20 LEISURE, RECREATION AND PERSONAL PREFERENCES

[Name]'s favorite recreational activities include \_\_\_\_\_

[Name] likes to be with the following people when he/she is engaged in these activities: \_\_\_\_\_

[Name]'s interests include \_\_\_\_\_

[Name] enjoys vacations such as \_\_\_\_\_

[Name] goes on vacation in \_\_\_\_\_

[Name] does \_\_\_\_\_ does not \_\_\_\_\_ need an accessible room in a hotel.

[Name] likes to wear \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

[Name]'s favorite books include \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

[I/We] hope that [Name] can do the following in the future:

## 21 RELIGIOUS PREFERENCES

[Name] is a member of (church, synagogue, temple, etc.): \_\_\_\_\_

[Name]'s clergy person is \_\_\_\_\_

[Name]'s attends religious services on \_\_\_\_\_

[I/We] hope that [Name] does \_\_ does not \_\_ observe and celebrate religious occasions and holidays in the future.

(CONTINUED)

## 22 RIGHTS AND VALUES

[I/We] feel strongly that [Name] should be entitled to \_\_\_\_\_

[I/We] hope that the following values will always be communicated and upheld to [Name] : \_\_\_\_\_

## 23 PHYSICAL AND EMOTIONAL WELL-BEING

[Name] needs the following things and services in order to be safe and healthy: \_\_\_\_\_

[Name] needs to avoid and be kept away from \_\_\_\_\_.

[Name] may exhibit the following behaviors: \_\_\_\_\_

These behaviors should be dealt with by \_\_\_\_\_

[Name] is upset by \_\_\_\_\_

[Name] is angered by \_\_\_\_\_

[Name] expresses his/her anger by \_\_\_\_\_

[Name] is afraid of \_\_\_\_\_

When [Name] is upset or angry the following helps him/her feel better: \_\_\_\_\_

## 24 SERVICES AND GOVERNMENT BENEFITS

[Name] receives the following services and benefits from his/her community:

Service/benefit: \_\_\_\_\_

Name of provider: \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Service/benefit: \_\_\_\_\_

Name of provider: \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

[Name] or his/her Representative Payee receives the following government benefits (e.g. Social Security, SSDI, SSI, etc.):

Service/benefit: \_\_\_\_\_

Frequency: \_\_\_\_\_

Amount: \_\_\_\_\_

(CONTINUED)

[I/We] keep the following records relating to [Name] :

Wills: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Trusts: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Living Wills: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Durable Powers of Attorney: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Guardianship Order: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Safe deposit box: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Income tax records: \_\_\_\_\_

Where kept (ie. safety deposit box, file cabinet, etc.): \_\_\_\_\_

Life insurance policy (Carrier's name): \_\_\_\_\_ Policy number: \_\_\_\_\_

Owner: \_\_\_\_\_ Insured: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Face amount: \_\_\_\_\_ Premium/frequency: \_\_\_\_\_

Agent's name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Where kept (ie. safe deposit box, file cabinet, etc.): \_\_\_\_\_

Health insurance—Medical: \_\_\_\_\_

Policy number: \_\_\_\_\_ Premiums/frequency: \_\_\_\_\_

Agent's name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Health insurance—Dental: \_\_\_\_\_

Policy number: \_\_\_\_\_ Premiums/frequency: \_\_\_\_\_

Agent's name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Health insurance—Vision: \_\_\_\_\_

Policy number: \_\_\_\_\_ Premiums/frequency: \_\_\_\_\_

Agent's name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Health insurance—Other: \_\_\_\_\_

Policy number: \_\_\_\_\_ Premiums/frequency: \_\_\_\_\_

Agent's name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Mortgage documents/deed/title: \_\_\_\_\_

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