Life Care Guide
(Special Needs Adult)

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Special Needs and Elder Law

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____________________________(NAME) AT ______________________(PHONE)

TO MAKE ARRANGEMENTS TO RETURN THIS BINDER. YOU MAY NOT COPY, SCAN, OR IN ANYWAY MAKE RECORDS OF THE INFORMATION CONTAINED IN THIS BINDER.
IMPORTANT NOTE TO USER:

As a reminder, this binder should be kept confidential because the information contained in here is highly personal to you and the special needs individual you care for. This should be made available only to those people who need to know to provide proper care for your special needs individual. If you have been directed by your attorney to complete the information in this binder, it may also be protected by the attorney client privilege and special care should be taken so as to avoid the inadvertent disclosure of this information to adverse parties or make any other disclosure which would destroy the privilege. If this applies to you, you should consult with your attorney about the proper maintenance of these records. [This generally applies in cases where the special needs individual has been involved in a lawsuit, but there are other situations which apply also, if you are uncertain, you are encouraged to consult with your attorney.]
DISCLAIMER

Use of this Life Care Guide does not create an attorney client relationship or any other professional client relationship with the Law Offices of Mark E. Biernath, P.C. or any of its attorneys. This is only done through a written retainer/engagement agreement entered into between the respective parties. This guide is provided for educational purposes to assist in understanding the complexities of estate planning for individuals with special needs. No promises or guarantees are made as to the fitness or usefulness of this guide for any purpose. If you have any questions or would like more information about the planning concepts addressed in this guide, the need for planning, or application of law to your specific situation you should seek the advice of competent legal counsel who focuses in this particular area of law. Estate planning involving individuals with special needs is a complex matter including many areas of law and life. If you feel you need additional counsel in this area you are encouraged to consult with an attorney of your choosing. You are welcome to call the Law Offices of Mark E. Biernath, P.C. to schedule an appointment.

It is our desire that this guide be useful to families with special needs, we welcome your comments and suggestions.

You may make as many copies of the pages you need for your personal use.
Life Care Guide
For

Maintained by:

Name: ____________________________ Relationship: ______________
Name: ____________________________ Relationship: ______________
Name: ____________________________ Relationship: ______________
Name: ____________________________ Relationship: ______________
Name: ____________________________ Relationship: ______________

Introduction

The goal of this guide is to serve as an essential tool in the event that the primary care giver of an individual with special needs is unable to provide care for him or her. This is a place for you to organize important information regarding the care of this person. In the unlikely event that a complete stranger must step in and provide proper care for this individual, this binder can be the primary source of information that person needs to know.

In the following pages, you can fill in detailed information concerning this person, including his or her medical, social, emotional, and spiritual needs as best you can describe them. This information should be kept confidential, but it is important that it is available when it is needed. This can be accomplished by keeping it up to date. Depending on the needs of this individual, a yearly review and revision may be sufficient, others may require a monthly or even a weekly review.

Please be aware that this guide, standing alone, is not legally enforceable for any purpose.
1. Quick Reference

This section contains a quick overview of critical information that would be needed in the event that the primary caregivers were unavailable.
General Information

Full legal name of individual with special needs ________________________________

Prefers to be called: ___________________________________________________________

Home Address: __________________________________________________________________

City, State, Zip: __________________________________________________________________

Phone: ________________________________________________________________________

Is currently living at (name of facility): _____________________________________________

Address: ___________________________________________________________________

City, State, Zip: __________________________________________________________________

Names of Individuals living with person:       Relation to person

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Does this individual require Home Health Aides/Nurse? Yes    No  (Circle one)

Name of person usually providing such care: _______________________________________

Name of Agency providing such care? ______________________________________________
Specific Information

Individual’s Name: _________________________________

Birth Date: _______________________________________

Social Security Number: ____________________________

Medicaid Number: _________________________________

Insurance (Health) Number: _________________________

Dental Insurance Number ____________________________

General Description of individual (attach photo if one is available)

Height ________  Weight ________  Hair Color ________  Eye Color ________
__________________________________________________________________________
__________________________________________________________________________

Please identify disabling condition if known/diagnosed (medical or developmental):
__________________________________________________________________________
__________________________________________________________________________

General description of disabling condition: ________________________________
__________________________________________________________________________

Prognosis: _______________________________________________________________

Please attach a copy or reference to a source of information you found helpful in learning about this individual’s disability. This should be information that you consider important for someone caring for this individual.
Is this individual able to communicate in spoken English?  Yes  No

Is he or she able to communicate in a spoken language other than English?  Yes  No

If yes, What language(s)?  ________________________________________________________________

Is he or she able to communicate with a non-verbal language such as sign-language?  Yes  No

If yes, what non-verbal language(s)?  ____________________________________________________

Is he or she able to communicate his or her needs or desires to others?  Yes  No

How does this individual communicate his or her needs or desires to others?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does this individual understand when new people speak with him or her?  Yes  No

If someone had to explain bad news to this person, would he or she understand?  Yes  No

Who would you want to explain bad news to this individual  if it were possible or practicable?
Name:  _______________  Phone:  _______________  Cell:  _______________
Relation to individual:  _____________________________________________________________

Please describe this person’s current awareness of disability and self-advocacy skills:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
This section contains important information about the medications your special needs individual takes. It is critically important that this information be kept up to date. As you are aware, changes in medication routine can have troubling effects that can take a long time to correct. It is suggested that you maintain a record of all previous medications and reason for discontinuing so that important medical history is not lost.

If there have been adverse reactions to over the counter meds please add a sheet on that medication as well. Also, if some over the counter medications have been particularly useful, add them to this binder as well.
Medications

Name of Medication: _________________________________________________________

Description: □ Tablet □ Capsule □ Oral Liquid □ Injection □ other: __________

Prescribing Physician: ______________________________ Phone: ________________

Pharmacy: ______________________________ Phone: ________________

Dosage: _________ Frequency: _______ When Given? (Circle) AM PM With Food

How is medication administered: _______________________________________________

Who administers medication: ______________ At home/work? _____________

Purpose of medication: _______________________________________________________

Location medication is stored: _________________________________________________

Side effects:
_________________________________________________________________________
_________________________________________________________________________

Date Started Med: ____________________ Date Stopped Med: ____________________

Reason for stopping medication:
□ Doctor Directed □ Allergy □ Side effects too severe

Please describe: _____________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
This section contains important information about the doctors, therapists, social workers, and other professionals involved in the care of your special needs individual. This will help provide critical continuity of care as well as identify where important medical information can be located.

It is suggested to maintain a record of doctors and professionals who have been used in the past and for what reason, in case a similar need arises in the future, then your special needs individual can have the same care as before. Or, in the alternative, if a professional was discontinued and you do not want that professional used again in the future, you can indicate the reason and your desire that they not be consulted. Please understand however that this does not put a legal obligation on a future caregiver to follow, rather it provides them with information about what may be in the special needs individual’s best interest.
Physicians

Physician’s Name: ___________________________ Primary Care? Y N

Practice Name: _____________________________________________________________

Phone: _________ Fax: _________ Pager: _________ Cell: _________

Address: __________________________________________________________________

City: ________________________________ State: ___________ Zip: _______________

Affiliated Hospital: ___________________________________________________________

Practice Area/Specialty: ______________________________________________________

Reason this individual sees this doctor: __________________________________________
__________________________________________________________________________

How often? □ Daily □ Bi-Weekly □ Weekly □ 2-weeks □ Monthly □ 3 months □ 4 months □ 6 months □ yearly □ other _________

Who usually takes this person to see this doctor? ________________________________

How does he or she react to having to go to doctor? ______________________________
__________________________________________________________________________

Tips or suggestions to help him or her with visiting this doctor: ______________________
__________________________________________________________________________

Date Started seeing Doctor: _____________ Date stopped seeing Doctor: _____________

Reason no longer seeing this doctor? ___________________________________________
__________________________________________________________________________
Therapists

Therapist’s Name: ________________________________

Practice Name: _________________________________________________________________

Phone: ____________ Fax: ____________ Pager: ____________ Cell: ____________

Address: __________________________________________________________

City: __________________ State: ___________ Zip: ____________

Affiliated Hospital: ___________________________________________________________

Practice Area/ Specialty: ______________________________________________________

Reason this person sees this therapist: __________________________________________

How often? □ Daily □ Bi-Weekly □ Weekly □ 2-weeks □ Monthly □ 3 months □ 4 months □ 6 months □ yearly □ other __________

Who usually takes him or her to see this therapist? ________________________________

How does he or she react to having to go to therapy? ______________________________

Tips or suggestions to help this individual with visiting this therapist: ________________

Date Started seeing therapist: ___________ Date stopped seeing therapist: ___________

Reason no longer seeing this therapist? ___________________________________________
Psychologists

Psychologist’s Name: _______________________________________________________________________

Practice Name: ____________________________________________________________________________

Phone: ___________ Fax: ___________ Pager: ___________ Cell: ___________

Address: ________________________________________________________________________________

City: ________________________________ State: _________ Zip: _______________

Affiliated hospital or treatment facility: _______________________________________________________________________________________

Practice Area/Specialty: _________________________________________________________________________________________________

Reason this individual sees this psychologist: ______________________________________________________________________________

__________________________________________________________________________________________

How often? □ Daily □ Bi-Weekly □ Weekly □ 2-weeks □ Monthly □ 3 months □ 4 months □ 6 months □ yearly □ other

Who usually takes this person to see this psychologist? ________________________________

How does he or she react to having to go to psychologist? ________________________________

________________________________________________________________________________________

Tips or suggestions to help this individual with visiting this psychologist: ______________________

________________________________________________________________________________________

Date Started seeing psychologist: _________ Date stopped seeing psychologist: _______

Reason no longer seeing this psychologist? ________________________________________________

________________________________________________________________________________________
Other Professionals

Name: ____________________________________________________________

Practice Name: _____________________________________________________

Phone: ___________ Fax: ___________ Pager: ___________ Cell: ___________

Address: __________________________________________________________

City: ________________________________ State: ___________ Zip: ___________

Affiliated hospital or treatment facility: __________________________________

Practice Area/Specialty: ______________________________________________

Reason this individual sees this person: __________________________________

How often? □ Daily □ Bi-Weekly □ Weekly □ 2-weeks □ Monthly
□ 3 months □ 4 months □ 6 months □ yearly □ other

Who usually takes him or her to see this person? ___________________________

How does he or she react to having to go here? _____________________________

Tips or suggestions to help this person with visiting this person: _______________

Date started seeing person: _____________ Date stopped seeing person: ___________

Reason no longer seeing this person? ______________________________________
This section contains information about any special equipment that your special needs individual may require. Please include information about durable medical equipment as well as anything else that contributes to your special needs individual’s ability to do things for themselves, brings them enjoyment, or has been simply helpful in his/her care.

By providing information about vendors and maintenance you make it easier for a future care giver to keep equipment in proper, safe working order.
Special Equipment

Equipment Name: _______________ How does this individual refer to it: _______________

Purpose: __________________________________________________________________________
________________________________________________________________________________

Can he or she use it independently?  Yes  No  Eyes on Supervised  Hands on Supervised

Who knows how to use it? _______________ Phone: _______________

Where is it kept? __________________________________________________________________

Who supplied it (see provider list for contact information)? _______________

Who maintains it? __________________________________________________________________

Who paid for it?  □ Medicaid  □ Medicare  □ Private Insurance  □ Private pay

Is it rented or owned? _______________

How often is it needed?

□ Daily  □ Bi-Weekly  □ Weekly  □ 2-weeks  □ Monthly

□ 3 months  □ 4 months  □ 6 months  □ yearly  □ other

Please describe how this individual uses it: __________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
5. Financial Information

This section contains important financial information regarding your special needs individual. Be as complete and through as possible. This will assist you or a future caregiver to appropriately provide for your special needs individual as well as assist in securing benefits for your special needs individual.
Government Benefits

Agency: ____________________________________________________________

Location: __________________________________________________________

Contact Name: _______________________________ Phone: ________________

Case or File Number: ________________________________

Location where ID card is kept (keep a photocopy of front and back of card in this manual):

____________________________________________________________________

Amount of monthly benefit: __________________________

Where does this money go? (Bank, Check sent to home, etc): ________________

Account Number: __________________________________

Is there an annual case review?   Yes   No

If so, when is this annual review usually done? ____________________________

Please indicate where previous copies of annual reviews and correspondence are kept, you
may want to keep them in this binder. ______________________________________

Any other helpful or useful information?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Current Private Benefits

Source of Private Benefit: _____________________________________________________

Location: ____________________________________________________________________

Contact Name: _________________________ Phone: _________________________

Case or File Number: ___________________________

Location where ID card is kept (keep a photocopy of front and back of card in this manual):
________________________________________________________________________

Amount of monthly benefit: ___________________________

Where does this money go? (Bank, Check sent to home, etc)

Account Number: _____________________________________________________________________

Is there an annual case review? Yes No

If so, when is this annual review usually done? ________________________________

Please indicate where previous copies of annual reviews and correspondence are kept, you may want to keep them in this binder.

What is the source of this benefit? ______________________________________________

Was this a settlement to a lawsuit? Yes No

If so, please indicate case, location, and attorney representing this individual: __________
________________________________________________________________________

Are these funds from an inheritance? Yes No

If so, please provide a copy of the instrument creating the funds: (Will, Certificate of Trust)
Current Private Medical Insurance

Source of Private Insurance: ___________________________________________________________

Location: __________________________________________________________________________

Contact Name: ___________________________ Phone: ______________________

ID Number: _________________________________________________________________________

Location where ID card is kept (keep a photocopy of front and back of card in this manual):

________________________________________________________________________________

Is this provided by an employer? Yes  No

Name of Employer: __________________________________________________________________

Contact Name: ___________________________ Phone: ______________________

Who is primary card holder? _______________ Social Sec No. _______________

Is there an annual case review? Yes  No

If so, when is this annual review usually done? ______________________________________

Please indicate where previous copies of annual reviews and correspondence are kept, you may want to keep them in this binder. If you have a summary of benefits, please include that here as well.

Under what circumstances will this coverage be terminated? _____________________________

________________________________________________________________________________

Any other helpful or useful information? _______________________________________________

________________________________________________________________________________
## Assets Belonging to Special Needs Individual

Assets include personal property, cars, bank accounts in their name, any real property, any sources of income. Identifying the assets this individual has will help identify exempt assets under need based qualifying standards, as well as if this individual is in a residential facility this will alert a care giver to secure any personal property and assure that this person has access to their property. Please identify if any of the items have a strong personal or sentimental value.

### Does special needs person own any land, house, building, real estate?  Yes  No

If yes please complete the following for each asset of this nature:

<table>
<thead>
<tr>
<th>Description of Asset</th>
<th>Location</th>
<th>Contact person</th>
<th>Phone</th>
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</table>

How is this property titled?  

How was this property acquired?  ________________  Insured?  ____________

<table>
<thead>
<tr>
<th>Description of Asset</th>
<th>Location</th>
<th>Contact person</th>
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</table>

How is this property titled?  

How was this property acquired?  ________________  Insured?  ____________

### Does special needs person own any vehicles (cars, trucks, vans, boats)?  Yes  No

If yes please complete the following:

<table>
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<tr>
<th>Description of Asset</th>
<th>Location</th>
<th>Contact person</th>
<th>Phone</th>
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</table>

How is this vehicle titled?  

How was this property acquired?  ________________  Insured?  ____________
### Assets (continued)

Please identify important personal property:

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Location</th>
<th>Importance to Individual</th>
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### Bank Accounts:

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</table>

How are accounts titled? ____________________________________________

How was account acquired/what is source of funds? ____________________

<table>
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<th>Location</th>
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</table>

How are accounts titled? ____________________________________________

How was account acquired/what is source of funds? ____________________
This section contains a wealth of information that will assist in maintaining continuity in routine for your special needs individual. This section should be reviewed by anyone who is charged with caring for your individual with special needs. It includes information about home, family, friends, social activities, pets, responsibilities, religious preferences, agencies and support groups, transportation needs, communication needs, eating, drinking, personal care, safety, mobility, sleeping habits, and social behaviors.
Home, Family, & Friends

Please list others who live with this individual and their relationships him or her.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any interaction problems that this individual has with any family members or friends? If so please describe.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does this person have any special family traditions?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Where does this person like to go for vacation? Check all that apply and add in your own.

☐ Mountains
☐ Big cities
☐ Camping
☐ Hiking
☐ Lake
☐ Snowy areas
☐ Boat
☐ ________________________
☐ ________________________
☐ ________________________
☐ ________________________
Recreation, Leisure, & Play activities

What activities or games does this individual enjoy most?

__________________________  ____________________________
__________________________  ____________________________
__________________________  ____________________________
__________________________  ____________________________
__________________________  ____________________________

With whom does this person usually spend free time with?

Name: _______________________________  Phone Number: __________________________
Address: __________________________________________________________________

Name: _______________________________  Phone Number: __________________________
Address: __________________________________________________________________

Are there any relatives who visit him or her on a regular basis?

Name: _______________________________  Phone Number: __________________________
Address: __________________________________________________________________

What is this individual’s favorite thing to do when it is raining?

What does he or she enjoy doing outside?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Responsibilities

What responsibilities does this person have at home? (chores, etc.)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Does he or she enjoy cleaning?  Y  N

Explain:
__________________________________________________________________________

Does he or she enjoy cooking?  Y  N

Explain:
__________________________________________________________________________

Does he or she enjoy yard work?  Y  N

Explain:
__________________________________________________________________________

What types of housework does this individual enjoy the most?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Pets

Does this person enjoy being around animals?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Does this individual have any family pets?  Y  N

If yes, what kind and what are their names?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Does anyone bring their dog or pet to visit this individual?  Y  N

If yes, how often do they visit?  _________________________________________________

Contact information

Name: __________________________________  Phone Number: _______________________

Address: ____________________________________________________________________
Agencies and Support Groups

Group Name: ______________________________________________________________

Location: __________________________________________________________________

Contact Name: _________________________________  Phone: ____________________

Briefly describe how this individual or his or her family participates and what types of support this group provides: _________________________________________________________

__________________________________________________________________________

Group Name: ______________________________________________________________

Location: __________________________________________________________________

Contact Name: _________________________________  Phone: ____________________

Briefly describe how this individual or his or her family participates and what types of support this group provides: _________________________________________________________

__________________________________________________________________________

Group Name: ______________________________________________________________

Location: __________________________________________________________________

Contact Name: _________________________________  Phone: ____________________

Briefly describe how this individual or his or her family participates and what types of support this group provides: _________________________________________________________

__________________________________________________________________________
Religious Affiliation

Group Name: ______________________________________________________________

Location: __________________________________________________________________

Contact Name: ___________________________ Phone: __________________

Type of activities this individual usually participates in:

☐ Regular Worship Services
☐ Special Services
☐ Sunday School
☐ Weekday programs
☐ Music Programs
☐ Camping trips
☐ Sporting trips
☐ Evening programs
☐ Youth program

Briefly describe how this person participates and what types of accommodations are necessary:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Are there any groups or activities that you do not want this person participating in?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Community

Is this individual a member of any religious group?  Y  N
If yes, name of group: __________________________________________
Location of the Group: __________________________________________
Contact person: _____________________________   Phone Number:  _____________

Does he or she participate in any community activities? (sports, etc)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does he or she enjoy going shopping?  Y  N
Explain: ____________________________________________________________
________________________________________________________________________

Are there any special affiliations with which this person is associated?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Transportation

Does this individual have any transportation needs? (van with a lift, special car or seat, community transportation)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Who maintains special equipment?

Company: _________________________________________________________________
Contact: _________________________________ Phone Number: __________________

Community Transport: _______________________________________________________
Contact: _________________________________ Phone Number: __________________

How does this person usually get to where he or she needs to go?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Communication

How are the needs of this individual communicated? (verbal, gestures, pictures, sign language, special equipment)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Does this individual communicate:

☐ Easily       ☐ With Some Difficulty       ☐ With Great Difficulty

Please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

On a scale of 1 to 5, how well are basic instructions understood?

1 _______________ 2 _______________ 3 _______________ 4 _______________ 5 _______________ 
Not understood at all       3          4          5          Understands with little difficulty

Describe what happens when this individual becomes frustrated when trying to communicate.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Eating

Is this individual able to eat by his or herself?  Y  N

If no, please describe help needed: __________________________________________________________

________________________________________________________________________

Have you created any special eating adaptations to make eating easier for him or her?

________________________________________________________________________

________________________________________________________________________

Does this individual have any special feeding equipment?  Y  N

Please describe: __________________________________________________________

________________________________________________________________________

________________________________________________________________________

Who maintains and supplies equipment? _________________________________________

Contact: _________________________________  Phone Number: ___________________

What is this person’s eating schedule?: __________________________________________

________________________________________________________________________

List this individual’s favorite foods:

__________________________  __________________________

__________________________  __________________________

What types of food does this person dislike?

__________________________  __________________________

__________________________  __________________________

Does he or she have any food restrictions? ______________________________________

________________________________________________________________________

Food allergies– List food and type of reaction (ex: choking/gagging, hives, etc.)

__________________________  __________________________

__________________________  __________________________
Drinking

Is this person able to drink by his or herself?  Y  N
If no, please describe help needed: _______________________________________________________
___________________________________________________________________________________

Have you created any special drinking adaptations to make drinking easier for him or her?
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

What are this person’s favorite drinks
_________________________________________  ______________________________
_________________________________________  ______________________________
_________________________________________  ______________________________

Least favorite drinks
_________________________________________  ______________________________
_________________________________________  ______________________________
_________________________________________  ______________________________

Does this individual have any beverage restrictions?  Y  N
If yes, please explain: ________________________________________________________________
_________________________________________________________________________________
Personal Care

Is this person potty-trained?  Y  N

Does he or she need any help or special equipment using the toilet?  Y  N
Explain: ________________________________________________________________

_______________________________________________________________________

How often (and when) do accidents happen?
_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Does he or she need any help bathing?
_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Describe this individual’s grooming habits and any help he or she may need.
_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Describe this individual’s dressing habits and any help he or she may need.
_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
Safety

On a scale of 1 to 5, describe the level of supervision that this individual requires?

1 __________ 2 __________ 3 __________ 4 __________ 5
Needs very little supervision                              Must always be supervised

Please explain:______________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

How would this person react if he or she had a simple cut or minor burn?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What would he or she do if there was a fire?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Does this individual know how to dial 911?      Y        N

Are there safety issues you are concerned about in or around your home?  Please explain
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Are there safety issues you are concerned about when in public?  Please explain.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Mobility

How much mobility does this individual have?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Does he or she need any special equipment for mobility?  Y  N

If yes, please describe:

__________________________________________________________________________

__________________________________________________________________________

Product Information—please list any important information including model numbers and names of equipment needed and where you purchase equipment from

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

If bed ridden, how often is this person re-positioned?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

What steps are taken to reduce or avoid bedsores?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Sleeping Habits

Please describe this individual’s bedtime routine (include usual bedtime)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

How often does he or she take a nap? __________________________________________________________________________
How long does he or she sleep? __________________________________________________________________________

Describe this person’s sleeping habits
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

How often does he or she wake up in the middle of the night? ________________________________
Describe how to best deal with night awakenings. ___________________________________________
__________________________________________________________________________
__________________________________________________________________________

Describe this individual’s morning routine (include when he or she usually wakes up)
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Social Behavior

Describe this individual’s general temperament.

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Does he or she enjoy being in public places?    Y     N

What are this person’s favorite places to go? ______________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Describe how this individual responds to unfamiliar situations? __________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Describe any behaviors that you feel are dangerous to this individual or to others

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Does he or she ever intentionally destroy things?    Y     N

If yes, please explain:

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Are there any behaviors that must be dealt with? ________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Describe your current behavior support plan. ________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Does this individual have a BIP (Behavior Intervention Plan) at school?    Y     N

If yes, please include a copy of it here or write where it is located. ____________________

_______________________________________________________________________________________________________________
Miscellaneous Information

Please use the space provided to add any additional information that is important for someone to know about this individual. Add additional pages if necessary.
7. Education and Employment

This section contains important information about the special needs individuals education and employment.

Education – Federal law provides significant safeguards to ensure a free, appropriate public education for individuals with disabilities. This is done in conjunction with the local school district and is usually specified in an Individualized Education Plan (IEP). Many IEPs are very thorough and occupy a separate binder. This section should either contain a copy of the current IEP and indicate where previous IEPs are located, or you should indicate where the IEP is kept so it can be located when needed. [NOTE: If you are unable to locate a copy of the current IEP, the local school district will have a copy on file, generally only a parent or guardian is able to access that information from the school system]

Employment – Many individuals with special needs are able to participate in a wide variety of occupational activities. There are numerous programs offered through the State and private companies. Often, a transition plan is developed in conjunction with the school system which includes work training and placement opportunities. This section will contain contact information if this applies to your special needs individual.
Education

Is this person currently enrolled in school?   Y   N   Where? _______________________________
______________________________________________________________________________________

Does he or she go everyday?   Y   N   If not, which days? ________________________________

Is IEP Information included in this Binder?   Y   N

Please identify where any other IEP information is stored. ________________________________
______________________________________________________________________________________

Does he or she enjoy going to school? ________________________________
______________________________________________________________________________________

What is his or her favorite subject in school? ________________________________
______________________________________________________________________________________

What supports does this individual need during the school day? See IEP

______________________________________________________________________________________

How does he or she get to school? (bus, car, etc)? See IEP

______________________________________________________________________________________
Employment

What is this individual’s current job placement?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How often does he or she work?

Does this person receive any employment supports? (job coach, employment counselor, transportation)

□ Y □ N

If yes, please list contact information

Name: _______________________________ Phone Number: _______________________

Address:  __________________________________________________________________

Job title:  __________________________________________________________________
This section contains important information about any legally recognized or court established/supervised guardianships for the special needs individual.

This section should contain copies of the Order creating the guardianship, Letters of Guardianship, any reports filed with the court such as the annual inventory and personal status report.
Guardianship Information

Name of Guardian: __________________________________________________________

Address: ______________________________________________________________________

City: ____________________________  State: ___________  Zip: ________________

Phone Number(s): Home: ____________________

Work: ____________________

Cell: ____________________

*Check all that apply, add additional sheets for additional guardians

Guardian of Person  Guardian of Property

Identify court where guardianship was first established

Name of Court

Probate Superior State

Common Other _____________

Of ______________________________ County

______________________________ State

Address of Court: __________________________________________________________

__________________________________________________________________________

Judge: ____________________________________________________________________

Clerk: ____________________________________________________________________

When is annual filing due: ________________ (Anniversary date of original order)

Attorney who represented Guardian: __________________________________________

Address of attorney: _________________________________________________________

__________________________________________________________________________

Phone Number: ____________________            Fax Number: ____________________

Was an attorney appointed to represent ward?  Y        N

If yes, who? Name: ____________________________________________________________________

Address: ______________________________________________________________________

__________________________________________________________________________

Phone Number: ____________________

**Include copies of all court reports/correspondence
Miscellaneous Information
Please use the space provided to add any additional information that is important for someone to know about this individual. Add additional pages if necessary

Special Concerns

Any Other Useful Information
9. Special Needs Trust
10. Care Giver’s Estate Plan Overview

This section contains information about you (the caregiver) and your estate plan. This is important so that your wishes are followed and any future caregiver can assist with making sure those plans become effective.

This section only contains an overview and probably will not contain the actual documents that put the plan into effect. There is a place to indicate where the documents are kept. The information provided here does not have any legal force or effect, only properly drafted and executed documents have the legal binding effect to put your estate planning in place. This means generally the originals of the various documents would be required at such a time as it becomes necessary.
Estate Plan Overview for: ___________________

Please note that information here has no legal force or effect, only properly drafted and executed documents will have such. If there is a conflict between information here and what is in a properly drafted and executed document, the properly drafted and executed document prevails. Any mistakes are inadvertent and should not be constructed as an amendment or revocation of a previous document.

I have a check all that apply:
✓ Will
✓ Trust (RLT)
✓ Durable Power of Attorney
✓ Durable Healthcare Power of Attorney
✓ Living Will
✓ HIPAA Authorization
✓ ILIT
✓ Other ________________________________

The documents are located in a:
✓ Bank safe deposit box
✓ Safe
✓ Fire box
✓ Other ________________________________

Answer any question that pertains to where the documents are located

The key is located: ____________________________________________________________
The combination is: ___________________________________________________________
The combination can be found at: ______________________________________________

Persons who have access to them are:
Name: ____________________________________________________________________
Address: __________________________________________________________________
Phone Number: _____________________________________________________________

General Durable Power of Attorney

Is this a springing Power of Attorney? Y N
Does it only come into effect upon disability or incapacity? Y N

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<tbody>
<tr>
<td>Agent</td>
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<tr>
<td>Joint/</td>
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<tr>
<td>Successor Agent</td>
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**Estate Plan Overview Continued**

**Durable Medical Power of Attorney**

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<td>1st Agent</td>
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<tr>
<td>Successor</td>
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**Trust**

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**Guardianship for Self**

Determination by: 
- Doctor
- Panel

Where is this nomination? 
- DPOA
- HCPOA
- Guardianship Nomination
- Trust

Nominated Guardian:

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If a panel was used to determine incapacity or nominate guardian, who is on the panel?

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Estate Plan Overview Continued

Who have you nominated as guardian for minor/dependant children?

Where is this nomination?
- Will
- Trust
- Guardianship Nomination

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<tr>
<th>Named Individuals</th>
<th>Panel to Nominate</th>
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