

**LETTER OF INTENT**  
**(INSTRUCTIONS FOR CAREGIVING)**

Please complete the following form to communicate to future caregivers and trustees what you think they need to know to care for you or your loved one. Regardless of where the person with a disability lives – in a group home, a parent’s or family member’s home, or his or her own home, you or the parent (spouse or other family caregiver) should indicate what you know best based upon a lifetime of your care. You can pass on the information to succeeding caregivers. These instructions should be given to successor caregivers (and trustees) after they have agreed to serve. A copy should also be kept on file by the attorney who prepared the disabled person’s special needs trust. Sharing the instructions in a Letter of Intent is best done though a meeting so the document can be reviewed and discussed by the parties involved.

This letter of intent is designed to give successor caregivers and trustees the realistic information they need to carry on effectively as caregivers after parents (or other family members) no longer can provide the care themselves. This practical information could also alleviate concerns that caregivers and trustees might have about how they best can fulfill expected family obligations.

If you run out of space, please attach additional sheets of paper as needed.

**For:** \_\_\_\_\_  
Name of person with disability

**Prepared by:** \_\_\_\_\_

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

**Signature:** \_\_\_\_\_

**Prepared by Richard L. Newman, Esquire\* (contact information on page 17).**

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**I. IDENTIFYING INFORMATION**  
**A. Person with Disability**

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	BIRTH DATE
HOME ADDRESS	CITY, STATE	ZIP
PHONE NUMBER		

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**B. Parents**

MOTHER'S NAME	DOB	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP
FATHER'S NAME	DOB	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP

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**C. Guardian**

NAME	RELATIONSHIP TO CLIENT	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP

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**D. Trustees**

TRUSTEE'S NAME	RELATIONSHIP TO CLIENT	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP
NAME OF 1ST SUCCESSOR	RELATIONSHIP TO CLIENT	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP
NAME OF 2ND SUCCESSOR	RELATIONSHIP TO CLIENT	PHONE NUMBER
HOME ADDRESS	CITY, STATE	ZIP





**II. MEDICAL INFORMATION**

A. Please identify the person's current physicians, therapists, and specialists:

Name: _____	Name: _____
Address: _____	Address: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Phone: _____	Phone: _____
Specialty: _____	Specialty: _____

Name: _____	Name: _____
Address: _____	Address: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Phone: _____	Phone: _____
Specialty: _____	Specialty: _____

B. Does the person have any healthcare coverage? \_\_\_\_\_ If so, please complete all questions that apply:

1. Medicare: Provide claim number \_\_\_\_\_. Does the person have Medicare coverage under parts A and B? If no, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Health insurance: Identify the company \_\_\_\_\_, type of coverage \_\_\_\_\_, group number if appropriate \_\_\_\_\_, Medicare Supplement Plan (A through J) \_\_\_\_\_, and identification number \_\_\_\_\_. Is insurance on parent's or guardian's account? \_\_\_\_\_ What are plans for continuing after death of parent or guardian? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Medicaid: Provide the Medicaid identification number \_\_\_\_\_

4. Any dental or vision coverage? If so, identify the company \_\_\_\_\_, type of coverage \_\_\_\_\_, group number, if appropriate, \_\_\_\_\_, and identification number \_\_\_\_\_.

C. Identify the hospital and the pharmacy that the person uses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. What medications does the person use, and what are the purposes? Who prescribed the medications?

Medication & Purpose	Doctor's Name
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E. What non-prescription medications or vitamins does the person take? (please indicate the purposes)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. How is payment made for health insurance, dental care, medical care, and medications?

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

H. Is the disabled person allergic to any medications, insect bites, chemicals, or any other item? If yes, please list and explain type of reaction and treatment required: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I. Provide any special instructions or procedures to follow when taking the person to a doctor or dentist: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

J. Please share additional comments or instructions about medical and dental care:

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K. In the event of an emergency, are there any special instructions? \_\_\_\_\_

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**III. PERSONALITY TRAITS & PREFERENCES:**

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

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B. Describe the person's basic characteristics and personality traits: \_\_\_\_\_

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C. What are the person's preferences (likes)? \_\_\_\_\_

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D. What does the person dislike? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. What are the person's special interests? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does the person prefer a male or female attendant? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

G. Please list the person's favorite type of clothing \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

H. Does the person have favorite places he or she likes to go? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I. Provide the person's shoe and clothing sizes: Shoes \_\_\_\_\_ Pants \_\_\_\_\_  
Shirt or Blouse \_\_\_\_\_ Skirt or Dress \_\_\_\_\_ Coat \_\_\_\_\_ Gloves \_\_\_\_\_  
Underwear \_\_\_\_\_ Belt \_\_\_\_\_ Other \_\_\_\_\_

J. What is the person's height? \_\_\_\_\_; weight \_\_\_\_\_

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**IV. PERSONAL CARE:**

A. Does the individual need any assistance with personal care? If yes, please explain what assistance is needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Does the person need assistance with taking Medicine (for example, you must give insulin shots or put certain pills in applesauce): \_\_\_\_\_

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C. What assistance does the person need with dressing (for example, do you need to help the person button clothes or tie shoes?): \_\_\_\_\_

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D. What assistance is needed for the following personal care activities?

Bathing: \_\_\_\_\_

Hair Care: \_\_\_\_\_

Shaving: \_\_\_\_\_

Using the toilet: \_\_\_\_\_

Brushing teeth: \_\_\_\_\_

Other personal hygiene: \_\_\_\_\_

E. Does the individual need any special reminders to take care of his/her personal care needs or to take medicine? If yes, please explain:

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

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## V. MEALS:

A. Does the individual prepare meals? If yes, please explain:

1. What foods can he/she prepare (for example, sandwiches or frozen dinners)?

\_\_\_\_\_

2. Which meals or snacks does he/she prepare? \_\_\_\_\_

B. Does the individual need assistance in preparing meals? If yes, what help is needed?

\_\_\_\_\_

\_\_\_\_\_

C. Is the individual allergic to any foods? If yes, please identify:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

E. Is the person able to feed him/herself, or does he/she need limited or total help at meals (for example, person cannot cut up his or her food or lift eating utensils)? If yes, please explain what help is needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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## VI. ACTIVITIES:

A. Does the individual assist with or do any house or yard work? If yes, please explain:

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

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

\_\_\_\_\_

3. What chores does the person like to do best? \_\_\_\_\_

\_\_\_\_\_

4. How often does he or she help with chores? \_\_\_\_\_

5. For how long can the person do the chore(s)? \_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

B. Does he/she have any hobbies, favorite entertainment, or recreation? If yes, please identify and explain what help or assistance is needed for the person to do the hobby, entertainment, or recreation (for example, person loves game shows on television but needs help to turn on television and select channel):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

1. Morning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Noon time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Evening: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Bedtime: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Does the person like to go to places such as church, sporting events, shopping malls, grocery stores, or theaters? \_\_\_\_\_

1. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

2. Does the person require assistance or supervision for activities or outings?  
Please explain: \_\_\_\_\_  
\_\_\_\_\_

Provide any further comments or instructions about activities.

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E. Does the person work (for example, Sheltered Workshop or competitive employment)? If so, specify employer, type of work, work schedule, how person gets to work, and any other information or instructions needed: \_\_\_\_\_

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F. Does the person attend a school or day care/program facility? If yes, identify school or day care facility and provide any instructions regarding person's attendance and participation at the school or day care/program facility: \_\_\_\_\_

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**VII. ABILITIES & DISABILITIES:**

A. Please circle and explain any of the following that the person has extraordinary powers or limitations:

- |               |               |          |              |        |
|---------------|---------------|----------|--------------|--------|
| Hearing       | Seeing        | Speaking | Walking      | Memory |
| Concentrating | Understanding | Standing | Coordination |        |
| Communicating | Making change | Other    | _____        |        |

Please Explain any circled items: \_\_\_\_\_

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B. Does the person need medical or adaptive equipment/supplies? If so, mark appropriate box, and describe in comment section what assistance the person will need with each item (for example, the person needs help to put on his or her braces):

- |         |                |              |                |
|---------|----------------|--------------|----------------|
| Glasses | Yes ___ No ___ | Dentures     | Yes ___ No ___ |
| Braces  | Yes ___ No ___ | Hearing Aids | Yes ___ No ___ |

Walker            Yes \_\_\_ No \_\_\_            Cane            Yes \_\_\_ No \_\_\_  
Wheelchair      Yes \_\_\_ No \_\_\_            Service Dog    Yes \_\_\_ No \_\_\_  
Other: \_\_\_\_\_

Comments:

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C.     What limitations does the person have because of one or more medical problems (for example, the person must rest after walking a short distance or cannot see without glasses), and what assistance must be provided? \_\_\_\_\_

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

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E.     If the person has problems coping with stress, please explain problems and provide instructions on how to handle them: \_\_\_\_\_

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

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**VIII. END-OF-LIFE ISSUES**

A. Does the person have an advance directive or a durable power of attorney for healthcare? \_\_\_\_\_ If yes, please attach a copy of the document. If not, indicate your end of life preferences, if any, for the person:

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B. What arrangements been made to take care of the person's body at death? Is there a pre-need or pre-arranged contract? \_\_\_\_\_ If yes, with what business or agency have the arrangements been made? \_\_\_\_\_

If no arrangements have been made, do you have a preference for a funeral home where you would like arrangements to be made? \_\_\_\_\_

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C. What are the person's plans for anatomical gifts (ie., organ donation)?

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D. Is a certain family member to be consulted regarding final service arrangements, if any? \_\_\_\_\_ If so, who? \_\_\_\_\_

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E. Where is body to be interred (or if it is to be cremated, what is to be done with the ashes)? \_\_\_\_\_

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F. What is to be placed on the marker or tombstone, if applicable? \_\_\_\_\_

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G. What are preferences for a memorial service? \_\_\_\_\_

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## IX. INCOME

A. Does the person receive Supplemental Security Income ("SSI")? \_\_\_\_\_  
If so, how much per month? \_\_\_\_\_

B. Does the person receive Social Security Disability Insurance ("SSDI" or "DIB")? \_\_\_\_\_  
If so, how much per month? \_\_\_\_\_

- C. Does the person receive the SSDI on his/her own account or on a parent's account as an Adult Disabled Child ("DAC") since before age 22 (called "Childhood Disability Benefit" or "CDB")? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- D. Does the person have any earned income from employment? \_\_\_\_\_ If so, how much average monthly income does the person receive from earnings? \_\_\_\_\_ Is this income from a sheltered workshop or part of a trial work period? If so, which? \_\_\_\_\_
- E. Does the person receive Veteran's Benefits? \_\_\_\_\_. If so, how much per month? \_\_\_\_\_
- F. Is the person receiving any income from a workers compensation matter, personal injury claim, or other legal or insurance compensation claim or judgment? \_\_\_\_\_ If so, how much and what are the terms \_\_\_\_\_  
 \_\_\_\_\_
- G. Does the person receive a disability or retirement pension? \_\_\_\_\_ If so, how much per month? \_\_\_\_\_
- H. Does the person receive any income from a trust? \_\_\_\_\_. If so, how much per month or per year? \_\_\_\_\_
- I. Does the person receive any income (or regular gifts) from a parent or family member? \_\_\_\_\_ If so, how much per month? \_\_\_\_\_
- J. Does the person receive any other income? \_\_\_\_\_. If so how much and what is the source? \_\_\_\_\_

**X. GENERAL INFORMATION**

- A. Describe any hopes that you have for the person in the future: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- B. What actions do you think would help the person in the future? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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Adapted by Richard L. Newman, Esquire from a Letter of Intent prepared by Turnbull Law Office, P.C.,