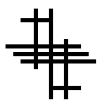


# Life Care Guide



LAW OFFICES OF  
MARK E. BIERNATH, P.C.



# Life Care Guide

**(Special Needs Adult)**



LAW OFFICES OF  
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### **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.]



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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.



**CONFIDENTIAL**

# Life Care Guide

## For

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**Maintained by:**

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.



# Life Care Guide

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Plan Overview

## 1. Quick Reference

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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: \_\_\_\_\_

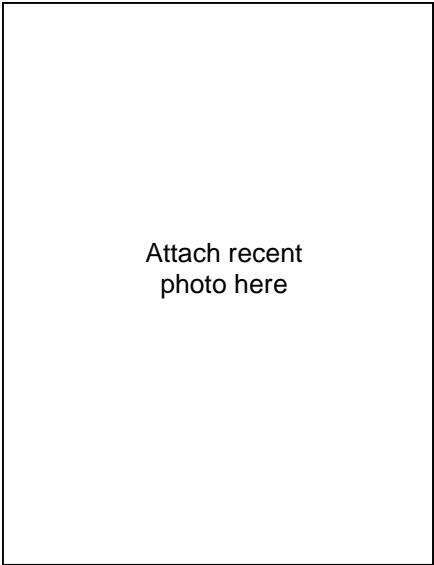
Birth Date: \_\_\_\_\_

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?

---

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---

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:

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---



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.



Cut this corner  
off when this  
medication is  
no longer used

## 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: \_\_\_\_\_  
\_\_\_\_\_



### 3. Doctors/Professionals

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 provided 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? \_\_\_\_\_

\_\_\_\_\_



## 4. Equipment

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

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This section contains important financial information regarding your special needs individual. Be as complete and thorough 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:

Description of Asset	Location	Contact person	Phone
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How is this property titled? \_\_\_\_\_

How was this property acquired? \_\_\_\_\_ Insured? \_\_\_\_\_

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Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

How is this property titled? \_\_\_\_\_

How was this property acquired? \_\_\_\_\_ Insured? \_\_\_\_\_

---

Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

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:

Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

How is this vehicle titled? \_\_\_\_\_

How was this property acquired? \_\_\_\_\_ Insured? \_\_\_\_\_



## Assets (continued)

**Please identify important personal property:**

Item Description	Location	Importance to Individual
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### **Bank Accounts:**

Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

How are accounts titled? \_\_\_\_\_

How was account acquired/what is source of funds? \_\_\_\_\_

Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

How are accounts titled? \_\_\_\_\_

How was account acquired/what is source of funds? \_\_\_\_\_

Description of Asset	Location	Contact person	Phone
----------------------	----------	----------------	-------

How are accounts titled? \_\_\_\_\_

How was account acquired/ what is source of funds? \_\_\_\_\_



## 6. Life Activities and Routines

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.)

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Does he or she enjoy cleaning?   Y   N

Explain:

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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?

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# Pets

Does this person enjoy being around animals?

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Does this individual have any family pets? Y N

If yes, what kind and what are their names?

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

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: \_\_\_\_\_



# 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:

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

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# 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: \_\_\_\_\_

\_\_\_\_\_



# 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)

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Does he or she enjoy going shopping? Y N

Explain: \_\_\_\_\_

---

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

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---



# 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?

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# 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. \_\_\_\_\_

---



## 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?            ﺕ   See IEP

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_



# Employment

What is this individual's current job placement?

---

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---

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: \_\_\_\_\_

Briefly describe this individual's employment history.

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## 8. Miscellaneous

This section is less structured and is provided so that the caregiver can provide other useful nuggets of information that will aid in providing the best possible care for the individual with special needs. If there is something either important or useful that has not been indicated elsewhere in this binder, this section is provided to record that information. Attach additional pages as needed.



## 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

### Likes & Dislikes

### Fears



## 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



## **Supervision**

## **Residence**



## Education

## Employment



## **Social Activities**

## **Behavior Management**



## Medical Care

## Religion



# Care Givers

## **Trustee of Assets**

## **Trustee/Guardian of Person**



# Care Givers

## **Direct Care Providers**

## **Advocates**



# Care Givers

## Special Instructions

Are there any family members or other people you  
DO NOT want to care for this individual or his or her assets?

## Other



## 9. Guardianship

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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



## 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

Name

Address

Phone Number

Agent \_\_\_\_\_

Joint/

Successor Agent \_\_\_\_\_



# Estate Plan Overview Continued

## Durable Medical Power of Attorney

Name	Address	Phone Number
1st Agent _____		
Successor _____		

## Trust

Name	Address	Phone Number
1st Agent _____		
Successor _____		
Successor _____		

## Guardianship for Self

Determination by:  Doctor  Panel

Where is this nomination?  DPOA  Guardianship Nomination  
 HCPOA  Trust

Nominated Guardian:

Name	Address	Phone Number
_____		
_____		
_____		

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

_____	_____
_____	_____
_____	_____



# Estate Plan Overview Continued

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

Where is this nomination?

- Will
- Trust
- Guardianship Nomination

Named Individuals

Panel to Nominate

Names: \_\_\_\_\_

Panel members: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

