# PERSONAL CARE PLAN

for

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I. PERSONAL INFORMATION
This section of the Personal Care Plan provides personal information about the individual who is going to receive benefits from PLAN: your Child/Beneficiary (C/B).

If the information below changes, please notify PLAN.

1. Basic Data
   Name_____________________________________________________________
   Address________________________________________________________________
   City, state, zip______________________________________________________
   Phone # ( )______________________________________________________
   Date of Birth _____________ Birthplace___________________________
   Highest level of education _________ US Citizen___________________
   Social Security # _________________ Medicare #_______________________
   Medicaid # (Title XIX) _____________________________________________
   States Medicaid was received_______________________________________
   Marital Status _____________ Ethnicity _____________________________
   Name of spouse, if married __________________________________________

   If any of the spousal information is different from the information supplied for your PB, please describe.

2. Housing
What is the current living arrangement of the C/B and is it satisfactory?

If a change in housing becomes necessary, what do you believe to be the best living arrangement for your C/B?

Is s/he on any housing waiting lists?

Please use the reverse side if you need additional space
3. Lifestyle

If member or participant, give the name and location of the church/ synagogue.

Does your C/B prefer
__relationships with one other person  __group relationships  __being alone

Typical daily routine:

Activities/Interests:

Dislikes (food, hobbies, activities, etc):

Favorite places to visit in the community where people are familiar:

Special supports and services s/he is receiving. Who provides them and how are they paid? (camp, job coach, items/bills you may be supplementing)

How does s/he react during stressful times? Are there certain techniques or people that will help during such a time?

Do you want special attention paid on birthdays, holidays or other occasions? If so, describe below.

Please use the reverse side if you need additional space
4. Future:

Describe your idea of what life will look like in the future for your child:

Name the three most important duties you see PLAN performing:

What type of help/support do you envision in your c/b’s future care?

What types of daily activities would you suggest (work, volunteer, recreation)?

How much financial support will s/he need outside of their entitlements? Consider what you are providing now.

Please use the reverse side if you need additional space
5. **Important contacts**

Please choose a contact person. This person is someone you trust and who knows what is in the best interest of your child and is likely to survive you. The contact person would be called only if a situation requires assistance.

Name of contact ________________________________________________________________
Address ______________________________________________________________________
City, state, zip ________________________________________________________________
Phone # (___) ________________________________________________________________
Relationship __________________________________________________________________

Please identify friends/relatives that have said they will continue to play a role in your C/B’s life. Is there a favorite relative or friend that your child has a special relationship with?

Identify any friends/relatives that you would NOT want to play a role in their life:

If your child is expected to receive supports from an agency are there any particular providers or other professionals who you would like considered? Please include contact information.

Will a rep payee be needed? Who will serve?

Who currently consents to medical care?

Have you made funeral arrangements for your child? Please provide information:
II. MEDICAL INFORMATION

The second section of this Care Plan requests medical information. If you do not have information for any particular part, just leave it blank.

1. Diagnosis

2. At what age did the disability begin? _________

3. Health insurance provider(s)
   Primary coverage: ______ Medicare ______ Other
   If Other, please complete the following:
   Company___________________________________________
   Policy #________________________________________

4. Primary Doctor________________ Frequency of visits_____________
   Phone #(___)___________________________________________
   Medications, if known___________________________________

5. Doctor #2____________________ Frequency of visits_____________
   Phone #(___)___________________________________________
   Medications, if known___________________________________

6. Dentist______________________ Frequency of visits_____________
   Phone #_____________________________________________
   Medications, if known___________________________________

7. Therapist (for example, psychiatrist, psychologist, social worker, physical therapist)
   Name____________________ Frequency of visits_____________
   Phone #_____________________________________________
   Medications or treatments________________________________

8. History of Hospitalizations
   Please describe overnight hospitalizations during the past two years plus any other earlier, significant hospitalization.
   Date of most recent hospitalization________________________
   Hospital name and location________________________________
   Length of stay________________________________________
   Was this a self admission? Yes_____ No_____
   Reason for admission:

Please use the reverse side if you need additional space
Please describe any other significant hospitalizations.

9. Does your c/b have a history of self injury, suicide attempts, violence or threatening behavior? Be as specific as possible. What were the triggering events?

10. Are there other behavioral issues or events we should know about, such as panic attacks, arrests, history of restraint, hoarding?

11. Are there physical impairments to vision, mobility, hearing, speech? Other impairments? Please describe.

12. Are there any allergies? Dietary restrictions/requirements Please describe.

13. Is there a history of drug or alcohol abuse? Please describe.

14. Are there other issues or events we should know? If yes, please describe.
III. FINANCIAL INFORMATION

This third section of the Personal Care Plan (PCP) asks you to describe the PLAN Beneficiary's monthly income and assets. Insurance (other than health care insurance, described in Section II) is the final subject of this section.

1. Entitlements/Income
   - Employment income: $_________________
   - Social Security Disability: $_________________
   - SSI: $_________________
   - Food Stamps: $_________________
   - HUD/Cash Assistance: $_________________
   - Other (med dispense, homemaker...): ____________

   Total: $ __________________

   Are there any applications for entitlements now pending?
   Yes________  No________  Please describe:

2. Assets
   Does your PB own any of the following? If so, please estimate the value and name the institution:

   **Savings Account**
   - Amount: ____________
   - Name of bank, credit union, etc.: ____________

   **Checking account**
   - Amount: ____________

   Please estimate the value of any other assets your PB owns:

   **Amount**
   - Real estate: ____________
   - Investments: ____________
   - Other: ____________

   Does your PB own an automobile Yes____  No____
   Does your PB have a driver's license Yes____  No____

3. Insurance
   Does your PB have insurance other than health care insurance described in Section II?

   **Life insurance**
   - Yes____  No____
   **Automobile insurance**
   - Yes____  No____

Please use the reverse side if you need additional space
IV. FAMILY INFORMATION

If any of the information requested is not relevant, just leave it blank.

1. Information about father
   Name____________________________________________________
   Address____________________________________________________________________________________
   City, state, zip_____________________________________________
   Phone#(___)_______________(home) (___)_______________(work)
   Date of Birth________________Birthplace______________________
   Social Security #__________________________________________

2. Information about mother
   Name____________________________________________________
   Address____________________________________________________________________________________
   City, state, zip_____________________________________________
   Phone#(___)_______________(home) (___)_______________(work)
   Date of Birth________________Birthplace______________________
   Social Security #__________________________________________

3. Information about brothers and sisters

   Name                                      Date of birth
   ____________________________________________________________
   ____________________________
   ____________________________
   ____________________________
   ____________________________

4. Non-family
   Guardian (if named)_______________________________
   Address____________________________________________________________________________________
   City, state, zip_____________________________________________
   Phone#(___)_______________(home) (___)_______________(work)
   Successor Guardian (if named)_______________________________
   Address____________________________________________________________________________________
   City, state, zip_____________________________________________
   Phone#(___)_______________(home) (___)_______________(work)
   Family Attorney _____________________________________________
   Address____________________________________________________________________________________
   City, state, zip_____________________________________________
   Phone#(___)_______________(home) (___)_______________(work)

Please use the reverse side if you need additional space
Conservator (if named)
Address
City, state, zip
Phone# (___)__________ (home) (___)__________ (work)

Power of Attorney (if named)
Address
City, state, zip
Phone# (___)__________ (home) (___)__________ (work)

5. Important documents

If there are other family papers such as wills, living wills, trusts, powers of attorney, and perhaps even information about safe deposit box, burial or other final arrangements, if made please list them below and provide copies, if available.
V. CHECKLIST OF ABILITIES

This section of the PCP describes the abilities of your PLAN Beneficiary. We ask you to read the skills in the left column and then check the appropriate level of ability in one of the three columns to the right.

<table>
<thead>
<tr>
<th>Skills</th>
<th>Ability</th>
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<tbody>
<tr>
<td></td>
<td>Independently</td>
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</table>

**Self care**
- Personal hygiene?  
- Dress appropriately?  
- Do laundry?  
- Self medicate?  

**Money management**
- Make change for $5.00  
- Pay bills on time  
- Budget money?  

**Vocation**
- Apply for a job?  
- Follow directions?  
- Get to work on time?  

**Independent living**
- Tell time?  
- Use telephone?  
- Cook a simple dinner?  
- Buy groceries?  
- Clean living quarters?  
- Use public transportation?  
- Drive?  
- Respond to an emergency?  
- Use proper judgment if a stranger offers a ride?  
- Make and keep a medical appointment?
VI. PRIORITIES

Please number from 1-9 in order of importance. This applies only to how the trust funds will be spent. A crisis situation will always take priority. You may also circle choices on the second line or add your own.

<table>
<thead>
<tr>
<th>Service</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment of supplemental bills (i.e. cable, internet, housekeeping)</td>
<td>_____</td>
</tr>
<tr>
<td>Monthly or as needed</td>
<td>_____</td>
</tr>
<tr>
<td>Transportation</td>
<td>_____</td>
</tr>
<tr>
<td>Car payment/maintenance/insurance, arrangement of, bus passes</td>
<td>_____</td>
</tr>
<tr>
<td>Periodic evaluation</td>
<td>_____</td>
</tr>
<tr>
<td>Random visits, weekly phone calls, etc?</td>
<td>_____</td>
</tr>
<tr>
<td>Entertainment/Recreation</td>
<td>_____</td>
</tr>
<tr>
<td>Dining out, companionship, camp</td>
<td>_____</td>
</tr>
<tr>
<td>Home furnishings</td>
<td>_____</td>
</tr>
<tr>
<td>Furniture, electronics, computer</td>
<td>_____</td>
</tr>
<tr>
<td>Travel</td>
<td>_____</td>
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<tr>
<td>Day trips (out of town), vacations, travel companion</td>
<td>_____</td>
</tr>
<tr>
<td>Health Care</td>
<td>_____</td>
</tr>
<tr>
<td>Co pays, vitamins, alternative medicine</td>
<td>_____</td>
</tr>
<tr>
<td>Housing</td>
<td>_____</td>
</tr>
<tr>
<td>Finding, moving expenses, property taxes, condo fees</td>
<td>_____</td>
</tr>
<tr>
<td>Other</td>
<td>_____</td>
</tr>
</tbody>
</table>

Please use the reverse side if you need additional space
VII. FUNDING and SIGNATURES

This is the final section where we ask for information. First, we ask about funding this trust, and then we ask you, the writer or writers of this document, to sign it.

Funding

Will the trust be funded now or in the future?
   Now___ In the future___

Estimated amount $___________

If the trust is to be funded now, who will fund it:

Name_______________________ _____________________________
Address___________________________________________________________
City, state, zip_______________________________________________
Phone#(___)______________________________________________

If the funding comes from an estate created by a will, please give the name of the estate and some information about the person responsible for carrying out the terms of the will.

Name(s) of estates(s)__________________________________________
Name(s) of executor(s)_________________________________________
Address________________________________________________________
City, state, zip_______________________________________________
Phone#(___)______________________________________________
Please provide a brief grantor(s) work history (title, company, occupation)
_________________________________________________________________
_________________________________________________________________

If the funding comes from a life insurance policy, please tell us

Name of insured_______________________________________________
Insurance company______________________________________________
Insurance policy #_____________________________________________

If the funding comes from a family and/or family trust, please tell us

Name of the Trust_______________________________________________
Original Grantor_______________________________________________
Grantor’s Work History ____________________________________________
_________________________________________________________________

Please use the reverse side if you need additional space
SIGNATURES

I/We the undersigned, both understand and agree that the services provided by PLAN of CT will be and should be only supplemental to the services and supports provided by federal and state programs for the disabled, if that option is selected in the Lifetime Advocacy Trust.

I/We also agree that the level of trust funds provided to PLAN of CT should be commensurate with the services requested above. If the annual trust funds are insufficient to carry out all of the services designated heretofore, PLAN of CT shall exercise prudent judgment as to which services cannot be fulfilled due to an annual insufficiency of funds.

__________________________  _________________________
Writer's signature          Writer's signature

__________________________  _________________________
Relationship to beneficiary  Relationship to beneficiary

____________  __________
Date          Date
VIII. NEXT STEPS

Congratulations. You have completed the Personal Care Plan. Be sure that you have signed page 13 before you mail the document to us. You will be contacted when the PCP has been accepted. Before mailing the PCP to PLAN, make a copy for your personal files, for future reference. **We ask that you update this PCP as conditions change.**

It will then be necessary for your attorney to call the PLAN office if he/she does not have the PLAN of CT Trusts. Once your Trust Agreement has been signed, it will be mailed to us along with your signed contract for services. Upon payment of any balance due, your job is completed.

Whether you are expecting to have PLAN provide services now or in the future, we are here to answer your questions at any time.

10/22/2014