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:

Please use the reverse side if you need additional space

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.

Please use the reverse side if you need additional space

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:

	$ Amount	Name of bank, credit union, etc.
Savings Account	_____________	__________________
Checking account	_____________	__________________

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.

Please use the reverse side if you need additional space

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.

Skills	Ability Independently	 With Help	 Not at all
<u>Self care</u>			
Personal hygiene?	___________	______	______
Dress appropriately?	___________	______	______
Do laundry?	___________	______	______
Self medicate?	___________	______	______
<u>Money management</u>			
Make change for $5.00	___________	______	______
Pay bills on time	___________	______	______
Budget money?	___________	______	______
<u>Vocation</u>			
Apply for a job?	___________	______	______
Follow directions?	___________	______	______
Get to work on time?	___________	______	______
<u>Independent living</u>			
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?	___________	______	______

Please use the reverse side if you need additional space

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.

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

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

Please use the reverse side if you need additional space

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.