

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

PLAN Beneficiary: _____

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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.

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:

	\$ <u>Amount</u>	<u>Name of bank, credit union, etc.</u>
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

<u>Name</u>	<u>Date of birth</u>
_____	_____
_____	_____
_____	_____
_____	_____

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)

PLAN Beneficiary: _____

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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.

<u>Service</u>	<u>Priority</u>
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 _____

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

Please use the reverse side if you need additional space