Beneficiary History and Preferences
Letter of Intent 2020 – 3rd Party

This Letter of Intent is a written document that provides vital information and instructions as well as passing along personal desires that fall outside the boundaries of a will. It is **not a legal document**. It should be updated annually to reflect the changing needs, desires and interests of the adult with a disability.

This should be considered a roadmap for current and future caregivers and caseworkers whether both important factual information about the beneficiary’s care can be recorded in one place and intentions and preferences can also be recorded to ensure a continuation of care that is as smooth as possible if a change in caregivers is needed. The intention is both for the beneficiary (the person with the disability) and the beneficiary advocate (the parent or sibling caregiver, or Conservator of the person) to contribute where appropriate to this document’s completion. This also allows both the beneficiary and beneficiary advocate a chance to reflect on hopes, dreams and fears and provide a direction for care in a change of circumstance.

**There are three sections to this document:**

I. **Factual Information** regarding the beneficiary’s background, abilities, and family support. **This section is mandatory and should be reviewed for accuracy once a year.**

II. **Beneficiary’s Preferences** on a wide range of items as specified both by the beneficiary and by his/her advocate as relevant. **For this section, we ask that you answer the sections most relevant to you.**

III. **Medical Information** including Medical Providers, Insurance Information and other relevant medical information. **This section is required to fill out and should be updated as soon as any changes are known.** Please note, this should be filled out in a separate document for HIPAA compliance purposes.

| Name of Beneficiary: __________________________________________ | Today’s Date: __________________ |
|_______________________________________________________________|________________________________|
| Name of Beneficiary Advocate (if other): ___________________________ | Relationship: ____________________ |
|_______________________________________________________________|________________________________|

**Please Note:** If the beneficiary is over 18 and not under a conservatorship, please sign below as a waiver to allow the beneficiary advocate to see the beneficiary’s responses:

| Signature of Beneficiary: __________________________________________ | Today’s Date: __________________ |
|_______________________________________________________________|________________________________|
Section I – Factual Information

A. Background Information

Name of Beneficiary: ____________________________ Birthdate: ____________________
Phone (circle one H / W / C): ____________________________ Email: ____________________
Address: ____________________________
Height: ____________________________ Weight: ____________________________ Color Eyes: ____________________________
U.S. Citizen: □ Yes □ No Registered to Vote: □ Yes □ No
Registered with Selective Service (males ages 18 – 25 only): □ Yes □ No
Is beneficiary a verbal communicator? □ Yes □ No If no, please indicate other modes of communication:

Beneficiary Advocate: ____________________________ Age Today: ____________________
Phone (H / W / C): ____________________________ Email: ____________________
Address: ____________________________
Relationship to Beneficiary: ____________________________
List any health concerns and/or medical conditions of beneficiary advocate, along with parents or other close relatives:

B. Family / Support Relationships

Is there a conservatorship in place? □ Yes □ No If yes, name of conservator: ____________________________
Is there a Power of Attorney / Durable Health Care Directive? □ Yes □ No

List all living Parents / Step Parents:

Name: ____________________________ Age: ____________________________
Home Address: ____________________________
Cell Phone: ____________________________ Home Phone: ____________________________ Work Phone: ____________________________
Email: ____________________________

Name: ____________________________ Age: ____________________________
Home Address: ____________________________
Cell Phone: ____________________________ Home Phone: ____________________________ Work Phone: ____________________________
Email: ____________________________

Name: ____________________________ Age: ____________________________
Home Address: ____________________________
Cell Phone: ____________________________ Home Phone: ____________________________ Work Phone: ____________________________
Email: ____________________________

Jewish Los Angeles Special Needs Trust Beneficiary History and Preferences / Letter of Intent - Confidential
Email: __________________________________________________________

Notes: __________________________________________________________________________

List all living Grandparents:

Name: ___________________________________________________________ Age: __________________________
Home Address: _______________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________

Name: __________________________________________________________________________
Home Address: ______________________________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________

Name: ___________________________________________________________ Age: __________________________
Home Address: _______________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________

List all living Siblings and indicate whether they have expressed interest in helping:

Name: ___________________________________________________________ Age: __________________________
Home Address: _______________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________
Notes / Interested in Helping: _______________________________________________________________________

Name: ___________________________________________________________ Age: __________________________
Home Address: _______________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________
Notes / Interested in Helping: _______________________________________________________________________

Name: ___________________________________________________________ Age: __________________________
Home Address: _______________________________________________________
Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________
Email: __________________________________________________________
Notes / Interested in Helping: _______________________________________________________________________

Email: __________________________________________________________
Notes: __________________________________________________________________________
List any Extended Family or Close Family Friends who have expressed interest in helping Beneficiary:

Name: _____________________________________________ Age: ____________________________
Home Address: __________________________________________
Cell Phone: _____________________________ Home Phone: _____________________________ Work Phone: _____________________________
Email: ____________________________________________
Notes / Interested in Helping: ____________________________________________

Name: _____________________________________________ Age: ____________________________
Home Address: __________________________________________
Cell Phone: _____________________________ Home Phone: _____________________________ Work Phone: _____________________________
Email: ____________________________________________
Notes / Interested in Helping: ____________________________________________

Name: _____________________________________________ Age: ____________________________
Home Address: __________________________________________
Cell Phone: _____________________________ Home Phone: _____________________________ Work Phone: _____________________________
Email: ____________________________________________
Notes / Interested in Helping: ____________________________________________

C. Professional Agency / Support Information

Is the beneficiary a current Regional Center client? □ Yes □ No  If yes:
Name of RC: _____________________________________________ Name of Service Coordinator: _____________________________________________
Phone: _____________________________ Email: _____________________________

Current Professional Service Providers (e.g. home/residential, employment, respite, personal care attendant)

Name: _____________________________________________ Agency: _____________________________________________
Address: _____________________________________________
Cell Phone: _____________________________ Work Phone: _____________________________
Email: _____________________________________________
Notes: _____________________________________________

Name: _____________________________________________ Agency: _____________________________________________
Address: _____________________________________________
Cell Phone: _____________________________ Work Phone: _____________________________
Email: _____________________________________________
Notes: _____________________________________________
Name: ___________________________  Agency: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________

Social and Recreation Support information (Does Beneficiary belong to gym, sports teams, classes?):
Name: ___________________________  Agency: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________

Name: ___________________________  Agency: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________

List any other close Family Friends / Neighbors / other People in the beneficiary’s life:
Name: ___________________________  Relationship: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Home Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________

Name: ___________________________  Relationship: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Home Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________

List any individuals who may jeopardize the beneficiary’s health and safety, including persons who you are concerned about taking advantage of the beneficiary financially:
Name: ___________________________  Relationship: ___________________________
Address: ___________________________
Cell Phone: ___________________________  Home Phone: ___________________________  Work Phone: ___________________________
Email: ___________________________
Notes: ___________________________
### D. Legal / Financial Information

Does beneficiary have a **Representative Payee** for their SSI or SSDI?  □ Yes  □ No  If yes:
Name: _______________________________  Company (if applicable): _____________________________
Address: ___________________________________  Phone: _____________________________
Email: ___________________________________

Does beneficiary have an **Estate Attorney**?  □ Yes  □ No  If yes:
Name: _______________________________  Company (if applicable): _____________________________
Address: ___________________________________  Phone: _____________________________
Email: ___________________________________

Does beneficiary have a **Financial Planner**?  □ Yes  □ No  If yes:
Name: _______________________________  Company (if applicable): _____________________________
Address: ___________________________________  Phone: _____________________________
Email: ___________________________________

Is there another **Special Needs Trust** established for the beneficiary?  □ Yes  □ No  If yes:
Is there a blocked account?  □ Yes  □ No
Is it court-supervised?  □ Yes  □ No  If yes, Case Number: _____________________________
Name of Trust: _______________________________  Trustee: _____________________________
Type of Trust: _______________________________  Phone: _____________________________
Address: ___________________________________

Is there a **Bank / ABLE Account** established for the beneficiary?  □ Yes  □ No  If yes:
Name of Bank: _______________________________  Account Number: _____________________________
Name of Bank: _______________________________  Account Number: _____________________________

Have the parents of beneficiary purchased **Life Insurance**?  □ Yes  □ No  If yes:
Name of Agent: _______________________________  Company: _____________________________
Address: ___________________________________
Phone: _______________________________ Email: _______________________________
Amount of Life Insurance: _______________________________ Type of Policy: _______________________________

E. Upon Death

Are any funeral / burial arrangements in place for the beneficiary? If so:
Provider Name: _______________________________
Provider Phone Number: _______________________________

Section II – Beneficiary’s Preferences

Note: Only fill out the relevant sections

F. Personality Characteristics of Beneficiary

1. Describe the beneficiary’s general mood and temperament, including both positive and challenging aspects of beneficiary’s personality:
2. What does the beneficiary like the most?
3. What does the beneficiary dislike the most?
4. Fears (e.g. Darkness, loud noises, etc):

Social Skills

1. How does the beneficiary act around family and close friends?
2. Who are some favorite friends and where and when did the beneficiary meet them?
3. Who are some favorite staff members and where and when did the beneficiary meet them?
4. Favorite pets, if any, and type of animals liked and disliked:
5. How does the beneficiary react when meeting new people?
6. Does the beneficiary enjoy organized group activities?
7. Does the beneficiary like to be alone? Where/When?

G. Abilities

1. Abilities and skills in reading and writing?
2. Abilities and skills with money and budgeting?
3. Abilities and skills with household chores such as laundry, cleaning up, taking out the trash, etc.
4. Abilities and skills with basic safety issues including emergency preparedness?

Safety Concerns

1. Explain any issues the beneficiary has in being able to identify an unsafe situation or individual.
2. Does the beneficiary wander? If so, please describe when and ways to prevent.
3. Does the beneficiary know basic safety issues including emergency preparedness?
H. Life / Work Preferences

1. Preferred residential setting/environment (for example Quiet/Lively, City/Suburb, Small/Large)
2. Favorite music, TV shows, movies, video games, websites?
3. Does the beneficiary have and use (Check all that apply):
   - □ Cellphone
   - □ iPad/Tablet
   - □ Laptop or Desktop Computer
   - □ Email use on a regular basis
4. Does the beneficiary engage in social media (Check all that apply)?
   - □ Facebook
   - □ Twitter
   - □ Instagram
   - □ Other: ________________________________
5. Favorite places to visit, locally and out of town:
6. List any work history, including volunteer work: __________________________________________
7. Career/employment goals, short-term and long-term: ______________________________________
8. Current and Future Educational Plans: __________________________________________________

I. Social / Recreational

1. Sports / Recreational Activities that the beneficiary has enjoyed in the past: _______________________
2. Sports / Recreational Activities that the beneficiary has expressed an interest in doing in the future: _______________________
Any Sports / Recreational Activities to avoid / past negative experiences:

J. Religion / Spiritual

1. Is the beneficiary practicing in a particular faith / religion? □ Yes □ No If yes, which one: _________________
2. Does the beneficiary attend a synagogue/church or other place of worship? □ Yes □ No

   Frequency of Visits: _________________

   If yes, name / location: _____________________________ Clergy Contact: _____________________________
3. Does the beneficiary have other spiritual beliefs / practices that a caregiver should be aware of? _________________

K. Romance / Love

1. Does the beneficiary want to date? □ Yes □ No Explanation, if needed: ________________________________
2. Is the beneficiary interested in marriage? □ Yes □ No Explanation, if needed: ________________________________
3. Does the beneficiary have children? □ Yes □ No Explanation, if needed: ________________________________
4. Is the beneficiary interested in having children? □ Yes □ No Explanation, if needed: ________________________________
### L. Behavioral Issues

1. Any sensory issues? □ Yes □ No  If yes, please explain: ____________________________

2. Provide suggestions to address any sensory issues or challenges: ____________________________

3. Biggest behavioral challenges: ____________________________

4. Provide suggestions on how to address any behavioral challenges: ____________________________

5. Best ways, based on experience, to motivate the beneficiary: ____________________________

6. What techniques or approaches should be avoided in dealing with the beneficiary’s challenging behavior: ____________________________

7. Do you have (or have you had) a professional to help with behavioral issues? □ Yes □ No  If yes, please fill out:
   - Name: ____________________________
   - Title: ____________________________
   - Agency: ____________________________
   - Phone (H/W/C): ____________________________
   - Email: ____________________________

### M. Physical Abilities

Please indicate if there are any issues / concerns in the following areas:

- Physical Mobility: ____________________________
- Small Motor Abilities / Challenges: ____________________________
- Hearing Ability: ____________________________
- Eyesight: ____________________________
- Responsiveness to Questions: ____________________________
- Ability to Initiate Self-Care: ____________________________
- Special Equipment: ____________________________

### N. Self-Care

For each aspect of self-care, please check if the beneficiary needs cueing, minimum assistance, or maximum assistance. If the beneficiary doesn’t need any assistance, please provide details as to when and how the person completes the task:

1. **Shaving:** □ Cueing □ Minimum Assistance □ Maximum Assistance □ N/A
   - Routine / Time of Day: ____________________________

2. **Bathing:** □ Shower □ Bathtub
   - □ Cueing □ Minimum Assistance □ Maximum Assistance □ N/A
   - Routine / Time of Day: ____________________________

3. **Dental Care:** include type of toothbrush, floss, mouthwash, etc.
   - □ Cueing □ Minimum Assistance □ Maximum Assistance □ N/A
   - Routine / Time of Day: ____________________________

4. **Dressing:**
   - □ Cueing □ Minimum Assistance □ Maximum Assistance □ N/A
   - Routine in the morning: ____________________________
   - Routine at night before sleep: ____________________________

5. **Toileting:** □ Cueing □ Minimum Assistance □ Maximum Assistance □ N/A
Notes on habits / frequency: 

6. **Haircare:**  ☐ Cueing  ☐ Minimum Assistance  ☐ Maximum Assistance  ☐ N/A
   How often does the beneficiary wash his / her hair? 
   Who cuts the beneficiary’s hair and how often (Name / Phone / Address): 

7. **Male or Female Personal Hygiene Care:**
   Females (Note when the beneficiary started menstruation and her ability to take care of this herself): 
   Males: 

8. **Sexuality Preferences / Issues:** Are there specific preferences or concerns to share? 

9. Any other health habits/hygiene, which a caregiver should know about? 

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**O. Eating / Meals / Dietary Concerns**

Is he/she (check all that apply):

- ☐ Tube-fed
- ☐ Gluten-Free
- ☐ Kosher
- ☐ Vegetarian
- ☐ Vegan
- ☐ Low-sodium diet
- ☐ Low-carb diet
- ☐ Other special diet: ________________________

General Food Preferences (such as soft/hard foods, sweet/savory, bland/spicy): ________________________

Favorite Restaurants: ____________________________________________________________

Mealtime issues or behavior concerns/cleanliness/messiness in eating: ________________________

Favorite Foods: ______________________________________________________________

Foods Disliked: _________________________________________________________________

What does the beneficiary usually drink: _____________________________________________

Any concerns about fluid intake: ___________________________________________________

Does the beneficiary ever drink alcohol: _____________________________________________

Does the beneficiary need assistance with the following?

1. **Grocery Shopping:**  ☐ No Assistance Needed  ☐ Minimum Assistance  ☐ Maximum Assistance  ☐ N/A
   Notes: ________________________

2. **Meal Prep:**  ☐ No Assistance Needed  ☐ Minimum Assistance  ☐ Maximum Assistance  ☐ N/A
   Notes: ________________________

3. **Eating:**  ☐ No Assistance Needed  ☐ Minimum Assistance  ☐ Maximum Assistance  ☐ N/A
   Notes: ________________________

4. **Clean Up:**  ☐ No Assistance Needed  ☐ Minimum Assistance  ☐ Maximum Assistance  ☐ N/A
   Notes: ________________________
Typical Meal / Eating Schedule:

<table>
<thead>
<tr>
<th>Meal</th>
<th>What Time?</th>
<th>What Usually Eaten?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-Morning Snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-Afternoon Snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedtime Snack</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Important Daily Routines:

<table>
<thead>
<tr>
<th></th>
<th>Wake Up Time / Habits</th>
<th>Bedtime / Habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekdays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekends</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is most important to the beneficiary about his or her daily routines? ________________

How flexible is the beneficiary with changes to the routines? ________________

Does the beneficiary use a calendar? What is the best way to inform the beneficiary of future events? ________________

P. Clothing

Does the beneficiary have any sensory issues with clothing? If yes, what is the best way to handle those issues? ______

Favorite brands / types of clothing: ____________________________

Favorite colors / patterns to wear: ____________________________

Favorite textures to wear: ____________________________

Colors / patterns / textures to avoid: ____________________________

Will the beneficiary wear a hat? ____________________________

Current Clothing / Shoe Sizes:

<table>
<thead>
<tr>
<th>Tops</th>
<th>Sneakers / Casual Shoes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pants / Skirts</td>
<td>Dress Shoes</td>
</tr>
<tr>
<td>Dresses</td>
<td>Socks</td>
</tr>
</tbody>
</table>
Section III – Medical Information

Please note, this information will not be seen by anyone other than JLA Trust Staff unless Beneficiary/Power of Attorney signs a Medical Release of Information. This is a requirement by the Health Insurance Portability and Accountability Act (HIPAA) and designed to protect your medical information.
R. Medical Information, Providers and Insurance

Beneficiary Disability(ies): List all, with primary diagnosis first.
1. ___________________________ Age at Onset: ________________
2. ___________________________ Age at Onset: ________________
3. ___________________________ Age at Onset: ________________

Hospitalizations/Surgeries of all types:
1. Date: ___________ Location: _______________________ Reason: _________________________________________________

Any serious chronic health conditions (such as asthma, diabetes, severe allergies etc.):
1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________

Current Insurance Provider:
Insurer Company: ___________________________ Policy Number: ___________________________
Primary Person Insured: ___________________________
Phone: ___________________________ Address: ___________________________

Name of Primary Care Physician: ___________________________
Phone (H / W / C): ___________________________ Email: ___________________________
Address: ___________________________
Notes: ___________________________________________

List any Specialists seen in the past three years:

Name of Specialist 1: ______________________ Area of Medical Expertise: ___________________________
How is the provider paid? □ Covered through insurance □ Private Pay
Phone (H / W / C): ___________________________ Email: ___________________________
Address: ___________________________
Notes: ___________________________________________

Name of Specialist 2: ______________________ Area of Medical Expertise: ___________________________
How is the provider paid? □ Covered through insurance □ Private Pay
Phone (H / W / C): ___________________________ Email: ___________________________
Address: ___________________________
Notes: ___________________________________________

Name of Specialist 3: ______________________ Area of Medical Expertise: ___________________________
How is the provider paid? □ Covered through insurance □ Private Pay
Phone (H / W / C): ___________________________ Email: ___________________________
Address: ___________________________
Notes: ___________________________________________
Name of Dentist:
How is the provider paid?  □ Covered through insurance   □ Private Pay

Name of Preferred Pharmacy:

Name of Preferred Hospital (covered by existing Health Insurance):

Current Medications / Dosages – Prescription Drugs (This is vital information that must be updated whenever there are relevant changes)

Current Medications – Non-Prescription Drugs (Including Vitamin Supplements)

Other current medical conditions / issues (including digestive/bowel habits) you would like to share:

S. Allergies / Bad Reactions

Food Allergies:

Name of Food: ___________________________  What Happened: ________________________________

Environmental Allergies:  _______________________________________________________________

Medication Allergies (either prescription or over-the-counter):

Name of Medication: ___________________________  What Happened: ________________________________

Any Additional Medical Information you would like to share: ________________________________