JEWISH LOS ANGELES SPECIAL NEEDS TRUST

Protecting Benefits.
Promoting Independence.
Providing Peace of Mind.

Beneficiary History and Preferences
Letter of Intent 2020 – 1st 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 your changing needs, desires and interests, so your trust can be used to best benefit you.

This should be considered a roadmap for current and future caregivers and caseworkers and a place where and a place where both important factual information about you and your care can be recorded. If you ever end up with limited communication ability, this where your 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 to allow you, the beneficiary to reflect on your hopes, dreams, and fears to provide direction for any care you might need now or in the future. If applicable, your beneficiary advocate (perhaps your spouse, parent, sibling, or Conservator) can contribute where appropriate to this document's completion.

There are three sections to this document:

I. Factual Information regarding your background, abilities, and family support. This section is mandatory and should be reviewed for accuracy once a year. Although there is some overlap with our Joinder document, please keep in mind that this document may be used for "stand-alone" purposes by social workers, Regional Centers, etc. Although there is some overlap with our Joinder document, please keep in mind that this document may be used for "stand-alone" purposes by social workers, Regional Centers, etc.

II. Beneficiary's Preferences on a wide range of items as specified both by the beneficiary (you) and by your 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 made or 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 applicable): _____ 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

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 If yes, please provide name_____

List any living Family Members (spouse, parents, children, grandparents, and siblings):

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Relationship: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Relationship: _____

*Name: ______________________________ Age: ______________________

Home Address: ____

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ____________________

Notes / Relationship: ____

*Name: ______________________________ Age: ______________________

Home Address: ____

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ____________________

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Home Address: ____

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ____________________

Notes / Relationship: ____

*Name: ______________________________ Age: ______________________

Home Address: ____

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ____________________

Notes / Relationship: ____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Relationship: _____

List any **Extended Family or Close Family Friends** who are actively involved in your life:

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Relationship: _____

*Name: _____ Age: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Notes / Relationship: _____

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: _____

List Any 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: _____

If applicable, list any people in your life you are concerned might take advantage of you financially:

*Name: _____ Relationship: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes: _____

*Name: _____ Relationship: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Notes: _____

D. Legal / Financial Information

Do you have a **Representative Payee** for your SSI or SSDI? ☐ Yes ☐ No If yes:

Name: _____ Company (if applicable): _____

Address: _____

Phone: _____ Email: _____

Do you have an **Estate Attorney**? ☐ Yes ☐ No

Do you have a **Financial Planner**? ☐ Yes ☐ No

Is there an additional **Special Needs Trust besides JLA Trust** established for you? ☐ Yes ☐ No

If yes, please attach a copy of the trust document and fill out:

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: _____

Do you have any **Bank or ABLE Accounts** established for yourself? ☐ Yes ☐ No If yes:

Name of Bank: _____ Account Number: _____

State Issued: _____ Account Balance: _____

Name of Bank: _____ Account Number: _____

State Issued: _____ Account Balance: _____

Name of Bank: _____ Account Number: _____

State Issued: _____ Account Balance: _____

Name of Bank: _____ Account Number: _____

State Issued: _____ Account Balance: _____

E. Upon Death

Do you have any funeral arrangements set up for yourself? If so, please provide a copy of the receipt.

_____

Section II – Your Preferences

F. Personality Characteristics

*What activities do you enjoy the most? _____

_____

*Do you enjoy organized group activities? If so, which ones? _____

_____

G. Abilities

1. On a scale from 1 to 10, how good would you say you are with money and budgeting? _____

_____

2. How well are you able to do household chores such as cooking for yourself, laundry, cleaning up, taking out the trash, etc. _____

H. Life / Work Preferences

1. What sort of residential environment do you prefer? (for example Quiet/Lively, City/Suburb, House/Apartment)

_____

2. Which of these do you have and use? (*Check all that apply*):

- ☐ Cellphone
- ☐ iPad / Tablet
- ☐ Laptop or Desktop Computer
- ☐ Email

4. Do you use any of the following social media accounts (*Check all that apply*)?

- ☐ Facebook
- ☐ Twitter
- ☐ Instagram
- ☐ Other: _____

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 you currently enjoy: _____

_____

2. Sports / Recreational Activities that you might have an interest in doing in the future: _____

_____

J. Religion / Spiritual

1. Do you practice 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

K. 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: _____

L. Eating / Meals / Dietary Concerns

Are you *(check all that apply):*

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

1. Grocery Shopping: ☐ No Assistance Needed ☐ Minimum Assistance ☐ Maximum Assistance ☐ N/A
2. Meal Prep: ☐ No Assistance Needed ☐ Minimum Assistance ☐ Maximum Assistance ☐ N/A
3. Eating: ☐ No Assistance Needed ☐ Minimum Assistance ☐ Maximum Assistance ☐ N/A
4. Clean Up: ☐ No Assistance Needed ☐ Minimum Assistance ☐ Maximum Assistance ☐ N/A

M. Any Additional Information you would like to share, including your hopes for the future:

_____

_____

Section III – Medical Information

N. Medical Information, Providers and Insurance

Your Disability(ies): List all, with primary diagnosis first.

1. _____ Age at Onset: _____
2. _____ Age at Onset: _____
3. _____ Age at Onset: _____

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: _____

How is the provider paid? ☐ Covered through insurance ☐ Private Pay

Phone (H / W / C): _____ Email: _____

Address: _____

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

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

O. Allergies / Bad Reactions

Food Allergies:

Name of Food: _____ Allergy/Reaction: _____
Name of Food: _____ Allergy/Reaction: _____
Name of Food: _____ Allergy/Reaction: _____

Environmental Allergies: _____

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

Name of Medication: _____ Allergy/Reaction: _____

Any Additional Medical Information you would like to share: _____