JEWISH LOS ANGELES SPECIAL NEEDS TRUST

Protecting Benefits.
Promoting Independence.
Providing Peace of Mind.

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: _____

Notes: _____

List all living **Grandparents:**

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: _____

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: _____

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: _____

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? _____

_____

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:

Meal	What Time?	What Usually Eaten?
Breakfast		
Mid-Morning Snack		
Lunch		
Mid-Afternoon Snack		
Dinner		
Bedtime Snack		

Important Daily Routines:

	Wake Up Time / Habits	Bedtime / Habits
Weekdays		
Weekends		

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:

Tops		Sneakers / Casual Shoes	
Pants / Skirts		Dress Shoes	
Dresses		Socks	

Jackets / Coats		Underwear (Bra size for females)	

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

Section III – Medical Information

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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: _____

Section III – Medical Information

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

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

Address: _____

Notes: _____

Name of Preferred Pharmacy: _____

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

Address: _____

Notes: _____

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

Address: _____

Notes: _____

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: _____