Schiff Hardin

Sample Letter of Intent

By Robert M. Freedman

Schiff Hardin

Letter of Intent

Please complete the information below for your loved one with special needs

PERSONAL INFORMATION

Name: _____

Preferred Nickname: _____

Date of Birth: _____

Citizenship: _____

Social Security Number: _____

Please provide the location of the following documents:

Birth Certificate: _____

Passport: _____

Social Security Card: _____

CONTACT INFORMATION

Home address: _____

Home phone: _____

Email: _____

Cell: _____

Age: ____

SCHOOL

Address: _____

Phone: _____

School District: _____

Classification: _____

Approximate Date of Annual Meeting: _____

Please attach the most current IEP to this Letter of Intent.

Principal: _____

Counselor: _____

Date of last evaluations: _____

Teacher(s): _____

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Bus Driver: _____

Bus Counselor: _____

SEIT/SETSS Provider: _____ Agency: _____

Favorite Friend(s): _____

_____

Parent's name and contact information: _____

Parent's name and contact information: _____

RESIDENTIAL PLACEMENT

Address: _____

Phone: _____

Director: _____

Case Worker: _____

FAMILY INFORMATION

Please provide the following information for each member of your family, including yourself. Please include children from prior relationships as well as any predeceased children. If necessary, please use the back of this page.

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

Age: ____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

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Age: ____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

Age: ____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

Age: ____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

Age: ____

Please provide the following information for a neighbor or other close friend who is familiar with your loved one's care needs and can be reached in case of emergency.

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

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Age: ____

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

Age: ____

*Please provide the following information for any individual(s) who should **not** be involved in caring for your loved one.*

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cell: _____

Email: _____

PROFESSIONAL CONTACTS

Attorney

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Advocate

Name: _____

Firm: _____

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Address: _____

Phone: _____

Cell: _____

Email: _____

Financial Planner

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Accountant

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Insurance Agent

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Primary Care Physician

Name: _____

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Practice Group: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Pharmacist

Name: _____

Pharmacy: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Therapist

Name: _____

Practice Group: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Social Worker

Name: _____

Practice Group: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

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Psychologist

Name: _____

Practice Group: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Clergy

Name: _____

House of Worship: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

Other

Name: _____

Company: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

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FINANCIAL INFORMATION

Please include checking, savings, and investment accounts.

Financial Institution	Account No.	Title	Account Type	Current Balance

Please include stock not held in any investment/brokerage accounts listed above.

Company	Shares	Title	Date of Purchase	Current Value

Please include any bonds or CDs not held in any investment/brokerage accounts listed above.

Company	Present Value	Title	Date of Purchase	Maturation Date

Is your loved one able to manage his or her own finances? Yes ___ No ___

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INCOME INFORMATION

If your loved one receives Social Security benefits (DAC, SSI or SSD), please provide the following information:

Source: _____

Monthly Amount: $_____

Representative Payee

Name: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

HEALTH INSURANCE INFORMATION

Medicare: _____

Part A: _____

Part B: _____

Part D: _____

Private Health Insurance: _____

Carrier:

Policy No.:

Primary Insured:

Medicaid: _____

CIN: _____

Please provide the location of the cards:

Medicare: _____

Health Insurance: _____

Medicaid: _____

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ESTATE PLANNING

If your loved one is over the age of 18 and is able to execute Estate Planning documents, please indicate if he or she has the following documents in place:

Power of Attorney: _____, dated executed: _____

Health Care Proxy: _____, dated executed: _____

HIPAA Release: _____, dated executed: _____

Who is holding these documents?

Name: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

If your loved one is the beneficiary of a Trust, please provide the following information:

Name of Trust: _____

Source of Funds: _____

Amount in Trust: $_____

Trustee

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

If your loved one has a legal guardian, please provide the following information:

Name: _____

Address: _____

Phone: _____

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Cell: _____

Email: _____

Date of Appointment: _____

Standby Guardian: _____

If your loved one is the primary or contingent beneficiary of any life insurance policies, please provide the details here:

Financial Institution: _____

Policy No.: _____

Cash Value: $_____

Death Benefit: $_____

Financial Institution: _____

Policy No.: _____

Cash Value: $_____

Death Benefit: $_____

If your loved one is the primary or contingent beneficiary of any retirement assets, please provide the details here:

Financial Institution: _____

Account No.: _____

Type of Account: _____

Amount: $_____

Financial Institution: _____

Account No.: _____

Type of Account: _____

Amount: $_____

If you and/or your spouse have Estate Planning documents in place, please provide the details here:

Last Will and Testament: Client _____ Spouse _____

Power of Attorney: Client _____ Spouse _____

Health Care Proxy: Client _____ Spouse _____

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Revocable Trust: Client _____ Spouse _____

Irrevocable Trust: Client _____ Spouse _____

Please provide the following information for your Estate Planning attorney:

Name: _____

Firm: _____

Address: _____

Phone: _____

Cell: _____

Email: _____

DAILY CARE NEEDS

Medications:

Name: _____

Treatment for: _____

Dosage: _____

Method of Administration: _____

Frequency: _____

Prescribing Physician: _____

"Tricks" of Administration: _____

Name: _____

Treatment for: _____

Dosage: _____

Method of Administration: _____

Frequency: _____

Prescribing Physician: _____

"Tricks" of Administration: _____

Name: _____

Treatment for: _____

Dosage: _____

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Method of Administration: _____

Frequency: _____

Prescribing Physician: _____

"Tricks" of Administration: _____

Name: _____

Treatment for: _____

Dosage: _____

Method of Administration: _____

Frequency: _____

Prescribing Physician: _____

"Tricks" of Administration: _____

Allergies:

Seasonal: _____

Food: _____

Medications: _____

Fabric: _____

Products: _____

General Likes (include foods, products, fabrics, favorite vacation and activities):

_____

_____

_____

General Dislikes (include foods, products, fabrics and activities):

_____

_____

_____

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If there are certain behavior modification techniques or strategies that are successful, please describe them here:

_____

_____

_____

If there are certain behavior modification techniques or strategies that are not successful, please describe them here:

_____

_____

_____

How does your loved one transition?

_____

_____

Does your loved one have a problem with substance abuse? If so, please describe.

_____

_____

Please describe your loved one's daily routine, including any particular habits that his or her care giver should be aware of (include bed time, meal time, and sleeping habits):

_____

_____

_____

Please describe the activities of daily living that require full assistance:

_____

_____

_____

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Please describe the activities of daily living that require prompting and support:

_____

_____

_____

Please describe the activities of daily living that can be done independently:

_____

_____

_____

FUTURE CARE NEEDS

Please describe your future plans for your loved one, including residential placement, community services and supports, daily activities, educational or vocational programs, etc.

_____

_____

_____

_____

_____

GENERAL INFORMATION

Please provide any additional information about your loved one that you wish for his or her current or future care givers to know.

_____

_____

_____

_____

_____

_____

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