



# **Sample Letter of Intent**

By Robert M. Freedman

**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): \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

*Psychologist*

Name: \_\_\_\_\_

Practice Group: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

*Clergy*

Name: \_\_\_\_\_

House of Worship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

*Other*

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_



**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 \_\_\_

**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: \_\_\_\_\_

**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: \_\_\_\_\_



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 \_\_\_\_\_

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: \_\_\_\_\_

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):*

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*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:*

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

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*How does your loved one transition?*

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

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*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):*

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*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:*

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

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**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.*

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**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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