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: __________________________
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: ____

Name: ______________________
Relationship: ______________________
Address: ______________________
Home Phone: ______________________
Cell: ______________________
Email: ______________________

Age: ____
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: __________________________
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.*

<table>
<thead>
<tr>
<th>Financial Institution</th>
<th>Account No.</th>
<th>Title</th>
<th>Account Type</th>
<th>Current Balance</th>
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*Please include stock not held in any investment/brokerage accounts listed above.*

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<thead>
<tr>
<th>Company</th>
<th>Shares</th>
<th>Title</th>
<th>Date of Purchase</th>
<th>Current Value</th>
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*Please include any bonds or CDs not held in any investment/brokerage accounts listed above.*

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<th>Company</th>
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<th>Title</th>
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<th>Maturation Date</th>
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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: __________________
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):
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

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

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
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.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

___________________________________________