



## Letter of Intent Worksheet – LAST WISHES

### **Residence:**

If something should happen to you tomorrow, where will your son or daughter live?

- 1)
- 2)
- 3)
- 4)

### **Employment:**

What has your child enjoyed? Consider your child's goals, aspirations, limitations, etc.

- 1)
- 2)
- 3)
- 4)

### **Medical Care:**

What has and has not worked for your child? What should future caregivers know?

- 1)
- 2)
- 3)
- 4)

**Behavior Management:**

What consistent approach has worked best in your absence during difficult transition periods in your child's life?

- 1)
- 2)
- 3)
- 4)

**Social:**

What activities make life meaningful for your child?

- 1)
- 2)
- 3)
- 4)

**Advocate/Guardian:**

Who will look after, fight for, and be a friend to your child?

- 1)
- 2)
- 3)
- 4)

**Trustee:**

Who do you trust to manage your child's supplementary funds?

- 1)
- 2)
- 3)
- 4)

# CHECKLIST

## Gather Contact Information for (at least) the following:

\_\_\_\_\_ Financial Advisor

\_\_\_\_\_ Special Needs Attorney

\_\_\_\_\_ Advocate

\_\_\_\_\_ Family Members

\_\_\_\_\_ Vocational Contact

\_\_\_\_\_ Government Benefit Contact

\_\_\_\_\_ Social Services Organizations

\_\_\_\_\_ Child's peers, and peers parents

\_\_\_\_\_ Aides/Babysitter's

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

## Gather Vital Information to provide:

\_\_\_\_\_ Full Name (nick names)

\_\_\_\_\_ Date and Place of Birth

\_\_\_\_\_ Social Security Number

\_\_\_\_\_ Height, Weight

\_\_\_\_\_ Blood Type

\_\_\_\_\_ Current Photo

**Insurance Provider (s) Information:**

\_\_\_\_ Provider (s) name (s), address (es) and phone number (s)

\_\_\_\_ Policy and group numbers (for any provider referred to above)

**Diagnosis Defined:**

\_\_\_\_ Identify and defined diagnosis (if not diagnosed list all abilities and limitations)

\_\_\_\_ Interventions being received (include contact information)

\_\_\_\_ Additional description of situation

**Medical:**

\_\_\_\_ Medications

\_\_\_\_ ER instructions

\_\_\_\_ All physicians (include contact information)

\_\_\_\_ Medical providers (therapists and any other to insure continuity of care. Include contact information)

**Medical Tests/Records:**

\_\_\_\_ What type of tests and explanation of reason

\_\_\_\_ General history (immunizations, allergies, operations, hospitalizations)

**Behavior:**

\_\_\_\_ Challenges and interventions (include contact information)

**Education:**

- \_\_\_\_\_ Current IEP
- \_\_\_\_\_ Family service plan information (include contact information)
- \_\_\_\_\_ Recent testing and evaluations
- \_\_\_\_\_ Area of concern and past intervention information

**Skill Level:**

- \_\_\_\_\_ Describe skills with money, cooking, bathing, dressing, toileting, and sleep routines
- \_\_\_\_\_ Skills currently developing (resources that an provide instructions)

**Assistive Devices:**

- \_\_\_\_\_ List all devices
- \_\_\_\_\_ Where and when purchased (include contact information)
- \_\_\_\_\_ Maintenance information (include contact information) and expected replacement date
- \_\_\_\_\_ Proper positioning information

**Feeding:**

- \_\_\_\_\_ Complete history
- \_\_\_\_\_ General information/instruction (portions, times of day, restrictions, likes/dislikes, specific types/brands)
- \_\_\_\_\_ Other

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**Values:**

\_\_\_\_\_ Religious

\_\_\_\_\_ Dating

\_\_\_\_\_ Sex

\_\_\_\_\_ Marriage

\_\_\_\_\_ Birth control

\_\_\_\_\_ Other

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**Clothing:**

\_\_\_\_\_ Shoe and clothing sizes

\_\_\_\_\_ Special adaptations for comfort

**Funeral Arrangements:**

\_\_\_\_\_ Details to your preferences for your child

**Financial Situation:**

\_\_\_\_\_ Insurance

\_\_\_\_\_ Property

\_\_\_\_\_ Investments

\_\_\_\_\_ Assets

\_\_\_\_\_ Estate/Trust information (include contact information for who prepared documents and final notarized copies)