PLAN *of* Massachusetts and Rhode Island
LIFE CARE PLAN

Guidance to Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.
(PLAN of Massachusetts and Rhode Island) as the Manager for
The PLAN of Massachusetts and Rhode Island 3rd Party Special Needs Pooled Trust

Developed for _____

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This Life Care Plan provides guidance to Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc. (PLAN of Massachusetts and Rhode Island) as the Manager for the PLAN of Massachusetts and Rhode Island Third Party Special Needs Pooled Trust.

The Life Care Plan is divided into two (2) parts, each of which is essential to understanding the current and future needs of the trust beneficiary.

In addition to providing PLAN of Massachusetts and Rhode Island essential medical and financial information, this Life Care Plan addresses the individual's physical and emotional needs, taking into account the assets that are available to him or her, including public benefits.

This Life Care Plan will be reviewed annually. If there are changes that you would like to make in between the annual reviews, please contact the PLAN of Massachusetts and Rhode Island office. You will receive a copy of the current Life Care Plan upon its completion and acceptance by PLAN of Massachusetts and Rhode Island.

A good Life Care Plan will also specify key elements of your family member's current lifestyle that are important to maintain in the future. In other words, what you and your family member want in the future and the supports that will likely be needed to make this happen.

Developing a Life Care Plan involves answering questions that cover an array of life issues. The questions help the family and the trust beneficiary think about what he or she wants and needs in the future. Through your answers, you will be able to plan how to maximize the likelihood that these wants and needs are met.

Developing the Life Care Plan usually begins with the family identifying all that they currently do for the family member with a disability. This is a comprehensive list which should include the everyday activities that the family may take for granted, such as transportation, fixing meals, paying bills, etc. A comprehensive list of what the family does now will provide assistance in identifying the needs of the trust beneficiary when the family is no longer able to provide care.

The process of developing a Life Care Plan requires a significant amount of time. The process can include as many people as you wish. Prior to beginning the process it is helpful to identify who else in your family member's life should be involved in the planning process. This can include the family member with a disability.

If additional space is needed for any question, please attach a separate sheet of paper to the Life Care Plan and kindly indicate the question number that the separate sheet refers to.

SECTION I: INFORMATION ABOUT THE TRUST BENEFICIARY

1. Full Name: _____ 2. Nickname(s): _____

3. Birth date: ___/___/___ 4. Age _____ 5. Place of Birth: _____

6. Current Address: _____

_____

7. Please describe the beneficiary's current living arrangement:
(E.g. living with parents, living independently in rented apartment or house, etc.)

_____

_____

8. Length of time at this address: _____

9. Is this a good living arrangement at the present time? _____

10. What type of living arrangement do you believe will be best in the future years?

_____

_____

EDUCATION

11. Grade or level completed: _____

12. Year of completion: _____ 13. Were accommodations provided? _____

14. If they were, please describe:

_____

_____

_____

15. Will further education or training be needed? If so, what and when?

_____

_____

MEDICAL

16. Nature of Disability: _____

17. Medical/Psychological Diagnosis: _____

18. Age at which diagnosed: _____

19. Limitations resulting from the disability: _____

_____

_____

20. Will these limitations become less or more significant over time?

_____

_____

21. Please describe the beneficiary's communication skills:

a. Ability to understand oral communication _____
b. Ability to understand written communication _____
c. Ability to communicate with others orally _____
d. Ability to communicate with others via written format _____

22. Does the beneficiary independently exercise good judgment when making decisions? Please check one.

a. All of the time _____
b. Most of the time _____
c. Some of the time _____
d. Never _____

23. Does the beneficiary have memory problems? Yes_____ No_____

23(a). If yes, are these memory problems related to:
a. Long term memory _____
b. Short term memory _____

24. Primary Doctor:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

25. Specialists:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

26. Other medical professionals who are involved in care and treatment:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

27. Hospitalizations:

REASON(S) FOR HOSPITALIZATION: _____

_____

_____

_____

DATE(S) AND PLACE (S) OF HOSPITALIZATION: _____

_____

_____

_____

28. Medications currently being taken:

For each medication, please give the name, dosage, reason for taking, and name of doctor who prescribed the medication.

MEDICATION NAME: _____

DOSE: _____

REASON: _____

MD PRESCRIBING: _____

MEDICATION NAME: _____

DOSE: _____

REASON: _____

MD PRESCRIBING: _____

MEDICATION NAME: _____

DOSE: _____

REASON: _____

MD PRESCRIBING: _____

MEDICATION NAME: _____

DOSE: _____

REASON: _____

MD PRESCRIBING: _____

29. Anticipated future medical needs: _____

_____

_____

_____

30. How are medical expenses paid? _____

_____

_____

31. What is the current mode of transportation being used to get the beneficiary to and from medical appointments?

_____

_____

DENTAL CARE

32. DENTIST NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

33. Anticipated future dental needs: _____

_____

34. How is dental care paid for? _____

35. What is the current mode of transportation being used to get the beneficiary to and from dental care appointments?

_____

_____

THERAPY

36. Type of therapy *(e.g. Counseling, physical therapy, speech therapy):*

_____

37. THERAPIST NAME: _____

ADDRESS: _____

PHONE: _____EMAIL_____

THERAPIST NAME: _____

ADDRESS: _____

PHONE: _____EMAIL_____

38. How is each different therapy paid for? _____

_____

39. What is the current mode of transportation being used to get the beneficiary to and from therapy appointments?

_____

_____

ASSISTANCE/SUPPORTS

40. What type of assistance is currently needed (*e.g. assistive technology, special equipment, personal care?*)

_____

_____

41. Will any of this assistance have to be replaced or upgraded in the next five years?

_____

42. How is this assistance currently paid for? _____

_____

43. Will that source of payment be available for the future? _____

44. If that source is not available, is there another source that will be available to pay for this assistance? *(Please specify the source):*

_____

45. What type of assistance do you believe will be needed in the next five years?

_____

_____

_____

46. What services are currently being received? (Please be as specific as possible, including frequency)*:*

_____

_____

47. PROVIDER OF SERVICES: _____

CONTACT PERSON: _____

ADDRESS: _____

_____

PHONE: _____

SOURCE OF FUNDING: _____

PROVIDER OF SERVICES: _____

CONTACT PERSON: _____

ADDRESS: _____

_____

PHONE: _____

SOURCE OF FUNDING: _____

48. What supports and services will be needed from service provider agencies in the future *(short and long term)*?

_____

_____

49. What type of agency do you believe would best meet future needs?

_____

_____

50. What are the beneficiary's current transportation needs?

_____

_____

51. Who provides transportation services now and how is that funded?

_____

_____

52. How will future transportation needs be funded?

_____

_____

SKILLS/WORK/INTERESTS

53. Does the beneficiary handle his or her own finances (e.g. pay bills regularly)? *If not, who provides assistance?*

_____

54. Does the beneficiary typically make his or her own decisions? *If not, who provides assistance in making decisions?*

_____

55. Does the beneficiary currently work? _____

56. If yes, please describe the work that he or she does, including the amount of time and the amount of pay.

_____

57. Is this a good work situation? _____

58. Do you think that the beneficiary should continue in this work situation?
(Please specify why or why not.)

_____

_____

_____

59. If the beneficiary is unable to work for pay, what type of activity do you think would be helpful and productive?

_____

_____

60. Please identify the particular skills that the beneficiary has:

_____

_____

61. What kinds of Social Activities does the beneficiary enjoy/participate in?
(Please include all types of social activities such as friends, religious organizations, etc.)

_____

_____

_____

_____

62. What types of recreational and leisure activities does the beneficiary enjoy?

_____

_____

_____

63. What types of vacations does the beneficiary like?

_____

_____

_____

64. Does the beneficiary attend religious services? (If yes, indicate place and frequency.)

_____

_____

65. What activities would the beneficiary like to pursue in the future?

_____

_____

_____

66. What other assets does the beneficiary have to plan with (or might be expected in the future)? For example, an inheritance, insurance proceeds, lawsuit settlements, SSDI benefits based on a parent's record.

_____

_____

67. What are the beneficiary's short and long term goals and dreams?

_____

_____

_____

SECTION II: FAMILY INFORMATION

PARENTS:

68. MOTHER'S MAIDEN NAME: _____

69. ADDRESS: _____

_____

_____

70. PHONE: HOME: _____CELL: _____OTHER:_____

71. DATE OF BIRTH: _____72. SOCIAL SECURITY NUMBER: _____

73. CURRENT EMPLOYMENT: _____

74. FATHER'S NAME: _____

75. ADDRESS: _____

_____

_____

76. PHONE: HOME: _____ CELL: _____OTHER:_____

77. DATE OF BIRTH: _____78. SOCIAL SECURITY NUMBER: _____

79. CURRENT EMPLOYMENT: _____

SIBLINGS:

80. NAME: _____

81. ADDRESS: _____

_____

_____

82. PHONE: _____

83. DATE OF BIRTH: _____84. EMAIL: _____

85. RELATIONSHIP: _____

86. NAME: _____

87. ADDRESS: _____

_____

_____

88. PHONE: _____

89. DATE OF BIRTH: _____90. EMAIL: _____

91. RELATIONSHIP: _____

92. NAME: _____

93. ADDRESS: _____

_____

_____

94. PHONE: _____

95. DATE OF BIRTH: _____96. EMAIL: _____

97. RELATIONSHIP: _____

OTHER FAMILY MEMBERS *who play a significant role in the beneficiary's life:*

98. NAME: _____

99. ADDRESS: _____

_____

_____

100. PHONE: _____

101. EMAIL: _____

102. RELATIONSHIP: _____

103. NAME: _____

104. ADDRESS: _____

_____

_____

105. PHONE: _____

106. EMAIL: _____

107. RELATIONSHIP: _____

108. NAME: _____

109. ADDRESS: _____

_____

_____

110. PHONE: _____

111. EMAIL: _____

112. RELATIONSHIP: _____

OTHER PEOPLE (non-relatives) *who play a significant role in the beneficiary's life:*

113. NAME: _____

114. ADDRESS: _____

_____

_____

115. PHONE: _____

116. EMAIL: _____

117. RELATIONSHIP: _____

118. NAME: _____

119. ADDRESS: _____

_____

_____

120. PHONE: _____

121. EMAIL: _____

122. RELATIONSHIP: _____

123. NAME: _____

124. ADDRESS: _____

_____

_____

125. PHONE: _____

126. EMAIL: _____

127. RELATIONSHIP: _____

128. From the list of people above (including parents) list those who you would like to be included in making decisions about the beneficiary and the role you would like these individuals to play (e.g. advocacy, service monitoring, emotional support, assistance with activities like shopping or budgeting or social activities.)

_____

_____

_____

_____

_____

129. What are your wishes for the near and distant future?

_____

_____

_____

130. What estimated costs related to the wishes and goals you have indentified will likely not be covered by government benefits like SSI or Medicaid, insurance or other public programs?

_____

_____

_____

131. If for some legal reason this plan cannot be fully implemented, which items that you have identified do you feel are the most important?

_____

_____

_____

132. What other information is important for us to consider?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Donor Signature: _____ Date: _____

Print Name: _____

Relationship to Trust Beneficiary _____

Donor Signature: _____ Date: _____

Print Name: _____

Relationship to Trust Beneficiary _____