Letter of Care

Prepared for:

Full Name

Date

Child's Name

The Letter of Care template is provided courtesy of Charleston Investment Advisors, an independent wealth management firm located in Charleston, South Carolina.

A Path Forward

Introduction

Our goal is to ease the emotional and financial burden associated with caring for a loved one with special needs. The steps you must take can be difficult. They may even make you, or your loved one, uncomfortable. But taking these steps can have a profound impact on the quality of your loved one's life after you are gone. Creating a Letter of Care for your loved one with special needs is one such step — emotional and difficult, yet tremendously important.

The Letter of Care is designed to provide basic information about your loved one's personal, medical, legal, and financial needs to guardians, caregivers, relatives or friends — those responsible for providing physical, emotional and financial care when you are unable to do so. Like a map, it guides the caregivers through the day-to-day support your loved one requires.

More importantly, your hopes and desires are put into writing so that others will know your wishes for the future and be able to carry them out.

This is meant to be a living document, something that you should revisit from time to time when information changes or when milestones are met. The Letter of Care is not a legal document, but it should be signed and dated upon completion. Any updates should also be signed and dated. Once complete, please share your Letter of Care with the people who are most likely to provide care and have responsibility for your family member with special needs. You should also place a copy with other important documents, such as your will.

Letter of Care — Personal Note to Your Caregiver

Date:

Prepared for: Name:

DOB:

SS#:

Phone number:

E-mail

Dear Caregiver ,

This is a letter of care for . It is intended to provide basic information about his/her personal, medical, legal, and financial needs to guardians, caregivers, relatives or friends — people like yourself who have agreed to provide physical, emotional and/or financial care when we are unable to do so.

This Letter of Care is not a legal document, but a living expression of our hope, dreams and care for [Child's Name].

Very sincerely yours,

Table of Contents

Personal Information

[I/We] want to give a brief overview of ’s life up to this point.

Provide an overview of the dreams and hopes you have for for the future.

Provide an overview of the fears you have for for the future.

Describe ’s day-to-day life.

Our aspiration is that can do the following in the future:

We feel strongly that should be entitled to:

We hope that the following values will always be communicated and upheld to :

Full Name: Full Name _____

Nickname: _____

Social Security number: _____ Date of birth: _____

Address: _____

_____

Home phone number: _____ Cell phone number: _____

E-mail address: _____ Password: _____

Weight: _____ Height: _____ Shoe size: _____ Clothing sizes: _____

Gender: ◯ Male ◯ Female

Race: _____ Religion: _____

Fluent language (s): _____

Country of citizenship: _____

If married, spouse's name: _____

Spouse's date of birth: _____

Children's name(s) and date(s) of birth:

_____

_____

_____

Personal Relationships

Mother's Name: _____

Address: _____

Phone number: _____ Social Security number: _____

E-mail address: _____ Birth date: _____

City and state where born: _____

Religion: _____ Race: _____

Blood type: _____

U.S. citizen: ◯ Yes ◯ No

Marital status and date: _____

Name of spouse: _____

Father's Name: _____

Address: _____

Phone number: _____ Social Security number: _____

E-mail address: _____ Birth date: _____

City and State where born: _____

Religion: _____ Race: _____

Blood type: _____

U.S. citizen: ◯ Yes ◯ No

Marital status and date: _____

Name of spouse: _____

Aunt(s) and Uncle(s) — Mother's side:

Name:_____ Age: ____

Address: _____

Phone: _____ E-mail address: _____

Name:_____ Age: ____

Address: _____

Phone: _____ E-mail address: _____

Aunt(s) and Uncle(s) — Father's side:

Name:_____ Age: ____

Address: _____

Phone: _____ E-mail address: _____

Name:_____ Age: ____

Address: _____

Phone: _____ E-mail address: _____

Siblings:

Sibling Name:_____

Age:_____ Gender: ◯Male ◯Female

Address: _____

Phone: _____ E-mail address: _____

Sibling Name:_____

Age:_____ Gender: ◯Male ◯Female

Address: _____

Phone: _____ E-mail address: _____

Other Relatives & Friends:

Name:_____ Relationship: _____

Address: _____

Phone: _____ E-mail address: _____

Name:_____ Relationship: _____

Address: _____

Phone: _____ E-mail address: _____

Name:_____ Relationship: _____

Address: _____

Phone: _____ E-mail address: _____

Personal Preferences/Routines

A copy of Individual Habitation Plan attached: ◯ Yes ◯ No

Favorite recreational activities include:

_____

_____

Likes to be with the following people when engaged in these activities:

_____

Interests and hobbies include:

_____

_____

Enjoys vacations such as:

_____

Needs an accessible hotel room: ◯ Yes ◯ No

Likes to wear:

_____

_____

Favorite books include:

_____

_____

Favorite movies/TV shows include:

_____

_____

Favorite music includes:

_____

_____

Needs the following things and services in order to be safe and healthy:

Needs to avoid and be kept away from:

May exhibit the following behaviors:

These behaviors should be dealt with by:

Is upset by:

Is angered by:

Expresses anger by:

Is afraid of:

When upset or angry, the following helps him/her feel better:

Weekday schedule includes:

_____

_____

_____

_____

Weekend schedule includes:

Calendar attached: Yes No

_____

_____

_____

_____

Usually awakens around _____ AM and goes to sleep around _____ PM

Morning routine:

_____

_____

_____

Nighttime routine:

_____

_____

_____

Primary method of ambulation: _____

Primary method of communication: _____

Primary signs include:

_____

Needs help with (eating, drinking, brushing teeth, brushing hair, dressing, bathing, toileting, etc.):

_____

_____

Uses the following incontinence supplies: _____

_____

Living Arrangements

The best living situation for [Name] is (e.g., living with relatives, living with friends, living in a group home or institution in a shared room or a single room, etc.)**:**

First choice: _____

Second choice:_____

Third choice:_____

Current living arrangements:

_____

_____

Past living arrangements:

_____

_____

If living on his/her own, complete the following:

Address: _____

Title: _____

Mortgage: _____

Insurance: _____

Property Tax: _____

Mortgage Documents/Deed/Title:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Homeowner's Insurance Policy (Carrier's name): _____

Policy number: _____

Owner: _____ Insured: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Address: _____

_____

E-mail address: _____

Utilities: **Cable/Internet — Provider:** _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Water — Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Electricity — Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Cell Phone — Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Landline Phone — Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Maintenance: Pest/Termite Control — Provider:

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Other (e.g., lawn, maid, etc.):

Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Provider: _____

Account: _____

Account holder: _____

Phone: _____

Billing address: _____

_____

Transportation

Can drive a car: ◯ Yes ◯ No

Daily transportation needs: _____

Car make: _____

Car model: _____ Year: _____

License plate #: _____

Driver's license #: _____

Expiration: _____

AAA membership account number: _____

AAA phone: _____

Auto insurance policy (Carrier's name): _____

Policy number: _____

Owner: _____ Insured: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Address: _____

_____

E-mail address: _____

School/Work

Currently Attends [level of school and type of school]:

_____

School name: _____

Address: _____

_____

Contact person: _____

Phone number(s): _____E-mail address: _____

Ages attended: _____Grade level completed: _____

Individual Education Plan (IEP) attached: ◯Yes ◯No

Also attends the program(s) below:

Program: _____

Length of program: _____ Teacher's name: _____

Address: _____

_____

Phone number(s): _____E-mail address: _____

Program: _____

Length of program: _____ Teacher's name: _____

Address: _____

_____

Phone number(s): _____E-mail address: _____

Program: _____

Length of program: _____ Teacher's name: _____

Address: _____

_____

Phone number(s): _____E-mail address: _____

Previously attended:

School/program: _____

Length of program: _____ Teacher's name: _____

Address: _____

_____

Phone number(s): _____E-mail address: _____

School/program: _____

Length of program: _____ Teacher's name: _____

Address: _____

_____

Phone number(s): _____E-mail address: _____

Special academic abilities include:

_____

_____

Integrated into regular classes during his/her education: ◯Yes ◯No

In the future, we hope that educational plans include:

_____

_____

Day Program:

Currently: ◯attends a day program ◯has a job

_____

Describe: _____

_____

Location: _____

Work phone number: _____ Contact name: _____

Past programs or jobs that were not appropriate:

_____

The best day program or job for him/her would be: _____

Legal

Current Guardian: _____

Relationship: _____

Name: _____

Address: _____

_____

Phone number(s): _____

E-mail address: _____

Declared incompetent: ◯ **Yes** ◯ **No**

Successor Guardian: _____

Relationship: _____

Address: _____

_____

Phone number(s): _____

E-mail address: _____

Name of Trust: _____ Date of trust: ____

Current Trustees:

Name: _____

Address: _____

_____

Phone number(s): _____

E-mail address: _____

Representative Payee:

The Representative Payee was appointed by the Social Security Administration to receive Social Security and/or Supplemental Security Income benefits for [name]. The Representative Payee's main responsibility is to use the benefits to pay for current and foreseeable needs of [name] and properly save any benefits not required to meet current needs.

Name: _____

Address: _____

_____

Phone number(s): _____

E-mail address: _____

Power of Attorney:

Name: _____

Address: _____

_____

Phone number(s): _____

E-mail address: _____

Date Power of Attorney was granted: _____

Wills:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Trusts:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Living Wills:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Durable Powers of Attorney:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Guardianship Order:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

Income Tax Records:

Where kept (i.e., safety deposit box, file cabinet, etc.):

_____

_____

Funeral arrangements have been made: ◯ **Yes** ◯ **No**

If "Yes," name of funeral home: _____

Address: _____

Phone number: _____ E-mail address: _____

Name of cemetery: _____

Address: _____

Phone number: _____ E-mail address: _____

Contact person: _____

Payments: ◯ have been made ◯ have not been made

Service to be held: ◯ Yes ◯ No

Monument/gravestone: ◯ Yes ◯ No

◯ Buried or ◯ Cremated

Final arrangements should include:

_____

_____

_____

Medical

Birth Information:

Weight: _____ Length: _____

Obstetrician name and address: _____

_____

City and state where born: _____

Hospital name and address: _____

_____

Information about the delivery: _____

Health Insurance:

Medical: _____

Policy number: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Dental: _____

Policy number: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Vision: _____

Policy number: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Other Health Insurance: _____

Policy number: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Diagnoses:

_____

_____

Diagnostic and genetic tests performed, including dates, doctor/laboratory performing tests and results:

_____

_____

Intellectual functioning level: _____

Vision level: _____

Contact lenses or glasses: _____

If contacts, brand and prescription: _____

Eye Doctor: _____

Vision prescription: _____

Hearing aid: ◯ Yes ◯ No

Speech and communication: _____

Seizures: ◯ Yes ◯ No

Blood type and conditions: _____

Primary Care Physician:

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Are visits scheduled at specific times of year? ◯ Yes ◯ No

Specialist:

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Are visits scheduled at specific times of year? ◯ Yes ◯ No

Dentist:

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Are visits scheduled at specific times of year? ◯ Yes ◯ No

Orthodontist:

Name:_____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Are visits scheduled at specific times of year? ◯ Yes ◯ No

Nursing care: ◯ Yes ◯ No

Nursing care required because:

_____

Care is given at home unless noted below.

Name of firm or facility: _____

Primary contact: _____

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Allergies:

Allergic to: _____

Method of birth control: _____

Ambulatory: ◯ Yes ◯ No

Medical equipment (e.g., wheelchair, adaptive cutlery, glasses, contact lenses, hearing aids, hand splints, orthotics, shower chair, accessible van, augmentative speech device, etc.):

_____

_____

Prescription Medication:

Name: _____

Dosage: _____

Reason for medication: _____

Prescribing doctor: _____

Over-the-counter medications and items:

_____

_____

_____

Needs help to take his/her medicine: ◯Yes ◯No Name of helper_____

Picks up/buys medicine: ◯Yes ◯No

Helps him/her to take medicine at this time: _____

Can swallow pills: ◯Yes ◯No

The best way to get him/her to take medicine is:

_____

_____

Diet is restricted as follows (e.g., no sugar, no salt, no foods that would present a choking hazard such as nuts or chewing gum, etc.):

_____

_____

Other: _____

_____

Please be aware of these additional medical conditions:

_____

_____

Financial

Needs help with banking: ◯ Yes ◯ No

Name of Bank: _____

Account holder: _____

Account number: _____

Type: _____

Debit card: _____

Web address: _____

Online user name: _____

Online password: _____

Billing address: _____

Statements: ◯ Online Only ◯ Mailed

Name of Bank: _____

Account holder: _____

Account number: _____

Type: _____

Debit card: _____

Web address: _____

Phone number: _____

Online user name: _____

Online password: _____

Billing address: _____

Statements: ◯ Online Only ◯ Mailed

Safety Deposit Box: _____

Bank: _____

Box holder: _____

Where is key located? _____

Name of Credit Card Company: _____

Account holder: _____

Account number: _____

Type: _____

Card number: _____

Web address: _____

Phone number: _____

Online user name: _____

Online password: _____

Billing address: _____

Statements: ◯ Online Only ◯ Mailed

Name of Brokerage Account Company: _____

Account holder: _____

Account number: _____

Account type: _____

Web address: _____

Phone number: _____

Online user name: _____

Online password: _____

Billing address: _____

Statements: ◯ Online Only ◯ Mailed

Financial Advisor:

Name: _____

Company name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

CPA:

Name: _____

Company name:_____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Can pay bills and stick to a budget: ◯ Yes ◯ No

Finances are managed on a day-to-day basis by:

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Relationship: _____

Person who is best able to help with personal finances is:

Name: _____

Address: _____

_____

Phone number(s): _____ E-mail address: _____

Relationship: _____

Receives an allowance: ◯ Yes ◯ No

Allowance amount of $_____ is paid weekly/monthly/quarterly by: _____

[Name] or his/her Representative Payee receives the following government benefits (e.g., Social Security, SSDI, SSI, etc.):

Service/benefit: _____

Frequency: _____ Amount: _____

Monthly bill schedule attached: ◯ Yes ◯ No

Federal/State/Community Benefits:

Service/benefit: _____

Provider: _____

Start date: _____ End date: _____

Service/benefit: _____

Provider: _____

Start date: _____ End date: _____

Life Insurance Policy (Carrier's name): _____

Policy number: _____

Owner: _____ Insured: _____

Premium/frequency: _____

Agent's name: _____

Phone number(s): _____

Address: _____

_____

E-mail Address: _____