

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 re-visit 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 own will.

Letter of Care — Personal Note To Your Caregiver

Date:
Prepared for: Name:
DOB:
SS#:
Phone Number:
Email

Dear Caregiver

This is a letter of care for [Child's Name]. 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

Very sincerely yours,

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Personal Information

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

Provide an overview of the Dreams and Hopes you have for [Name] for the future.

Provide an overview of the Fears you have for [Name] for the future.

Describe [Name]'s day to day life.

Our aspiration is that [Name] can do the following in the future:

We feel strongly that [Name] should be entitled to:

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

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:

See attached calendar 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.):

Home Owners 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 — 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 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: _____