

# **PLAN of Massachusetts and Rhode Island, Inc.**

## **LIFE CARE PLAN**

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

**Developed for Trust Beneficiary:** \_\_\_\_\_

## Table of Contents

Introduction . . . . .	Page 2
Section I. Introducing Our Family . . . . .	Page 3
Section II. Medical History/Service Providers . . . . .	Page 6
Section III. Skills/Work/Interest . . . . .	Page 7
Section IV. Trust Beneficiary’s Benefits . . . . .	Page 8
Section V. Social Service Agencies . . . . .	Page 9
Section VI. Legal/Financial Advisors . . . . .	Page 10
Section VII. Wish List . . . . .	Page 10
Signature Page . . . . .	Page 11

### Introduction

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 will want and need in the future. The answers provide the framework for planning how to maximize the likelihood that these wants and needs will be met. PLAN will use the Life Care Plan as a guide and reference while working with the Trust Beneficiary to ensure quality service and appropriate use of funds.

It is never too early to develop a Life Care Plan. Taking the time and care to develop a good Life Care Plan helps ensure that the trust beneficiary will benefit from the trust assets and continue or obtain public benefits which he or she may be eligible to receive. Developing a Life Care Plan early allows the family the opportunity to make informed decisions together.

The process of developing a Life Care Plan requires a significant amount of time. The process can include as many people as you wish, including the Trust Beneficiary. Once a Life Care Plan is developed, it should be reviewed on a regular basis and at any time when there has been a change in circumstances.

**SECTION I: INTRODUCING OUR FAMILY**

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**Trust Beneficiary**

1. Name \_\_\_\_\_  
(Last name) (First name) (Middle name)
  
2. Date of Birth: \_\_\_\_\_
  
3. Disability: \_\_\_\_\_
  
4. Functional Ability and Limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Has the Social Security Administration (SSA) made a determination that the Trust Beneficiary has a disability?  YES  NO
  
6. Is the Trust Beneficiary applying to the SSA for a disability determination?  
 YES  NO
  
7. Current Living arrangement (i.e. lives independently, lives with family member, group home): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_
  
8. Does the Trust Beneficiary receive a Housing Subsidy or is he/she on a waiting list to receive a Housing Subsidy?  YES  NO

**Family Members**

**9. Father**

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**10. Mother**

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

11. Is the Trust Beneficiary married?  YES  NO

If yes, please list the name and address of the spouse:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Does the Trust Beneficiary have children?  YES  NO

If yes, please list the names and address(es) of any children:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13. Siblings and Significant Others** (significant others can be a friend, neighbor, clergy, etc.)

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Relationship to the Trust Beneficiary: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Relationship to the Trust Beneficiary: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Relationship to the Trust Beneficiary: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last name) (First name) (Middle name)  
Relationship to the Trust Beneficiary: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone and/or Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**If you wish to include additional people, please provide names and contact information on a separate sheet.**

**SECTION II: MEDICAL HISTORY/SERVICE PROVIDERS**

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14. Please indicate any current medical conditions in addition to the disability:

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15. Please list all current medications: \_\_\_\_\_

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16. Please list the Name, Address, and Phone Number of the Trust Beneficiary's Primary Care Doctor:

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17. Please list the Name, Address, and Phone number of any other health care provider you feel it is important to list (for example: therapist, psychiatrist, psychologist):

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**Special Physical Requirements**

The Trust Beneficiary may require special equipment or supplies to meet physical needs. Use this worksheet to record any requirements for equipment such as a wheelchair, hearing aids, special glasses, or communication devices.

18. Equipment needed: \_\_\_\_\_

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19. Supplies needed: \_\_\_\_\_

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20. How are the equipment and supplies currently paid for? \_\_\_\_\_

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**SECTION III: SKILLS/WORK/INTERESTS**

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21. Does the Trust Beneficiary handle his or her own finances (e.g. pay bills regularly)?

YES    NO   If not, who provides assistance?

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22. Does the Trust Beneficiary typically make his or her own decisions?  YES    NO

If not, who provides assistance in making decisions?

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23. Does the Trust Beneficiary currently work?  YES  NO

If yes, please describe the work that he or she does, including the amount of time and amount of pay: \_\_\_\_\_

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24. Do you think that the Trust Beneficiary should continue in this work?  YES  NO

Why or why not? \_\_\_\_\_

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25. If the Trust Beneficiary is unable to work for pay, what type of activity do you think would be helpful and productive? \_\_\_\_\_

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26. Does the Trust Beneficiary attend a day program?  YES  NO

If yes, please provide the name of the program and address:

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27. Please identify the particular skills that the Trust Beneficiary has: \_\_\_\_\_

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28. What kinds of social/recreational activities does the Beneficiary enjoy? (Please include recreational memberships, cultural memberships, volunteer agencies, and other community/social organizations that will remain central to your loved one's care.):

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**SECTION IV: BENEFICIARY'S BENEFITS**

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29. Does the beneficiary receive SSI?  YES  NO  
If yes, how much per month? \$ \_\_\_\_\_

30. Does the beneficiary receive SSDI?  YES  NO  
If yes, how much per month? \$ \_\_\_\_\_

31. Does the beneficiary receive a Pension?  YES  NO  
If yes, how much per month? \$ \_\_\_\_\_

32. Does the beneficiary have Veterans benefits?  YES  NO

33. Does the beneficiary have Medicare?  YES  NO

34. Does the beneficiary have Medicaid?  YES  NO  
(MassHealth if beneficiary resides in Massachusetts)

35. Does the Trust Beneficiary have supplemental private health insurance?  YES  NO  
If yes, please provide the provider name and ID number: \_\_\_\_\_

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36. Does the beneficiary have a pre-paid funeral plan in place?  YES  NO

If yes, please provide the name and address of the funeral home:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION V: SOCIAL SERVICE AGENCIES PROVIDING SERVICES TO THE TRUST BENEFICIARY** (E.G. CASE MANAGEMENT SERVICES, COMPANIONS, PCA, HOMEMAKER)

37. Name of Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

38. Name of Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

39. Name of Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**SECTION VI: LEGAL/FINANCIAL ADVISORS**

40. Does the Trust Beneficiary have his or her own attorney?  YES  NO

If yes:

Name of Attorney: \_\_\_\_\_

Firm: \_\_\_\_\_

Office Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

41. Does the Trust Beneficiary have a Guardian?       YES    NO

If yes:

Name of Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

42. Does the Trust Beneficiary have a Conservator?       YES    NO

If yes:

Name of Conservator: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

43. Does the Trust Beneficiary have a Representative Payee?       YES    NO

If yes:

Name of Rep Payee: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**SECTION VII: WISH LIST**

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44. What are your wishes for the Trust Beneficiary for the near and distant future? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

45. If for some reason you wishes cannot be fully implemented, which items that you have identified do you feel are most important? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

46. Please share any further information that would help us in understanding this Trust Beneficiary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CONTACT US REGARDING ANY CHANGES IN INFORMATION.**

**Donor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relationship to Trust Beneficiary:** \_\_\_\_\_