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
3rd Party Special Needs Pooled Trust

Developed for Trust Beneficiary: ________________________________
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

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

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

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

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

15. Please list all current medications:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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):

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
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: ________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

19. Supplies needed: _________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

20. How are the equipment and supplies currently paid for? __________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SECTION III: SKILLS/WORK/INTERESTS

21. Does the Trust Beneficiary handle his or her own finances (e.g. pay bills regularly)?
☐ YES  ☐ NO  If not, who provides assistance?
________________________________________________________________________

22. Does the Trust Beneficiary typically make his or her own decisions? ☐ YES  ☐ NO
If not, who provides assistance in making decisions?

________________________________________________________________________
________________________________________________________________________

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: ________________________________________________
________________________________________________________________________
________________________________________________________________________

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

Why or why not? ________________________________________________
________________________________________________________________________
________________________________________________________________________

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

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

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

27. Please identify the particular skills that the Trust Beneficiary has: ___________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SECTION IV: BENEFICIARY’S BENEFITS

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: _______________________
   ______________________________________________________________________
   ______________________________________________________________________

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

44. What are your wishes for the Trust Beneficiary for the near and distant future? ________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
45. If for some reason you wish 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: ________________________________