Memorandum of Intent

A **Memorandum of Intent** is a document for use by your loved one's future care-givers. This document can be one part of your estate planning process. It provides pertinent information about your loved one's needs and the individuals involved in his or her life, and also provides an opportunity to communicate your desires and vision of the future when you are no longer alive.

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Section One: Personal Information About Your Child or Loved One

Child (or other Loved One's) Name: _____

Address:_____

Phone Number:_____

Driver's License Number: _____

Social Security Number: _____

Other ID? _____Yes _____ No Identify _____

Name and Contact Information of Person Completing This Memorandum: _____

_____

_____

_____

Close Family Members:

_____

_____

_____

_____

_____

_____

Close Friends:

_____

_____

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_____

_____

_____

_____

Section Two: Current Living Situation

_____

_____

Important information about current living situation:

_____

_____

Section Three: Future Living Situation

After I (we) are gone, I (we) would ask that _____could live (where, with whom):

_____

_____

_____

_____

_____would like to live with:

_____

_____

_____

_____

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_____would like to live in (City, State, general location)

_____

_____

_____

_____

_____would like the following persons to assist him/her with the following household tasks if possible:

_____

_____

_____

_____

_____can do the following household tasks for himself/herself:

_____

_____

_____

_____

Important information when considering future living situation for _____:

_____

_____

_____

_____

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Section Four: Estate/Legal Plans

Special Needs Trust

I (we) have developed a special needs trust for _____. ____Yes ____No

The Trustee of his/her trust is: _____

_____'s Attorney is: _____

Important information regarding _____'s Special Needs Trust:

_____

_____

_____

Power of Attorney/Guardianship

_____has a Power of Attorney ____Yes ____No

If yes, please identify _____

I (we) currently have Guardianship for _____ ____Yes ____No

If yes, please identify _____

_____ is authorized to receive medical information by way of

_____.
(Name the Authorizing Document)

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Section Five: Financial Information

SSI_____ Current Amount: _____ Medicaid: _____

SSDI_____ Current Amount: _____ Medicare: _____

Social Security _____ Current Amount: _____

Other _____Current Amount _____

Caseworker: _____
(Name and contact information)

Other Health Insurance: _____

ID Number: _____

Banking

Bank/Credit Union Name: _____

Address: _____

Contact Person/Phone: _____

Savings Account Number: _____

Checking Account Number: _____

Special Financial Information: _____

_____

Pension/Retirement Plans/IRA: _____

_____

_____

A copy of the Summary Plan Description is available: ____Yes ____No

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Other Resources and/or Financial Planning Services: _____

_____

_____

Paychecks

_____works at:

_____

Contact Information: _____

_____

Amount of paychecks _____

Uses paychecks for: _____

_____

Does own banking: ____Yes ____No

Needs assistance with banking: ____Yes ____No

Specific assistance needed: _____

_____

Home _____

_____

Tax information

Accountant Name: _____

Contact Information: _____

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_____

_____

Can do own taxes: ____Yes ____No

Needs assistance with taxes: ____Yes ____No

Section Six: Community Assistance

Case Management Agency: _____

Contact Information: _____

_____

Supports Coordinator: _____

Phone Number: _____

Case Number: _____

_____ receives the following services (i.e. supported employment, respite, sheltered employment, counseling, housing, etc.).

Include agency and contact information:

_____

_____

_____

_____

_____

Section Seven: Medical/Emergency Information

Current Doctors (Include name, address and phone number(s))

_____

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Dentist:

Specialists:

Allergies:

Vision:

Hearing:

Seizures:

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Seizure Medications:

Therapist/Counselor/Psychologist/Psychiatrist:

Medications: (include dosage, times, side effects, and how medication is given)

Past Operations/Conditions:

Other Important Medical Information:

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_____

_____

I (we) would like _____to continue with his/her current doctors

____Yes ____No

Comments:

_____

_____

_____

_____

_____

_____

Section Eight: School Information

School Name: _____

Address: _____

_____

Phone: _____

Teacher: _____

_____will remain in Special Education until he/she reaches the age of _____.

_____Yes _____No, he/she can graduate when ready

_____has a current IEP: _____Yes _____No

Important information regarding educational planning for _____:

_____

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_____

_____

_____

_____currently has a transition plan: _____Yes _____No

Important information regarding transition planning for _____

_____

_____

_____

_____

Section Nine: Employment

I (we) would like _____to seek out community employment at some point in the future. _____Yes _____No

Important information regarding future community employment opportunities:

_____

_____

_____

Section Ten: Personal Possessions

_____owns the following items: (i.e. home, care, collections, TV, VCR, stereo, CDs, tapes, etc.)

_____

_____

_____

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_____

Section Eleven: Personal Care

_____appreciates assistance with the following personal care tasks:

_____

_____

_____

_____

_____is able to do the following personal care tasks alone:

_____

_____

_____

_____

_____is used to the following personal care items (i.e. brands of shampoo, soap, toothpaste, razor, etc.):

_____

_____

_____

_____is used to the following personal care routine:

_____

_____

_____

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_____

Section Twelve: Food and Eating

_____appreciates assistance with the following food preparation and clean-up:

_____

_____

_____

_____

_____is able to do the following food preparation and clean-up:

_____

_____

_____

_____

_____likes the following foods:

_____

_____

_____

_____

_____dislikes the following foods:

_____

_____

_____

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_____

Special information regarding food and _____.

_____

_____

_____

_____

Section Thirteen: Leisure and Recreation

_____likes the following leisure/recreation activities:

_____

_____

_____

_____

_____dislikes the following leisure/recreation activities:

_____

_____

_____

_____

Favorite activities/places to go:

_____

_____

_____

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Favorite friends to go with: (include phone number)

Vacations:

Fitness/exercise programs or activities:

Section Fourteen: Special Interests/Abilities

Section Fifteen: Religion

Church: (include address, phone, pastor, how often he/she attends)

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_____

_____

Funeral Arrangements:

_____

_____

_____

_____

Special information regarding religion:

_____

_____

_____

_____

Section Sixteen: Family Culture

Our family is: _____close _____not close

Our family celebrates the following events: (i.e. birthdays, holidays, anniversaries, etc.)

_____

_____

_____

_____

Our family celebrates events by:

_____

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_____

_____

_____

Other important cultural/ethnic information:

_____

_____

_____

_____

Section Seventeen: Community Participation

_____participates in the following community functions:

Voting _____ Absentee ballot _____ in person _____

Library: _____

Clubs:

_____

_____

_____

_____

Health Clubs (YWCA, YMCA, etc.):

_____

_____

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_____

_____

Section Eighteen: Habits/Routines

_____is used to the following routines:

_____

_____

_____

_____has the following habits:

_____

_____

_____

Section Nineteen: Disposition

_____'s disposition is generally (i.e. happy, playful, quiet, withdrawn, assertive, passive, easily influenced, etc.)

_____

_____

_____

_____might become upset/violent if…

_____

_____

_____

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This is how we calm/comfort him/her:

_____

_____

_____

Section Twenty: Communication

_____uses speech to communicate. _____Yes _____No

Special information about _____'s speech

_____

_____

_____

_____does not use speech to communicate. _____Yes_____No

Section Twenty One: Other Information

Other information that you would like to add about _____:

_____

_____

_____

_____

_____

_____

Parent (or other caregiver) Signature Date

_____

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Parent (or other caregiver) Signature Date

_____

Date Updated