



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: _____

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

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

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 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: _____