



# CUMBERLAND TRUST

## Letter of Intent

A letter of intent is one of the most critical documents that parents of children with special needs can leave behind. Detail all needed information about your child in this form. Some of the most obvious details are included, but be sure to think through anything else that may be specific to your child and his or her needs. This form can be filled out and saved to your computer, or printed out and filled out by hand. However, make sure that it is easily accessible to anyone who might need to find it and remember to update it on a regular basis.

### GENERAL INFORMATION

Beneficiary Name	<input type="text"/>	SSN	<input type="text"/>
Driver's License	<input type="text"/>	Birth Date	<input type="text"/>
		Blood Type	<input type="text"/>

### MEDICAL INFORMATION

Beneficiary Health Summary	<input type="text"/>		
Doctor	<input type="text"/>		
Specialty	<input type="text"/>	Phone Number	<input type="text"/>
Diagnosis	<input type="text"/>	When Diagnosed?	<input type="text"/>
Current Symptoms	<input type="text"/>		
Doctor	<input type="text"/>		
Specialty	<input type="text"/>	Phone Number	<input type="text"/>
Diagnosis	<input type="text"/>	When Diagnosed?	<input type="text"/>
Current Symptoms	<input type="text"/>		

Doctor

Specialty

Phone Number

Diagnosis

When Diagnosed?

Current Symptoms

Dentist

Phone Number

Hospital

Location

Phone Number

History of Seizures?  Yes  No If Yes, When?

Therapy (i.e., physical, speech, occupational, psychotherapy) Please list type of therapy and name and phone number of therapist

Allergies

Medication

When Taken?

Needs Assistance?  Yes  No

Medication

When Taken?

Needs Assistance?  Yes  No

Medication

When Taken?

Needs Assistance?  Yes  No

Medical Equipment Needed

- Mobility  Moves Unassisted  Wheelchair  Can Drive
- Moves with Assistance  Walker  Cannot Drive
- Does Not Walk  Cane  Needs Special Car Equipment
- Bedbound  Needs Special Seat

Other Medical Issues

## PERSONAL CARE AND PREFERENCES

- Personal Care  Unassisted  Pads  Diapers  Bedpan  Catheter  Bedside Commode

Meal Times

Breakfast	<input type="text"/>	Lunch	<input type="text"/>	Dinner	<input type="text"/>	Snack	<input type="text"/>
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- Likes Pets?  Yes  No

Religion

Faith	<input type="text"/>	Denomination	<input type="text"/>	Clergy	<input type="text"/>
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Place of Worship Address	<input type="text"/>	Phone Number	<input type="text"/>
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Number of Times Visited	<input type="text"/>	Desired Participation	<input type="text"/>
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## LEGAL AND FINANCIAL INFORMATION

- Beneficiary has been declared incompetent and a guardian has been appointed?  Yes  No

Name(s) of Guardians

Who Would Take Care of Beneficiary if Current Guardian Cannot?

Has a Family Member Set up a Trust for the Beneficiary?  Yes  No

If Yes, Who Is the Trustee?

Is the Beneficiary Currently Enrolled in any Benefit Programs?  Yes  No

If No, Has the Beneficiary Recently Applied for Benefits?  Yes  No

If Yes, When?

## EDUCATION, WORK AND HOME

Current School

Current Programs

Extracurricular Activities

Does the Beneficiary Work or Attend a Day Program?  Yes  No

Describe the Type of Work or Program

What Physical Limitations Would Employers Need To Be Aware Of?

Housing

Renting an Apartment or House

Buying a House or Condo

Moving to a Group Home or Supported Living Home

## PERSONAL CONTACTS

Names of all people involved with the beneficiary (please include all persons living in the home and emergency contacts):

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name  Relationship  Phone Number

Name  Relationship  Phone Number

Name  Relationship  Phone Number

**PROFESSIONAL CONTACTS**

**Estate Executor**

Name  Email   
Address  Phone Number   
City, State, ZIP

**Professional Attorney**

Name  Email   
Address  Phone Number   
City, State, ZIP

**Accountant**

Name  Email   
Address  Phone Number   
City, State, ZIP

**Financial Advisor**

Name  Email   
Address  Phone Number   
City, State, ZIP

**Banker**

Name  Email   
Address  Phone Number   
City, State, ZIP

**Veterinarian**

Name  Email   
Address  Phone Number   
City, State, ZIP

## ADDITIONAL CONTACTS

Use this page as needed to add additional contacts, including friends and family, medical personnel or professional advisors.

Name  Email  Relationship

Address  Phone Number   
City, State, ZIP

Name  Email  Relationship

Address  Phone Number   
City, State, ZIP

Name  Email  Relationship

Address  Phone Number   
City, State, ZIP

Name  Email  Relationship

Address  Phone Number   
City, State, ZIP

*Remember to save and print this document, and keep it in a secure, but accessible location. Also, update this form regularly to keep it current.*