

**LETTER OF INTENT**

Prepared by, \_\_\_\_\_,

for \_\_\_\_\_ (Beneficiary),

on \_\_\_\_\_, 20\_\_\_\_\_.

**VITAL STATISTICS**

Beneficiary's full name: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Marriage: \_\_\_\_\_

Prior Marriages: \_\_\_\_\_

\_\_\_\_\_

**FAMILY**

Beneficiary's Spouse (name, address, telephone number, date of birth, social security number):

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

Parents (name, address, telephone number, date of birth, social security number):

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

Siblings (name, address, telephone number, date of birth):

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Children (name, address, telephone number, date of birth, social security number):

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Other key relatives (name, address, telephone number, date of birth):

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Friends (name, address, telephone number): \_\_\_\_\_

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**MEDICAL HISTORY**

Primary Physician (name, address, telephone number): \_\_\_\_\_

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Other Physicians (name, address, telephone number): \_\_\_\_\_

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Dentist (name, address, telephone number): \_\_\_\_\_

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Disability: \_\_\_\_\_

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Medical History: \_\_\_\_\_

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Allergies: \_\_\_\_\_

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Location of Medical Records: \_\_\_\_\_

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Current Medication: \_\_\_\_\_

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Other key information: \_\_\_\_\_

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**LEGAL/FINANCIAL**

Attorney (name, address, telephone number):

LAW OFFICES OF HERBERT D. HINKLE,

2651 MAIN STREET, SUITE A,

LAURENCEVILLE, NEW JERSEY 08648-1012; (609) 896-4200.

Financial Planner (name, address, telephone number): \_\_\_\_\_

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Insurance Agent (name, address, telephone number) : \_\_\_\_\_

Insurance policies (company, account number, beneficiary and ownership):

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Accountant (name, address, telephone number): \_\_\_\_\_

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Guardianship (name, address, telephone number):

(Attach copy of Judgment and Letters of Guardianship)

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When obtained (give state and county): \_\_\_\_\_

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Parents: Wills (date) \_\_\_\_\_

Medical Directives (date) \_\_\_\_\_

Durable Powers of Attorney (date) \_\_\_\_\_

Special Needs Trust (date) \_\_\_\_\_

Location where stored: \_\_\_\_\_

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Trustees (give names, addresses and phone numbers): \_\_\_\_\_

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Beneficiary's Assets: \_\_\_\_\_

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Location: \_\_\_\_\_

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**EDUCATION**

Secondary Education: \_\_\_\_\_

Schools Attended: \_\_\_\_\_

Classification for Special Education: \_\_\_\_\_

Location of Educational Records: \_\_\_\_\_

Vocational Training: \_\_\_\_\_

Schools Attended: \_\_\_\_\_

Classification for Special Education: \_\_\_\_\_

Location of Educational Records: \_\_\_\_\_

College Education: \_\_\_\_\_

Schools Attended: \_\_\_\_\_

Location of Educational Records: \_\_\_\_\_

**ADULT SERVICES/VOCATIONAL HISTORY**

Current Employer (name, address, telephone number, starting date): \_\_\_\_\_

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Other Employers (name, address, telephone number, date of service): \_\_\_\_\_

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Day Services Program (name, address, telephone number): \_\_\_\_\_

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Agency Providing Funding, Services: (name, address, telephone number): \_\_\_\_\_

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Agency Delivering Day/Vocational Services (name, address, telephone number): \_\_\_\_\_

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Other Residences (name, address, telephone number, date of residency): \_\_\_\_\_

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**RESIDENTIAL SERVICES (OUTSIDE OF HOME)**

Current Residence (name, address, telephone number, starting date): \_\_\_\_\_

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Other Residences (name, address, telephone number, date of residency): \_\_\_\_\_

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**ORGANIZATION PROVIDING SERVICES**

Organization (name, address, telephone number, services provided, service date):

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**PARENTS' ASPIRATIONS FOR THE BENEFICIARY**

Working Arrangements: \_\_\_\_\_

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Living Arrangements: \_\_\_\_\_

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Other key facts: \_\_\_\_\_

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**MISCELLANEOUS**

Religious Instruction: \_\_\_\_\_

Recreational Interests: \_\_\_\_\_

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Likes\Dislikes: \_\_\_\_\_

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Burial Arrangements: \_\_\_\_\_

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Is the beneficiary enrolled in a community trust? If so, list the name, address and telephone number  
of the beneficiary's case manager: \_\_\_\_\_

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