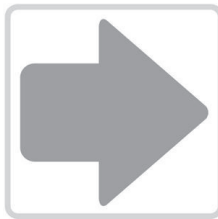




**Letter of Intent
for
Families with Special Needs**





Workbook

Letter of Intent

You will be describing your child's current medical condition, medical history, medications, allergies, hospitalizations, etc. List all of your child's physicians with contact information. If nursing services, home infusions, or durable medical equipment of any kind is in use, make sure to list the provider, contact information, and exactly what is being provided to your child.

Personal Information

Child's Full Name (First, Middle Initial, Last): _____

Male Female

Date of Birth (Month/Day/Year): _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) ____ - ____ Alternate Phone: (____) ____ - ____

Race: _____ Social Security #: _____

Weight: _____ Height: _____

Clothing Sizes: _____ Shoe Size: _____

Family Information

NAME

ADDRESS

PHONE NUMBER

Father: _____

Mother: _____

Sibling: _____

Sibling: _____

Sibling: _____

Sibling: _____

Other: _____

Other : _____

Other: _____

Other: _____

Pets: _____

Other languages spoken?

Yes No

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Life Care Planning for Special Needs Families

Necessary Safety Precautions: _____

Vision: _____

Hearing: _____

Speech: _____

Communication Needs: _____

Augmentative communication systems? (Picture Exchange Communication System [PECS],
sign language, voice output device) Yes No

Mobility: _____

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Medical Insurance

Primary Insurance: HMO PPO POS
ID#: _____ Group #: _____
Plan#: _____ Member Services Phone #: (____) ____ - ____
Policy Holder: _____ Social Security #: _____
Employer: _____ Date of Birth: _____

Secondary Insurance HMO PPO POS
ID#: _____ Group #: _____
Plan#: _____ Member Services Phone #: (____) ____ - ____
Policy Holder: _____ Social Security #: _____
Employer: _____ Date of Birth: _____

Additional Insurance HMO PPO POS
ID#: _____ Group #: _____
Plan#: _____ Member Services Phone #: (____) ____ - ____
Policy Holder: _____ Social Security #: _____
Employer: _____ Date of Birth: _____

Hospitalizations:

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Hospital of Preference for Emergencies: _____

List of Diagnosed Conditions

Condition: _____ **Date Diagnosed | Doctor | Notes:** _____

Developmental Delay: _____
 Yes No _____

Attention Deficit: _____
 Yes No _____

Autism: _____
 Yes No _____

Vision Problems: _____
 Yes No _____

Cognitive Deficits: _____
 Yes No _____

Diabetes: _____
 Yes No _____

Stomach Disorders: _____
 Yes No _____

Cancer: _____
 Yes No _____

Hearing Problems: _____
 Yes No _____

Epilepsy: _____
 Yes No _____

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Condition: _____ **Date Diagnosed | Doctor | Notes:** _____

Neurological (Stroke, Cerebral Palsy): _____

Yes No _____

Depression: _____

Yes No _____

Sensory Processing Dysfunction: _____

Yes No _____

Heart Condition: _____

Yes No _____

High Blood Pressure: _____

Yes No _____

Chemical Dependency: _____

Yes No _____

Lung Problems: _____

Yes No _____

Hepatitis: _____

Yes No _____

Other: _____

Yes No _____

Contact List for Doctors and Specialists

Make sure to include everyone: developmental pediatrician, neurologist, ears, nose, and throat (ENT) specialist, audiologist, allergist, gastroenterologist, nutritionist, psychologist, behavioral specialist, therapists, cardiologist, pulmonologist, urologist, orthopedic, obstetrician/gynecologist, endocrinologist, hematologist, hepatologist, nephrologist, rheumatologist, dentist, and eye doctor.

Specialist: _____
Address: _____ Phone: (____) ____ - ____
Last Visit Date: _____
Plan of Care/Recommendations: _____

Specialist: _____
Address: _____ Phone: (____) ____ - ____
Last Visit Date: _____
Plan of Care/Recommendations: _____

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Address: _____ Phone: (____) ____ - ____
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Last Visit Date: _____
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Medical Devices and Equipment Used

Device/Equipment: _____
Purpose: _____
Vendor: _____ Phone: (____) ____ - _____
Address: _____

Device/Equipment: _____
Purpose: _____
Vendor: _____ Phone: (____) ____ - _____
Address: _____

Device/Equipment: _____
Purpose: _____
Vendor: _____ Phone: (____) ____ - _____
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Vendor: _____ Phone: (____) ____ - _____
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Purpose: _____
Vendor: _____ Phone: (____) ____ - _____
Address: _____

Diet and Nutrition

What does your child eat? _____

When does your child eat? _____

Any food allergies? _____

Any limitations on food or drink? _____

Mealtime Schedules/Routines:

Breakfast: _____

Snacks: _____

Lunch: _____

Snacks: _____

Dinner: _____

Before Bed: _____

Educational and Social History

Past Academic History:

School: _____	Years Attended: _____
School: _____	Years Attended: _____
School: _____	Years Attended: _____
School: _____	Years Attended: _____
School: _____	Years Attended: _____

Current School Placement:

School Name: _____ Phone Number: (____) ____ - _____
Address: _____
Contact Person: _____
Teacher's Name: _____
Type of Classroom: Regular Special Education

Does your child have an Individualized Education Program (IEP) or 504 plan? Yes No
(If so, include copy with the LOI)

Sending District Name: _____
(If appropriate)

Child Study Team Contact: _____
Phone Number: (____) ____ - _____
Address: _____

Services Received:
(Include physical therapy/occupational therapy/speech therapy [PT/OT/ST] with frequency, nursing services, transportation, any additional supports or accommodations needed)

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Your goals for your child's school program: _____

Any transition planning that has taken place: _____

Your wishes for future schooling: _____

Current Employment:

Company Name: _____ Phone Number: (____) ____ - _____
Address: _____
Contact Person: _____
Date Started: _____ Job Title: _____ Wages: _____

Transportation needs: _____

Additional supports or accommodations needed: _____

Your wishes for future employment: _____

Current Living Arrangements:

Address: _____

Phone Number: (____) ____ - _____

Contact Person: _____ Phone Number: (____) ____ - _____

Type of Setting: _____

Roommates (*if appropriate*): _____

How is housing being paid for? _____

Transportation needs: _____

Additional supports or accommodations needed: _____

Your wishes for future living arrangements: _____

Social Activities:

Does your child have friends of his or her age? Yes No

With whom does your child spend most of his or her time? _____

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Activities:

(Sports, clubs, art classes, etc. If appropriate, include specific program name, address, and phone number)

Transportation Arrangements:

Community Groups:

(Support groups, social agencies, etc. If appropriate, include specific program name, address and phone number)

Transportation Arrangements:

Specific Hobbies and Interests:

Religious Needs

Faith: _____ Church/Synagogue Name: _____

Address: _____

Contact: _____ Phone Number: (____) ____ - _____

Schedule: _____

Typical Schedules and Routines:

Use this area to describe in detail a day in the life of your loved one.

Describe the individual's personality, quirks, things to calm him or her, any specifics necessary for positioning, medication administration, bathing and grooming, waking and sleeping schedule, differences in daily structure on a weekend versus a weekday, etc.

Other things to consider: _____

What type of assistance with daily living is needed? _____

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What is done independently? _____

Self-care and Grooming: _____

Finances: _____

Housekeeping: _____

Shopping: _____

Meal Preparation: _____

Typical Schedule:

Morning: _____

Lunchtime: _____

After School/Work: _____

Dinnertime: _____

After Dinner: _____

Bedtime: _____

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Services and Benefits Being Received Currently

(SSI, SSDI, Medicaid, Medicare, etc.)

Name of Program: _____
Contact Person: _____ Phone Number: (____) ____ - ____
Benefits Being Received: _____
Any Additional Information Needed: _____

Name of Program: _____
Contact Person: _____ Phone Number: (____) ____ - ____
Benefits Being Received: _____
Any Additional Information Needed: _____

Name of Program: _____
Contact Person: _____ Phone Number: (____) ____ - ____
Benefits Being Received: _____
Any Additional Information Needed: _____

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Contact Person: _____ Phone Number: (____) ____ - ____
Benefits Being Received: _____
Any Additional Information Needed: _____

Name of Program: _____
Contact Person: _____ Phone Number: (____) ____ - ____
Benefits Being Received: _____
Any Additional Information Needed: _____

Additional Contacts

Be sure to include: friends, Case Manager, Nursing Services, Attorney, Financial Advisor, Designated Guardian, Trustee of Special Needs Trust, Advocate, and anyone else you can think of who is involved in your child's care/life and not already listed in this document. Include any special instructions as well.

Name: _____ Relationship: _____

Address: _____

Home Phone: (____) ____ - _____ Work or Cell Phone: (____) ____ - _____

Notes: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: (____) ____ - _____ Work or Cell Phone: (____) ____ - _____

Notes: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: (____) ____ - _____ Work or Cell Phone: (____) ____ - _____

Notes: _____

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Notes: _____

Name: _____ Relationship: _____

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Notes: _____

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Address: _____
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Notes: _____

Name: _____ Relationship: _____
Address: _____
Home Phone: (____) ____ - _____ Work or Cell Phone: (____) ____ - _____
Notes: _____

Gwendolyn Ann Canonico, CFP® is a Certified Financial Planner who specializes in guiding families through the unique financial challenges of special needs planning. With over two decades of experience, she helps parents and caregivers build strategies that protect benefits, fund long-term care, and create lasting security for their loved ones. Gwendolyn combines her professional expertise with a compassionate, hands-on approach, ensuring families have both the financial tools and the confidence to plan for the future.



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