Special Needs Personal Planning Guide

Providing peace of mind to individuals with disabilities and their families

ACHIEVA FAMILY TRUST

United Way Impact Fund AWARD FOR EXCELLENCE

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ACHIEVA FAMILY TRUST

Special Needs Personal Planning Guide

Welcome to the ACHIEVA Family Trust Special Needs Personal Planning Guide:

Think of the Special Needs Personal Planning Guide as creating a picture of your family member, containing all the information that makes him or her one of a kind. When the Special Needs Personal Planning Guide is complete, it will show your family member as the unique individual he or she is.

The details of this picture will include your family member's health history and finance. It will include his or her experiences with life and learning, family and friends, and likes and dislikes.

The Special Needs Personal Planning Guide can assist you in developing a plan to help ensure that your family member's needs are met day to day, on special occasions and in times of emergency. The plan you choose to develop based on the Special Needs Personal Planning Guide may require financial and legal assistance to implement. This guide can be an important step in developing plans for your family member's future but should supplement, not replace, legal advice.

The Special Needs Personal Planning Guide can preserve the picture of your family member, even after you are gone. You may choose to share the Special Needs Personal Planning Guide with other people who are important to your family member (other relatives, a service provider, etc.) during your lifetime. Periodically, you may want to consider updating the Special Needs Personal Planning Guide as information becomes outdated.

The Special Needs Personal Planning Guide was designed by family members like you to be easy to understand and to use. An introduction at the beginning of each section tells you what information you need in order to get started. It is divided into seven major sections:

- General
- Family & Friends
- Likes & Dislikes
- Life & Learning
- Health
- Finances
- Final Arrangements

To store copies of all the important documents that relate to your family member, it may be best to keep this document in a 3-ring binder with pockets or storage file for additional documentation and paperwork.

After the Special Needs Personal Planning Guide is complete, please store it in a safe, secure place. For example, a safe-deposit box, fire-proof case, or personal safe. Most importantly, inform the anticipated caregiver or other family members of the location of these documents.

Thank you for creating a full and lasting picture of your family member through the ACHIEVA Family Trust Special Needs Personal Planning Guide.

ACHIEVA FAMILY TRUST

Table of Contents

ACHIEVA FAMILY TRUST

Introduction

This document is an individual picture of:	
First Name:	
Middle Name:	
Last Name:	
Date of Birth:	

Created By:	
First Name:	
Middle Name:	
Relationship to Person:	
Home Phone:	
Work Phone:	

Created By:	
First Name:	
Middle Name:	
Relationship to Person:	
Home Phone:	
Work Phone:	

Date Completed:	

Section 1: General Information

Think of the first section of the Future Planning Guide as the frame of the picture you are creating of your family member. In this section, you will record general information about your family member. In this section, you will record general information about your family member. This general information will introduce your family member to other caregivers. It will also serve as the basis of all of the information that follows.

In order to get started, you may need to draw on information from the following documents relating to you family member:

- Family member's birth certificate
- Family member's Social Security card
- Family member's photo
- Family member's address and phone book/ Family's address and phone book
- Family member's Individual Program Plan (if available)

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

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General Information

Personal Information:	
First Name:	
Middle Name:	
Last Name:	
Nickname: (if any)	
Gender:	□ Male □ Female □ Other _____
Birth Date:	_____/_____/_____
Height & Weight:	_____feet _____inches _____lbs.
Eye Color:	□ Blue □ Brown □ Green □ Gray □ Hazel □ Other _____
Hair Color:	□ Blonde □ Brown □ Red □ Gray □ Black □ Other _____
Religion:	
Race:	□ White □ Hispanic/Latino □ Asian/Pacific Islander □ Multiracial □ African-American □ American Indian □ Other _____
Ethnicity:	□ Hispanic or Latino □ Non-Hispanic or Non-Latino
Citizenship:	□ U.S. Citizen □ Other_____ City of Birth: _____ Country of Birth: _____ Social Security Number: _____-_____-_____
IQ Information:	IQ: _____ Date of Test: _____/_____/_____ Test Administered By: _____
Languages Spoken:	□ English □ Spanish □ American Sign Language □ Other _____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____
Voter Registration Information:	Is this person registered to vote? □ Yes □ No City: _____ County: _____ State:_____ Needs assistance to vote? □ Yes □ No

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General Information

Residence Information:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	_____-_____-_____
Type of Residence:	□ Own Home □ Group Home □ Relative's Home □ Supported Living □ Family-owned Home □ Other_____ Date Moved to Current Address: _____/_____/_____ Number of Roommates/Housemates: _____ Number of Staff (if any): _____ Level of Supervision: □ Part-time □ 24-hour
Primary Contact at Person's Residence:	Name: _____ Home Phone Number: _____ Work Phone Number: _____ Other Phone Numbers: _____ Relationship to Person: _____
Services Information:	
Supports Coordinator:	Does this person have a Supports Coordinator? □ Yes □ No Name of Agency? _____ Base Service Unit Number? _____
Supports Coordinator Information:	Supports Coordinator Name: _____ Address: _____ Work Phone Number: _____ Work Fax Number: _____
Individual Care Plan:	Does this person have an Individual Program Plan? □ Yes □ No ***Note: Please include a copy of this plan with this Planning Guide.***

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General Information

Special Advocates:
Does this person have any special advocate(s) (friend, relative, or professional who agrees to protect person's interests, but does not have the legal authority of a guardian)? □ Yes □ No

Special Advocate #1	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Special Advocate #2	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Special Advocate #3	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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General Information

Emergency Contacts:
In case of an Emergency, contact these individuals:

Emergency Contact #1	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Emergency Contact #2	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Emergency Contact #3	**Relationship to Individual:**_____
Name:	
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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General Information

Is a current copy of the Person Centered Plan included with this Future Planning Guide?	□ Yes □ No

If not, which family member has this person's Person Centered Plan?	
Name:	
Phone:	

Notes & Comments:

Section 2: Family & Friends

Think of the second section of the Future Planning Guide as the heart of the picture you are creating of your family member.

Family and friends are among the most important things in any individual's life. They give a sense of happiness, a sense of belonging, and a sense of purpose. By creating this part of your family member's picture, you will be providing information that does not exist in any other document.

This information will allow other caregivers to know your family member more fully. By being aware of family and friends, these caregivers can ensure that your family member's most important relationships continue throughout his or her lifetime.

In order to get started, you may need to draw on information from the following documents and other items relating to your family member:

- Immediate family's Social Security Card
- Photo IDs
- Immediate Family's Death Certificates (if applicable)
- Family member's address and phone book/family's address and phone books
- Photographs of family and friends (labeled)
- Family mementoes (cards sent on special occasions, etc.)

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

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Family & Friends: Spouse & Children

Spouse/Former Spouse	
Name:	
Currently Married?	□ Yes □ No
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Street Address:	Apt Number: _____
City:	
State/Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Child #1	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Spouse & Children

Child #2	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Child #3	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Parents

Biological Mother	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Biological Father	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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Family & Friends: Siblings

Sibling #1	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Sibling #2	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Siblings

Sibling #3	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Sibling #4	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

ACHIEVA FAMILY TRUST

Family & Friends: Siblings

Sibling #5	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Sibling #6	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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Family & Friends: Other Relatives

Relative #1	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Relative #2	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Other Relatives

Relative #3	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Relative #4	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Other Relatives

Relative #5	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Relative #6	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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Family & Friends: Friends

Friend #1	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Friend #2	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

ACHIEVA FAMILY TRUST

Family & Friends: Friends

Friend #3	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Friend #4	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Friends

Friend #5	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Friend #6	
Name:	
Date of Birth:	_____/_____/_____ Place of Birth: _____
Social Security Number:	_____-_____-_____
Currently Living?	□ Yes □ No Date of Death: _____/_____/_____
Marital Status:	□ Single □ Married □ Domestic Partnership □ Widowed □ Divorced □ Separated □ Minor Child □ Other _____ Spouse's Name: _____ Date of Marriage: _____/_____/_____ Number of Children: _____
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

Family & Friends: Social Groups

Does this person have an organized social group? **□ Yes □ No**

Social Group #1	
Name of Group:	
Contact Person Name:	
Address:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____
Location of Meeting	
Place Name:	
Address:	
Meeting Frequency:	□ Daily □ Weekly □ Monthly □ Other _____
Day/Time:	

Social Group #2	
Name of Group:	
Contact Person Name:	
Address:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____
Location of Meeting	
Place Name:	
Address:	
Meeting Frequency:	□ Daily □ Weekly □ Monthly □ Other _____
Day/Time:	

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Family & Friends: Photographs & Mementoes

In order to preserve this person's most important family members, friends, and experiences, please include some family/friend photos and mementoes. These items add value to their reminiscences and provide reference and evidence of things from times past.

Having photographs and items collected over the years can be very reassuring to have around. These possessions can serve as their roots to important people in the individual's life. Having things from childhood, items that tell a story, can be an important source of comfort and help to document their relationship and provide a stronger sense of bonding and connection. It makes their experience unique and can also provide nostalgia, reflection and an important perspective at times of stress.

Mementoes are also a special part of the individual's story. They chart his/her travels, friendships and different experiences along the way. Having possessions that each tell their own story and remind him/her of various times in his/her past can be an evocative way to collect memories. The little gifts and souvenirs that are given to this person over the years provide another reminder that someone cares about him/her.

Are labeled photos of this person's family and friends included with this Future Planning Guide? □ Yes □ No

Are personal mementoes included with this Future Planning Guide? □ Yes □ No

If not, which friend or family member holds this person's photos/mementoes?

Name:	
Street Address:	Apt Number: _____
City, State, Zip Code:	
Phone Number:	Home _____-_____-_____ Work _____-_____-_____

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Family & Friends: Special Relationships

The following questions relate to this person's particular relationships with family and friends. Please make sure that all individuals mentioned below are included in the earlier sections **Spouse & Children**, **Parents**, **Brothers & Sisters**, **Other Family Members**, and **Friends**.

To which family member does this person best relate?	
Name:	

Which family member does this person admire most?	
Name:	

Which family member listens best to this person?	
Name:	

Which family member understands this person best (may not be the one who listens best)?	
Name:	

To which family member does this person go when troubles or upset?	
Name:	

To which friend does this person best relate?	
Name:	

Which friend shows the most interest in this person?	
Name:	

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Family & Friends: Special Occasions

Birthdays

Does this person celebrate birthdays of family/friends?	□ Yes □ No
Buys birthday cards?	□ Yes □ No
Buys birthday gifts?	□ Yes □ No
Gift price range:	$_____ - $_____
Attends birthday parties?	□ Yes □ No
Does person need assistance with these activities?	□ Yes □ No

Wedding Anniversaries

Does this person celebrate wedding anniversaries of family/friends?	□ Yes □ No
Buys anniversary cards?	□ Yes □ No
Buys anniversary gifts?	□ Yes □ No
Gift price range:	$_____ - $_____
Attends anniversary parties?	□ Yes □ No
Does person need assistance with these activities?	□ Yes □ No

Funerals/Memorials

Does this person attend funerals of family/friends?	□ Yes □ No
Buys flowers?	□ Yes □ No
Buys sympathy cards?	□ Yes □ No
Flower/donation price range:	$_____ - $_____
Does person need assistance with these activities?	□ Yes □ No
Visits grave sites?	□ On anniversary(ies) □ On Holidays □ Occasionally □ Brings flowers on visits □ Does not visit graves □ Other _____

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Family & Friends: Special Occasions

Holidays

What holidays does this person celebrate? (Indicate all that are applicable)	
□ New Year's Day	□ Yom Kippur
□ Valentine's Day	□ Thanksgiving
□ St. Patrick's Day	□ Hanukkah
□ Easter	□ Christmas
□ Passover	□ Kwanza
□ Mother's Day	□ Other _____
□ Memorial Day	□ Other _____
□ Father's Day	□ Other _____
□ Independence Day	□ Other _____
□ Labor Day	□ Other _____
□ Rosh Hashanah	□ Other _____

With whom does this person celebrate holidays?	1._____ 2._____ 3._____ 4._____ 5._____ 6._____
Buys holiday cards?	□ Yes □ No
Buys holiday gifts?	□ Yes □ No
Gift price range:	$_____ - $_____
Does this person attend church, temple, or place of worship on appropriate holidays?	□ Yes □ No
Name/Address of church/temple/place of worship?	
Does person need assistance with these activities?	□ Yes □ No

Family & Friends: Special Occasions

Vacations & Trips

Does this person go on vacations with family/friends?	□ Yes □ No
Name of family members and/or friends (make sure these people are listed in earlier sections of Family & Friends)	□ Yes □ No
Frequency of vacations/trips:	□ Occasional □ 2-4 times/year □ Annual □ Other _____
Types of vacations (check all that apply)	□ At homes of family/friends □ At vacation homes of family/friends □ Travel with family/friends □ Other _____ □ Other _____ □ Other _____
Favorite places this person has vacationed (for example, Disney World, Jersey Shore, Aunt Rita's summer home, etc.)	_____ _____ _____ _____
Does this person have spending money for vacations?	□ Yes □ No
Amount Range:	$_____ - $_____

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FAMILY TRUST

Family & Friends: Notes

Notes & Comments:

Section 3: Likes and Dislikes

Think of Section 3 as providing the color for the picture you are creating of your family member.

Every individual has unique likes and dislikes – what makes him or her happy, what makes him or her miserable. Often only the people closest to an individual are aware of these small but important details.

By filling in this part of your family member's picture, you will be providing information that does not exist in any other document.

This information will allow other caregivers to know your family member more fully. By being sensitive to his or her likes and dislikes, these caregivers can ensure that your family member is happy on a a day-to-day basis. They can also help your family member through the changes that may occur in his or her life.

In order to get started, you may need to draw on information from the family member's:

- Person Centered Plan
- Individual Service Plan
- Essential Lifestyles Plan

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

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Likes: People & Pets

Favorite people to live with?	
Name:	
Name:	
Name:	
Name:	

Favorite people to spend time with?	
Name:	
Name:	
Name:	
Name:	

Favorite animals and pets?	
Name/Type:	
Name/Type:	
Name/Type:	
Name/Type:	

Likes: Possessions

Favorite types of clothing?	
Clothing:	
Clothing:	
Clothing:	
Clothing:	
Clothing:	

Favorite toys/games?	
Toy/Game:	
Toy/Game:	
Toy/Game:	
Toy/Game:	
Toy/Game:	

Other favorite possessions?	
Item:	
Item:	
Item:	
Item:	
Item:	

Likes: Food & Drinks

Favorite foods?	
Food:	
Food:	
Food:	
Food:	
Food:	

Favorite drinks?	
Drink:	
Drink:	
Drink:	
Drink:	
Drink:	

Favorite restaurants?	
Restaurant:	
Restaurant:	
Restaurant:	
Restaurant:	
Restaurant:	

Are recipes for favorite foods included with this Future Planning Guide?	□ Yes □ No

If not, who has these recipes?	
Name:	

Likes: Recreation

Favorite TV shows?	
TV Show:	
TV Show:	
TV Show:	
TV Show:	
TV Show:	

Favorite movies?	
Movie:	
Movie:	
Movie:	
Movie:	
Movie:	

Favorite songs/music?	
Song/Music:	
Song/Music:	
Song/Music:	
Song/Music:	
Song/Music:	

Likes: Recreation

Favorite sports activities?	
Sport:	
Sport:	
Sport:	
Sport:	
Sport:	

Favorite hobbies?	
Hobby:	
Hobby:	
Hobby:	
Hobby:	
Hobby:	

When is/has this person been the happiest?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ACHIEVA FAMILY TRUST

Dislikes: People & Pets

People (or types of people) this person dislikes living with?	
Name/Type of Person:	
Name/Type of Person:	
Name/Type of Person:	
Name/Type of Person:	

People (or types of people) this person dislikes spending time with?	
Name/Type of Person:	
Name/Type of Person:	
Name/Type of Person:	
Name/Type of Person:	

Least favorite animals and pets?	
Name/Type:	
Name/Type:	
Name/Type:	
Name/Type:	

Dislikes: Possessions

Disliked types of clothing?	
Clothing:	
Clothing:	
Clothing:	
Clothing:	
Clothing:	

Disliked toys/games?	
Toy/Game:	
Toy/Game:	
Toy/Game:	
Toy/Game:	
Toy/Game:	

Disliked/unfavorite possessions?	
Item:	
Item:	
Item:	
Item:	
Item:	

Dislikes: Food & Drinks

Disliked foods?	
Food:	
Food:	
Food:	
Food:	
Food:	

Disliked drinks?	
Drink:	
Drink:	
Drink:	
Drink:	
Drink:	

Disliked restaurants?	
Restaurant:	
Restaurant:	
Restaurant:	
Restaurant:	
Restaurant:	

Dislikes: Recreation

Disliked TV shows?	
TV Show:	
TV Show:	
TV Show:	
TV Show:	
TV Show:	

Disliked movies?	
Movie:	
Movie:	
Movie:	
Movie:	
Movie:	

Disliked songs/music?	
Song/Music:	
Song/Music:	
Song/Music:	
Song/Music:	
Song/Music:	

Do violent or sexually suggestive TV, movies, music and/or sports lead to behavior problems for this person?	□ Yes □ No

ACHIEVA FAMILY TRUST

Dislikes: Recreation

Disliked sports activities?	
Sport:	
Sport:	
Sport:	
Sport:	
Sport:	

Disliked hobbies?	
Hobby:	
Hobby:	
Hobby:	
Hobby:	
Hobby:	

When is/has this person been the happiest?

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

Dislikes: Fears and Phobias

Which of the following is this person afraid of? (Indicate all that are applicable)	
□ Strangers	□ Insects
□ Animals	□ Clowns/masked people
□ Loud Noises	□ Sudden movements
□ The Dark	□ Being alone
□ Enclosed Spaces	□ Social Situations
□ Enclosed Spaces	□ Crowds
□ Open Spaces	□ Other _____
□ Height	□ Other _____
□ Water (Pools, lakes, etc)	□ Other _____
□ Cars	□ Other _____
□ Buses	□ Other _____

Notes & Comments:

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Section 4: Life & Learning

Think of Section 4 as providing the landscape of the picture you are creating of your family member.

As an individual goes through life, he/she learns and grows. Your family member's life and learning experiences may include schooling, vocational training, and employment. They may include hopes and plans that you and your family member have for the future.

This information will allow other caregivers to know hyour family member more fully. By being aware of your family member's life and learning experiences, caregivers can ensure that your family member continues to reach his/her goals.

In order to get started, you may need to draw upon information from the following documents relating to your family member:

- Family member's Individual Program Plan (if available)
- Family member's school reports, records and diplomas
- Family member's work information

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

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Life & Learning: Education Information

Is a current copy of this person's Individual Education Plan (IEP) included with this Future Planning Guide?	□ Yes □ No

If not, which family member has this person's Person Centered Plan?	
Name:	
Phone:	

Early Intervention (Ages 0-3)	
Did this person attend any early intervention programs?	□ Yes □ No
Name of Program #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of Program #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor
Notes & Comments:	
_____	
_____	
_____	

ACHIEVA FAMILY TRUST

Life & Learning: Education Information

Preschool (Ages 3-5)	
Did this person attend preschool?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor
Notes & Comments:	
_____	
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ACHIEVA FAMILY TRUST

Life & Learning: Education Information

Elementary School (Ages 5-11)	
Did this person attend Elementary School?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor
Notes & Comments:	
_____	
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ACHIEVA FAMILY TRUST

Life & Learning: Education Information

Middle School (Ages 11-14)	
Did this person attend Middle School?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor

Notes & Comments:

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ACHIEVA FAMILY TRUST

Life & Learning: Education Information

High School (Ages 14-18+)	
Did this person attend High School?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Diploma or G.E.D. received?	□ Yes □ No
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor

Notes & Comments:

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ACHIEVA FAMILY TRUST

Life & Learning: Education Information

College (Ages 18+)	
Did this person attend college?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
College diploma received?	□ Yes □ No
Major area of study:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor

Notes & Comments:

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Life & Learning: Education Information

Trade/Technical School (Ages 18+)	
Did this person attend trade/technical school?	□ Yes □ No
Name of School #1:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Name of School #2:	
Address:	
From Date (mm/yy) to Date (mm/yy)	_____/_____ to _____/_____
Was person included in regular classes?	□ Yes □ No
Did person receive special services?	□ Yes □ No
Special Services:	
Diploma/Certificate received?	□ Yes □ No
Field or Certification:	
Person's relationship with peers?	□ Excellent □ Good □ Fair □ Poor

Notes & Comments:

_____

_____

_____

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_____

Life & Learning: Education Information

Academic Skills	
Reading Skills:	Reads? □ Yes □ No Grade Level? _____ Reads/Recognizes safety words (such as "STOP") □ Yes □ No Notes: _____ _____ _____
Writing Skills:	□ Prints □ Writes in cursive □ Prints/Writes own name □ Makes mark for signature Specify Mark _____
Math Skills:	Recognizes numbers? □ Yes □ With Assistance □ No Knows/can call emergency numbers? □ Yes □ With Assistance □ No Knows and can call other numbers? □ Yes □ With Assistance □ No Can use a pay phone? □ Yes □ With Assistance □ No Tells time with analog watch/clock? □ Yes □ With Assistance □ No Tells time with digital watch/clock? □ Yes □ With Assistance □ No Knows value of coins? □ Yes □ With Assistance □ No Knows value of paper money? □ Yes □ With Assistance □ No Carries spending money/allowance? □ Yes □ With Assistance □ No Amount per week? $_____ Can make change? □ Yes □ With Assistance □ No Can make bank deposits? □ Yes □ With Assistance □ No Uses MAC card? □ Yes □ With Assistance □ No Writes checks? □ Yes □ With Assistance □ No Balances checkbook? □ Yes □ With Assistance □ No Budgets own funds? □ Yes □ With Assistance □ No

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Life & Learning: Education Information

Learning/Social Skills	
What motivates this person to learn?	□ Praise □ Rewards □ Practice/Repetition □ Examples from other people □ Other_____
Does person adapt to new situations easily?	□ Yes □ No
Does person become upset/agitated in new situations?	□ Yes □ No
Does person engage in destructive or self-abusive behaviors when agitated? Specify behaviors:	□ Yes □ No _____ _____ _____ _____
What calms this person when agitated?	□ Praise □ Rewards □ Affection □ Other_____ □ Other_____ □ Other_____
Is this person overly friendly / affectionate to strangers?	□ Yes □ No
Does person respect his/her own property?	□ Yes □ No
Does person respect the property of others?	□ Yes □ No
Does person have age-appropriate manners?	□ Yes □ No
Does person take medication to enhance focus and/or learning? If yes, list names of medication(s):	□ Yes □ No _____ _____ _____

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Life & Learning: Job/Vocational Information

Is a current copy of this person's Individual Program Plan (IPP) included with this Future Planning Guide?	□ Yes □ No

If not, which family member has this person's Individual Program Plan (IPP)?	
Name:	
Phone:	

Job/Vocational Information	
Does this person have a job?	□ Yes □ No
If yes, what type of job does person work in?	□ Day Program □ Regular Job □ Full-Time □ Part-Time □ Other_____
Person's Job Title:	
Salary:	$_____ Health Benefits? □ Yes □ No
Name of Employer/Program:	
Street Address:	
City/State/Zip Code:	
Work Phone Number:	_____-_____-_____
Supervisor Name/ Phone:	_____-_____-_____
How does person dress for work?	□ Uniform □ Casual Clothes □ Dress Clothes □ Other_____
Does this person have a special advocate at work? If yes, name/phone:	□ Yes □ No _____ / _____-_____-_____
Does this person have a job coach at work? If yes, name/phone:	□ Yes □ No _____ / _____-_____-_____
Does this person have an Office of Vocational Rehabilitation (OVR) Contact? If yes, name/phone:	□ Yes □ No _____ / _____-_____-_____

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Life & Learning: Daily Routines

Morning Routines

What times does this person usually wake up?	
How does this person usually wake up?	□ Alarm Clock □ Called/awakened □ Wakes self

For the following activities, please check whether the person needs assistance or adaptations and what special assistance or adaptations are necessary.

Activity	Needs Assistance/ Adaptations	Does Independently	Not Applicable	Type of Assistance/ Adaptation
Getting out of bed	□	□	□	
Going to toilet	□	□	□	
Taking a shower	□	□	□	
Taking a bath	□	□	□	
Washing hair	□	□	□	
Brushing teeth	□	□	□	
Flossing teeth	□	□	□	
Shaving (blade)	□	□	□	
Shaving (razor)	□	□	□	
Cleaning nails	□	□	□	
Removing ear wax	□	□	□	
Menstrual needs	□	□	□	
Washing hands	□	□	□	
Combing/Styling hair	□	□	□	
Dressing	□	□	□	
Choosing appropriate clothes for school/work	□	□	□	
Choosing appropriate clothes for weather	□	□	□	
Preparing breakfast	□	□	□	
Eating breakfast	□	□	□	
Preparing lunch	□	□	□	
Taking medications in morning	□	□	□	

If person takes medications in the morning, list medications:

_____ _____ _____

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Life & Learning: Daily Routines

Eating Habits	
Does person pray before meals?	□ Yes □ No
Can person distinguish between food and inedible objects	□ Yes □ No
Does person eat moderate portions without supervision?	□ Yes □ No
Does person eat all of one type of food before starting another?	□ Yes □ No
Does person have any unique morning routines/rituals?	□ Yes □ No If yes, please specify: _____ _____

Daytime Routine	
Where does person spend weekdays?	□ School □ Work □ Day Program □Home □ Other _____

For the following activities, please check whether the person needs assistance or adaptations and what special assistance or adaptations are necessary.

Activity	**Needs Assistance/ Adaptations**	**Does Independently**	**Not Applicable**	**Type of Assistance/ Adaptation**
Walks to/from activities	□	□	□	
Takes public transportation to/from activities	□	□	□	
Takes private transportation to/from activities	□	□	□	
Drives to/from activities	□	□	□	
Takes Access/Paratransit to/from activities	□	□	□	
Rides bicycle to/from activities	□	□	□	
Takes medication during the day	□	□	□	

If person takes medications during the day, list medications:

_____ _____ _____

Life & Learning: Daily Routines

Evening Routine

For the following activities, please check whether the person needs assistance or adaptations and what special assistance or adaptations are necessary.

Activity	Needs Assistance/ Adaptations	Does Independently	Not Applicable	Type of Assistance/ Adaptation
Clothes Shopping	☐	☐	☐	
Grocery Shopping	☐	☐	☐	
Cooking Meals	☐	☐	☐	
Doing laundry	☐	☐	☐	
House cleaning	☐	☐	☐	
Eating	☐	☐	☐	
Attending leisure activities	☐	☐	☐	
Attending volunteer activities	☐	☐	☐	
Laying out clothes for next day	☐	☐	☐	
Taking medications at night	☐	☐	☐	

If person takes medications in the morning, list medications:

_____ _____ _____

What time does the person usually go to bed?	
How many hours does the person usually sleep?	
Does the person usually sleep through the night?	☐ Yes ☐ No
Does the person say prayers before bed?	☐ Yes ☐ No
Does the person take medications before bed?	☐ Yes ☐ No

If person takes medications in the morning, list medications:

_____ _____ _____

Does person prefer to be tucked in?	☐ Yes ☐ No
Does this person have a light on during the night?	☐ Yes ☐ No
Does person have other unique nighttime routines?	☐ Yes ☐ No

If yes, specify routines/rituals:

_____ _____ _____

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Life & Learning: Daily Routines, Safety Skills

Weekend Routine	
Does this person regularly attend church, temple, or any other religious/spiritual service?	□ Yes □ No
Name of Church/Temple:	
Church/Temple Address:	
If Yes, does this person participate as a volunteer?	□ Yes □ No
If Yes, please specify volunteer activities: _____ _____ _____	
Does person require assistance/adaptations to perform these activities?	□ Yes □ No
If Yes, please specify assistance/adaptations: _____ _____ _____	

Safety Skills	
Can person be left unsupervised?	□ Yes □ No
If yes, for how long?	
Which of the following does the person recognize the danger of:	□ Heat Sources □ Sharp Objects □ Poisonous Materials □ Traffic □ Hot water □ Open windows
Can person evacuate building on hearing alarm?	□ Yes □ No
Does person need physical/verbal prompt to evacuate building?	□ Yes □ No
Safety Notes:	_____ _____ _____ _____

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Life & Learning: Future Plans

Housing	
In the future, I (we) hope this person will live in the following residence:	□ Relative's Home □ Group Home □ Supported Living □ Own Home □ Family-owned Home □ Other _____
Optimal # of house mates:	
Optimal # of staff (if any):	
Optimal level of supervision:	□ Low □ Medium □High □ Other _____
I (we) have made plans to give property to a residential provider for person to live in:	□ Yes □ No
If yes, is there a copy of this plan included with this planning guide?	□ Yes □ No
If not, who has a copy of the plan?	Name: _____ Phone: _____
Housing Notes:	_____ _____ _____

Education	
In the future, I (we) hope this person will achieve the following level of education:	□ High School □ College □ Vocational/Technical School □ Adult Enrichment □ Other _____

Job/Vocation	
In the future, I (we) hope this person will achieve the following job/vocation:	□ Day Program □ Regular Job □ Other _____ □ Other _____

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Life & Learning: Notes

Notes & Comments:

Section 5: Health

Think of Section 5 as providing important details of the picture you are creating of your family member.

Proper health care is crucial to an individual's well being, both day to day and long term. Frequently updated information about your family member's health history must be readily available to caregivers, especially when family members are not there to provide it.

This information will allow other caregivers to know your family member more fully. By being knowledgeable about your family member's health history, these caregivers can ensure the best decisions are made concerning your family member's medical treatment.

In order to get started, you may need to draw on information from the following documents related to your family member:

- Family health history
- Family member's health records
- Names/addresses/phone numbers of family member's doctors and other health care professionals
- List of family member's medications and dosages
- List of family member's adaptive aids

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

Health: General Health Information

Is a current copy of this person's Medical Record included with this Future Planning Guide?	□ Yes □ No

If not, who has this person's Medical Records?	
Name:	
Phone:	

General Health Information			
Date of Birth:	___/___/_____	Place of Birth:	Hospital:_____
Height:	_____ _____ (feet) (inches)	Weight:	_____ _ (pounds) □ Underweight □ Average Weight □ Overweight
Special Diet Notes:	_____ _____ _____		
Blood Type:	□ O+ □ O- □ A+ □A- □B+ □B- □AB+ □AB-		
Blood Disorder?	□ Yes □ No Specify Blood Disorder: _____		
Date of last physical exam:	___/___/_____ Physician performing exam:_____		

Disability Information			
Primary Diagnosis:			
Date Diagnosed:	___/___/_____	Cause: (if known)	
Secondary Diagnosis #1:			
Date Diagnosed:	___/___/_____	Cause: (if known)	
Secondary Diagnosis #2:			
Date Diagnosed:	___/___/_____	Cause: (if known)	

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Health: General Health Information

Genetic Testing	
Has this person undergone genetic testing?	□ Yes □ No
Name of Test:	
Diagnosis:	
Date: (MM/DD/YYYY)	___/___/_____
Name of Test:	
Diagnosis:	
Date: (MM/DD/YYYY)	___/___/_____

Family Members (Genetic Testing Information)			
Have family undergone genetic testing?		□ Yes □ No If yes, please list below.	
Name:		Relationship:	
Name of Test:		Date:	___/___/_____
Diagnosis:			
Name:		Relationship:	
Name of Test:		Date:	___/___/_____
Diagnosis:			
Name:		Relationship:	
Name of Test:		Date:	___/___/_____
Diagnosis:			

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Health: General Health Information

Other Chronic Health Information			
Does person have other chronic health conditions?			□ Yes □ No
Condition #1:		Treatment/ Medication:	
Condition #2:		Treatment/ Medication:	
Condition #3:		Treatment/ Medication:	

Does person suffer from seizures?	□ Yes □ No
Seizure frequency?	
Seizure type?	
Accompanied by Aura?	□ Yes □ No
Seizure Triggers:	_____ _____
Seizure Treatments/Medications:	_____ _____
Side Effects:	_____ _____

Does person have allergies?	□ Yes □ No □ Medication(s) □ Pollen/Ragweed □Sun Exposure □Foods □ Insects □Pollution □ Other _____ □ Other _____		
Allergy #1:		Treatment/ Medication:	
Allergy #2:		Treatment/ Medication:	
Allergy #3:		Treatment/ Medication:	

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Health: General Health Information

Sexuality & Birth Control	
If female, is person:	□ Not Yet Menstruating □ Menstruating □ In Menopause
Length of menstrual cycle (in days):	_____ days Menstrual difficulties? □ Yes □ No
Is person sexually active?	□ Yes □ No
If yes, does person use birth control?	□ Yes □ No
What form of birth control does person use?	□ Condoms □Birth Control pills □ Diaphragm □Depo-provera □ IUD □ Other _____
Does person need assistance in the proper use of birth control?	□ Yes □ No If yes, specify type of assistance: _____ _____
Describe person's sexual habits?	_____ _____ _____

Smoking, Drugs and Alcohol	
Does person smoke cigarettes?	□ Yes □ No # of packs per week _____
Does person drink alcohol?	□ Yes □ No # of drinks per week _____
Does person use recreational drugs?	□ Yes □ No Drug Name: _____ Drug Name: _____
Is the person aware of the dangers of smoking, drugs and alcohol?	□ Yes □ No

ACHIEVA FAMILY TRUST

Health: General Health Information

Awareness of Death	
Is person aware of death/dying?	□ Yes □ No
Has person experienced the death of a family member or loved one?	□ Yes □ No
Has person experienced the death of a pet?	□ Yes □ No
Has person ever undergone grief counseling?	□ Yes □ No

Sensory Statuses	
Hearing:	□ Normal □ Normal with hearing aid(s) □ Impaired □ Deaf □ Hypersensitive If hypersensitive, how does person block out sounds? _____ _____ Notes:_____
Vision:	□ Normal □ Normal with glasses □ Impaired □ Normal w/contacts □ Legally Blind □ Color Blind Notes:_____
Speech:	□ Normal □ Uses Sign Language □ Impaired □ Uses Communication Device, specify device _____ □ Uses other method of communication, specify method _____ Notes:_____
Mobility:	□ Normal □ Impaired □ Uses Wheelchair □Uses special shoes □ Uses Walker □ Uses artificial limb □ Uses other orthopedic device(s) _____ _____ Notes:_____

ACHIEVA FAMILY TRUST

Health: Adaptive Devices

Adaptive Devices

Fill out information on every adaptive device this person uses. For the heading "How Paid For", write in one of the following choices: Health Insurance, Medicare, Medicaid, or Other. If you select "Other", specify the other method of payment.

A blank line has been provided beneath certain items so you can write in specific device information.

Adaptive Device	**Needs Assistance Using/ Maintaining**	**Where purchased**	**Where repaired**	**How Paid For** (Health Insurance, Medicare, Medicaid, or Other)
Hearing Aid(s)	Yes / No			
Eye Glasses	Yes / No			
Contact Lenses	Yes / No			
Sunglasses	Yes / No			
Dentures	Yes / No			
Communication Device	Yes / No			
Wheelchair	Yes / No			
Walker	Yes / No			
Special Shoes	Yes / No			
Artificial Limb(s)	Yes / No			
Orthopedic Device	Yes / No			
Other _____	Yes / No			
Other _____	Yes / No			
Other _____	Yes / No			
Other _____	Yes / No			

ACHIEVA FAMILY TRUST

Health: Prescriptions & Medication Skills

Medication Skills	
Can person do the following (check all that apply):	
Take medication without assistance?	Yes / No
Needs medication mixed with food/juice?	Yes / No
Knows names of own medication(s)?	Yes / No
Can recognize own medication(s)?	Yes / No
Knows purposes of own medication(s)?	Yes / No
Can remember proper doses and times without supervision?	Yes / No
Can pick up medication refills?	Yes / No
Can take over the counter medication without supervision?	Yes / No

Current Prescription Medication			
Medication Name:			
Purpose:		Dose:	
When Taken:	□ Once Daily □ Twice Daily □ Three Time Daily □ Other _____		
How Taken:	□ With Meals □ Before Meals □ Other _____		
Requires Blood Levels?	□ Yes □ No Frequency _____		
Prescribing Doctor:	_____ Phone: _____		
Medication Name:			
Purpose:		Dose:	
When Taken:	□ Once Daily □ Twice Daily □ Three Time Daily □ Other _____		
How Taken:	□ With Meals □ Before Meals □ Other _____		
Requires Blood Levels?	□ Yes □ No Frequency _____		
Prescribing Doctor:	_____ Phone: _____		

ACHIEVA FAMILY TRUST

Health: Prescriptions & Medication Skills

Current Prescription Medication (continued)			
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ Other ______________		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______________________________		
Requires Blood Levels?	☐ Yes ☐ No Frequency ____		
Prescribing Doctor:	____ Phone: __________________		
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ Other ______________		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______________________________		
Requires Blood Levels?	☐ Yes ☐ No Frequency ____		
Prescribing Doctor:	____ Phone: __________________		
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ Other ______________		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______________________________		
Requires Blood Levels?	☐ Yes ☐ No Frequency ____		
Prescribing Doctor:	____ Phone: __________________		

Health: Non-Prescription Medications

Current Over-the-Counter Medications			
Note: Include vitamins, shampoos, ointments, etc.			
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ As Needed ☐ Other ______		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______		
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ As Needed ☐ Other ______		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______		
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ As Needed ☐ Other ______		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______		
Medication Name:			
Purpose:		Dose:	
When Taken:	☐ Once Daily ☐ Twice Daily ☐ Three Time Daily ☐ As Needed ☐ Other ______		
How Taken:	☐ With Meals ☐ Before Meals ☐ Other ______		

Health: Health Care Professionals

Primary Care Physician	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Dentist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Health: Health Care Professionals

Ophthalmologist/Optometrist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

LPN/RN	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Health: Health Care Professionals

Psychiatrist/Psychologist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Physical Therapist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Occupational Therapist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Speech Therapist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Health: Health Care Professionals

Behavioral Therapist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Recreational Therapist	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Specialist #1	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Specialist #2	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Specialist #3	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Specialist #4	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Specialist #5	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Specialist #6	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Specialist #5	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

Specialist #6	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Location of Treatment:	□ Home □ Office □ Other _____
Frequency of Treatment:	□ Weekly □ Monthly □ Annually □ Other _____
Notes:	_____ _____

ACHIEVA FAMILY TRUST

Health: Health Care Professionals

Previous Physician #1	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Treated from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Reason Treatment Ended:	_____ _____

Previous Physician #2	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Treated from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Reason Treatment Ended:	_____ _____

Health: Health Care Professionals

Previous Physician #3	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Treated from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Reason Treatment Ended:	_____ _____

Previous Physician #4	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Purpose of Treatment:	
Treated from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Reason Treatment Ended:	_____ _____

ACHIEVA FAMILY TRUST

Health: Person's Health History

Prenatal History	
Did person have prenatal health problems?	□ Yes □ No
If yes, specify problems:	

Birth	
Did person have problems in delivery?	□ Yes □ No
If yes, specify problems:	
Was birth full term?	□ Yes □ No
Birth Weight:	_____ lbs _____ounces
Was birth full term?	□ Yes □ No
Did person have congenital illnesses/disabilities?	□ Yes □ No
Illness/Disability #1	
Illness/Disability #2	
Illness/Disability #3	

Infancy	
Did person experience failure to thrive?	□ Yes □ No
If yes, specify problems:	
Did person have feeding problems?	□ Yes □ No
If yes, specify problems:	

Early Childhood			
Age at which person crawled:	_____ Years	_____ Months	□ Not Applicable
Age at which person walked:	_____ Years	_____ Months	□ Not Applicable
Age at which person first began talking:	_____ Years	_____ Months	□ Not Applicable

ACHIEVA FAMILY TRUST

Health: Childhood Immunization History

Childhood Immunizations/Tests	Date(s) or Age(s) Given	Date Person Had Disease (if applicable) mm/dd/yy
Hepatitis B1 (HepB)		
Rotavirus2 (RV) RV1 (2-dose series) RV5 (3-dose series)		
Diphtheria, tetanus, & acellular pertussis3 (DTaP: 7 yrs)		
Haemophilus influenzae type b5 (Hib)		
Pneumococcal conjugate6 (PCV13)		
Pneumococcal polysaccharide6 (PPSV23)		
Influenza8 (IIV; LAIV) 2 doses for some		
Measles, mumps, rubella9 (MMR)		
Varicella10 (VAR)		
Hepatitis A1 1 (HepA)		
Human papillomavirus1 2 (HPV2: females only; HPV4: males and females)		
Meningococcal1 3 (Hib-MenCY > 6 weeks; MenACWY-D >9 mos; MenACWY-CRM ≥ 2 mos)		
Other _____		
Other _____		
Other _____		
Other _____		
Other _____		
Other _____		

ACHIEVA FAMILY TRUST

Health: Family History

Family History of Illness
Has this person or any other family member ever had any of the following conditions (check all that apply)

	Person	Mother	Father	Sister	Brother	Grandmother	Grandfather	Aunts/ Uncles
Mental Retardation								
Mental Illness								
Hypertension								
Stroke								
Heart Disease								
Diabetes Mellitus/Sugar								
Cancer								
Multiple Sclerosis								
Epilepsy								
Asthma/Breathing Issues								
Heart Murmur								
Anemia								
Blood Clot/ Legs or Lungs								
Bleeding Problems								
Kidney Disease								
Thyroid								
Liver/Gall Stones								
Seizures								
Migraines								
Hemophilia								
Sickle Cell Anemia								
Bone/Joint Disorders								
Tuberculosis								
Other _____								
Other _____								
Other _____								
Other _____								
Other _____								

Health: Hospitalization History

Has person been hospitalized? □ Yes □ No

Hospitalization #1	
Purpose of Treatment:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

Hospitalization #2	
Purpose of Treatment:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

ACHIEVA FAMILY TRUST

Health: Hospitalization History

Hospitalization #3	
Purpose of Treatment:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

Hospitalization #4	
Purpose of Treatment:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

ACHIEVA FAMILY TRUST

Health: Surgery History

Surgery #1	
Purpose of Surgery:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

Surgery #2	
Purpose of Surgery:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

Health: Surgery History

Surgery #3	
Purpose of Surgery:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

Surgery #4	
Purpose of Surgery:	
Hospitalized from/to:	_____/_____/_____ to _____/_____/_____ (mm/dd/yy)
Hospital Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Emergency _____-_____-_____
Attending Physician:	

ACHIEVA FAMILY TRUST

Health: Notes & Comments

Notes & Comments

Section 6: Finances

Think of Section 6 as providing more important details of the picture you are creating of your family member.

Careful handling of finances is important to maintaining an individual's well-being and happiness in the future.

This information will allow other caregivers to know your family member more fully. By being informed about your family member's finances, these caregivers can safeguard your family member's eligibility for government assistance. They can also use your family member's resources wisely to enhance his or her quality of life.

In order to get started, you may need to draw on information from the following documents related to your family member:

- Name/address/phone number of family member's attorney
- Name/address/phone number of guardian and guardianship document (if applicable)
- Name/address/phone number of future guardian (if applicable)
- Name/address/phone number of power of attorney and relevant documentation
- Name/address/phone number of family members bank
- Records of family member's bank accounts
- Family member's insurance policies
- Records and receipts for all family member's current benefits and sources of income, including social security, SSI, SSDI, pension(s), trust(s), and veteran's benefits.
- All documents in which family member is naed as a future beneficiary, indlucing wills, insurance policies, trusts, annuities, 401-K, IRA and retirement accounts.

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

Finances: Attorney Information/ Capacity Status

Attorney for Person & Family	
Name of Attorney:	
Name of Firm:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Office _____-_____-_____ Other _____-_____-_____
Notes:	_____ _____

Capacity Status	
Has this person been deemed incapacitated?	□ Yes □ No
Does person have a guardian?	□ Yes □ No
Type of guardianship:	□ Plenary (Person & Estate) □ Guardianship of Person □ Guardianship of Estate
Is guardianship:	□ Full □ Limited
Is copy of guardianship court order or case number included with this guide?	□ Yes □ No
If not, who has a copy of guardianship court order or case number?	

Finances: Guardianship

Current Guardian	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____

Preferred Successor Guardian	
Has a preferred successor guardian been named? □ Yes □ No	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____

Notes & Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ACHIEVA FAMILY TRUST

Finances: Power of Attorney & Rep Payee

Power of Attorney	
Does person have Power of Attorney? □ Yes □ No Is Power of Attorney: □ Limited □ Durable	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____

Representative Payee	
Does person have a Representative Payee? □ Yes □ No	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____

Notes & Comments
_____
_____
_____
_____
_____
_____
_____

Finances: Benefits & Income

Current Benefits/Income		Amount per Month
Does person receive Social Security?	□ Yes □ No	$
Does person receive Supplemental Security Income (SSI)?	□ Yes □ No	$
Does person receive Social Security Disability Income (SSDI)?	□ Yes □ No	$
Does person receive his/her own pension?	□ Yes □ No	$
Does person receive his/her own retirement?	□ Yes □ No	$
Does person receive his/her own income?	□ Yes □ No	$
Does person receive veteran's benefits?	□ Yes □ No	$
Does person receive father's pension/retirement/income?	□ Yes □ No	$
Does person receive mother's pension/ retirement/ income?	□ Yes □ No	$
Does person receive trust income?	□ Yes □ No	$
Other Benefit/Income _____		$
Other Benefit/Income _____		$
Other Benefit/Income _____		$
Other Benefit/Income _____		$
Other Benefit/Income _____		$
Other Benefit/Income _____		$

Finances: Banking Information

Account #1	
Name of Bank:	
Branch Office:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____
Account Number:	
Account Type:	□ Checking □ Savings □ Jointly Held □ Bank/Debit Card □ CD
If jointly held, list names & phone number:	

Account #2	
Name of Bank:	
Branch Office:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____
Account Number:	
Account Type:	□ Checking □ Savings □ Jointly Held □ Bank/Debit Card □ CD
If jointly held, list names & phone number:	

ACHIEVA FAMILY TRUST

Finances: Banking Information

Account #3	
Name of Bank:	
Branch Office:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____
Account Number:	
Account Type:	□ Checking □ Savings □ Jointly Held □ Bank/Debit Card □ CD
If jointly held, list names & phone number:	

Account #4	
Name of Bank:	
Branch Office:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____ Other _____-_____-_____
Account Number:	
Account Type:	□ Checking □ Savings □ Jointly Held □ Bank/Debit Card □ CD
If jointly held, list names & phone number:	

Finances: Insurance Coverage

Medical Insurance	
Does person receive Medical Assistance?	□ Yes □ No
Is copy of Medical Card included with this Personal Planning Guide?	□ Yes □ No
Does person have other medical insurance?	□ Yes □ No
Name of Insurance Company:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone: _____

Finances: Insurance Coverage

Supplemental Medical Insurance	
Does person have Supplemental Medical Insurance?	□ Yes □ No
Name of Insurance Company:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____

Finances: Insurance Coverage

Supplemental Dental Insurance	
Does person have Supplemental Dental Insurance?	□ Yes □ No
Name of Insurance Company:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____

Finances: Insurance Coverage

Life Insurance	
Does person have a Life Insurance Policy?	□ Yes □ No
Name of Insurance Company:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____
Life Insurance policy beneficiaries:	Name: _____ Phone _____-_____-_____ Name: _____ Phone _____-_____-_____ Name: _____ Phone _____-_____-_____
Will benefits be used to cover funeral expenses? See section 7: Final Arrangements	□ Yes □ No

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Future Benefits: Life Insurance **Where person is named as beneficiary of another person's policies and/or accounts**	
Is person named as beneficiary of life insurance polic(ies)?	□ Yes □ No _____ # of policies

Policy #1 Inheritance	
Policy #1 Account Number:	
Policy Holder's Name:	
Policy Holder's Phone Number:	
Current Policy Value/Percentage of Benefit to Person:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____

Finances: Future Benefits

Policy #2 Inheritance	
Policy #1 Account Number:	
Policy Holder's Name:	
Policy Holder's Phone Number:	
Current Policy Value/Percentage of Benefit to Person:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____

Finances: Future Benefits

Policy #3 Inheritance	
Policy #1 Account Number:	
Policy Holder's Name:	
Policy Holder's Phone Number:	
Current Policy Value/Percentage of Benefit to Person:	
Insurance Company Contact Person:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Who is responsible for paying premiums?	
Is a copy of the policy included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of policy?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Future Benefits: Wills **Where person is named as beneficiary of another person's will**	
Is person named as beneficiary of will(s)?	□ Yes □ No _____ # of wills

Will #1 Inheritance	
Testator's Name:	
Testator's Phone Number:	Phone _____-_____-_____
Percentage of Benefit to Person:	
Attorney's Name:	
Attorney's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

Will #2 Inheritance	
Testator's Name:	
Testator's Phone Number:	Phone _____-_____-_____
Percentage of Benefit to Person:	
Attorney's Name:	
Attorney's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Will #3 Inheritance	
Testator's Name:	
Testator's Phone Number:	Phone _____-_____-_____
Percentage of Benefit to Person:	
Attorney's Name:	
Attorney's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

Will #4 Inheritance	
Testator's Name:	
Testator's Phone Number:	Phone _____-_____-_____
Percentage of Benefit to Person:	
Attorney's Name:	
Attorney's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Future Benefits: Trusts Where person is named as beneficiary of another person's trust or a trust funded for the person	
Is person named as beneficiary of trust(s)?	□ Yes □ No _____ # of trusts

Trust #1 Inheritance	
Name or Type of Trust:	
Source of Trust Funds:	
Trust Administrator's Name:	
Trust Administrator's Phone Number:	Phone _____-_____-_____
Value of trust:	**$**
Percentage of Benefit to Person:	
Trustee's Name (#1):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#2):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#3):	
Trustee's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Trust #2 Inheritance	
Name or Type of Trust:	
Source of Trust Funds:	
Trust Administrator's Name:	
Trust Administrator's Phone Number:	Phone _____-_____-_____
Value of trust:	**$**
Percentage of Benefit to Person:	
Trustee's Name (#1):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#2):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#3):	
Trustee's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Trust #3 Inheritance	
Name or Type of Trust:	
Source of Trust Funds:	
Trust Administrator's Name:	
Trust Administrator's Phone Number:	Phone _____-_____-_____
Value of trust:	**$**
Percentage of Benefit to Person:	
Trustee's Name (#1):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#2):	
Trustee's Phone Number:	Phone _____-_____-_____
Trustee's Name (#3):	
Trustee's Phone Number:	Phone _____-_____-_____
Is a copy of the will included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of will?	Name: _____ Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Finances: Future Benefits

Future Benefits: Annuity(ies) **Where person is named as beneficiary of another person's trust**	
Is person named as beneficiary of annuity(ies)?	□ Yes □ No _____ # of annuities

Annuity #1	
Owner of Annuity Name:	
Owner of Annuity Phone Number:	Phone _____-_____-_____
Account Number:	
Approximate Value:	**$**
Percentage of Benefit to Person:	
Carrier's Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of annuity information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of annuity information?	Name: _____ Phone _____-_____-_____

Finances: Future Benefits

Annuity #2	
Owner of Annuity Name:	
Owner of Annuity Phone Number:	Phone _____-_____-_____
Account Number:	
Approximate Value:	**$**
Percentage of Benefit to Person:	
Carrier's Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of annuity information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of annuity information?	Name: _____ Phone _____-_____-_____

Finances: Future Benefits

Annuity #3	
Owner of Annuity Name:	
Owner of Annuity Phone Number:	Phone _____-_____-_____
Account Number:	
Approximate Value:	**$**
Percentage of Benefit to Person:	
Carrier's Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of annuity information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of annuity information?	Name: _____ Phone _____-_____-_____

Finances: Future Benefits

Future Benefits: Retirement Account(s) **Where person is named as beneficiary of a retirement account**	
Is person named as beneficiary of retirement account(s)?	□ Yes □ No _____ # of accounts

Retirement Account #1	
Owner of Account Name:	
Owner of Account Phone Number:	Phone _____-_____-_____
Account Number:	
Type of Account:	□ IRA Account □ 401K Account □ Other _____
Approximate Value:	**$**
Percentage of Benefit to Person:	
Administrator's Name:	
Administrator's Phone Number:	Phone _____-_____-_____
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of account information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of account information?	Name: _____ Phone _____-_____-_____

Finances: Notes & Comments

Notes & Comments:

Section 7: Final Arrangements

Think of the 7th and final section of this guide as putting the finishing touches on the picture you have created of your family member.

Final arrangements allow an individual to leave life with dignity and in a manner consistent with the customs and wishes of his or her family.

This information will allow other caregivers to know your family member more fully. By being informed about your family member's final arrangements, these caregivers can ensure that the proper decisions are made in the event of your family member's death.

In order to get started, you may need to draw on information from the following documents related to your family member:

- Name/address/phone number of person to be contacted in event of family member's death
- Name/address/phone number of priest, minister, rabbi, or other religious figure (if applicable)
- Name/address/phone number of designated funeral director
- Special arrangements for family member's funeral
- Family member's reserve burial account, irrevocable burial fund, life insurance policy, or funeral insurance policy.

If you have any questions or concerns about completing this section, please contact ACHIEVA Family Trust at (412)995-5000 x565 or email futureplanning@achieva.info.

Final Arrangements: Contacts

Person(s) to Contact in Case of Death	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Relationship to Person:	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Relationship to Person:	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Relationship to Person:	

ACHIEVA FAMILY TRUST

Final Arrangements: Contacts

Designated Funeral Director	
Is there a designated Funeral Director?	□ Yes □ No
Business Name:	
Contact Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____

Preferred Rabbi/Minister/Priest/Religious Figure	
Is there a preferred religious figure?	□ Yes □ No
Temple/Church Name:	
Contact Name:	
Title:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Final Arrangements: Service Arrangements

Viewing	
Will there be a viewing?	□ Yes □ No
Location of viewing:	□ Church/Temple □ Funeral Home □ Cemetery □ Other _____

Service	
Will there be a service?	□ Yes □ No
Location of service:	□ Church/Temple □ Funeral Home □ Cemetery □ Other _____
Location Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____

ACHIEVA FAMILY TRUST

Final Arrangements: Service Arrangements

Burial	
Is there a burial choice?	□ Yes □ No
Type of burial:	□ Burial □ Internment in Mausoleum □ Cremation/Burial of Ashes □ Cremation/Internment of Ashes □ Cremation/ Ashes given to specific person □ Other _____
Burial Plot purchased?	□ Yes □ No
Burial Marker Purchased?	□ Yes □ No
Cemetery Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____

Person(s) to Receive Ashes	
Name:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Relationship to Person:	

ACHIEVA FAMILY TRUST

Final Arrangements: Prepaid Burial Accounts

Prepaid Burial Account(s)	
Does person have prepaid burial account(s)?	□ Yes □ No _____ # of accounts

Prepaid Burial Account #1	
Policy Holder Name:	
Beneficiary:	
Account/Policy Number:	
Type of Account:	□ Reserve Burial Account □ Life Insurance Policy □ Irrevocable Burial Fund □ Funeral Insurance Policy □ Other _____
Policy Value:	**$**
Percentage of Benefit to Person:	
Name of Bank/Insurance Company:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of account information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of account information?	Name: _____ Phone _____-_____-_____

Final Arrangements: Prepaid Burial Accounts

Prepaid Burial Account #2	
Policy Holder Name:	
Beneficiary:	
Account/Policy Number:	
Type of Account:	□ Reserve Burial Account □ Life Insurance Policy □ Irrevocable Burial Fund □ Funeral Insurance Policy □ Other _____
Policy Value:	**$**
Percentage of Benefit to Person:	
Name of Bank/Insurance Company:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of account information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of account information?	Name: _____ Phone _____-_____-_____

Final Arrangements: Prepaid Burial Accounts

Prepaid Burial Account #3	
Policy Holder Name:	
Beneficiary:	
Account/Policy Number:	
Type of Account:	□ Reserve Burial Account □ Life Insurance Policy □ Irrevocable Burial Fund □ Funeral Insurance Policy □ Other _____
Policy Value:	**$**
Percentage of Benefit to Person:	
Name of Bank/Insurance Company:	
Street Address:	
City:	
State/Zip Code:	
Phone Number:	Phone _____-_____-_____
Is a copy of account information included with this Personal Planning Guide?	□ Yes □ No
If not, who has a copy of account information?	Name: _____ Phone _____-_____-_____

Final Arrangements: Notes & Comments

Notes & Comments: