The Arc
King County

Family Centered

Future Planning Organizer

Provided by The Arc of King County

Updated: March, 2013

For people with intellectual and developmental disabilities

The Arc of King County
233 Sixth Ave. N.
Seattle, WA 98109

PHONE 206-364-6337
TOLL-FREE 1-877-964-0600
TTY 1-877-666-2348

FAX 206-364-8140
www.arcofkingcounty.org

Question regarding this material or replication or re-distribution, please contact:

Hye Kyong Jeong, MSW
Director of Outreach and Advocacy
Direct 206.957.7080
Email hjeong@arcofkingcounty.org

The Arc of King County
233 6th Ave N, Seattle, WA 98109
Main 206.364.6337 | Fax 206.364.8140
www.arcofkingcounty.org

Future Planning Organizer

For The _____ Family

ALL ABOUT _____

(Pictures of the person and family – optional)

I like…

-
-
-
-
-
-
-
-
-
-
-
-
-
-
-
-
-

I dislike…

-
-
-
-
-
-
-
-
-
-
-
-
-
-
-
-
-

DAILY ACTIVITIES AND ROUTINES

Typical waking time and routine:

Typical bedtime and routine:

Daily routine

Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

GUIDELINES FOR SUPPORTING MY INDEPENDENCE

Dressing

I can:

I can use some help to:

Grooming and other personal care

I can:

I can use some help to:

Meal planning/Nutrition

I can:

I can use some help to:

Eating

I can:

I can use some help to:

Household Chores

I can:

I can use some help to:

Money management and budgeting

I can:

I can use some help to:

Transportation

I can:

I can use some help to:

In-home activities/interests

I can:

I can use some help to:

Mobility/Ambulation

I can:

I can use some help to:

Assistive Devices/Technology

Item	*Purpose*

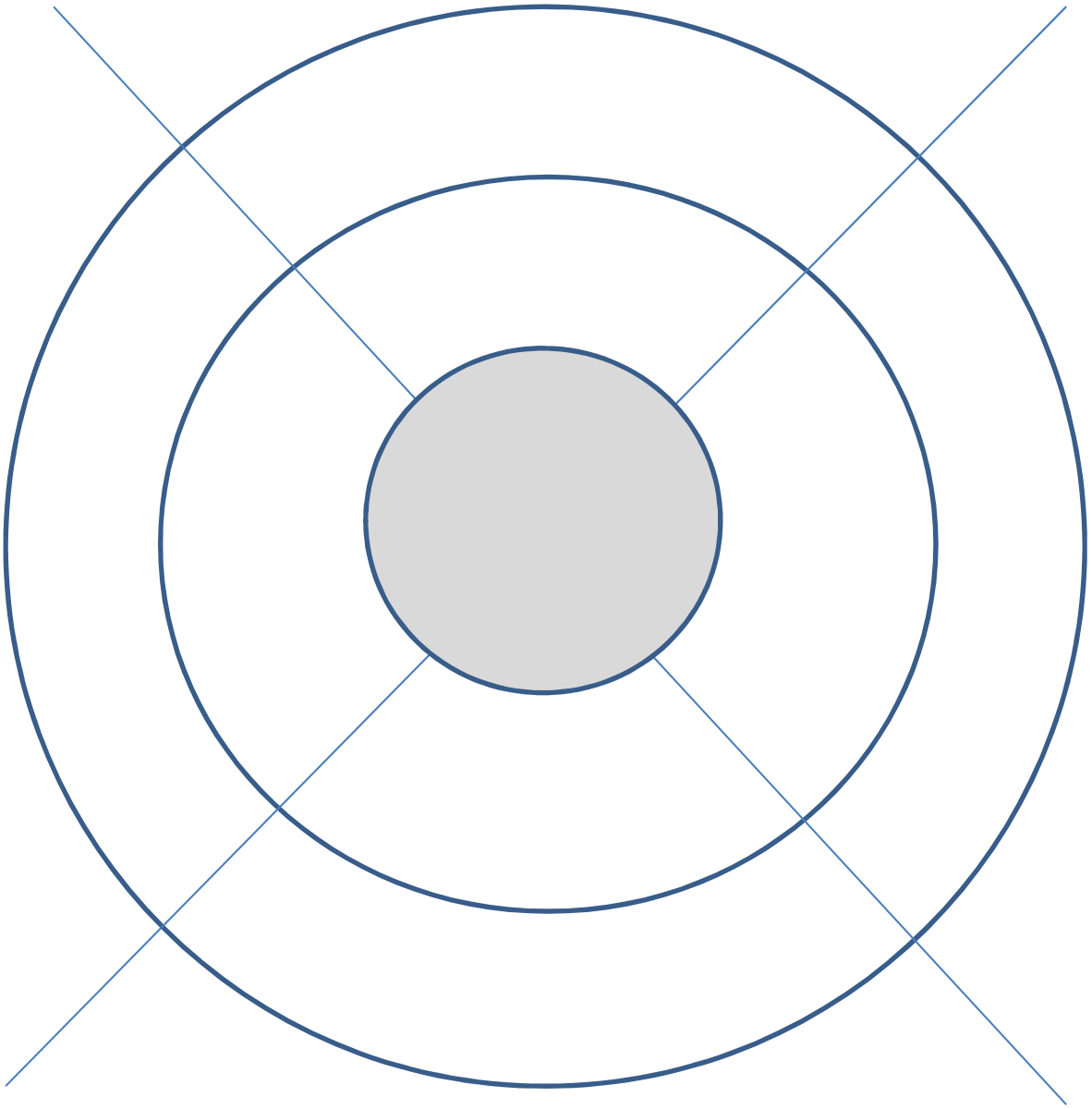
COMMUNICATION

When I am happy… 	You may find me… (ex: dancing) • • • • • • • •
When I am sad… 	You may find me… (ex: sitting alone in my room) • • • • • • • •
When I am angry 	Some ways to help me calm down are… (ex: turning on the radio or telling me a joke) • • • • • • • •
When I am sleepy 	You may find me… (ex: becoming cranky or closing my eyes) • • • • • • • •

RELATIONSHIP WEB

Use this as a visual representation of the key supports in your life including the inner circle as those who

Family



Work

Community

Friends and partners

Source reference : adapted from Etmanski, Al. "Step Two: Building Relationships." *A Good Life: For You and Your Relative with a Disability*. Surrey, B.C.: Planned Lifertime Advocacy Network (PLAN), 2000. 101. Print

MY BOOSTER CLUB

Everyone needs a boost every now and then, who are the people in your life who boost you up?

Name/relationship:

Telephone #

Cell #

Email:

Address

Best for:

Name/relationship:

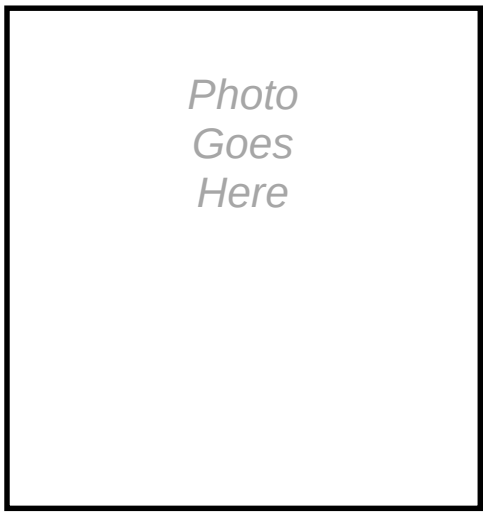
Telephone #

Cell #

Email:

Address

Best for:



Name/relationship:

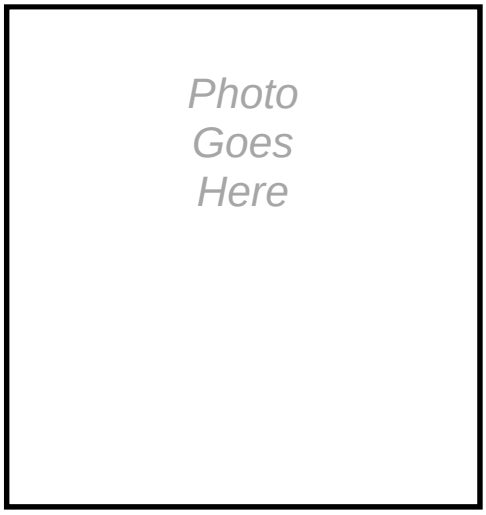
Telephone #

Cell #

Email:

Address

Best for:



Name/relationship:

Telephone #

Cell #

Email:

Address

Best for:

Name/relationship:

Telephone #

Cell #

Email:

Address

Best for:

Name/relationship:

Telephone #

Cell #

Email:

Address

Best for:

HEALTH INFORMATION

Legal Name: _____

Date of Birth: _____

SSN#: _____

Pharmacy Information

Name:

Address:

Phone Number:

Allergies:

Key diagnoses:

***Attach copies of medical, psychological and/or neurological assessments if available*

Current Medications

Medication Name	**Dose**	**Special Instructions?**

Medical Provider Contact Information

Primary Care Physician	**Specialty:**
Name of contact:	Name of contact:
Name of practice:	Name of practice:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:
Specialty:	**Specialty:**
Name of contact:	Name of contact:
Name of practice:	Name of practice:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:
Specialty:	**Specialty:**
Name of contact:	Name of contact:
Name of practice:	Name of practice:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:
Specialty:	**Specialty:**
Name of contact:	Name of contact:
Name of practice:	Name of practice:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:

Private Insurance Information

Provider:

ID Number:

Paste copy here

Medicare Information

Provider:

ID Number:

Paste copy here

Medicaid Information

Provider:

ID Number:

Paste copy here

DISABILITY SERVICE INFORMATION

Division of Developmental Disabilities (DDD)
Enrolled with DDD? ☐ Yes ☐ No
DDD Case Manager?
Name: _____
Telephone: _____
Email: _____

DDD Waiver Status
- ☐ No paid services
- ☐ Core
- ☐ Basic Plus
- ☐ Community Protection
- ☐ CIIBS
- ☐ MPC Hours
- ☐ Supported Living Program
- ☐ Adult Family Home
- ☐ Other

Home and Community Services (HCS)
Enrolled with HCS ☐ Yes ☐ No

HCS Case Manager?
Name: _____
Telephone: _____
Email: _____

COPES Waiver
- ☐ COPES waiver
- ☐ Adult Day Health
- ☐ MPC Hours
- ☐ Adult Family Home
- ☐ Other

Division of Vocational Rehabilitation Services? ☐ Yes ☐ No
(see employment section for provider details)
Supported Employment Services? ☐ Yes ☐ No
(see employment section for provider details)

Residential Services

Provider Name: Agency Name:

Provider Telephone #: Supervisor:

Telephone #:

Telephone #: Email:

Medicaid Personal Care Services

Provider Name: Alternate Provider:

Provider Telephone #: Provider Telephone #:

Number of hours:

Other DDD or waivered services?

EMPLOYMENT

Currently Employed? ☐ Yes ☐ No

1) Place of Employment _____ Hours per week ____

Name of Supervisor: _____ How long? _____

2) Place of Employment _____ Hours per week ____

Name of Supervisor: _____ How long? _____

3) Place of Employment _____ Hours per week ____

Name of Supervisor: _____ How long? _____

Employment Supports

Department of Vocational Rehabilitation services? ☐ Yes ☐ No

Division of Developmental Disabilities employment services? ☐ Yes ☐ No

Case Manager? ☐ Yes ☐ No

Name: _____

Telephone: _____

Email: _____

Vendor	Provider/"job coach"
Name:	Name:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:

RECREATION

Day Program? ☐ Yes ☐ No

Name:	Name:
Phone number:	Phone number:
Email / website:	Email / website:
Address:	Address:

Specialized Recreation? ☐ Yes ☐ No

City:	City:
Which activities?	Which activities?

Special Olympics? ☐ Yes ☐ No

Sport/Team Name:	Sport/Team Name:
Coach Name:	Coach Name:
Contact:	Contact:

Other Leisure

What do you enjoy doing for fun as a family?
Remember to include seasonal favorites and preferred places of worship.

FINANCES

Bank Account Information

Bank:	Bank:
Account #:	Account #:
☐Checking ☐Savings	☐Checking ☐Savings

Bank:	Bank:
Account #:	Account #:
☐Checking ☐Savings	☐Checking ☐Savings

Special Needs Trust? ☐ Yes ☐ No Trustee: _____

Bank:	Bank:
Account #:	Account #:

CD's

Bank:	Bank:
Account #:	Account #:

Stocks/Bonds? ☐ Yes ☐ No

FYI: You may find it helpful to place copies of all pertinent financial records including copies of trust documents behind his section.

SUMMARY OF FINANCIAL BENEFITS

Please use as a tool to document all income and resources other than wages

Representative Payee? ☐ Yes ☐ No

Payee Information
Name:
Address:

Phone Number:

SSI ☐ Yes ☐ No
Amount: $ _____ Check or Direct Deposit?

SSDA ☐ Yes ☐ No
Amount: $ _____ Check or Direct Deposit?

SSDI ☐ Yes ☐ No
Amount: $ _____ Check or Direct Deposit?

Veteran's benefits ☐ Yes ☐ No
Amount: $_____ Check or Direct Deposit?

(EBT stands for 'Electronic Benefits Transfer' and is similar to a debit card, loaded with a certain amount per month from the DSHS.)

EBT Cash Benefit ☐ Yes ☐ No Amount: $_____

EBT Food Benefit ☐ Yes ☐ No Amount: $_____

Other income?

_____ Amount: $_____ How often? _____

_____ Amount: $_____ How often? _____

_____ Amount: $_____ How often? _____

_____ Amount: $_____ How often? _____

_____ Amount: $_____ How often? _____

LEGAL DOCUMENTS CHECKLIST

Use this checklist to keep track of what legal documents you have provided copies of under this tab and for quick reference.

☐ ***Guardianship: Person***

Current Guardian	Back Up Guardian
Name:	Name:
Address	Address:
Home telephone:	Home telephone:
Work #	Work #
Cell #	Cell #
Email:	Email:

☐ ***Guardianship: Estate***

Current Guardian	Back Up Guardian
Name:	Name:
Address	Address:
Home telephone:	Home telephone:
Cell #	Cell #
Email:	Email:

☐ ***Durable Power of Attorney for Health***

Primary	Alternate (if applicable)
Name:	Name:
Address	Address:
Home telephone:	Home telephone:
Cell #	Cell #
Email:	Email:

☐ ***Durable Power of Attorney for Finance***

Primary	Alternate (if applicable)
Name:	Name:
Address	Address:
Home telephone:	Home telephone:
Work #	Work #
Cell #	Cell #
Email:	Email:

☐ Advanced Directives/POLST form *(filled out by physician)*

☐ Will – Attorney: _____ Copy attached? ☐ Yes ☐ No

☐ Trust – ☐1st party ☐3rd party ☐Special ☐Other

☐ Other legal arrangements

☐ Attorney for possible contact :

HOME INFORMATION FOR HOME OWNERS

Address:

Name of owner(s):

Purchased property for: $

Last assessed value:

Mortgage Information

Bank Name:

Account Number:

Monthly Payment amount:

Automatic payment withdrawal? Yes ☐ No ☐

Home Owner's Insurance

Insurer:

Policy Number:

Payment amount:

Automatic payment withdrawal? Yes ☐ No ☐

Location of:

First Aid Kit:

Fire Extinguisher:

Emergency Supplies Kit:

Smoke Alarms:

Notes: *Please note any professionals that support you on housing issues.*

Spare Keys

*Name:*_____
*Contact:*_____

*Name:*_____
*Contact:*_____

*Name:*_____
*Contact:*_____

Security System?

Company name:

Number:

Code:

FHOME INFORMATION FOR RENTERS

Address:

Landlord Name:

Landlord Phone #:

Maintenance Contact:

Rental Agreement Information

Month to Month ☐ Lease ☐

Term of Lease:

Monthly Payment amount:

Rent subsidized? ☐ Yes ☐ No

Section 8 Voucher? ☐ Yes ☐ No

Renter's Insurance

Insurer:

Policy Number:

Payment amount:

Location of:

First Aid Kit:

Fire Extinguisher:

Emergency Supplies Kit:

Smoke Alarms:

Notes: *Please note any professionals that support you on housing issues.*

Spare Keys

Name:_____
Contact:_____

Name:_____
Contact:_____

Name:_____
Contact:_____

Building Access

Notes:

Entry Code?

UTILITIES

Power	**Water/Sewer**
Name of company:	Name of company:
Account #:	Account #:
Phone number:	Phone number:
Address:	Included in rent? ☐Yes ☐ No

Gas	**Garbage**
Name of company:	Name of company:
Account #:	Phone number:
Phone number:	Included in rent? ☐Yes ☐ No
Included in rent? ☐Yes ☐ No	

Telephone	**Cable**
Name of company:	Name of company:
Account #:	Account #:
Phone number:	Phone number:

Internet	**Other**
Name of company:	Name of company:
Account #:	Account #:
Phone number:	Phone number:
Email / website:	Email / website:

Receiving energy assistance? ☐Yes ☐ No From? _____

Receiving telephone assistance? ☐Yes ☐ No From? _____

Receiving utility assistance? ☐Yes ☐ No From? _____

EMERGENCY PLAN AND CONTACTS

Always call 9-1-1 first in case of life threatening emergencies

In case of a fire, our family plan is…

☐ Evacuate the house following our exit plan map that is attached

If we become separated and cannot reach one another by phone, we will meet at _____

In case of an earthquake, our family plan is…

☐Get away from windows, find a sturdy surface to drop, cover and hold under _____

Locate emergency supplies kit if needed. Ours is _____

First Aid Kit is located: _____

Fire extinguisher is located: _____

Emergency Contacts

Local contact:

Local contact:

Local contact:

Local contact:

Out of town contact:

Out of town contact:

Reflecting on the now

Use this as a place to reflect on the topics and information covered specifically in this section. Thoughts? Feelings?

Looking forward to the future

How might this information look different in the future? What can I do now to be more prepared? What are our family's next steps?