The Portfolio

Documenting hopes, dreams, preferences and plans for the future

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ALL ABOUT MY *FUTURE*: Planning checklist for my family

Item	Complete?	To do
"All about me NOW" complete	☐ YES ☐ NO	
"All about my FUTURE" complete	☐ YES ☐ NO	
Successor guardian or trustee identified	☐ YES ☐ NO	
Letter of Intent complete	☐ YES ☐ NO	
Financial benefits analyzed and understood	☐ YES ☐ NO	
Will completed	☐ YES ☐ NO	
Special needs or supplementary trust established	☐ YES ☐ NO	
Provisions made to fund this trust with assets or insurance	☐ YES ☐ NO	
All documents stored in a safe place	☐ YES ☐ NO	
Other:	☐ YES ☐ NO	
Other:	☐ YES ☐ NO	

The Portfolio

The Portfolio is for you:

- ☆ If a family member with a developmental disability lives with you ***and*** you are planning for the future

It's never too early or too late!

- ☆ Even if you can't or don't want to fill in ***all*** the information, ***any*** information you record will help others in a family crisis or transition.
- ☆ The information can be updated around the time the individual's ISP is updated or on the individual's birthday.

Part 1: "All about me *NOW*"

- ☆ Documents how you do things now, for anyone who may take over in a family crisis or transition
- ☆ Records things that are important to and important for the individual
- ☆ Provides a smoother transition for your family member

Part 2: "All about my *FUTURE*"

- ☆ Explains your wishes for your family member's future living arrangements and other matters
- ☆ Addresses these hard questions now, ***before*** a family crisis or transition

Where to keep it:

- ☆ The information belongs to you. Keep it where you can easily refer to it and share it with others.
- ☆ It's a good idea to share a copy with your Individual Support Coordinator, so that he/she is prepared to assist in a family crisis or transition.

For help with the Portfolio:

- ☆ Your Individual Support Coordinator (ISC) can help you organize and record information.
- ☆ Your attorney is a good source of information and guidance about legal matters.

Advice from other family members:

- ☆ Make it your own: Add photos, change the format, add new questions. It's a way to organize information, not a form to fill out.
- ☆ You don't have to do it all at once. If you work section by section, it's a good idea to date the page you work on when you work on it.
- ☆ Some items will apply, others won't, depending on your family member's situation.
- ☆ Using the Portfolio is a good excuse to start or continue a conversation about the future with other family members and close friends.

The Portfolio

My name **Date of birth**

Date when this Portfolio was last reviewed and updated

Table of Contents

Who is ?
What is 's story?
What will others learn about as they get better acquainted that you already know?
Include photos here (and elsewhere in the Portfolio)

ALL ABOUT ME *NOW*: Typical day

Activity	Usual time	Comments
Wake up		
Eat breakfast		
Get dressed		
Leave for work/school		
Eat lunch		
Take medication:		
Take medication:		
Eat dinner/supper		
Watch TV		
Get ready for bed		
Bathe		
Bedtime routines		
Go to sleep		
Other:		
Other:		
Other:		

ALL ABOUT ME *NOW*: Likes and dislikes

Item	Favorites	Dislikes or fears
Breakfast food		
Lunch food		
Dinner/supper food		
Snacks		
Weekday clothes		
Weekend clothes		
Hairstyle		
Makeup		
Personal possessions		
Clubs and groups		
Hobbies		
Sports		
Movies		
TV shows		
Pets		
Birthday celebrations		
Holiday traditions		
Vacations		
Religious participation		

ALL ABOUT ME *NOW*: Important people

Relationship	Name(s)	Contact information	Notes about the relationship
Mother			
Father			
Sisters			
Brothers			
Aunts			
Uncles			
Cousins			
Other relatives			
Friends			
Personal advocate			
Personal care provider			
Clergy			
Neighbors			
Durable power of attorney			
Other:			

ALL ABOUT ME *NOW*: Communication

Item	Way of expressing	Comments
Mother		
Father		
Brother		
Sister		
Toilet		
Hungry		
Hot		
Cold		
Happy		
Tired		
Angry		
Sad		
Outside		
Hello		
Goodbye		
Other:		
Other:		

ALL ABOUT ME *NOW*: Education (for children)

Item	Description	Comments
Current school		
Principal		
Teacher		
Personal assistant		
Physical Therapist		
Speech Therapist		
School nurse		
Other contact:		
School routines		
Specialized services		
Next major transition		
Other		
Other		

ALL ABOUT ME *NOW*: Employment (for adults)

Item	Description	Comments
Current employer		
Job title		
Job responsibilities		
Supervisor		
Job coach		
Job routines		
Accommodations		
Coworkers		
Work clothes		
Work schedule		
Workday lunches		
Spending money		
Other		
Other		

ALL ABOUT ME *NOW*: Medical information

Doctors, dentists, pharmacy and therapists

Name	Address	Phone and fax	Specialty	Frequency of visits	Last visit

Medication summary

Prescribing doctor	Medication	Dosage	Schedule	Instructions	Purpose	Side effects

Allergies	☐ Medication – specify: ☐ Food – specify: ☐ Environmental – specify:
Medical conditions/ diagnoses	
Physical limitations	
Special diet	
Adaptive equipment	
Health-related concerns	

Individual gives consent for medical procedures:	☐ Yes	☐ No	**Living will in place:**	☐ Yes	☐ No
Legal guardian gives consent:	☐ Yes	☐ No	**Advance directive:**	☐ Yes	☐ No

Personal medical history

- ☐ Measles – date: _____
- ☐ Mumps – date: _____
- ☐ Whooping cough – date: _____
- ☐ Diphtheria – date: _____
- ☐ Smallpox – date: _____
- ☐ Polio – date: _____
- ☐ Scarlet fever – date: _____
- ☐ Tuberculosis – date: _____
- ☐ Rheumatic fever – date: _____
- ☐ Infectious mononucleosis – date: _____
- ☐ Chicken pox – date: _____
- ☐ Bronchitis – date: _____
- ☐ Pneumonia – date: _____
- ☐ Asthma – date: _____
- ☐ Emphysema – date: _____
- ☐ Heart disease/heart attack – date: _____
- ☐ Heart murmur – date: _____
- ☐ High blood pressure – date: _____
- ☐ Stroke – date: _____
- ☐ Vascular (blood vessel) disease – date: _____
- ☐ Glaucoma – date: _____
- ☐ Cataracts – date: _____
- ☐ Anemia – date: _____
- ☐ Bleeding tendencies – date: _____
- ☐ Blood transfusions – date: _____
- ☐ Kidney disease – date: _____
- ☐ Bladder infections – date: _____
- ☐ Liver disease/cirrhosis – date: _____
- ☐ Hepatitis – date: _____
- ☐ Stomach ulcer – date: _____
- ☐ Thyroid problems – date: _____
- ☐ Diabetes – date: _____
- ☐ Cancer Type: _____– date: _____
- ☐ Arthritis – date: _____
- ☐ Skin problems – date: _____
- ☐ Hives/eczema – date: _____
- ☐ Headaches/migraines – date: _____
- ☐ Mental illness – date: _____
- ☐ Seizures/epilepsy – date: _____
- ☐ Hernia – date: _____
- ☐ Hemorrhoids – date: _____
- ☐ Other (specify): _____– date: _____

Hospitalizations and surgeries

Reason for hospitalization, surgery, severe injury	Year

Diagnostics

Procedure		
EKG	☐ Yes Date: _____	☐ No
EEG	☐ Yes Date: _____	☐ No
Brain CT Scan	☐ Yes Date: _____	☐ No
Brain MRI	☐ Yes Date: _____	☐ No
Echocardiogram	☐ Yes Date: _____	☐ No

Any problem with anesthetic? ☐ No ☐ Yes Describe: _____

Notes/comments:

Screening

Most recent	Date
Stool blood test	
Sigmoid	
Colonoscopy	
TB skin test	
Bone density test	
Cholesterol test	
Blood sugar test	
Hearing test	
Eye exam	
Physical therapy eval.	
Men only: Prostate (PSA)	

Immunizations

Most recent	Date
Tetanus	
Oral polio	
MMR	
Chicken pox	
Pneumovax	
Hepatitis B primary	
Hepatitis B booster	
Rubella	
Flu shot	
H. Influenza B (HIB)	
Other:	

Behavioral health

Current	
Tobacco use	☐ Yes PPD _____ ☐ No
Smoking in home	☐ Yes ☐ No
By whom?	
Alcohol use	☐ Yes ☐ No
Drinks per week	
Caffeine use	☐ Yes ☐ No
Cups per day	
Illicit drug use	☐ Yes Type ☐ No
Exercise type	
Minutes per day	
Times per week	

Women only:

Most recent	Date	Results	Comments
Pap test		☐ normal ☐ abnormal	
Mammogram		☐ normal ☐ abnormal	
Breast exam		☐ normal ☐ abnormal	
Menstrual period		Age of onset of menses:	

Notes/comments:

Current diagnoses (Corresponds to IDS)

☐ Alzheimer's Disease/Dementia	☐ Fetal Alcohol Syndrome	☐ Post-Traumatic Stress Disorder
☐ Anxiety Disorder	☐ Fragile X Syndrome	☐ Prader-Willi Syndrome
☐ Asperger Syndrome	☐ Hearing Impairment	☐ Schizophrenia/ Psychotic Disorders
☐ Attention Deficit Disorder	☐ Mood Disorder	☐ Spina Bifida
☐ Autistic Disorder	☐ Obsessive Compulsive Disorder	☐ Stereotyped Movement Disorder with SIB
☐ Bipolar Disorder	☐ Panic Disorder with Agoraphobia	☐ Substance Related Disorder
☐ Cerebral Palsy	☐ Paraphilia/ Pedophilia	☐ Tourette Syndrome
☐ Conduct Problem/Intermittent Explosive Disorder	☐ Parkinson's Disease	☐ Traumatic Brain Injury
☐ Down Syndrome	☐ Pervasive Developmental Disorder	☐ Visual Impairment
☐ Epilepsy/Seizure Disorder	☐ Pica Behavior	☐ Other (specify): _____

Assistance or adaptations needed

☐ Sedation for health care exams	☐ Uses sign language	☐ Assistance with oral hygiene
☐ Special positioning for exams	☐ Assistance with toileting	☐ Assistance with walking
☐ Special staffing for exams	☐ Incontinent	☐ Uses walker
☐ Staff assistance taking medications	☐ Catheterized	☐ Uses cane
☐ Trained staff administer meds	☐ Assistance with eating	☐ Uses gait belt
☐ Nurse administers meds	☐ Uses feeding tube	☐ Uses wheelchair part-time
☐ Assistance with other procedures	☐ Modified diet	☐ Uses wheelchair full-time
Specify:	☐ Thickened liquids	☐ Uses brace
☐ Assistance expressing self	☐ Assistance with dressing	☐ Uses splint
☐ Assistance understanding language	☐ Assistance with bathing	☐ Wears helmet

Response to pain: ☐ Normal ☐ Unusual – describe:
Preferred time for appointments: ☐ Any time ☐ Early day ☐ End of day ☐ Limited waiting time for exam:

Notes/comments:

Family history

Family member	Age, if living	Health status	Age at death	Cause of death	Other health problems
Father					
Mother					
Brother					
Brother					
Sister					
Sister					

Conditions diagnosed in other close blood relatives, including grandparents, aunts, uncles, cousins

☐ Cancer – type: ☐ Colon polyps ☐ Migraine headaches ☐ Severe osteoporosis ☐ High cholesterol ☐ High blood pressure ☐ Heart attack ☐ Other heart problems	☐ Stroke ☐ Diabetes ☐ Mental illness ☐ Suicide ☐ Alcohol/drug abuse ☐ Other: specify ☐ Other: specify ☐ Other: specify

Notes/comments:

Medicaid # (12-digit number on front of card): _____

Type	Cost	Comments
☐ Traditional (monthly paper) ☐ Molina ☐ CareSource	Spend down? ☐ Yes ☐ No Spend down amount:	
Medicaid Buy In for Workers with Disabilities? ☐ Yes ☐ No	Monthly premium amount:	

Medicare #: _____

Part A	effective date(s):	
Part B	effective date(s):	Premium deducted from Social Security check: ☐ Yes ☐ No
Part C		Med Advantage plan name: Med Advantage premium amount:
Part D		Prescription plan name: Premium amount:

Uncovered medications paid out of pocket: _____

ALL ABOUT ME *NOW*: Finances

Private insurance	Company name	Policyholder	Policy #	Who's covered?	Contact information
Health insurance					
Dental insurance					
Vision insurance					
Prescription drug insurance					
Life insurance ☐ whole ☐ partial whole ☐ term					

Income and assets	Amount	Comments
Wages		
SSI		
SSDI		
Special needs or other trust		
VA Benefit		
Black Lung benefit		
Parent's retirement income		
Dividends		
401K		
Rent/utility payment to family		
Food Stamps		
Other benefits:		
Homestead Act		
Prepaid burial plan		
Personal home ownership		
Personal vehicle ownership		
Bank account: savings		
Bank account: checking		
Payee	Name:	

ALL ABOUT ME *NOW*: Housing and home life

Item	Description
Own or rent?	
Household members	
Condition of the house or apartment	
Neighborhood environment	
Assistance from other family members	
Holiday traditions	
Chores at home	
Rules about smoking	
Other rules of the household	
Parking arrangements for providers	
What works about the current living situation?	
What doesn't work about the current living situation?	

Household expense	Amount	Paid to	Comment
Rent or mortgage			
Electric service			
Natural gas service or propane			
Water			
Telephone			
Cable			
Internet			
Other:			

ALL ABOUT ME *NOW*: Personal assistance needed

Item	Type of assistance needed	Current provider of assistance
Dealing with other agencies		
Arranging for government benefits		
Paying rent		
Paying utilities		
Managing finances		
Doing yard work		
Snow removal		
House cleaning		
Doing laundry		
Cooking		
Contacting maintenance service		
Resetting a Ground Fault Interrupter (GFI) circuit		
Clearing lint from a clothes dryer vent		
Emptying trash containers		
Vacuuming or cleaning carpets		
Coordinating with pest control service		
Maintaining water filters and water softeners		
Resetting electric circuit breakers		
Maintaining home appliances		
Managing home security systems		
Communicating preferences or feelings		

Emergency information

Item	Contact information	Comments
Fire Department		
Police/Sheriff		
Emergency medical		
Poison Control		
First Aid kit	Location:	

ALL ABOUT MY *FUTURE*: Hopes, dreams and worries

Item	Description
What are the individual's hopes and dreams for a safe, secure and satisfying life?	
What are the family's hopes and dreams for a safe, secure and satisfying life for the individual?	
What supports will the individual need to make these positive futures happen?	
What plans are in place for a living arrangement for the individual when the current caregiver can no longer continue in that role?	
What are your worries and nightmares about the individual's future?	
What do you want others to be sure to avoid when helping the individual make and carry out future plans?	
What do you consider most important for future caregivers to know about the individual?	
What do you most want other surviving family members to help with, after your death?	
What other things do you want others to know about your wishes for the individual?	

ALL ABOUT MY *FUTURE*: Legal issues

Item	Description
Location of important documents	
Executor of will	
Funeral plans	
Family plot	
Preferred legal guardian for individual	
Durable Power of Attorney	
Plans for the current home after owners' death	
Letter of Intent	
Special needs trust established	
ISC/ISP/IEP	
Most important things for future legal guardian and caregivers to do as soon as current legal guardian and caregiver are unable to continue	