PLAN of AZ
Planned Lifetime Assistance Network
Planning • Trust • Care

Client Profile

Date Completed: _____

CLIENT INFORMATION

Beneficiary of Special Needs Trust

Name of Client:_____

Social Security #: _____ ☐ Male ☐ Female

Age:_____ Date of Birth:_____ Place of Birth:_____

Phone Number (H): _____ Phone Number (C):_____

Email Address: _____

Physical Address: _____

_____

Mailing Address (if different from above):_____

_____

What county does client live in:_____

Client Lives: ☐ Independently at home/apartment ☐ Independent living center

☐ Group home ☐ Assisted Living ☐ Rehab hospital ☐ Host home

With family (specify relationship):_____

Other (specify):_____

Cultural or ethnic group:_____ Religion:_____

Auto Related

Do you drive? ☐ No ☐ Yes Driver's License or State ID #: _____

Expiration Date:_____ State:_____

Do you have access to or own a car? _____ Registration #: _____

Auto Insurance Provider:_____ Policy #: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

Times Married: _____ Assessment of Current Relationship: _____

GENERAL FAMILY INFORMATION

Name of Parents or Guardians:_____

Phone Number (H): _____ Phone Number (C):_____

Email Address: _____

Physical Address: _____

_____

_____

Mailing Address (if different from above):_____

_____

_____

Father's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Mother's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Spouse's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Children's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Children's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Sibling's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Sibling's Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Relationship: _____ Name: _____ DOB: _____

Deceased: ☐ No ☐ Yes- Date of Death: _____ Living with Client: ☐ No ☐ Yes

Are there others involved with the beneficiary that we could:

_____

_____

Phone Number (H): _____ Phone Number (C):_____

Email Address: _____

Address: _____

_____

_____

DISABILITY INFORMATION

Mental Illness

When did you become disabled? _____

Primary Diagnosis: _____

Other Diagnosis: _____

Have you ever had a Psych Evaluation: ☐ No ☐ Yes

If yes, what was the date of your last evaluation:_____

Contact Name: _____

Address: _____

Phone: _____

Have you been diagnosed with a SMI?: ☐ No ☐ Yes

If yes, date of diagnoses:_____

Contact Name: _____

Address: _____

Phone: _____

Disability: ☐ CP ☐ Epilepsy ☐ Autism ☐ Asperger's ☐ Cognitive Disability

Other_____

Physical Disability: Deaf/HI___ Blind/VI___ SCI___ TBI___

Other_____

Mobility: Wheel Chair___ Walker___ Adaptive Equipment___ Assistive Devices___

Describe if necessary:_____

_____

List physical or mental disabilities that limit life functioning:_____

_____

Other Disability:_____

Have you been legally declared incompetent? ☐ No ☐ Yes

Legal Guardian Name: _____

Address: _____

Phone: _____

MEDICAL INFORMATION

Primary Insurance Provider: _____

Policy #: _____ Phone: _____

Medicare #: _____ Medicaid #: _____

Secondary Insurance Provider: _____

Policy #: _____ Phone: _____

Medicare #: _____ Medicaid #: _____

PCP Doctor: _____

Address: _____

Phone: _____

Other Doctor: _____

Address: _____

Phone: _____

Psychiatrist: _____

Address: _____

Phone: _____

Dental Insurance Provider: _____

Policy #: _____ Phone: _____

Dentist: _____

Address: _____

Phone: _____

PROVIDERS

Mental Healthcare Providers

Provider Network Organization:_____

Address: _____

Phone: _____

Primary Social Worker/Case Manager: _____

Address: _____

Phone: _____

DDD Providers or Programs

Provider: _____

Contact Name: _____

Address: _____

Phone: _____

Provider: _____

Contact Name: _____

Address: _____

Phone: _____

Provider: _____

Contact Name: _____

Address: _____

Phone: _____

Current Government Services

☐ DDD ☐ CRS ☐ RSA ☐ ALTCS ☐ AHCCCS ☐ Medicare ☐ HUD

☐ Housing Voucher ☐ ADA Dial-a-ride ☐ Bus Card ☐ Educational Aid / Scholarships

☐ Other _____

FINANCES

Do you handle your own finances? ☐ No ☐ Yes

Representative Payee: _____

Address: _____

Phone: _____

Conservator: _____

Address: _____

Phone: _____

Source of Income and benefit amount per Month:

SSI:	$_____
SSDI:	$_____
VA Benefits:	$_____
Work:	$_____
Other:	$_____

Please list financial resources that may become available in the future (e.g. inheritance, trust, support by relatives, etc.) Be specific about sources and amounts.

_____

_____

LEGAL

Name of Attorney: _____

Firm: _____

Address: _____

Phone: _____

Power of Attorney? ☐ No ☐ Yes

Name: _____

Address: _____

Phone: _____

Medical Power of Attorney? ☐ No ☐ Yes

Name: _____

Address: _____

Phone: _____

Mental Health Power of Attorney? ☐ No ☐ Yes

Name: _____

Address: _____

Phone: _____

Health Care Directive/Living Will? ☐ No ☐ Yes

Date Signed:_____ Location of Copy: _____

What are the final arrangements for the Client? ☐ Cremation ☐ Burial

Has this been prepaid? ☐ No ☐ Yes

Please provide details (place, phone, address, etc.) _____

_____

_____

Legal History

Are you currently involved in any active cases (traffic, civil, criminal)? ☐ No ☐ Yes

If Yes, please indicate the court, hearing/trial dates, and charges: _____

_____

Are you currently on probation or parole? ☐ No ☐ Yes

If Yes, please list the name and number of your Parole Officer: _____

_____

Traffic Violations: ☐ No ☐ Yes DWI, DUI, etc.: ☐ No ☐ Yes

Criminal Involvement: ☐ No ☐ Yes Civil Involvement: ☐ No ☐ Yes

If you responded 'Yes' to any of the above, please fill in the following information.

DATE	CHARGES	WHERE (City)	RESULTS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEVELOPMENTAL INFORMATION

Were there any special, unusual, or traumatic circumstances that affected your development? ☐ No ☐ Yes- please explain: _____

_____

Has there been history of child abuse? ☐ No ☐ Yes

Has there been history of child neglect? ☐ No ☐ Yes

If Yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional ☐ Malnutrition

If Yes, the abuse was as a: ☐ Victim ☐ Perpetrator

Do you have any other comments? _____

MEDICAL AND PHYSICAL HEALTH

Please check the symptoms that you are currently experiencing or have been treated for:

☐ AIDS	☐ Chronic Pain	☐ Headaches	☐ Pneumonia
☐ Abdominal Pain	☐ Colds/Coughs	☐ Hearing Problems	☐ Rheumatic Fever
☐ Abortion	☐ Constipation	☐ Hepatitis	☐ Scarlet Fever
☐ Alcoholism	☐ Dental Problems	☐ High Blood Pressure	☐ Sexual Dysfunction
☐ Allergies	☐ Diabetes	☐ Kidney Problems	☐ Sinusitis
☐ Anemia	☐ Diarrhea	☐ Measles	☐ Sleeping Disorders
☐ Appendicitis	☐ Dizziness	☐ Menstrual Pain	☐ Small Pox
☐ Arthritis	☐ Drug Abuse	☐ Miscarriages	☐ Stroke
☐ Asthma	☐ Ear Infections	☐ Mononucleosis	☐ Thyroid Problems
☐ Bed Wetting	☐ Eating Problems	☐ Mumps	☐ Tonsilitis
☐ Bronchitis	☐ Epilespy	☐ MRSA	☐ Tuberculosis
☐ Cancer	☐ Fainting	☐ Nausea	☐ Vision Problems
☐ Chest Pain	☐ Fatigue	☐ Neural Disorders	☐ Vomiting
☐ Chicken Pox	☐ Frequent Urination	☐ Nose Bleeds	☐ Whooping Cough

- Other- please describe: _____

CURRENT MEDICATIONS

Prescribed Meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Over-the-Counter Meds	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? ☐ No ☐ Yes: _____

Have you been told that you abuse prescription drugs? ☐ No ☐ Yes- by: _____

MEDICAL HISTORY

	Date	Reason	Results
Last Physical Exam			
Last Doctor's Visit			
Last Dental Exam			
Most Recent Surgery			
Other Surgery			
Upcoming Surgery			

Please indicate if there have been any recent changes in the following:

☐ Anxiety/Tension ☐ Eating Patterns ☐ General Disposition ☐ Sleep Patterns

☐ Behavior ☐ Energy Level ☐ Physical Activity ☐ Weight

Please describe these changes: _____

_____

Family History of Medical Problems

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Children: _____

Other: _____

HISTORY OF CHEMICAL USE

	Amount Used	Frequency of Use	Age of First Use	Age of Last Use	Used in Last 48 Hours	Used in Last 30 Days
Alcohol	_____	_____	_____	_____	No / Yes	No / Yes
Barbiturates	_____	_____	_____	_____	No / Yes	No / Yes
Valium/Librium	_____	_____	_____	_____	No / Yes	No / Yes
Cocaine/Crack	_____	_____	_____	_____	No / Yes	No / Yes
Heroin/Opiates	_____	_____	_____	_____	No / Yes	No / Yes
Marijuana	_____	_____	_____	_____	No / Yes	No / Yes
PCP/LSD/Mescaline	_____	_____	_____	_____	No / Yes	No / Yes
Inhalants	_____	_____	_____	_____	No / Yes	No / Yes
Other Drugs	_____	_____	_____	_____	No / Yes	No / Yes

Substance(s) of preference: _____

_____

SUBSTANCE ABUSE

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends: _____

Reason(s) for use: ☐ Addicted ☐ Build Conidence ☐ Escape ☐ Socialization

☐ Self-Medication ☐ Taste ☐ Other- please describe: _____

Who/what has helped stop or limit your use? _____

Do you have family/friends that past or present have had drug and/or alcohol issues?

☐ No ☐ Yes- please describe: _____

Do you experience withdrawal symptoms when you stop using drugs and/or alcohol?

☐ No ☐ Yes- please describe: _____

Have you had adverse reactions or overdosed due to drugs and/or alcohol?

☐ No ☐ Yes- please describe: _____

Do you think that you have a drug and/or alcohol abuse problem?

☐ No ☐ Yes- please describe: _____

TREATMENT AND COUNSELING HISTORY

Client's History

Have you had counseling or psychiatric treatment? ☐ No ☐ Yes- when, where, and what was the result? _____

Have you had drug and/or alcohol treatment? ☐ No ☐ Yes- when, where, and what was the result? _____

Have you been hospitalized? ☐ No ☐ Yes- when, where, for what reason, and what was the result? _____

Have you attended self-help groups (e.g. AA, NA, etc.)? ☐ No ☐ Yes- when, where, and what was the result? _____

Have you attempted suicide? ☐ No ☐ Yes- when, where, how many times, and for what reason?

_____

Please check behaviors/symptoms you feel you experience too frequently:

☐ Aggression	☐ Distractability	☐ Hopelessness	☐ Scattered Thoughts
☐ Alcoholism	☐ Dizziness	☐ Impulsivity	☐ Sexual Addiction
☐ Anger	☐ Drug Dependence	☐ Irritability	☐ Sexual Dysfunction
☐ Antisocial Behavior	☐ Eating Disorder	☐ Judgment Errors	☐ Sick Frequently
☐ Anxiety	☐ Elevated Mood	☐ Loneliness	☐ Sleep Problems
☐ Avoiding People	☐ Fatigue	☐ Memory Impairment	☐ Speech Problems

☐ Chest Pain ☐ Gambling ☐ Mood Shifts ☐ Suicidal Thoughts

☐ Cyber Addiction ☐ Hallucinations ☐ Panic Attacks ☐ Trembling

☐ Depression ☐ Heart Palpitations ☐ Phobias ☐ Withdrawal

☐ Disorientation ☐ High Blood Pressure ☐ Recurring Thoughts ☐ Worrying

☐ Other- please describe: _____

EDUCATION

Are you currently enrolled in school: ☐ No ☐ Yes

If Yes, describe level of education: _____

Fill in all that applies:

☐ High School- Number of Years: _____ Graduated: ☐ No ☐ Yes Major: _____

☐ College- Number of Years: _____ Graduated: ☐ No ☐ Yes Major: _____

☐ Graduate- Number of Years: _____ Graduated: ☐ No ☐ Yes Major: _____

☐ Other- Number of Years: _____ Graduated: ☐ No ☐ Yes Major: _____

List any special circumstances (e.g. learning disabilities, ADHD, gifted): _____

_____

EMPLOYMENT

Beginning with most recent job, please list your job history:

Employer: _____ Dates: _____ Position: _____

Reason for leaving: _____

Employer: _____ Dates: _____ Position: _____

Reason for leaving: _____

Employer: _____ Dates: _____ Position: _____

Reason for leaving: _____

Current Employer:_____

Name of supervisor: _____

Address: _____

Phone: _____

(check all that apply):

☐ Full Time ☐ Part Time ☐ Temporary/Seasonal ☐ Laid-Off ☐ Disabled ☐ Retired

☐ Social Security ☐ Student ☐ Other, please describe: _____

How many hours do you work a week? ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50

Would you like to have a job? ☐ No ☐ Yes

Doing What: _____

MILITARY

Did you serve in the military? ☐ No ☐ Yes

Where did you serve? _____

Branch: _____ Discharge Date: _____

Date Enlisted: _____ Type of Discharge: _____

Date Drafted: _____ Rank at Discharge: _____

Do you have Combat experience? ☐ No ☐ Yes- please explain: _____

_____

Is there anything else regarding your Military experience that you would like to add?

_____

LEISURE AND RECREATION

Describe your areas of interest or hobbies (e.g. art, reading, physical fitness, outdoor activities, church activities, traveling, etc.):

Activity	Amount of Time (Present)	Amount of Time (Past)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Form Completed By

Name: _____

Phone Number (H): _____

Phone Number (C): _____

Address: _____

_____

_____

Email Address: _____

Was this Questionnaire completed with the Client present? ☐ No ☐ Yes

_____ _____

Signature of Beneficiary Date

_____ _____

Signature of Trustor Date

_____ _____

Signature of PLAN Staff Member Date