SECTION 3:

PERSONAL INFORMATION SUMMARY

Personal Information Summary

For: _____

Prepared By: _____

Date Last Completed: _____

_____

Section A. Person's Information

Directions: Write information about the person with a disability. Provide as much detail as possible.

Full Legal Name _____ Nickname or Aliases _____

Current Mailing Address _____

Current Physical Address _____

Home Telephone Number _____ Work Telephone Number _____

Mobile Telephone Number _____ Email Address _____

Gender F Race Other Height _____ Weight _____ Eye Color _____

Hair Color _____ Primary Spoken Language _____

Date of Birth _____ City and State of Birth _____

U.S. Citizenship Status _____

Religious Affiliation _____

Driver's License No. (or State Identification No.) _____

Social Security No.: _____

Marital Status Single Spouse's Legal Name _____

Voting

Registered to Vote ○ Yes ○ No Date Registered _____

Registered Selective Service ○ Yes ○ No _____

_____

Religious Affiliation

Regularly attends religious services ○ Yes ○ No

These services are held at _____

Address _____

_____

Phone _____

Usually attends on _____ (Day) _____ AM _____ PM

Is a member ○ Yes ○ No Requires assistance to attend ○ Yes ○ No

Attends church related activities _____

_____

Education

School Records

Last school attended _____

Name _____ Phone Number _____

Address _____

Classes: Regular Diploma Track ○ Yes ○ No Special Diploma Track ○ Yes ○ No

Other Special Program _____

Relationship with peers ○ Excellent ○ Good ○ Fair ○ Poor

Learning Style

Adapts to new situation easily ○ Yes ○ No Becomes upset/agitated in new situation ○ Yes ○ No

Becomes destructive or self abusive when agitated ○ Yes ○ No

Describe behaviors _____

_____

What calms person when agitated? _____

_____

Overly friendly/affectionate to strangers ○ Yes ○ No Has age appropriate manners ○ Yes ○ No

Section B. Residential History/Plans

Describe the type of home or residence where the person has lived in the past, where he lives now, and how he would like to live in the future.

Currently lives in _____

(Own Apartment, Shared Home/Apartment, Family Home, Assisted Living Facility, Foster Home, Group Home, IDF/DD, Residential Habilitation Center, Skilled Nursing Home)

Other (describe) _____

_____

Requires the following support services to live there: _____

_____

_____

Lives with _____

Optimal level of supervision required ○ Low ○ Medium ○ High

Other _____

Monthly cost is _____ Paid by _____

Caregivers with whom the person has lived previously (start with most current):

Name	Address	Reason for Leaving

In the future, the particular type of home the individual prefers is _____

(Own Apartment, Shared Home/Apartment, Family Home, Assisted Living Facility, Foster Home, Group Home, IDF/DD, Residential Habilitation Center, Skilled Nursing Home)

Other (describe) _____

_____

If the person prefers a group setting, preference for number of residents who live there is _____

If the person prefers living with family or friends, arrangements (have/have not) already been made with:

Name	Address	Phone Number

The type of neighborhood preferred is ☐ Urban ☐ Suburban ☐ Rural

The home should be near (Bus Stop / Grocery Store / Work Place / Hospital / Church / Family Members)

Other _____

_____

Can use this kind of transportation:	☐ Bus	☐ Train	☐ Taxi
With help:	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Other _____

_____

Section C. Employment/Retirement

During the day goes to (select all that apply):

Regular Job ○Fulltime ○Parttime _____

☐ Activities Program ☐ Sheltered Workshop ☐ Service Center ☐ Volunteer

Other _____

Dress For Work: ○Uniform ○Casual ○Dress

Has a Job Coach: ○Yes ○No

Name _____ Phone Number _____

Complete employment table, if person has an employment record.

It is anticipated that the person will be ready to retire by _____

Upon retirement, the individual would like to participate in _____

Employment History

Jobs Held Beginning with Current Job

Employer Address/Phone#	Paid/Volunteer	Supports Required	Job Title, Description and Salary	Job Coach (Yes/No)
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No
	Volunteer			No

Section D. General Health Information

Provide a Brief Summary of Diagnoses and Medical History _____

_____

_____

This section deals with health issues of the person with a disability. First gather all current medications and medical records, past and present. Addresses and phone numbers for health care providers are also needed, so have them handy. Provide as much detail as possible.

Birth Date _____ Age _____ Height _____ Feet _____ Inches

Weight ○ Average ○ Overweight ○ Underweight _____

Special Diet _____

Blood Type AB- Blood Disorder _____

Name of Physician _____ Phone Number _____

Date of Last Physical _____

Who has person's medical records? Name _____

Address _____ Phone Number _____

_____

Health Insurance

Medicare No. _____ Medicaid No. _____

Private Insurance Co. _____ Plan No. _____

Prescription Plan Provider. _____ Plan No. _____

Other Insurance _____

_____

_____

_____

Does person smoke? ○ Yes ○ No Amount _____

Drinks alcohol? ○ Yes ○ No Amount _____

Use recreational drugs? ○ Yes ○ No Drug Used _____

Frequency _____

Current Physicians

Name	Profession	Phone Number	Date Last Seen
	Primary Physician		
	Dentist		
	Optometrist/Ophthalmologist		

Specialists and other health care providers (Therapists, Nutritionist, Nurse Practitioner, Psychologist, etc.)

Allergies (Food, Medicine or Substances)

List

When an allergic reaction occurs, this is what happens, and this is what should be done:

Medications

Able to take medication without assistance ○ Yes ○ No
Describe assistance needed or special way required (e.g. crushed, with food, etc)

Knows names of own medications ○ Yes ○ No
Recognizes own medications ○ Yes ○ No
Knows purposes of own medications ○ Yes ○ No

Prescription Medicines

Look at the bottles of medicines now being taken for the following information.
Copy this information on the form provided on the following page.

Remember to update when changes are made to medications.

MEDICATIONS (Prescription and Over-The-Counter)

Name of Medicine	For What Condition	Amount Given (Dosage)/ When & How Often	Side Effects	Doctor's Name/Ph#	Pharmacy Ph#

Other Health Information

Use special equipment, assistive device(s) or consumable medical product(s):

Device/Item	Vendor	Phone#	Method of Payment

Signs own consent forms for health care? ○ Yes ○ No Copies are located at _____

Has signed an advance directive? ○ Yes ○ No Copies are located at _____

Living Will? ○ Yes ○ No Copies are located at _____

Health Care Surrogate Name _____ Copies are located at _____

Do not resuscitate order? ○ Yes ○ No Copies are located at _____

Carries copies in wallet or purse? ○ Yes ○ No *Attach copies with this Personal Information Summary

Has signed an organ/tissue donation card? ○ Yes ○ No

Has been admitted to a hospital within the past five (5) years? ○ Yes ○ No

Reason	Emergency	Hospital (Location)	Date
	No		
	No		
	No		

Has had any surgical procedures (an operation)?

Reason	Name of Surgeon	Hospital (Location)	Date

Presently receiving physical, occupational therapy or speech?

Type of Therapy	Therapist's Name	How Often	Date Started

Presently receiving mental health services?

Type of Services	Physician's Name	How Often	Date Started

The following activity (such as, being overheated) results in seizures:

Certain activities can cause other problems (such as, ear infections). Activity and problem that results:

List preference for performing health and hygiene routines in special ways:

Task Needed	How Performed

List Immunizations:

Name of Immunization	Date	Booster(s) Date
Tetanus and Diptheria		
Measles		
Hepatitis B		
Flu Shot (Influenza)		
Pneumonia (pneumonococcus)		

Provide any special diet requirements:

Special food preparation:

List functions sometimes requiring assistance:

Life Area			Help Needed
Seeing/Vision	○ Normal	○ Normal with Glasses	
	Last Eye Exam		
	Frequency Required		
Hearing	Normal	Normal with Hearing Aid	
	Hypersensitive	Impaired	
	Deaf		
Speech	Normal	Uses Sign Language	
	Impaired	Uses Communication Device	
Mobility	Normal	Wheelchair	
	Special Shoes	Impaired	
	Uses Walker	Uses Artificial Limb	
	Uses other Orthopedic Devices (List)		

Periodic health screenings are an important way to stay healthy. Indicate the most current medical examinations:

Examination	Date	Examination	Date
Mammogram		Dental Checkup	
Vision Check		Blood Pressure Check	
Gynecological Exam, Pap Smear		Annual Physical Checkup	
Hearing Check		Glaucoma (Family history)	
Prostate			

A doctor has recommended that the person have the following special checkups regularly:

Prescribed by	Where Administered	For What Problem	Frequency Required	Duration

Frequency of bowel movement _____

Problems with constipation ○ Yes ○ No Remedy _____

Problems with urination ○ Yes ○ No Remedy _____

Urinary Infections _____ Frequent Urination _____ Bladder Leakage (Frequency) _____

Section E. Benefits and Services

APD Services

Write information about services received from the Agency for Persons with Disabilities

If APD services not yet received, give date APD application submitted _____

APD District _____ Phone # _____

Support Coordinator Name _____

Support Coordinator Mailing Address _____

Support Coordinator Email Address _____

Support Coordinator Work Telephone Number _____

Support Coordinator Emergency Telephone Number _____

Fax _____

Date of Annual Support Plan _____

Remember to attach support plan to the Personal Information Summary

See Next Page For Table - Name And Service Provided By APD

APD Services

Name Of Service Provided Through APD	Service Provider Name	Mailing Address	Telephone	Email	Fax

Attach cost plan and/or I-Budget.

Other Programs and Services

This section deals with government benefits and services provided to the person. Check any that apply. Attach extra pages as needed. Refer to the Financial Section for details regarding funding benefits.

Person is now receiving:

Social Security Benefits as (Select all that apply) ☐ Worker ☐ Dependent

Food Stamps ☐ _____ Housing Assistance ☐ _____ Medicare ☐ _____

Supplemental Security Income (SSI) ☐ _____ Medicaid ☐ _____ Other Benefits _____

Needed services or benefits that have not been provided are:

Name of Service (Benefit) & Agency Name	On Waiting List (Yes/No)
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No
	No

Section E. Other Programs and Services

Write information about services received from government agencies and community resources.

Description Of Services	Source	Contact Person	Mailing Address	Email Address	Work	Telephone / Fax

Section F. Financial Resources

Income

Please list all financial resources available to the person, such as wages, Social Security income (include name of Social Security program), SNAP/Food Stamps, OSS, interest income.

Source of Income	Income Amount	How Often Received

Banking and Brokerage Accounts

Name of Bank or Brokerage Acct.	Name(s) on Account *(Signature Authority)*	Acct. Number	Type *(Savings, Checking, Brokerage)*

Other Assets

Real Estate — Property Value

Personal Property — Property Value

Trusts Where Person Is A Named Beneficiary — Trustee Contact Information

Automobiles — Value

Insurance Policies — Value

Safe Deposit Box — Location

Other

Future Benefits

Is person named as beneficiary of another person's policies or accounts? ○ Yes ○ No

Policy Holder

Name — Address — Phone Number

Insurance Company (Name) — Address — Policy Number

Section G. Decision-Making Assistance

This section describes the financial arrangements that have been made to benefit the person and protect legal rights. Be sure that the names of any financial advisors are included as well as copies of court orders or other legal papers.

Banking Services

Person needs assistance with (circle all that apply):

☐ Banking ☐ Paying Bills ☐ Making Purchases

☐ Counting Money ☐ Recognizing Denominations of Money

List assistance currently in use (such as co-signer on bank account) _____

_____

Power of Attorney

Has this person given a Power of Attorney or Durable Power of Attorney to someone else? ◯ Yes ◯ No

Name of Attorney-in-Fact _____

Address _____

Phone Number _____

_____

Representative Payee

Has Social Security assigned a representative payee? ◯ Yes ◯ No

Name and contact information of the representative payee? _____

_____

Living Will

Has the person signed a living will? ◯ Yes ◯ No

The living will documents are located: _____

_____

Health Care Surrogate Designation/Durable Power of Attorney for HealthCare

Has the person named a Health Care Surrogate or Power of Attorney for Health Care? ◯ Yes ◯ No

What is the name of the Health Care Surrogate/Power of Attorney for Health Care?

_____

Is there an alternate Health Care Surrogate/Power of Attorney for Health Care? ○ Yes ○ No

What is the name of the alternate Health Care Surrogate/Power of Attorney for Health Care?

_____

_____

Medical Proxy

If the person has no health care advance directive and the person cannot make his or her medical decisions, who can serve as medical proxy? (See Planning Ahead Guide, page 92, for list of order of priority.)

_____

_____

Trust

Name of Trust _____

This trust is: Revocable ☐ Special Needs ☐ Irrevocable ☐

Trustees: Names Address(es) Phone Number(s)

Current _____

Successors _____

Copy of the trust can be found at _____

_____

Guardian Advocacy and Guardianship

A guardian or guardian advocate has been appointed (Yes / No)

Type of guardianship: ☐ Plenary Guardian ☐ Limited Guardian ☐ Guardian Advocate

Date of appointment _____ County _____ State _____

Court Case No. _____

A copy of the guardianship court order is located at _____

Name of Guardian _____ Relationship _____

Address _____ Phone Number _____

Name of Guardian Advocate _____ Relationship _____

Address _____ Phone Number _____

Name of Co-Guardian/ Advocate (if any) _____ Relationship _____

Address _____ Phone Number _____

Name areas for which guardian/guardian advocate must give consent:

_____

_____

_____

Has a standby guardian/guardian advocate been appointed? ○ Yes ○ No

Name _____

Address _____

Name and telephone number of attorney who prepared guardianship:

_____

Section H. Final Arrangements

Last Will and Testament

The Person's Personal Representative named in the will:

Name Address

Name of Attorney who prepared will: _____ Phone Number _____

Address _____

A copy of the will is located at: _____

The person is named as a beneficiary in other wills ○ Yes ○ No

Testator(s) Name Address Phone Number

Copy of this will can be found at _____

Life Insurance Coverage

The person is covered by the following insurance policy:

Type of Policy Policy Number Company Address

Life

Other

Identification cards are with

Name Address Phone Number

Premiums are paid by

Name Address Phone Number

Copies of policy(ies) are with

Name Address Phone Number

Awareness of Death

Have you discussed your own death with the person? ○ Yes ○ No
Have you discussed the person's death with him/her? ○ Yes ○ No
Has the person experienced the death of a loved one? ○ Yes ○ No
Has the person experienced the death of a pet? ○ Yes ○ No
Has the person visited a funeral home? ○ Yes ○ No
Has the person visited a cemetery? ○ Yes ○ No
Have you discussed the person's desires regarding organ or tissue donation? ○ Yes ○ No
What are the person's wishes? _____
Any concerns expressed by the person about end-of-life discussions? _____

List the members of the immediate family who have died during the person's lifetime. Indicate their relationships (uncle, grandmother, etc.), and date when each death occured.

Relative who Died	Who told about the death	Date of Death	Attended funeral
			No
			No
			No
			No

How did the person grieve these losses? Descibe their behaviors.

Did the person ever undergo grief counseling? ○ Yes ○ No

Name others who were close to the person and left either to retire, relocate or for other reasons. List these persons and their relationships.

Name Relationship Can be reached at

Funeral Arrangements

Person to contact at time of death:

Name Address Phone Number Relationship
(Personal, co-worker, neighbor, other)

_____

_____

_____

Funeral and burial arrangements have been made ○ Yes ○ No

If prepaid, policies/contracts can be found _____

Preferred funeral company _____

Address _____ Phone Number _____

BURIAL:

Burial Plot Purchased ○ Yes ○ No Headstone/Marker ○ Yes ○ No

Type of Marker preferred and epitaph _____

Cemetery/Mausoleum Name _____

Address _____ Other _____

CREMATION:

Burial /Interment of Ashes Scattering of Ashes

Ashes are to be scattered at: _____

Memorial Service? ○ Yes ○ No Location _____

Special content of service ○ Yes ○ No Describe _____

_____

Flowers? ○ Yes ○ No Memorial donations can be made to: _____

Songs to be played _____

_____

Invite these persons to the service

_____

_____

_____

_____

_____

Preferred Clergy/Eulogist _____ Phone Number _____

Address _____

Section I. A Day In The Life Of...

A DAY IN THE LIFE OF (Name) _____

Arises at _____(AM) _____

List morning medications _____

Needs assistance with: ☐ Hygiene ☐ Dressing ☐ Grooming

Prefers ○ Shower ○ Bath Taken _____ (PM)_____ (AM)

Aids or appliances used to get around include (Select all that apply):

☐ Braces ☐ Special Shoes ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Positioning Aids

Other _____

Uses: ☐ Eyeglasses ☐ Contact Lens ☐ Hearing Aids

☐ Telecommunication Devices (TDD) ☐ Communication Board

Other Communication Devices _____

Able to eat without help ○ Yes ○ No If No, needs help with _____

☐ Special Plate ☐ Special Utensils ☐ Special Cup ☐ Straw

Has problems with choking ○ Yes ○ No

Dietary Restrictions:

Is able to drink: Thin Liquids _____

Thickened Liquids _____

Usually ready to start the day at _____ (AM) By going to _____

_____

Transported by _____

_____

Bedtime Preparation

List bedtime medications _____

_____

List any routine activities performed at bedtime _____

Usual bedtime _____ (PM) Is there a quiet time/meditation ○ Yes ○ No If Yes, describe

_____

_____

Help needed getting to sleep ○ Yes ○ No Describe sleep pattern (how well, how long usually sleeps)

_____

_____

Use of CPAP or BPAP? _____

_____

A DAY IN THE LIFE OF (Name) _____ **(cont.)**

Safety Precautions

Can the person be left unsupervised? ◯Yes ◯No

For how long? _____ (Minutes) _____ (Hours) _____ (Days)

Recognizes danger of (Select all that apply): ☐Heat Sources ☐Poisonous Materials

☐ Electricity ☐Open Windows ☐Sharp Objects ☐Water ☐Traffic ☐ Strangers

Can evacuate building on hearing alarm? ◯Yes ◯ No

Needs physical/verbal prompt to evacuate building? ◯Yes ◯ No

Likes and Dislikes

Favorite People to live with:

Name Address Phone Number

Favorite People to spend time with:

Name Address Phone Number

Favorite Pets:

Name Type

Favorite Color _____

Favorite clothing or possessions:

Clothing Possessions

A DAY IN THE LIFE OF (Name) _____ **(cont.)**

Favorite foods, drinks, restaurants:

Foods Drinks Restaurants

Recipe for favorite food may be found _____

Favorite recreation

TV Shows Movies Music Sports Hobbies

Others

When is the person most happy? _____

Dislikes living with _____

Dislikes spending time with _____

Disliked pets Name Type

Disliked clothing/possessions Clothing Possessions

Disliked recreation

TV Shows Movies Music Sports Hobbies

Others

A DAY IN THE LIFE OF (Name) _____ **(cont.)**

Do violent or sexually suggestive TV, movies, music, sports activities lead to behavior problems? (Yes / No)

When has the person been most unhappy?

_____

_____

_____

Fears and Phobias

Afraid of ☐ Strange People ☐ Enclosed Spaces ☐ Buses ☐ Animals

☐ Open Spaces ☐ Loud Noises ☐ Heights ☐ The Dark

☐ Cars Other _____

Comments

_____

_____

_____

Special Occasions

Special dates usually observed _____

_____

Holidays observed _____

Recognizes the special dates of others:

Name	Occasions	Date

Usually buys cards ○ Yes ○ No Attends Party ○ Yes ○ No

Usually buys gifts ○ Yes ○ No Price Range $_____ - $_____

Social and Recreational Activities

Activities enjoyed: ☐ Arts&Crafts ☐ Fishing ☐ Visiting Neighbors

☐ Senior Center Activities ☐ Community Outings ☐ A Hobby ☐ Sporting Activities

☐ Movies/Concerts ☐ Going to Recreation Parks ☐ Specialized Camps ☐ Shopping

Other _____

_____

Describe current social and recreational activities: _____

_____

A DAY IN THE LIFE OF (Name) _____ **(cont.)**

Vacations and Travel

Travel Enjoyed (Select all that apply):
Specialized Camps ☐ Group Day Trips ☐
Going on Vacation ☐ Visiting Family/Friends ☐
Other _____

_____

Travel Enjoyed by (circle all that apply): Car ☐ Bus ☐ Train ☐
Plane ☐ Boat/Ship ☐

Usual travel companion is _____

Favorite vacation destinations _____

_____

_____

_____

Frequency of trips _____ Planned by _____

Unpleasant vacation experiences in the past _____

_____

_____

_____

Has spending money for vacation? ○ Yes ○ No Amt. range $_____ - $ _____

Section J. Key Family and Friends

Spouse's Information

Directions: Write information about the person with a disability's spouse.

Spouse's Legal Name _____

Address, if different than the person's: _____

_____

Date of Birth: _____

Telephone: Home _____ Work _____ Mobile _____

Email Address _____

Citizen Status _____

Social Security No. _____ Medicare No. _____

Military Status and Date of Discharge, if applicable _____

Date of Marriage _____ Date of Divorce _____

Parents Information

Directions: Write information about the person with a disability's parents.

Mother's Legal Name _____

Mother's Maiden Name _____ Name at time of Person's Birth _____

Mother's Date of Birth _____ Mother's Place of Birth _____

Mother's Current Address _____

Mother's Current Home Telephone Number _____

Work Telephone Number _____ Mobile Telephone Number _____

Mother's Email Address _____

Mother's U.S. Citizenship Status _____

Mother's Social Security Number _____ Mother's Medicare Number _____

Mother's Military Status and Date of Discharge, if applicable _____

If Deceased, Date and Place _____

Date of Marriage _____ Date of Divorce _____

Date Retired _____ Source of Any Retirement Benefits _____

Mother's Blood Type AB- _____

Current primary caregiver ○ Yes ○ No _____

Father's Legal Name _____

Father's Date of Birth _____ Father's Place of Birth _____

Father's Current Address _____

Father's Current Home Telephone Number _____

Work Telephone Number _____ Mobile Telephone Number _____

Father's Email Address _____

Father's U.S. Citizenship Status _____

Father's Social Security Number _____ Father's Medicare Number _____

Father's Military Status and Date of Discharge, if applicable _____

If Deceased, Date and Place _____

Date of Marriage _____ Date of Divorce _____

Date Retired _____ Source of Any Retirement Benefits _____

Father's Blood Type AB- _____

Current primary caregiver ○ Yes ○ No _____

Other Caregivers

If current primary caregiver is not a parent, write current primary caregiver information here.

Legal Name _____

Current Address _____

Work _____ Home _____ Mobile _____

Email Address _____

Drivers License Number _____

Responsibilities _____

Other Important Individuals

List relatives who are emotionally closest to the person:

Name	Address	Phone No.	Email	Relationship

List other relatives who know and care about the famly member:

Name	Address	Phone No.	Email	Relationship

List special friends who are well known and liked by the person:

Name	Address	Phone No.	Email	Relationship/Length of Relationship (Personal, co-worker, neighbor, other/ years)

The following individual(s) has at times been an advocate helping get needed services and supports:

Name	Address	Phone No.	Email	Relationship (Personal, co-worker, neighbor, other)

Has a circle of friends (Organized Social Group) ○ Yes ○ No

Name of organized social group _____

Contact person _____

Address _____

Phone Number _____

Frequency of Meetings _____ ☐ Weekly _____ ☐ Monthly _____ Other

Other _____

ADDITIONAL NOTES

Florida
Developmental
Disabilities
Council

124 Marriott Drive, Suite 203 | Tallahassee, FL 32301
(850)488-4180 | (800) 580-7801 | Fax (850) 922-6702 | TDD (888) 488-8633

www.fddc.org