GRANTOR OBJECTIVES & BENEFICIARY PROFILE

Empowering individuals with disabilities to live their fullest life. John 10:10

CONFIDENTIAL INFORMATION: Please help us get to know the Beneficiary to ensure we administer the trust to meet his/her financial and medical needs. Please complete the information in as much detail as possible. It is recommended that this information be updated annually or as needed.

VISION FOR THE TRUST
Grantor's Vision Please describe your goals and how you foresee the trust meeting the needs of the Beneficiary.
_____ _____ _____ _____ _____ _____ _____ _____ _____

FAMILY AND IMPORTANT CONTACTS			
Family Members			
Mother:			
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Father:			
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Sibling:			
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Sibling:			
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:

The Full Life Center, Inc.
349 E. High Ave., New Philadelphia, Ohio 44663
Phone: (330) 343-0008 Fax: (330) 602-2822 Email: office@TheFullLifeCenter.org
www.thefulllifecenter.org

Other Important Contacts			
Name:		Relationship to Beneficiary:	
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Name:		Relationship to Beneficiary:	
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Name:		Relationship to Beneficiary:	
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:
Name:		Relationship to Beneficiary:	
Primary Phone:	Email Address:		
Address:			
City:		State:	Zip:

MEDICAL INFORMATION

Nature of Disability

Please describe the Beneficiary's medical condition and primary diagnosis.

Special Needs and Instructions

Identify any treatments or special care that the Beneficiary must receive at home or in a medical setting, including assistance with medication.

Medical or Adaptive Equipment Used by the Beneficiary

Drug or Food Allergies

Medical Professionals List the primary physician, dentist, therapists, and specialists responsible for the Beneficiary's medical care.			
Primary Physician:			
Phone Number:	Email Address:		
Address:			
City:		State:	Zip:
Dentist:			
Phone Number:	Email Address:		
Address:			
City:		State:	Zip:
Other Professional:			
Phone Number:	Email Address:		
Address:			
City:		State:	Zip:
Other Professional:			
Phone Number:	Email Address:		
Address:			
City:		State:	Zip:

BENEFICIARY INSURANCE INFORMATION				
Type of Insurance	**Company Name**	**Policy Number**	**Contact Name**	**Phone Number**
Health: Medicaid ☐Y ☐N Medicare ☐Y ☐N Other ☐Y ☐N				
Dental				
Vision				
Prescription				
Life				
Other				

PERSONAL INFORMATION ABOUT THE BENEFICIARY

Please share any relevant information about the Beneficiary's needs and preferences that will help in administering this trust.

Personal Characteristics

Please describe the following characteristics about the Beneficiary.

Personality:

Likes:

Dislikes:

Daily routine:

Religious preference:

Important holidays or traditions:

Favorite places:

Pets:

Friends:

Personal Care

Please check the tasks the Beneficiary may need assistance to complete.

☐ Dressing ☐ Hair Care ☐ Using the toilet ☐ Shaving
☐ Bathing ☐ Meal Preparation ☐ Other: _____

Special Instructions:_____
_____

Personal Equipment

☐ Cell Phone ☐ Assistive Technology ☐ Television, DVD Player
☐ Computer ☐ Stereo, iPad ☐ Other: _____

Transportation

Public Transportation:

☐ Can use public transportation: ☐ Without Supervision ☐ With Supervision
☐ Not able to use public transportation

☐ Beneficiary may choose to own or operate his/her own vehicle
☐ Beneficiary may need someone to transport them to appointments and community activities

Special Instructions:_____
_____

Activities

Please indicate any specific interests of the Beneficiary that the trust may support in the future.

☐ Sports and related activities ☐ Sporting events
☐ Membership to a gym ☐ Camps or community outings
☐ Music lessons or attending concerts ☐ Movies
☐ Amusement parks and museums ☐ Other: _____

Travel

☐ Vacation with family or friends
☐ Travel to visit family or friends
☐ Other:_____
Is supervision or a companion required for outings or activities? ☐ Yes ☐ No

EDUCATION AND EMPLOYMENT INFORMATION

Education or Training Programs

Dates Attended	School or Facility	Program

Does the Beneficiary have issues that may limit his/her ability to participate in school or work? ☐ Yes ☐ No
If yes, please describe: _____

Do you anticipate the Beneficiary using Trust funds for educational purposes? ☐ Yes ☐ No
If yes, please describe: _____

Employment and Volunteerism Experience

Please describe previous or current work/volunteer experience.

Dates Worked / Volunteered	Employer/Organization	Position

The Beneficiary is capable of:

- ☐ Self-support through employment
- ☐ Partial self-support through employment
- ☐ In need of education or training to be self-supporting through employment
- ☐ Incapable of self-support through employment