

FAMILY  
HEALTH  
COMMUNITY

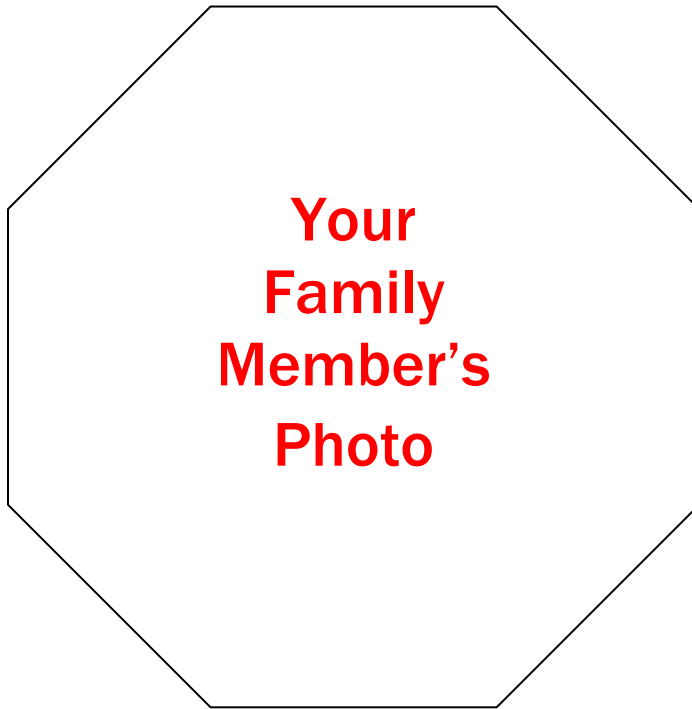
**F**  **tp**rints for  
**the Future**™

*A Personal Planning Manual*

EDUCATION  
HISTORY  
SUPPORT  
EMPLOYMENT



Unlike footprints in the sand, which the waves wash away, this document leaves footprints for the future. These special footprints leave a trail of where we have been to guide those who will follow us. This ensures the future for those we love.



**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Prepared by:** \_\_\_\_\_

**When this document is updated, don't forget to give new copies to:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## A LETTER TO YOU

If you are reading this, you love someone who needs you. My son, Jonathan, was born in 1979 with Down syndrome and four heart defects known collectively as Tetralogy of Fallot. He wears hearing aids, has sleep apnea, has had open heart surgery three times and has an implantable defibrillator.

Jon is also a high school graduate, attended community college and is an accomplished athlete. He has been inducted into the National Jewish Sports Hall of Fame. He has his own home, a great job and many friends and a loving family. Jon is also afraid of the dark, drinks lots of diet soda, loves wrestling, listens to an iPod, likes to travel, go to the movies and eat in restaurants. As Jon increased his independence I worried about him a lot. I worry about all the information only I know. What would happen if I were gone? Who would know his medical record numbers and where the records were? Who would know all his benefit and staffing information? Who would remember to have night lights everywhere and flashlights handy? Who would make sure he had an ample supply of soda or transfer his new CD's to his iPod? The worries went on and on. I needed to address my worries and that is why we created **Footprints for the Future**.

**Footprints for the Future** is a personal planning tool that provides a place for you to record specific and personal information about your loved one.

We developed this so I could sleep more easily at night, comfortable in the knowledge that important information would be available to future caregivers and to the people who currently support Jonathan.

We wanted this document to be inviting, complete and easier than the other products that were available. We also wanted families and caregivers to have free access to it and be able to make changes easily. This downloadable MS Word document available at <http://www.thearmac.org/resources12.html> can be saved onto your computer. Once downloaded any changes you make in the future can be saved.

This work would not be possible without Jonathan who is and continues to be my greatest teacher.



20 GOULD STREET  
READING, MA 01867  
[www.thearmac.org](http://www.thearmac.org)

**Jo Ann Simons, MSW**  
**Executive Director**  
**The Arc of East Middlesex**

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## Personal Information

Today's date: \_\_\_\_\_

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Address (Street & Number)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Passport Number

( ) - \_\_\_\_\_  
Home Phone

( ) - \_\_\_\_\_  
Cell Phone

( ) - \_\_\_\_\_ ext.  
Work Phone

( ) - \_\_\_\_\_  
Fax Number

( ) - \_\_\_\_\_  
Other Phone

\_\_\_\_\_  
E-mail

US Citizen

Yes

No

Registered to Vote

Yes

No

Registered Selective Service:

Yes

No

\_\_\_\_\_  
Height

\_\_\_\_\_  
Weight

\_\_\_\_\_  
Hair Color

\_\_\_\_\_  
Eye Color

\_\_\_\_\_  
Medicaid Number

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_  
Spouse name if applicable

## Personal Information

*Mother*

Name			Date of Birth		
Home Address (Street & Number)			( ) -		
City State Zip			Home E-mail		
( ) -	( ) -	( ) -			
Cell Phone	Other Phone	Home Fax			
Employer Name					
Employer Address					
( ) - ext.	( ) -	Work e-mail			
Work Phone	Work Fax				
Health Concerns / Conditions:					

## Personal Information

*Father*

Name			Date of Birth		
Home Address (Street & Number)			( ) -		
City State Zip			Home E-mail		
( ) -	( ) -	( ) -			
Cell Phone	Other Phone	Home Fax			
Employer Name					
Employer Address					
( ) - ext.	( ) -	Work e-mail			
Work Phone	Work Fax				
Health Concerns / Conditions:					

Use "Extended Family and Friends Worksheet" on page 27 to identify siblings, relatives and other important people in your family member's life.



## Disability Information

Primary Diagnosis	Cause (if known)
Secondary Diagnosis	Cause (if known)

## Hospitalizations/Major Illnesses

Condition	Age at Onset	Treatment/Medication	On-going	Resolved
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Use "Additional Hospitalizations Worksheet" to list any other major hospitalizations.

## Other Chronic Health Conditions

Condition	Age at Onset	Treatment/Medication	On-going	Resolved
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

## Insurance Information

Primary Health Insurance Company	Subscriber Number ( ) - ext.
Address	Phone
Subscriber	
Secondary Health Insurance Company	Subscriber Number ( ) - ext.
Address	Phone
Subscriber	
Medicare Number	( ) - ext.
Address of Office	Phone
Case Manager	
Medicaid Number	( ) - ext.
Address of Office	Phone
Case Manager	
Dental Health Insurance Company	Subscriber Number ( ) - ext.
Address	Phone
Subscriber	
Prescription Drug Insurance Company	Subscriber Number ( ) - ext.
Address	Phone
Subscriber	



---

Vision Health Insurance Company

---

Address

---

Subscriber

---

Subscriber Number

( ) - *ext.*

---

Phone

---

Other Health Insurance Company

---

Address

---

Subscriber

---

Subscriber Number

( ) - *ext.*

---

Phone

---

Other Health Insurance Company

---

Address

---

Subscriber

---

Subscriber Number

( ) - *ext.*

---

Phone

# Current Physicians

## Primary Care Physician

Name		Hospital or Clinic		
Street Address ( ) - <i>ext.</i>		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

## Dentist

Name		Hospital or Clinic		
Street Address ( ) - <i>ex.</i>		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

## Specialist (Type: )

Name		Hospital or Clinic		
Street Address ( ) - <i>ex.</i>		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

## Specialist (Type: )

Name		Hospital or Clinic		
Street Address ( ) - <i>ex.</i>		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

**Specialist (Type:            )**

Name		Hospital or Clinic		
Street Address (    ) - <i>ex.</i> (    ) -		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

**Specialist (Type:            )**

Name		Hospital or Clinic		
Street Address (    ) - <i>ex.</i> (    ) -		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

**Specialist (Type:            )**

Name		Hospital or Clinic		
Street Address (    ) - <i>ex.</i> (    ) -		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

**Specialist (Type:            )**

Name		Hospital or Clinic		
Street Address (    ) - <i>ex.</i> (    ) -		City	State	Zipcode
Phone	Fax	e-mail address		
Tests and/or Frequency of Visits:				

**Use “Additional Physicians Worksheet” if you need to document more medical professionals.**

## Pharmacy and Hospital Information

### Pharmacy

Name	( ) -	Telephone		
Fax	( ) -	e-mail		
Street Address		City	State	Zip Code

### Pharmacy

Name	( ) -	Telephone		
Fax	( ) -	e-mail		
Street Address		City	State	Zip Code

### Regional or Specialized Hospital

Name		Medical Record Number		
Address	( ) -	City	State	Zip Code
Phone		Fax		

### Local Hospital

Name		Medical Record Number		
Address	( ) -	City	State	Zip Code
Phone		Fax		

**Allergies (Food, Medicine, Substances)**

Allergy to	Reaction	Treatment

**Intolerance (Food, Medicine, Substances)**

Intolerance to	Reaction	Treatment

# Medicines

## Prescription and Non-Prescription

Medicine	Condition	Dosage	Doctor's Name / Phone Number	Start/End Date	Comments/Side Effects
<b>COMMENTS:</b>					

Attach extra pages as needed

\*Adapted from Planning Ahead, Florida Developmental Disabilities Council, Inc. 2002

## Service Providers/Agencies

Primary State Agency / School District

Email

( ) - *ext.*

Street Address

Phone

( ) -

City

State Zip

Fax

Contact Person / Title

Supervisor or Director

Services received:

Comment or other information:

**Residential**

( ) - - *ext.*

Telephone

( ) - -

Fax

**Contact**

Address

City

State

E-mail

Services Received:

Comment or other information:



---

**Day/Employment/Program**  
( ) - - *ext.*

---

Telephone  
( ) - -

---

Fax

---

---

**Contact**

---

Address

---

City State

---

E-mail

Services Received:

Comment or other information:

---

**Family Support**  
( ) - - *ext.*

---

Telephone  
( ) - -

---

Fax

---

---

**Contact**

---

Address

---

City State

---

E-mail

Services Received:

Comment or other information:

---

**Transportation**

( ) - - *ext.*

---

Telephone

( ) - -

---

Fax

---

E-mail

Services Received:

Comment or other information:

---

**Personal Care**

( ) - - *ext.*

---

Telephone

( ) - -

---

Fax

---

E-mail

Services Received:

Comment or other information:

---

**Contact**

---

Address

---

City

State

---

**Contact**

---

Address

---

City

State

---

**Fiscal Intermediary**  
( ) - - *ext.*

---

Telephone  
( ) - -

---

Fax

---

E-mail

---

**Contact**

---

Address

---

City State

Services Received:

Comment or other information:

---

**Education**  
( ) - - *ext.*

---

Telephone  
( ) - -

---

Fax

---

E-mail

---

**Contact**

---

Address

---

City State

Services Received:

Comment or other information:

<b>Other</b> ( ) - - <i>ext.</i>	<b>Contact</b>
Telephone ( ) - -	Address
Fax	City State

E-mail

Services Received:

Comment or other information:

<b>Other</b> ( ) - - <i>ext.</i>	<b>Contact</b>
Telephone ( ) - -	Address
Fax	City State

E-mail

Services Received:

Comment or other information:

## Employment History (include volunteer positions)

Jobs held (begin with first job)					
Employer / Address / Phone	Job Title	Start/End Salary	Reason Left	Supports Required	Start/End Dates

Attach extra pages as needed. \*Adapted from Planning Ahead, Florida Developmental Disabilities Council, Inc. 2002

## Benefits

---

### Social Security (SSI, SSDI) Office

---

### Address

---

Contact

( ) - *ext.*

---

Phone

Benefits Received:

---

City

State Zip Code

---

( ) -

---

Fax

---

Other Information (recertification, etc):

---

---

### Section 8

---

### Address

---

Contact

( ) - *ext.*

---

Phone

Benefits Received:

---

City

State Zip Code

---

( ) -

---

Fax

---

Other Information (recertification, etc):

---

---

### Food Stamps

---

### Address

---

Contact

( ) - *ext.*

---

Phone

Benefits Received:

---

City

State Zip Code

---

( ) -

---

Fax

---

Other Information (recertification, etc):

---

---

**Transportation**

---

Contact

---

( ) - *ext.*

---

Phone

---

Benefits Received:

---

Other Information (recertification, etc):

---

---

**Address**

---

City

---

State Zip Code

---

( ) -

---

Fax

---

**Other**

---

Contact

---

( ) - *ext.*

---

Phone

---

Benefits Received:

---

Other Information (recertification, etc):

---

---

**Address**

---

City

---

State Zip Code

---

( ) -

---

Fax

---

**Other**

---

Contact

---

( ) - *ext.*

---

Phone

---

Benefits Received:

---

Other Information (recertification, etc):

---

---

**Address**

---

City

---

State Zip Code

---

( ) -

---

Fax



## Community Services/Supports

(Religious, Recreation, Arts, Special Olympics, etc.)

Name of Organization	Address
Contact ( ) - ext.	City State Zip Code ( ) -
Phone	Fax
Participation:	
Other Information:	

Name of Organization	Address
Contact ( ) - ext.	City State Zip Code ( ) -
Phone	Fax
Participation:	
Other Information:	

Name of Organization	Address
Contact ( ) - ext.	City State Zip Code ( ) -
Phone	Fax
Participation:	
Other Information:	

---

<b>Name of Organization</b>	<b>Address</b>
<hr/>	<hr/>
Contact ( ) - <i>ext.</i>	City State Zip Code ( ) -
Phone	Fax
Participation:	
<hr/>	
Other Information:	
<hr/>	

---

<b>Name of Organization</b>	<b>Address</b>
<hr/>	<hr/>
Contact ( ) - <i>ext.</i>	City State Zip Code ( ) -
Phone	Fax
Participation:	
<hr/>	
Other Information:	
<hr/>	

---

<b>Name of Organization</b>	<b>Address</b>
<hr/>	<hr/>
Contact ( ) - <i>ext.</i>	City State Zip Code ( ) -
Phone	Fax
Participation:	
<hr/>	
Other Information:	
<hr/>	

## Legal & Financial Information

Representative Payee Name	Address
e-mail	City State Zip Code
( ) - Home Phone	( ) - Fax
( ) - <i>ext.</i> Work Phone	( ) - Cell
<b>Successor Rep Payee</b>	( ) - Phone

Power of Attorney	Address
e-mail	City State Zip Code
( ) - Home Phone	( ) - Fax
( ) - <i>ext.</i> Work Phone	( ) - Cell
<b>Successor Power of Attorney</b>	( ) - Phone

Health Care Proxy	Address
e-mail	City State Zip Code
( ) - Home Phone	( ) - Fax
( ) - <i>ext.</i> Work Phone	( ) - Cell
<b>Successor Health Care Proxy</b>	( ) - Phone

---

**Authorization to Advocate**

---

e-mail

---

( ) -  
Home Phone

---

( ) - *ext.*  
Work Phone

---

**Successor Advocate**

---

**Name of Trust**

---

Type of Trust

---

Successor of Trustee

---

**Life/Burial Insurance**

---

Company

---

Contact

---

**Financial Planner**

---

Company

---

Contact

---

**Address**

---

City State Zip Code

---

( ) -  
Fax

---

( ) -  
Cell

---

( ) -  
Phone

---

**Trustee**

---

Address

---

Location of copy of trust

---

**Policy Number**

---

Address

---

( ) - *ext.*  
Phone

---

**Account Number**

---

Address

---

( ) - *ext.*  
Phone

---

**Insurance Agent**

---

Company

---

Contact

---

**Policy Number**

---

Address

---

( ) - *ext.*

---

Phone

---

**Accountant/Tax Assistance**

---

Company

---

Contact

---

**Account Number**

---

Address

---

( ) - *ext.*

---

Phone

## *Map to Important Papers*

Health Insurance Cards

Location: \_\_\_\_\_

Social Security Card

Location: \_\_\_\_\_

Bank Books/Statements

Location: \_\_\_\_\_

Life Insurance/Wills

Location: \_\_\_\_\_

Birth Certificate

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

\_\_\_\_\_

Location: \_\_\_\_\_

# Final Arrangements

Persons to contact at time of death:			
NAME	ADDRESS		PHONE NUMBERS
			( ) - ( ) -
			( ) - ( ) -
			( ) - ( ) -
Funeral and burial arrangements have been made:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Prepaid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Burial plot purchased:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Headstone/Marker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Marker preferred and epitaph:		If prepaid, policies, contracts can be found:	
Cemetery/Mausoleum Name:	Address		Phone Number
			( ) -
Preferred funeral company (if applicable):			
Name		Address	Phone Number
			( ) -
Cremation:			
Ashes Given to:	Name :		Address :
Memorial Service:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Special content:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
Flowers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specified donations:	
Songs to be played:			
Invite these persons to the service:			
Preferred Clergy/Eulogist	Address		Phone Number
			( ) -
			( ) -

Attach extra pages as needed.

\*Adapted from Planning Ahead, Florida Developmental Disabilities Council, Inc. 2002



## Friends and Extended Family

These are the people who know and understand the best interests of your family member and that could be helpful and supportive.

<hr/>			<hr/>	
<b>Name</b>			<b>Relationship</b>	
<hr/>			<hr/>	
Address			Home Phone ( ) -	
<hr/>			<hr/>	
City	State	Zip Code	Home Fax ( ) -	Cell Phone ( ) -
<hr/>			<hr/>	
Email			Additional Information	
<hr/>			<hr/>	

<hr/>			<hr/>	
<b>Name</b>			<b>Relationship</b>	
<hr/>			<hr/>	
Address			Home Phone ( ) -	
<hr/>			<hr/>	
City	State	Zip Code	Home Fax ( ) -	Cell Phone ( ) -
<hr/>			<hr/>	
Email			Additional Information	
<hr/>			<hr/>	

<hr/>			<hr/>	
<b>Name</b>			<b>Relationship</b>	
<hr/>			<hr/>	
Address			Home Phone ( ) -	
<hr/>			<hr/>	
City	State	Zip Code	Home Fax ( ) -	Cell Phone ( ) -
<hr/>			<hr/>	
Email			Additional Information	
<hr/>			<hr/>	

<hr/>			<hr/>	
<b>Name</b>			<b>Relationship</b>	
<hr/>			<hr/>	
Address			Home Phone ( ) -	
<hr/>			<hr/>	
City	State	Zip Code	Home Fax ( ) -	Cell Phone ( ) -
<hr/>			<hr/>	
Email			Additional Information	
<hr/>			<hr/>	

# Likes and Dislikes

## Likes

Favorite foods, drinks, restaurants:

Favorite TV shows, movies, sports, hobbies, etc:

Favorite clothing or possessions (include styles, patterns, preferred fastners, etc):

Provide clothes/shoe sizes:

Favorite destinations:

Favorite friends:

Favorite staff:

Other favorites (pets, colors, etc.)

## Dislikes

People:

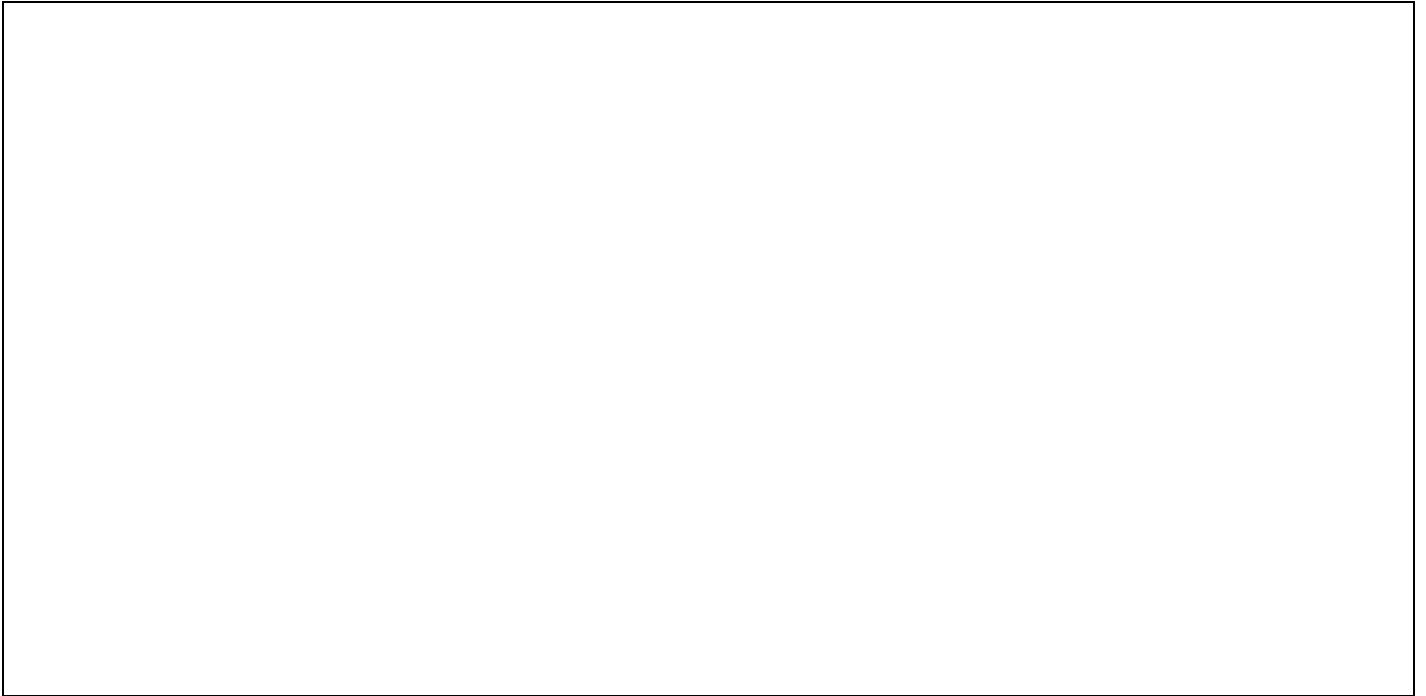
Animals:

Clothing:

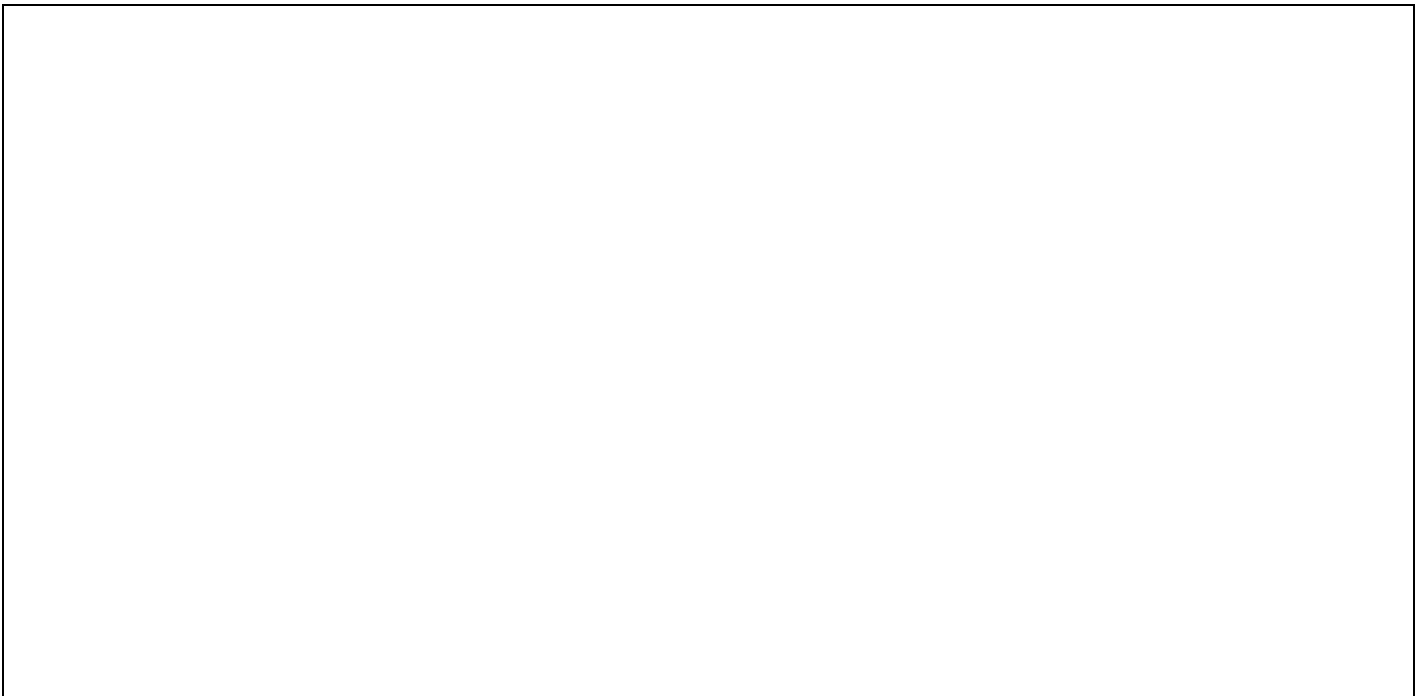
Fears (the dark, loud noises, heights, etc)

**Other likes/dislikes not yet mentioned:**

## ***Significant Behaviors***



## ***Issues And Ways To Resolve***



# Daily Routines

---

Shaving

---

Bathing/Showering/Toileting

---

Oral hygiene, dental care

---

Dressing

---

Toileting

---

Menstrual care (if appropriate)

---

Eating/cooking

---

Housekeeping

---

Shopping

---

Budgeting

---

Sleeping /Nap patterns

---

Communication

---

Mobility

---

Hearing/speech

---

Vision

---

Adaptive Equipment

---

Other

## ***Making a Life***

Here is an opportunity to provide some details about a typical day in the life of your family member.

**Wakes up at:** a.m. and

**Has breakfast at** a.m. and

**Goes to school / work at:** a.m. and

**Other activities**

**Has dinner at:** p.m. and

**Gets ready for bed at:** p.m. and

**Any other information:**

## *Having a Life*

This is where you can let others know about your family member's personality, ability, skills, hobbies and special interests. Don't forget to include what kind of environment is preferred.



# Monthly Calendar

January	February	March	April

May	June	July	August

September	October	November	December

Comment:

--

## ***Author Biography***

### **Jo Ann Simons, MSW**

Jo Ann Simons is Executive Director of The Arc of East Middlesex. She is currently on the Boards of the Association of Developmental Disability Providers, the National Down Syndrome Society and LIFE, Inc, and a consultant to the Healthy Athletes program of Special Olympics, Inc. She previously was President of the National Down Syndrome Congress and a Board Member of Special Olympics, Inc.

Jo Ann addresses audiences around the country and throughout the world on topics such as transition, employment, housing, post-secondary programs and independent living in addition to the Personal Life Planning. Jo Ann has received the Human Rights Award from the Massachusetts Department of Mental Retardation, Outstanding Advocacy Award from the National Down Syndrome Society and service awards from the National Down Syndrome Congress.

Jo Ann is a graduate of Wheaton College (MA), and the University of Connecticut's School of Social Work. She and her husband, Chet Derr, live in Swampscott, MA. Their son Jon, who has Down syndrome and is Jo Ann's best teacher lives, independently on Cape Cod. Their daughter Emily reminds her that being "typical" is special, too.

Jo Ann put off writing the Footprints for the Future plan for too long and is committed to helping others get theirs done.

Jo Ann Simons

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