

SPECIAL NEEDS TRUST FOUNDATION

Information Sheet

Person with Special Needs:		
Name	SSAN:	
Residence Address	Tel #	
City	State	Zip
Residential Provider:		
Name:	Tel#:	
Resident Type	Comments	
<input type="checkbox"/> Group Home	_____	
<input type="checkbox"/> Board & Care	_____	
<input type="checkbox"/> Residential/Nursing Home	_____	
<input type="checkbox"/> Independent Living	_____	
<input type="checkbox"/> With Family or Relative	Who? _____	
<input type="checkbox"/> Other Describe	_____	
Date entered this residence	YRS _____	

Special Needs Trust Foundation Contact		Named in Joinder
Assigned Agency		
Access To Independence		
Arc San Diego		
Community Catalysts		
Community Options		
Developmental Services Continuum		
Home of Guiding Hands		
NAMI San Diego		
Sharp Healthcare Foundation		
St. Madeleine Sohpie's Center		
United Cerebral Palsy Assoc. SD		
Unyeway		
Vista Hill Foundation		

Medical Insurance Type/Name		Tel#
Dental Insurance Type/Name		Tel#
Other Insurance Coverage Type/Name		Tel#

SSI/SSA Income (Describe)	
Trust and/or Other Income (Describe)	
Name of Social Security Rep/Payee	Tel#
Name of Regional Center (if Eligible):	Tel#
Case Manager and Unit Assigned	
Other Agencies providing services	Tel#
Type of Services and Contact Person	

DISABILITY/DIAGNOSIS (Use Additional Sheet(s) if necessary)	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Personal Physician(s)	Specialty	Tel#
_____	_____	_____
_____	_____	_____
_____	_____	_____
Hospital Preferred	Address	Tel#
_____	_____	_____

Method(s) or Source(s) of Funding (list all that apply)	Est. Value \$ _____
1. Current Funding (Assets described in Attachment "A")	\$ _____
2. Future Funding via Donors:	
Will	\$ _____
Living Trust	\$ _____
Life Insurance	\$ _____
Other	\$ _____