SHARED HORIZONS
ENHANCING LIVES, PROTECTING FUTURES

QUALITY OF LIFE PLAN

Date of Meeting: _____ (mm/dd/yyyy)

Participants/Attendees:

Beneficiary Information:

Name: _____ (Last, First)
DOB: _____ (mm/dd/yyyy)
SS#: _____ (xxx-xx-0000 Last 4 Digits)
Address: _____
_____
_____

Type of Residence:

❑ Independent (Self, Family)	❑ Group Home	❑ Assisted Living	❑ Nursing Home

Phone: _____ (Format: (xxx) xxx-xxxx) **Email:** _____

Benefits:

❑ SSI (Amount: $_____/mo)	❑ Medicaid (Amount: $_____/mo)	❑ Medicare (Amount: $_____/mo)	❑ SSDI (Amount: $_____/mo)
❑ Housing (Amount: $_____/mo)	❑ Other (Amount: $_____/mo)		

Primary Contact: _____ (Last, First)

Circle of Support (Authorized representative, family, friends, people who know you best)
Who are the critical members of your circle of support? Are they present?

Name	Relationship	Contact Information	Present? Yes or No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

What are the individual's current disabilities and/or diagnosis?

Type of Disability(check each that apply)			
❑ ADHD	❑ Blindness	❑ Chronic Neurological Disorder	❑Speech/Language Disability
❑ Dementia	❑Hearing Impaired	❑ Cerebral Palsy	❑ Specific Learning Disability
❑ Depression	❑ Intellectual Disability	❑ Muscular Dystrophy	❑ Cardiopulmonary Diseases
❑ Bipolar	❑Autism Spectrum Disorder	❑ Multiple Sclerosis	❑ Locomotor Disability (i.e. Polio, paralyzes, etc..)

Other Disabilities and/or Diagnoses:

Does the individual require assistance with activities of daily living (ADLs)?

Type of Disability(check each that apply)			
❑ Bathing	❑ Toileting	❑ Eating	❑ Medication Reminders/Administration
❑ Mobility(transfers to/from bed, chair, toilet)	❑ Oral Care	❑ Grooming	❑ Incontinence ❑ urine ❑ bowel ❑ both

Use of Assistive Devices:

Type of Device(check each that apply)			
❑ Cane/Walker	❑ Glasses/Contact Lenses	❑ Gheri Chair	❑ Prosthetic (i.e.: arm, leg, eye, etc..)
❑ Wheelchair	❑ Dentures ❑ Upper ❑Lower ❑Both	❑ Hoyer Lift	❑ Hospital Bed
❑ Corrective shoes	❑ Hearing Aid	❑	❑

Other Assistive Devices:

Other Discussion items:

Questions:	Details/Notes:
Resident Background	
Hobbies & Activities	
Spiritual needs	
Daily Routine	
Participation in outside programs	
Transportation	❑ Travels independently, all modes of transportation ❑ Needs some assistance/escort ❑ Complete assistance/needs specialized vehicle
Finances	❑ Independent ❑ Legal Representative (POA, Guardian, Conservator, etc..) manages all financial matters ❑ Individual manages financial matters with supervision ❑ Provider program manages finances

Immediate Needs:

Standard Needs	Budget Amount	Proposed Date Needed	Notes
❑ Housing			❑
❑ PEX Card Upload			❑
❑ Clothes/Shoes			❑
❑ Furniture(i.e.TV, Chair, Bed)			❑
❑ Phone			❑
❑ Smart Trip Upload			❑
❑ Medical			❑
❑ Bed Linens			❑

Future Needs:

Standard Needs	Budget Amount	Proposed Date Needed	Notes
❑ Educational			❑
❑ Transportation			❑

Special Needs/Requests/Additional Information:

Name of Representative authorized to make requests on beneficiary's behalf:

_____ _____

Name Agency/Relationship

_____ _____

Address Telephone

Upon the Death of Beneficiary, distribution of funds and assets shall be made to the following:

1st. Shared Horizons, Inc. will retain 50%

2nd. Up to 50% will be used to reimburse Medicaid for care.

3rd Name of person to receive balance if funds remain:

_____ _____

Name Address

_____ _____

Telephone Social Security #

_____ _____

Beneficiary's Name Shared Horizon's Signature

_____ _____

Representative's Name Representative's Signature

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