Advocare Trust, Inc.
Enrollment Information

Date Completed: _____

Personal Data

Name: _____ DOB: _____
First, Middle, Last

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip Code: _____

Group Home: _____ ALF: _____ Home _____

Date of Birth: _____ Place of Birth: _____

City, State: _____

*Please attach copy of birth certificate and photo ID

Religious Preference: _____

Hospital Preference: _____

Medicare Number: _____ Medicaid Number: _____

*Please attach copies of Medicare/ Medicaid cards

Primacy Care Physician: _____

Phone Number: _____

Dentist: _____ Phone Number: _____

Address: _____

Specialists:

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Physician Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Parent Information:

Father's Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

Email address: _____

If Applicable:

Date of Death: _____ Place of Internment: _____

Cause of Death (If Known): _____

*Please attach birth and death certificates if available

Mother's Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Maiden Name: _____

Place of Birth: _____ Social Security Number: _____

Email address: _____

If Applicable:

Date of Death: _____ Place of Internment: _____

Cause of Death (If Known): _____

*Please attach birth and death certificates if available

Parents are: _____ married _____ divorced _____ separated _____ widowed

How frequently does the beneficiary see their parents? _____

What are the visiting arrangements? _____

_____

Siblings:

Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Married: _____ Spouse's Name: _____

Date of Birth: _____

Email address: _____

Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Married: _____ Spouse's Name: _____

Date of Birth: _____

Email address: _____

Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Married: _____ Spouse's Name: _____

Date of Birth: _____

Email address: _____

Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Married: _____ Spouse's Name: _____

Date of Birth: _____

Email address: _____

How frequently does the beneficiary see their siblings? _____

What are the visiting arrangements? _____

Family Medical History:

Have any of the family (include extended family) have any of the following:

Developmental disability _____ Heart Disease: _____

Chronic Mental Illness: _____ Kidney Disease: _____

Cancer: (Type) _____ Diabetes: _____

Dementia: _____

Please list any other medical issues that you feel are important for us to know:

_____

Surgeries: _____

Beneficiary Primary Diagnosis: _____

Etiology of mental retardation/developmental disability: _____

Level of retardation: _____ IQ Score: _____

*Attach copy of IQ testing

State Programs:

Is the beneficiary a consumer of The Agency of Persons with Developmental Disabilities (APD)? _____

Waiting List Date: _____ Support Coordinator: _____

Company name: _____ Phone Number: _____

Address: _____ City/FL/Zip: _____

Supported Living Coach: _____ Company: _____

Phone Number: _____ Email: _____

Supported Employment Coach: _____ Company: _____

Phone Number: _____ Email: _____

In Home Supports: _____ Company: _____

Phone Number: _____ Email: _____

Durable Medical Equipment Provider: _____

Address: _____ City/FL/Zip: _____

Phone Number: _____ Email: _____

Behavior Specialist: _____ Company: _____

Phone Number: _____ Email: _____

Companion: _____ Company: _____

Phone Number: _____ Email: _____

Pharmacy: _____ Address: _____

Phone Number: _____ Email: _____

Transportation Provider: _____ Address: _____

Phone Number: _____ Email: _____

*Please attach current support plan

Guardianship:

Is the beneficiary under any form of legal guardianship? _____

Type of Guardianship: 744 Person _____ 744 Property _____

393 Guardian Advocate: _____

Date of Guardianship Inception: _____ Uniform Case Number: _____

Attorney: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Power of Attorney: _____

Heath Care Surrogate: _____

Living Will: _____

*Please attach copies of Guardianship Letters, Power of Attorney, Heath Care Surrogate and Or Living Will.

Day Program:

Provider: _____ Program: _____

Employment:

Employer: _____ Date of Hire: _____

Address: _____ City/FL/Zip: _____

Job Title: _____

Number of Hours Worked per Week: _____

Military Information:

Is the beneficiary entitled to any Survivor Benefits through either parent's military service? _____

Does the beneficiary have a military ID? _____

Financial:

Current Social Security Award: _____

Current Representative Payee: _____

Bank: _____ Direct Deposit: _____

Are there any other benefits? _____ (i.e.: VA, Railroad) _____

*Please attach annual award letter

Is there a Special Needs Trust for the benefit of your child? _____

Trustee: _____ Phone Number: _____

Address: _____ City: _____

State: _____ Zip: _____

Email address: _____

*Please attach copy of Trust

Recreation

Does the Beneficiary participate in Special Olympics? _____

Sport: _____

Coach: _____ Phone Number: _____

Reach Out: _____

St Paul's: _____

Person completing packet: _____ Date: _____

Document Check List:

Birth Certificate of beneficiary and parents
Death Certificate of parents, if appropriate
Interment Contact/Burial Wishes
Guardianship Letters
Power of Attorney Forms
Living Will
Health Care Surrogate
Social Security Card
Social Security Award Letter
Medicare Card
Medicaid Card
Support Plan
Picture
Medication list with prescribing physician and dosage
IQ Testing
Special Needs Trust

Letter of Instruction: (letter to our staff from the parents informing us of your wishes for your child. Dated and signed. This can be submitted once and updated as you see fit.

Please provide us with a letter indicating whom you like us to send reports to after your demise.

Please complete the packet and begin to send the information as soon as possible so we can begin to build a file. We you would prefer, bring the originals into our office and we will be happy to copy them for you.