

LIFE PLAN FOR [LOVED ONE]

ANNUAL REVIEW

1. Review your Letter of Intent, adding any new details from this past year. Print a new copy, sign, and date.
2. Review your Emergency Plan and update insurance info, medication info, and emergency contacts.
3. Review “Government Resources for Financial & Long-Term Care” and determine if you need to apply, update, or reapply.
4. Communicate with your loved one’s potential future caregivers about this binder

* I suggest sending an annual email with the updated letter of intent and the location if the binder if you are keeping this as a physical binder.

* If you are updating this as a PDF, you could email out an updated copy of the whole binder each year.

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Letter of Intent

The letter of intent serves as the foundation of any comprehensive Life Plan for your Loved One. By compiling as much information as possible, parents are equipping future care providers with the knowledge and insight needed to increase the likelihood of good choices to maximize the Loved One's quality of life and avoid the need for caregivers to learn by trial and error. The letter of intent can be a difficult and extremely emotional document to write, as it often is the first time parents envision their Loved One with special needs navigating this world without them.

This worksheet is a rough draft for your letter of intent.

- The letter of intent may be addressed to anyone you wish – for example “To Whom it May Concern,” “To my Guardian(s), Trustee(s) and Executor.” Who are you envisioning as you write this letter?_

- The Past: A description of your Loved One's birth and his connections to specific family members or friends will complement your account of favorite memories and feelings about your Loved One.

Emergency Plan

Name	
DOB	
Home address	

WHO TO CONTACT IN ORDER OF PREFERENCE:

Name	
Cell phone	
Alternate phone	
Relationship	

Name	
Cell phone	
Alternate phone	
Relationship	

Name	
Cell phone	
Alternate phone	
Relationship	

Name	
Cell phone	
Alternate phone	
Relationship	

MEDICAL SUMMARY:

Diagnoses	
Medications	
Allergies	
Doctor	
Office	
Fax	
Specialty	

Current immunization record & Medical Insurance cards attached

Initial and date

Emergency Plan

Is this person under guardianship/conservatorship?

- Yes, they are a minor and their parents are natural guardians.
 - Authorization to Consent to Medical Treatment (attached)
- Yes, they are a minor and under Conservatorship through a legal agreement (attached)
 - Authorization to Consent to Medical Treatment (attached)
- Yes, they are an adult who has been placed under guardianship in the Court of (list county)_____.
- No, they are an adult.
 - No other decision-making agreements or documents have been completed.
 - They have created a Supported-Decision Making agreement (attached)
 - They have signed a Medical Power of Attorney (attached)

If the guardian/conservator is incapacitated, has a successor been named?

- No
- Yes, named in:
 - Last Will & Testament of _____
 - Letter of Intent - location _____
 - Guardianship Documents – location _____

Authorization to Consent to Medical Treatment

1. We, (parent or guardian) _____
of (address) _____

make oath and say we are the lawful guardians of the person(s) listed below and there are no court orders now in effect that would prohibit us from conferring the power to consent upon another person.

Person 1

[Loved One] _____, born [DOB] _____ in (city, state) _____
and currently residing at (address) _____
_____.

Allergies:

Medication	
Environmental	
Treatments	

Health Insurance:

<u>Primary Insurance</u>		<u>Secondary Insurance</u>	
Company		Company	
Group #		Group #	
Member #		Member #	
Notes		Notes	

Current on the following medications:

<u>Name</u>	<u>Dosage</u>	<u>Frequency/Time of day</u>	<u>Treatment for</u>

Initial & Date _____

2. We hereby authorize and appoint (names of grandparents, siblings, caregivers) _____

as our agents. Our agents may consent to our children’s surgical, dental, developmental, mental health, and/or

- Transportation by an ambulance
- Examination
- X-rays
- Diagnoses
- Hospitalizations
- Anesthesia
- Surgery
- Medication
- Transfusion of blood or blood products.

Our agents may have access to any and all records, including, but not limited to insurance records regarding any such services.

3. Our family doctors may be contact at:

Name	
Phone	
Name	
Phone	

4. The purpose of this instrument is to give our agents, each individually, the power and authority to consent to medical treatment for our children, and this power and authority will be effective as of (date)_____.

5. We give this consent freely and knowingly in order to provide for the children and not as a result of pressure, threats, or payments by any person or agency.

6. This consent will remain in effect until it is revoked by notifying [Loved One]’s medical, mental health care, and insurance providers, in writing, and the agents named above that we wish to revoke it.

Initial & Date_____

7. Any questions or concerns regarding this authorization may be directed to us at:

<u>Parent or Guardian</u>		<u>Parent or Guardian</u>	
Name		Name	
Address		Address	
Phone		Phone	
Email		Email	

IN WITNESS WHEREOF, we hereunto sign our names at (city, state) _____
 this (date) _____.

 Parent or Guardian signature

 Parent or Guardian signature

 Witness 1 signature

 Witness 2 signature

 Witness 1 Name

 Witness 2 Name

 Witness 1 Phone

 Witness 2 P

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF AN ALTERNATE AGENT:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

Phone: _____

Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of the document is kept at: _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior medical power of attorney.

ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of ____/____ (month, year) at _____ (City and State)

(Signature)

(Print Name)

State of Texas, County of _____

This instrument was acknowledged before me on _____ (date) by _____ (name of person acknowledging).

NOTARY PUBLIC, State of Texas

Notary's printed name:

(Seal, if any, of notary)

My commission expires: _____

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on _____ day of ____/____ (month, year)
at _____ (City and State)

(Signature)

(Print Name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Address: _____

Print Name: _____

Date: _____

SIGNATURE OF SECOND WITNESS

Signature: _____

Address: _____

Print Name: _____

Date: _____

DISCLOSURE STATEMENT FOR MEDICAL POWER OF ATTORNEY

Advance Directives Act (see §166.163, Health and Safety Code)

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because “health care” means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent’s instructions or allow you to be transferred to another physician.

Your agent’s authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer’s assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your

execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT

WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE

OF THE WITNESSES:

(1) the person you have designated as your agent; (2) a person related to you by blood or marriage; (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law; (4) your attending physician; (5) an employee of your attending physician; (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

Overview of Life

As you are filling this out, imagine a person picking up this book while you are in the hospital, unable to tell them anything.

The Basics

Full Name	
Nicknames	
Birthday	
Phone number	
Home address	
Social Security #	
State ID #	
Diagnoses that effect daily living	

Personality, Emotional, Sensory, and Behavioral Characteristics

Describe their personality.	
How can you tell they are happy?	
How do they act when anxious?	
How do they act when afraid?	
How do they act when angry?	

What triggers fear and/or anxiety?		
What are some nonverbal cues that caregivers need to know?		
Describe strategies that help when they are angry, anxious, afraid, or overwhelmed.		
Describe strategies that have been tried and DON'T work.		
Are they touch-seeking or touch avoiding?		
Do they have any sensory issues?		
Who do they connect emotionally with?		Phone:
Who can calm them down?		Phone:

Daily & Weekly Routines and Schedules

Because levels of functionality vary for each Loved One and future caregivers may fail to recognize this fact, it is important to include a list of your Loved One's daily routines, favorite activities, and events or tasks he loves or hates.

Use the tables that apply to your Loved One, delete the ones that don't.

If they have a weekly routine, put it here - list the times when they eat, bathe, sleep, and any other specific routines.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

If they have an alternate routine, put it here:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Food Preferences, Restrictions, and Allergies

Describe your Loved One's level of independence with eating. _____

Describe your Loved One's level of independence with cooking. _____

Food Preferences		
Food	When	Preparation, support, condiments

Restaurant Preferences	
Restaurant	Typical Order

Food Allergies, Sensitivities, or limitations	
Item or category	Description

Residential Environment

Describe your Loved One's living arrangements with family, friends or other organizations.

If your Loved One will be unable to continue living with these individuals after you stop being the primary contact for his care, **describe what you consider to be the best alternative arrangements.**

- For instance, explain whether you prefer that your Loved One live in a group home or institution located in the same community, the preferred size of the institution, or that your Loved One have a single room or roommate.

Short term idea:

Long term ideas:

Government ideas:

Group Networks

Groups they are part of (Special Olympics, sports, city, advocacy, support, church, etc)	Who is your contact within this group?	How do you get info about events?	Who are key friends within this group?

Specify your Loved One's religion and any local place of worship your family attends. List all local clergy that may be familiar with your Loved One and your family. Describe your Loved One's religious education and indicate whether this is of interest to your Loved One. _____

In Progress

After-Visit notes				
Condition	Visit Date	Visit Notes	Action Steps	Follow up

Caregiver Observations and Concerns

Concerns/Symptom	Date(s) observed	How often does it happen? How severe is it?	Does there seem to be a trigger or cause? Or a pattern?	Did you discuss this with the doctor? What date?

Current Medical Snapshot as of _____

Primary Care Doctor:

Current Chronic Health Conditions, Treatments, Doctors

This list should include every doctor and every therapist... aligned with why you see them... and what medications you take

Condition	First Diagnosed	Milestones related to condition	Treatments – Medication, Therapy, Adaptive Equipment, Surgery	Specialists, Therapists, DME providers, Home Health Agencies

Current Chronic Health Conditions, Treatments, Doctors

This list should include every doctor and every therapist... aligned with why you see them... and what medications you take

Chronic Conditions Individual Subsections

1. Go to the Current Chronic Health Conditions, Treatments, Doctors table, and make a cover page for each condition.
2. Behind each page include any of these that are relevant to the current treatment for that condition:

Clinical Visit notes, Hospital, Surgery and Emergency Department Reports

Try to get a copy of the narrative reports that clinicians create when a person comes the emergency room, or is hospitalized. These are the reports that are written by health providers, for other health providers. **Note: these are not same reports as the patient discharge instructions that are always handed out.**

Radiology and Imaging Results

Includes x-ray reports, ultrasound reports, CT scans, MRIs, etc from last 1-5 years – if CD, place in a sleeve in this folder

Other Developmental & Diagnostic Reports

Especially useful if related to the diagnosis or management of a current chronic condition.

Include pulmonary function tests, EKGs, cardiac catheterization reports, biopsy results, neuropsychology evaluations, and so forth.

Laboratory Results

Include at least last 2 years

Medical History

Past Health Conditions that have been Resolved				
Condition	First Diagnosed – Resolution	Milestones related to condition	Treatments (therapies and Medication)	Specialists, Therapists, DME providers, Home Health Agencies

Surgery History			
Surgeries	Condition being treated	Outcome of Surgery	Surgery completed by, and where

Current Services

List the types of governmental benefits your Loved One receives, including Detail the agencies' contact information, identification numbers for your child's case(s), the recertification process for each benefit, including important dates and other reporting requirements.

Social Security SSI or SSDI services			
SSI info: https://www.ssa.gov/benefits/ssi/			
SSDI for DAC: https://www.ssa.gov/benefits/disability/qualify.html#anchor7			
Service	Identification/Case #	Contact Person Name & info	Renewal date
Supplemental Security Income	Loved one's SS#		
Social Security Disability Insurance	Parents' SS#s		

If you have a letter, this is where you put a page break, and leave room to most recent letter.

Medicaid/Medicare/Tricare Healthcare + related services			
Medicaid: https://www.ssa.gov/ssi/text-child-ussi.htm			
Medicare: https://www.ssa.gov/benefits/medicare/			
Service	Case or ID #	Contact Person Name & info	Renewal date

If you have an ISP, this is where you put a page break, and leave room to add ISP

Medicaid Waiver services, LIDDA services, ICF-IDD, Respite programs

Waivers: <https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/home-community-based-services-hcbs>

LIDDA: <https://www.hhs.texas.gov/providers/long-term-care-providers/local-idd-authority-lidda>

ICF: <https://www.hhs.texas.gov/providers/long-term-care-providers/intermediate-care-facilities-icfiid>

Service	Through agency	Contact Person Name & info	Renewal date

If you have an IPC, this is where you put a page break, and leave room to add the IEP

Educational services			
Service	Local ISD	Contact Person Name & info	Renewal date

If you have an IEP, this is where you put a page break, and leave room to add the IEP

Vocational services			
Programs might be offered by local ISD as part of completing IEP, community college, and may be funded by Texas Workforce Commission Vocational Rehabilitation Services.			
Service	Through agency	Contact Person Name & info	Renewal date

If you have an IPE, this is where you put a page break, and leave room to add IPE

Other Government or Community Housing and Food Benefits

Such as housing assistance, SNAP (food stamps), and Reduced or Free School Lunch program

Service	Through agency	Contact Person Name & info	Renewal date

If you have an IEP, this is where you put a page break, and leave room to add the IEP

Loved One's Financial Resources

Loved One's financial power of attorney document is located	
Appointed agent is	
Bank Account Information	
Bank	
Names on the account	
Account type	
Account number	
Online username	
Monthly Budget/Cash Flow	

ABLE Account

Bank Account Information	
Names on the account	
Bank	
Account type	Achieving a Better Life Experience (ABLE) Act of 2014 provided Americans with disabilities the opportunity to save up to \$15,000 per year in a tax-deferred account similar to a 529 college savings plan, as a supplement to their government benefits.
Account number	
Online username	

Credit Card Information	
Names on the account	
Account type	
Account number	
Online username	
INVESTMENTS: Stocks, bonds, and more	
Description	
Account number	
Contact	
OTHER ACCOUNTS: Frequent flyer, rewards programs, etc	
Name of account	
Information	
Tax Records	
Federal and state records are located	
Online tax account	
User name	
Password	

Special Needs Trusts

- An individual can have a 3rd party Trust funded with resources of friends and family.
- An individual can have a 1st party Trust funded with their own resources.
- An individual can participate in a Pooled Trust.

Bank Account Information	
Trustee(s)	
Bank	
Account type	
Account number	
Online username	
TRUST INVESTMENTS: Stocks, bonds, and more	
Description	
Bank	
Account number	
Contact	
Trust Tax Records	
Federal and state records are located	
Online tax account	
Username	
Password	

Timeline Resources for Financial, Government, & Long-Term Care

When to access

Anytime

- **LTC:** Medicaid waiver interest lists
 - o **MDCP:** Date added: Interest List number:
 - o **DMBD:** Date added: Interest List number:
 - o **CLASS:** Date added: Interest List number:
 - o **HCS:** Date added: Interest List number:
 - o **TxHmL:** Date added: Interest List number:

Age 3+

- Local Intellectual & Development Disability Authority (LIDDA) for your County
 - o Become a client and complete a Determination of Disability (DID)
 - o Meet with a Service Coordinator to find out what services are immediately available and what services have a waiting list:
 - LIDDA manages waiting list for HCS & TxHmL Medicaid Waivers
 - LIDDA has General Revenue funds for Respite
 - o When requesting Community First Choice PAS/Hab, LIDDA must upload a Level of Care to the Medicaid Portal

After age 5

- Specialized Telecommunication Assistance Program (STAP) funds for phone or tablet
<https://staptx.com/apply>
 - o Individual has a hearing impairment, vision impairment, or speech impairment
 - o Eligible every 5 years

Age 0-18

- Determine what the best option for supporting your Loved One as an adult may be:
 - o Supported Decision Making + Power of Attorney documents
 - Individual maintains all legal rights to make decisions.
 - Tools are used to share these rights with trusted supporters
 - o Guardianship
 - Individual is declared by a court to be incapacitated.
 - Legal rights are assigned to a guardian.
- **Social Security SSI** (Supplemental Security Income) if
 - o Child has a disability
 - o Family's income is low
 - o Family's assets are less than \$5,000 total
- **Medicaid Buy In for Children** (MBIC)
<https://texasmedicaidwaivers.com/medicaid/medicaid-buy-in-programs/medicaid-buy-in-for-children/>
 - o Child has a disability
 - o Family's income in moderate
 - o Family's assets are unlimited

Age 14+

- Texas Workforce Commission's Texas Workforce Solutions – Vocational Rehabilitation (TWS-VRS)
 - o Individual's TWS-VRS access will be coordinated through school special education starting at 14 years old as a "potentially eligible" client
 - o Before high school ends, complete an application to become an official TWS-VRS client and continue to receive employment training and supports

Age 18+

- **Social Security SSI** (Supplemental Security Income) if
 - o Individual has a disability
 - o Individual's income is low
 - o Individual's assets are less than \$2,000 total

Age 22+

- **Supplemental Nutrition Assistance Program (SNAP)** aka Food Stamps
<https://texasmedicaidwaivers.com/other-programs/supplemental-nutrition-assistance-program-snap/>

Upon parent's death or disability

- **Social Security RSDI** (Retirement, Survivors, and Disability Insurance)
 - o Child or adult has a disability