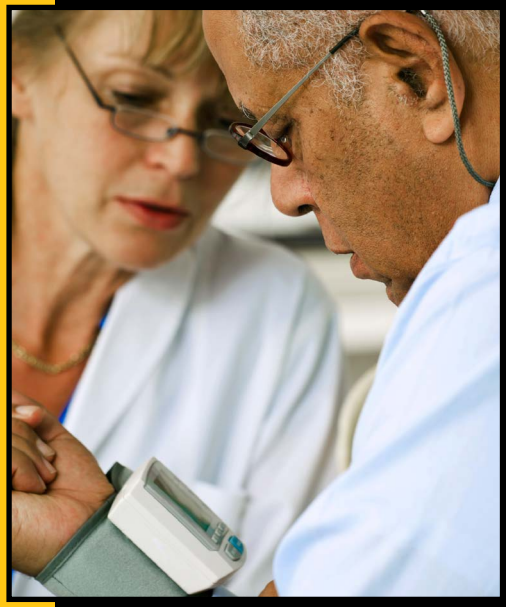
Special Care Organizational Record

for Elderly Family Members



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Introduction

The Special Care Organizational Record for Elderly Family Members is designed to facilitate the care of the older members of your family. It provides a central location for keeping track of your relative's records and other pertinent information. This is particularly helpful if someone else needs to provide care for your family member because you are away or unable to provide care. The SCOR also provides a care guide section that can provide a wealth of detailed information to a new caregiver on topics such as daily routine, diet, and preferred leisure activities.

To maximize the benefits of the SCOR, incorporate other pieces of health-related information, such as information from doctors or even articles that you feel are valuable. The SCOR can also be taken to doctor's appointments to keep track of pertinent information and manage health appointments.

The SCOR is available in Adobe Acrobat format, allowing you to type information directly into the forms. If you do not have your information readily available, save the SCOR and update it later or print the forms you need and fill them out by hand.

Please keep in mind that the SCOR is not intended to take the place of official medical records, nor is it a legally binding document. It contains private information such as Social Security numbers, medical histories and insurance information. To maintain your family's privacy, keep your SCOR in a safe, secure place.

Special Care Organizational Record for Elderly Family Members

What is the SCOR for Elderly Family Members?

The SCOR for Elderly Family Members is a tool to help families organize and keep track of medical records and related information for an elderly family member in the event that care must be provided by someone outside the family.

How can the SCOR for Elderly Family Members help you?

In the process of caring for your elderly family member, it can be challenging to keep track of rapidly changing health or medical issues. The SCOR will help you organize this information for quick access. It will also allow you to share key information with those who provide care for your family member.

Use the SCOR for Elderly Family Members to:

- Track changes in your family member's medicines or treatments
- List telephone numbers for health care providers and community organizations
- Prepare for appointments
- File information about your family member's health history
- Share new information with your family member's primary doctors and other care providers

Some helpful hints for using the SCOR for Elderly Family Members:

- Keep the SCOR where it is easy to find so it will always be on hand when you need it.
- Be mindful that the SCOR contains private information and should be kept in a safe place.
- Keep the SCOR as up-to-date as possible. Add new information to the SCOR whenever there is a change in your family member's treatment.
- Bring the SCOR with you to appointments and hospital visits so that the information you need will be close at hand.

SCOR for Elderly Family Members (Continued)

How do you set up your family member's SCOR? Follow these steps:

STEP ONE: Gather information you already have.

Gather any health information that you have about your family member. This may include reports from recent doctor's visits, immunization records, a summary of a recent hospital stay, test results or informational pamphlets, etc.

STEP TWO: Look through the pages of the SCOR.

Select the pages that you think will be most beneficial for tracking your family member's health and care. Once you have determined what you need, print out those selected pages.

STEP THREE: Decide which information is most important to keep in the SCOR.

What information do you find yourself looking for often? What information do the care providers need when caring for your family member? Include frequently referenced and important information in your portable SCOR and store additional, less critical information in a file drawer or box where you can find it if needed.

STEP FOUR: Put the SCOR together.

Organize the SCOR in a way that makes the most sense for you and your family member. Here are some supplies that may help:

- Three-ring binder or large accordion envelope to hold papers securely
- Tabbed dividers for creating separate sections
- Pocket dividers for storing reports
- Plastic pages for storing business cards and photographs

Things to remember about the SCOR:

- While the SCOR does contain a lot of your family member's medical history/information, it is not intended to replace official medical records.
- The SCOR is not legally binding in any way. It is intended to provide a place to start thinking about the care your family member would receive if you were no longer able to provide it. Please keep in mind proper legal protocol prior to making legally binding decisions.
- It contains very private information (e.g., Social Security numbers, insurance information, medical history). It is imperative that you keep it in a safe place.

Personal Information

Name:			
Date of Birth:		SSN:	Blood Type:
Location of Social Security Card (include copy):			
Address:			
Phone:	Fax:	County:	
Location of Birth Certificate (include copy):			
Location of Adoption Certificate, if applicable (include copy):			
Location of Naturalization Papers, if applicable (include copy):			

Emergency Contact:	
Relationship:	Emergency Contact Number:

Emergency Contact:	
Relationship:	Emergency Contact Number:

Emergency Contact:	
Relationship:	Emergency Contact Number:

Notes (allergies, medications, etc.):

Spouse Information

Name:	
Address:	
Phone:	Dates of Marriage:

Previous Spouse Information

Name:	
Address:	
Phone:	Dates of Marriage:
Location of Marriage License (include copy):	
Location of Divorce Records, if applicable (include copy):	
Location of Death Certificate, if applicable (include copy):	

Children's Information

Name:		
Address:		
Phone:	Date of Birth:	Child's Spouse:

Name:		
Address:		
Phone:	Date of Birth:	Child's Spouse:

Name:		
Address:		
Phone:	Date of Birth:	Child's Spouse:

Name:		
Address:		
Phone:	Date of Birth:	Child's Spouse:

Parent's Information

Mother's Name:	
Address:	
Phone:	Date of Birth:

Father's Name:	
Address:	
Phone:	Date of Birth:

If parent is deceased, provide:

Mother's Date of Death:	Burial Site:
Father's Date of Death:	Burial Site:

Sibling's Information

Sibling's Name:		
Address:		
Phone:	Date of Birth:	Sibling's Spouse:

Sibling's Name:		
Address:		
Phone:	Date of Birth:	Sibling's Spouse:

Sibling's Name:		
Address:		
Phone:	Date of Birth:	Sibling's Spouse:

Pet Information

Name:	Age:
Veterinarian:	Phone:
Address:	
Location of Veterinary Care Records (include copy):	
Medical Conditions (allergies, medications, etc.):	
Special Instructions (food, daily care, etc.):	

Name:	Age:
Veterinarian:	Phone:
Address:	
Location of Veterinary Care Records (include copy):	
Medical Conditions (allergies, medications, etc.):	
Special Instructions (food, daily care, etc.):	

Military Service Information

Branch:
Last Rank Held:
Dates of Service:
Location of Discharge Paperwork (DD Form 214, include copy):
Military ID Number:
Veterans Benefits (provide details):

Employment Information

Name:	
Address:	
Phone:	Employment Dates:
Starting Salary:	Ending Salary:
Pensions, Life Insurance, Disability Insurance, Health Insurance or other Benefits:	
Location of Pension or Benefits Documents:	

Name:	
Address:	
Phone:	Employment Dates:
Starting Salary:	Ending Salary:
Pensions, Life Insurance, Disability Insurance, Health Insurance or other Benefits:	
Location of Pension or Benefits Documents:	

Employment Information (Continued)

Name:	
Address:	
Phone:	Employment Dates:
Starting Salary:	Ending Salary:
Pensions, Life Insurance, Disability Insurance, Health Insurance or other Benefits:	
Location of Pension or Benefits Documents:	

Name:	
Address:	
Phone:	Employment Dates:
Starting Salary:	Ending Salary:
Pensions, Life Insurance, Disability Insurance, Health Insurance or other Benefits:	
Location of Pension or Benefits Documents:	

Name:	
Address:	
Phone:	Employment Dates:
Starting Salary:	Ending Salary:
Pensions, Life Insurance, Disability Insurance, Health Insurance or other Benefits:	
Location of Pension or Benefits Documents:	

Important Dates to Remember (Birthdays, Anniversaries, Graduations, etc.)

Date:
Event:
Notes:

Date:
Event:
Notes:

Date:
Event:
Notes:

Date:
Event:
Notes:

In Case of an Emergency

Contact Information

The Person You Have Appointed to Make Decisions On Your Behalf

Name:
Address:
Email:
All Telephone Numbers:

Alternate Person's Contact Information (if applicable)

Name:
Address:
Email:
All Telephone Numbers:

Emergency Plan

Use the tables below to list any health-related or other emergencies that may occur and how the emergency should be handled (e.g., if your family member is epileptic and has a seizure or your family member becomes combative under certain circumstances).

What Might Happen:
What to Do:
Step one:
Step two:
Step three:
Step four:
Other:

What Might Happen:
What to Do:
Step one:
Step two:
Step three:
Step four:
Other:

Medical Health

Health Insurance — TRICARE

Use this link to find a local TRICARE Service Center: http://www.tricare.mil/contactus

TRICARE Regional Office:		
Address:		
City:	State:	Zip:
Phone:	Email:	

TRICARE Service Center:		
Address:		
City:	State:	Zip:
Phone:	Email:	

Beneficiary Counseling and Assistance Coordinator:		
Address:		
City:	State:	Zip:
Phone:	Email:	

Health Insurance — TRICARE (Continued)

Debt Collections Assistance Officer:		
Address:		
City:	State:	Zip:
Phone:	Email:	

TRICARE Nurse Advice Line: 800-TRICARE (Option 1)

- Talk to a registered nurse
- Get health care advice
- Ask urgent care questions
- Get help finding a doctor

Health Insurance — TRICARE Dental Program

Use this website to find information regarding basic dental program benefits, the address for filing claims, enrollment information, and a directory of network dentists: http://www.tricare.mil/CoveredServices/Dental/TDP.aspx.

Dentist:		
Address:		
City:	State:	Zip:
Phone:	Email:	

Note: On July 1, 2007, TRICARE implemented coverage for anesthesia services and associated costs for dental treatment for beneficiaries with developmental, mental, or physical disabilities, and children age 5 and under. The services require preauthorization through the regional TRICARE contractors (http://www.tricare.mil/CoveredServices/Dental/TDP). The change in this benefit does not provide coverage for the actual dental care services. Coverage for dental care services is available through the TRICARE Dental Program and the TRICARE Retiree Dental Program.

Additional Insurance

Please note all other insurance providers. Visit the TRICARE website for information about filing claims: http://tricare.mil/Resources/Claims.

Name of Other Insurance:		
Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Name of Other Insurance:		
Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Additional Insurance (Continued)

Name of Other Insurance:		
Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Medicare

Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Medicaid

Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Additional Insurance (Continued)

Medigap (carrier)

Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Long-term Care Insurance (carrier)

Policy Number:		
Contact Person:		
Address:		
Email:	Phone:	Fax:
Case Manager:		
Email:	Phone:	Fax:

Medical Bill Tracker

Date	Provider	Amount Billed	Amount Allowed	Amount Paid	Paid by Health Insurance	Family Owes	Debt Paid

Current Medical Diagnoses

Date	Diagnosis	Notes

Current Medication

Start Date	Stop Date	Medication (brand/generic)	Prescribed by	Dose/ Route	Time Given	Reason for Medication	Special Care Instructions

Significant Illnesses

Date	Illness	Notes

Surgical Procedures

Date	Surgical Procedure	Procedure/Treatment Plan	Notes

Allergies (e.g., food, medications, materials)

Allergen	Allergic Reaction	How to Respond

Care Providers

Primary Care Manager:		
Military Treatment Facility:		
Address:		
Email:	Phone:	Fax:

Civilian Hospital:		
Address:		
Email:	Phone:	Fax:

Dentist:		
Address:		
Email:	Phone:	Fax:

Specialist and Specialty:		
Address:		
Email:	Phone:	Date of First Visit:

Specialist and Specialty:		
Address:		
Email:	Phone:	Date of First Visit:

Nutritionist:		
Address:		
Email:	Phone:	Date of First Visit:

Care Providers (Continued)

Social Worker:		
Address:		
Email:	Phone:	Date of First Visit:

Physical Therapist:		
Address:		
Email:	Phone:	Date of First Visit:

Speech Therapist:		
Address:		
Email:	Phone:	Date of First Visit:

Occupational Therapist:		
Address:		
Email:	Phone:	Date of First Visit:

Therapy:	Therapist:	
Address:		
Email:	Phone:	Frequency:

Therapy:	Therapist:	
Address:		
Email:	Phone:	Frequency:

Care Providers (Continued)

Nursing Agency:		Contact Person:	
Address:			
Email:	Phone:	Date of First Visit:	
Number of Hours Approved:	Day:	Night:	Weekend:

Case Manager:		
Address:		
Email:	Phone:	Date of First Visit:

NOTE: Please attach the plan of care provided by the case manager.

Additional notes:

Doctor Visits

Date	Seen by	Notes/Updates from Visit

Appointment Log

Date	Provider	Reason Seen/Care Provided	Next Appointment

Health Screening and Tests

Date	Health Screening/Test	Results

Hospital Tracker

Date	Hospital	Reason for Admission	Notes

Family Medical History

Check the box if one or more family members have had one of these health conditions and note how they are related.

Condition	Relative	Condition	Relative
☐ Cardiac		☐ Diabetes	
☐ Hypertension		☐ Blood	
☐ Renal		☐ Ear	
☐ Tuberculosis		☐ Thyroid	
☐ Gastrointestinal		☐ Vision	
☐ Cancer		☐ Psychological	
☐ Allergy		☐ Autoimmune	
☐ Orthopedic		☐ _____	
☐ Lung		☐ _____	

Additional family information:

Name	Date of Birth	Health
Mother:		
Father:		
Sibling:		
Sibling:		
Sibling:		
Sibling:		
Sibling:		

Family Medical History (Continued)

List any other health conditions in your family member's history that are not listed above and the person's relationship to your family member.

Lifestyle Habits

In this section, list any notes regarding your family member's lifestyle habits using the questions below to guide you.

Diet:

a. What does your family member typically eat for each meal?

b. Does he or she eat meals at consistent times throughout the week? _____

c. Does he or she snack between meals? If so, how often and what does he or she eat for snacks?

Exercise:

a. Has your family member ever exercised? _____

b. When, for how long, and how often?

c. Does your family member currently exercise? _____

d. How long and how often?

Lifestyle Habits (Continued)

Sleep Habits:

a. How many hours per night does your family member typically sleep? _____

b. Does your family member regularly have trouble falling asleep or staying asleep? _____

Stress:

a. Does your family member often feel stressed or under pressure? _____

b. How often? _____

Smoking:

a. Has your family member ever smoked? _____

b. When and how often? _____

c. Does your family member currently smoke? _____

d. How often? _____

Alcohol Consumption:

a. Has your family member previously consumed alcohol? _____

b. When and how often approximately? _____

c. Does your family member currently drink alcohol? _____

d. How often? _____

e. Does your family member drink socially or when alone? _____

Care Guide

Daily Routine

Provide a description of your family member's typical day/daily routine. Include information such as when he or she wakes up, eats meals, takes medications, exercises, visits with friends, etc.:

Day	Routine
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Personal Care

List tasks that your family member is able to do independently (e.g., eating, bathing, toileting, dressing, moving):

List tasks for which your family member requires assistance (e.g., eating, bathing, toileting, dressing, moving):

List other information related to personal care that would be helpful to those providing care for your family member:

Food and Eating

List foods that your family member particularly enjoys and or dislikes:

Likes	Dislikes

Typical daily diet:

Meal	Preferred Foods/Drinks
Breakfast	
Lunch	
Dinner	
Snack	

Favorite restaurants and preferred meals:

Restaurant	Preferred Meals

Diet Tracking Form

Copy this form and use it to track your family member's diet on a weekly basis.

Week of:	Weight:
Date Checked:	

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6 a.m.							
7 a.m.							
8 a.m.							
9 a.m.							
10 a.m.							
11 a.m.							
12 p.m.							
1 p.m.							
2 p.m.							
3 p.m.							
4 p.m.							
5 p.m.							
6 p.m.							
7 p.m.							
8 p.m.							

Other Likes and Dislikes

To provide additional helpful information to your caregiver, list any of your family member's specific likes or dislikes (e.g., enjoys spending some time outside each day, dislikes certain television programs or books, likes to be read to):

Likes	Dislikes

Leisure Activities

List any leisure activities that your family member particularly enjoys or particularly dislikes.

TV shows/movies:

Likes	Dislikes

Hobbies/activities in the home:

Likes	Dislikes

Clubs outside the home:

Name of Club:	Name of Club:
Contact Person:	Contact Person:
Phone:	Phone:
How Often:	How Often:
Other Notes:	Other Notes:

Vacation/travel:

Likes	Dislikes

Home Safety

A home safety inspection is critical to prevent injuries from home accidents. Simple precautions or adjustments to the environment can help ensure safety.

- Emergency numbers and address are posted by phones
- Phones are available in each room and accessible in the event of a fall
- Windows and doors are in working order, have easy to use knobs and secure locks
- Water heater is set at 120 degrees to prevent scalding
- Medications are clearly labeled and safely stored
- Electrical outlets and cords are in good condition and correctly used
- Electrical overload protection and ground fault circuit interrupters are used in important areas
- Smoke alarms and carbon monoxide detectors are installed and batteries are checked every six months
- Adequate lighting, including nightlights, are used in kitchen, hallways, bathrooms and stairs
- Tripping hazards are removed (thresholds, carpets, cords, stairs)
- Flooring is even and non-slippery
- Steps, stairs, and railings are in proper condition and free of debris or objects
- Furniture is stable and easy to use

Planning Ahead

Introduction

It might be difficult to consider that, at some point, illness may prevent you from continuing to provide care for your family member. It is even more difficult to consider your elder family member outliving you. It is important to legally establish the level of care you would like to continue for your family member in the event of your absence.

This section is intended to help you organize information and plans in the event that someone would have to assume your caregiving responsibilities. It can be used to facilitate discussion among your family members or to organize your own thoughts.

Legal and Estate Information

Location of Will (include copy):	
Location of Codicil (include copy):	
Date of Will:	Date of Codicil:
Will Prepared by:	
Witness to the Will:	
Name of Executer:	
Executor's Phone:	
Executor's Address:	

Legal and Estate Information (Continued)

Location of Trust Agreement (include copy):	
Name of Trust:	Date of Trust:
Name of Trustee:	
Trustee's Phone:	
Trustee's Address:	
Name of Beneficiary:	
Beneficiary's Phone:	
Beneficiary's Address:	
Approximate Value of Trust:	

Advance Health Care Directives Quick Glance

This is not an Advance Health Care Directive and should not be used as a legally binding document. Rather, this page provides you with some things to consider when developing an Advance Health Care Directive. Be sure to include a copy of the official Advance Health Care Directive with this sheet in the SCOR.

Have you spoken about your wishes with your:

☐ **Family** ☐ **Physician(s)** ☐ **Friends**

☐ **Clergy** ☐ **Attorney** ☐ **Case manager**

Does the person(s) you have appointed to make decisions on your behalf understand your wishes?

○ **Yes** ○ **No**

Have you spoken to this person about your current and future medical care?

○ **Yes** ○ **No**

Is the person(s) you have appointed to make decisions on your behalf aware of your "Do Not Resuscitate Order" if you have one?

○ **Yes** ○ **No**

Have you given a copy of your completed and signed Advance Health Care Directive to the person(s) you have appointed to make decisions on your behalf?

○ **Yes** ○ **No**

Are you an organ donor? Is the person appointed to make decisions on your behalf aware of your wish to donate your organs?

○ **Yes** ○ **No**

Advance Health Care Directives Quick Glance (Continued)

Attending Physician's Contact Information:

Name:
Address:
Email:
All Telephone Numbers:
Fax:

Secondary Physician's Contact Information (If available):

Name:
Address:
Email:
All Telephone Numbers:
Fax:

Additional Resource:

U.S. Living Will Registry (http://www.uslivingwillregistry.com): This website provides Advance Health Care Directives information for each state.

Advance Health Care Directives Quick Glance (Continued)

Sibling's Name:
Sibling's Spouse:
Date of Birth:
Address:
Phone Numbers:
Email:

Sibling's Name:
Sibling's Spouse:
Date of Birth:
Address:
Phone Numbers:
Email:

Sibling's Name:
Sibling's Spouse:
Date of Birth:
Address:
Phone Numbers:
Email:

Future Living Arrangements

It is important to consider your family members future living arrangements. Where and in what type of situation would you like to see your family member live? Alone or with other family members? How much supervision will be necessary?

First Choice of Future Residential Provider:

Name: _____

Phone Number: _____

Second Choice of Future Residential Provider:

Name: _____

Phone Number: _____

If currently in a supported living environment, list the following information:

Home Manager Name: _____

Phone Number: _____

Case Manager Name: _____

Phone Number: _____

Level of supervision required:

Financial Information

Bank		
Company:	Phone:	
Branch Location:		
Checking Account Number:	Savings Account Number:	Safe Deposit Box:
Contact Person/Title:		
Email:	Phone:	Fax:

Bank		
Company:	Phone:	
Branch Location:		
Checking Account Number:	Savings Account Number:	Safe Deposit Box:
Contact Person/Title:		
Email:	Phone:	Fax:

Financial Accountant/Advisor		
Company:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:

Financial Information (Continued)

Investment Banker		
Company:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:

Income Tax Preparer		
Company:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:

Attorney		
Company:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:

Power of Attorney (Finances)		
Company:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:

Financial Information (Continued)

Checking and Money Market Accounts
Name on Account:
Name of Bank:
Address:
Type of Account:
Account Number:
Name of Banker:

Checking and Money Market Accounts
Name on Account:
Name of Bank:
Address:
Type of Account:
Account Number:
Name of Banker:

Checking and Money Market Accounts
Name on Account:
Name of Bank:
Address:
Type of Account:
Account Number:
Name of Banker:

Financial Information (Continued)

Individual Retirement Accounts	
Name on Account:	
Type:	Account Number:
Name of Institution:	
Address:	
Date Opened:	Interest Rate:
Maturity Date:	Original Deposit Amount:

Safe Deposit Box
Name of Bank/Branch
Safe Deposit Box Address:
Name of Box Holder:
Box Number:
Location and Custodian of Key:

Credit Cards	
Name on Account:	
Issuing Company:	
Address:	
Phone:	
Account Number:	Expiration Date:

Financial Information (Continued)

Credit Cards	
Name on Account:	
Issuing Company:	
Address:	
Phone:	
Account Number:	Expiration Date:

Certificates of Deposit	
Date:	Interest Rate:
Bank:	
Certificate Number:	Maturity Date:
Amount Deposited:	

Securities (Stocks, Mutual Funds, etc.)	
Name of Security:	
Name of Broker:	
Date:	Number of Shares Purchased:
	Price:
	Net Total Cost:
Date:	Number of Shares Sold:
	Price:
	Net Total Proceeds:
	Profit/Loss:

Financial Information (Continued)

Securities (Stocks, Mutual Funds, etc.)	
Name of Security:	
Name of Broker:	
Date:	Number of Shares Purchased:
	Price:
	Net Total Cost:
Date:	Number of Shares Sold:
	Price:
	Net Total Proceeds:
	Profit/Loss:

Securities (Stocks, Mutual Funds, etc.)	
Name of Security:	
Name of Broker:	
Date:	Number of Shares Purchased:
	Price:
	Net Total Cost:
Date:	Number of Shares Sold:
	Price:
	Net Total Proceeds:
	Profit/Loss:

Financial Information (Continued)

Bonds				
Broker:			Account Exec. Phone:	
Address:				
Name on Account:			Account Number:	
Transaction Date	Bond Name	Bought or Sold	Quantity	Unit Price

Bonds				
Broker:			Account Exec. Phone:	
Address:				
Name on Account:			Account Number:	
Transaction Date	Bond Name	Bought or Sold	Quantity	Unit Price

Financial Information (Continued)

Income Tax						
Names	SSN	Year	Prepared by (name, number)	Federal Tax Paid	Refund Amount	Location of Tax Records

Loan	
Name of Loan:	
Type of Loan:	Loan Account Number:
Original Amount of Loan:	Due Date:
Interest Rate:	Term:
Lender:	Phone:
Address:	

Financial Information (Continued)

Loan	
Name of Loan:	
Type of Loan:	Loan Account Number:
Original Amount of Loan:	Due Date:
Interest Rate:	Term:
Lender:	Phone:
Address:	

Automobile	
Name on Title:	
Make/Model:	Year:
VIN:	Color:
Price	Date Purchased:
Dealer:	Phone:
Address:	
Location of Title (include copy):	

Financial Information (Continued)

Automobile	
Name on Title:	
Make/Model:	Year:
VIN:	Color:
Price	Date Purchased:
Dealer:	Phone:
Address:	
Location of Title (include copy):	

Automobile	
Name on Title:	
Make/Model:	Year:
VIN:	Color:
Price	Date Purchased:
Dealer:	Phone:
Address:	
Location of Title (include copy):	

Financial Information (Continued)

Property	
Description:	
Name on Property:	
Date Acquired:	Purchase Date:
Attorney:	Phone:
Address:	
Mortgager:	
Address:	
Mortgage Amount:	Term:
Date Sold:	Sale Price:
Location of Deed (include copy):	

Financial Information (Continued)

Property	
Description:	
Name on Property:	
Date Acquired:	Purchase Date:
Attorney:	Phone:
Address:	
Mortgager:	
Address:	
Mortgage Amount:	Term:
Date Sold:	Sale Price:
Location of Deed (include copy):	

Collections and Valuables	
Item:	
Date Acquired:	Purchase Price:
Date Sold:	Sale Price:
Comments:	
Location of Property Appraisals (include copy):	

Financial Information (Continued)

Collections and Valuables	
Item:	
Date Acquired:	Purchase Price:
Date Sold:	Sale Price:
Comments:	
Location of Property Appraisals (include copy):	

Collections and Valuables	
Item:	
Date Acquired:	Purchase Price:
Date Sold:	Sale Price:
Comments:	
Location of Property Appraisals (include copy):	

Collections and Valuables	
Item:	
Date Acquired:	Purchase Price:
Date Sold:	Sale Price:
Comments:	
Location of Property Appraisals (include copy):	

Financial Information (Continued)

Life Insurance		
Company:	Phone:	
Policy Number:		
Location of Policy (include copy):		
Insurance Company Location:		
Contact Person/Title:		
Email:	Phone:	Fax:

Burial Policy		
Funeral Home:	Phone:	
Cemetery:	Phone:	
Contact Person/Title:		
Address:		
Email:	Phone:	Fax:
Plot Number and Location:		
Location of Pre-Payment Receipts or Deeds (include copy):		
Specific Instructions:		

Guardianship

Letters of Guardianship have been approved by:	
Judge:	Date:
Approved Guardian's Name:	
Relationship:	
Address:	
Phone:	Fax:

Approved Successor Guardian's Name:	
Relationship:	
Address:	
Phone:	Fax:

Approved Successor Guardian's Name:	
Relationship:	
Address:	
Phone:	Fax:

If a guardian has not yet been appointed, list in order of preference the people who you would like to serve as guardian, should guardianship prove necessary in the future. Include name, address, phone number and the person's relationship to you and your family member.

Name	Address	Phone Number	Relationship

Other Resources

Military OneSource: http://www.militaryonesource.mil

Military OneSource is a 24/7/365 service for military members and their families and is available online and by telephone at 800-342-9647. All information and materials are provided at no cost for service members and their families. Features for families with special needs include:

Special Needs Specialty Consultants - Families with special needs can call to schedule a session with a Special Needs Consultant. Master's level consultants provide information, referrals, and assistance in the area of special needs including advocacy, legal and financial planning, respite care and more.

Website - The Military OneSource website offers information on subjects relevant to military family life, including the area of special needs and the Exceptional Family Member Program. The site offers resource lists, financial calculators, moderated charts, online workshops, podcasts and webinars. Information specific to family members with special needs and the Exceptional Family Member Program can be found at http://www.militaryonesource.mil/efmp.

Plan My Move: http://planmymove.militaryonesource.mil

Plan My Move, available through MilitaryOneSource, is a set of online organizational tools designed to make frequent moves easier and less disruptive for service members and families. Available tools include a customizable calendar, to-do lists, departure and arrival checklists, installation overviews, and installation-specific information on a number of topics, such as education, transportation, child care, and employment. This site is easy to use and provides quick information and results.

TRICARE: http://www.tricare.mil

The TRICARE website provides information about military health plans, military treatment facilities, and other TRICARE resources.

Acronym Index

Use the table below to list any acronyms that you may need to remember.

Acronym	Meaning

Created for you by the Department of Defense
Exceptional Family Member Program