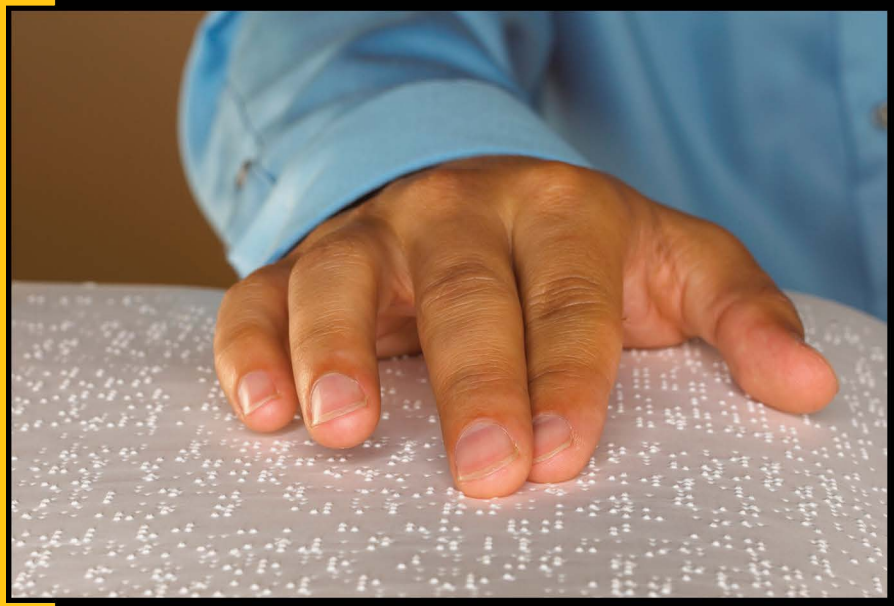
SCOR

Special Care Organizational Record

for Adults With Special Health Care Needs



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Introduction

The Special Care Organizational Record for Adults is specifically designed as an organizing tool for families with an adult member with special health care needs. This includes spouses and adult children with special health care needs as well as any other adult dependent family member. The SCOR for Adults is intended to help track and organize information in one central location and to make it easier for someone to care for your family member when you are unable to do so. While the SCOR is organized into different sections, you are encouraged to reorganize it to accommodate your needs.

Please note that while the SCOR for Adults is a toolkit to help you care for your family member, it is not legally binding in any way nor can it take the place of official medical records. It also contains very private information such as Social Security numbers, medical history/information, and insurance information. In order to ensure that you maintain your family's privacy, make sure to keep your SCOR in a safe place that is not easily accessible by those who should not have access to it.

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.

SCOR for Adults With Special Health Care Needs

What is the SCOR for Adults?

The SCOR for Adults is an organizing tool for families who have an adult family member with special health care needs. This includes spouses and adult children with special health care needs, as well as other adult dependent family members. It is designed to help you keep track of all of the relevant information regarding your family member's health and care.

How can the SCOR help you?

While caring for your family member with special health needs, you receive information and paperwork that must be readily accessible. The SCOR will help you organize all of this information and make it easier to quickly find what you need. It will also make it easier to share key information with those who are part of your family member's care team.

Use the SCOR 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 doctor and others providing care
- Review the checklist prior to making a permanent change of station move

Some helpful hints for using your family member's SCOR:

- 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 that it 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 information you need will be close at hand.

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 already 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 to you and 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? Additional, less critical information can be stored 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 to you and your family member. Here are some supplies that may help you put it together:

- 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.
- It is not legally binding in any way. The SCOR provides a place to start thinking about who would take care of your family member if you were no longer able to do so. However, you would still need to go through the proper legal protocol to make these decisions legally binding.
- 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.

In Case of an Emergency

Emergency Quick Glance	
Name:	
Date of Birth:	Blood Type:
Address:	
Phone:	
Diagnosis(es): (For more on diagnoses, go to the "Current Medical Diagnoses" sheet in the Medical Information Section.)	

Emergency contacts

List in order of who should be contacted, first to last.

Name	Relationship	Cellphone	Work Phone	Evening Phone

Current medications

For more on medications, go to the "Medication History Tracking" sheet in the Medical Information section.

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

Medication allergies

For more on allergies, go to the "Food and Other Allergies" sheet in the Routines and Preferences section.

Allergen	Allergic Reaction	How to Respond

In Case of an Emergency: 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).

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

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

Birth

Personal Information			
Name:		Prefers to be Called:	
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):			
Caregivers:			
Emergency Contact Name:			
Emergency Contact Number:			
Mother's Name:	SSN:	Sponsor (Yes/No):	
Address:			
Daytime Phone:	Cellphone:	Evening Phone:	
Father's Name:	SSN:	Sponsor (Yes/No):	
Address:			
Daytime Phone:	Cellphone:	Evening Phone:	

Personal Information		
Sibling's Name:	Age:	Phone:
Sibling's Name:	Age:	Phone:
Sibling's Name:	Age:	Phone:
Other Household Members:		
Language Spoken at Home:		
Other Languages:		

Birth: Birth History

Birth History
Birth Location:
Complications During Birth:
Neonatal Hospitalization:

Diagnosis

Date	Diagnosis

Surgeries

Date	Procedure	Results

Note: Space is provide on the following page for any additional comments concerning diagnosis and surgeries.

Birth: Birth History (continued)

Comments Regarding Diagnosis

Comments Regarding Surgeries

Routines and Preferences

Daily Routine

If you have a plan of care for your family member, please describe it and include copy.

Plan of Care

Daily treatments (e.g., respiratory treatment, 0_2, vent, trach, G-tube, etc.) include:

Vital Signs

Respiratory Treatment

Trach/G-tube/Other Care

Routines and Preferences: Daily Routine (continued)

Bowel/Bladder Routine

Adaptive Equipment (wheelchair, braces, splints, speech devices)

Medications

Medication	Dose	When to Administer

Routines and Preferences: Describe a Typical Day

Provide a description of your family member's daily routine throughout the week including when he or she wakes up and goes to sleep, takes naps, has mealtimes, when medications should be taken, bathing, and grooming information.

Day	Routine
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Routines and Preferences: Daily Schedule and Support Providers

Use this table to track your family member's daily schedule and associated care providers. Identify particular activities (e.g., sleeping, eating, working, attending therapy) and who is responsible for your family member during that time (e.g., family member, friend, job coach, speech therapist).

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8–8:30 a.m.							
8:30–9 a.m.							
9–9:30 a.m.							
9:30–10 a.m.							
10–10:30 a.m.							
10:30–11 a.m.							
11–11:30 a.m.							
11:30 a.m–12 p.m.							
12–12:30 p.m.							
12:30–1 p.m.							
1–1:30 p.m.							
1:30–2 p.m.							
2–2:30 p.m.							
2:30–3 p.m.							
3–3:30 p.m.							
3:30–4 p.m.							
4–4:30 p.m.							
4:30–5 p.m.							
5–5:30 p.m.							
5:30–6 p.m.							
6–6:30 p.m.							
6:30–7 p.m.							
7–7:30 p.m.							
7:30–8 p.m.							
8–8:30 p.m.							
8:30–9 p.m.							

Routines and Preferences: 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) and the kind of assistance that should be provided	
Task	Assistance Required

List tasks that your family member may try to do independently that could endanger him or her

List other information related to personal care that would be helpful to those providing care for your family member (e.g., shoe and clothing sizes, menstrual cycle)

Routines and Preferences: Food Preferences

List foods that your family member particularly enjoys and or dislikes	
Likes	**Dislikes**

Typical Daily Diet	
Meal	**Preferred Foods/Drinks**
Breakfast	
Lunch	
Dinner	
Snack	

Routines and Preferences: Food Preferences (continued)

Favorite restaurants and preferred meals:

Restaurant	Preferred Meals	Additional Information (e.g., favorite server, routines before or after the meal)

Average total caloric intake/day: _____

Average total water/day: _____

Food taken by: ☐ Mouth ☐ G-tube ☐ GJ tube ☐ NG ☐ NJ

Note: It might be helpful to make a video for care providers of how your family member eats/takes in nourishment and any routines surrounding meals.

Size of tube: _____

Routines and Preferences: Communication

Communication devices (e.g., picture book or communication board)

Device	Location of Warranty (include copy)	Point of Contact (e.g., speech therapist) and Phone

Note: It might be helpful to make a video for care providers of your family member using his or her communication device.

How to use the communication device with your family member

Routines and Preferences: Food and Other Allergies

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

Allergen	Allergic Reaction	How to Respond/ Who to Contact

Routines and Preferences: Diet Tracking Form

Diet Tracking Form							
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.							

Routines and Preferences: Behavior Help

Provide a description of any behavior problems (e.g., disruptive, self-injurious, aggressive/violent outbursts) that commonly arise with your family member. Describe anything that might trigger the negative behavior (e.g., introduced to a new person or a new place or otherwise placed in an uncomfortable situation) and how a caregiver should respond to the behavior and address it. Provide the name and description of techniques or things that are helpful and where they can be located (e.g., afraid of thunderstorms — use headphones and music to help block out the noise). Describe acceptable behavior (e.g., rocking, flapping hands and other forms of stimming).

	What Often Occurs Before Behavior Problem	Behavior Problem/ Impact on Family Member	How to Respond/ Successful Interventions
1.			
2.			
3.			

Routines and Preferences: Leisure Activities and Social Experiences

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

TV Shows/Movies/Video Games	
Likes	Dislikes

Music/Books	
Likes	Dislikes

Routines and Preferences: Leisure Activities and Social Experiences (continued)

Hobbies/Activities in the Home	
Likes	Dislikes

Leisure Activities/Clubs Outside the Home	
Name of Club:	Name of Club:
Contact Person:	Contact Person:
Phone:	Phone:
How Often:	How Often:
Other Notes:	Other Notes:

Routines and Preferences: Leisure Activities and Social Experiences (continued)

Vacation/Traveling	
Likes	Dislikes

Travel Destination Wish List

Special Interests

Situations that make your family member uncomfortable

Routines and Preferences: Pets and Service Animals

Pets		
Pet's Name	Type of Animal	Notes About Pet Care

Any additional notes about the pet(s)
Location of veterinary care records (include copy):

Service Animal(s)			
Service Animal's Name	Type of Animal	How the Animal Helps Me	Notes About Service Animal Care

Any additional notes about the service animal
Location of license and veterinary care records (include copies):

School

School History

Year	School	Teacher	School Nurse	Phone

School: School Evaluations and Discipline

Include any evaluations here (e.g., school district evaluations, independent evaluations)

Note any disciplinary actions received at school (e.g., suspension, detention) and the reason for the action

School: Education Plans

Please attach copy of Individualized Education Program or Individual Habilitation Plan.

School Information		
School Name:	School Phone:	
Teacher:	School Nurse:	
School OT:	Phone:	Frequency:
School PT:	Phone:	Frequency:
School ST:	Phone:	Frequency:

Employment

Current Employment and Employment History

Current Place of Employment
Contact person:
Address:
Phone:
Hours/days worked:

Job Coach
Name:
Address:
Email:
Phone:
Fax:

Employment History

Employment: Vocational Experience

List work potential below. What kinds of employment support, if any, is received and from which agencies?

Work Potential

List capabilities, skill level, and other pursuable opportunities

Volunteer Experience

Medical Information

Medication History Tracking Sheet

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

Briefly note any medication allergies (see the allergies chart on Page 18 for more information)

Medical Information: Pharmacist

Pharmacist	
Name:	Phone:
Email:	
Address:	

Pharmacist	
Name:	Phone:
Email:	
Address:	

Pharmacist	
Name:	Phone:
Email:	
Address:	

Pharmacist	
Name:	Phone:
Email:	
Address:	

Medical Information: Hospital Tracker

Date	Hospital	Reason for Admission	Notes

Medical Information: Lab Work/Tests

Date	Test	Result	Comments

Medical Information: Immunization Records

Include the date when the listed immunizations were received. Use the remaining blocks at the bottom as necessary.

Immunization Chart					
DTaP	1.	2.	3.	4.	5.
DT	1.	2.			
Polio	1.	2.	3.	4.	
HIB	1.	2.	3.	4.	
Prevnar	1.	2.	3.	4.	
MMR	1.	2.			
Varicella	1.				
HBV	1.	2.	3.		
TB					
Flu					
Other					
Other					
Other					

Below, note any reactions to shots/immunizations.

Shot/Immunization	Reaction	Treatment

Medical Information: Current Medical Diagnoses

Date	Diagnosis	Notes

Medical Information: Appointment Log

Date	Provider	Reason Seen/Care Provided	Next Appointment

Medical Information: 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:		

Medical Information: Equipment/Supplies

Type of Equipment/ Supplies	Prescribed by	Reason Prescribed	Date Started	Date Ended	Vendor Phone/Fax

Medical Information: Equipment/Supplies (continued)

List any other relevant notes regarding any equipment used or needed.

Service Providers

Provider Information

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

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

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

Specialist		
Name:	Specialty:	
Address:		
Email:	Phone:	Fax:

Service Providers: Outpatient Therapy

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

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

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

Service Providers: Case Manager(s)

Case Manager		
Name:		Agency:
Address:		
Email:	Phone:	Fax:
Please attach the plan of care provided by the case manager.		
Notes:		

Case Manager		
Name:		Agency:
Address:		
Email:	Phone:	Fax:
Please attach the plan of care provided by the case manager.		
Notes:		

Case Manager		
Name:		Agency:
Address:		
Email:	Phone:	Fax:
Please attach the plan of care provided by the case manager.		
Notes:		

Service Providers: Transportation (To and From Medical Therapy Appointments)

Transportation		
Contact Person:		
Agency:		
Address:		
Email:	Phone:	Fax:

Transportation		
Contact Person:		
Agency:		
Address:		
Email:	Phone:	Fax:

Transportation		
Contact Person:		
Agency:		
Address:		
Email:	Phone:	Fax:

Service Providers: Appointment Log

Date	Provider	Reason Seen/Care Provided	Next Appointment

Support

Family Support Resources

Exceptional Family Member Program Point of Contact: _____

Note: To locate an EFMP service provider in your area visit, http://www.militaryinstallations.dod.mil.

The Exceptional Family Member Program		
Contact Person:		
Address:		
Email:	Phone:	Fax:

Parent Group		
Contact Person:		
Address:		
Email:	Phone:	Fax:

Religious Organization		
Contact Person:		
Address:		
Email:	Phone:	Fax:

Service Organization		
Contact Person:		
Address:		
Email:	Phone:	Fax:

Counseling Services		
Contact Person:		
Address:		
Email:	Phone:	Fax:

Support: School Support

School Information		
School:		Start Date:
Address:		
Phone:	Fax:	
Contact Person/Title:		
Email:	Phone:	Fax:
Contact Person/Title:		
Email:	Phone:	Fax:

Support: Respite Care

Provider		
Respite Care Provider:		Start Date:
Agency:		Contact Person:
Address:		
Email:	Phone:	Fax:

Provider		
Respite Care Provider:		Start Date:
Agency:		Contact Person:
Address:		
Email:	Phone:	Fax:

Provider		
Respite Care Provider:		Start Date:
Agency:		Contact Person:
Address:		
Email:	Phone:	Fax:

Note: If this care is to be covered by TRICARE, is the provider a TRICARE authorized provider? Has the Managed Care Support Contractor authorized this respite care? Keep a copy of your respite care applications and any related documentation in this section.

Support: Advocates

List individuals, advocates, and/or service providers who are important to your family member's well-being and are not otherwise listed in this document:

Advocate		
Name:		
Address:		
Email:	Phone:	Fax:
Note what he or she does for or with your family member:		

Advocate		
Name:		
Address:		
Email:	Phone:	Fax:
Note what he or she does for or with your family member:		

Advocate		
Name:		
Address:		
Email:	Phone:	Fax:
Note what he or she does for or with your family member:		

Health Benefits and Insurance

TRICARE

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

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

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

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

Debt Collections Assistance Officer Information		
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 Benefits and 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		
Name:		
Address:		
City:	State:	Zip:
Phone:	Email:	

Orthodontist		
Name:		
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.

Health Benefits and Insurance: Insurance Information

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

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

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

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

Health Benefits and Insurance: Medical Bill Tracker

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

Transitioning/Moving

Transitioning/Moving Checklist

Use this checklist to help organize your move. Add to it to meet your specific needs.

Arrangements

- ☐ Service animal travel and requirements
- ☐ Emergency telephone numbers (relief societies, American Red Cross, physician)
- ☐ Accessible lodging arrangements
- ☐ Power for medical equipment while traveling
- ☐ Vehicle trailer for transporting necessary support equipment and supplies

Air Travel Arrangements

- ☐ Notice for special accommodation for air travel (48 hours; Passenger Support Specialist TSA Hotline: 855-787-2227)
- ☐ Assistance with boarding, deplaning, and making connections
- ☐ Additional fee for oxygen
- ☐ Be prepared to provide battery (dry and wet cell) information
- ☐ On-board wheelchairs
- ☐ Record height, width, and depth of wheelchair
- ☐ Accessible vehicle transportation at the destination

Preparation for Packing

- ☐ Prepare first aid kit
- ☐ Prepare a travel entertainment backpack
- ☐ Locate medical documents to hand-carry
- ☐ Locate dental documents to hand-carry
- ☐ Locate special education Individualized Education Program paperwork to hand-carry
- ☐ Locate military and MedicAlert ID cards
- ☐ Locate medical supplies
- ☐ Medications (try to have enough medications to last you for the next three months)

Packing

- ☐ Medical supplies
- ☐ Medications
- ☐ Medical equipment, e.g., nebulizer, portable suction machine
- ☐ School documents
- ☐ IEP paperwork

- ☐ Section 504
- ☐ Teacher observations/recommendations
- ☐ Legal documents
- ☐ Special bedding
- ☐ Positioning or body support cushions
- ☐ Child/adult diapers and cleansing cloths
- ☐ Washcloths, towels, and extra sheets if needed
- ☐ Garbage bags for soiled diapers and cloths
- ☐ First-aid kit
- ☐ Special food items
- ☐ Assistive technology devices and battery chargers
- ☐ Important phone numbers
- ☐ Arrival checklist
- ☐ Military IDs
- ☐ Handicapped parking placard
- ☐ MedicAlert jewelry or cards
- ☐ Bath chair (remember it may take a few weeks for you to receive your household goods)
- ☐ Lift
- ☐ Wheelchair or scooter
- ☐ Wheelchair tray
- ☐ Wheelchair battery charger
- ☐ Wheelchair transfer board
- ☐ Weather protection
- ☐ Eating and drinking utensils
- ☐ Bibs
- ☐ Service animal rabies tag
- ☐ Service animal license
- ☐ Service animal food and bowls
- ☐ Medications, if necessary
- ☐ Disposable bags
- ☐ Favorite toys for service animal
- ☐ Extra harness
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Transitioning/Moving: Transportation When Moving

Note which forms of transportation are NOT acceptable for your family member when moving and provide a brief explanation

Note any lodging-related needs when traveling with your family member (e.g., must be wheelchair accessible to include the shower stall; must have TTY/TDD telephone)

Other notes regarding transitioning/moving

Note: Speak with your installation Household Goods/Transportation Office regarding the shipment of required medically necessary equipment. Required medical equipment must be certified by an appropriate uniformed services health care provider as necessary for the medical treatment of the authorized family member.

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 harder to consider that your family member may outlive you. Because you would not want your family member's quality of life to be affected or altered in any significant way it is important to legally establish the level of care you would like to continue for your family member in your absence.

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

Planning Ahead: Advance Directive Quick Glance

This is not an Advance 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 Directive. Be sure to include a copy of the official Advance 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 Advanced Directive to the person(s) you have appointed to make decisions on your behalf?

○ **Yes** ○ **No**

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:

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 directive information for each state.

Planning Ahead: Family Information

Spouse	
Spouse's Name:	Email:
Date of Birth:	
Address:	
Phone Number:	

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

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

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

Planning Ahead: Family Information (continued)

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

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

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

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

Planning Ahead: Other Relatives

If you have established a Special Needs Trust for your family member, note whether other family members have been told about it to ensure that they are aware of the option of leaving money or contributing to the trust.

Relative		
Name:		
Address:		
Phone:	Email:	
Notified: ○ Yes ○ No	Date Notified:	Method of Notification:

Relative		
Name:		
Address:		
Phone:	Email:	
Notified: ○ Yes ○ No	Date Notified:	Method of Notification:

Relative		
Name:		
Address:		
Phone:	Email:	
Notified: ○ Yes ○ No	Date Notified:	Method of Notification:

Relative		
Name:		
Address:		
Phone:	Email:	
Notified: ○ Yes ○ No	Date Notified:	Method of Notification:

Planning Ahead: Living Arrangements for Your Family Member in the Future

Where and in what type of situation would the family member prefer to live? Alone or with roommates? What neighborhood? 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: _____

Planning Ahead: 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:

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

Planning Ahead: 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:	
Policy Number:		
Location of Policy (include copy):		
Contact Person/Title:		
Email:	Phone:	Fax:
Specific Instructions:		

Planning Ahead: Supplemental Security Income

When the special needs family member turns 18, he or she can apply for Supplemental Security Income at your local Social Security Office. The SSI payments are provided as a provision of Title XVI of the Social Security Act.

The following table was designed by the Social Security Administration to help you keep track of SSI and expenses.

Contact the Social Security Administration at 800-772-1213 to request Form SSA-623.

Note: Form SSA-623 is not available online.

Income and Expenses Worksheet

Month and Year	Amount of SSI Benefits Received	Expenses for food and housing	Expenses for clothing, medical/dental, personal items, recreation, misc.
TOTAL for report period	$ _____	$_____ Put this figure on line 3B of the Form SSA-623	$_____ Put this figure on line 3C of the Form SSA-623
Show the amount of benefits you saved for the beneficiary, including any interest earned.			$ _____ Put this figure on line 3D of the Form SSA-623

Planning Ahead: Guardianship

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

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

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

Guardian Ad Litem	
Name:	
Email:	
Address:	
Phone:	Fax:

Note: Keep a copy of all relevant court documents in this section.

Planning Ahead: Guardianship (continued)

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 the family member with special needs.

Name	Address	Phone Number	Relationship

Other Resources

Military OneSource: http://www.militaryonesource.mil
Military OneSource provides information and resources to help balance work and family life. Consultants are available 24 hours a day, seven days a week by phone, online, or via email offering personalized support to any service or family member. 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 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.

Relevant Forms
DD Form 2792, Exceptional Family Member Medical Summary can be found at http://www.dtic.mil/whs/directives/forms/eforms/dd2792.pdf.

DD Form 2792-1, Exceptional Family Member Special Education/Early Intervention Summary can be found at http://www.dtic.mil/whs/directives/forms/eforms/dd2792-1.pdf.

Acronym Index

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

Acronym	Meaning

Acronym Index (continued)

Acronym	Meaning

Notes

Notes

Notes

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