SCOR

Special Care Organization Record

for Adults with Special Health Care Needs

Introduction

The Special Care Organization Record (SCOR) 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 has been created using the form features of Microsoft Word. You can type directly into the gray areas found throughout the form and then save and print the completed document. You can also click on the various sections of the Document Map panel on the left of the screen to move quickly to the different sections of the SCOR. The Document Map is displayed by clicking on the View Menu then Document Map. In some versions of Word, The Document Map is displayed by first clicking on the View Menu then the Navigation Pane. Once the Navigation Pane is visible select Document Map from the Navigation Pane dropdown menu.

If you prefer to print out the forms in this document and then fill them out by hand, you may wish to turn off the field shading first to prevent the boxes from printing too. You can turn the field shading off by displaying the Word Forms Toolbar (right-click on the tool bar area at the top of your Word screen, then click on Forms under Toolbars). Once you can see the Forms Toolbar, click the Form Field Shading icon to turn shading off.

If you have Word 2007 and wish to remove the field shading before printing, right click on the Windows Office icon in the upper left hand corner of the screen. Click “Customize the Quick Access Toolbar.” In the drop-down menu under “Choose commands from,” click on “Developer Tab” and then select and add “Legacy Tools.” Once you have added Legacy Tools to your Toolbar, you will have the option of turning off the field shading.

If you have any questions or comments about the SCOR for Adults, please feel free to submit them through the MilitaryHOMEFRONT Feedback Function.

SCOR for Adults Guide

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 for you to quickly find what you need. It will also make it easier for you 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 (PCS) move

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

- Keep the SCOR where it is easy to find. That way it will always be on hand when you need it.
- Be mindful that your SCOR contains very 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.
- Keep the SCOR with you at 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 1: 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 2: 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 3: Decide which information is most important to keep in the SCOR.
What information do you find yourself looking for often? What information do your 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 4: Put the SCOR together.
Organize your 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:

- 3-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	Cell Phone	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 table 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 1:
Step 2:
Step 3:
Step 4:
Other:
What Might Happen:
What To Do:
Step 1:
Step 2:
Step 3:
Step 4:
Other:

Birth

Personal Information

Name:	**Prefers to be Called:**	
Date of Birth:	**SSN:**	**Blood Type:**
Caregivers:		
Location of Birth Certificate:		
Location of Social Security Card:		
Home Address:		
Home Phone:	**Fax:**	**County:**
Emergency Contact Name:		
Emergency Contact Number:		
Mother's Name:	**SSN:**	**Sponsor (Yes/No):**
Address:		
Daytime Phone:	**Cell Phone:**	**Evening Phone:**
Father's Name:	**SSN:**	**Sponsor (Yes/No):**
Address:		
Daytime Phone:	**Cell Phone:**	**Evening Phone:**
Sibling's Name:		**Age:**
Sibling's Name:		**Age:**
Sibling's Name:		**Age:**
Other Household Members:		

Birth - Personal Information (continued)

Language Spoken at Home:
Other Languages:

Birth – Birth History

Birth Location:
Complications During Birth:
Neonatal Hospitalization:

Diagnosis:

MM/DD/YY	Diagnosis

Birth – Birth History (Continued)

Surgeries:

MM/DD/YY	Procedure	Results

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 insert it here.

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

Vital signs:

Respiratory treatment:

Trach/ g-tube/other care:

Bowel/bladder routine:

Adaptive equipment (W/C, braces, splints, speech devices):

Routines and Preferences – Daily Routine (continued)

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. Use different colors to denote particular activities (e.g., sleeping, eating, working, attending therapy) and identify who is responsible for your family member during that time (e.g., family member, friend, job coach, speech therapist). By way of example, the 9-9:30AM slot on Monday and Wednesday is color coded yellow to denote Speech Therapy. "ST" stands for "Speech Therapist." The NOON -12:30PM slot every day is color coded blue to denote a mealtime. "F" stands for "Family."

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 -8:30AM							
8:30-9AM							
9-9:30AM	ST		ST				
9:30-10AM							
10-10:30AM							
10:30 – 11AM							
11-11:30AM							
11:30-NOON							
NOON -12:30PM	F	F	F	F	F	F	F
12:30-1PM							
1-1:30PM							
1:30-2PM							
2-2:30PM							
2:30-3PM							
3-3:30PM							
3:30-4PM							
4-4:30PM							
4:30-5PM							
5-5:30PM							
5:30-6PM							
6-6:30PM							
6:30-7PM							
7-7:30PM							
7:30-8PM							
8-8:30PM							
8:30-9PM							

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

Likes and dislikes:

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:

I use _____ to communicate what I want (e.g., picture book or communication board). (If necessary, briefly describe how to use the communication device with your family member.)

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

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

Week of:				**Weight:**			
Date Checked:							
	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
6am							
7am							
8am							
9am							
10am							
11am							
12pm							
1pm							
2pm							
3pm							
4pm							
5pm							
6pm							
7pm							
8pm							

Routines and Preferences – Behavior Help

Provide a description of any behavior problems that commonly arises 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).

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

Places he or she would like to visit in the future:

Special interests:

Situations that make me uncomfortable:

Routines and Preferences – Pets and Service Animals

Include your service animal's license and shot record here.

Pet(s):

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

Any additional notes about the pet:

Service animal(s):

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

Any additional notes about the service animal:

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 that your family member has had at school (e.g., suspension, detention) and the reason for the action:

School – Education Plans

Please attach copy of Individualized Education Program (IEP) or Individual Habilitation Plan (IHP).

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

What is family member's work potential? What kinds of employment support does he/she receive and from which agencies?

What are your family member's capabilities and skill levels? What other opportunities would you like your family member to be able to pursue?

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 for more information):

Medical Information – Pharmacist

Name:	**Phone:**
Email:	
Address:	
Name:	**Phone:**
Email:	
Address:	
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

List the date when your family member received the listed immunizations. Use the remaining blocks at the bottom labeled "Other" as necessary.

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 that your family member has had to any 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 to your adult special needs family member.

Condition	Relative	Condition	Relative	Condition	Relative
☐ **Cardiac**		☐ **Hypertension**		☐ **Renal**	
☐ **Tuberculosis**		☐ **Gastro-intestinal**		☐ **Cancer**	
☐ **Allergy**		☐ **Orthopedic**		☐ **Lung**	
☐ **Diabetes**		☐ **Blood**		☐ **Ear**	
☐ **Thyroid**		☐ **Vision**		☐ **Psychological**	
☐ **Auto Immune**		☐ **Other**		☐ **Other**	

Additional family information:

Name	Date of Birth	Health
Mother:		
Father:		
Brother/Sister:		
Brother/Sister:		
Brother/Sister:		
Brother/Sister:		
Brother/Sister:		

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 notes that you feel are relevant regarding any equipment your family member uses or needs:

Service Providers

Provider Information

Social Worker:		
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:**
My Specialist:	**Specialty:**	
Location:		
Email:	**Phone:**	**Fax:**
My Specialist:	**Specialty:**	
Location:		
Email:	**Phone:**	**Fax:**

Service Providers – Outpatient Therapy

Therapy:	**Therapist:**	
Location:		
Email:	**Phone:**	**Frequency:**
Therapy:	**Therapist:**	
Location:		
Email:	**Phone:**	**Frequency:**
Therapy:	**Therapist:**	
Location:		
Email:	**Phone:**	**Frequency:**

Service Providers –Case Manager(s)

Case Manager:	**Agency:**	
Address:		
Email:	**Phone:**	**Fax:**
Please attach the plan of care provided by your Case Manager.		
Notes:		
Case Manager:	**Agency:**	
Address:		
Email:	**Phone:**	**Fax:**
Please attach the plan of care provided by your Case Manager.		
Notes:		
Case Manager:	**Agency:**	
Address:		
Email:	**Phone:**	**Fax:**
Please attach the plan of care provided by your Case Manager.		
Notes:		

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

Contact Person:		
Agency:		
Address:		
Email:	**Phone:**	**Fax:**
Contact Person:		
Agency:		
Address:		
Email:	**Phone:**	**Fax:**
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:		
Army Navy Air Force Marine Corps Coast Guard National Guard		
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:		**Start Date:**
Address:		
Phone:	**Fax:**	
Contact Person / Title:		
Email:	**Phone:**	**Fax:**
Contact Person / Title:		
Email:	**Phone:**	**Fax:**

Support – Respite Care

Respite Care Provider:		**Start Date:**
Contact Person:		
Agency:		
Address:		
Email:	**Phone:**	**Fax:**
Respite Care Provider:		**Start Date:**
Contact Person:		
Agency:		
Address:		
Email:	**Phone:**	**Fax:**
Respite Care Provider:		**Start Date:**
Contact Person:		
Agency:		
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:		
Name:		
Address:		
Email:	**Phone:**	**Fax:**
Note what he or she does for or with your family member:		
Name:		
Address:		
Email:	**Phone:**	**Fax:**
Note what he or she does for or with your family member:		
Name:		
Address:		
Email:	**Phone:**	**Fax:**
Note what he or she does for or with your child:		
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 your local TRICARE Service Center (TSC): **http://www.tricare.mil/contactus/**		
TRICARE Regional Office (TRO):		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
TRICARE Service Center:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Beneficiary Counseling and Assistance Coordinator (BCAC):		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Debt Collections Assistance Officer (DCAO):		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	

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.tricaredentalprogram.com/tdptws/home.jsp**		
Dentist Name:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Orthodontist:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Please 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 five and under. The services require preauthorization through the regional TRICARE contractors (http://www.tricare.mil/mybenefit). 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.		
Name of Other Insurance:		
Policy Number:		
Contact Person/Title:		
Address:		
Email:	**Phone:**	**Fax:**
Case Manager:		
Email:	**Phone:**	**Fax:**
Name of Other Insurance:		
Policy Number:		
Contact Person/Title:		
Address:		
Email:	**Phone:**	**Fax:**
Case Manager:		
Email:	**Phone:**	**Fax:**
Name of Other Insurance:		
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 Other Health Insurance	Family Owes	Debt Paid

Transitioning / Moving

Checklist for Your Special Needs Family Member

Use this checklist to help organize your move. Add to it or edit 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 (forty-eight hours notice)
- ☐ 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 (IEP) paperwork to hand-carry
- ☐ Locate military and medic alert 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

Packing (continued)

- ☐ 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
- ☐ Medical Alert jewelry or cards
- ☐ Bath chair (remember it may take a few weeks for you to receive your household goods)
- ☐ Hoyer 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 down lodging-related needs when traveling with your family member (e.g., must be wheelchair accessible (to include the shower stall), 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

When caring for your family member, it might be difficult to take the time to consider that, at some point, illness may prevent you from continuing to provide that care. It is even harder to consider that your family member may outlive you. You have provided a level of care that you would want to ensure continued.

This section is intended to help you organize information and plans in the even 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 – Advanced Directive Quick Glance

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

Is the person(s) you have appointed to make decisions on your behalf aware of your "Do Not Resuscitate (DNR) Order" if you have one?
☐ Yes ☐ No

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

Contact Information (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/forms.shtm) - This website provides advanced directive information for each state.

Planning Ahead – Family Information

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

Planning Ahead – Family Information (continued)

Sibling's Name:	**Email:**
Sibling's Spouse:	
Date of Birth:	
Address:	
Phone Number:	
Sibling's Name:	**Email:**
Sibling's Spouse:	
Date of Birth:	
Address:	
Phone Number:	
Sibling's Name:	**Email:**
Sibling's Spouse:	
Date of Birth:	
Address:	
Phone Number:	
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's Name:		
Address:		
Phone:	**Email:**	
Notified: ☐Yes ☐No	**Date Notified:**	**Method of Notification:**
Relative's Name:		
Address:		
Phone:	**Email:**	
Notified: ☐Yes ☐No	**Date Notified:**	**Method of Notification:**
Relative's Name:		
Address:		
Phone:	**Email:**	
Notified: ☐Yes ☐No	**Date Notified:**	**Method of Notification:**
Relative's 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 you like to see your family member 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:**	**Safety Deposit Box:**
Contact Person/Title:		
Email:	**Phone:**	**Fax:**
BANK		
Company:	**Phone:**	
Branch Location:		
Checking Account Number:	**Savings Account Number:**	**Safety Deposit Box:**
Contact Person/Title:		
Email:	**Phone:**	**Fax:**
LIFE INSURANCE		
Company:	**Phone:**	
Policy Number:		
Where Policy is Located:		
Insurance Company Location:		
Contact Person/Title:		
Email:	**Phone:**	**Fax:**

Planning Ahead – Financial Information (continued)

LIFE INSURANCE		
Company:	**Phone:**	
Policy Number:		
Where Policy is Located:		
Insurance Company Location:		
Contact Person/Title:		
Email:	**Phone:**	**Fax:**
BURIAL POLICY		
Funeral Home:	**Phone:**	
Cemetery:	**Phone:**	
Policy Number:		
Where Policy is Located:		
Contact Person/Title:		
Email:	**Phone:**	**Fax:**
Specific Instructions:		

Planning Ahead – Supplemental Security Income (SSI)

When your child with special needs turns eighteen years old, he or she can apply for Supplemental Security Income (SSI) at your local Social Security Office. 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 (SSA) to help you keep track of SSI and expenses:

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 in 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

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

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:**
Guardian Ad Litem's Name:	
Email:	
Address:	
Phone:	**Fax:**

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 your child.

Name	Address	Phone Number	Relationship

OTHER RESOURCES

Below are some websites and resources you may find helpful.

MilitaryHOMEFRONT: http://www.militaryhomefront.dod.mil/
MilitaryHOMEFRONT is the official Department of Defense website for quality of life information and resources. Through sections tailored to meet the specific and unique needs of Leadership, Troops and Family Members, and Service Providers, MilitaryHOMEFRONT provides current, reliable, and easily accessible information for the military community. Whether you live the military lifestyle or support those who do, you'll find what you need! Information specific to special needs family members and the Exceptional Family Member Program (EFMP) can be found at http://www.militaryhomefront.dod.mil/efm.

HOMEFRONTConnections: https://apps.mhf.dod.mil/homefrontconnections
HOMEFRONTConnections is a Department of Defense social networking environment, designed for those who are in the military, in a military family, or who support the military and their families. Within the password protected site, group (or "Communities") can share best practices, post pictures and videos, or just share information about the work they are doing. Families can also use the site to meet each other or to establish online family readiness groups.

Plan My Move: http://www.militaryhomefront.dod.mil/tf/movingandrelocation
Plan My Move, available through MilitaryHOMEFRONT, 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.

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

TRICARE: http://www.tricare.mil/
The TRICARE website provides information about military health plans, military treatment facilities, and other TRICARE resources.

Exceptional Family Member Program:

Army Navy Air Force Marine Corps

Relevant Forms

DD Form 2792, Exceptional Family Member Medical Summary

DD Form 2792-1, Exceptional Family Member Special Education/Early Intervention Summary

ACRONYM INDEX

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

Acronym	Meaning

Acronym	Meaning

Exceptional Families Exceptional Service

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

Military Community & Family Policy

Providing policy, tools, and resources to further enhance the quality of life of service members and their families.