Children With Special Health or Educational Needs

EFMP Exceptional Family Member Program

SPECIAL CARE ORGANIZATIONAL RECORD | SCOR

Table of Contents

Introduction

The Special Care Organizational Record for Children With Special Health Care Needs is specifically designed as an organizing tool for parents. It is intended to help track and organize your child's information to make it easier for someone to care for your child in your absence. The SCOR can be used to capture a variety of information, including your child's birth history, likes and dislikes, medical and educational information, insurance and step-by-step action plans in case of an emergency. While the SCOR is organized into different sections, you are encouraged to reorganize it to accommodate your needs.

Please note that while the SCOR provides instructions for the care and keep of your child, it is not legally binding in any way. It also contains private information such as Social Security numbers, medical history/information, and insurance information. To maintain your family's privacy, keep your SCOR in a safe place.

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 Children With Special Health Care Needs

What is the SCOR for Children With Special Health Care Needs?

The SCOR is an organizing tool for families who have children with special health care needs. It is designed to help you keep track of relevant information regarding your child's health and care in the event that you are unable to provide the care yourself.

How can the SCOR help you?

In the process of caring for your child with special health needs, information and paperwork must be readily accessible. The SCOR will help you organize 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 your child's care providers.

Use the SCOR to:

- Track changes in your child's medications or treatments
- List telephone numbers for health care providers and community organizations
- Prepare for appointments
- File information about your child's health history
- Share new information with your child's primary doctor, public health or school nurse, daycare staff and others caring for your child

Some helpful hints for using your child'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 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 child's treatment.
- Bring the SCOR with you to appointments and hospital visits so that information you need will be close at hand.

SCOR for Children With Special Health Care Needs (continued)

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

STEP ONE: Gather information you already have.

Gather any health information that you have about your child. This may include reports from recent doctor's visits, immunization records, a summary of a recent hospital stay, test results, 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 child's health and care. Once you have determined what you need, print or collect only those pages to create your personalized SCOR.

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 child? 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 child. If you downloaded and printed the SCOR, here are some supplies that may help:

- Three-ring binder or large accordion envelope to hold papers securely (provided by Military OneSource if ordered from the website)
- 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 child'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 be a place to start when you begin thinking about the care your child would receive if you were no longer able to provide it. You need to go through the proper legal protocol to make legally binding decisions.
- The SCOR contains private information (e.g., Social Security numbers, insurance information, medical history). It is imperative that you keep it in a safe place.

Resources

The Department of Defense Special Needs Parent Tool Kit Birth to 18 was designed to provide information for military families with children with special health care needs. The Tool Kit provides information regarding the services and support that are available to these families, as well as how to use them. The modules of the Tool Kit may provide you with additional information for your child's SCOR. Below, SCOR sections are listed next to related Special Needs Parent Tool Kit module information.

Use this link to access the Special Needs Parent Toolkit: http://download.militaryonesource.mil/12038/EFMP/PTK_SCORs/ParentToolkit_Apr2014.pdf.

SCOR Section	Corresponding Module of Special Needs Parent Toolkit
Birth, All About Your Child, Support	Module 1: Birth to Age Three
School and Employment	Module 2: Special Education
Health Benefits and Insurance	Module 3: TRICARE Health Benefits
Transitioning/Moving; In Case of an Emergency; Estate/Future Plan	Module 4: Families in Transition
Support, Child Advocacy	Module 5: Advocating for Your Child
Other Resources/Websites	Module 6: Resources and Support

In Case of an Emergency

Emergency Quick Glance

Name:	
Date of Birth:	Blood Type:
Address:	
Phone:	
Diagnosis(es): (For more on diagnoses, refer 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, refer 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, refer to the "Food and Other Allergies" sheet in the All About Your Child section.)

Allergen	Allergic Reaction	How to Respond

In Case of an Emergency: Emergency Plan

Use the tables below to list health-related or other emergencies that may occur and how the emergency should be handled (e.g., if your child is epileptic and has a seizure or your child 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:
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:			
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:	

Birth: Personal Information (continued)

Sibling's Name:	Date of Birth:
Sibling's Name:	Date of Birth:
Sibling's Name:	Date of Birth:
Other Household Members:	
Language Spoken at Home:	
Other Languages:	

Birth: Birth History

Birth Location:
Complications During Birth:
Neonatal Hospitalization:

Diagnosis(es):

MM/DD/YY	Diagnosis(es)

Surgical Procedures:

MM/DD/YY	Surgical Procedures	Results

NOTE: Space is provided on the following page for any additional comments concerning diagnoses and surgeries. Include a copy of the Individualized Family Services Plan in this section.

Birth: Birth History (continued)

Comments regarding diagnosis(es):

Comments regarding surgical procedures:

All About Your Child

Watch Them Grow!

Date	Age	Height	Weight	Head Circumference	Major Developmental Milestones (e.g., crawls, talks, walks)

All About Your Child: Daily Routine

If you have a plan of care, please describe and include copy.

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

Vital signs:

Respiratory treatment:

All About Your Child: Daily Routine (continued)

Bowel/bladder routine:

Adaptive equipment (wheelchair, braces, splints, speech devices):

Medications:

Medication	Dose	When to Administer

All About Your Child: Describe a Typical Day

Provide a description of your child'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, as well as bathing and grooming information.

Day	Routine
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

All About Your Child: Personal Care

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

List tasks for which your child requires assistance (e.g., eating, bathing, toileting, dressing) and the kind of assistance that should be provided:

List tasks that your child 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 child (e.g., shoe and clothing sizes, menstrual cycle):

All About Your Child: Food Preferences

List foods that your child particularly enjoys and/or dislikes:

Likes	Dislikes

Typical daily diet:

Meal	Preferred Foods/Drinks
Breakfast	
Lunch	
Dinner	
Snack	

All About Your Child: 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 child eats/takes in nourishment and any routines surrounding meals.

Size of tube: _____

All About Your Child: Food and Other Allergies

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

Allergen	Allergic Reaction	How to Respond/ Who to Contact

All About Your Child: 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.							

All About Your Child: 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 child using his or her communication device.

All About Your Child: Behavior Help

What consistent approach has worked best when parents/caregivers have not been available during difficult transition periods? List typical interventions that have worked. Provide names and descriptions of techniques or things that are helpful and where they can be located. Example: afraid of thunderstorms, use headphones to help block out the noise.

Behavioral interventions:

Things that help to calm your child:

All About Your Child: Leisure Activities and Social Experiences

List any leisure activities that your child particularly enjoys or dislikes.

TV shows/movies/video games:

Likes	Dislikes

Music/books:

Likes	Dislikes

All About Your Child: 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:

All About Your Child: Leisure Activities and Social Experiences (continued)

Vacation/traveling:

Likes	Dislikes

Travel destination wish list:

Special interests:

Situations that make your child uncomfortable:

All About Your Child: Pets and Service Animals

Pet(s):

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 Your Child	Notes About Service Animal Care

Any additional notes about the service animal:

Location of license and veterinary care records (include copies):

School and Employment

School History

Year	School	Contact Person	School Nurse	Phone

School and Employment: School Evaluations and Discipline

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

Year	School	Evaluation	Comments

List any disciplinary actions received at school (e.g., suspension, detention).

Year	School	Disciplinary Action	Reason

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:

Vocational Experience

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

Year	Company	Supervisor	Contact	Comments

Vocational Experience (continued)

List capabilities, skill level, and other pursuable opportunities.

Current Employment and Employment History

Current place of employment:

Contact person:
Address:
Phone:
Hours/days worked:

Employment history:

Volunteer Experience

Medical Information

Medication History Tracking

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

Briefly note any medication allergies (refer to the Allergies chart on Page 19 for more information):

Medical Information: Pharmacies

Name:	Phone:
Email:	
Address:	

Name:	Phone:
Email:	
Address:	

Name:	Phone:
Email:	
Address:	

Name:	Phone:
Email:	
Address:	

Medical Information: Doctor Visits

Date	Seen by	Notes

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 Diagnosis(es)

Date	Diagnosis(es)	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 equipment that your child has specifically received through the school. Include when it has to be returned and any other parameters regarding use of the equipment. A copy of the IEP can be beneficial in this section as well because you may be required to return assistive technology received through the school when you leave the school district.

Item	School and Year	Contact	Due Date

List any other notes that you feel are relevant regarding any equipment your child needs:

Medical Information: Medical Providers

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

Civilian Hospital:		
Address:		
Email:	Phone:	Fax:

Dentist:		
Address:		
Email:	Phone:	Fax:

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

Medical Information: Medical Providers (continued)

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

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

Care 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:

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

Specialist:	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:

Support

Early Intervention Services

Developmental Center:		Start Date:
Agency:		
Address:		
Email:	Phone:	Fax:

Family Resources Coordinator:		Start Date:
Agency:		
Address:		
Email:	Phone:	Fax:

NOTE: A copy of your Individual Family Services Plan can be kept here or in the "Birth" section.

Family Support Resources

Exceptional Family Member Program Point of Contact: _____

NOTE: To locate an EFMP service provider in your area, visit http://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: Child Care Support

Child Care Provider:		Start Date:
Contact Person:		
Address:		
Email:	Phone:	Fax:

Child Care Provider:		Start Date:
Contact Person:		
Address:		
Email:	Phone:	Fax:

Child Care Provider:		Start Date:
Contact Person:		
Address:		
Email:	Phone:	Fax:

NOTE: Include any relevant child care documents (such as the SNRT paperwork) in this section.

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

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

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: Child Advocates

List individuals, advocates, and/or service providers who are important to your child'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 child:		

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 child:		

Health Benefits and Insurance

TRICARE

Use this link to contact Beneficiary Counseling and Assistance Coordinators for beneficiary questions and concerns: https://tricare.mil/bcacdcao.

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:	

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: https://www.tricare.mil/CoveredServices/Dental/TDP.

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 five 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: https://tricare.mil/FormsClaims/Claim.

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 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
- ☐ Onboard 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
- ☐ Hand-carry medications (try to have enough medications to last you for three months)

Packing

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

Packing (continued)

- ☐ 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 (see Plan my Move calendar at http://planmymove.militaryonesource.mil)
- ☐ Military IDs
- ☐ Handicapped-accessible 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 child when moving and provide a brief explanation:

Note any lodging-related needs when traveling with your child (e.g., must be wheelchair accessible to include the shower stall; need 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.

Estate/Future Plan

Letter of Intent

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

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

Estate/Future Plan: Family Information

Mother's Name:	Maiden Name:
SSN:	
Address:	
Phone Numbers:	
Email:	

Father's Name:
SSN:
Address:
Phone Numbers:
Email:

Sibling's Name:
Sibling's Spouse:
Address:
Phone Numbers:
Email:

Estate/Future Plan: Family Information (continued)

Sibling's Name:
Sibling's Spouse:
Address:
Phone Numbers:
Email:

Sibling's Name:
Sibling's Spouse:
Address:
Phone Numbers:
Email:

Sibling's Name:
Sibling's Spouse:
Address:
Phone Numbers:
Email:

Estate/Future Plan: Informing Other Family Members

If you have established a Special Needs Trust for your child, 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 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		
Bank Name:	Phone:	
Branch Location:		
Checking Account Number:	Savings Account Number:	Safe Deposit Box:
Contact Person/Title:		
Email:	Phone:	Fax:

Bank		
Bank Name:	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: Guardianship

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

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

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

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

Planning Ahead: Guardianship (continued)

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

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

If a guardian has not yet been appointed, list in order of preference the person/s who you would like to serve as guardian/s, 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

Planning Ahead: Advance Directive Considerations

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 Advance 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)

Primary 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.

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.

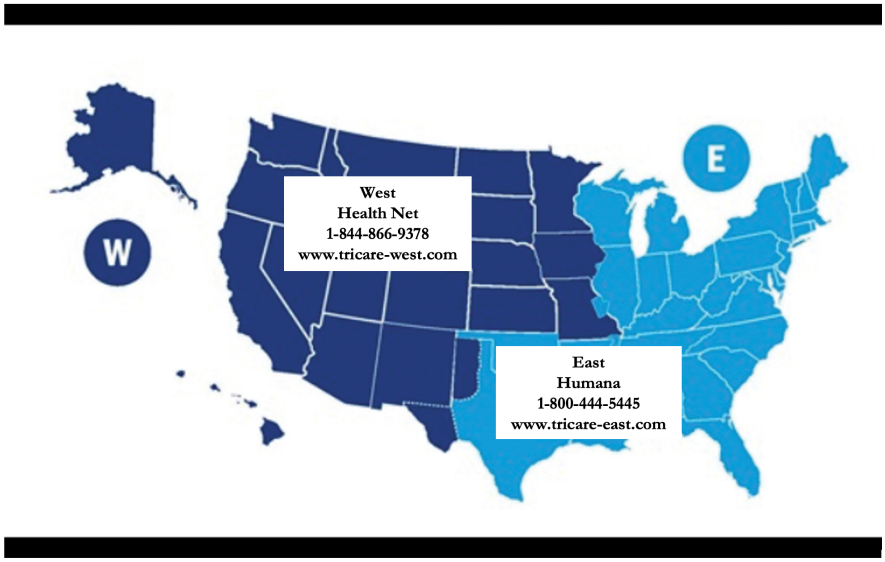
Plan My Move: http://planmymove.militaryonesource.mil
Plan My Move, available through MilitaryHOMEFRONT, is a set of online organizational tools designed to make frequent moves easier and less disruptive for service members and families. Available tools include a customizable calendar, to-do lists, departure 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.

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

Relevant Forms

http://www.dtic.mil/whs/directives/forms/eforms/dd2792.pdf

http://www.dtic.mil/whs/directives/forms/eforms/dd2792-1.pdf



TRICARE Overseas
Eurasia-Africa Area 1-877-678-1207
Latin America and Canada Area 1-877-451-8659
Pacific Area 1-877-678-1208/1209

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

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Military OneSource is your 24/7 connection to information, resources and support — your one source for your best MilLife.