Young Adults With Special Needs

U.S. Department of Defense

EFMP Exceptional Family Member Program

SPECIAL CARE ORGANIZATIONAL RECORD | SCOR

Table of Contents

Introduction

The Special Care Organizational Record for Young Adults is an organizing tool for young adults (around ages 18-24) with special educational or medical needs. The SCOR can help them collect, maintain and organize information in one central location to help as they increase their independence and self-advocacy skills. Young adults are encouraged to complete as much of the SCOR as possible on their own and stay involved if a parent or guardian completes the SCOR. The SCOR is organized into different sections but the owner can reorganize it to accommodate their individual needs.

This SCOR is not legally binding nor can it take the place of official medical records. It may also contain very private information such as Department of Defense ID numbers, medical history/ information and insurance information. Keep the SCOR in a safe place that is only accessible by those who should have access in order to maintain privacy and security.

SCOR for Young Adults With Special Needs

What is the SCOR for Young Adults?

The SCOR for Young Adults is a tool to help you keep track of all relevant information as you transition into adulthood.

How can the SCOR help you?

You will receive information and paperwork that you should keep 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 care team so they can help you, if needed.

Use the SCOR to:

- Track changes in your medicines or treatments.
- List telephone numbers for health care providers and community organizations.
- Prepare for appointments.
- File information about your health history.
- Share new information with your primary doctor and care providers.
- Review the checklist prior to making a move.
- Have your important information ready to go in the event of an emergency.

Some helpful hints for using your SCOR:

- Reach out to your support system (parents, teachers, medical providers, care providers, etc.) if you have questions or need help obtaining information to add to the SCOR.
- The "In Case of Emergency" section is the quick, need-to-know information. Consider printing this section for care providers or keep it in a place where you can easily find it.
- Be mindful that the SCOR contains your private information and you should keep it 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 medications or medical treatment.
- Bring the SCOR with you to appointments and hospital visits so the information you need will be close at hand.

How do you set up your SCOR?

Follow these steps:

STEP ONE: Gather information you already have.

Gather any medical, educational or vocational information that you already have. This may include reports from recent doctor's visits, immunization records, a summary of a recent hospital stay, test results, informational pamphlets, an Individualized Education Program or 504 Plan, job training program, etc.

STEP TWO: Look through the pages of the SCOR.

Select the pages that you think will be most beneficial to you and your near-future endeavors. Visit Military OneSource to find fillable PDF forms to fill out, save, download and add to your SCOR.

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

What information did you find most helpful to have? Ask your support system/care providers what information is most helpful for them to know. 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 may contain a lot of your medical history/information, it is not a replacement for official medical records.
- It is not legally binding in any way. The SCOR provides a place to start thinking about who or how you would want help taking care of yourself if something happened. However, you still need to go through the proper legal protocol to make these decisions legally binding.
- It contains very private information (e.g., DOD ID numbers, insurance information, medical history). It is imperative that you keep it in a safe, secure 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	Phone No.	Address	Email

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

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 you are epileptic and have a seizure or if you become overwhelmed in a crowd and may have difficulty maintaining your composure, then what needs to happen).

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:

Personal Information

Personal Information	
Full Legal Name:	Prefers to be Called:
Date of Birth:	Blood Type:
DOD ID No.:	
Location of Social Security Card (include copy):	
Address:	
Phone:	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:	

Personal Information: Family		
Parent/Guardian #1:		Sponsor (Yes/No):
DOD ID (if still using parent health insurance):		
Military Command/Installation:		
Address (if not the same as yours):		
Cell Phone:	Work Phone:	
Email:		
Parent/Guardian Name #2:		Sponsor (Yes/No):
DOD ID (if still using parent health insurance):		
Military Command/Installation:		
Address (if not the same as yours):		
Cell Phone:	Work Phone:	
Email:		
Sibling's Name:	Age:	Phone:
Sibling's Name:	Age:	Phone:
Sibling's Name:	Age:	Phone:
Sibling's Name:	Age:	Phone:

Personal Information: Family
Other Household Members:
Language Spoken at Home:
Other Languages:

Medical Information

Online Portal Information

If you have an online portal to access medical information or communicate with your medical providers

Portal Website Address: _____

Your User Name: _____

Your Password: _____

Security Question(s) if Applicable: _____

_____

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 26 for more information:

Medical Information: Pharmacist

Pharmacist No. 1	
Name:	Phone:
Email:	
Address:	
Pharmacist No. 2	
Name:	Phone:
Email:	
Address:	

Medical Information: Hospital Tracker

Date: _____ Hospital: _____

Reason for Admission: _____

Notes:

Date: _____ Hospital: _____

Reason for Admission: _____

Notes:

Date: _____ Hospital: _____

Reason for Admission: _____

Notes:

Medical Information: Lab Work/Tests

Date	Test	Result	Comments

Medical Information: Immunization Records

Keep track of your immunizations by attaching your immunization record (or a copy) here.

Below, note any reactions to shots/immunizations.

Shot/Immunization	Reaction	Treatment

Additional Notes:

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

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

Routines and Preferences

Daily Routine

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

Daily treatments *(e.g., respiratory treatment, O2, vent, trach, G-tube, etc.) include:*

Treatments	Days of the Week	Times
Vital signs		
Respiratory treatment		
Trach/G-tube/other care		
Bowel/bladder routine		
Adaptive equipment *(wheelchair, braces, splints, speech devices)*		
Medication Management		

Routines and Preferences: Describe a Typical Day

Provide a description of your daily routine throughout the week. This may include sleep routines, meal times, medication times, grooming routines, school, therapies, vocational assignments, favorite activities and more. (Note: You will have an opportunity to include specific times of day on the next page.)

Day	Routine
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Routines and Preferences: Daily Schedule and Support Providers

Use this table to track your daily schedule and associated care providers. Identify particular activities (e.g., sleeping, eating, working, attending therapy) and who is associated with those activities (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

Tasks that you are able to do independently *(e.g., eating, bathing, taking the bus, taking medication).*

Tasks for which you require assistance *(e.g., eating, bathing, toileting, dressing).*

Task	Assistance Required

List other information related to personal care that would be helpful to those assisting you with care *(e.g., shoe and clothing sizes, menstrual cycle).*

Routines and Preferences: Food Preferences

List foods that you particularly enjoy and/or dislike	
Likes	**Dislikes**

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

Routines and Preferences: Food Preferences

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 you eat/take in nourishment and any routines surrounding meals.

Size of tube: _____

Additional Notes:

Routines and Preferences: Communication

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

Assisted Technology 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 you using your assistive technology device.

How to use the 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

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 concerns (e.g., disruptive, self-injurious, aggressive/violent outbursts) that you may sometimes experience. Describe anything that might trigger this behavior (e.g., introduced to a new person or a new place or otherwise placed in an uncomfortable situation) and how someone else should respond to the behavior and address it. Provide 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). You may not be aware of the impact of your behaviors or how to address them, so reach out to your support system to ask them what they observe.

	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 or hobbies that you particularly enjoy or dislike.

TV Shows/Movies/Video Games	
Likes	**Dislikes**

Music/Books	
Likes	**Dislikes**

Routines and Preferences: Leisure Activities and Social Experiences

Hobbies/Activities in the Home	
Likes	**Dislikes**

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

Routines and Preferences: Leisure Activities and Social Experiences

Vacation/Traveling	
Likes	Dislikes
Travel Destination Wish List	
Special Interests	
Situations that make you uncomfortable	

Routines and Preferences: Pets and Assistance Animal(s) Information

Pets		
Pet's Name	**Type of Animal**	**Notes About Pet Care**
Any additional notes about the pet(s)		
Location of license and veterinary care records (include copies):		

Service Animal(s)			
Service Animal's Name	**Type of Animal**	**How the Animal Helps Me**	**Notes About Service Animal Care**
Any additional notes about service animal			
Location of documentation and veterinary care records (include copies):			

Emotional Support Animal		
Support Animal's Name	Type of Animal	Notes About Emotional Support Animal
Any additional notes about the pet(s)		
Location of documentation and veterinary care records (include copies):		

Education

School Information

Year Graduated: _____

School Name and Phone Number: _____

Lead Teacher: _____

School Nurse: _____

School Counselor: _____

Additional School Information:

Education: School Evaluations

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

Education: Educational Documents

Please attach a copy of Individualized Education Program, Behavior Intervention Plan, 504 Plan, 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:	Salary:
Skills learned (i.e. customer service, inventory management, making change, etc.):	

Job Coach
Name:
Address:
Email:
Phone:

Employment History
Attach resume here:

Employment: Vocational Experience

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

Work Potential

List interests, skill set and other pursuable opportunities

Volunteer Experience

Service Providers

Provider	Name	Phone	Address
Primary Care Physician			
Psychiatrist			
Mental Health Provider			
Autism System Navigator			
ECHO Coordinator			
Case Manager			
Speech Therapist			
Occupational Therapist			
Physical Therapist			
Specialty Care			
Social Worker			

Support

Family Support Resources

Note: To locate an EFMP Family Support provider in your area visit, https://installations.militaryonesource.mil/

The Exceptional Family Member Program	
Support Provider:	
Address:	
Email:	Phone:

Support Group	
Contact Person:	
Address:	
Email:	Phone:

Religious Organization	
Contact Person:	
Address:	
Email:	Phone:

Service Organization	
Contact Person:	
Address:	
Email:	Phone:

Counseling Services	
Contact Person:	
Address:	
Email:	Phone:

Support: School Support

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

Support: Advocates

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

Name:	
Address:	
Email:	Phone:
Note how that person provides assistance:	
Name:	
Address:	
Email:	Phone:
Note how that person provides assistance:	

Health Benefits and Insurance

Use this link to help find a local TRICARE Service Center: http://www.tricare.mil/contactus. Use this link to contact beneficiary counseling and assistance coordinators for beneficiary questions and concerns: https://tricare.mil/bcacdcao.

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

TRICARE Service Center Information (OCONUS Only)		
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:	

Health Benefits and Insurance: Insurance Information

Please notate your civilian insurance providers and/or Medicare or Medicaid. Visit the TRICARE website for information about filing claims: https://tricare.mil/FormsClaims.

Other Insurance	
Policy Holder's Name:	
Policy Number:	
Contact Person/Title:	
Address:	
Email:	Phone:

Other Insurance	
Policy Holder's Name:	
Policy Number:	
Contact Person/Title:	
Address:	
Email:	Phone:

Other Insurance	
Policy Holder's Name:	
Policy Number:	
Contact Person/Title:	
Address:	
Email:	Phone:

Moving/PCS

Moving/PCS Checklist

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

Arrangements

- ☐ Assistance 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 documents to hand-carry
- ☐ Locate military and medical 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
- [ ] Adult diapers, cleansing cloths, garbage bags
- [ ] Washcloths, towels and extra sheets if needed
- [ ] 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)
- [ ] Lift
- [ ] Wheelchair or scooter
- [ ] Wheelchair tray
- [ ] Wheelchair battery charger
- [ ] Wheelchair transfer board
- [ ] Weather protection
- [ ] Eating and drinking utensils
- [ ] Assistance animal rabies and immunization records
- [ ] Assistance animal documentation
- [ ] Assistance animal food and bowls
- [ ] Medications, if necessary
- [ ] Disposable bags
- [ ] Favorite toys for assistance animal
- [ ] Extra harness
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Moving/PCS: Transportation When Moving

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

Note any lodging-related needs when traveling (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

As you prepare for the future, you have important decisions to make. Remember that you can reach out to your support system to talk about your concerns and for assistance in completing this SCOR. This section can help you organize information and plans in case you need someone to make important decisions on your behalf. You can use it to facilitate discussion among your support system or to organize your own thoughts.

Planning Ahead: Advance Directive Quick Glance

This is not an advance directive and is not useful 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 or Guardian	☐ 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 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:

Attending Physician's Contact Information
Name:
Address:
Email:
All Telephone Numbers:
Secondary Physician's Contact Information (if available)
Name:
Address:
Email:
All Telephone Numbers:

Additional Resource: U.S. Living Will Registry (https://www.theuswillregistry.org/): This website provides advance directive information for each state.

Planning Ahead: Living Arrangements

Where and in what type of situation would you 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:		
Phone:	Email:	

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

Special Needs Trust	
Financial Institution:	Phone:
Address:	
Trust Name:	
Trustee's Name:	
Phone:	Email:

Planning Ahead: Supplemental Security Income

At age 18, you can apply for Supplemental Security Income at your local Social Security Office. If approved, Social Security will send you SSI payments 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.

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	$ _____	$_____	$_____
Show the amount of benefits you saved for the beneficiary, including any interest earned.			$ _____

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

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

Name	Address	Phone Number	Relationship

Other Resources

EFMP & Me tool: https://efmpandme.militaryonesource.mil/

Stay organized and up to date with 24/7 access to the latest information and resources by creating an EFMP & Me account and building your customized checklist.

Acronym Index

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

Acronym	Meaning

Notes

Notes

Notes

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

U.S. Department of Defense

EFMP Exceptional Family Member Program