Elder Care

EFMP Exceptional Family Member Program

SPECIAL CARE ORGANIZATIONAL RECORD | SCOR

Table of Contents

Introduction

The Special Care Organizational Record for Elder Care can help facilitate your care. It provides a central location for keeping track of your records and other pertinent information. This is particularly helpful if someone else needs to step in to provide care or assistance for you. The SCOR also provides a care guide section that allows you to provide a wealth of detailed information on topics such as daily routine, diet and preferred leisure activities.

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

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 social security numbers, 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 your privacy and security.

Special Care Organizational Record for Elderly Family Members

What is the SCOR for Elderly Family Members?

The SCOR for Elderly Family Members is a tool to help you and/or your family members organize and keep track of your medical records and related information.

How can the SCOR help you?

It can be challenging for you and/or your family members to keep track of rapidly changing health or medical issues. The SCOR will help you organize this information for quick access and allow you to share key information with family members or those who assist with your care.

Use the SCOR for Elderly Family Members 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 doctors, family members and other care providers

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

- Keep the SCOR where it is easy to find so it will always be on hand when you need it.
- Be mindful that the SCOR contains private information and 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 treatment.
- Bring the SCOR with you to appointments and hospital visits so that information you need will be close at hand.

How do you set up your SCOR?

Follow these steps:

STEP ONE: **Gather information you already have.**

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

STEP TWO: **Look through the pages of the SCOR.**

Select the pages that you think will be most beneficial for tracking your health and care. Visit Military OneSource to find fillable PDF forms to fill out, save, download and add to your SCOR. You can also download and print checklists from EFMP & Me to insert into your SCOR. These can help you stay organized and prepare for appointments, PCS moves and more: https://efmpandme.militaryonesource.mil/

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

What information do 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 for you and/or your family member. Here are some supplies that may help:

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

Things to remember about the SCOR:

- While the SCOR 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 your decisions legally binding.
- It contains very private information (e.g., 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.)	

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:

Current medications

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

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

Allergies:

For more on allergies, refer to the "Allergies" sheet Medical Health 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 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).

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

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

Medical Health

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:

Health Insurance — TRICARE

Use this link to 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:		
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 Insurance — TRICARE Dental Program

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

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

Additional Insurance

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

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

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

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

Medicare

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

Medicaid

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

Medigap (carrier)

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

Long-term Care Insurance (carrier)

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

Medical Bill Tracker

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

Current Medical Diagnoses

Date	Diagnosis	Notes

Current Medication

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

Significant Illnesses

Date	Illness	Notes

Surgical Procedures

Date	Surgical Procedure	Procedure/Treatment Plan	Notes

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

Allergen	Allergic Reaction	How to Respond

Care Providers

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

Civilian Hospital:		
Address:		
Email:	Phone:	Fax:

Dentist:		
Address:		
Email:	Phone:	Fax:

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

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

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

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

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

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

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

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

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

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

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

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

Additional notes:

Doctor Visits

Date	Seen by	Notes/Updates from Visit

Appointment Log

Date	Provider	Reason Seen/Care Provided	Next Appointment

Health Screening and Tests

Date	Health Screening/Test	Results

Hospital Tracker

Date	Hospital	Reason for Admission	Notes

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:

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:		

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

Personal Information

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

Spouse Information

Name:	
Address:	
Phone:	Dates of Marriage:
Location of Marriage License (include copy):	

Additional Notes:

Children's Information

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

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

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

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

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

Sibling's Information

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

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

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

Pets and Assistance Animal Information

Pets

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

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

Any additional notes about the pet(s)

Service Animal(s):

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

Any additional notes about the service animal:

Emotional Support Animal:

Emotional Support Animal's Name	Type of Animal	How the Animal Helps Me

Any additional notes about the emotional support animal and care:

Location of service animal documentation, emotional support animal documentation and veterinary care records (include copies):

Military Service Information

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

Employment Information

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

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

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

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

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

Additional Notes:

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

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Date:

Event:

Notes:

Lifestyle Habits

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

Diet:

a. What do you typically eat for each meal?

b. Do you eat meals at consistent times throughout the week? _____

c. Do you snack between meals? If so, how often and what do you eat for snacks?

Exercise:

a. Have you ever exercised? _____

b. When, for how long and how often?

c. . Do you currently exercise? _____

d. How long and how often?

Sleep Habits:

a. How many hours per night do you typically sleep ?_____

b. Do you regularly have trouble falling asleep or staying asleep? _____

Stress:

a. Do you often feel stressed or under pressure? _____

b. How often? _____

Smoking:

a. Did you ever smoke?_____

b. When and how often?_____

c. Do you currently smoke?_____

d. How often? _____

Alcohol Consumption:

a. Have you previously consumed alcohol?_____

b. When and how often approximately?_____

c. Do you currently drink alcohol?_____

d. How often?_____

e. Do you drink socially or when alone?_____

Care Guide

Daily Routine

Provide a description of typical day/daily routine. Include information such as when you wake up, eat meals, take medications, exercise, visit with friends, etc.:

Day	Routine
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Personal Care

List tasks that you are able to do independently (e.g., eating, bathing, toileting, dressing, moving):

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

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

Food and Eating

List foods that you particularly enjoy or dislike:

Likes	Dislikes

Typical daily diet:

Meal	Preferred Foods/Drinks
Breakfast	
Lunch	
Dinner	
Snack	

Favorite restaurants and preferred meals:

Restaurant	Preferred Meals

Diet Tracking Form

Copy this form and use it to track your diet on a weekly basis.

Week of:	Weight:
Date Checked:	

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

Other Likes and Dislikes

List any of your specific likes or dislikes (e.g., enjoy spending some time outside each day, dislikes certain television programs or books, likes to be read to):

Likes	Dislikes

Leisure Activities

List any leisure activities that you particularly enjoy or particularly dislike.
TV shows/movies:

Likes	Dislikes

Hobbies/activities in the home:

Likes	Dislikes

Leisure Activities/Clubs/Sports Outside the Home

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

Vacation/travel:

Likes	Dislikes

Home Safety

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

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

Planning Ahead

Introduction

It is important to legally establish the level of care you would like in the event you are unable to care for yourself. This section is intended to help you organize information and plans in the event that you would need someone to assume the duties as your caregiver. It is a good starting point to facilitate discussion among your family members or to just to organize your own thoughts.

Legal and Estate Information

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

Legal and Estate Information: Trust Agreement

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

Advance Health Care Directives Quick Glance

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

Have you spoken about your wishes with your:

☐ **Family** ☐ **Physician(s)** ☐ **Friends**
☐ **Clergy** ☐ **Attorney** ☐ **Case manager**

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

◯ **Yes** ◯ **No**

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

◯ **Yes** ◯ **No**

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

◯ **Yes** ◯ **No**

Have you given a copy of your completed and signed advance directive to the person(s) you have appointed to make decisions on your behalf?

◯ **Yes** ◯ **No**

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

◯ **Yes** ◯ **No**

Advance Health Care Directives Quick Glance: Physcians

Attending Physician's Contact Information:

Name:
Address:
Email:
Telephone:

Secondary Physician's Contact Information (If available):

Name:
Address:
Email:
Telephone:

Additional Resource:

U.S. Living Will Registry (http://www.uslivingwillregistry.com): This website provides advance health care directives information for each state.

Future Living Arrangements

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

First Choice of Future Residential Provider:

Name: _____

Phone Number: _____

Second Choice of Future Residential Provider:

Name: _____

Phone Number: _____

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

Home Manager Name: _____

Phone Number: _____

Case Manager Name: _____

Phone Number: _____

Level of supervision required:

Financial Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Guardianship

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

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

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

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

Name	Address	Phone Number	Relationship

Other Resources

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

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