



Access to
Emergency Information & Documents
For Adults with Special Needs

Providing
Independence,
Protection and
Peace of Mind



 **docubank**
For Adults With Special Needs
S.N.A.P.

Whether your adult with special needs has a mental disability, a physical disability, or both, you are committed to helping him or her be as independent as possible. Yet, you also want to be there right away if and when you are needed, especially in an emergency.

The DocuBank Special Needs Access Program (S.N.A.P.) can help you provide both **independence** and **protection**. S.N.A.P. offers continuous access to the information that caregivers and first responders need most in an emergency: vital medical information, emergency contacts and critical documents.

And as a primary emergency contact for your special needs adult, you receive an alert from DocuBank whenever the S.N.A.P. card is used, so you can have up-to-date information about your loved one as quickly as possible.

The Documents Medical Professionals Need, When They Need Them

The DocuBank S.N.A.P. card also provides medical professionals and other authorities with ready access to the documents they need to ensure that your loved one with special needs receives the best possible care and treatment in an emergency. Any of the following documents that you or the special needs adult have created can be stored and accessed quickly and easily by website or fax.

- * Medication List
- * Letter of Intent (outlining your expectations and goals for the care of your special needs adult)
- * S.N.A.P. Emergency Information Form (listing specialists, contacts, and more)
- * Guardianship Form
- * Health Care Power of Attorney
- * Living Will
- * And More



Having ready access to these documents also helps ensure that any decisions are made by the right person, whether this be you, the special needs adult, or another named surrogate.



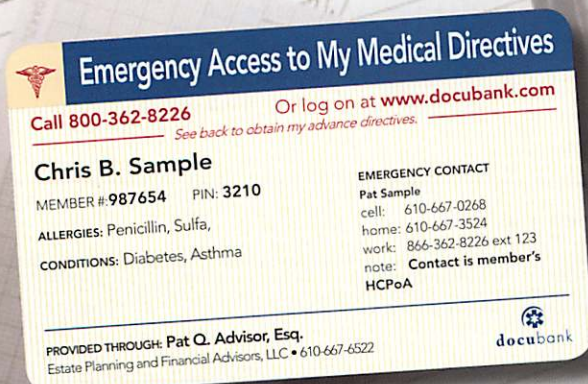
Always In Touch, Always Informed. 24/7/365

S.N.A.P. members receive two Emergency Access Cards. The member should always carry one of these cards. It can be used by concerned authorities should he or she become lost or confused while away from home, as well as by medical professionals in case of an emergency. The additional card can be carried by the primary caregiver and/or be passed along to temporary caregivers while the S.N.A.P. member is with them.

The S.N.A.P. Card Itself Displays Critical Information, Including:

- * Medical Conditions
- * Allergies
- * Emergency Contact Name & Phone Number
- * Physician Name & Phone Number
- * Name & Phone Number of Attorney or other Professional

This information can make a world of difference in the appropriateness of the care provided, both at the hospital and in other care facilities.



DocuBank SNAP Enrollment Form

A. Member Information

Information on bold will appear on your card. *Email address is required to access account online.

Prefix **Name** Home Phone
Permanent Address Cell Phone
City, State, Zip Email Address
Professional/Sponsor Firm/Organizer

B. Registration Fee

1 Year - \$45 4 Year - \$145

C. Payment Method

Paid through Attorney Credit Card Check (payable to DocuBank®)

Credit Card Number _____ Exp Date _____
Name on Credit Card _____ Card Type _____

D. Emergency Contact

(Guardian/Caregiver Information here) *Email required for Alert when card is used

Name Relationship
Home Phone **Work Phone**
Cell Phone Email (required)*

Emergency Contact Note

EMERGENCY CONTACT 2

Name Relationship
Home Phone Work Phone
Cell Phone Email (required)*

EMERGENCY CONTACT 3

Name Phone
Home Phone Work Phone
Cell Phone Email (required)*

E. Medical Information

PHYSICIAN'S INFORMATION

Name Phone

ALLERGIES: Please number up to 4 selections in order of importance (All selections may not fit on the card)

Penicilin Sulfa Latex _____ _____

PERMANENT MEDICAL CONDITIONS: (All selections may not fit on the card. Do not list medications here)

_____ _____ _____ _____

OPTIONAL NOTES: (To Hospital Staff, will appear on card)

MEDICATION LIST (signed and dated) included? Yes No

Member Statement I have chosen to enroll myself or my ward in DocuBank to help ensure prompt access to the information stored with DocuBank, including document(s), emergency contact and health information. I authorize that the information stored be accessible to anyone who provides the member number and PIN on the member's DocuBank card. I will notify DocuBank promptly of changes in any of the stored information, and also of the revocation or replacement of any document(s). I understand that DocuBank is not responsible for the validity or accuracy of any information stored by DocuBank, including the health information that also appears on the DocuBank SNAP card. I understand that: by accepting the card, I have verified and confirmed the accuracy of all information on the card before carrying or distributing it; I am granting DocuBank permission to alert the emergency contacts listed with DocuBank when the member's information is requested; DocuBank does not provide legal advice; and that this membership may be cancelled in writing at any time by written request to DocuBank.

Signature (Member or Guardian)

Date

Enrolling In S.N.A.P. Is A Snap

To enroll in S.N.A.P., just fill out the Enrollment Form, and optional Emergency Information Form, and send it with a copy of your documents and payment.

You can enroll by mail, fax or email:

Mail: DocuBank | PO BOX 325
Narberth PA 19072

Fax*: 610-667-2582

Email*: joindocubank@docubank.com

**Requires payment by credit card.*

Inexpensive Yet Priceless

It is impossible to put a price tag on the added level of protection provided by S.N.A.P. Not to mention the peace of mind you will enjoy by knowing DocuBank is always looking out for your loved one.

We strive to make membership in S.N.A.P. as affordable as possible and offer the following rates:

One year: \$45

Four years: \$145

If you have any questions about enrolling or the S.N.A.P. program itself, call DocuBank toll-free at

1-866-DOCUBANK (866-362-8226).



www.DocuBank.com

SNAP Emergency Information Form

Name	Sex	Eye Color	Hair Color
Unique Appearance Identifiers			Blood Type (optional)

Health Insurance

Policy Number	Group Number	Phone
Company	Subscriber	Other

Additional Physicians/Specialists (other than the primary listed on the Enrollment Form)

Name	Type	Phone
Name	Type	Phone

Dental Information

Dentist Name	Phone
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Work/School/Care Center Information

Name	Phone	Contact
Name	Phone	Contact

Additional Emergency Contacts

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Unique Behavior Traits _____

Notes _____

I understand that I am responsible for maintaining the accuracy of information and making updates as needed.

Name	Signature	Date
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