CARE Kit

Consistency, Advocacy, Reassurance, Education

CARE Kit

Consistency, Advocacy, Reassurance, Education

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CONFIDENTIAL INFORMATION

Please seek permission from the owner of this CARE Kit or primary caregiver before sharing enclosed information with others or making copies.

Introduction

Dear Caregiver,

I realize that you are holding a copy of this CARE Kit because you need it, or because you are preparing to need it one day and that caring for someone you love is many things - wonderful and challenging things. But the fact that you have a copy of our Joy's House CARE Kit makes me happier than I can put into words. Joy's House opened our doors in 2000, and over the years, we have been actively caring for the growing number of families in need of adult day services. Years ago, it became very clear that family caregivers need us too. As family caregivers, we can easily become emotionally, physically and financially exhausted. This Kit was born out of the need to educate and support you, the caregiver.

It's our hope that this Kit will bring you improved communication with your medical team and support circle, reduced stress, some guidance in this world of caregiving and a place to keep all of the information needed to care not only for your loved one, but to better care for you. At Joy's House, we're here for you.

Please use this Kit as you see fit. We want you to add your own materials, discard the ones that don't work for your household and make copies of those that do. (I even encourage you to use a CARE Kit for yourself.)

If there is anything more that Joy's House can do to support your family and you, please know that you can contact me directly. My email is tina@joyshouse.org and I can be reached by phone at (317) 254-0828.

Warmly ~

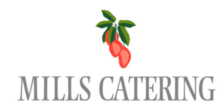
Tina

Tina McIntosh
President & Founder

Joy's House Partnerships

Thank you to our partners for their commitment to helping us provide much-needed support for our Guests and caregiving families.

Special thanks to the following partners of Joy's House programs and services.



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Glossary of Terms

A few definitions of terms found throughout this binder can be found on this page. These words may be starred with an asterisk to refer you back to this page if needed.

Ambulatory: Referring to the ability to walk.

CARE Act: In Indiana, the Caregiver Advise, Record, Enable (CARE) Act allows every patient admitted to a hospital to designate a family caregiver. Hospital staff must notify the caregiver when the patient is admitted, and prior to discharge, must instruct the caregiver on how to perform medical tasks needed at home.

Care Partner: A person who is providing assistance to a loved one who can still care for him or herself in part.

Caregiver: A person who provides consistent assistance with activities of daily living to a loved one.

Elopement/Flight Risk: Referring to a person thought likely to leave or flee.

Guardian (also referred to as a Conservator): Person appointed by the court to protect and manage the financial affairs and/or the person's daily life due to physical or mental limitations or old age.

Health Care Proxy: A legal document that designates another person to make healthcare decisions in the event that the patient is incapable of making his or her wishes known.

Incontinent: Having little to no control over one's bladder and bowel movements.

Long-Term Care Insurance: Insurance for policyholders that helps cover the cost of nursing home care, home health care and adult day services.

Medicaid: State health insurance for those requiring financial assistance.

Medicaid Waiver: Programs that help provide services to people who would otherwise be in an institution, nursing home or hospital so they can access long-term care in the community.

Medicare: Federal health insurance for people over 65 years of age and certain younger people with disabilities.

Medigap: A Medicare supplement insurance sold by private companies that can help pay for some of the health care costs that Medicare doesn't cover.

Power of Attorney: Person legally granted authority (Agent) of another person (Principal) in specified matters, such as financial or in general. A Power of Attorney becomes invalid upon the incapacitation of the Principal.

Durable Power of Attorney: The same as a Power of Attorney, but the Agent's authority remains in effect after the incapacitation of the Principal.

Health Care Power of Attorney: Person legally granted authority (Agent) on behalf of another person (Principal) to determine what medical procedures may be done on the Principal in event of the Principal's incapacitation. The document naming the Health Care Power of Attorney is sometimes called the Health Care Proxy.

Representative Payee: A person authorized to receive an individual's Social Security check for bill-paying purposes.

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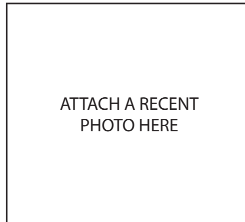
The best and most beautiful things in the world cannot be seen or even touched. They must be felt with the heart.

- Helen Keller

Date this Form was Completed: ___________



Emergency Information Sheet

Please fill out this form on behalf of your loved one.

Place a copy of this form on the refrigerator or near a phone for emergency reference.

Personal Information

Name: ___________________________

Medical Diagnoses and Conditions: ___________

____

Contagious Diagnoses: ___________________

Address: ___________________________

____

Phone (C): ___________________________

SSN: ______ - ______ - _____ DOB: ___ / ___ / _____

Sex: M / F Gender Identity: ______________

Race: ____________ Ethnicity: ______________

Eye Color: ___________ Hair Color: __________

Height: ____________ Weight: ____________

Marital Status: S D M W Separated

Dentures: Y / N Upper: ______ Lower: ______

Hearing Aids: Y / N Right: ______ Left: ______

Glasses: Y / N Contacts: Y / N

Prosthetics: Y / N ___________________

Ambulatory: Y / N Walker Cane Wheelchair

Continent: Y / N Bowel: _____ Bladder: _____

Advance Directives: Y / N Do Not Resuscitate: Y / N

Living Will: Y / N Donor: Y / N ___________

Blood Type: ________ Last Tetanus Shot: _________

Last COVID-19 Shot or Booster: ______________

First Language: ___________________________

Other Languages: _________________________

Clergy Name: ___________________________

Clergy Phone Number: ____________________

Physicians

Primary Care Physician: ___________________

Phone: ___________________________

Neurologist: ___________________________

Phone: ___________________________

Cardiologist: ___________________________

Phone: ___________________________

Specialists: ___________________________

Hospital Choice: _________________________

Medications Taken on a Regular Basis: ___________

____

____

____

Allergies

Animals: ___________________________

Foods: ___________________________

Meds: ___________________________

____

Other: ___________________________

Insurance

Medicare #: ___________________________

Medicaid #: ___________________________

Insurance Carrier/#: ______________________

Policy Holder: ___________________________

Policy Holder DOB: ______ / _________ / _________

See back side of this page for Emergency Contacts.

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Emergency Contacts

Caregiver/Primary Emergency Contact/POA

Name: ______________________ Relationship: ______________________

Address: ______________________

Cell: ______________________

Work: ______________________

Home: ______________________

Durable Power of Attorney for Health Care: Y / N Power of Attorney Name: ______________________

Power of Attorney Phone: ______________________

Comments/Instructions: ______________________

Caregiver/Secondary Emergency Contact

Name: ______________________

Relationship: ______________________

Cell: ______________________

Work: ______________________

Home: ______________________

Comments/Instructions: ______________________

My Loved One has a History of:

		Describe
Disorientation/Confusion	☐	______________________
Delusions/Hallucinations	☐	______________________
Disorganized Speech	☐	______________________
Mania/Elevated mood	☐	______________________
Depression	☐	______________________
Fear/Timidity	☐	______________________
Elopement	☐	______________________
Belligerence/Uncooperativeness	☐	______________________
Threatening behaviors	☐	______________________
Harm to self or others	☐	______________________
Triggers	☐	______________________
Other	☐	______________________

Suggested Interventions and De-escaltion Techniques

____

____

____

____

Additional Emergency Contacts

Place this form in a cabinet, on the refrigerator or near a phone to keep for emergency reference.

Name: ______________________________

Relationship: ______________________________

Cell: ______________________________

Work: ______________________________

Home: ______________________________

Comments/Instructions: ______________________________

Name: ______________________________

Relationship: ______________________________

Cell: ______________________________

Work: ______________________________

Home: ______________________________

Comments/Instructions: ______________________________

Name: ______________________________

Relationship: ______________________________

Cell: ______________________________

Work: ______________________________

Home: ______________________________

Comments/Instructions: ______________________________

Name: ______________________________

Relationship: ______________________________

Cell: ______________________________

Work: ______________________________

Home: ______________________________

Comments/Instructions: ______________________________

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Additional Information

Prefers to be called (Mr./Mrs./Miss, Nickname): ___________________________

Anniversary: ___________________________

Clothing size(s): ___________________________ Shoe size: __________

Children: ___________________________

U.S. Citizenship: Y / N Country of Origin: __________ Hometown City and State: __________

Veteran: Y / N Years in Service: _____ Service Branch: __________ Rank: __________

Important social history (schooling, career, membership organizations, etc): __________

____

____

____

____

Spiritual background: ___________________________

Church Name: ___________________________ Church phone number: __________

Enjoys spending time by (social activities): ___________________________

____

Favorite places to go (museums, restaurants): ___________________________

____

Favorite pastimes (hobbies, games, songs, TV shows): ___________________________

____

Food, drink & snack preferences: ___________________________

____

Daily Routine Overview

Wakes up at	
Breakfast	
Morning Routine	
Lunch	
Afternoon Routine	
Dinner	
Before Bed	
Bedtime	

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Self-Care Abilities & Needs

If assistance is needed, list responsible party on the line provided.

Personal Care

	Independent	*Assistance Needed (Describe)*		*Unable*	*Responsible Party*
Bathing	☐	☐	____________________	☐	____________________
Dressing	☐	☐	____________________	☐	____________________
Grooming Hair	☐	☐	____________________	☐	____________________
Dental Hygiene	☐	☐	____________________	☐	____________________
Nails	☐	☐	____________________	☐	____________________
Eating	☐	☐	____________________	☐	____________________
Walking/Mobility	☐	☐	____________________	☐	____________________
Toileting	☐	☐	____________________	☐	____________________
Medications	☐	☐	____________________	☐	____________________

Household Management

	Independent	*Assistance Needed (Describe)*		*Unable*	*Responsible Party*
Meal Preparation	☐	☐	____________________	☐	____________________
Food Shopping	☐	☐	____________________	☐	____________________
Light Housework	☐	☐	____________________	☐	____________________
Laundry	☐	☐	____________________	☐	____________________
Transportation	☐	☐	____________________	☐	____________________
Mail	☐	☐	____________________	☐	____________________
Bill/Money Management	☐	☐	____________________	☐	____________________

Notes/Comments

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Safety Abilities & Needs

Safety Needs

	Yes	No	Helpful Info/Suggestions
Elopement* Risk	☐	☐	____________________
Risk of Ingesting Harmful Substances	☐	☐	____________________
Fall Risk	☐	☐	____________________
Kitchen Appliance Monitoring	☐	☐	____________________
Hides Objects	☐	☐	____________________
Harms Self	☐	☐	____________________
Harms Others	☐	☐	____________________
Smoking Habits	☐	☐	____________________
Medication Issues	☐	☐	____________________
Driving Issues	☐	☐	____________________

Vision: ____________________ ____________________

Hearing: ____________________ ____________________

Speech: ____________________ ____________________

Cognition: ____________________ ____________________

Other: ____________________ ____________________

Other: ____________________ ____________________

Other: ____________________ ____________________

Other: ____________________ ____________________

Other: ____________________ ____________________

Notes/Comments

____

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To accomplish great things, we must not only act,
but also dream; not only plan, but also believe.

- Anatole France

Caregiver Information

Primary Caregiver

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________

Cell #: ______________________________

Email: ______________________________

Frequency of visits: ______________________________

Visits via ☐ In Person ☐ Phone ☐ Email

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________________________

Secondary Caregiver

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________

Cell #: ______________________________

Email: ______________________________

Frequency of visits: ______________________________

Visits via ☐ In Person ☐ Phone ☐ Email

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________________________

Paid Caregiver

Name: ______________________________

Employer: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________

Cell #: ______________________________

Email: ______________________________

Frequency of visits: ______________________________

Visits via ☐ In Person ☐ Phone ☐ Email

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________________________

Other Informal Caregiver

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________

Cell #: ______________________________

Email: ______________________________

Frequency of visits: ______________________________

Visits via ☐ In Person ☐ Phone ☐ Email

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________________________

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Area Agency on Aging Care Manager

Name: ______________________________

Agency Name: ______________________________

Address: ______________________________

Website: ______________________________

Phone: ______________ Email: ______________

Adult Day Service

Name: ______________________________

Address: ______________________________

Contact Person: ______________________________

Phone: ______________ Email: ______________

Days and Times of Attendance: ______________________________

Door Code: ______________________________

List of Approved Visitors: ______________________________

____

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Other: ______________

Inquiry Date: __________ Assessment Date: __________ Start Date: __________ ☐ Follow up Needed

Home Health Care Company

Company Name: ______________________________

Address: ______________________________

Contact Person: ______________________________

Phone: ______________ Email: ______________

Days and Times of Care: ______________________________

____

List of Preferred Attendants: ______________________________

____

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________

Inquiry Date: __________ Assessment Date: __________ Start Date: __________ ☐ Follow up Needed

Long Term Care Facility

Facility Name: ______________________________

Address: ______________________________

Contact Person: ______________________________

Phone: ______________ Email: ______________

Room Number: ______________________________

Door Code: ______________________________

List of Approved Visitors: ______________________________

____

Assistance Provided

- ☐ Personal Care
- ☐ Medication: ☐ Set up ☐ Prompt ☐ Administration
- ☐ Meal Prep: ☐ Breakfast ☐ Lunch ☐ Dinner
- ☐ Shopping
- ☐ Transportation
- ☐ Medical Appointments
- ☐ Bill Paying/Money Management
- ☐ Other: ______________

Inquiry Date: __________ Assessment Date: __________ Start Date: __________ ☐ Follow up Needed

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Assistance Needed Worksheet

Personal Care Tasks

Tasks	*People who can help*
Bathing	____
Dressing	____
Grooming (hair, teeth, nails)	____
Walking/Mobility	____
Lifting/Transferring	____
Toileting	____
Eating	____
Medications: Setting up pill box	____
Medications: Prompting to take	____
Medications: Helping to take	____

Household Care Tasks

Tasks	*People who can help*
Meal Preparation	____
Food Shopping/Errands	____
Housework	____
Laundry	____
Transportation	____
Medical Appointments	____
Mail/Correspondence	____
Banking/Bill Payments	____
Fix it/Repair	____
Lawn Care	____
Snow Removal	____
Automobile Care	____
Pet Care	____

Other Assistance

Tasks	*People who can help*
________________________	____
________________________	____
________________________	____

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One person caring about another represents life's greatest value.

- Jim Rohn

Physicians

Primary Care Start Date: ________________ End Date: ________________

Name: ____

Address: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

Specialty Physician Start Date: ________________ End Date: ________________

Name: ____

Specialty: ____

Hospital/Clinic: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

Specialty Physician Start Date: ________________ End Date: ________________

Name: ____

Specialty: ____

Hospital/Clinic: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

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Additional Specialty Physicians

Specialty Physician Start Date: ________________ End Date: ________________

Name: ____

Specialty: ____

Hospital/Clinic: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

Specialty Physician Start Date: ________________ End Date: ________________

Name: ____

Specialty: ____

Hospital/Clinic: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

Specialty Physician Start Date: ________________ End Date: ________________

Name: ____

Specialty: ____

Hospital/Clinic: ____

Phone: ____

Days/Hrs: ______________________ After Hours Number: ________________

Fax: ______________________ Email: ______________________

Hospital Affiliation(s): ____

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Other Medical & Health Professionals

Use this page to note other health professionals such as Chiropractor, Dentist, Ophthalmologist, Optometrist, Audiologist and Podiatrist.

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

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Other Medical & Health Professionals

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

Name: ______________________________

Specialty: ______________________________

Hospital/Clinic: ______________________________

Phone: ______________________________

Days/Hrs: ______________ After Hours Number: ______________

Fax: ______________ Email: ______________

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Medication List

Write all prescriptions, over-the-counter medicines and supplements below. Keep this list up-to-date and show the list to your loved one's doctors at each visit. Ask them to check for unnecessary duplications or medicines that could interact to cause harm.

Tip: Since medications change often consider copying this page before making your first entry.

Medicine Name	Prescribing Doctor	How much at each dose?	When and how taken?	Why taken?	Date Started	Date Stopped
Example: Medicine Name	*Dr. Jones*	*1 tablet, 250 mg*	*7 a.m. and 7 p.m., with food*	*Arthritis*	*7/31/2017*	*N/A*

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Allergy Log

Date	Allergen/Medication Name	Duration of Reaction	Type of Reaction *(ex: rash or breathing difficulties)*	Noted By

Preferred Pharmacy: ____________________

Phone: ____________ Address: ____________________

Mail Order Instructions: ____________________

____

____

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Medical Information

Medical Diagnoses

Diagnosis	Date of Diagnosis	Doctor	Treatment/Status

Surgeries and Procedures

Date	Surgery	Surgeon	Hospital	Complications/Notes

Hospitalizations & Rehabilitation Stays

Date	Hospital/Facility	Reason	Discharged Date/To

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Upcoming Doctor Appointment

Appointment Date: ______________________ Time: ______________

Doctor's Name: ______________________ Specialty: ______________

Office/Clinic Location: ______________________ Phone: ______________

Reason for visit (current symptoms): ______________________

____

Remember to bring: ______________________

Name of Caregiver to Accompany Patient: ______________________

Questions/Concerns to discuss:

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Additional Notes: ______________________

____

____

Tests Done ***Results/Call for results***

____

____

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________

Medication Changes: ______________________

____

Additional Tests *Treatment* *Scheduled for* *What to Expect*

____

____

Follow up appt. date/time: ______________________

Remember to bring: ______________________

Joy's House
Caregiver Support

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Upcoming Doctor Appointment

Appointment Date: ______________________ Time: ______________

Doctor's Name: ______________________ Specialty: ______________

Office/Clinic Location: ______________________ Phone: ______________

Reason for visit (current symptoms): ______________________

____

Remember to bring: ______________________

Name of Caregiver to Accompany Patient: ______________________

Questions/Concerns to discuss:

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Additional Notes: ______________________

____

____

Tests Done ***Results/Call for results***

____

____

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________

Medication Changes: ______________________

____

Additional Tests *Treatment* *Scheduled for* *What to Expect*

____

____

Follow up appt. date/time: ______________________

Remember to bring: ______________________

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Upcoming Doctor Appointment

Appointment Date: ______________________ Time: ______________

Doctor's Name: ______________________ Specialty: ______________

Office/Clinic Location: ______________________ Phone: ______________

Reason for visit (current symptoms): ______________________

____

Remember to bring: ______________________

Name of Caregiver to Accompany Patient: ______________________

Questions/Concerns to discuss:

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Additional Notes: ______________________

____

____

Tests Done ***Results/Call for results***

____

____

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________

Medication Changes: ______________________

____

Additional Tests *Treatment* *Scheduled for* *What to Expect*

____

____

Follow up appt. date/time: ______________________

Remember to bring: ______________________

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Upcoming Doctor Appointment

Appointment Date: ______________________ Time: ______________

Doctor's Name: ______________________ Specialty: ______________

Office/Clinic Location: ______________________ Phone: ______________

Reason for visit (current symptoms): ______________________

____

Remember to bring: ______________________

Name of Caregiver to Accompany Patient: ______________________

Questions/Concerns to discuss:

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Additional Notes: ______________________

____

____

Tests Done ***Results/Call for results***

____

____

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________

Medication Changes: ______________________

____

Additional Tests *Treatment* *Scheduled for* *What to Expect*

____

____

Follow up appt. date/time: ______________________

Remember to bring: ______________________

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Upcoming Doctor Appointment

Appointment Date: ______________________________ Time: ______________

Doctor's Name: ______________________________ Specialty: ______________

Office/Clinic Location: ______________________________ Phone: ______________

Reason for visit (current symptoms): ______________________________

____

Remember to bring: ______________________________

Name of Caregiver to Accompany Patient: ______________________________

Questions/Concerns to discuss:

Q: ______________________________

A: ______________________________

Q: ______________________________

A: ______________________________

Q: ______________________________

A: ______________________________

Additional Notes: ______________________________

____

____

Tests Done	*Results/Call for results*

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________________

Medication Changes: ______________________________

____

Additional Tests	*Treatment*	*Scheduled for*	*What to Expect*

Follow up appt. date/time: ______________________________

Remember to bring: ______________________________

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Upcoming Doctor Appointment

Appointment Date: ______________________ Time: ______________

Doctor's Name: ______________________ Specialty: ______________

Office/Clinic Location: ______________________ Phone: ______________

Reason for visit (current symptoms): ______________________

____

Remember to bring: ______________________

Name of Caregiver to Accompany Patient: ______________________

Questions/Concerns to discuss:

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Q: ______________________

A: ______________________

Additional Notes: ______________________

____

____

Tests Done ***Results/Call for results***

____

____

Outcome - Diagnosis and Next Steps:

Diagnosis: ______________________

Medication Changes: ______________________

____

Additional Tests *Treatment* *Scheduled for* *What to Expect*

____

____

Follow up appt. date/time: ______________________

Remember to bring: ______________________

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Call Log

Date/Time	**Call Made By**	**Notes** *(Spoke with, Agency name, Phone #, What was discussed)*	**To Do**

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Call Log

Date/Time	Call Made By	**Notes** *(Spoke with, Agency name, Phone #, What was discussed)*	To Do

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Appointment Calendar

Month ______________________ **Year** ________

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐

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Appointment Calendar **Month** ____________ **Year** ______

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐

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Important Tests

(Blood draw, CAT scan, X-Ray, MRI, etc.)

Date	Type of Test	Ordered By	Phone	Test Results

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Important Tests

(Blood draw, CAT scan, X-Ray, MRI, etc.)

Date	Type of Test	Ordered By	Phone	Test Results

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Vaccinations

(PPD/CXR, Flu shot, etc.)

Date	Type of Vaccine	Ordered By	Phone	Results/Comments

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Vaccinations

(PPD/CXR, Flu shot, etc.)

Date	Type of Vaccine	Ordered By	Phone	Results/Comments

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Medical Progress Notes

Use this form to document any behavioral or physical changes or new interactions with medications.

Date	Observation	Noted by

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Progress Tracker

Date	Type of Appt. & Location	Name of Practitioner	Progress Report	Homework	Noted By

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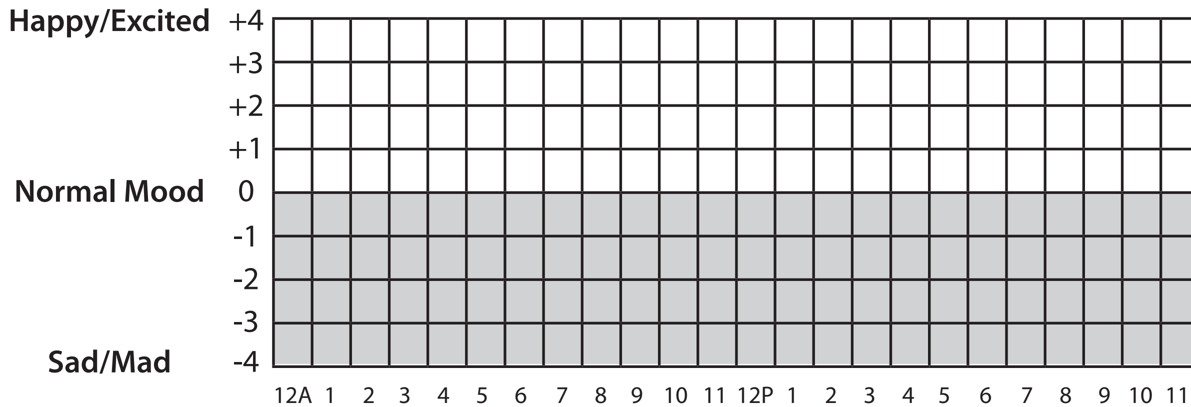
Mood Tracker

Date	
Mood Details	
Weather Details	
Medications Taken	
Hours of Sleep	
Physical Activity	
Food Intake	
Notes and Comments	
Noted By	



Use this mood graph to determine changes in behavior from new medications, therapy, rehabilitation, etc. Zero represents "normal" behavior for the individual, +1 and above represent heightened activity or mood and so on.

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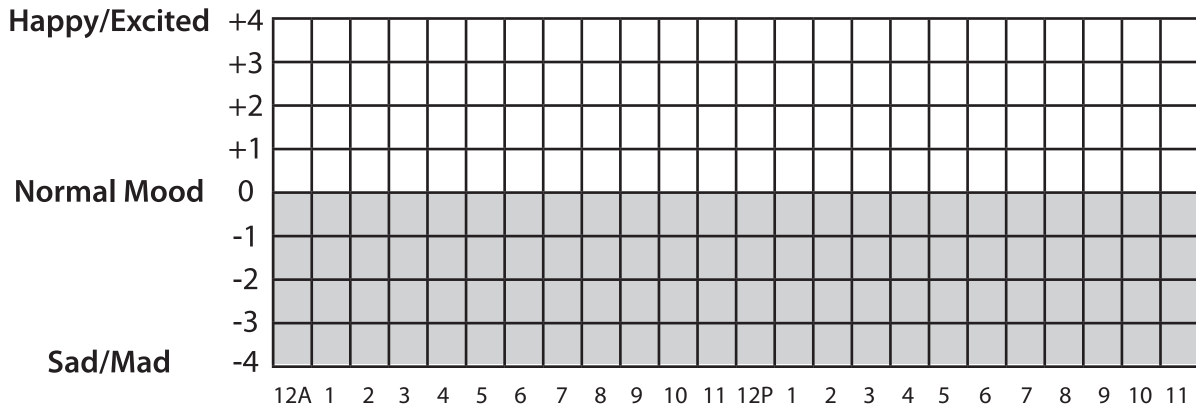
Mood Tracker

Date	
Mood Details	
Weather Details	
Medications Taken	
Hours of Sleep	
Physical Activity	
Food Intake	
Notes and Comments	
Noted By	



Use this mood graph to determine changes in behavior from new medications, therapy, rehabilitation, etc. Zero represents "normal" behavior for the individual, +1 and above represent heightened activity or mood and so on.

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Sleep Tracker

Week of ________________

Day	6PM	7	8	9	10	11	12A	1	2	3	4	5	6	7	8	9	10	11	12P	1	2	3	4	5

Color the boxes to indicate your loved one's sleep hours and leave boxes blank to indicate hours when he/she was awake.

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Sleep Tracker

Week of ____________

Day	6PM	7	8	9	10	11	12A	1	2	3	4	5	6	7	8	9	10	11	12P	1	2	3	4	5

Color the boxes to indicate your loved one's sleep hours and leave boxes blank to indicate hours when he/she was awake.

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Vital Health Log

Date	Time	Weight	Blood Pressure	Blood Sugar	Notes	Noted By

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Vital Health Log

Date	Time	Weight	Blood Pressure	Blood Sugar	Notes	Noted By

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Love begins by taking care of the closest ones — the ones at home.
- Mother Teresa

Preferred Contractors

Plumber: ______________________________

Company Name: ______________________________

Phone: ____________________ Fax: ____________________

Address: ______________________________

City/State/Zip: ______________________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

Electrician: ______________________________

Company Name: ______________________________

Phone: ____________________ Fax: ____________________

Address: ______________________________

City/State/Zip: ______________________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

HVAC Contractor: ______________________________

Company Name: ______________________________

Phone: ____________________ Fax: ____________________

Address: ______________________________

City/State/Zip: ______________________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

Roofing Contractor: ______________________________

Company Name: ______________________________

Phone: ____________________ Fax: ____________________

Address: ______________________________

City/State/Zip: ______________________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

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General Contractor: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

Locksmith: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

Gardener/Landscaper: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

Alarm/Security: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other:__________

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Other Contractors

Other: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other: __________

Other: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other: __________

Other: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other: __________

Other: ____________________

Company Name: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail: ____________________ Website: ____________________

Preferred Method of Payment: ☐ Online ☐ Check ☐ Autopay ☐ Other: __________

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Utilities

Water Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Gas Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Electricity Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Sewage Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Cell Phone Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Home Phone Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Cable Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Internet Company: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions: ______________________________

Trash Removal and Recycling: ____________________ Phone: ____________

Account Name/#: ______________________________

Special Instructions/Pick Up Day: ______________________________

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Animal Care

Name of Pet: ______________________________ Type of Animal: ____________________________

Breed/Color/Description: ____

Name of Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Name of Emergency Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Feeding Instructions: ____

____

List of Medications, Special Instructions: ____

____

____

Name of Pet: ______________________________ Type of Animal: ____________________________

Breed/Color/Description: ____

Name of Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Name of Emergency Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Feeding Instructions: ____

____

List of Medications, Special Instructions: ____

____

____

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Name of Pet: ______________________________ Type of Animal: ____________________________

Breed/Color/Description: ____

Name of Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Name of Emergency Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Feeding Instructions: ____

____

List of Medications, Special Instructions: ____

____

____

Name of Pet: ______________________________ Type of Animal: ____________________________

Breed/Color/Description: ____

Name of Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Name of Emergency Vet: ____

Address: ____

City/State/Zip: ____

Phone: ____

Feeding Instructions: ____

____

List of Medications, Special Instructions: ____

____

____

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Plants & Garden Care

Type of Plant:____

Location(s): ____

Special Instructions: ____

____

____

____

Type of Plant:____

Location(s): ____

Special Instructions: ____

____

____

____

Type of Plant:____

Location(s): ____

Special Instructions: ____

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Type of Plant:____

Location(s): ____

Special Instructions: ____

____

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Type of Plant:____

Location(s): ____

Special Instructions: ____

____

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Type of Plant:____

Location(s): ____

Special Instructions: ____

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Type of Plant:____

Location(s): ____

Special Instructions: ____

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Type of Plant:____

Location(s): ____

Special Instructions: ____

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Home Maintenance Checklists

Like a health physical, routine maintenance is important for every homes upkeep and well-being. Continuing to check up on your exterior, appliances, heating and cooling, plumbing, security and electrical systems will help prevent breakdowns, save money and keep your home looking its best.

Monthly Home Improvements:

___ Clean or change the furnace filter to remove dust build-up, making it easier to regulate your homes temperature and ultimately decreasing utility bills

___ Check the water softener and replenish salt if necessary

___ Clean faucet aerators and shower heads to remove mineral deposits

___ Inspect tub and sink drains for debris; unclog

___ ____

___ ____

In many regions, spring and fall are the perfect seasons to tackle important home improvement projects because the temperatures are moderate. Before you start your seasonal home improvement tasks, examine both the interior and exterior of your home. Most of these home maintenance items can be accomplished without the help of a professional, but it's always better to be safe and call for assistance if a home improvement project is beyond your abilities. Here are seasonal home improvement recommendations for spring and fall.

Spring Maintenance Checklist:

___ Inspect roofing for missing, loose or damaged shingles and leaks

___ Change the air-conditioner filter

___ Clean window and door screens

___ Polish wood furniture and dust light fixtures

___ Refinish the deck

___ Power-wash windows and siding

___ Remove leaves and debris from gutters and downspouts

___ Replace the batteries in smoke and carbon monoxide detectors

___ Have a professional inspect and pump the septic tank

___ Inspect sink, shower and bath caulking for deterioration

___ Vacuum lint from dryer vent

___ ____

___ ____

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Fall Maintenance Checklist:

___ Rake leaves and aerate the lawn

___ Have forced-air heating system inspected by a professional. *Tip: Schedule an inspection in late summer or early fall before the heating season begins*

___ Check fireplace for damage or hazards and consider having it professionally inspected

___ Seal cracks and gaps in windows and doors with caulk or weather stripping; replace if necessary

___ Swap old, drafty windows for more energy-efficient models

___ Touch up exterior siding and trim with paint

___ Inspect roofing for missing, loose or damaged shingles and leaks

___ Power-wash windows and siding

___ Remove leaves and debris from gutters and downspouts

___ Mend cracks and gaps in the driveway and walkway

___ Drain and winterize exterior plumbing

___ Tune up major home appliances before the holidays

___ Repair or replace siding

___ Replace the batteries in smoke and carbon monoxide detectors. Install a smoke detector on every floor of your home, including the basement

___ Clean the carpets

___ Clean window and door screens

___ Vacuum lint from dryer vent

___ Inspect exterior door hardware; fix squeaky handles and loose locks

___ Check for frayed cords and wires

___ ____

___ ____

Notes:____

____

____

____

____

“Home Maintenance Basics” Better Homes & Gardens, https://www.bhg.com/home-improvement/advice/home-maintenance-checklist/ Accessed February 29, 2024.

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Special Deliveries & Services

Newspaper/Mail: ____

Location(s): ____

Special Instructions: ____

____

____

____

Cleaning Services: ____

Location(s): ____

Special Instructions: ____

____

____

____

Groceries/Meal Delivery: ____

Location(s): ____

Special Instructions: ____

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____

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Other: ____

Location(s): ____

Special Instructions: ____

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Other: ____

Location(s): ____

Special Instructions: ____

____

____

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Other: ____

Location(s): ____

Special Instructions: ____

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Other: ____

Location(s): ____

Special Instructions: ____

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Other: ____

Location(s): ____

Special Instructions: ____

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Vehicle Maintenance

Vehicle Make and Model: ____

Year: ________________________ Mileage: ________________ As of Date: _____________

License Plate Number: ___________ Vehicle Identification Number (VIN): _________________

Location(s): ____

Special Instructions: ____

____

____

____

Vehicle Make and Model: ____

Year: ________________________ Mileage: ________________ As of Date: _____________

License Plate Number: ___________ Vehicle Identification Number (VIN): _________________

Location(s): ____

Special Instructions: ____

____

____

____

Repair/Service Company: ____

Phone:____

Special Instructions: ____

____

____

____

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Vehicle Make and Model: ____

Year: _______________________ Mileage: _______________ As of Date: _____________

License Plate Number: __________ Vehicle Identification Number (VIN): _________________

Location(s): ____

Special Instructions: ____

____

____

____

Vehicle Make and Model: ____

Year: _______________________ Mileage: _______________ As of Date: _____________

License Plate Number: __________ Vehicle Identification Number (VIN): _________________

Location(s): ____

Special Instructions: ____

____

____

____

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All of us, at certain moments of our lives,
need to take advice and to receive help from other people.

- Alexis Carrel

Budget Planner

This budget planner compiles income and expenses to help determine a monthly budget.

HOUSEHOLD INFORMATION	
Number of people living in home with loved one:	
Number of people for whom you are responsible (claimed as deductions on federal tax form). Please explain if different from number living at home: ______________________	
TOTAL ANNUAL HOUSEHOLD INCOME (INCLUDING BUT NOT LIMITED TO EMPLOYMENT EARNINGS, PENSIONS, SOCIAL SECURITY)	
Name:	$
Name:	$
Name:	$
Name:	$
TOTAL INCOME:	$
Other Income: *(such as regular support payments from family members outside the household or unreported income of Guest)*	$
Additional Assets: *(attach supporting documentation for investments, additional homes, savings, etc.)*	$
GRAND TOTAL INCOME:	**$**
Divide Grand Total Income by 12 for **MONTHLY INCOME:**	**$**

FIXED MONTHLY EXPENSES	
MORTGAGE OR RENT	$
*Comments:*______________________	

GROCERIES	$
*Comments:*______________________	

continued on the following pages

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UTILITIES	
Electricity:	$
Gas:	$
Phone / Internet / Cable:	$
Water:	$
Trash:	$
Other:	$
Comments: ______________________________	
TOTAL UTILITIES:	$

AUTO EXPENSES	
Monthly Car Payments:	$
Gas:	$
Maintenance:	$
Comments: ______________________________	
TOTAL AUTO:	$

CREDIT CARD INSTALLMENT PAYMENTS	
Installment 1: *(List)* ______________________________	$
Installment 2: *(List)* ______________________________	$
Installment 3: *(List)* ______________________________	$
Installment 4: *(List)* ______________________________	$
Comments: ______________________________	
TOTAL CREDIT CARD:	$

OTHER INSTALLMENT PAYMENTS	
Installment 1: *(List)* ______________________________	$
Installment 2: *(List)* ______________________________	$
Installment 3: *(List)* ______________________________	$
Comments: ______________________________	
TOTAL INSTALLMENT:	$

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INSURANCE	
Life:	$
Auto:	$
Medical:	$
Home Owners / Renters:	$
Long-Term Care*:	$
*Comments:*_______________	
TOTAL INSURANCE:	$

MEDICAL EXPENSES	
Prescriptions:	$
Doctor:	$
Other:	$
Other:	$
*Comments:*_______________	
TOTAL MEDICAL:	$

OTHER REGULAR MONTHLY EXPENSES	
Expense 1: *(List)*_______________	$
Expense 2: *(List)*_______________	$
Expense 3: *(List)*_______________	$
Expense 4: *(List)*_______________	$
*Comments:*_______________	
TOTAL OTHER:	$

GRAND TOTAL EXPENSES:	**$**
Subtract Grand Total Expenses from Monthly Income for: **APPROX. NET INCOME:**	**$**

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Legal, Investment & Accounting Contacts

Attorney

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Financial Advisor

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Accountant/Tax Advisor

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Other ______________________________

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

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Other ______________________________

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Other ______________________________

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Other ______________________________

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

Other ______________________________

Name: ______________________________

Firm Name: ______________________________

Assistant's Name: ______________________________

Address: ______________________________

Office Phone: ________________ Cell: ________________

Email: ________________ Office Hours: ________________

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Decision Makers

These contacts are able to make decisions on behalf of your loved one. Please refer to the Glossary of Terms at the beginning of this Kit for definitions of terms followed by an asterisk.

Power of Attorney* (POA) Durable*? ☐ Yes ☐ No

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Document Location: ______________________

Backup Power of Attorney Durable? ☐ Yes ☐ No

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Document Location: ______________________

Health Care Power of Attorney*/Agent (if different than POA) and Health Care Proxy*

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Documents on File with Physician(s):

Name: ______________________ Phone: ______________________

Name: ______________________ Phone: ______________________

Documents Locations: ______________________

Physician signed Do Not Resuscitate (DNR) on file? Yes No

Living Will? Yes No

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Backup Health Care Power of Attorney/Agent

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Document Location: ______________________

Guardian/Conservator*

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Document Location: ______________________

Backup Guardian/Conservator

Name: ______________________ Relationship: ______________________

Address: ______________________

Home Phone: ______________________ Work: ______________________

Cell: ______________________ Email: ______________________

Contact Instructions: ______________________

Document Location: ______________________

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Insurance Information

Home Insurance

Policy #: ______

Agent Name : ______ Phone: ______

Agency Name: ______

Address: ______

Email: ______ Office Hours: ______

Insurance Company/Underwriter: ______

24-Hour Claim Phone #: ______

Website Address: ______ Username: ______ Password: ______

Automobile Insurance

Vehicle 1 Make/Model/Year: ______

Policy #: ______

Agent Name : ______ Phone: ______

Agency Name: ______

Address: ______

Email: ______ Office Hours: ______

Insurance Company/Underwriter: ______

24-Hour Claim Phone #: ______

Website Address: ______ Username: ______ Password: ______

Vehicle 2 Make/Model/Year: ______

Policy #: ______

Agent Name : ______ Phone: ______

Agency Name: ______

Address: ______

Email: ______ Office Hours: ______

Insurance Company/Underwriter: ______

24-Hour Claim Phone #: ______

Website Address: ______ Username: ______ Password: ______

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Insurance Information

Life Insurance

Name of Insured: ______________________________ Beneficiary: ________________________

Policy #: _____________________________________ Amount of Benefit: ___________________

Agent Name :____ Phone: _____________________

Agency Name:____

Address: ____

Email: ____ Office Hours: ______________

Insurance Company/Underwriter:____

24-Hour Claim Phone #: ____

Website Address: _________________________ Username: __________ Password: ___________

Disability Insurance

Name of Insured: ____

Policy #: _______________________________________ Monthly Benefit: ____________________

Agent Name :____ Phone: _____________________

Agency Name:____

Address: ____

Email: ____ Office Hours: ______________

Insurance Company/Underwriter:____

24-Hour Claim Phone #: ____

Website Address: _________________________ Username: __________ Password: ___________

Long-Term Care Insurance

Name of Insured: ____

Policy #:____

Agent Name :____ Phone: _____________________

Agency Name:____

Address: ____

Email: ____ Office Hours: ______________

Insurance Company/Underwriter:____

24-Hour Claim Phone #: ____

Website Address: _________________________ Username: __________ Password: ___________

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Insurance Information

Medigap* Insurance

Name of Insured: ______________________________

Policy #: ______________________________

Agent Name: ______________________ Phone: ____________

Agency Name: ______________________________

Address: ______________________________

Email: ______________________ Office Hours: ____________

Insurance Company/Underwriter: ______________________________

24-Hour Claim Phone #: ______________________________

Website Address: ______________ Username: ________ Password: ________

Medicare* Insurance

Name of Insured: ______________________________

Policy #: ______________________________

Agent Name: ______________________ Phone: ____________

Agency Name: ______________________________

Address: ______________________________

Email: ______________________ Office Hours: ____________

Insurance Company/Underwriter: ______________________________

24-Hour Claim Phone #: ______________________________

Website Address: ______________ Username: ________ Password: ________

Medicaid* Insurance

Name of Insured: ______________________________

Policy #: ______________________________

Agent Name: ______________________ Phone: ____________

Agency Name: ______________________________

Address: ______________________________

Email: ______________________ Office Hours: ____________

Insurance Company/Underwriter: ______________________________

24-Hour Claim Phone #: ______________________________

Website Address: ______________ Username: ________ Password: ________

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Insurance Information

Health Insurance

Name of Insured: ____________________

Policy #: ____________________

Agent Name: ____________________ Phone: ____________________

Agency Name: ____________________

Address: ____________________

Email: ____________________ Office Hours: ____________________

Insurance Company/Underwriter: ____________________

24-Hour Claim Phone #: ____________________

Website Address: ____________________ Username: __________ Password: __________

Pharmacy Insurance

Name of Insured: ____________________

Policy #: ____________________

Agent Name: ____________________ Phone: ____________________

Agency Name: ____________________

Address: ____________________

Email: ____________________ Office Hours: ____________________

Insurance Company/Underwriter: ____________________

24-Hour Claim Phone #: ____________________

Website Address: ____________________ Username: __________ Password: __________

Other Insurance (Personal property, boat, etc.) ____________________

Policy #: ____________________

Agent Name: ____________________ Phone: ____________________

Agency Name: ____________________

Address: ____________________

Email: ____________________ Office Hours: ____________________

Insurance Company/Underwriter: ____________________

24-Hour Claim Phone #: ____________________

Website Address: ____________________ Username: __________ Password: __________

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Location of Key Documents

Document	Location	Date Noted
Social Security Card		
Birth Certificate		
Passport		
Medicare Card		
Health Insurance Cards		
Health Care Proxy*		
Living Will/Advance Directive		
Power of Attorney*		
Guardianship/Conservator* Information		
Voter Registration Card		
Life Insurance Policy(s)		
Will		
Trust Information		
Military ID/Papers		
Real Estate Property Deeds		
Vehicle Titles		
PO Box Number		

Bank and Other Financial Documents

Note: Specify name of bank, financial institution or company.

Document	Location	Date Noted
Loan Documents		
Annuity Contracts		
Stock Certificates/Bonds		

Bank Vault/Safe/Safe Deposit Box Location: ____________________
Box#: _______________ Location of Key: ______________________
Code: _______________ Location of Code: ____________________
Name/Signatures on File: ____________________________________

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Password Manager

Website	Username	Password

Other Accounts/Access Codes

Account	Location	Access/Pass Code

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We are each of us angels with only one wing,
and we can only fly by embracing one
another.

- LucianoCrescenzo

End-of-Life Care Tips

Brought to you by Flanner Buchanan Funeral Centers

Flanner Buchanan
CREMATION • BURIAL

Frequently Asked Questions

1. What does it mean to pre-arrange or pre-plan?

Pre-arranging allows you to make all the decisions regarding your final arrangements for cremation or burial. By pre-planning, you relieve your family of the emotional and financial burden associated with funeral arrangements. Your family can be assured that your wishes are being carried out. This also keeps your family from emotionally overspending at the time of your death. Pre-planning provides financial security to your loved ones as you are locking in today's prices for the services you choose.

2. I have life insurance. I can just sign it over to the funeral home, can't I?

Insurance can be signed over to the funeral home, however this is typically only executed in the case of Medicaid spend downs. Although insurance policies can be assigned to the funeral, it does not lock in today's costs unlike a funded pre-arrangement through the funeral home.

3. Can I transfer my funeral pre-arrangement?

Many funded pre-arrangements are secured by an insurance product specific to the funeral industry. These policies are transferable nationwide should you move or choose another provider.

4. Does a Power of Attorney (POA) have the right of disposition?

Power of Attorney typically ends at the time of death unless it is specifically stated otherwise that the power of attorney also has the right to final disposition and funeral arrangements.

5. What is a Funeral Declaration and how does it help me get what I want?

The Funeral Declaration in Indiana allows you to designate a person to carry out your wishes and allows you to specify what those wishes are. Under the law your designee is required to carry out those plans. The document must be signed and properly witnessed to be valid. In addition, you must provide funding for the declaration to be valid. This supersedes your next of kin's ability to make decisions, if the individual stated in the declaration is not your current next of kin.

6. Can I access the bank account of the deceased (without a Death Certificate) if my name is on it?

We encourage you to discuss this with your bank, as banks vary on their requirements. This also depends on how the accounts are set up. Most banks will ask for a certified death certificate.

7. Why is it important to have an updated will?

Everyone needs a will. A will is one of the finest protections you give your loved ones. Your will is the least expensive way to protect your life's work and savings. With a will, you name the person or persons to administer your estate, handle financial matters and act as a guardian for your minor children. Without a will, the probate judge makes these decisions and the cost for this process can be as high as 10% of the net value of your estate. The law is very precise in its requirements with respect to the writing, signing and witnessing of wills. It is recommended that the preparation and execution of a will be handled by an attorney.

However, we encourage you to put your final wishes regarding funeral arrangements in writing with a funeral home as many times the will is not read until after services.

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Social Security Benefit Information

Brought to you by Flanner Buchanan Funeral Centers

Social Security Benefits

Death Benefit

When you die, whether still working or retired, a lump sum of $255 is payable to a surviving spouse who is living with you at the time of death. If you don't have a spouse living with you, then payment may be made to a spouse or children who are immediately eligible for monthly benefits based on your earnings record. Otherwise, the benefit is not payable. To facilitate receiving Social Security benefits, your survivor will need:

1. Marriage Certificate
2. Birth Certificate of applicant
3. Birth Certificate of the deceased
4. Birth Certificate of minor children
5. Social Security number of the deceased
6. Social Security number of spouse
7. Death Certificate
8. W-2 Form or Schedule "C"

Survivor's Benefits

If an insured dies, the widow, dependent widower, children and dependent parents of that person may be eligible for monthly survivor's benefits. To receive a free booklet detailing survivors benefits contact the Social Security Administration.

To be sure your Social Security payroll deductions have been properly credited to your account, you should request a statement for the Social Security Administration every three years. If an error occurs in your records, it must be corrected within 39 months. If it isn't it could affect the amount that you receive monthly upon retirement. To receive a free statement of your earnings covered by Social Security and your estimated future benefits, call the Social Security Administration.

Note: Social Security Administration toll free number is 1-800-772-1213.

Veterans Benefits

Veteran survivors are entitled to receive various benefits, depending upon the status of the service person. The Veterans Administration offers a free pamphlet entitled "Summary of Department of Veterans Affairs Benefits." To receive this pamphlet or to obtain any other veteran information, contact the U.S. Department of Veteran Administration at 1-800-827-1000.

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Immediate Decisions and Arrangements That Must Be Made

Brought to you by Flanner Buchanan Funeral Centers

There are many decisions and arrangements that must be made when there is a death in the family. Very few people are aware of the high cost and complexity of last minute arrangements. With the help of this Kit your family will be spared of this burden. Here is a list of things that must be done.

Notify Immediately		
1. Cemetery	1. Select cemetery	11. Order death certificates
2. Funeral Director	2. Check Will for special wishes	12. Provide obituary to newspaper
3. Physician	3. Select burial property	13. Select Pallbearers
4. Clergy	4. Select casket	14. Type of service (military, etc.)
5. Attorney/Executor of Estate	5. Select burial vault	15. Select clergy
6. Relatives	6. Select clothing for deceased	16. Time & location of services
7. Friends	7. Select flowers	17. Special readings and music
8. Employer of deceased	8. Select memorialization	18. Organist
9. Employers of family members	9. Check and sign burial permit	19. Provide information for eulogy
10. Insurance Agents (life, health, etc.)	10. Funeral transportation	
11. Organizations (religious, civic, etc.)		
12. Notices for Newspapers		

Necessary Vital Statistics	Necessary Documents	Necessary Payments
1. Name, home address & phone	1. Cemetery arrangement documents	1. Cemetery services
2. How long in state	2. Funeral arrangement documents	2. Cemetery merchandise
3. Business name, address & phone	3. Will	3. Funeral services
4. Occupation and title	4. Birth certificate	4. Funeral merchandise
5. Social Security number	5. Social Security card	5. Clergy/Officiant
6. Veteran's Serial number	6. Marriage license	6. Organist
7. Date of birth	7. Citizens paper	7. Florist
8. Place of birth	8. Insurance policies	8. Transportation
9. U.S. Citizenship	9. Bank books	9. Death Certificates
10. Father's name	10. Deeds to property	10. Obituaries
11. Mother's name including maiden	11. Bill of sale for car	
12. Highest level of education	12. Income tax returns	* Include sales tax when applicable
	13. Veteran's discharge certificate	
	14. Disability and pension claims	
This information is required for the burial permit by the board of health.	*This information is required to determine payments and benefits from insurance, pension, social security, etc.*	*Most of these items can be arranged and paid for in advance of need, thus easing the emotional and financial burden for the family.*

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CREMATION • BURIAL

What do you need death certificates for?

The original death certificate is filed with the County Board of Health where the death occurred. If you do not order enough certificates with the original filing, additional copies can be obtained later for an additional state fee. We recommend ordering at least 2-3 more copies than you anticipate needing.

Certified copies of death certificates are needed for the following cases.

_____ Transfer of real property, houses, and lots

_____ Settling of insurance claims, 1 for each company

_____ Obtaining union benefits, usually 2 or 3 required

_____ Transfer of automobile, boat, trailer or camper title

_____ Transfer of stocks or bonds, 1 for each corporation

_____ Transfer of bank savings or trust accounts

_____ Transfer of checking accounts

_____ Phone and utility companies

_____ Entry into a bank safety deposit vault

_____ Filing Federal income tax returns

_____ Social Security benefits

_____ Veteran's Administration benefits

_____ For insured loans, insured credit cards and department store cards

_____ For credit union accounts

_____ To qualify for bereavement time compensation from some employers

_____ Personal requests from children, family members

_____ *Estimated Total Number*

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FlannerBuchanan.com

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To Our Loved Ones

Brought to you by Flanner Buchanan Funeral Centers

"I know it sounds odd, but one of the most remarkable – and one of the kindest – gifts my father gave me was to plan the details of his own funeral service."

– Ellen Ficklen, as quoted in Newsweek Magazine

In this Kit you will find information which we have recorded to assist you in completing our final arrangements. We have tried to minimize the emotional strain and distress you are now feeling.

We hope this information will help you to avoid confusion, anxiety and unnecessary expense.

Love,

Signed: ________________________________ Date: ________________

Signed: ________________________________ Date: ________________

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What is that hot pink form on the next page? It's a POST form.

Here is more information about a POST form and when you might need one.
Please note, this POST form is for the state of Indiana. Information found at www.indianapost.org.

What is a POST form?
A POST form is a doctor's order that describes your loved one's wishes for health care in a medical emergency and helps you keep control over medical care at the end-of-life. Like a Do Not Resuscitate (DNR) order, the form tells emergency medical personnel and other health care providers whether or not to administer cardiopulmonary resuscitation (CPR) in the event of a medical emergency.

Who should have a POST form?
Unlike an advance directive, which is appropriate for all adults, the POST form is specifically intended for seriously ill persons with advanced chronic progressive illness, advanced chronic progressive frailty or terminal conditions. It is also appropriate for people who are unlikely to benefit from cardiopulmonary resuscitation. Use of the POST form is typically not appropriate for persons with early stage progressive illness or functionally disabling problems who have many years of life expectancy.

How to complete a POST form:
A health care professional can help you create a POST form if your loved one enters a medical facility or health care setting such as a hospital, nursing home or hospice care in a facility or at home. To be legally valid, a POST form must be signed in Section H by a licensed physician. The POST cannot be signed by a nurse practitioner or physician assistant. The form travels with your loved one from one health care setting to another.

The POST form and other Health Care Directives:
A POST form may be used in addition to or instead of a DNR order. A POST form differs from a DNR order in one important way: a POST form also includes directions about life-sustaining measures in addition to CPR, such as intubation, antibiotics and feeding tubes. The POST form helps medical providers understand your wishes at a glance, but it is not a substitute for a properly prepared Advance Health Care Directive.

What if a loved one or legally authorized representative changes his/her mind about the preferences documented on the POST form?
Requests for alternative treatment should be honored as a person can change his or her mind at any time. The representative can revoke the POST form only if the loved one lacks decisional capacity. If a loved one or representative wishes to revoke the POST form, this can be done by writing these wishes down with a signature and date, physical cancellation or destruction of the form, or a verbal expression of the intent to revoke. Health care providers and the physician who initially signed the POST form should be notified as well.

Where should the original POST form be kept?
In most circumstances, the original POST form should be kept with the loved one. If they reside at home, the POST form should be kept with the loved one's medication or on the refrigerator. Family members and caregivers should know where the form is located.

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INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R2 / 12-16)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial

Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

	DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.
A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR):** Patient has no pulse AND is not breathing ☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders in **B, C** and **D**
B *Check One*	**MEDICAL INTERVENTIONS:** If patient has pulse AND is breathing OR has pulse and is NOT breathing ☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible. ☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.
C *Check One*	**ANTIBIOTICS:** ☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means. ☐ Use antibiotics consistent with treatment goals.
D *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food and fluid by mouth if feasible. ☐ No artificial nutrition. ☐ Defined trial period of artificial nutrition by tube. (Length of trial: ________ Goal: ____________________) ☐ Long-term artificial nutrition.
	OPTIONAL ADDITIONAL ORDERS:
	SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name: ______________ Date of Birth *(mm/dd/yyyy)*: ______________

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity ***(required by statute)***	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician and only if:

(1) the treating physician has determined that:

(A) the individual is a qualified person; and

(B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.

(2) An advanced chronic progressive frailty.

(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:

(A) there can be no recovery; and

(B) death will occur from the condition within a short period without the provision of life prolonging procures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G **DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:**

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H **SIGNATURE OF TREATING PHYSICIAN**

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician ***(required by statute)***	Print Treating Physician Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*
Physician Office Telephone Number ***(required by statute)***	Physician License Number ***(required by statute)***	Health Care Professional preparing form if other than the physician

I **APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found at https://www.in.gov/health/

Who to Notify

This is just a starting point to begin discussing and gathering information for end-of-life planning. It can be a difficult task, but it is important to know these details ahead of time to make it much easier on the family when the time comes.

Health Care Power of Attorney*/Agent

Name: ______________________________ Relationship: ____________

Work #: ______________________ Cell #: ______________________

Email: ____

Contact Instructions: ____________________________________

Family/Friend to be Notified

Name: ______________________________ Relationship: ____________

Home #: ____________ Work #: ______________ Cell #: ______________

Email: ____

Contact Instructions: ____________________________________

Name: ______________________________ Relationship: ____________

Home #: ____________ Work #: ______________ Cell #: ______________

Email: ____

Contact Instructions: ____________________________________

Name: ______________________________ Relationship: ____________

Home #: ____________ Work #: ______________ Cell #: ______________

Email: ____

Contact Instructions: ____________________________________

Social Media

Type of Social Media Account: ______________________________

Username: ______________________ Password: __________________

Instructions: ____

Type of Social Media Account: ______________________________

Username: ______________________ Password: __________________

Instructions: ____

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Clergy to be Notified

Name: ______________________________

Church Name/Affiliation: ______________________________

Phone: ______________________________

Email: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Attorney to be Notified

Name: ______________________ Firm Name: ______________________

Work #: ______________________ Cell #: ______________________

Email: ______________________________

Funeral Home to be Notified

Funeral Home: ______________________________

Phone: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

☐ Pre-Paid

Cemetery to be Notified

Cemetery: ______________________________

Phone: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

☐ Pre-Paid

Other Instructions: ______________________________

____

____

____

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Funeral Planning

Memorial Services

Funeral Home: ______________________________

Funeral Director: ______________________________

Funeral Certificate Number: ______________________________

Location of Viewing: ______________________________

Location of Service: ______________________________

Lengths of Viewing and Service: ______________________________

Officiant: ______________________________

Military/Fraternal/Social Organization or Lodge Members to be Present: ______________________________

____

Pallbearers: ______________________________

____

Transportation: ______________________________

Veteran's Flag: ☐ Folded ☐ Draped on Casket ☐ ______________

Music: ______________________________

Slideshow: ______________________________

Reading or Scripture Selections: ______________________________

Flowers (Type and Color): ______________________________

Memorial Donations: ______________________________

Casket: ☐ Open ☐ Closed ☐ Both: Open at this time ________ Closed at this time ________

Clothing: ______________________________

Glasses to be Worn: ☐ Yes ☐ No ☐ Remove before Internment Return to: ______________

Jewelry to be Worn: ______________________________

☐ Remove before Internment Return to: ______________________________

Cremated Remains Present: ☐ Yes ☐ No

Preparation and/or Printing of the Order of Memorial Services: ______________________________

____

Personal Requests or Wishes: ______________________________

____

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Burial

Cemetery: ______________________________

Cemetery Documents Located: ______________________________

Casket Type: ______________________________

Certificate of Burial Rights Number: ______________________________

Certificate in the Name of: ______________ Phone: ______________

Burial Vault: ______________________________

Property or Crypt Location: ______________________________

Type of Burial: ☐ Earth Burial ☐ Crypt ☐ Mausoleum ☐ Other:

In-ground Interment: Section ________ Lot: ________ Block: ________ Grave: ________

Memorialization Preferences: ☐ Flush Memorial ☐ Upright Monument ☐ Granite
☐ Bronze ☐ Companion ☐ Single ☐ Other: ________

Inscription: ______________________________

____

Cremation

Funeral Home or Cremation Society: ______________________________

Address: ______________________________

Phone: ______________________________

Urn type: ______________________________

Location of Cremated Remains: ______________________________

Cemetery: ______________________________

Private Estate: ______________________________

Disposition: ☐ Earth burial ☐ Mausoleum ☐ Crypt ☐ Columbarium ☐ Other:

Alternative Disposition: ______________________________

Type of Memorial/Monument: ______________________________

Inscription: ______________________________

____

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Obituary Planning

Name (and maiden name, if applicable): ____

Spouse's Name (and maiden name, if applicable): ____________________________________

Date and Place of Birth (City, State and County): ___________________________________

Date and Place of Death: ____

Past Residences and Number of Years at Addresses: ___________________________________

____

State Residence Since (State and Year): ____

County Residence Since (County and Year): ____

Children/Cities Where they Reside: ____

____

____

Grandchildren/Cities Where they Reside: ____

____

____

Siblings/Cities Where they Reside: ____

____

____

Parents/Cities Where they Reside (or Resided, if Deceased) and Places of Birth: ____________

____

Number of Great Grandchildren _____ Number of Nieces _____ Number of Nephews _____

Date, Time, Place of Viewing/Funeral/Burial: ____

____

Officiant: ____

Address of Funeral Home: ____

Address of Cemetery: ____

Memorial Contributions to: ____

Preferred Photo and Location of Photo: ____

Education (School, Degree and Years): ____

Wedding Date: ____

Military Service (Branch, Rank and Serial No., Years Served): ___________________________

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Employment: ____

____

____

Religious Affiliation: ____

____

Other Affiliations: ____

____

Significant Recognition and Achievements: ____

____

____

____

Special Background Interests: ____

____

____

Preceded in Death by: ____

____

____

____

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Personal Property Memorandum

I bequeath the following items of tangible personal property to the beneficiaries listed below:

	Description of Item	Location	History of Item	Name of Recipient (relationship and contact info if needed)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Signature:__________________________ Date:____________

Notes:
- You can use this document for items of tangible personal property such as furniture, art, jewelry, collections and in some states vehicles.
- You cannot use it for real estate or for intangible property such as money, including bank accounts, IOU's, stocks or bonds and copyrights.
- Consider numbering your items with an inconspicuous sticker that corresponds with this document.
- If you want to make changes, don't cross out anything on your existing memorandum. Instead, make a new one and throw the old one away.
- To avoid contradictions, don't include items that you've already specifically left in your will.
- Keep the memorandum with your will, in this CARE Kit or in a place where your personal representative will be able to find it easily.
- To make this memorandum legally binding, refer to it in your will.

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What is the Legacy?

Tip: Record this on a phone or any other recording device.

What is the legacy for: ____________________

Fondest childhood memory: ____________________

____

____

____

____

Greatest personality trait and why: ____________________

____

____

____

____

How to be remembered: ____________________

____

____

____

____

Major accomplishments: ____________________

____

____

____

____

Improvements made to the world: ____________________

____

____

____

____

Lessons taught to others: ____________________

____

____

____

____

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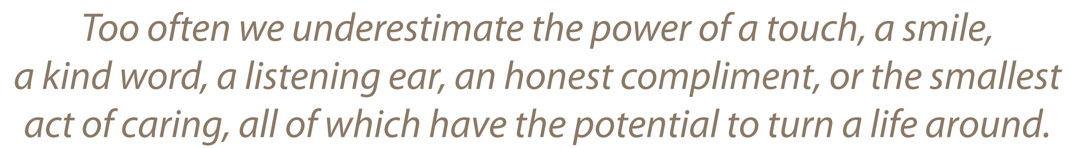

Too often we underestimate the power of a touch, a smile,
a kind word, a listening ear, an honest compliment, or the smallest
act of caring, all of which have the potential to turn a life around.

- Leo Buscaglia

This space is left blank intentionally for you to add information
that is customized to the needs of your loved one.

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- **Finding peer caregiver support groups**
- **Planning for in-home or long-term care**
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CICOA is a local nonprofit in Central Indiana that empowers older adults and people with disabilities to remain in their homes with the greatest possible independence, dignity and quality of life.

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