Keeping It All Together

Information Kit

Caring Beast

Keeping It All Together - Information Kit

The *Keeping It All Together* Information Kit is a tool that allows seniors to put together a comprehensive compilation of their personal, legal, medical and financial information. This provides the critical information needed to make decisions and handle their affairs when they are no longer able to do so for themselves.

The kit provides documents where you can compile information on topics such as:

- Who to call in an emergency and next-of-kin contact information
- Household information such as where your extra house keys or if you have a pet that needs to be cared for
- Whether you have an advance directive or living will that makes your medical wishes known and where it can be found
- Medical information such as medications and health insurance
- An overview of pertinent financial documents and their location
- And much, much more

It takes only once for those who care for seniors to know what they don't know. It takes the *Keeping It All Together* Information Kit to provide the answers.

Emergency Contacts section
Information for My Emergency Contacts form

Financial section
Financial Accounts form
Financial Assets & Liabilities form
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Business Assets form
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Guide to Advance Directives – what are they and do you need one?
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Medical Advance Directives

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Legal Documents form

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- Preparing the Home form
- Daily & Lifestyle Routines form
- Caregiver Resources guide

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- Basic Health Information Profile form
- Health Care Providers Contact List form
- Medical Conditions & History Guide form

End of Life section
- Funeral Planning form
- After Death Checklist
- Guide to the Probate Process

Information for my Emergency Contacts

Instructions for individual filling out this form:

- Complete as much information as you can that will assist your Emergency Contact in finding important information in the event that you become seriously ill or injured.
- **Give this form to your Emergency Contact(s)!**

Instructions for the Emergency Contact:

- The person who has given you this form trusts you to handle their most private information.
- In the event that he or she becomes seriously ill or injured, you may be called upon to utilize this information and assist them as they have instructed you here.
- Please keep this form in a safe place that is easily accessible should you need it suddenly.

Name of person filling out this form _____

Access to my house

Access to my house involves these steps:

My key is hidden here:

I have given you a key to my house with this form. (circle one): Yes No

Health related information (more information is available on other forms as indicated below.)

I am allergic to:

I have these health conditions:

My doctor: Phone

My preferred hospital:

My health insurance: Company Policy/Group No.

Medicare/Medicaid ID# Other

Contact this person immediately: Phone

Keeping It All Together Information Kit – The kit is located: _____

Information that is included in my Information for Life kit:

Advance Directives
Health Needs and Medical History
Important Legal Documents (including Will and Trusts)
Financial Information
Insurance Policies
Home, Family, Friends, and Community
End of Life (including a Funeral Plan)

This is what I want you to do with the Keeping It All Together kit once you have it in your possession:

Financial Accounts

Instructions:

- Provide information on your financial accounts for each category that applies to you.
- **Ensure that the individual(s) who hold your Power of Attorney have copies of this form.**
- File your original documents separate from copies and with this form.

Accountant / Financial Advisor contact information

Accountant: Phone:

Address:

Financial Advisor: Phone:

Address:

Safe deposit box – List where safe deposit box is located and who has access (if applicable).

Institution where safe deposit box is located:

Address:

Where the key is located or with whom:

Name(s) of person(s) with official access to the safe deposit box

1. Name: Phone:

2. Name: Phone:

Financial accounts and cash – List where accounts are held and the account number.

Include checking, savings, FSA/HSA, and money market accounts.

Institution: Type: Account no.

Institution: Type: Account no.

Institution: Type: Account no.

Institution: Type: Account no.

Institution: Type: Account no.

Credit cards – List where accounts are held and the account number.

Include department store cards, general credit cards, lines of credit, etc.

Institution: Type: Account no.

Institution: Type: Account no.

Institution: Type: Account no.

Institution: Type: Account no.

Financial Assets and Liabilities

Instructions:

- Provide information on your financial assets for each category that applies to you.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- File your original documents separate from copies and with this form.

Owned Properties – List information related to any properties that you own.

Make sure to include 1st, 2nd and reverse mortgages for all properties.

1. Property address:

☐ I am living at this property ☐ Property is empty ☐ Property is being rented

Renter name: Phone:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other:

If bank-owned, institution name:

Account number: Phone:

If self-owned, location of property title:

2. Property address:

☐ I am living at this property ☐ Property is empty ☐ Property is being rented

Renter name: Phone:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other:

If bank-owned, institution name:

Account number: Phone:

If self-owned, location of property title:

3. Property address:

☐ I am living at this property ☐ Property is empty ☐ Property is being rented

Renter name: Phone:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other:

If bank-owned, institution name:

Account number: Phone:

If self-owned, location of property title:

Financial Assets and Liabilities continued

Instructions:

- Provide information on your financial assets for each category that applies to you.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- File your original documents separate from copies and with this form.

Rented Properties – List information related to any properties that you rent or lease.

1. Property address:
   Name of Leasing Company:
   Location of lease:
2. Property address:
   Name of Leasing Company:
   Location of lease:

Automobile Information – List information related to any automobiles you own or lease.

1. Vehicle (make, model, year):
   Ownership status: ☐ Loan ☐ Lease ☐ Other: Self-owned
   If under a loan or lease, institution name:
   Account number: Phone:
   If self-owned, location of vehicle title:
2. Vehicle (make, model, year):
   Ownership status: ☐ Loan ☐ Lease ☐ Other: Self-owned
   If under a loan or lease, institution name:
   Account number: Phone:
   If self-owned, location of vehicle title:

Other Assets or Liabilities

Other loan(s) or title(s) to other vehicle(s), property, and equipment

1. Description:
   Location of loan papers or title:
2. Description:
   Location of loan papers or title:

Student loan, tuition agreements
   Description: Phone:
   Location of documents:

Coins, stamps, other collections:

Season tickets to sports venues, theatre:

Financial Investments

Instructions:

- Provide information that applies to investments you have for each category.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- File your original documents separate from copies and with this form.

Investments - List which institutions hold these investments and the account numbers.

Mutual funds

Institution: Account no.

Institution: Account no.

Stocks and bonds

Institution: Account no.

Institution: Account no.

Annuities

Institution: Account no.

Institution: Account no.

CDs (Certificates of Deposit)

Institution: Account no.

Institution: Account no.

REITs (Real Estate Investment Trust)

Institution: Account no.

Other:

Treasury Securities/Notes/Bills (if physical notes, location):

Institution: Account no.

Savings bonds (if physical bonds, location):

Institution: Account no.

Other investments:

Loans from you to others – business and personal

1. Loanee name:

   Address:

   Location of contract/note:

2. Loanee name:

   Address:

   Location of contract/note:

Business Assets

Instructions:

- Provide information on your business assets and intellectual property as applicable.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- Attach additional pages as necessary.

Key Business Information

1. Business name:

   Admin contact: Phone:

   Accounting contact: Phone:

   Location of ownership documents:

   Location of bank account documents:

2. Business name:

   Admin contact: Phone:

   Accounting contact: Phone:

   Location of ownership documents:

   Location of bank account documents:

Domain Names, Blogs, Websites

Name	Registrar	Account Manager

Trade Names, Trademarks, Copyrights, Patents

Name: Registrar:

Name: Registrar:

Name: Registrar:

Business Licenses (i.e. sales tax, county, etc.)

1.

2.

3.

Other Business Assets

Financial Retirement Benefits

Instructions:

- Provide information on your retirement benefits for each category that applies to you.
- File your original documents separate from copies and with this form.
- File your original documents separate from copies and with this form

Retirement Information

Social Security: Are you collecting Social Security? ☐ Yes ☐ No

401(k), IRAs, etc.

1. Institution name:
   Type of plan: Account no.
   Location of documents:
2. Institution name:
   Type of plan: Account no.
   Location of documents:
3. Institution name:
   Type of plan: Account no.
   Location of documents:

Stock options (employee stock, profit sharing, ownership plans, etc.)

1. Company name: Account no.
   Location of documents: Type:
2. Company name: Account no.
   Location of documents: Type:
3. Company name: Account no.
   Location of documents: Type:

Pension(s)

1. Institution name: Account no.
   Location of documents:
2. Institution name: Account no.
   Location of documents:

Veterans Benefits *(www.va.gov)*

I have a: ☐ Veterans Retirement plan ☐ Survivors Benefit plan ☐ Death Gratuity/Pension plan

Location of DD 214:

Last branch of service: Dates of service:

Medical Advance Directives

What is an Advance Directive?

If you become unable to make decisions for yourself, an advance directive tells healthcare providers what kind of treatments you do want and what kinds of treatment you don't want. The directives also provide guidance and peace of mind for family members and friends because your wishes are clearly indicated.

Any person 18 years of age or older can prepare advance directives so their wishes are known in case of an accident or the sudden onset of an illness. Advance directives are typically prepared by people who are terminally or seriously ill.

Advance directives are different in each state and can take various forms. Be sure to check with your state when preparing your advance directives.

Preparing Advance Directives:

- Get thorough information about the various life-sustaining treatments.
- Make a decision about what treatment(s) you prefer.
- Talk to your family and/or healthcare providers about your preference.
- Use a form provided by your doctor, write down your directives yourself, or talk with an attorney.
- Follow your state-specific guidelines which can be found at the state health department or state department on aging.
- Have the document signed by appropriate witnesses or a notary.
- You do not need a lawyer to prepare advance directives, but follow your state's guidelines for this document.

Storing Advance Directives:

- They must be easily accessible and protected from theft, fire, flood, etc.
- Make several copies and distribute to – your doctors, a trusted family member or loved one, your Durable Power of Attorney for Health Care/ Healthcare Agent, your attorney, and your own files.

Types of Advance Directives:

1. **Living Will** – A written legal document which expresses your decisions for medical treatment or life-sustaining treatments in the event you are incapacitated. This document does not let you designate someone to make decisions for you like a Durable Power of Attorney for Health Care form does.
2. **Durable Power of Attorney for Health Care** – This document asserts who you have chosen to make health care decisions for you. It is activated when you become unconscious or not able to make decisions for yourself.

   Choosing a Healthcare Agent – Because this person will be making significant decisions for you, selecting a person who you trust and who knows you well, such as a family member or close friend.
   (See the 'Durable Power of Attorney for Health Care Discussion Questions' sheet in this packet.)
3. **Do Not Resuscitate Order (DNR)** –

   In-Hospital DNR - This specifies to doctors and hospital staff that you do not want to be given CPR (cardiopulmonary resuscitation) if your heart stops or if you stop breathing. If you tell your doctor prior to being admitted to the hospital that you do not want to be resuscitated, the doctor will put a DNR order into your chart. DNR orders are recognized in all states.

   Out-of-Hospital DNR- This document allows a person to specify that in the event that they should stop breathing and their hearts stop beating while in their own home, out in their community, in a medical care facility or hospice setting they do not want to be resuscitated by emergency medical services personnel. The program allows people to declare that certain resuscitative measures will not be used on them.
4. **Organ donor card or form** – A driver's license has organ donor preferences on the back side. You can also fill out an organ donor card or form, downloadable at organdonor.gov.
5. **Funeral plan** – A plan for funeral arrangements can take many forms. The purpose if gathering this information is to guide loved ones in planning your funeral and writing your obituary at the time of your death. (*See the 'Funeral Services Planning Guide' sheet in this packet.)*

Medical Advance Directives

Instructions:

- Provide information on your medical advance directives for each category.
- Collect only the information that applies to you.
- **Provide copies to the individuals who are part of your Advance Directive plan.**
- File your original documents separate from copies and with this form.

Power of Attorneys – List the name and phone of the person who fulfils these roles for you.

Medical Power of Attorney

Name: Phone:

Location of the original document:

Durable Medical Power of Attorney

Name: Phone:

Location of the original document:

Legal Power of Attorney:

Health Care Directives – List the location of these documents.

Do Not Resuscitate (DNR) order – In-Hospital, Out-of-Hospital
Location of original document:

Organ Donor card
Location of original document:

Five Wishes (www.agingwithdignity.org)
Location of original document:

Psychiatric advance directive
Location of original document:

Other:
Location of original document:

Contacts – List contacts who would be helpful with your advance directives.

Attorney (medical): Phone:

Physician: Phone:

Medical Advance Directives

The role of a 'medical power of attorney' is different than that of a 'power of attorney' for legal and business matters. See how each is different and the important role a medical power of attorney has:

What is a Power of Attorney ?

A power of attorney is an authorization to act on someone else's behalf in a legal or business matter. The individual who authorizes another person to act is the principal or grantor. The individual who is authorized to act is the agent. The term 'durable power of attorney' means that the power of attorney remains in affect in the event that the principle becomes incapacitated or dies.

What is a Medical Power of Attorney?

Also known as Durable Power of Attorney for Health Care or as Health Care Agent, this authorization is made by an individual to allow someone to make decisions about healthcare on their behalf should the authorizing party become incapacitated or otherwise unable to make decisions regarding medical treatment.

Benefits of having a Medical Power of Attorney

- The agent knows you well and understands your desired medical treatments.
- As your condition changes, the agent can discuss options for treatment with physicians and has the power to either authorize or withdraw them.
- The agent can actively advocate on your behalf throughout your period of incompetence.
- If you have prepared a living will, your agent has that as a guide for your preferred treatment and can encourage healthcare providers to follow those guidelines.

Choosing the right person to be your Medical Power of Attorney

The person chosen to be a Medical Power of Attorney should be a trusted family member or friend who knows you well and is willing to take on the responsibility should the need arise.

When selecting someone for this position, consider the following:

- Select someone who you trust completely and who understands your decisions for medical care. Suggestions for discussion are below.
- Acting as a Medical Power of Attorney is a significant responsibility. Be sure that the person you ask is willing to be an effective agent for you, will ask questions of healthcare professionals, and will gather information needed to make decisions.
- Ultimately, the person you select will be making decisions based on your living will and your discussions with them. Be sure they have full understanding of your wishes.

Talking with your Medical Power of Attorney about your end-of-life wishes

Your Medical Power of Attorney should be aware of your values, quality-of-life beliefs, and how you feel about identified medical treatments and situations.

Discussion questions to help you clarify your wishes with yourself and your Medical Power of Attorney:

What medical treatments would you refuse or accept at the point you become incapacitated and why?
What are you afraid might occur if you can't make decisions for yourself?
What are your family member's beliefs in relation to your own beliefs about what should happen?
What are your views about artificial nutrition (food) and hydration (fluid)?
Under what conditions is it acceptable and not acceptable by you for hospital staff to perform CPR (cardiopulmonary resuscitation) to restart your heart?
What are your feelings about receiving treatments such as mechanical ventilation, antibiotics or a feeding tube?
What situations does it make sense for you to receive these treatments?
If your condition doesn't improve, would you want them discontinued after a time? What does that mean specifically?

Important Legal Documents

Instructions:

- Provide information about your legal documents that apply to you for each category.
- Make copies of the original documents (including the front and back of cards) and **keep them separate from the originals.**

Identification Documents – List where these documents are located (if not with this kit).

Birth Certificate:

Driver's license:

Social Security card:

Marriage certificate:

Passport:

Military ID:

Will – List information that helps to locate these items and people.

Attorney

Name: Phone:

Address:

My Executor

Name: Phone:

General or Durable Power of Attorney Appointee

Name: Phone:

Trusts – List information related to any trusts that you have set up.

1. Name of Trust:

☐ *Copy of this trust included with this kit.*

Location of original document:

Trustee of this trust: Phone:

2. Name of Trust:

☐ *Copy of this trust included with this kit.*

Location of original document:

Trustee of this trust: Phone:

Important Legal Documents continued

Instructions:

- Provide information about your legal documents that apply to you for each category.
- Make copies of the original documents (including the front and back of cards) and **keep them separate from the originals.**

Contracts / agreements – List where these documents are located (if not with this form).

Divorce, annulment, pre- or post-nuptial agreements

1. Document type:
   Location:
2. Document type:
   Location:
3. Document type:
   Location:

Child support, alimony, adoption papers

1. Document type:
   Location:
2. Document type:
   Location:

Rental lease, senior housing contract, home care agreements

1. Document type:
   Location:
2. Document type:
   Location:
3. Document type:
   Location:

Other legal documents (e.g. cell phone contracts, automobile title, etc.)

1. Document type:
   Location:
2. Document type:
   Location:
3. Document type:
   Location:

Health Insurance

Instructions:

- Provide information that applies to your health insurance category for each category.

Health Insurance Information

- ☐ Medicare Policy number:
- ☐ Medicaid Policy number:
- ☐ Social Security Disability Policy number:
  Sponsor name:
- ☐ Other Disability Name of entity:
  Policy number:
  Sponsor name:
- ☐ Veteran's Coverage Name of entity:
  Policy number:
  Sponsor name:
- ☐ Other Name of entity:
  Policy number:
  Sponsor name:
- ☐ Other Name of entity:
  Policy number:
  Sponsor name:

Private Insurance Coverage

- ☐ Company:
  Group / Policy Number: Sponsor name:
  Phone:
- ☐ Company:
  Group / Policy Number: Sponsor name:
  Phone:
- ☐ Company:
  Group / Policy Number: Sponsor name:
  Phone:

Personal Insurance

Instructions:

- Provide information on your personal insurance policies for each category that applies to you.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- File your original documents separate from copies and with this form.

Home and Property policies

Homeowner's policy

Company: Account no.

Company: Account no.

Property, Casualty policy

Company: Account no.

Company: Account no.

Umbrella liability policy

Company: Account no.

Auto policy

Company: Account no.

Company: Account no.

Boat, RV, motorcycle, golf cart, or motorized chair policy

Company: Account no.

Company: Account no.

Pet Medical policy

Company: Account no.

Other policies – if you have other insurance policies not already listed, please list them here

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Business Insurance and Other Policies

Instructions:

- Provide information on your personal insurance policies for each category that applies to you.
- Ensure that your Executor or Power of Attorney knows where to find this form.
- File your original documents separate from copies and with this form.

Business policies

Life Insurance policy (key-man, etc.)

Company: Account no.

Company: Account no.

Disability Policy (long-term and/or short-term)

Company: Account no.

Company: Account no.

Business Overhead Expense (BOE) policy

Company: Account no.

Property and Casualty policy (Commercial or General, Fleet Auto, etc.)

Company: Account no.

Company: Account no.

Liability policy (General, Product, Professional, etc.)

Company: Account no.

Company: Account no.

Business Interruption

Company: Account no.

Other policies – if you have other insurance policies not already listed, please list them here

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Coverage for:

Company: Account no.

Information for Caregiver

Instructions:

- Individuals needing care and Caregivers may fill out this form.
- Collect only the information that applies to the person for whom care is given.

DailyRoutines

Descriptions, preferences, and schedules for personal care items such as bathing, skincare, dentalcare, dressing, sleeping, exercise, etc.

LifestyleRoutines

Descriptions, preferences, and schedules for activities and favorite items such as leisure time, foods, television, radio, people and places to visit, etc.

I have a 'Keeping It All Together' Information Kit with all of my important information. My Emergency Contact(s) has access to this Kit. Please contact my Emergency Contacts to obtain any of the following information:

- ☐ Health Needs and Medical History Information
- ☐ Advance Directives
- ☐ Home, Family, Friends, and Community Information
  - ☐ (INCLUDING MY EMERGENCY CONTACTS)
- ☐ Insurance Policies Information
- ☐ Financial Information
- ☐ Important Legal Documents
- ☐ Will and Trusts Information
- ☐ End-of-Life Information

General Information – The information provided here is to help the caregiver appropriately organize the home and provide resources to assist the caregiver.

- ☐ Checklist of how to prepare a safe home for the senior
- ☐ A list of resources to assist you
- ☐ Contact information for family, friends, care team

Information for Caregiver

Instructions:

- Individuals needing care and/or caregivers may fill out this form.
- Supply information regarding daily and lifestyle routines that apply to the person receiving care.

Daily and Lifestyle Routines

Daily Routine – List descriptions, preferences and schedules for these items.

Personal care at home – bathing, skin care, dental care, dressing, sleeping, exercise, etc.

Care item	Description / preferences	Schedules

Lifestyle routines – List descriptions, preferences and schedules for these items.

Activities and Favorites – leisure activities, foods, television, radio, people and places to visit, etc

Item	Description / preferences	Schedules

Information for Caregiver

Instructions:

- Use this list to create a safer home environment for the person under your care.
- Use only the information that applies to your situation.

Preparing the Home

Medication Safety

- ☐ Ask pharmacist for child resistant containers.
- ☐ Organize medicine in daily dosage packs to prevent medication distribution errors.
- ☐ Know what each pill is for and what it looks like. Write a description on the outside of the bottle or take a picture of each pill and put it on the outside of the bottle or with medication information.
- ☐ Throw away – expired prescriptions, unmarked bottles.
- ☐ Keep all medications in original containers.
- ☐ Store all medicine in a secure location.

General Home Safety

- ☐ Post all emergency numbers near the phone or on the refrigerator, i.e. emergency contacts, doctors, poison control.
- ☐ Lock up all cleaning products in the kitchen, bathroom, laundry room, etc.
- ☐ Place frequently used items within reach and off of high shelves.
- ☐ Remove potential tripping hazards: electric cords, area rugs.
- ☐ Inspect walkways and driveways and repair any problem areas.
- ☐ Install night lights throughout the home to light the way.
- ☐ Check light levels for daytime and nighttime vision to be sure they are adequate in work areas, hallways, and frequently used rooms
- ☐ Check that footwear worn in the home has non-skid soles and are in good condition.
- ☐ Install or inspect smoke alarms to assure proper functioning.
- ☐ Check that small appliances are working properly and are in good condition, i.e. toasters, space heaters, blenders, coffee makers, microwaves, etc.
- ☐ Dispose of flammable liquids, i.e. paint, gasoline, etc.
- ☐ Remove clutter from main traffic areas.
- ☐ Inspect hand rails for proper, secure installation and that they can support appropriate weight.
- ☐ Position furniture to allow plenty of space for walking. Remove furniture if need be.
- ☐ Replace handles on doors, cabinets, and furniture that makes grasping them easier.
- ☐ Lock any cabinets that contain sharp or dangerous items or remove the items from the home.

Kitchen Safety

- ☐ Remove knobs from the stove or unplug it from the wall to avoid accidents.
- ☐ Keep knives out of reach or locked up, if necessary.
- ☐ Regularly inspect foods for freshness and expiration dates.

Information for Caregiver

Instructions:

- Use this list to create a safer home environment for the person under your care.
- Use only the information that applies to your situation.

Preparing the Home - Continued

Bedroom Safety

- ☐ Do not allow smoking in the bedroom. Remove all sources of flame from the bedroom.
- ☐ Move furniture with sharp corners or edges away from the bed in case of a fall out of bed.
- ☐ Move breakable items away from the bed.
- ☐ Have the person under your care wear nonskid socks to bed to help avoid slipping and falling if they get up in the middle of the night.
- ☐ Install adjustable bed rails on one or both sides of the bed. These are good to keep a person in bed and to assist them getting in or out of bed.

Bathroom Safety

- ☐ Install non-skid surfaces on the floors, shower and tub.
- ☐ Install grab bars near the toilet and tub.
- ☐ Have shower/tub chairs accessible.
- ☐ Install a raised toilet seat for easier transferring.
- ☐ Replace faucet fixtures to easy-to-use style.
- ☐ Set water heater at 120 degrees or less to avoid scalding.
- ☐ Remove all sharp objects, such as razors.

Extra Safety Steps

- ☐ Use a cordless phone or cell phone in the home that the senior can carry around with them.
- ☐ Install a call button system that can alert authorities immediately in case of emergency. Some models include a device that can be worn around the neck.
- ☐ Install a web cam that can be accessed from a remote location to keep an eye on the senior.
- ☐ Install a GPS in the home or car to allow for easy tracking.
- ☐ Reduce phone calls to the home. Add the phone number to the Do Not Call Registry, **1-888-382-1222** or **www.donotcall.gov**. Or forward all phone calls to a different phone number.

Information for Caregiver continued

Instructions:

- Keep this list of commonly used caregiver resources accessible.
- These resources offer caregivers the support they need.

Caregiver Resources

AARP
800-424-3410
www.aarp.org

Aging with Dignity
888-594-7437
www.agingwithdignity.org

Alzheimer's Association
800-272-3900
www.alz.org

American Red Cross
202-303-4498
www.redcross.org

Caregiver Assistance Network
513-241-7745
www.cssdoorway.org/can

Children of Aging Parents
800-227-7294
www.caps4caregivers.org

Elder Care Locator
800-677-1116
www.n4a.org or www.eldercare.gov

Family Caregive Alliance
800-445-8106
www.caregiver.org

Hospice Foundation of America
800-854-3402
www.hospicefoundation.org

Meals on Wheels Association
703-548-5558
www.mowaa.org

National Association for Home Care
202-547-7424
www.nahc.org

National Association for Geriatric Care Managers
520-881-8008
www.caremanager.org

National Council on Aging (NCOA)
800-424-9046
www.ncoa.org

National Family Caregivers Association (NFCA)
800-896-3650
www.nfca.org

National Hospice Organization
800-658-8898
www.hospiceinfo.org

National Institute on Aging
410-496-1752
www.nia.nih.gov

The Society of Certified Senior Advisors
800-653-1785
www.csa.us

US Administration on Aging
202-619-0724
www.aoa.gov

Information for Caregiver continued

Caregiver's Bill of Rights - *by Jo Horne*

I have the right:

To take care of myself. This is not an act of selfishness. It will give me the capability of taking better care of my loved one.

To seek help from others even though my loved ones may object. I recognize the limits of my own endurance and strength.

To maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things just for myself.

To get angry, be depressed, and express other difficult feelings occasionally.

To reject any attempts by my loved one (either conscious or unconscious) to manipulate me through guilt, and/or depression.

To receive consideration, affection, forgiveness, and acceptance for what I do, from my loved ones, for as long as I offer these qualities in return.

To take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my loved one.

To protect my individuality and my right to make a life for myself that will sustain me in the time when my loved one no longer need my full-time help.

To expect and demand that as new strides are made in finding resources to aid physically and mentally impaired persons in our country, similar strides will be made towards aiding and supporting caregivers.

Home, Family, Friends & Community

Instructions:

- Use the list and the accompanying form as guides for collecting information about how your home functions, family and friends contact information, pet care, and community involvement.
- Include only the information that applies and would be helpful in the event you become ill or injured.

Contacts

Home Information

- Passwords
- Keys
- Mail and Deliveries
- Vendors/services and Schedules

Pets

- Who can care for my pets
- Description and Daily care
- Veterinarian/Emergency
- Financial arrangements

Community

- Work
- Religious affiliation
- Community affiliation
- People who depend on me for assistance

Home, Family, Friends & Community continued

Instructions:

- List your family and friends not already listed on the Emergency Contacts envelope of this kit.
- Use this form to include people you would like notified if you become ill or injured by marking the box above each contact's name.
- Complete as much information as you can for each contact

Contacts

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

Contacts continued on next page.

Home, Family, Friends & Community continued

Contacts - Continued

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

☐ Notify this person if I am ill or injured

Name:

Street Address:

City: State: Zip:

Home phone: Work phone:

Cell phone: Email address:

Relationship:

Home, Family, Friends & Community continued

Instructions:

- Provide information about your home that would be helpful in the even you become ill or injured.

Home Information

General - List the information that describes access to your home and schedule.

Passwords (computer, voicemail, email, home security system, garage key pad):

Landlord (if you have one): Phone:

Security System Company: Phone:

My appointment calendar is located:

Keys – List the location of your keys or who has possession of them.

Car keys: Safe deposit box keys:

House keys: Mailbox keys:

Other keys (shed, office, etc.)

Mail and Deliveries – List where you get your mail and any regular deliveries your receive.

Location of Mailbox for daily mail:

- ☐ At primary residence:
- ☐ PO Box #: Address:
- ☐ Mailbox kiosk. Box #: Located at:

Regular deliveries: (Items where a subscription would need to be canceled, such as newspapers, magazines, products, etc.):

Vendors – List the location of your keys or who has possession of them.

Home cleaning: Company: Phone:

Schedule of service:

Garbage collection: Company, city, county Phone:

Schedule of service:

Lawn services: Company: Phone:

Schedule of service:

Plant watering: Company: Phone:

Schedule of service :

Home, Family, Friends & Community continued

Instructions:

- Provide information that would be helpful in caring for your pets if you become ill or injured.

Pet Information

Person who can care for my pet if I am not able:

Name: Phone:

My pets:

1. Name: Type of Animal:

Daily Routine:

Where the food and medicine is found:

Where the water and food bowls are:

Food: (amount) times per day

Medicine: (amount) times per day

2. Name: Type of Animal:

Daily Routine:

Where the food and medicine are:

Where the water and food bowls are:

Food: (amount) times per day

Medicine: (amount) times per day

Veterinarian:

Street Address:

City: State: Zip: Phone:

Animal Emergency Clinic/Hospital:

Street Address:

City: State: Zip: Phone:

Financial arrangements to pay for the care of my pet(s):

- ☐ Self-pay
- ☐ Pet insurance, company name: group #:
- ☐ Other

Home, Family, Friends & Community continued

Instructions:

- Provide information that is important for someone to know in the even you become ill or injured.

Community Information

Work Information

Employer:

Main Contact Person:

Address:

City: State: Zip:

Phone:

Religious/Spiritual Information

Affiliation: Pastor, Rabbi, Spiritual leader:

Name: Phone:

Church, Synagogue, Religious, Spiritual organization:

Name: Phone:

Address:

City: State: Zip:

Community Affiliations – List associations you have with groups or individuals.

Clubs, community groups, volunteer organizations:

People who depend on me for support - List people who you provide help to on a regular basis. The kind of help which would need to be covered by someone else in the event that you are not able.)

Name: Phone:

Address: Email:

Nature Support:

Name: Phone:

Address: Email:

Nature of Support:

Basic Health Information Profile

Instructions:

- Provide information that applies to you for each category.
- Provide copies to the individuals who are your Emergency Contact.

Personal Information

Full Name:

I like to be called:

Date of Birth: Gender:

Address:

City: State: Zip :

Phone: Cell Phone:

Email

Advance Directives

I have filled out the following forms:

- ☐ The Medical Conditions & History form
  It is located at:
- ☐ The Healthcare Providers form
  It is located at:
- ☐ The Healthcare Insurance form
  It is located at:
- ☐ The Medical Advance Directives form
  It is located at:
- ☐ The Emergency Contacts form

It is located at: ☐ Other form:

It is located at: ☐ Other form:

Health Care Providers

Instructions:

- Complete information about your medical and health providers for each category that applies to you.

Primary Care Doctor

Name:

Address:

City: State: Zip:

Phone: Email:

Specialists and Other Medical Providers

1. Name: Phone:
   Specialty:
2. Name: Phone:
   Specialty:
3. Name: Phone:
   Specialty:
4. Name: Phone:
   Specialty:

Home Health Aide or Caregiver

Name:

Phone: Cell Phone:

Geriatric Care Manager or Social Worker

Name:

Phone: Cell Phone:

Pharmacy

Name:

Phone: Cell Phone:

Medical Conditions & History Guide

Instructions:

- Provide information you feel is appropriate about your current medical conditions.
- **This form is not meant to replace your full medical records.**

Medical Conditions – List the current medical problems and diagnosis you have.

Neurologic:

- ☐ Cerebral Palsy
- ☐ Epilepsy/Seizure Disorder
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Other: _____

Gastrointestinal:

- ☐ GERD
- ☐ Dysphagia
- ☐ Constipation
- ☐ Other: _____

Cancer / Neoplasm:

- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Stomach Cancer
- ☐ Brain Cancer
- ☐ Skin
- ☐ Other:

Cardiovascular:

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Other: _____

Musculoskeletal:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other: _____

Metabolic / Endocrine:

- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other: _____

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ COPD
- ☐ Recurrent infection
- ☐ Aspiration
- ☐ Other: _____

Kidney / Urinary:

- ☐ Renal Insufficiency / Failure
- ☐ Urinary Retention
- ☐ Recurrent Infection
- ☐ Other:

Other – List any other major conditions or health issues that would be helpful to health care providers.

Medical Conditions & History Guide continued

Instructions:

- Provide information about your past surgical, trauma and hospitalization events as well as other pertinent past medical conditions.
- **This form is not meant to replace your full medical records.**

Surgical, Trauma, Hospitalizations – List any of these events that happened in the past.

Date / Year of Event	Type of Event	Outcome

Other – List any other major conditions or health issues that would be helpful to health care providers.

Medical Conditions & History Guide continued

Instructions:

- Provide information about your family health history for each category.
- **This form is not meant to replace your full medical records.**

Family History – List any known family history health issues and your relationship to that person

- ☐ Diabetes. Relationship:
- ☐ High Cholesterol. Relationship:
- ☐ High Blood Pressure. Relationship:
- ☐ Heart Disease. Relationship:
- ☐ Colon Polyps. Relationship:
- ☐ Osteoporosis. Relationship:
- ☐ Osteoarthritis. Relationship:
- ☐ Stroke. Relationship:
- ☐ Cancer. If yes, what kind:

  Relationship

Other – List any other major conditions or health issues that would be helpful to health care providers.

Medical Conditions & History Guide continued

Instructions:

- Provide information you feel is appropriate about your current medications.
- **This form is not meant to replace your full medical records.**

Medications – List the prescribed, over-the-counter medicine or supplements you currently take.

☐ **Please see a different document for a full list, located at:**

Medication/Supplement Name and description of pill	Reason for Taking	Frequency and Dosage

Medical Conditions & History Guide continued

Instructions:

- Provide information you feel is appropriate about your current medical conditions.
- **This form is not meant to replace your full medical records.**

Immunizations – List any recent immunizations you have had.

1. Date:
2. Date:
3. Date:

Allergies – List any latex, food, bee sting, and medication allergies

1. Allergic to:
   Reaction to this:
2. Allergic to:
   Reaction to this:
3. Allergic to:
   Reaction to this:

Physical Aids – List any equipment that you for physical assistance

- ☐ General aids such as: ☐ Glasses ☐ Dentures ☐ Hearing Aid
- ☐ Mobility aids such as: ☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter
- ☐ Diabetic footwear. Details:
- ☐ Prostheses. Details:
- ☐ Transfer Aids such as a transfer sling or belt. Details:
- ☐ Bed accessories such as bed rails. Details:
- ☐ Bathroom accessories such as sitx bath. Details:
- ☐ Other aids:

Funeral Planning Guide

Instructions:

- This is a guide for dealing with after the details of death and the estate of the deceased.
- Each estate is different and each state has their own laws regarding after death issues.
- Professional advice may be necessary to determine the proper course of action.

Documents to obtain in order to complete after death responsibilities:

- ☐ Death certificates - 10-15 certified copies
- ☐ Will
- ☐ Social Security card
- ☐ Marriage certificate
- ☐ Birth certificate?Insurance policies
- ☐ Deed and titles to property
- ☐ Stock Certificates
- ☐ Bank records
- ☐ Military discharge papers or DD214
- ☐ Recent income tax return and W-2 forms
- ☐ Car title and registration papers
- ☐ Loan documents

Within the First 5 Days After the Death

- ☐ Contact a funeral home and make arrangements for services. If you don't know of one to contact, ask friends, family or clergy for references.
- ☐ If appropriate, contact a church or a clergy member to assist in the organization of the services.
- ☐ Contact people involved in the services – pallbearers, person giving the eulogy, readers, etc
- ☐ If the deceased is a veteran, contact your local veterans' agency to obtain discharge papers. You may be provided assistance with the funeral, burial plot or other benefits.
- ☐ Obtain 10-15 copies of the death certificate. The funeral director you work with should be able to provide you with these or they can be obtained at www.vitalrec.com/deathrecords .

Within the First 30 Days After the Death

- ☐ If the deceased was receiving Social Security benefits, notify the Social Security office. Survivor's benefits for surviving spouses may be available, and applied for through the Social Security office.
- ☐ Contact insurance companies – Life insurance health insurance, etc. Some account balances, such as loans, mortgages and credit card accounts may be covered by credit life insurance.
- ☐ If the deceased was employed, contact the employer to inquire about pension plans, credit unions and death benefits related to employment.
- ☐ Contact banks and credit card companies where the deceased had accounts to notify them.
- ☐ Make arrangements with banks, stockbrokers, credit card companies where deceased had joint accounts and arrange to have the deceased's name removed.
- ☐ Make sure that important bills continue to get paid or that services are discontinued.
- ☐ Seek the advice of an accountant, tax advisor and/or attorney.

***** Mortuaries and cemeteries offer as part of their service to file the death certificate, submit obituaries, take care of Social Security, life insurance and VA benefits.***

Funeral Planning Guide continued

Instructions:

- Provide basic historical information that loved ones would need to know as they plan your end-of-life services.
- Provide only the information that you feel is necessary and that would create the end-of-life situation with which you are comfortable.

Basic Information

Full name:

Place of birth: Date of birth:

Marital status: Maiden name:

Marriage date: Marriage location:

Family Members

Children:

Grandchildren:

Siblings:

Work History

Date of official retirement:

Occupation:

Company: Position:

Duration of employment:

Occupation:

Company: Position:

Duration of employment:

Education

Elementary school:

High school:

College:

Other:

Military Service

Veteran: ☐ **Yes** ☐ **No**

Branch: Dates served:

War(s):

Medals / Honors:

Funeral Planning Guide continued

Instructions:

- Provide information regarding your wishes for each item and that would be helpful in guiding others with plans for your final disposition.
- Check answers where necessary.

Obituary

I have written my own obituary: ☐ **Yes** ☐ **No**

Fill in the information that you want included in your obituary.

Basic (name, age, city of residence, name of spouse, funeral arrangements): ☐ Yes ☐ No

Donations requested: ☐ Yes ☐ No If yes, where to:

Manner of passing: ☐ Yes ☐ No

Preceded in death by: ☐ Yes ☐ No If yes, who:

Picture with obituary: ☐ Yes ☐ No If yes, which one:

Other:

Publications obituary is to be published in:

Wishes for Your Remains

Organ donation: ☐ Yes ☐ No If yes, specify which organs:

If yes, specify where (e.g. medical schools, science institutions, etc.):

If arrangements have already been made, specify with who and where the paperwork located:

Dispersement of Remains: ☐ Casket burial ☐ Cremation & burial ☐ Cremation (no burial)
☐ Other:

Burial Option – Wishes for Physical Remains

1. Funeral home / mortuary of choice:
2. Do you have a prearranged policy with this company? ☐ Yes ☐ No
   Location of the policy:
3. Embalmed: ☐ Yes ☐ No
4. Clothes to be worn:
5. Jewelry to be worn:
   Is the jewelry to be removed before internment: ☐ Yes ☐ No
6. Glasses to be worn: ☐ Yes ☐ No
7. Preferences for casket or urn type (e.g. metal, wood, kosher, green burial, etc.):
8. Other requests

Funeral Planning Guide continued

Instructions:

- Provide information regarding your wishes for each item and that would be helpful in guiding others with plans for your final disposition.
- Check answers where necessary.

Burial Information

Burial Site Location

1. Type of site: ☐ Cemetery ☐ Lawn Crypt ☐ Mausoleum ☐ Columbarium ☐ Other:
2. Location name:
   Section: Lot #: Grave:
   Location of deed:
3. Other details:

Burial Site Preferences

1. Marker: ☐ Yes ☐ No
   Type of marker (flat, upright, marble, stone, etc.):

   Inscription details (image, picture, wording, etc.):

2. Monument ☐ Yes ☐ No
   Details:

3. If veteran, do you want a flag on your casket? ☐ Yes ☐ No
   If yes, should the flag be draped over the casket or folded? ☐ Draped ☐ Folded
4. Other requests:

Funeral Planning Guide continued

Instructions:

- Provide information regarding your wishes for each item and that would be helpful in guiding others with plans for your final disposition.
- Check answers where necessary.

Service Information

Please see the Guide to Funeral Rituals at www.csa.us/FuneralGuide for information on the different types of funeral and memorial services.

I want the following services: ☐ Funeral ☐ Memorial ☐ Burial ☐ Other:

Service Details

List your service choice(s) and the details you prefer regarding each service:

1. Type of Service:

a. Clergy to Officiate:

b. Location:

c. Remains present at service? ☐ Yes ☐ No

Casket viewing ☐ Yes ☐ No If yes: ☐ Open ☐ Closed

d. Attendees (e.g. family & friends only, immediately family only, etc.):

e. Pallbearers:

f. Eulogy (who will give): I wrote my own: ☐ Yes ☐ No

g. Description of service (readings, music, flowers):

2. Type of Service:

a. Clergy to Officiate:

b. Location:

c. Remains present at service? ☐ Yes ☐ No

Casket viewing ☐ Yes ☐ No If yes: ☐ Open ☐ Closed

d. Attendees (e.g. family & friends only, immediately family only, etc.):

e. Pallbearers:

f. Eulogy (who will give): I wrote my own: ☐ Yes ☐ No

g. Description of service (readings, music, flowers):