**Caregiver Planner / Organizer**

Thank you for being a caregiver! We know it can be a lot to manage. We’ve put together this binder to help you gather all the moving pieces.

Work together with family and friends of the person you care for to fill out these essential forms. You can also create your own and save them.

*Note: Keep this binder in a safe, secure place because it contains a lot of personal information.*

**Contents:**

* Important information
* Emergency wallet cards
* Emergency packet
* Routine care and support
* Personal profile
* Medicine list
* Prepare for their doctor visit
* Home and Finance
* Key document checklist

Insert photo

 How to best care for:

(Preferred name)

|  |
| --- |
| **PERSONAL INFORMATION (THE PERSON YOU CARE FOR)** |

|  |  |
| --- | --- |
| **Full name:** (including other names used) |  |
| **Address:** |  |
| **Phone numbers:** | **Home:****Work:****Cell:****Other:** |
| **E-mail:** |  |
| **Date of birth:** |  |
| **Medicaid ID:** |  |
| **Medicare ID:** |  |
| **Military ID:** |  |
| **Other:** |  |

*Note: The social security number, driver’s license number and passport number may be needed too. But please keep these in a safe, different place to protect against identity theft.*

|  |
| --- |
| **CAREGIVER INFO (INCLUDING YOURSELF)** |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| **EMERGENCY CONTACTS** |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |

|  |
| --- |
| **OTHER IMPORTANT CONTACTS** |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |

**EMERGENCY ID CARDS**

Fill out the cards below. Then cut them out and place them in each of your wallets in case of emergency.

**Emergency Medical ID:**

Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Medical ID**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_

**Emergency Contacts**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY ID CARDS**

Do not list the name and address of the person you care for. If your wallet is stolen, you do not want to alert the wrong people that they are alone and at risk. Instead, list emergency contacts who can then check in them.

**Card for the main caregiver:**

**IN CASE OF EMERGENCY**

I AM A CAREGIVER.

My name is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

If I am injured or unavailable, please contact the caregiver listed on the back of this card. Ask them to check on the person that I am a caregiver for.

**IN CASE OF EMERGENCY**

Name: Phone:

­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY PACKET**

Keep this in an easy-to-get-to, safe and separate place with a copy of any advance directive and any medical orders. Label the papers with emergency medical information clearly visible. If more than one person lies in this house, include a photo. Remember to update the information and papers often.

|  |
| --- |
| **BASIC INFORMATION** |

|  |  |
| --- | --- |
| **Name:** |  |
| **Nickname or preferred name:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Cell:** |  |
| **Work:** |  |
| **Date of birth:** |  |
| **Gender:** |  |
| **Primary language:** |  |
| **Primary health insurance:** |  |
| **ID number:** |  |
| **Secondary health insurance:** |  |
| **ID number:** |  |
| **Is there a living will?** |  Yes No |
| **Health care proxy?** |  Yes No |
| **Height:** |  |
| **Weight:** |  |
| **Blood type:** |  |
| **Main doctor:** |  |
| **Phone:** |  |
| **Other doctor:** |  |
| **Phone:** |  |
| **Preferred hospital:** |  |
| **Phone:** |  |

|  |
| --- |
| **EMERGENCY CONTACTS** |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |
| Name: |  |
| Relationship: |  |
| Contact info: |  |

|  |
| --- |
| **HEALTH CONDITIONS** |

|  |
| --- |
|  Anxiety Arthritis Asthma Cancer COPD Cerebral Palsy Depression Dementia Diabetes Heart disease High blood pressure Muscle disease – please list:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mental/behavioral health issue – please list:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure disorder – please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Swallowing disorder Other – please list:­­­ |

|  |
| --- |
| **ALLERGIES (FOOD, MEDICINE, ETC.)** |

|  |  |
| --- | --- |
| Allergic: | Reaction: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **SHOT DATES/HISTORY** |

|  |  |
| --- | --- |
| **Tetanus:** |  |
| **Flu:** |  |
| **Pneumonia:** |  |
| **Hepatitis:** |  |
| **Shingles:** |  |
| **Other:** |  |

|  |
| --- |
| **PAST SURGERIES** |

|  |  |
| --- | --- |
| Date: | Type/comments: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **OTHER** |

|  |
| --- |
| **Please check all the following that you have/use:** Glasses Contacts Dental implants Dentures Hearing aid Oxygen  Communication device Cane/walker Manual wheelchair Motorized wheelchair Pacemaker Metal implants Other – please list: |

List all medicines in pencil (including over-the-counter drugs and supplements). Update this list every time they change.

|  |
| --- |
| **PRESCRIPTION MEDICINES** |

|  |  |  |
| --- | --- | --- |
| Medicine: | Dose: | Frequency/time: |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |
| --- |
| **OVER-THE-COUNTER MEDICINES/SUPPLEMENTS** |

|  |  |  |
| --- | --- | --- |
| Medicine: | Dose: | Frequency/time: |
|  |  |  |
|  |  |  |
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| --- |
| **MEDICAL CONTACTS** |

|  |  |
| --- | --- |
| Main doctor: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Drug store: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Dentist: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Hospital: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Urgent care center: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Specialist: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Specialist: |  |
| Name: | Phone: |
| Address: | E-mail: |

|  |
| --- |
| **PERSONAL AND COMMUNITY SPPORTS** |

|  |  |
| --- | --- |
| Family/caregiver: |  |
| Name:Relationship: | Phone: |
| Address: | E-mail: |
| Family/caregiver: |  |
| Name:Relationship: | Phone: |
| Address: | E-mail: |
| Transportation: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Meal/nutrition: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Chore/home repair: |  |
| Name: | Phone: |
| Address: | E-mail: |
| In home support/respite: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Day center: |  |
| Name: | Phone: |
| Address: | E-mail: |

|  |
| --- |
| **PERSONAL AND COMMMUNITY SUPPORTS** |

|  |  |
| --- | --- |
| Local senior center: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |
| Other: |  |
| Name: | Phone: |
| Address: | E-mail: |

 **A CAREGIVER’S GUIDE TO DEVELOPING A PERSON CENTERED DESCRIPTION**

This guide will help you and your loved one develop a one-page description. This description helps other caregivers understand how to best support your loved one. It describes what is important to you loved one to be happy and content as well as what is important for them to be healthy and safe.

Please keep in mind that you do not have to develop a perfect one-page description with your loved one. You can do this over time and remember you can always add or remove what has been listed on the description. Each page highlights what people like and admire about your loved one, what is important to them and how best to support them. You can complete this description with help from your loved one and those closest to them.

We have listed a set of questions on the following pages as well as examples to help you complete the one page description with your loved ones and others who know them best.

**What people like and admire about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:**

|  |
| --- |
| This is sometimes hard to answer so you may want to ask other people close to you and your loved one. Consider:* What are some great things about your loved one?
* What some things your loved one is good at?
* What compliments do you people give your loved one?
* What do people thank you loved one for?

Examples:* George has a nice smile.
* Jenny always remembers birthdays.
* Alice can hug you with just her eyes.
* John has a strong memory.
 |

**What is important to ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:**

|  |
| --- |
| Talk with your loved one and other people important in their life.Consider:* What are things that make your loved one happy?
* What do they like to do?
* Who are the people closest to your loved one? Favorite people to spend time with?
* What makes a good day? What do they look forward to?
* What makes a bad day? What are the things that bug your loved one?

Examples:* Jane likes to watch her granddaughter play soccer.
* Mike loves to fill the bird feeder every morning even if it is full and is grumpy if there is not time to feed the birds.
* Laura likes to look stylish and her best even at home.
* Troy likes his independence and privacy.
* Addy loves chatting with anyone who is willing to sit down and talk.
 |

**How to best support \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:**

|  |
| --- |
| Take the information you have written down and think about how best to support your loved one. Remember to think about what your loved one would think is important to know. This helps you to both think about what others need to know or do to support your loved one.Consider:* What does your loved one do without help/support?
* When does your loved one need help/support?
* When things go wrong, what comforts your loved one?

Examples:* Encourage Rose to work hard at her therapies and praise her once she has completed exercises.
* Wait for James o try to do something before helping and wait for James ask for help.
* When Jayden is scared look directly in Jayden’s eyes, ask to hold hands and say everything is going to be okay.
 |

**Characteristics of people who support \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ best:**

|  |
| --- |
| Look at what you have written down in the other sections and think about people your loved one gets along with, what other like and admire about loved one and who they were with the last time they had a good time or day. Ask your loved one or other people closest what is important to them.Consider:* What are the people like that your loved one gets along with most?
* Are there personality traits that are common among your loved one’s favorite people?
* What are some things that are important to your loved one that needs to be considered?
* Are there character traits that your loved one finds upsetting or frustrating?

Examples:* Willing to go with Jane to her granddaughter’s soccer match and enjoys soccer too.
* Chatty and talkative like Addy.
* Respectful of routines and honors what is important to Bob?
 |

**What people like and admire about \_\_\_\_\_\_\_\_\_\_\_\_\_:**

*Insert photo*

**Things that are important to**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_:**

**What others need to know/do to best support \_\_\_\_\_\_\_\_\_\_\_\_\_:**

**Characteristics of people who best support \_\_\_\_\_\_\_\_\_\_\_\_\_:**

**MEDICINE LIST**

List all prescriptions and over-the-counter drugs, vitamins and supplements. Be sure to update the list every time medicine changes.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Rx #** | **Medicine name** | **Dose and instructions*****(with/without food, blood, work and how often)*** | **Treats** | **Who prescribes** | **Pharmacy name, phone and address** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- |
| **Rx #** | **Medicine name** | **Dose and instructions*****(with/without food, blood, work and how often)*** | **Treats** | **Who prescribes** | **Pharmacy name, phone and address** |
|  |  |  |  |  |  |
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**PREPARE FOR THEIR DOCTOR VISIT**

**Before the visit:**

* Fill out all questions on the following pages.
* Review their medicine list. Make sure it is up to date and bring it to the appointment.
* Write down a list of any questions – it is easy to forget things when you are sitting with the doctor.
* Talk with the person you care for and their other caregivers. Find out if they have questions or concerns for the doctor.
* Think about what is most important to you and the person you care for to talk about during the visit.
* Be prepared to discuss health details. For example, “Their bowel movements have been a problem lately. Could this be because of the new medicine they’re taking?”
* Consider keeping a notebook where you save al doctor visit notes.

**During the visit:**

* Make sure the person you care for speaks for themselves as much as possible.
* When the doctor asks questions, let the person you care for answer first. Answer for them only if asked to or needed.
* Take notes
	+ Doctor’s advice and instructions
	+ Any answers to you questions
* If you do not understand the doctor’s words or advice, say so and they will rephrase.
* Ask for instructions in writing or pamphlets that are condition specific.
* Ask for medical and/or community resources to help you follow up on doctor’s advice.
* The person you care for may ask that you stay or leave the room during an exam or procedure – respect their wishes and privacy. The doctor or technician should be willing to let you stay.

**DOCTOR VISIT FORM**

Doctor’s name: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for the visit? (Illness, injury, yearly checkup)

­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have they experienced this before? Yes No not sure

How long has this been going on? ( a week, month or longer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know what may have caused it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Write down all questions for the doctor. Make sure to list the most important ones first:

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have they had any life changes? (routine, ability to do things, a family illness, moving to new house, etc.) Yes No

If yes, describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have there been any medicine changes? Yes No

­­­­­­­­­­­­­­­­­­­­­If yes, describe: (and update the medicine list)

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As a caregiver, is there anything you need help with? (someone to talk to, someone to stay with the person you care for while you run errands, information about community resources, etc.)

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List any changes or symptoms in their health since the last visit, what may have caused them and when they started:

 Activity level

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 Movement (trouble walking, changing positions, etc.)

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 Sleeping habits

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 Bone/joint stiffness or pain

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 Headaches

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 Mood or behavior changes

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 Shortness of breath

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 Skin changes

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 Hearing changes

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 Vision changes

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 Memory changes

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 Other

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| **List other health care providers they see:** | **Date of last visit:** | **For what reason:** |
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| FINANCIAL AND LEGAL CONTACTS |

|  |  |
| --- | --- |
| **Bank** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Property/renter’s insurance** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Life insurance** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Burial insurance** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Lawyer** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |

*Note: Keep any personal information like logins and passwords in a safe place.*

|  |  |
| --- | --- |
| **Other** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Other** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Other** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Other** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |
| **Other** |  |
| Name: | Phone: |
| Account #: | Website: |
| Address: | E-mail: |

*Note: Keep any personal information like logins and passwords in a safe place.*

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| --- |
| ROUTINE BILLS |

|  |  |
| --- | --- |
| **Mortgage/rent** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Electricity** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Gas** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Water/sewer** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |

*Note: Keep any personal information like the logins and passwords in a safe place.*

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| ROUTINE BILLS |

|  |  |
| --- | --- |
| **Landlord/rental office** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Home owner’s/renter’s insurance** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Garbage** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Phone** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |

*Note: Keep any personal information like the logins and passwords in a safe place.*

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| --- |
| ROUTINE BILLS |

|  |  |
| --- | --- |
| **Other** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Other** |  |
| Company & Address: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Other** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |
| **Other** |  |
| Company & Address:: | Phone: |
| Account #: | Website: |
| How paid: | E-mail: |

*Note: Keep any personal information like the logins and passwords in a safe place.*

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| --- |
| ROUTINE HOME UPKEEP |

|  |  |
| --- | --- |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |

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| --- |
| ROUTINE HOME UPKEEP |

|  |  |
| --- | --- |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |
| **Task:** |  |
| How often: |  |
| Who does it: |  |
| Comment: |  |

**NEED TO KNOW HOME INFORMATION**

**Heating, ventilation and air conditioning (HVAC)**

* Where is the HVAC system located?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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*Note: replace filters often*

Fuel type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Location of all emergency shut off valves:

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* When was the last time the flue was cleaned?

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*Note: if the home uses wood burning heat, ensure all flues are checked and/or cleaned once per year.*

**Electrical**

* Where are the main electrical shutoffs?

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*Notes:*

*- know how and when to use electrical breakers in emergencies*

*- avoid shocks and shortages by replacing cracked cover plates or switches*

*- make sure all appliances are plugged n grounded outlets (have three prongs)*

*- buy surge protectors for major electronics*

*- test outlets in damp areas (besides sinks and outdoor)*

*- cap off outlets not in use*

**Water**

* Where is the main water shut off valve?

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**Fire safety**

* Where are smoke and/or carbon monoxide alarms?

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*Notes:*

* *If the home does not have these, install new devices*
* *Check all batteries at least yearly*
* *Check expiration dates on all fire extinguisher and replace if expired*
* *Flush dryer ventilation yearly to prevent fires*

**Security**

* Who owns a spare key to the house? (should be a family member and/or a trusted neighbor)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Notes:*

* *Check that all door and window locks are functional in the home. If not replace or fix.*
* *Ensure that garage doors have functioning safety sensors.*
* *In case a key is lost, keep a spare in a safe place.*

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| HOME SAFETY CHECKLIST |

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| **Phone checklist:** |
|  Make sure the person you care for knows how to use al phones, including cell phones. |
|  Program 911, your phone number and other caregivers’ numbers on speed dial. |
|  Post emergency info by the phone(s), on the refrigerator and other places clearly visible. Include who to call in an emergency, the house address and cross street. |
| **Emergency checklist** |
|  Check that smoke and carbon monoxide detectors work. |
|  Make a plan for what to do in a power outage, fire an other emergencies. |
|  Store flashlights by the bed and other easy to get to places. |
| **Prevent fails:** |
|  Remove or tack down loose carpet. |
|  Donate or throw away throw rugs – big and small. |
|  Fix loose floorboards and remove thresholds in doorways. |
|  Clear pathways of clutter, small furniture, electrical cords, etc. |
|  Install handrails along stairs and hallways (one on each side of a stariwell). |
|  Get rid wobbly chaits, tables or other unstable furniture. |
|  Use nonslip treads and/or mark the edges of steps woth bright tape. |
|  Use rubber mats and nonslip strips on floors that might be wet (in bathrooms/kitchen). |
| **Lighting and visibility:** |
|  Check that ligthing is bright in all areas in the home. |
|  Add nightlights along any oath used at night. |
|  Be sure light switches are easy to find and use. |
|  Clearly mark stove dials, espeically the off position with red tape or nail polish. |
|  Clearly mark hot and cold water taps. |
|  Be sure all medicines are clearly laveled so they can be read easily. |
| **Accessibility:** |
|  Switch to level style handles and doorknobs. |
| Place frequently used items on shelves that are within reach. |
| Research products that will help make the home safer and easier to navigate. |
| Consider a raised toilet seat. |
| **Other:** |
|  Set the hot water heater to 120 degrees. |
| Throw away medicines that are no longer needed. |
| Note food expiration dates and review food safety tips. |

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| KEY DOCUMENT CHECKLIST |

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| **Legal documents:** |
| Certificates of birth, marriage, divorce/separation, spousal death, citizenship, etc. |
|  Passport |
|  Will |
| **Financial documents:** |
|  Credit, debit and other banking cards |
|  Checkbooks, registers and savings passbooks |
|  Mortgage ad loan agreements |
|  Titles to real estate, cars, boats or other vehicles |
|  Insurance policies (life, home, etc.) |
|  Personal property appraisals |
|  Receipts for property tax and other recent purchases |
|  Copies of federal and state tax returns from the past 3-5 years |
| **Health care:** |
|  Medical records |
|  Copy of the plan of care (if in case management) |
|  Living will, health care proxy and/or durable power of attorney |
|  DNR or other medical orders |
| **Job Records:** |
|  List of recent employers, dates of employment and terms of employment |
|  Military records |
| **Special instructions:** |
|  Internet passwords, access codes, PINs |
|  Combination to any safe or lock |
|  Burial, cremation and/or funeral instructions, if any |
|  Instructions on how to care for a pet, plants, house or dependent |
| **Other:** |
|  Keys to house, office, safe-deposit box, post office box, etc. |
|  Jewelry and other valuables |

**You and other caregiver or family member should be the sole keeper of all important documents. Store them in one secure location. All caregivers should be able to either access them or contact the keeper, when needed.**