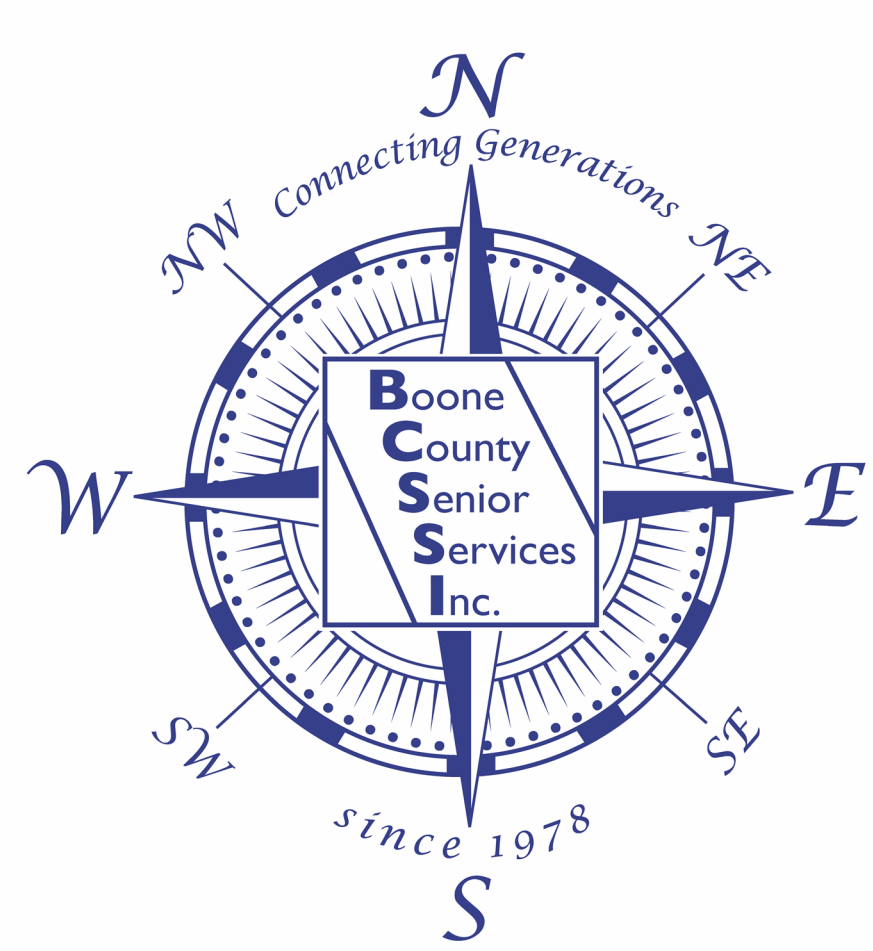


The Caregiver Navigator

Organizing your loved one's healthcare journey

Boone County Senior Services Inc.

Connecting Generations since 1978

Mission Statement:

To promote independence and provide enriching opportunities for older adults in Boone County.

BCSSI-Lebanon
515 Crownpointe Dr
Lebanon, IN 46052
765-482-5220
Mon-Fri 8:00am-4:30pm

BCSSI-Zionsville
1100 W Oak St Rm??
Zionsville, IN 46077
317-873-8939
Wed & Fri 9:00am-4:00pm
or by appointment

www.booneseniors.org

Services include:

Homemaker & Personal Services
Guardianship
Respite
Transportation (all ages)
Information & Assistance
Activities & Workshops
Insurance Information
Legal Assistance
Prescription Counseling
Computer/Electronic Device Classes
Group Travel
Caregiver Support & more…!

Information Request and Donation Forms

Would you like more information on BCSSI...?

Email us at bcssi@booneseniors.org, call us at 765-482-5220 or 317-873-8939 or

Mail the form below to our Lebanon Office.

BCSSI Information Request Card

Name _____

Address _____

City/ST/Zip _____

Email _____

Subjects: Transportation Personal Services Homemaker Services

Respite Care Caregiver Support Activities/Workshops

Please consider donating to BCSSI. We depend on the contributions of community members like you to keep our organization going in order to provide help and resources to the seniors of Boone County and their caregivers. If you would like to make a gift , donate online at www.booneseniors.org or place the form below in an envelope and mail to: BCSSI 515 CrownPointe Dr Lebanon, IN 46052

Donation, Memorial and Honorarium Form

I would like my donation to be used for (select one below):

_____A donation to the Agency _____A donation to the Foundation

_____A memorial in memory of:_____

_____An honorarium in honor of: _____

Please send notification card to:_____

Street Address:_____

City, State, Zip:_____

Thank you for your gift. Please mail form with payment to:

BCSSI, 515 CrownPointe Dr., Lebanon, IN 46052

_____

_____

_____

_____

Place
Stamp
Here

515 CrownPointe Drive
Lebanon, IN 46052

How to get Started….

The Caregiver Navigator was created to be a launching point to being a better informed and organized Caregiver, it covers a wide range of information and details. Keep in mind you don't need to complete every line in each section. Use this as your framework for gathering and organizing information.

Tips on how to get started and how to make the most of The Caregiver Navigator.

- Pace yourself by starting with the pages and sections that are most relevant now.
- As much as possible, involve your loved one in completing the information. It will provide the opportunity for discussion and may also provide a sense of control during a time when control may be fleeting to them.
- You don't have to do it alone. Enlist a trusting family member/members or friend that is close to your loved one to help complete a page or an entire section.
- Customize this binder to suit personal organizational style. Rearrange the sections. Decide which sections you want on the ready, which sections would be better left at home or removed to be stored in a safe place.
- Create a portable binder for pages you need to take on the go.
- Photocopy important papers or documents to insert into the binder and keep the originals in a safe place.
- Use colored Post-It flags to alert family members, friends, or other caregivers of important changes or additions to the binder.
- Collecting a month's worth of mail and financial statements (also those that come quarterly) will give you a good snapshot of your loved one's financial information. The most recent tax return is another good source of financial information. Remember, it is always best to ask for permission to access financial or confidential information.
- Pages of The Caregiver Navigator are available to download and print if you need additional pages/copies at www.booneseniors.org

Emergency and Courtesy Cards

Emergency Info Card

Name_____

Address_____

City/St/Zip_____

Sex M/F DOB_____ Blood Type_____

Organ Donor Y/N Advance Directives Y/N

Medical Conditions_____

Medications_____

Allergies_____

fold here

Emergency Info Card

Emergency Contact Name 1._____

Relationship_____

Phone _____

Emergency Contact Name 2._____

Relationship_____

Phone_____

Primary Doctor_____

Preferred Hospital_____

Emergency Info Card

Name_____

Address_____

City/St/Zip_____

Sex M/F DOB_____ Blood Type_____

Organ Donor Y/N Advance Directives Y/N

Medical Conditions_____

Medications_____

Allergies_____

fold here

Emergency Info Card

Emergency Contact Name 1._____

Relationship_____

Phone _____

Emergency Contact Name 2._____

Relationship_____

Phone_____

Primary Doctor_____

Preferred Hospital_____

In Case of Emergency
I am a caregiver for someone

My name is_____

Loved Ones Name_____

Is living with a diagnosis of_____

and requires immediate assistance. Please contact the people listed on the backside on this card.

fold here

In Case of Emergency

My loved one is dependent upon me and requires assistance. If I'm incapacitated please notify immediately

Name_____

_____

Cell # Home # Wrk #

Name_____

_____

Cell # Home # Wrk #

Please have patience with us.

My loved one is living with

_____

and may require extra time to gather their thoughts.

THANK YOU…!

Please have patience with us.

My loved one is living with

_____

and may require extra time to gather their thoughts.

THANK YOU…!

The Caregiver

Section 1-At a Glance

- Personal Information
- Self-Care Abilities & Needs
- Emergency Contacts
- Caregiver Providers
- Medical Contacts

Section 2-Medical

- Insurance Information
- Medical History
- Medications
- Allergies
- Doctor Visit Log
- Lab Tests, Vaccine Log
- Trackers Blood Sugar & Pressure, Mood, Sleep
- Vitals Log

Section 3-Caregiver Templates

- Blank Calendar Pages
- Weekly & Daily Routine
- How Friends & Family Can Help
- Caregiver Information/Report Sheet
- Care Considerations

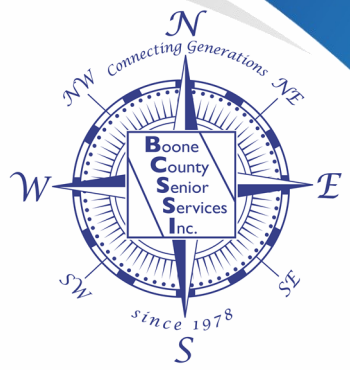
Section 4-Household Info

- Preferred Contractors
- Utilities
- Pet Care
- Special Deliveries & Services
- Vehicle Maintenance
- Monthly Budget Planner

Section 5-Legal Matters & End of Life Planning

- Legal & Financial Contacts, Insurance Information
- Decision Makers
- Key Documents Locator
- Who to Notify, Funeral & Obituary Planning

The Caregiver Navigator



Section 1

At a Glance
Personal Information

About Your Loved One: Overview

Personal Information

Name :_____ Preferred Name/Nickname:_____

Address:_____ City/State/Zip:_____

Phone:_____ Cell:_____

Male/Female Date of Birth ____/____/____ Marital Status:_____

SSN:_____-____-_____ Medicare #_____ Medicaid # _____

Insurance Provider:_____ Group #:_____ Policy #:_____

Ambulatory: Y / N Walker Cane Wheelchair Scooter

Dentures: Y / N Upper:_____ Lower:_____ Hearing Aids: Y / N Right:_____ Left:_____

Glasses: Y / N Contacts: Y /N Prosthetics: Y / N _____

Continent: Y / N Bladder:_____ Bowel:_____

Advanced Directives: Y / N DNR: Y / N Living Will: Y / N Organ Donor: Y / N

Blood Type:_____ Last Tetanus Shot:_____

Medical Diagnoses/Conditions:_____

_____

_____

_____

_____

Physicians

Primary Care:_____Phone:_____

Neurologist:_____ Phone:_____

Cardiologist:_____ Phone:_____

Specialist:_____ Phone:_____

Other:_____ Hospital Choice:_____

About Your Loved One: Overview

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

First Language_____ Other Languages:_____

U.S Citizenship Y / N Country of Origin_____ Hometown City & State:_____

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

Important Relationships (children, close relatives & friends):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Important Social History (schooling, career, membership organizations, etc.):_____

_____

Enjoys spending time by (social activities, etc.): _____

_____

Favorite places to go (restaurants, museums, parks, etc.): _____

_____

Favorite Pastimes (hobbies, games, songs, TV Shows):_____

_____

Topics of Interest (current events, sports, history, etc.):_____

_____

Food, snack & drink preferences:_____

_____

Daily Routine Snapshot

Wake Time	
Breakfast	

Lunch	
PM Snack	

Dinner	
Bed Time	

Morning Routine

_____

_____

_____

_____

Afternoon Routine

_____

_____

_____

_____

Evening Routine

_____

_____

_____

_____

Self-Care Abilities & Needs

As you fill this out, think about whether you are comfortable with your loved one seeing your assessment of their abilities. If not, consider using it as an opportunity to discuss your concerns with them.

Personal Care	Independent	Assistance Needed	Unable	Describe
Bathing				
Dressing				
Grooming (hair, teeth, shaving)				
Eating				
Walking/Mobility				
Toileting				
Medications				

Household Mgmt	Independent	Assistance Needed	Unable	Describe
Meal Prep				
Grocery Shopping				
Light Housekeeping				
Laundry				
Transportation				
Mail				
Bill/Money Mgmt				

Note/Comments

Emergency Contacts

Contact 1	Contact 2
Name:______________________________	Name:______________________________
Relationship:______________________________	Relationship:______________________________
Cell:______________________________	Cell:______________________________
Work:______________________________	Work:______________________________
Home:______________________________	Home:______________________________
Comments/Instructions:____________________	Comments/Instructions:____________________
______________________________	______________________________
______________________________	______________________________

Contact 3	Contact 4
Name:______________________________	Name:______________________________
Relationship:______________________________	Relationship:______________________________
Cell:______________________________	Cell:______________________________
Work:______________________________	Work:______________________________
Home:______________________________	Home:______________________________
Comments/Instructions:____________________	Comments/Instructions:____________________
______________________________	______________________________
______________________________	______________________________

Contact 5	Contact 6
Name:______________________________	Name:______________________________
Relationship:______________________________	Relationship:______________________________
Cell:______________________________	Cell:______________________________
Work:______________________________	Work:______________________________
Home:______________________________	Home:______________________________
Comments/Instructions:____________________	Comments/Instructions:____________________
______________________________	______________________________
______________________________	______________________________

Caregiver Information

Primary Caregiver

Name :_____ **Relationship:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Cell:**_____

Work:_____ **Email:** _____ **Frequency of Visits:**_____

Visits Via: **In Person** **Phone** **Email** **Other:**_____

Assistance Provided: Personal Care_____ **Medication:** Set-up____ Prompt____ Administration_____

Meal Prep: Breakfast_____ Lunch_____ Dinner_____

Shopping_____**Transportation**_____ **Medical Appts.**_____ **Bill Paying/Money Mgmt.**_____

Other:_____

Secondary Caregiver

Name :_____ **Relationship:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Cell:**_____

Work:_____ **Email:** _____ **Frequency of Visits:**_____

Visits Via: **In Person** **Phone** **Email** **Other:**_____

Assistance Provided: Personal Care_____ **Medication:** Set-up____Prompt____Administration____

Meal Prep: Breakfast_____ Lunch_____ Dinner_____

Shopping_____**Transportation**_____ **Medical Appts.**_____ **Bill Paying/Money Mgmt.**_____

Other:_____

Caregiver Information

Home Health Care Provider/Paid Caregiver

Name :_____ **Relationship:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Cell:**_____

Work:_____ **Email:** _____ **Frequency of Visits:**_____

Visits Via: **In Person** **Phone** **Email** **Other:**_____

Assistance Provided: Personal Care_____ **Medication:** Set-up____ Prompt____ Administration_____

Meal Prep: Breakfast_____ Lunch_____ Dinner_____

Shopping_____**Transportation**_____ **Medical Appts.**_____ **Bill Paying/Money Mgmt.**_____

Other:_____

Other Informal Caregiver

Name :_____ **Relationship:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Cell:**_____

Work:_____ **Email:** _____ **Frequency of Visits:**_____

Visits Via: **In Person** **Phone** **Email** **Other:**_____

Assistance Provided: Personal Care_____ **Medication:** Set-up____Prompt____Administration____

Meal Prep: Breakfast_____ Lunch_____ Dinner_____

Shopping_____**Transportation**_____ **Medical Appts.**_____ **Bill Paying/Money Mgmt.**_____

Other:_____

Caregiver Information

Area on Aging Agency

Name :_____ **Contact Person:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Cell:**_____

Work:_____ **Email:** _____ **Frequency of Visits:**_____

Visits Via: **In Person** **Phone** **Email** **Other:**_____

Assistance Provided: Personal Care_____ **Medication:** Set-up____ Prompt____ Administration_____

Meal Prep: Breakfast_____ Lunch_____ Dinner_____

Shopping_____**Transportation**_____ **Medical Appts.**_____ **Bill Paying/Money Mgmt.**_____

Other:_____

Adult Day Service

Name :_____ **Phone:**_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Contact Person:**_____

Door Code:_____ **Email:** _____

Frequency of Visits:_____

Notes:_____

_____

_____

_____

Medical Contacts

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:__________________________ **Hospital Affiliation(s):**____________________

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:__________________________ **Hospital Affiliation(s):**____________________

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:__________________________ **Hospital Affiliation(s):**____________________

Medical Contacts

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:___________________________ **Hospital Affiliation(s):**____________________

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:___________________________ **Hospital Affiliation(s):**____________________

Practitioner:

Specialty:______________________________ **Start Date**____________ **End Date**____________

Name:____

Address:____

Phone:____

Fax:____ **Email**_______________________________________

After Hours Number:___________________________ **Hospital Affiliation(s):**____________________

The Caregiver Navigator

Section 2

Medical Information

Medical Insurance

Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

____

Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

____

Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

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Medical Insurance

Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

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Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

____

Insurance Company:

Agent:____

Insurance Type:____________________________________

Policy #:____

Phone:____________________ **Email**____________________

Website:____

Notes:____

____

Medical History

Diagnosis	Date	Physician	Treatment/Status

Surgeries & Procedures

Date	Surgeon	Hospital	Notes/Complications

Hospitalizations & Rehabilitation

Date	Hospital	Reason	Discharge Date	Discharged To

Medical History

Diagnosis	Date	Physician	Treatment/Status

Surgeries & Procedures

Date	Surgeon	Hospital	Notes/Complications

Hospitalizations & Rehabilitation

Date	Hospital	Reason	Discharge Date	Discharged To

Medications

Write all prescriptions, over the counter and supplements in the chart below. Keep the list up to date and show the list to your loved one's doctors at each visit. Ask them to check for duplications or medicine interactions that could cause harm. ***Tip: Medications change frequently. Make additional copies of this page before making your first entry.***

Medication	Dose	For	Doctor	Pharmacy	Notes

Allergy Log

Date	Allergen	Reaction/Duration	Treatment

Chronic Conditions:_____

_____

_____

_____

_____

Notes:_____

_____

_____

_____

_____

Doctor Visit Log

Practitioner: **Specialty:**

Address:____

Phone:_______________________________ **Frequency:**_________________________

Seen For:____

Appt. Date & Time:

Reason for Visit:_________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:____________________________________

Follow Up:______________________________

Tests Done:_____________________________

Notes:__________________________________

____

Appt. Date & Time:

Reason for Visit:_________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:____________________________________

Follow Up:______________________________

Tests Done:_____________________________

Notes:__________________________________

____

Appt. Date & Time:

Reason for Visit:_________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:____________________________________

Follow Up:______________________________

Tests Done:_____________________________

Notes:__________________________________

____

Appt. Date & Time:

Reason for Visit:_________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:____________________________________

Follow Up:______________________________

Tests Done:_____________________________

Notes:__________________________________

____

Doctor Visit Log

Practitioner:	**Specialty:**

Address:____

Phone:________________________________ **Frequency:**_________________________

Seen For:____

Appt. Date & Time:

Reason for Visit:________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:___________________________________

Follow Up:_____________________________

Tests Done:____________________________

Notes:________________________________

____

Appt. Date & Time:

Reason for Visit:________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:___________________________________

Follow Up:_____________________________

Tests Done:____________________________

Notes:________________________________

____

Appt. Date & Time:

Reason for Visit:________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:___________________________________

Follow Up:_____________________________

Tests Done:____________________________

Notes:________________________________

____

Appt. Date & Time:

Reason for Visit:________________________

Diagnosis:______________________________

Treatment:_____________________________

Rx:___________________________________

Follow Up:_____________________________

Tests Done:____________________________

Notes:________________________________

____

Lab Tests & Results

Blood, CAT Scan, X-Ray, MRI, etc.

Date	Lab/Test	Provider	Phone	Result	Follow-Up

Medical Expenses

Date	Provider	Expense	Amount	Due	Paid

Vaccination Record

PPD/CXR, Flu Shot etc.

Date	Vaccine Type	Doctor Office/Clinic	Next Dose	Results/Comments

Blood Sugar Tracker

Week of: _____

	Before	Meals	1 HR.	2 HRS.	3 HRS
M		B			
		L			
		D			
		S			
TU		B			
		L			
		D			
		S			
W		B			
		L			
		D			
		S			
TH		B			
		L			
		D			
		S			
F		B			
		L			
		D			
		S			
SA		B			
		L			
		D			
		S			
SU		B			
		L			
		D			
		S			

Blood Sugar Tracker

Week of: _____

	Before	Meals	1 HR.	2 HRS.	3 HRS
M		B			
		L			
		D			
		S			
TU		B			
		L			
		D			
		S			
W		B			
		L			
		D			
		S			
TH		B			
		L			
		D			
		S			
F		B			
		L			
		D			
		S			
SA		B			
		L			
		D			
		S			
SU		B			
		L			
		D			
		S			

Blood Pressure Log

Blood Pressure Log

		SBP	DBP		
	*Target:				

Date	Time	SBP	DBP	BPM	Notes

Blood Pressure Log

		SBP	DBP		
	*Target:				

Date	Time	SBP	DBP	BPM	Notes

Blood Pressure Log

Blood Pressure Log

		SBP	DBP		
	*Target:				

Date	Time	SBP	DBP	BPM	Notes

Blood Pressure Log

		SBP	DBP		
	*Target:				

Date	Time	SBP	DBP	BPM	Notes

Mood Tracker

Date:_____

Mood Details:_____

Weather Details:_____

Medications Taken:_____

_____

Physical Activity:_____

Food Intake:_____

Note/Comments:_____

Date:_____

Mood Details:_____

Weather Details:_____

Medications Taken:_____

_____

Physical Activity:_____

Food Intake:_____

Note/Comments:_____

Mood Tracker

Date:_____

Mood Details:_____

Weather Details:_____

Medications Taken:_____

_____

Physical Activity:_____

Food Intake:_____

Note/Comments:_____

Date:_____

Mood Details:_____

Weather Details:_____

Medications Taken:_____

_____

Physical Activity:_____

Food Intake:_____

Note/Comments:_____

Sleep Tracker **Month**_____

	PM												AM											
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
1																								
2																								
3																								
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Sleep Tracker **Month**_____

	PM												AM											
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
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31																								

Vital Health Log

Date	Time	Weight	Blood Pressure	Blood Sugar	Notes

Vital Health Log

Date	Time	Weight	Blood Pressure	Blood Sugar	Notes

The Caregiver Navigator

Section 3

Caregiver Templates

Month:				Year:		

Month:				Year:		

Household Routines & Preferences

e.g. Please keep the thermostat set at 70 ° F

Weekly Routine

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MORNING							
AFTERNOON							
EVENING							

Daily Routines

Loved One's Routine	Main Caregiver's Routine

How Friends & Family Can Help

Task ***e.g. Mowing the Lawn***	**Who Can Help** ***e.g. Tom-Neighbor***

CAREGIVER INFORMATION SHEET

Caregiver: _____ Date: _____ Shifts: _____

Rest

- ☐ Woke Up Feeling Rested
- ☐ Woke Up Not Feeling Rested
- ☐ Tossed-n-Turned All Night
- ☐ Can We Get a Do-Over?

Notes on last night: _____

Today's nap time & duration: _____

Eat

- ☐ Good Appetite
- ☐ Poor Appetite

Notes: _____

Activities

- ☐ Exercise _____
- ☐ Errands _____
- ☐ Other Activities _____

Medications

Time Given	Medicine	Dose	Notes

Mood

Today is going to be awesome! Smile :)

CAREGIVER INFORMATION SHEET

Caregiver: _____ Date: _____ Shifts: _____

Rest

- ☐ Woke Up Feeling Rested
- ☐ Woke Up Not Feeling Rested
- ☐ Tossed-n-Turned All Night
- ☐ Can We Get a Do-Over?

Notes on last night: _____

Today's nap time & duration: _____

Eat

- ☐ Good Appetite
- ☐ Poor Appetite

Notes: _____

Activities

- ☐ Exercise _____
- ☐ Errands _____
- ☐ Other Activities _____

Medications

Time Given	Medicine	Dose	Notes

Mood

Today is going to be awesome! Smile :)

CAREGIVER INFORMATION SHEET

Caregiver: _____ Date: _____ Shifts: _____

Rest

- ☐ Woke Up Feeling Rested
- ☐ Woke Up Not Feeling Rested
- ☐ Tossed-n-Turned All Night
- ☐ Can We Get a Do-Over?

Notes on last night: _____

Today's nap time & duration: _____

Eat

- ☐ Good Appetite
- ☐ Poor Appetite

Notes: _____

Activities

- ☐ Exercise _____
- ☐ Errands _____
- ☐ Other Activities _____

Medications

Time Given	Medicine	Dose	Notes

Mood

Today is going to be awesome! Smile :)

CAREGIVER INFORMATION SHEET

Caregiver: _____ Date: _____ Shifts: _____

Rest

- ☐ Woke Up Feeling Rested
- ☐ Woke Up Not Feeling Rested
- ☐ Tossed-n-Turned All Night
- ☐ Can We Get a Do-Over?

Notes on last night: _____

Today's nap time & duration: _____

Eat

- ☐ Good Appetite
- ☐ Poor Appetite

Notes: _____

Activities

- ☐ Exercise _____
- ☐ Errands _____
- ☐ Other Activities _____

Medications

Time Given	Medicine	Dose	Notes

Mood

Today is going to be awesome! Smile :)

Care Considerations-Triggers

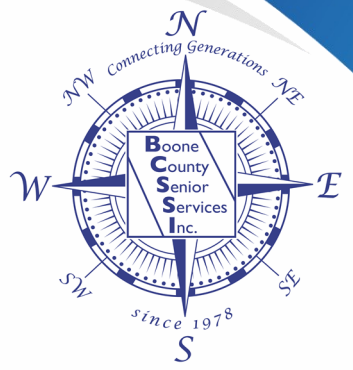
When planning or providing care, it's important to make your loved one's environment as comfortable as possible. Use this section to write down any triggers, pet peeves or fears, that may cause them to react in a negative way.

Trigger	Reaction	Possible Alternatives

Care Considerations-Comfort Items

Knowing the things that make your loved one happy or give them comfort can be a useful tool in a Caregiver's toolbox. Use this section to create a list of your loved one's current & past hobbies, things that they are passionate about or puts them in their happy place, comfort items, self soothing activities and favorite music or playlist.

The Caregiver Navigator



Section 4

Household Information

Preferred Contractors

Plumber

Company Name:_____

Phone #:_____ **Fax:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Electrician

Company Name:_____

Phone #:_____ **Fax:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

HVAC

Company Name:_____

Phone #:_____ **Fax:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Preferred Contractors

Roofing Contractor

Company Name: _____

Phone #: _____ **Fax:** _____

Address: _____

City/State/Zip: _____ **Email** _____

Website: _____

Notes: _____

_____

General Contractor

Company Name: _____

Phone #: _____ **Fax:** _____

Address: _____

City/State/Zip: _____ **Email** _____

Website: _____

Notes: _____

_____

Lawn Maintenance

Company Name: _____

Phone #: _____ **Fax:** _____

Address: _____

City/State/Zip: _____ **Email** _____

Website: _____

Notes: _____

_____

Utilities

Water Company

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Gas

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Electric

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Utilities

Phone/Landline

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Phone/Mobile

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Cable/Satellite

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Utilities

Internet

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Trash Removal

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Other

Company Name:_____ **Account #:**_____

Phone #:_____**Payment:** ___ **Check** ___ **Online** ___ **Auto Pay**___

Address:_____

City/State/Zip:_____ **Email**_____

Website:_____

Notes:_____

_____

Animal Care

Vet:

Address:____

Phone:______________________ **After Hours #:**____________________

Emergency Vet:____________________ **Phone:**____________________

Address:____

Notes:____

Pet Name:

Breed:________________________

Color/Description:____________________

Feeding Instructions :____________________

____

Medications:________________________

Special Instructions:____________________

____

Pet Name:

Breed:________________________

Color/Description:____________________

Feeding Instructions :____________________

____

Medications:________________________

Special Instructions:____________________

____

Pet Name:

Breed:________________________

Color/Description:____________________

Feeding Instructions :____________________

____

Medications:________________________

Special Instructions:____________________

____

Pet Name:

Breed:________________________

Color/Description:____________________

Feeding Instructions :____________________

____

Medications:________________________

Special Instructions:____________________

____

Special Deliveries & Services

Newspaper

Name:_____ **Website:**_____

Phone #:_____ **Address:**_____

City/State/Zip:_____ **Email**_____

Notes:_____

_____

Cleaning Services

Company Name:_____ **Contact Person:**_____

Phone #:_____ **Website:**_____

Address:_____ **City/State/Zip:**_____

Email:_____ **Notes:**_____

_____

Grocery Delivery

Company Name:_____

Phone #:_____ **Address:**_____

City/State/Zip:_____ **Email**_____

Website:_____ **Notes:**_____

_____

Meal Delivery

Company Name:_____

Phone #:_____ **Address:**_____

City/State/Zip:_____ **Email**_____

Website:_____ **Notes:**_____

_____

Special Deliveries & Services

Other

Name: _____ **Website:** _____

Phone #: _____ **Address:** _____

City/State/Zip: _____ **Email** _____

Notes: _____

_____

Other

Company Name: _____ **Contact Person:** _____

Phone #: _____ **Website:** _____

Address: _____ **City/State/Zip:** _____

Email: _____ **Notes:** _____

_____

Other

Company Name: _____

Phone #: _____ **Address:** _____

City/State/Zip: _____ **Email** _____

Website: _____ **Notes:** _____

_____

Other

Company Name: _____

Phone #: _____ **Address:** _____

City/State/Zip: _____ **Email** _____

Website: _____ **Notes:** _____

_____

Vehicle Maintenance

Repair/Service

Name: ______________________________ Phone: ______________________________

Address: ______________________________ City/St/Zip ______________________________

Notes:____

____

Vehicle

Make & Model:______________________________

VIN #:______________________________

Plate# :______________________________

Location(s):______________________________

Registration Renewal Date:__________________

Bureau Motor Vehicle Address:______________

________________________Phone:________

Notes:______________________________

Vehicle

Make & Model:______________________________

VIN #:______________________________

Plate# :______________________________

Location(s):______________________________

Registration Renewal Date:__________________

Bureau Motor Vehicle Address:______________

________________________Phone:________

Notes:______________________________

Vehicle

Make & Model:______________________________

VIN #:______________________________

Plate# :______________________________

Location(s):______________________________

Registration Renewal Date:__________________

Bureau Motor Vehicle Address:______________

________________________Phone:________

Notes:______________________________

Vehicle

Make & Model:______________________________

VIN #:______________________________

Plate# :______________________________

Location(s):______________________________

Registration Renewal Date:__________________

Bureau Motor Vehicle Address:______________

________________________Phone:________

Notes:______________________________

Monthly Budget Planner

Income Description	Amount
	$
	$
	$
	$
	$
Total Income	$
Divide Total by 12 for Monthly Income **Total**	$
Minus Grand Total Expenses	
Equals Approx. Net Monthly Income	

Insurance	Amount
Home Owners/Renters	$
Life	$
Auto	$
Medical	$
Long-Term Care	$
Other	$
Other	$
Expense Total	**$**

Housing & Utilities	Amount
Mortgage/Rent	$
Electricity	$
Gas/Oil	$
Water & Sewage	$
Trash	$
Landline	$
Cell	$
Cable/Satellite	$
Maintenance/Repairs	$
Other	$
Expense Total	**$**

Loans	Amount
Personal	$
Credit Card	$
Credit Card	$
Credit Card	$
Credit Card	$
Other	$
Other	$
Other	$
Expense Total	**$**

Medical	Amount
Medical	$
Prescriptions	$
Doctor	$
Doctor	$
Doctor	$
Medical Supplies	$
In Home Health	$
Other	$
Expense Total	**$**

Transportation	Amount
Car Loan or Lease	$
Gas	$
Public or Senior Transit Fees	$
License & Registration	$
Maintenance	$
Other	$
Other	$
Other	$
Expense Total	**$**

Food	Amount
Groceries	$
Dining Out	$
Other	$
Expense Total	**$**

Pets	Amount
Food	$
Grooming	$
Medical	$
Other	$
Expense Total	**$**

Other Expenses	Amount
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Expense Total	**$**

The Caregiver Navigator

Section 5

Legal Matters
End of Life Planning

Legal, Investment & Accounting Contacts

Attorney

Name:_____ **Firm Name:**_____

Phone #:_____ **Cell:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Notes:_____

_____

Financial Advisor

Name:_____ **Firm Name:**_____

Phone #:_____ **Cell:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Notes:_____

_____

Accountant/Tax Advisor

Name:_____ **Firm Name:**_____

Phone #:_____ **Fax:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Notes:_____

_____

Insurance Information

Home/Rental Insurance

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Auto Insurance (Vehicle 1)

Make/Model/Year:_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Auto Insurance (Vehicle 2)

Make/Model/Year:_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Insurance Information

Health Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Long-Term Care Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Disability Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Insurance Information

Medicare Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Medigap Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Medicaid Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Insurance Information

Life Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Other Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Other Insurance

Name of Insured:_____ **Policy #:**_____

Agency Name:_____ **Agent Name**_____

Phone #:_____ **24-Hour Claim Phone #:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Insurance Company/Underwriter:_____

Website_____ **Username:**_____ **Password:**_____

Decision Makers

Power of Attorney (POA) Durable? Yes/No

Legal Authorization to handle personal & financial affairs of another.
Durable POA-Remains in effect in the event of mental incapacity

Name:_____ **Relationship:**_____

Phone #:_____ **Cell:**_____ **Work:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Contact Instructions:_____

Backup Power of Attorney (POA) Durable? Yes/No

Name:_____ **Relationship:**_____

Phone #:_____ **Cell:**_____ **Work:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Contact Instructions:_____

Document Location:_____

Medical Power of Attorney (Health Care Proxy)/Agent

Name:_____ **Relationship:**_____

Phone #:_____ **Cell:**_____ **Work:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Contact Instructions:_____

Document Location:_____

Document on file with Physician(s):

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Physician Signed Do Not Resuscitate (DNR) Order on file? Yes/No

DNR Order states there will be no medical intervention to restore cardiac or respiratory function, should either fail.

Decision Makers

Back Up Medical Power of Attorney (Health Care Proxy)/Agent

Person authorized to make decisions on medical treatment in the event of mental incapacity

Name:_____ **Relationship:**_____

Phone #:_____ **Cell:**_____ **Work:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Contact Instructions:_____

Document Location:_____

Document on file with Physician(s):

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Physician Signed Do Not Resuscitate (DNR) Order on file? Yes/No

DNR Order states there will be no medical intervention to restore cardiac or respiratory function, should either fail.

Living Will? Yes/No

Guardian/Conservator

Person appointed by the court to protect & manage the financial affairs and/or the person's daily life due to physical, mental or age limitations.

Name:_____ **Relationship:**_____

Phone #:_____ **Cell:**_____ **Work:**_____

Address:_____

City/State/Zip:_____ **Email**_____

Contact Instructions:_____

Document Location:_____

Key Documents Location *CONFIDENTIAL*

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

Bank/Financial Documents

Specify bank name, financial institute or company.

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

Key Documents Location *CONFIDENTIAL*

Bank Vault/Safe/ Safe Deposit Box	Location	Box #	Key/Code	Location of Key or Code	Name/Signatures on File

Other Accounts/Access Codes

Account	Location	Access Code/Pass Code

Password Manager

Website	Username	Password

End-of-Life Care/Who to Notify

Medical Power of Attorney (Health Care Proxy)/Agent

Name:___________________________________ **Relationship:**____________________________

Phone #:____________________ **Cell:**__________________ **Work:**____________________

Contact Instructions:____

Family/Friend

Name:___________________________________ **Relationship:**____________________________

Phone #:_____________________ **Cell:**__________________ **Work:**____________________

Contract Instructions:____

Family/Friend

Name:___________________________________ **Relationship:**____________________________

Phone #:______________________ **Cell:**__________________ **Work:**____________________

Contract Instructions:____

Family/Friend

Name:___________________________________ **Relationship:**____________________________

Phone #:______________________ **Cell:**__________________ **Work:**____________________

Contract Instructions:____

Family/Friend

Name:___________________________________ **Relationship:**____________________________

Phone #:______________________ **Cell:**__________________ **Work:**____________________

Contract Instructions:____

Family/Friend

Name:___________________________________ **Relationship:**____________________________

Phone #:______________________ **Cell:**______________ **Work:**___________________

Contract Instructions:____

End-of-Life Care/Who to Notify

Medical Power of Attorney (Health Care Proxy)/Agent

Name:______________________________________ **Relationship:**______________________________

Phone #:______________________ **Cell:**___________________ **Work:**_____________________

Contact Instructions:____

Family/Friend

Name:______________________________________ **Relationship:**_______________________________

Phone #:_______________________ **Cell:**___________________ **Work:**______________________

Contract Instructions:____

Family/Friend

Name:______________________________________ **Relationship:**_______________________________

Phone #:________________________ **Cell:**___________________ **Work:**______________________

Contract Instructions:____

Family/Friend

Name:______________________________________ **Relationship:**_______________________________

Phone #:________________________ **Cell:**___________________ **Work:**______________________

Contract Instructions:____

Family/Friend

Name:______________________________________ **Relationship:**______________________________

Phone #:________________________ **Cell:**___________________ **Work:**_____________________

Contract Instructions:____

Family/Friend

Name:______________________________________ **Relationship:**_____________________________

Phone #:________________________ **Cell:**_______________ **Work:**____________________

Contract Instructions:____

End of Life Section Funeral/Obituary Planning

Funeral Director

Funeral Home:_____ Funeral Director Name:_____

Phone #:_____ Email:_____

Address_____ City/State/Zip:_____

Service Information

Viewing Service Location:_____ Date & Time:_____

_____

Funeral Service Location:_____ Date & Time:_____

_____

Officiant:_____ Musician:_____

Poems/Prayers/Hymns/:_____ Music:_____

_____ _____

_____ _____

Flowers Type & Color:_____ Memorial Donations:_____

_____ _____

Casket Open or Closed:_____ Clothing:_____

Jewelry/Glasses:_____ Return Jewelry to:_____

Military/Fraternal/Lodge Members _____ Veteran's Flag Folded or Draped on Casket

_____ Cremated Remains Present:_____

Order of Service:_____ Pallbearers:_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Requests or Wishes:_____

_____

_____

End of Life Section Funeral/Obituary Planning

Burial

Cemetery:_____ Cemetery Documents Location:_____

Certificate of Burial Rights #:_____

Certificate in the Name of:_____ Phone:_____

Burial Vault_____

Property or Crypt Location:_____

Type of Burial: Earth Burial_____ Crypt_____ Mausoleum_____ Other_____

In-ground Internment: Section:_____ Lot:_____ Block:_____ Grave:_____

Monument Preferences: Flush :_____ Upright:_____ Granite:_____ Bronze:_____

Companion:_____ Single:_____ Other:_____

Inscription:_____

_____

Cremation

Funeral Home or Cremation Society:_____ Phone:_____

Address:_____ City/State/Zip:_____

Urn Type:_____ Location of Cremated Remains:_____

Burial Vault_____

Cemetery:_____ Private Estate:_____

Disposition: Earth Burial:_____ Mausoleum:_____ Crypt:_____ Columbarium/Other:_____

_____

Type of Memorial/Monument:_____

Inscription:_____

_____

End of Life Section Funeral/Obituary Planning

OBITUARY INFORMATION FORM

Last (Maiden) Name: _____ First Name: _____

Middle Name: _____ Age: _____

Professional Title: _____ Military Rank: _____

Date of Death: _____ Place of Death: _____

Date of Birth: _____ Birthplace: _____

Parent Names: _____

High School/College: _____ Graduation Year: _____

_____ _____

Spouse(s): _____ Marriage Date(s): _____

Occupation(s): _____ Position(s): _____

_____ _____

_____ _____

Awards: _____

Accomplishments: _____

Membership(s): _____ Dates: _____

_____ _____

_____ _____

Volunteer Position(s): _____ Dates: _____

_____ _____

_____ _____

Religious Affiliation: _____ Church: _____

Hobbies/Interests: _____

_____

Survivor(s)/where they reside _____

_____

_____

Preceded in Death by: _____

_____

_____

Memorial Contributions to: _____

Preferred Photo & Location: _____

Everything you could, you did.

All the love you had you gave.

You took such great care of someone so loved.

That's a gift that will last forever...

BCSSI-Boone County Senior Services, Inc
515 CrownPointe Dr
Lebanon, In 46052
765-482-5220 or 317-873-8939
www.booneseniors.org

N
NW Connecting Generations NE
W
E
SW
SE
S
since 1978
Boone County Senior Services Inc.