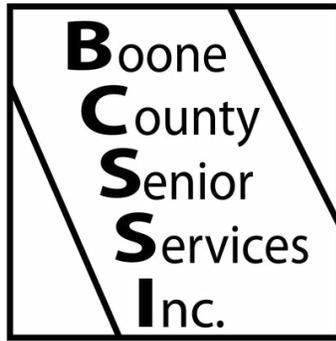


The Caregiver Navigator

*Organizing your loved one's
healthcare journey*



*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



*Connecting Generations
since 1978*

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: _____

Gender _____ Date of Birth ____/____/____ Marital Status: _____

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

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

Ambulatory: _____ Walker _____ Cane _____ Wheelchair _____ Scooter _____

Dentures: _____ Upper: _____ Lower: _____ Hearing Aids: _____ Right: _____ Left: _____

Glasses: _____ Contacts: _____ Prosthetics: _____

Continent: _____ Bladder: _____ Bowel: _____

Advanced Directives: _____ DNR: _____ Living Will: _____ Organ Donor: _____

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 | Country of Origin _____ Hometown City & State: _____

Veteran: Service Branch: _____ Rank: _____ Years in Service: _____

Important Relationships (children, close relatives & friends):

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	

Morning Routine

Lunch	
PM Snack	

Afternoon Routine

Dinner	
Bed Time	

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

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
Comments/Instructions: _____

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
Comments/Instructions: _____

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
Comments/Instructions: _____

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
Comments/Instructions: _____

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
Comments/Instructions: _____

Name: _____
Relationship: _____
Cell: _____
Work: _____
Home: _____
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:

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:

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:

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:

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			

Mood Tracker

Date: _____



Mood Details: _____

Weather Details: _____

Medications Taken: _____

Physical Activity: _____

Food Intake: _____

Note/Comments: _____

Date: _____



Mood Details: _____

Weather Details: _____

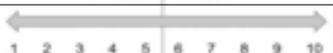
Medications Taken: _____

Physical Activity: _____

Food Intake: _____

Note/Comments: _____

Mood Tracker

Date: _____	 Unhappy Happy  1 2 3 4 5 6 7 8 9 10 Happiness rating
Mood Details: _____	
Weather Details: _____	
Medications Taken: _____ _____	
Physical Activity: _____	
Food Intake: _____	
Note/Comments: _____	

Date: _____	 Unhappy Happy  1 2 3 4 5 6 7 8 9 10 Happiness rating
Mood Details: _____	
Weather Details: _____	
Medications Taken: _____ _____	
Physical Activity: _____	
Food Intake: _____	
Note/Comments: _____	

*The
Caregiver
Navigator*



Section 3

*Caregiver
Templates*

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 <i>e.g. Mowing the Lawn</i>	Who Can Help <i>e.g. Tom-Neighbor</i>

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 :)

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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 :)

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Caregiver: _____

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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

*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	\$
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?

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?

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

Living Will ?

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?

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

Living Will?

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

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: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact 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: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact Instructions: _____

Family/Friend

Name: _____ Relationship: _____

Phone #: _____ Cell: _____ Work: _____

Contact 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

