Age the way *you* choose.

Let our resources & experience help you maintain your independence

We offer

- Coordination of legal, financial and health care professionals
- Caregiver referral
- Placement and transition assistance
- Crisis Intervention
- Ongoing dementia care services
- Assistance with meals, bill pay and transportation
- 100 years combined eldercare experience

Call for your FREE consultation today!

Aging Outreach Services

AOS | At Home Care AOS | Care Management

910.692.0683 | 855.590.7679

AgingOutreachServices.com

AGE WITH SUCCESS AOS AOSNC.com

LIFE PLANNING GUIDE

Aging Outreach Services

AOS | At Home Care AOS | Care Management

INTRODUCTION

The purpose of this guide is to be a way of putting your wishes on paper and become a communication tool for you and your family.

This planning guide will bring you comfort, knowing that you are conveying helpful information about yourself for your family, trusted friends and professional partners in your life. It is wise to take on the assignment now, no matter your age, and to review and update the information annually.

This information should be readily accessible in your home and it is advisable to inform your family members of its existence. Keep in a safe place for confidentiality purposes.

This Planning Guide is compiled by Aging Outreach Services.

Established in 1999, Aging Outreach Services is a full-service elder care firm

providing services to older adults residing in south central North Carolina. We can help you determine the service or combination of services to best meet your needs. We offer client-driven care and professionally trained staff that can assist you and your loved ones through the many challenges of aging.

Our services include:

AOS Care Management

When care becomes complicated or you need help developing a plan, a professional care manager can help you each step of the way. We offer a group of professionally trained and certified care managers who implement plans to assist older adults and their families with all the aspects of aging.

AOS at Home Care

Our registry provides pre-screened and pre-verified professional caregivers. We'll help you select a private-duty caregiver who suits your needs and provides you with the best and most professional care in the comfort of your home.

AOS Cares - 24 Hour Accessibility

A professional on-call for you 24/7 to rely on and help navigate your needs when a crisis occurs.

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MY CONTACTS

In the event something should happen to me, the below individuals should be contacted:

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

Name:_____

Address:_____

Home Phone:_____Cell:_____Relationship:_____

AOS CARE MANAGEMENT

We are a multi-service elder care service provider. The complexities of in home care, facility placement, hospitalization, government programs, legal and financial professionals, health concerns and related costs can be overwhelming. We have extensive knowledge and experience coordinating the needs and services that provide quality ongoing care to you and your family.

Our caring services begin with an assessment of your needs to determine the first step needed in tailoring our services to meet your personalized needs.

Where do you see yourself in 5 years (location and how you envision aging in place):_____

_____

_____

_____

Preferences on living arrangements:_____

_____

_____

_____

Role you wish family to have in decision making:_____

_____

_____

_____

What type of caregiver would you find most helpful and why:_____

_____

_____

Notes:_____

_____

_____

_____

_____

_____

CONTENTS

MY PERSONAL INFORMATION

In the event someone will be acting on my behalf, it is important that they have detailed information about me and my history.

Name:_____

Address:_____

Address:_____

City:_____ State:_____ Zip:_____

Mailing Address (if different):_____

Gender: Male ❑ Female ❑

Home Telephone:_____ Cell:_____

Social Security No.:____-____-_____ Date of Birth:_____

Place of Birth (city, county, state, country):_____

_____

_____

Religious Affiliation: _____

Name of church/city:_____

Current Relationship status:_____

Date of marriage (list all):_____

_____

Education (highest grade completed):_____

Degrees:_____

Occupation:_____

Father's Name:_____
First Middle Last Suffix (Sr., Jr.,etc.)

Mother's Name:_____
First Middle Last Maiden

MY MEMORIES & WISHES

Preference on flowers:_____

In lieu of flowers, donate to the following charities :_____

_____

_____

Important songs or readings for service:_____

Type of service request (church, funeral home, visitation, graveside, memorial at later date, include locations: _____

My Career:_____

_____

_____

Location of My Family:_____

_____

_____

My Civic Accomplishments:_____

_____

_____

My Favorite Things:_____

_____

_____

What I want you to remember most:_____

_____

_____

_____

_____

_____

_____

IN THE EVENT OF MY DEATH

Funeral Home: _____ Location: _____

Phone: _____

Cemetery: _____

Other disposition location: _____

Embalming request: _____

Type of Casket: _____

Any specific clothing instructions (can include beautician requests): _____

_____

_____

Crematory: _____

Prepaid Funeral Expenses Arrangements: Yes ❑ No ❑

Information may be found: _____

I have a deceased spouse, parent, child who is buried at: _____

_____

_____

Special Requests: _____

Organ or body donation: (Please list name of program selected and location of paperwork):

_____

_____

_____

_____

_____

Minister/Rabbi to perform service: _____

Following persons to be involved in service: _____

_____

_____

_____

MY PERSONAL INFORMATION

Health Care POA: _____

Contact Name: _____ Contact Phone: _____

Durable Financial POA: _____

Contact Name: _____ Contact Phone: _____

Executor/Executrix of Estate: _____

Contact Name: _____ Contact Phone: _____

PET INFORMATION

Pet's Name: _____ Age: _____

Gender: Male ❑ Female ❑ Breed: _____

Veterinarian: _____

Boarding Facility: _____

Other Specifics: _____

Pet's Name: _____ Age: _____

Gender: Male ❑ Female ❑ Breed: _____

Veterinarian: _____

Boarding Facility: _____

Other Specifics: _____

MEDICAL & PROFESSIONAL INFORMATION

MY MEDICAL PROVIDERS

Primary Care Physician/Nurse Practitioner:_____

Cardiologist:_____

Neurologist:_____

Dentist:_____

Podiatrist:_____

Dermatologist:_____

Audiologist:_____

ENT:_____

Oncologist:_____

Gastroenterologist:_____

Urologist:_____

Psychiatrist:_____

Pharmacist:_____

PROFESSIONALS FOR HOME & VEHICLE

Home Association contact (if applicable):_____

Housekeeper/Cleaning Service:_____

Yard Maintenance:_____

Electrician:_____

Roofer:_____

Plumber:_____

Handyman:_____

Carpet Cleaner:_____

Car Mechanic:_____

Other information:_____

ONLINE ACCOUNT INFORMATION

WEBSITE	USER NAME	PASSWORD

NOTES:_____

MY IMPORTANT DOCUMENTS

Document Type		Location of Document
Last Will and Testament	Yes ❑ No ❑	
Living Trust	Yes ❑ No ❑	
Living Will	Yes ❑ No ❑	
Medical Power of Attorney	Yes ❑ No ❑	
General Power of Attorney	Yes ❑ No ❑	
Limited Power of Attorney	Yes ❑ No ❑	
Life Insurance	Yes ❑ No ❑	
Charitable Trust	Yes ❑ No ❑	
Organ Donation Form	Yes ❑ No ❑	
Other Medical Directives	Yes ❑ No ❑	
Deeds to Real Property	Yes ❑ No ❑	
Marriage License	Yes ❑ No ❑	
Domestic Partner Agreement	Yes ❑ No ❑	
Pre and/or Post Nuptial Agreement	Yes ❑ No ❑	
Divorce or Separation Agreement	Yes ❑ No ❑	
Birth Certificates	Yes ❑ No ❑	
Death Certificates of Family Members	Yes ❑ No ❑	
Automobile Title(s)	Yes ❑ No ❑	
Burial or Pre-Need Agreement	Yes ❑ No ❑	
Life Insurance Beneficiary Form	Yes ❑ No ❑	
Military Discharge Papers DD214	Yes ❑ No ❑	
Rental Agreement Copy (of retirement community or apartment)	Yes ❑ No ❑	
Other Important Documents:	Yes ❑ No ❑	
I have a bank safe deposit box	Yes ❑ No ❑	

Those listed as signers on my box and have access to it: _____

_____

Key to my safe deposit box is kept: _____

HEALTH INSURANCE INFORMATION

PLEASE PROVIDE COPIES OF ALL CARDS (FRONT AND BACK IF POSSIBLE) AND ATTACH

Medicare Number: _____

Part A | Eligible when? _____ **Part B** | Eligible when? _____

Part C Supplemental Policy: _____

Policy No.: _____

Contact Info: _____

Part D Prescription Drug Coverage: _____

Policy No.: _____

Contact Info: _____

There is an annual open enrollment period at the end of the year. Consult your pharmacist or care manager to see if changing your plan would be beneficial.

VA No. and/or File No.: _____

DD214 (*if served in military and honorably discharged*): _____

Long term Care Insurance: _____

Policy No.: _____

Contact Info: _____

Life Insurance: _____

Policy No.: _____

Contact Info: _____

ATTACH COPIES OF INSURANCE CARDS HERE:

Aging Life Care Manager:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

_____

Home Health Company or Care Agency involved:

Name:_____

Address: _____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

_____

Estate Planning Attorney:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

_____

Other Advisor:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

_____

Financial Advisor/Planner:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

CPA/Accountant:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

Property and Auto Insurance Provider:

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

Primary Banking Institution (checking/savings/money market/CD):

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____

Additional Banking Institution (checking/savings/money market/CD):

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Comments:_____

_____