Alzheimer's Arkansas
Caring for Caregivers

Family Caregiver

Care Binder

This was compiled by Alzheimer's Arkansas as a resource for family caregivers.

Information contained here may not be all-inclusive.

If there is an emergency, please call 911 immediately.

About Us

Alzheimer's Arkansas Programs and Services was first incorporated in 1984 as the "Alzheimer's Support Group of Central Arkansas," with the purpose of providing information and support to persons with dementia and their caregivers. Later, the group of volunteer leaders joined the national Alzheimer's Association. In 2002, the Board of Directors elected to disaffiliate from the national association to become Alzheimer's Arkansas Programs and Services.

Our mission is to help caregivers in Arkansas whose loved ones are affected by Alzheimer's disease and other forms of dementia.

Alzheimer's Arkansas is an independent nonprofit organization. Our volunteer Board of Directors is composed of local community members, our services are free, and our funds are spent ONLY in Arkansas. While our office is located in Little Rock, we travel all across the state to reach families who need our information and support.

Our programs and services include:

- Toll-free 24-hour telephone support for caregivers
- Support groups
- Caregiver educational sessions and workshops
- Respite activities and grants
- Community awareness presentations
- Financial assistance for caregivers
- A lending library of printed and video materials

Office Hours: M-F 8:30am to 4:30pm.

Phone: 501-224-0021 / Fax: 501-227-6303 / Caregiver Hotline: 800-689-6090

Email	**Website:**	**Social Media:**
info@alzark.org	www.alzark.org	Facebook/Instrgra/YouTube

Location: 201 Markham Center Dr Little Rock, AR 72205

About our Programs

Alzheimer's Arkansas offers free programs and services to caregivers of those living with Alzheimer's or related dementia.

Support Groups

We have support groups across the state. You can find a support group in your area by going to alzark.org. We have in-person and virtual options available.

Online Facebook Support Group

This is a private group and only for personal unpaid caregivers. You can post questions, stories, and chat with caregivers all over the state. This group is very engaged and ready to help. Our staff is always there to moderate and help point you in the right direction. Visit our facebook page and click groups to join!

Coffee with Caregivers

Coffee with Caregivers is a zoom support group designed to be a safe space for caregivers to vent, talk, and share their stories alongside our trained staff. Grab your cup of coffee the last Tuesday of every month and join our Education and Outreach Director for an hour that will lift your spirits and give you the tools to keep going. Learn more about this zoom support group meeting at alzark.org.

Grants

We offer different grants throughout the year. These are designed to provide respite care, help with expenses, and offer peace of mind. Just visit our website for up to date information.

Educational Resources

Alzheimer's Arkansas offers several educational opportunities to help caregivers on their journey. Whether you are looking for workshops, guest speakers, or in-service training, we have options to meet your needs.

Hope Caregiver Workshops

These workshops happen around the state throughout the year. Topics include:

- Financial planning/Estate planning
- Research
- Navigating home health
- Stress reduction
- Topics of interest to family caregivers

Caregivers will be able to interact with a variety of vendors to learn about services in their area.

Let's Talk

You've got questions. We've got answers. Let's Talk is your chance to talk with experts about topics important to you as caregivers. Our goal is to lead a conversation, not a lecture.

Throughout the program, you will have chances to ask questions and engage in meaningful dialogue to get your questions answered. You'll be able to learn more about home heath, insurance and medicaid, what resources are available, research, and much more.

Catch Let's Talk on the 3rd Thursday of every month at 2 PM on our Facebook page or at alzark.org/live.

Other Educational Programming

You can request our staff for the following types of education as well:

- Presentations to employees/staff
- Community awareness presentations
- Health fairs

Community Services

Use this section to record services for your loved one. You can find community resources by going to your local area on agency (agingarkansas.org) or by contacting Alzheimer's Arkansas.

	Phone/Website	Contact Person	Notes
Area Agency on Aging			
Senior Center			
Adult Day Services			
Transportation Services			
Meal Programs			
Housecleaning/Repair/lawn care			
Home Care Agency			
Hospice			
Legal Services			
Other:			

Outside Agencies and Caregivers

Caregiving Agency: _____

Address: _____ Phone: _____

Contact Person: _____ Web: _____

Notes: _____

_____

_____

_____

Skilled Nursing and Rehabilitation

Agency Name: _____

Address: _____ Phone: _____

Contact Person: _____ Web: _____

Notes: _____

_____

_____

_____

House cleaning Service

Agency Name: _____

Address: _____ Phone: _____

Contact Person: _____ Web: _____

Notes: _____

_____

_____

_____

Lawn Maintenance

Agency Name: _____

Address: _____ Phone: _____

Contact Person: _____ Web: _____

Notes: _____

_____

_____

_____

Other agencies

Agency Name: _____
Address: _____ Phone: _____
Contact Person: _____ Web: _____

Notes: _____
_____
_____
_____

Agency Name: _____
Address: _____ Phone: _____
Contact Person: _____ Web: _____

Notes: _____
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Agency Name: _____
Address: _____ Phone: _____
Contact Person: _____ Web: _____

Notes: _____
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_____

Agency Name: _____
Address: _____ Phone: _____
Contact Person: _____ Web: _____

Notes: _____
_____
_____
_____

Alzheimer's Arkansas
Caring for Caregivers

Month:

2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Notes:

Appointments

Date	Time	Place/who	Reason	Phone

Notes:

Daily Activity Log

Use this log to track daily activities including meals, what they did, where they went, phone calls, visitors, etc.

Date: _____

Morning	
Afternoon	
Evening	

Notes: _____

Daily Log

Use this log help keep track of daily things needed for your loved one. This log can be useful if you have multiple caregivers and need to track what has been done.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Bathing							
Oral Care							
Shave							
Dressing							
Breakfast							
Morning Med							
Laundry							
Lunch							
Afternoon Med							
Exercises							
Dinner							
Night Med							
Dress for bed							
Other							

Notes:

_____

_____

_____

Daily Routines

Morning

Task	Time	Notes
Wakes up at		
Breakfast		

Afternoon

Task	Time	Notes
Lunch		

Evening

Task	Time	Notes
Dinner		

Notes: _____

_____

Call Log

Date/Time	Notes (spoke with, about, phone #s, etc.)	Actions to Take

Home Safety Checklist

☐ Emergency information posted by the phone and/or on refrigerator including important contacts, medical information, and home street address.

☐ Lock up and/or clearly label dangerous cleaning agents (such as bleach, liquid laundry, pods) chemicals (such as insecticides) etc.

☐ Consider storing items such as alcohol, matches, sharp objects, etc. in a locked cabinet.

☐ Lock up or remove firearms.

☐ Check smoke and carbon monoxide detectors and inspect regularly.

☐ Keep a flashlight by the bed.

☐ Secure things such as bookshelves, cabinets, etc.

☐ Secure or remove loose rugs, extension cords, or other items that may cause trips.

☐ Clear pathways of clutter, small furniture, electrical cords, etc.

☐ Install handrails along stairs and hallways.

☐ Fix loose floorboards.

☐ Get rid of unstable furniture (anything that wobbles, is missing legs, etc.).

☐ Use nonslip treads and/or mark edges of steps with bright tape.

☐ Be sure light switches are easy to locate and use.

☐ Consider aiming lights at walls or the ceiling to reduce glare.

☐ Make sure paths they take at night are lit. Consider using night-lights.

☐ Consider a raised toilet seat.

☐ Use rubber mats and nonslip strips on floors that might be wet.

☐ Consider placing all shelves at heights that are easy to reach to prevent reaching or items from falling overhead.

☐ Note and clearly label food expiration dates and review basic food safety tips.

☐ Be sure all medications are clearly labeled.

☐ Dispose of medications that are no longer needed.

Location of Key Documents and Information

Item	Location	Notes
Certificates such as Birth, Marriage, etc.		
Wills		
Durable Power of Attorney		
DNR		
Insurance Policies		
Titles to Real Estate, Cars, etc.		
Safe		
Passwords (internet, PINS, etc.)		
Tax Returns		
Burial Instructions		
Important Contracts		
Jewelry/Valuables		

Notes: _____

Emergency Information Sheet

Address: _____ Phone: _____

Important Contacts

Type	Name	Number
Landlord		
Property Manager		
Neighbor		
Neighbor		
Police		
Fire		
Ambulance		

Home Maintenance

Type	Name	Number
Plumber		
Electrician		
Repair Person		

Utility Companies

Type	Name	Number	Account #
Electric			
Gas			
Oil			
Telephone			
Cable			
Internet			

Location of important Items

Item	Location
Fire Extinguisher	
Flashlight	
Circuit Breaker	
Water Valve Shut off	

Notes: _____

About Your Loved One

Use this to help outside agencies to learn more about your loved one.

Name: _____ Preferred Name or Nickname: _____

Primary Language: _____ Other Language Spoken:_____

Social History
Education: _____ Career: _____

Memberships in clubs/organizations:

_____

_____

Other:

_____

Hobbies and Activities
Favorite Activities: Favorite TV shows:

Favorite Movies: Favorite Games:

Places to visit: Favorite Music:

Other notable hobbies:

Relationships

Name	Relation	Location	Type and Frequency of Contact

Food and Snacks
Types of food they enjoy: _____
Types of food they dislike: _____
Favorite Meal: _____
Favorite beverage: _____
Favorite snack: _____

Needs and Self-care Abilities

Activities

	Independent	Needs Help	Notes
Bathing	☐	☐	_____
Dressing	☐	☐	_____
Grooming	☐	☐	_____
Eating	☐	☐	_____
Walking	☐	☐	_____
Toileting	☐	☐	_____
Medications	☐	☐	_____
Cooking	☐	☐	_____
Shopping	☐	☐	_____
Housework	☐	☐	_____
Laundry	☐	☐	_____
Transport	☐	☐	_____
Mail	☐	☐	_____
Bills	☐	☐	_____
Driving	☐	☐	_____

Devices and Equipment

	Needs Help	Notes
Glasses	☐	_____
Hearing Aid	☐	_____
False Teeth	☐	_____
Walker	☐	_____
Wheelchair	☐	_____

	Needs Help	Notes
Other: _____	☐	_____
Other: _____	☐	_____
Other: _____	☐	_____

Medical History

Current Diagnosis

Diagnosis	Date	Physician	Notes

Major Illness

Illness	Start	End	Physician	Notes

Vaccinations

Name	Date	Name	Date
Hepitis A		Pneumonia	
Hepatitis B		Tetanus	
MMR			
Zoster			
Influenza			
COVID			

Hospitalizations and Rehabilitation Stays

Date	Hospital	Reason	Discharge Date	Discharge to

Notes: _____

Medical Info

Name: _____ Preferred Name: _____
Address: _____
Phone: _____ Date of Birth: _____
Primary Language: _____ Secondary Language: _____
Gender: _____
Primary Insurance: _____ Policy: _____
Secondary Insurance: _____ Policy: _____

Do you have a living will? Y N Health Care Proxy: Y N
Health Care Proxy: _____ Phone: _____

Emergency Contacts

Name	Phone	Relationship

Physicians

Type	Name	Phone	Notes
Primary			
Secondary			

Preferred Hospital: _____ Phone: _____

List of Medical Conditions:

_____
_____
_____
_____

Baselines:

Weight: _____
Blood Pressure: _____
Blood Sugar: _____
Blood Type: _____

Allergies:

Type	Reaction

Upcoming Doctors Visit

Fill this section out pre-visit.

Appointment Date: _____ Time: _____

Clinic: _____ Physician's Name: _____

Clinic Address: _____ Phone: _____

Reason for Visit: _____

_____

_____

List of Symptoms: _____

Items to bring: _____

_____

Questions and concerns to discuss:

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Notes: _____

_____

_____

Outcomes:

Tests Ordered: _____

Diagnosis: _____

Medication: _____

Notes: _____

_____

Follow up visit? Y N Date:_____ Time: _____ Location:_____

Surgery/Procedure Log

Date	Description	Ordered By	Phone	Results

Medical Test Log

Use this to record blood tests, MRIs, X-rays, and other diagnostic tests run.

Date	Description	Ordered By	Phone	Results

List of Medications

Name	Description (Shape, Color, etc.)	Form	Dosage	Purpose	Start Date	End Date	Doctor/Pharmacy	Notes
XYZ		*Pill*	*10 mg 2x/day*	*Blood Pressure*	*1/1/2020*		*Doe/Walgreens*	*Take with food*

Pharmacy Name: _____
Address: _____
Fax: _____
Website: _____

Login: _____ **Password:** _____

Drug Allergies:

_____

_____

Weekly Medication Chart

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Drug: Dose: Instr:	Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Notes: ____

Emergency Room Checklist

What to bring:

☐ Insurance Cards ☐List of medications ☐Hearing Aides, glasses, walker, etc.
☐ Information on all doctors and health care providers ☐comfortable clothing
☐Important medical info (diagnosis, allergies)
☐Other:_____

Who needs to be notified?

Name:_____ Relation:_____
Phone:_____ Notes:_____

Name:_____ Relation:_____
Phone:_____ Notes:_____

If admitted to the hospital, I need to consider suspending or cancelling the following:

Service	Contact	Notes
Meal/Food Delivery		
Cleaning Services		
Home Health Services		

Are there any upcoming appointments that I need to cancel?

Notes:

_____
_____
_____
_____

End of Life Wishes and Instructions

End of life discussions are never easy and can be difficult but also necessary. Use this guide to help answer questions and put together a plan with your loved one and their physician.

Does your loved one have a living will or health care proxy? Y N

What is a health care proxy?

A proxy is someone appointed to make health care decisions for you if you are unable to make them yourself. This may also be referred to a durable medical power of attorney. This person is not necessarily your power of attorney but someone who is specifically appointed to make health care decisions for you. Things to consider and discuss:

- Who will make medical decisions for me if I am unable to make them myself?
- Will this person be able to make difficult choices?
- Do members of the family know who your proxy is and accept that?
- Who else might need to be consulted besides your doctor and proxy?
- Do I need a backup proxy?

Questions to consider.

What would you describe as good health? _____
What situations would you find as intolerable? _____
How do your religious beliefs factor in? _____
How important is where you die (at home, in a hospital, etc.) _____
What is your goal in treatment? _____
How aggressively should doctors act to keep you alive? _____
What circumstances would you not want to live under? _____
Notes: _____
_____
_____

Medical Decisions

If your prognosis were bleak, how would you feel about the following:
Hospitalization: _____ Surgery: _____
Resuscitation: _____ Ventilator: _____
Artificial Nutrition/Hydration: _____
What would make you comfortable:

The following requests have been made:

☐Do not hospitalize ☐Do not resuscitate ☐Do not intubate
☐No feeding tube ☐no extraordinary measures
☐Comfort measures only
Other requests: _____
_____

Health Care Proxy Phone:_____
Name:_____

Notes: _____

Family/Friends to be notified:
Name: _____ Phone: _____ Relation: _____

Notes:_____

Name: _____ Phone: _____ Relation: _____

Notes:_____

Name: _____ Phone: _____ Relation: _____

Notes:_____

Attorney
Name: _____ Firm:_____ Phone:_____

Address: _____
Notes: _____

Clergy
Name:_____ Phone:_____ Church:_____

Address:_____
Notes:_____

Funeral Home:_____ Phone:_____
Address:_____

Cemetery: _____ Phone:_____
Address:_____ Lot#:_____
Notes:_____

Financial and Legal Contacts

Primary Bank: _____ Phone: _____
Address: _____ City:_____ Zip:_____

Account Type/Description: _____
Account #:_____ Website:_____
Login: _____ Password:_____

Secondary Bank: _____ Phone: _____
Address: _____ City:_____ _ Zip:_____

Account Type/Description: _____
Account #:_____ Website:_____
Login: _____ Password:_____

Accountant: _____ Phone:_____
Firm:_____ Website:_____
Email:_____ Address:_____

Financial Advisor: _____ Phone:_____
Firm:_____ Website:_____
Email:_____ Address:_____

Insurance Agent: _____ Phone:_____
Firm:_____ Website:_____
Email:_____ Address:_____

Lawyer: _____ Phone:_____
Firm:_____ Website:_____
Email:_____ Address:_____

Other: _____ Phone:_____
Firm:_____ Website:_____
Email:_____ Address:_____

Financial Planning

Use this sheet to help keep track and organize your loved ones finances.

Assets	Account #	Balance
Savings Account		
Checking Account		
Investment Account		
Other securities		
Retirement Accounts		
	Description	**Value**
Real Estate		
Cars, Boats, Other vehicles		
Valuables (Jewelry, Painting, etc.)		
Business and Partnership Agreements		
Profit-sharing and pension plans		
Annuities		
Life Insurance		
Other		

Debts	Description	Amount
Mortgage		
Car Loan		
Other outstanding loans		
Credit card debt		
Other		

Estimated Future Expenses	Cost
Home renovations	
Assisted living devices	
Medical Bills	
Home health care	
Assisted living	
Legal/financial fees	
Funeral expenses	

Monthly Budget

Use this to help your loved one create a monthly budget.

Monthly Income	Amount
Salary/Wages	
Other business income	
Retirement benefits	
Social Security	
Interest	
Dividends	
Rental Income	

Monthly Bills	Amount
Housing	
Taxes	
Utilities	
Insurance	
Groceries	
Auto Payments	
Medical Bills	
Home/Yard upkeep	
Clothing	
Cable	
Entertainment	
Gifts/donation	
Credit Cards	

Notes:_____

_____

Representatives and Decision Makers

Health Care Proxy
Name: _____ Relation: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____ Work #: _____
Notes: _____
_____
_____

Power of Attorney
Name: _____ Relation: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____ Work #: _____
Durable Y N

Notes: _____
_____
_____

Conservator
Name: _____ Relation: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____ Work #: _____
Notes: _____
_____
_____

Guardian
Name: _____ Relation: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____ Work #: _____
Notes: _____
_____
_____

General Notes: _____