

RightConversationsSM Information Journal

The **RightConversations Information Journal** is designed to assist you in gathering the important information that you will need as you prepare to care for your loved one. This information will likely be needed as you continue to provide care for your loved one.

My Personal, Insurance & Financial Information:

Personal Information:	
Name: _____	Social Security Number: _____
Date of Birth: _____	Place of Birth: <i>(City, State, Country)</i> _____

Insurance Information:	
Medicare Number: _____	Medicaid Number: _____
Life & Health Insurance Company: _____	Policy Number: _____ Group Number: _____
Insurance Representative's Name: _____	Email Address: _____ Phone Number: _____ ()
Auto Insurance Company: _____	Policy Number: _____
Car Model: _____	Year: _____
Insurance Representative's Name: _____	Email Address: _____ Phone Number: _____ ()

Financial Information:		
Primary Bank Account <i>(Bank's Name)</i> : _____	Account Number: _____	Phone Number: _____ ()
Savings Account Name: _____	Account Number: _____	Phone Number: _____ ()

My Important Paperwork:			
Please check all that apply.			
<input type="checkbox"/> Living Will	<input type="checkbox"/> Marriage Certificate	<input type="checkbox"/> Military Papers	<input type="checkbox"/> Insurance Policies
<input type="checkbox"/> List of Personal Assets	<input type="checkbox"/> Tax Returns	<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Trusts
These documents can be found in the following location(s): _____			
The following people/person have/has access to this information: _____			

My Personal & Family Information:			
I served in the military: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, my service dates were from _____ to _____	
Mother's maiden name: _____	Mother's place of birth: _____	Father's name: _____	Father's place of birth: _____
I was married on: _____	Place we were married: _____	My husband/wife's name: _____	
Number of children we have: _____	Our children's names are: _____		

My Medical Wishes:

Would you like to have any of the following if, for some reason, you are not verbally able to state your wishes? The following information will be used to make medical decisions in accordance with your wishes.

CPR: Attempt to restart the heart. Mouth-to-mouth resuscitation may be necessary to restart the heart.

Yes No

Hospitalization: Transfer from a long-term care facility to a hospital if you needed additional care.

Yes No

Feeding Tube: If you were no longer able to swallow, a feeding tube may be placed on a temporary or long-term basis to provide you with life-sustaining nourishment.

Yes No

Life-Sustaining Procedures: This would include a ventilator that would breathe for you or other life-prolonging equipment and procedures.

Yes No

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Financial Snapshot for Future Planning:

Monthly Income:

Cash on Hand:	\$.
Monthly VA Benefits:	\$.
Monthly Social Security:	\$.
Monthly Pension:	\$.
Annuities:	\$.
Other:	\$.
Total Monthly Income:	\$.

Medication Information & Expenses:

Medication Name:	Medication Used for:
_____	_____
Monthly Medication Cost:	\$.
Medication Name:	Medication Used for:
_____	_____
Monthly Medication Cost:	\$.
Medication Name:	Medication Used for:
_____	_____
Monthly Medication Cost:	\$.
Medication Name:	Medication Used for:
_____	_____
Monthly Medication Cost:	\$.
Total Monthly Medication Expenses:	\$.
	× 12 months
Yearly Medication Expenses: \$.
Subtract medication assistance or prescription medication insurance:	\$.
Total Yearly Medication Expenses:	\$.

Direct-Care Costs:

These fees may be hourly, weekly or monthly, related to the direct care a loved one receives. List the total cost without subtracting, at this point, any reimbursed services.

Case Manager's Name: _____

Phone Number: _____ Email Address: _____
 () _____

Monthly Care Manager-related Fees or Contribution: \$.

Total Monthly Direct-Care Expenses: **\$.**

Consumable Supplies:

Items that must be purchased monthly for care such as medical supplies, incontinent briefs, supplemental meals, etc.

Item:	Monthly Cost:
_____	\$.
_____	\$.
_____	\$.
_____	\$.
Total Monthly Consumable Expenses:	\$.

Other Monthly Expenses:

Mortgage/Rent:	\$.
Utilities:	\$.
Supplemental Insurance Premium:	\$.
Groceries/Meals:	\$.
Clothing:	\$.
Transportation:	\$.
Total Other Monthly Expenses:	\$.

Available Monthly Income:

Total Monthly Income:	\$.
Total Monthly Expenses:	- \$.
Available Monthly Income:	= \$.