GOOD STEWARD SENIOR CARE PRESENTS

Good Steward Healthcare Advocacy Resource Guide

Clear steps for seniors and the families who love them

Plain words, real scripts, and step-by-step actions to protect the person you love.
In a crisis right now? Go straight to the **Crisis Day 1 Checklist**.



Good Steward Senior Care

Replacing overwhelm with clarity, peace, and honest guidance

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What Is Inside — with page numbers

In a hurry or in a crisis? Go to the **Crisis Day 1 Checklist** (page **5**) or the **Red Flag Index** (page **90**) — it matches what is happening right now to the exact chapter you need.

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How to Use This Guide: Two Paths

Most people open this guide in the middle of an emergency. Mom fell. Dad had a stroke. The hospital is calling. If that is you right now — take a breath. You do not need to read this whole book today. You only need the **Crisis Day 1 Checklist**, one page ahead.

There are two ways to read this book. Pick the one that fits your life today.

The Preparedness Path	The Crisis Path
Nothing is wrong yet — and that is the best time to act. Read **Phase 1** first. Get the legal papers done. Build the medication list. Set up the Digital Keyring. A calm hour today saves a terrible week later.	Something is wrong right now. Use the Crisis Day 1 Checklist. Then jump straight to the chapter that matches your problem. The **Red Flag Index** (page **90**) matches what is happening — "they want to discharge Dad tomorrow" — to the exact page you need.

HOW TO READ THE MARKERS IN THIS GUIDE

Original Medicare = this rule applies to Original (traditional) Medicare.

Medicare Advantage = this rule is different if your parent has a Medicare Advantage plan.

State Rules Vary = the law is different from state to state. Check your state's rules (see page **10**).

PRINTING TIPS FOR THIS GUIDE

- Print on **letter-size paper, both sides (duplex)**, in color if you can.
- Ask any print shop for **spiral binding** — the guide will lie flat while you write in it.
- The fill-in pages (Appendix A) also work great printed **separately**, one copy per event.
- This guide prints clearly in black & white too — we checked every colored box for readability.

The Crisis Day 1 Quick-Start Checklist

If you are reading this with your heart pounding — in the waiting room, or on the phone with the hospital — this page is all you need today. Do these eight things, in order.

✔ CHECKLIST: Your First 24 Hours

- ☐ **Write down where they are.** Hospital name, room number, and the unit phone number.
- ☐ **Get one name.** Ask: "Who is the nurse caring for my mom today?" Write it down with the time.
- ☐ **Say the magic sentence.** "Please note in the chart that my mother gives verbal consent for you to speak with me." (See Chapter 1.)

- [ ] **Grab three things from home:** the medication list (or the pill bottles in a bag), the insurance cards, and any legal papers (power of attorney, living will). The full packing list is the **ER Go-Bag Checklist** on page **79**.
- [ ] **Ask one key question:** "Is my parent admitted as an INPATIENT, or under OBSERVATION?" Write down the answer and who said it. (This one word can cost or save thousands of dollars. See Chapter 10.)
- [ ] **Start a notebook.** Every call, every name, every time. This notebook becomes your best weapon. (A ready-made log is on page **83**.)
- [ ] **Do not sign anything you do not understand.** You can always say: "I need to review this first."
- [ ] **Then flip to the chapter you need:** In the ER? Chapter 8. Being pushed out the door? Chapter 14. Bills piling up? Chapter 21.

Fast Answers: The 12 Questions We Hear Most

Short on time? Find your question, get the short answer, then go to the chapter listed for the full plan.

Your question	The short answer — and where to go
The hospital says "HIPAA" and won't tell me anything. Now what?	Your parent can give **spoken permission** — right at the bedside, no form needed. Ask the nurse to note it in the chart. **Chapter 1.**
Which legal papers do we need most?	**Two:** a medical decision-maker paper (healthcare proxy/medical POA) and a financial power of attorney. One does not replace the other. **Chapters 2–3.**
How do I bring up legal papers without starting a fight?	Make it about control, not decline: "This paper is how you stay in charge." Word-for-word openers in **Chapters 5–6.**

Your question	The short answer — and where to go
Mom fell and is in the ER right now. What first?	**Crisis Day 1 Checklist** (page **5**), then the 30-second ER handoff script in **Chapter 8.**
What is "observation status" — and why does everyone warn about it?	A hospital label that can make Medicare refuse to pay for rehab. Ask every day: "Inpatient or observation?" **Chapter 10.**
They want to discharge Dad tomorrow and it's not safe.	Say: "I am concerned this is an unsafe discharge — please document it." Then file the **free fast appeal** before midnight. **Chapters 14–15.**
How do we pick a good rehab or nursing home — fast?	Staffing matters more than the lobby. 30-minute check at Care Compare (medicare.gov/care-compare) + the tour checklist on page **80**. **Chapter 16.**
Is Medicare or Medicare Advantage better?	Neither, for everyone — but they play by **different rulebooks**. Follow the wrong one and you lose appeals. **Chapter 18.**
Who pays for a nursing home long-term?	**Not Medicare** — not for ongoing custodial care. Medicaid is the main payer, with strict rules and a 5-year look-back. **Chapter 22.**
Is palliative care the same as hospice?	**No.** Palliative care works alongside treatment at any stage. Hospice is comfort-focused care near the end of life. **Chapter 30.**
My siblings and I disagree about everything.	Assign three roles — medical lead, financial lead, communications lead — and hold a 30-minute monthly call. **Chapter 32.**

Your question	The short answer — and where to go
I'm exhausted. Where is help for ME, the caregiver?	Respite care, adult day programs, and caregiver support groups exist — many low-cost. Call the Eldercare Locator: **1-800-677-1116**. **Chapter 32.**
Bonus: Can a family member get PAID to provide care?	Often, yes — through state Medicaid waiver programs, VA benefits, or some long-term care insurance. **Chapter 22** (see the gold box).

Key Numbers & Websites to Keep

Tear this page out and tape it to the refrigerator. These are real, official, and free — most run by the government or nonprofits. (Numbers verified August 2026; hours vary.)

Who	Phone / Website	Call them for
Emergencies	**911**	Life-threatening emergencies, any time.
Medicare (1-800-MEDICARE)	**1-800-633-4227** medicare.gov	Coverage questions, claims, plan enrollment. Open 24/7.
Your state SHIP office (State Health Insurance Assistance Program)	**1-877-839-2675** shiphelp.org	**Free, unbiased** one-on-one Medicare counseling — plan choices, denials, savings programs. No sales pitch, ever.

Who	Phone / Website	Call them for
Eldercare Locator	**1-800-677-1116** eldercare.acl.gov	Free connection to local services: rides, meals, respite care, your Area Agency on Aging.
Social Security (SSA)	**1-800-772-1213** ssa.gov	Benefits questions; applying to be a Representative Payee (Chapter 3).
VA Benefits	**1-800-827-1000** va.gov	Veterans benefits including Aid & Attendance for wartime veterans and surviving spouses.
Medicare Rights Center	**1-800-333-4114** medicarerights.org	Free national helpline for billing problems, denials, and appeals.
Care Compare (facility quality ratings)	medicare.gov/ care-compare	Free official ratings: nursing homes, home health, hospice — staffing stars and inspection history (Chapter 16).
Long-Term Care Ombudsman	Find yours: theconsumervoice.org or call the Eldercare Locator	**Free, confidential** advocate for nursing home & assisted living residents — complaints, rights, quality concerns.

Who	Phone / Website	Call them for
988 Suicide & Crisis Lifeline	Call or text **988**	Free, 24/7 support in emotional crisis — for you or your loved one. Caregivers: this includes you.
Elder law attorney (find one)	naela.org/findlawyer	Powers of attorney, Medicaid planning, guardianship — documents that must hold up in court.
Adult Protective Services	Find yours via the Eldercare Locator	To report suspected elder abuse, neglect, or financial exploitation.
Good Steward Senior Care	**662-622-1831** goodstewardseniorcare.com	**Free, no-pressure consultation** — care navigation, facility research, and someone in your corner. Flat fees, zero kickbacks.

State Rules Vary — Please Read This First

Health law is not the same in every state. Power of attorney forms, POLST programs, caregiver laws, and guardianship rules all change at the state line. This guide teaches you the ideas that are true everywhere — but always confirm your state's exact forms and rules.

Your five best free starting points:

- **Your state's official POLST program** — many states have their own form and name (Chapter 4).

- **Your Area Agency on Aging** — free local help in every county.
- **The Eldercare Locator — 1-800-677-1116** — connects you to services near you.
- **Your state SHIP office** — free, unbiased Medicare counseling (Key Numbers page).
- **An elder law attorney licensed in your state** — for documents that must hold up in court.

★ IF YOU ARE READING THIS FOR YOURSELF…

Welcome. This book is for you too — not just your kids. Every plan works better when YOU lead it. You get to choose who speaks for you, what care you want, and what "a good life" means. Signing papers now does not take away your power. It protects your power — so no stranger ever decides for you.

PHASE 1

Legal Access, Privacy & Verbal Consents

Chapter 1: HIPAA Demystified — Getting Information TODAY

HIPAA is the privacy law that stops hospitals from sharing health details with just anyone. Families hear "HIPAA" and think they are locked out. You are not.

Here is the secret most families never learn: **your parent can give verbal consent** — spoken permission — right at the bedside or over the phone. No form. No lawyer. No waiting. If your mother says, "Yes, you can talk to my daughter," the staff can talk to you. Ask the nurse to write that consent in the chart so every shift can see it.

The signed HIPAA release form still matters. It is the long-term key — it works when your parent is asleep, sedated, or unable to speak. Get it signed at every hospital, every clinic, and every doctor's office your parent uses. But in an emergency, **start with the spoken yes**.

SCRIPT: GETTING VERBAL CONSENT ON THE RECORD

At the bedside: "Mom, is it okay for the doctors and nurses to share your health information with me?" (She says yes.) Then to the nurse: "My mother just gave verbal consent for me to be included. Could you please note that in her chart, and add my name and phone number as her contact?"

On the phone: "I know you can't share details yet. Could you please walk into her room, ask if she consents to speak with me, and note her answer in the chart? I'll hold. Her name is ___, room ___."

✔ DO THIS TODAY

Call your parent's primary doctor's office. Ask: "Is there a HIPAA release form on file naming me? If not, can you send one?" Ten minutes today opens every door later.

✦ RED FLAGS

- Staff says "HIPAA means we can't tell you anything" without ever asking your parent. That is wrong — ask them to check with the patient.

- A verbal consent "disappears" between shifts. Ask again, and ask that it be charted.
- Any hospital that cannot find your signed release. Always keep your own copy (see the Digital Keyring, Chapter 7).

Chapter 2: Healthcare Proxy vs. Medical Power of Attorney

These two names describe the same basic idea: a legal paper where your parent picks **ONE person** to make medical choices if they cannot speak for themselves. Some states say "healthcare proxy." Others say "medical power of attorney" or "healthcare agent." State Rules Vary

Three simple truths:

- **It only turns on when needed.** As long as your parent can speak and decide, they stay in charge.
- **Pick one decider, plus a backup.** "All three kids together" sounds fair but fails in a crisis. Choose one voice, name an alternate.
- **Do it before it is needed.** Your parent must understand what they are signing. After a stroke or deep dementia, it is too late — then you face guardianship court (Chapter 6).

★ IF YOU ARE READING THIS FOR YOURSELF…

Choosing your healthcare agent is one of the most loving gifts you can give your family. Pick the person who will honor YOUR wishes — even under pressure. That is not always the oldest child. It is the calmest one who listens best.

✔ DO THIS TODAY

Find out if a healthcare proxy exists. If yes — locate the physical copy. If no — download your state's official form (most are free from the state health department or bar association) and set a signing date this month. Then do Chapter 5 — the wishes talk — so your agent knows what you actually want.

✦ RED FLAGS

- The document is from another state, decades old, or names someone who has died. Update it.
- No one can find the original when the hospital asks. A photo in your phone solves this (Chapter 7).
- A sibling claims "verbal authority" with no paper. Hospitals follow documents and state surrogate laws — not the loudest voice.

Chapter 3: Financial Power of Attorney & the Two-Document Rule

Here is the trap: a medical power of attorney lets you make health decisions — but it does **NOT** let you pay the mortgage, talk to the bank, or handle the insurance premium. For money matters you need a second document: the **financial power of attorney**. One parent, two documents. That is the Two-Document Rule.

Two flavors to know:

- **Durable POA:** works now AND keeps working after incapacity. This is what most families need.

- **"Springing" POA:** only "springs" to life after doctors declare incapacity. Sounds safer, but the proof process can freeze you out for weeks — right when bills are due.

Two traps almost everyone hits:

- **Banks are picky.** Some banks push their own POA forms. Visit your parent's bank NOW, with the POA, and get it accepted while your parent can still confirm it in person.
- **Social Security ignores POAs entirely.** To manage a parent's Social Security checks, you must apply to become their **Representative Payee** — a separate process through Social Security (1-800-772-1213). A POA is not enough. Most families learn this the hard way.

✔ DO THIS TODAY

Ask one question at dinner: "If you were in the hospital for a month, who could legally pay your bills?" If the answer is "nobody," you have found the gap. The Consumer Financial Protection Bureau's free "Managing Someone Else's Money" guides explain an agent's duties in plain language (consumerfinance.gov).

✦ RED FLAGS

- Automatic payments failing while a parent is hospitalized — the first sign no one has financial authority.
- A "helpful" new friend or distant relative suddenly named as agent. Financial abuse of elders often starts with a rushed POA.
- Assuming a joint bank account solves everything. It helps with that one account — and creates its own risks.

Chapter 4: Living Wills vs. POLST/MOLST — Who Must Follow What

These two documents sound alike. They are not. Mixing them up can lead to exactly the treatment your parent did not want.

	Living Will (Advance Directive)	POLST / MOLST
What it is	A statement of wishes: "If I am dying, here is what I want and don't want."	An actual **medical order**, signed by a doctor or authorized clinician.
Who follows it	Guides your family and doctors in the hospital. EMS crews generally cannot follow it — paramedics need medical orders, not wish statements.	EMS and hospitals must follow it in states with POLST programs. It travels with the patient.
Who needs it	**Every adult.**	People with serious illness or frailty, where a 911 call is realistic.

State Rules Vary Your state may call it POLST, MOLST, POST, or MOST, and registry rules differ. Find yours through polst.org or your state health department.

Placement is everything. A perfect POLST locked in a filing cabinet saves no one. Paramedics are trained to look in two places: the refrigerator door and near the bed. Post a copy on the fridge. Tell every caregiver where it is.

✔ DO THIS TODAY

If your parent has serious illness and clear wishes about resuscitation, ask their doctor at the next visit: "Should we complete a POLST form together?" Then put a copy on the refrigerator.

✦ RED FLAGS

- Family believes the living will "protects Dad from CPR at home." It does not — without a POLST or out-of-hospital DNR, EMS will attempt full resuscitation.
- A POLST that no longer matches your parent's wishes. It can be updated or voided any time — review it after every major health change.
- Nursing home staff who have never been shown the form. Hand it over at admission and confirm it is in the chart.

Chapter 5: The Wishes Talk — Questions to Ask Before You Sign

A healthcare proxy form without a conversation behind it is just a name on paper. The person you pick can only honor your wishes if they **know** your wishes. This chapter is the conversation that makes the paperwork work.

Set aside one unhurried hour — a Sunday afternoon, a quiet coffee. Not in a hospital. Not in a fight. The agent you chose should be there, and the backup too if possible. Write the answers down on the **All About Me page** (Appendix A1, page **72**) so they live on paper, not in memory.

✦ THE TALK: SEVEN QUESTIONS THAT MATTER MOST

1. **What does a good day look like for you?** (Walking to the mailbox? Watching the grandkids? Just sitting on the porch?)
2. **What abilities matter most to you — the ones you never want to lose?** (Recognizing family? Feeding yourself? Living at home?)
3. **What would make life feel not worth living to you?** This is the hard one. Ask it gently, and listen.
4. **If you couldn't speak for yourself, who should speak — and is there anyone who should NOT?**
5. **Are there treatments you would never want?** (Breathing machine long-term? Feeding tube? How do you feel about CPR?)
6. **If the end were near, where would you want to be — and who should be in the room?**
7. **What should we know about the personal things?** Faith leader to call, favorite music, the dog, photos, traditions.

Two more questions for the person chosen as agent: "Are you willing to do this?" And: "Could you follow my wishes even if they are not what you would choose for yourself?" An honest yes to both is what you are looking for.

SCRIPT: OPENING THE WISHES TALK

"I finished my own paperwork last month, and it got me thinking. If anything ever happened and you couldn't speak up, I'd want to get it right for you — your way, not my guess. Could we spend an hour Sunday talking about what matters most to you? I'll write it down so we never have to guess."

✔ DO THIS TODAY

Put the date on the calendar right now — one hour, this month. Then give a copy of the written answers to the agent, the backup, and the primary doctor. Repeat the talk after every big health change, because wishes can change too.

✦ RED FLAGS

- An agent who has never been asked if they want the job — or who has never heard the wishes out loud.
- "We talked about it years ago" — but nobody wrote anything down. Memory fades exactly when it is needed.
- Wishes on paper that contradict the legal forms. The forms and the talk must match; fix whichever is outdated.

Chapter 6: The Resistant Parent Playbook — and When It's Too Late

The hardest part of Phase 1 is not the paperwork. It is the parent who says, "I'm fine. Stop fussing." Pushing harder usually backfires. Try these instead:

- **Make it about control, not decline.** "Dad, this paper is how you stay in charge. Without it, a judge could pick a stranger to decide for you."
- **Use a story, not a lecture.** "Remember what happened to Uncle Ray's family? Six months in court, fighting. One form would have prevented all of it."
- **Go first.** "I did my own healthcare proxy last month. Want to see how simple it was?" Adult children signing their own documents is the single most disarming move.

- **Borrow a trusted voice.** Doctors, pastors, and attorneys succeed where children fail. Ask the primary care doctor to raise it at the annual visit.
- **Take small yeses.** A HIPAA release is an easy first signature. Momentum matters more than completeness.

When it is already too late: if a parent has lost the ability to understand documents and nothing was signed, the only path left is **guardianship** (called conservatorship in some states) — a court process where a judge appoints a decision-maker. State Rules Vary It is public, it can cost thousands of dollars, and it can take months — though courts can grant emergency temporary guardianship in a true crisis. Ask the court and an elder law attorney about less drastic options first. Let this paragraph be the reason you finish Phase 1 early.

SCRIPT: OPENING THE CONVERSATION

"Mom, I'm not worried about today. You're doing great. But I love you, and if something sudden ever happened, I don't want strangers making your choices. Can we spend one hour this month making sure YOU stay in charge, no matter what?"

✔ DO THIS TODAY

Pick your opener and your moment — after a doctor visit, after a friend's health scare, or during a calm Sunday call. Rehearse one sentence. Then say it this week.

✦ RED FLAGS

- Repeated missed bills, scam calls, or confusion about medications — capacity may already be slipping. Move quickly and kindly.

- A sibling "waiting for the right time" for years. There is no perfect time. There is only before the crisis and after it.

Chapter 7: The Digital Keyring — Every Document, in Your Pocket

In the ER at 2 a.m., nobody can drive home to dig through a filing cabinet. The **Digital Keyring** is a simple, secure folder on your phone that holds a photo or PDF of everything:

- Healthcare proxy / medical POA
- Financial POA
- Living will and POLST/MOLST
- HIPAA releases
- Insurance cards — front AND back — Medicare, supplement, Part D, dental
- The medication master list (Chapter 23; template on page **74**)
- Photo ID, allergy list, surgery history, doctor and pharmacy phone numbers
- The All About Me profile and the Baseline Page (pages **72** and **77**)

Use a password-protected notes app, an encrypted cloud folder, or a secure document app. Then share access with every sibling — the brother three states away should see the exact same files at the exact same moment. Update it after every hospital stay and every medication change.

✔ DO THIS TODAY

Photograph both sides of every insurance card in your parent's wallet. That is the Keyring's first entry — five minutes, done.

✦ **RED FLAGS**

- Documents that exist only as one paper original in one drawer.
- Only one family member holding all access. If YOU are unreachable, the system fails.
- Unsecured photos of Medicare numbers in a regular camera roll — protect them like credit cards.

PHASE 2

Mastering the Hospital & Acute Care System

Chapter 8: The Emergency Department Survival Playbook

The ER runs on **triage**: the sickest go first, not the first in line. Your job is not to fight that system. Your job is to make sure the team sees the FULL picture of your parent — fast.

Elderly patients get under-triaged for one big reason: **they minimize**. "Oh, I'm fine, just a little dizzy." Your parent's politeness can literally slow their care. You are there to add the facts.

- **Bring the one-page brief:** medication list, allergies, conditions, baseline ("Two days ago she was walking and cooking. Today she can't stand."). **Baseline is the magic word** — it tells the team how far your parent has fallen from normal. (Ready-made: the Baseline Page, Appendix A4, and the ER Go-Bag list, Appendix A5.)

- **Be the calm one.** Staff move toward calm, organized families and brace against hostile ones. "I know you're slammed — here's her med list and a 30-second summary" wins allies.
- **Advocate in facts, not volume.** "Her pain is worse than an hour ago and she's now confused — that's new" gets action. Shouting gets security.
- **Never leave a confused parent alone** if you can help it. You are their memory, their translator, and their safety rail.

SCRIPT: THE 30-SECOND ER HANDOFF

"This is my father, Robert, 84. Baseline: lives alone, walks without help, sharp mind. Since this morning: slurred words and a fall. He takes blood thinners — the list is right here. He minimizes symptoms, so please weigh what I'm telling you. I'll stay out of your way and I'm here for any questions."

✔ DO THIS TODAY

Write the 30-second brief for each parent NOW, while you are calm. Store it in the Digital Keyring and on the Baseline Page. In a real ER you will be too rattled to write it well.

✦ RED FLAGS

- A parent on blood thinners who hit their head — insist on evaluation even if they "feel fine."
- New confusion dismissed as "just age." Sudden confusion is a medical alarm, not normal aging.
- Discharge from the ER without written instructions you understand. Ask: "What do we watch for, and what brings us back?"

Chapter 9: Hospitalist Dynamics — Who Is Actually in Charge?

Surprise: your parent's regular doctor probably will **NOT** treat them in the hospital. Inpatient care is run by **hospitalists** — doctors who work only in the hospital, often in 5-to-7-day shift blocks. They are skilled, but they have never met your parent, and they hand off to a new hospitalist when their block ends. Things fall through cracks at handoffs. You are the crack-filler.

- Day one, ask: **"Who is the attending physician today, and how do I reach their team?"** Write it down daily — the answer changes.
- Ask for the daily rhythm: "What time are rounds? Can I be present or on speakerphone?" Rounds are where decisions happen.
- **Request a family care conference** for any complex stay: one meeting with the hospitalist, nurse, case manager, and family — everyone hearing the same plan at once.
- **Connect the dots:** ask the hospitalist to send notes to the primary care doctor, and tell the primary care office your parent is admitted. Do not assume anyone called them.

SCRIPT: REQUESTING A FAMILY CARE CONFERENCE

"We'd like to request a brief family care conference in the next day or two — the attending, the case manager, and family, together for 15 minutes. We want everyone aligned on the plan and the discharge goal. Who should I ask to schedule that?"

✔ DO THIS TODAY

If a parent is hospitalized now: start a **daily log** — date, attending's name, nurse's name, what changed, what was promised. (Ready-made on page **83**.) If not: save this script for the day you need it.

✦ RED FLAGS

- Three days in and you cannot name the doctor in charge — neither can the care plan.
- Each new hospitalist seems to restart the plan from scratch. Bring your log and re-anchor them.
- "We're waiting on…" for days with no owner. Ask: "Who exactly is waiting on what, and when do we escalate?"

Chapter 10: Observation Status vs. Inpatient Admission — The $20,000 Word

Your mother is in a hospital bed, wearing a gown, getting IV fluids. She has been there three days. Obviously she has been "admitted"… right? **Not necessarily.** She may be under **observation status** — receiving care in the building but classified as an outpatient.

Why this one word matters so much: Original Medicare pays for rehab in a skilled nursing facility only after a qualifying **3-day inpatient** hospital stay. Observation days generally do not count. Families have been handed rehab bills of $10,000–$20,000+ because of this invisible label. Observation status can also shift drug and service costs onto the patient.

Your protections:

- **The MOON notice.** Hospitals must give Medicare patients a written "Medicare Outpatient Observation Notice" within 36 hours if they are under observation more than 24 hours. Do not let it become drawer paper — it is your alarm bell.
- **Ask, every single day:** "Is my parent inpatient or observation today?" The status can change mid-stay.
- **Push for reclassification** when it is medically justified: ask the attending, "Does her condition meet inpatient criteria? Would you consider changing the order?"
- **New appeal rights:** as of 2025, certain patients whose status was switched from inpatient to observation have a path to appeal — ask the hospital case manager and your BFCC-QIO about eligibility.
- Medicare Advantage **Different rulebook:** many MA plans waive the 3-day rule — but require prior authorization for the skilled nursing facility instead. Call the plan directly and ask both questions.

SCRIPT: THE DAILY STATUS CHECK

"Before anything else today: is my mother classified as inpatient or under observation? … If observation: what would her condition need to show to meet inpatient criteria, and can the attending review that today? Please note my question in the chart. If she stays under observation and later needs rehab, we understand Medicare may not cover it — we want that on the record now."

✔ DO THIS TODAY

If a parent is hospitalized: ask the status question before dinner tonight. Write down the answer, who gave it, and the time — the Hospital Daily Log (page **83**) has a column just for this.

✦ RED FLAGS

- Anyone waving off the question with "don't worry, insurance handles it." That is exactly when to worry.
- A MOON notice signed in a stack of admission papers no one read.
- Rehab being planned while your parent is still on observation status under Original Medicare — sort the status out BEFORE the transfer.

Chapter 11: Patient Advocates, Ombudsmen & the Chain of Escalation

When something is going wrong — ignored call bells, a medication mistake, a doctor who will not call back — do not stew, and do not explode. **Climb the ladder**, one calm rung at a time:

1. **The bedside nurse.** Most problems die here when raised kindly and specifically.
2. **The charge nurse** — runs the unit this shift. "Could I speak with the charge nurse about a concern?"
3. **The hospital's patient advocate / patient relations office.** Every hospital has one. They exist to fix exactly these problems, and using them is normal, not rude.

4. **The nurse manager or the attending physician,** for clinical disagreements.
5. **For nursing home concerns: the Long-Term Care Ombudsman** — a free, independent advocate for residents in every state (Key Numbers page).

Magic words that change conversations: "I'm not comfortable with the plan" and "I'd like my concern documented in the chart." Documented concerns get answered.

✔ DO THIS TODAY

Save two numbers into your phone: the hospital's patient relations office (on its website) and your state's Long-Term Care Ombudsman program.

✦ RED FLAGS

- The same problem reported twice with no change — stop repeating, start escalating.
- Staff retaliation worries. Ombudsman complaints are confidential, and retaliation is illegal.
- Being labeled "difficult" for asking questions. Calm + specific + documented = impossible to dismiss.

Chapter 12: Preventing Hospital-Acquired Delirium & Decline

Hospitals can make elderly patients worse in ways that have nothing to do with their illness. **Delirium** — sudden, severe confusion — strikes a large share of hospitalized seniors, and every day in bed steals muscle that can take weeks to rebuild. The good news: **family at the bedside is one of the strongest medicines.**

Hospitals increasingly follow the **4Ms of age-friendly care** — What Matters, Medication, Mentation (mind), Mobility. You can run the same playbook from a visitor's chair:

- **Mentation:** Bring the glasses and the hearing aids — a senior who can't see or hear becomes "confused" fast. Open the blinds by day, dim lights at night. Re-orient gently: "Hi Dad, it's Tuesday morning, you're at Baptist, I'm here."
- **Mobility:** Ask daily, "Is she cleared to walk? Can PT see her today?" Push for out-of-bed-for-meals unless truly unsafe.
- **Medication:** Ask about every NEW drug: "Is this on the risky-for-seniors list? Is it necessary?" (See the Beers Criteria, Chapter 24.) Sleep and sedation drugs are common delirium triggers.
- **What Matters:** Tell the team who your parent IS: "He's a retired teacher, sharp as a tack last week." Staff fight harder for a person than a diagnosis.
- **Basics that prevent spirals:** hydration, food intake, bowel habits, and sleep. Ask about all four, every visit.

✔ DO THIS TODAY

Pack a **hospital go-bag** for your parent's closet: spare glasses, hearing aid batteries, a large-print clock, family photos, and the All About Me sheet (page **72**). The full packing list is on page **79**. Grab-and-go ready.

✦ RED FLAGS

- Sudden confusion in a previously clear parent — demand evaluation for delirium, infection, or medication causes. Never accept "that's just how they get."
- Physical restraints or sedating drugs used for "agitation" before anyone looked for a cause like pain or a full bladder.
- Day after day in bed "to be safe." Bed rest is not safe — it is how walking is lost.

Chapter 13: The Long-Distance Caregiver Protocol

Caring from 500 miles away is its own skill. Guilt says "I should be there." Strategy says "I can be effective from anywhere — if I build the system."

- **Get on the record:** verbal consent + HIPAA release naming you (Chapter 1), your number in the chart as first contact.
- **Schedule the update call:** "What time each day works for a 5-minute nurse update? I'll call then — one call, not five."
- **Join rounds by speakerphone.** Ask the nurse to dial you in when the team is at the bedside.

- **Hire local boots on the ground:** an Aging Life Care professional (geriatric care manager) can visit, assess, attend meetings, and report back — your eyes and ears with clinical training (aginglifecare.org).
- **Divide roles across siblings:** one medical lead, one financial lead, one communications lead — with a shared note file so no one hears news last (Chapter 32).
- **Know your "get on a plane" triggers, in advance:** ICU transfer, major surgery decisions, care conferences that set long-term direction, hospice discussions, or your gut after a video call.

✔ DO THIS TODAY

Long-distance? Set up one shared family note file (any shared doc works) with three tabs: Contacts, Daily Log, Decisions Pending. Invite every sibling tonight.

✦ RED FLAGS

- Getting all news secondhand through one exhausted local sibling — a recipe for errors and resentment.
- A parent who "sounds fine" on the phone but whose neighbors report weight loss, confusion, or a home in disarray. Phones hide decline; video and visits reveal it.
- No local contact at all. Even one neighbor with your number changes everything.

PHASE 3

Discharge Planning, Appeals & Rehab Transitions

Chapter 14: Fighting Unsafe Discharges

"Good news — she's being discharged tomorrow!" Sometimes that IS good news. Sometimes it means a woman who cannot walk to her own bathroom is being sent to an empty house. Hospitals face constant pressure to free up beds. Your job is to make sure "medically stable" also means **actually safe**.

The safe-discharge test — ask yourself honestly:

- ☐ Can she get to the toilet, prepare food, and take medications correctly — alone, if alone she will be?
- ☐ Is every piece of equipment (walker, oxygen, hospital bed) already AT the house?
- ☐ Is home health actually scheduled — with a date — not just "ordered"?
- ☐ Does everyone know the follow-up appointments and warning signs?

If any answer is no, say the sentence hospitals must take seriously: **"I am concerned this is an unsafe discharge, and I want that documented in the chart."** Then ask for the case manager and require a real discharge plan: where, with what support, with what equipment, starting when. (The full Discharge-Readiness Checklist is on page **84**.)

Important honesty: you usually cannot block discharge forever, and a parent with capacity can refuse services you wish they'd accept. But you can force the system to slow down, document, and solve the gaps — which is usually enough.

★ A LAW MANY FAMILIES MISS: THE CARE ACT STATE RULES VARY

Most states have passed a caregiver law — often called the **CARE Act** (Caregiver Advise, Record, Enable Act). Where it applies, the hospital must do three things:

1. **Record** your name in the chart as the designated family caregiver — at admission, when you ask.
2. **Notify** you before your parent is discharged or moved to another facility.
3. **Teach** you the care tasks your parent will need at home — medications, wound care, transfers, mobility — and show you how, before discharge day.

Your move: at intake (or today), say: "Please list me as the designated family caregiver in the chart, and note that we want discharge teaching before she goes home." If staff say they "don't do that," ask the patient relations office whether your state has a caregiver designation law.

SCRIPT: CHALLENGING THE DISCHARGE PLAN

"I understand she's medically stable, and we want her home too. But she cannot stand without help, the walker hasn't arrived, and no home health visit is scheduled. Discharging her tomorrow into that situation is unsafe, and I'd like my concern documented. What needs to happen for a safe discharge — and can we meet with the case manager today to build that plan?"

✔ **DO THIS TODAY**

If discharge talk has started, ask the case manager for the written discharge plan NOW — not on discharge morning. Gaps found early are gaps you can fix.

✦ **RED FLAGS**

- Discharge announced same-day with no plan discussion — that is when the appeal clock matters (next chapter).
- "Equipment will be delivered sometime this week" for a patient who needs it tonight.
- A Friday-afternoon discharge with weekend services "starting Monday." Weekends are where unsafe discharges hide.

Chapter 15: The Immediate Appeal — Your Free Emergency Brake (BFCC-QIO)

Here is one of the most powerful and least-known rights in all of Medicare: if you believe a hospital discharge is too soon, you can file a **free, fast appeal** — and while it is being reviewed, your parent generally stays in the hospital without owing for those extra days.

How it works, step by step:

1. **Find the notice.** At admission (and again near discharge), Medicare patients receive the "Important Message from Medicare." It names your regional **BFCC-QIO** — the Beneficiary and Family Centered Care Quality Improvement Organization — and its phone number. Lost it? Ask any nurse for a copy.

2. **Call before the deadline.** To keep the protections, call the QIO no later than **midnight on the planned discharge day** — earlier is better.
3. **Say the simple sentence:** "I am appealing this discharge because it is not safe." No forms, no lawyer, no fee.
4. The QIO reviews the medical record — usually deciding within about a day — and the hospital must give you a detailed notice explaining why it believes discharge is appropriate.
5. **Win:** your parent stays, covered. **Lose:** you typically owe only from a set point after the decision — you bought time either way, often enough time to fix the unsafe plan.

Medicare Advantage MA members have the same fast-appeal right for hospital discharges through the QIO, and similar fast appeals when a plan cuts off skilled nursing, home health, or rehab services — watch for the written "Notice of Medicare Non-Coverage" and appeal by its deadline.

SCRIPT: FILING THE QIO APPEAL

"My name is ___, calling for my mother ___, a Medicare patient at ___ Hospital, planned discharge tomorrow. I am formally appealing this discharge as unsafe. She cannot [walk/manage medications/be alone], and the home plan is not in place. Please confirm this appeal is filed as of today and tell me the next steps." Then tell the nurse and case manager the appeal is filed.

✔ DO THIS TODAY

Hospitalized parent? Locate the "Important Message from Medicare" in the admission packet and put the QIO phone number in your phone — before you ever need it.

✦ **RED FLAGS**

- Anyone telling you an appeal will "anger the doctors" or "cost thousands." It is a federal right, it is free, and retaliation is prohibited.
- Waiting until after discharge to object. The power is in appealing BEFORE they leave the building.
- No "Important Message from Medicare" in your packet — ask for it; hospitals are required to provide it.

Chapter 16: Vetting Skilled Nursing Facilities — Beyond the Glossy Brochure

The hospital may hand you a list of rehab facilities and ask you to pick by tomorrow. The lobby with the fireplace tells you nothing. **Staffing tells you almost everything** — care quality lives and dies on how many nurses and aides are actually on the floor.

The 30-minute desk audit (before any tour):

- ☐ Look up each facility on Medicare's **Care Compare** website (medicare.gov/care-compare) — overall stars, and click into the staffing detail, including weekend staffing and nurse turnover.
- ☐ Check health inspection results for serious deficiencies and complaint history.
- ☐ Call your **Long-Term Care Ombudsman** and ask: "Any patterns of complaints at these facilities?"
- ☐ Confirm the facility actually has a bed AND accepts your parent's insurance for the expected stay.

The in-person gut check: visit if humanly possible — unannounced, ideally at mealtime or on a weekend. Smell the hallway. Watch whether staff greet residents by name. Count call lights blinking unanswered. Ask an actual floor nurse: "How many residents per aide on nights?" (The printable tour checklist with all of these is on page **80**.)

✔ DO THIS TODAY

Even with no crisis in sight: run the desk audit on the three nearest rehab facilities. Knowing your local landscape BEFORE the hospital hands you a list is pure power.

✦ RED FLAGS

- Pressure to decide in hours: "This bed will be gone by tonight." Beds open constantly; bad decisions last months.
- A tour that shows the therapy gym but steers you away from resident hallways.
- One-star staffing with a five-star lobby. Choose the staffing.

Chapter 17: Equipment, Home Health & Getting a Ride

The rule that prevents disasters: everything must be in place BEFORE your parent crosses the front door — not "coming later this week."

- **Durable Medical Equipment (DME)** — walkers, wheelchairs, hospital beds, oxygen, commodes. Medicare Part B covers medically necessary DME when prescribed and supplied through enrolled providers. Before

discharge, ask the case manager: exactly what is ordered, from which supplier, delivered exactly when? Get the supplier's phone number yourself.

- **Home health** — nurse visits, physical therapy at home, aide support. Medicare covers skilled home health when the doctor certifies it and the person is homebound. Pin down the agency name and the date of the first visit before leaving the hospital. "A referral was sent" is not a plan — **a scheduled visit is a plan.** (Interview questions for choosing an agency: page **82**.)
- **Transportation — the forgotten link.** How does a person who cannot climb into a car actually get home, or to follow-up visits? Original Medicare generally does NOT pay for routine non-emergency rides. Options: Medicare Advantage plans sometimes include transportation benefits — call and ask; Medicaid covers non-emergency medical transportation for eligible members; and your Area Agency on Aging or the Eldercare Locator (1-800-677-1116) can point to local senior ride programs. Book wheelchair vans a day or more ahead — they are not taxis.

✔ DO THIS TODAY

Call the Eldercare Locator or your Area Agency on Aging and ask one question: "What senior transportation programs serve our county?" Save the answer for the day you need it.

✦ RED FLAGS

- Discharge scheduled but the hospital bed or oxygen has no confirmed delivery time. Refuse to accept "sometime."

- "Home health will call you." Get the agency's name and number and call THEM before discharge.
- Missed follow-up appointments because no ride existed. Missed follow-ups are how people bounce back into the hospital.

PHASE 4

Insurance, Billing & Financial Advocacy

Chapter 18: Original Medicare vs. Medicare Advantage — Two Different Rulebooks

Before you fight any insurance battle, answer one question: **which Medicare does your parent actually have?** Everything in this phase — appeals, referrals, networks, rehab coverage — changes with the answer. Look at the wallet: a red-white-and-blue card used alone (often with a separate supplement/Medigap card) usually means Original Medicare. A card from a private company like an HMO or PPO plan means Medicare Advantage.

	Original Medicare	Medicare Advantage (MA)
Doctors	Nearly any provider that accepts Medicare, nationwide.	Plan networks — going outside can cost much more or be uncovered.
Prior approval	Rarely required.	Frequently required — for SNFs, imaging, home health, and more.
SNF rehab	Requires the 3-day inpatient hospital stay.	Many plans waive the 3-day rule but require prior authorization instead.

	Original Medicare	Medicare Advantage (MA)
Appeals	Through Medicare's appeal system and the BFCC-QIO for fast appeals.	First through the PLAN itself, on plan deadlines — plus QIO fast-track rights for hospital and service cutoffs.
Extras	No dental/vision/hearing; pair with Part D and often a Medigap supplement.	Often bundles drug coverage and extras like dental or transportation.

Neither is "better" for everyone. The danger is **following the wrong playbook** — like assuming the 3-day rule applies when the real barrier is a prior authorization, or appealing to Medicare when the appeal belongs with the plan. When in doubt, call your state **SHIP office — free, unbiased, one-on-one Medicare counseling** in every state (1-877-839-2675, shiphelp.org).

✔ DO THIS TODAY

Photograph your parent's insurance cards, then write one sentence in your notes: "Mom has [Original Medicare + supplement + Part D] / [Medicare Advantage with ___]." That sentence directs every strategy in this book.

✦ RED FLAGS

- Nobody in the family can name the plan. In a crisis, that is a blindfold.
- A parent switched plans at a kitchen-table sales pitch and lost access to longtime doctors.
- Advice from someone earning commission. For big decisions, verify with SHIP first.

Chapter 19: The Prior Authorization Trap

Prior authorization means the insurance plan must say yes BEFORE a service happens — or it may refuse to pay. It is where urgent care goes to wait. You can speed it up:

- **Ask early, at the doctor's office:** "Does this need prior auth? Has it been submitted? What's the reference number?" Then track that number like a package.
- **Use the urgency lane.** Plans must decide faster when a doctor certifies that waiting endangers health — ask the doctor to request an **expedited review**.
- **Feed the machine what it eats:** denials often just mean "not enough documentation." Ask the office to send chart notes showing medical necessity WITH the request, not after the denial.
- **The peer-to-peer:** when a plan doctor denies, your parent's doctor can request a peer-to-peer review — doctor to doctor, live. Many denials flip on this single call. Ask your doctor's office to request it by name.
- **A denial is an invitation to appeal, not a final answer.** Chapter 21 gives the framework.

SCRIPT: CHASING A STUCK AUTHORIZATION

"I'm calling about prior authorization reference #___ for [service], submitted [date]. This is urgent — her physician states delay risks her health, and we're requesting an expedited review as of today. What exactly is missing, who has the file right now, and what is the decision deadline? Please note this call, and give me a call reference number."

✔ DO THIS TODAY

Start an "insurance log": date, person's name, reference number, promise made. Every call. This log wins appeals later.

✦ RED FLAGS

- "It's pending" for more than a few business days on anything urgent — invoke the expedited lane.
- A test or rehab stay scheduled without confirmed authorization. Confirm BEFORE, or the bill may land on you.
- The doctor's office and the plan each say the other has the ball. Get them on a three-way call.

Chapter 20: Medical Necessity — Speaking the Insurer's Language

Insurance companies do not pay for what is helpful. They pay for what is **medically necessary and documented**. Two doctors can order the same walker — one gets it approved, one gets it denied — purely because of the words in the chart.

- **Vague loses:** "Patient is weak and unsteady." **Specific wins:** "Patient has fallen twice in 30 days, cannot walk 10 feet without assistance, and requires a walker to safely perform daily activities in the home."
- **Function is the currency.** Coverage decisions turn on what your parent can and cannot DO: walk, bathe, dress, cook, manage medications. Give doctors those specifics at every visit — you are feeding the record.

- **Match the order to the rule.** Coverage rules list what qualifies. Ask the doctor's office: "Can the note document the specific criteria the plan requires for this item?"
- **For rehab coverage, know the improvement myth:** Medicare coverage for skilled care does NOT require that the patient keep "improving" — maintenance of function can qualify. If someone says "she plateaued, coverage ends," ask them to cite the rule, and call SHIP or the Medicare Rights Center (1-800-333-4114).

✔ DO THIS TODAY

Write a plain "function list" for your parent: what they could do 6 months ago vs. today. Bring it to every appointment — it turns into the chart language that approvals are made of.

✦ RED FLAGS

- A denial reading "not medically necessary" for something the doctor clearly ordered — usually a documentation gap, not a final verdict.
- Your parent performing heroically at the doctor's office ("I'm fine!") while struggling at home. Tell the doctor what home really looks like — privately if needed.

Chapter 21: Decoding Bills & Winning Appeals

First rule of medical bills: never pay the first bill without checking it. Billing errors are common, and they are almost never in your favor.

The three-paper match. Line up: (1) the provider's **itemized bill** — request it; the summary bill hides everything; (2) the **Explanation of Benefits (EOB)** or Medicare Summary Notice; (3) your own notes of what actually happened. Then hunt for the five classic errors below.

The appeal ladder — a denial is a speed bump, not a wall. Persistent, well-documented appeals succeed remarkably often:

1. **Call first.** Many "denials" are coding errors fixed in one call. Log everything.
2. **Internal appeal, in writing:** the denial's exact words, why it is wrong, the doctor's supporting note, and the sentence "Please provide the specific policy language and criteria used for this denial." File before the deadline printed on the notice.
3. Original Medicare Follow the appeal levels printed on the Medicare Summary Notice — redetermination, then upward. Medicare Advantage Appeal to the PLAN first; if the plan upholds its denial, the case automatically goes to an independent outside reviewer.
4. **External/independent review** — decided by reviewers who don't work for the plan. Many families quit before this level. **Don't.** This is where wins happen.
5. **Get free expert help:** SHIP counselors (1-877-839-2675) and the Medicare Rights Center helpline (1-800-333-4114) exist for exactly this.

Surprise bills: the federal **No Surprises Act** protects patients from many out-of-network surprise charges — especially emergency care and out-of-network providers working at in-network facilities. If a surprise bill arrives, say

the law's name, dispute it, and do not pay while disputing. For other big balances: request the itemized review, ask about **financial assistance** (nonprofit hospitals must have charity-care policies), and negotiate — "What is the self-pay price? Can we settle this for less?" works more often than people believe.

✔ DO THIS TODAY

Pull the most recent confusing bill from the pile. Request the itemized version and match it to the EOB. Most families find their first error within 15 minutes.

✦ RED FLAGS — THE FIVE CLASSIC BILLING ERRORS

- **Duplicates** — the same service billed twice.
- **Things that never happened** — a therapy session on a day she was at dialysis.
- **Upcoding** — billed for a longer/more complex visit than occurred.
- **Unbundling** — one procedure split into pieces to charge more.
- **Wrong insurance info** — the #1 boring cause of giant "you owe" letters. One corrected digit can erase a bill. And: "balance due" letters that arrive before insurance finished processing — verify with the EOB before paying a cent; a provider pushing you to pay TODAY by phone; missed appeal deadlines (calendar them the day the notice arrives).

Chapter 22: The Annual Coverage Audit, Medicaid Basics & Hidden Money

The one-hour yearly ritual that saves thousands. Every fall, Medicare Open Enrollment (**October 15 – December 7**) lets your parent change plans. Plans change their drug lists and networks every January — last year's perfect plan can quietly become this year's expensive one. Each fall: run the CURRENT medication list through Medicare's Plan Finder, confirm the doctors are still in-network, and compare. Free one-on-one help: your SHIP office.

Medicaid & long-term care — know enough to avoid irreversible mistakes. The fact that shocks every family: **Medicare does not pay for ongoing custodial nursing home care** — the help-with-daily-living care that costs $8,000+ a month. The main payer for long-term nursing home care in America is **Medicaid**, which requires spending down to strict income and asset limits. Three warnings:

- **The five-year look-back:** gifts and asset transfers within five years of applying can trigger penalty periods. That "just put the house in the kids' names" idea from a neighbor can be a catastrophe. **State Rules Vary**
- **The healthy spouse has protections** — spousal impoverishment rules let the at-home spouse keep a share of assets and income. Do not spend down to zero out of fear before learning the rules.
- **When real money is at stake, hire an elder law attorney** (find one at naela.org/findlawyer). Legal, legitimate planning strategies exist — but they are state-specific and unforgiving of DIY errors.

Hidden money most families never claim:

- **VA Aid & Attendance** — an extra pension for eligible wartime veterans and surviving spouses who need help with daily activities. Huge, underused. Apply free through a VA-accredited representative — never pay anyone to "qualify" you (VA: 1-800-827-1000).
- **Medicare Savings Programs & Extra Help** — pay Medicare premiums and slash drug costs for lower-income seniors. SHIP can screen eligibility in minutes.
- **PACE programs** — all-inclusive care programs in some areas that keep nursing-home-eligible seniors living at home.
- **Hospital financial assistance** — nonprofit hospitals must offer charity care policies. You have to ask.

★ CAN A FAMILY MEMBER GET PAID TO PROVIDE CARE?

Often, yes — and most families never ask. Four real paths:

- **Medicaid home-care waiver programs:** many states let a senior who qualifies for Medicaid home care choose and pay their caregiver — including an adult child. State Rules Vary Call your Area Agency on Aging and ask about "self-directed care" or "consumer-directed care."
- **VA programs:** Aid & Attendance funds and the Veteran Directed Care program can pay family members who care for eligible veterans (1-800-827-1000).
- **Some long-term care insurance policies** pay family caregivers — read the policy or call and ask directly.

- **State paid family leave:** a handful of states offer partial wage replacement when you take time off to care for a parent.

Two cautions: pay means real employment (taxes, anyone?) — and paying family cash with no paper trail can create Medicaid look-back problems. Put a simple written **personal care agreement** in place first; an elder law attorney sets this up routinely and cheaply.

✔ DO THIS TODAY

Two calls: (1) your SHIP office for a free benefits check-up; (2) if your parent or their late spouse served during wartime — the VA about Aid & Attendance.

✦ RED FLAGS

- "Medicare will cover the nursing home." For long-term custodial care, it will not. Plan for the reality.
- Anyone charging fees to "protect assets" or "get VA benefits" with high-pressure annuity pitches. Verify credentials; use accredited, fee-transparent professionals.
- Letting a Part D plan auto-renew for years without checking. That is a silent leak of thousands.

PHASE 5

Medication Safety & Multi-Specialist Coordination

Chapter 23: The Universal Medication Master List

If this guide could hand you only one tool, it might be this one. Medication mistakes are one of the most common ways seniors are harmed — and most are preventable with **one living document**.

The Master List includes, for EVERY substance taken:

- [ ] Name (brand AND generic — confusion between the two causes double-dosing)
- [ ] Dose and strength
- [ ] Exact timing ("8 am with food," not "daily")
- [ ] What it is for, in plain words ("blood pressure," "water pill")
- [ ] Prescribing doctor
- [ ] Every over-the-counter drug, vitamin, and supplement — yes, the fish oil, the sleep gummies, the "harmless" antacid. They interact.
- [ ] Allergies and past bad reactions, at the top, in bold

Rules of the list: it lives in the Digital Keyring AND on the refrigerator; it is updated the same day anything changes; and it travels to every appointment and every ER visit. The list is only as good as its last update. (A full-page fill-in version is Appendix A2, page **74** — print extras.)

✔ DO THIS TODAY

The **brown-bag sweep:** collect every bottle in the house — cabinets, purse, nightstand, kitchen counter — into one bag and build the list from the labels. Expect surprises.

✦ RED FLAGS

- Pills in unlabeled containers or "I know them by color." Colors change between refills.
- Prescriptions filled at multiple pharmacies — no single pharmacist can catch interactions. Consolidate to one.
- Expired drugs and "leftover antibiotics" in the cabinet. Clear them out.

Chapter 24: Polypharmacy Audits, Beers Criteria & the 4Ms

Many seniors take 10, 12, 15 medications — often prescribed by different doctors who never compared notes. Each drug may make sense alone; together they can cause falls, confusion, and hospital stays. This chapter is about **subtraction as medicine**.

- **Demand a real medication reconciliation at every care transition** — hospital to rehab, rehab to home. Sit with the nurse or pharmacist and go line by line: "Is each of these still needed? What was stopped? What is new?" Transitions are where duplicate and abandoned prescriptions are born.

- **Book an annual comprehensive review:** pharmacists can review the whole list for interactions and candidates for deprescribing. Many Part D plans offer free **Medication Therapy Management** reviews for people with multiple conditions — ask the plan or pharmacist.
- **Know the Beers Criteria.** The American Geriatrics Society keeps an expert list of medications that are often inappropriate for older adults — including certain sleep drugs, anxiety benzodiazepines, older antihistamines (like the "PM" in nighttime pain relievers), and some muscle relaxants. It is not a banned list; it is a **"justify this" list**. Ask: "Is this on the Beers list? Is there a safer alternative or a lower dose?"
- **Watch for the prescribing cascade:** Drug A causes a side effect → Drug B is prescribed to treat the side effect → Drug B causes another → Drug C appears. Whenever a NEW symptom follows a NEW medication, ask: "Could this be the drug?" before accepting drug number three.
- **Use the 4Ms as your framework** — What Matters, Medication, Mentation, Mobility — the age-friendly care model hospitals and health systems are adopting. It gives you shared language: "Under the medication M — can we review whether this drug still serves what matters to her?"

SCRIPT: REQUESTING THE DEPRESCRIBING REVIEW

"My father takes 13 medications from four different doctors. I'd like a comprehensive medication review focused on what can be reduced or stopped safely — including anything on the Beers Criteria list. Can we schedule that as its own appointment, and should a pharmacist or geriatrician lead it?"

✔ DO THIS TODAY

Count the medications on the Master List. If the number is 5 or more, call the pharmacy and ask about a comprehensive medication review — including whether their Part D plan offers one free.

✦ RED FLAGS

- New confusion, falls, or dizziness soon after any medication change — call the prescriber the same day.
- A "PM" sleep aid or old-school antihistamine used nightly by a senior — a classic Beers-list delirium and fall risk.
- No one able to say why a drug started years ago is still being taken. "We've always given it" is not a reason.

Chapter 25: Cross-Specialist Communication — Building the Quarterback System

The cardiologist adjusts a heart drug. The kidney doctor doesn't hear about it for a month. The neurologist adds something that fights both. Nobody is being careless — the system simply has no built-in conductor. So **the family becomes the conductor.**

- **Name a quarterback.** Usually the primary care doctor (or a geriatrician). Tell them directly: "We want you coordinating the big picture. Can we make sure every specialist's notes reach you?"
- **Carry the record with you.** Open every specialist visit the same way: hand over the Master List and say, "Here's what changed since you last saw her." Thirty seconds, endless saves.

- **Master the portals.** Sign up (with permission or as authorized proxy) for each health system's patient portal. Read the actual notes and results; message doctors between visits; download records to the Digital Keyring.
- **Close every loop yourself:** after any specialist changes anything, message the primary care office: "Dr. Chen increased the dose of ___ on Tuesday — please note it and flag any concerns." Never assume the letter arrived.
- **End every appointment with three questions:** What changed today? Who else needs to know? What do we watch for? (The Doctor Visit Worksheet, page **75**, has these printed and ready.)

✔ DO THIS TODAY

List every doctor your parent sees. Ask your parent which one they trust as the "main brain," then ask that office to be the record hub for the others.

✦ RED FLAGS

- Two specialists prescribing similar drugs for the same problem without knowing about each other.
- A specialist who seems unaware of a recent hospitalization. Hand them the discharge summary yourself.
- Test results "pending" forever. No news is NOT good news — no news means call.

PHASE 6

Choosing & Managing the Care Setting

Chapter 26: The Care Setting Decision Tree

"Where should Mom live?" is really four questions braided together: What can she DO? How is her MEMORY? What can the family SUSTAIN? What can she AFFORD? Answer honestly, and the setting usually chooses itself.

Setting	Right when…	Watch out for…
Home (aging in place)	Safe with the current level of help; support can grow as needs grow.	Isolation, caregiver exhaustion, "one more fall" thinking.
Independent living	Managing personal care fine, but wants meals, social life, no house upkeep.	It provides little to no CARE — plan the next step before it's needed.
Assisted living	Needs daily help with bathing, dressing, or medications, but not around-the-clock nursing.	Fee "levels" that climb as needs rise; discharge clauses when needs exceed license.
Memory care	Dementia with wandering risk or safety concerns; needs a secured, trained environment.	Verify actual dementia training and staffing, not just a locked door and a nice name.
Nursing home (SNF)	Needs 24/7 nursing-level care.	Staffing levels above all — recheck Care Compare and ombudsman history.

Two rules for the decision:

- **Measure function, not age.** Clinicians use ADLs (bathing, dressing, toileting, eating, transferring, continence) and IADLs (cooking, driving, finances, medications). Count honestly how many need help. The count — not the birthday — points to the setting.
- **Decide one step BEFORE the crisis.** The worst placements are made from a hospital lobby in 48 hours. If this year has brought falls, weight loss, medication mistakes, or wandering — start touring now, while "no" is still an option.

★ IF YOU ARE READING THIS FOR YOURSELF…

Choosing to accept more help is not giving up your independence — it is how you KEEP it. The people who wait until a crisis get the fewest choices. The people who plan get to pick the place, the timing, and the terms. Stay the one doing the choosing.

✔ DO THIS TODAY

Do the honest ADL/IADL count for your parent — or yourself. Write the number down and date it. Compare again in six months; the trend is the truth.

✦ RED FLAGS

- The family averaging feelings instead of counting function. "She seems okay to me" from the sibling who visits twice a year does not outvote the daily caregiver's reality.
- A move chosen purely on price or proximity with no staffing check.

- Waiting for the parent to "agree it's time." Sometimes the family must lead — kindly, with options, but lead.

Chapter 27: Aging in Place Safely

Most seniors want to stay home — and with the right layers, many can, far longer than families fear. **Falls are the enemy:** they are among the leading causes of injury and lost independence in older adults. Attack the house before the house attacks your parent.

- **Budget tier 1 — under $100, this weekend:** remove throw rugs (the classic villain), tape down cords, nightlights in every hallway and bathroom, grab-friendly non-slip bath mat, brighter bulbs, clear walking paths, move daily-use kitchen items below shoulder height.
- **Budget tier 2 — a few hundred dollars:** professionally installed grab bars at toilet and shower (towel bars are NOT grab bars), raised toilet seat, shower chair and handheld shower head, stair railings on BOTH sides, a medical alert system — wearable, waterproof, worn in the shower, where falls happen.
- **Budget tier 3 — bigger projects:** walk-in shower conversion, ramps, stair lift, first-floor bedroom conversion, widened doorways. Use certified aging-in-place professionals for formal modifications. Your Area Agency on Aging can point to local home-modification and fall-prevention programs, some low-cost or free (Eldercare Locator: 1-800-677-1116).

Then **layer the human help:** start small — a few housekeeping/companion hours — and grow to personal care aides as needs grow. Layering in help EARLY is what makes staying home last.

✔ **DO THIS TODAY**

Walk your parent's home like a detective: floor by floor, rug by rug, light by light. Fix five things this weekend. Total cost: usually under $50 and one hardware run.

✦ **RED FLAGS**

- A fall that "wasn't a big deal." The first fall predicts the second. Investigate every one — cause, footwear, lighting, medications, blood pressure.
- The alert-button pendant living in a drawer. Worn or worthless.
- Stairs plus laundry in the basement plus bedroom upstairs. Rearrange the house before the house forces the issue.

Chapter 28: Vetting Assisted Living & Memory Care — What Contracts Hide

Assisted living is largely private-pay and less federally regulated than nursing homes — which means **the CONTRACT is where families win or lose**. State Rules Vary Oversight and inspection reports live at the state level; find your state's licensing agency and read the facility's inspection history before signing anything.

Contract traps to hunt down (bring reading glasses and patience):

- ☐ **Level-of-care escalators:** the advertised price is for the LOWEST care level. Ask: "What does each level cost, what triggers a level change, and who decides?" A $4,200 room can quietly become $6,800.

- [ ] **Involuntary discharge clauses:** under exactly what conditions can they make your parent leave? (Needing "too much care," behaviors, exhausted funds?) You want the answer BEFORE move-in, not in a 30-day notice letter.
- [ ] **Community fees and deposits:** what is refundable, and on what timeline?
- [ ] **Medication management fees, transport fees, care-plan reassessment schedules** — get the full fee schedule in writing.

Touring smart: tour twice — once scheduled, once unannounced (mealtime or weekend evening tells the truth). Watch faces: do staff greet residents by name? Ask point blank: "What's your caregiver-to-resident ratio on the overnight shift?" and "How long has your director been here?" (Constant leadership turnover is a quiet alarm.) For memory care, add: "What specific dementia training do floor staff receive, and how many hours?" Talk to families in the parking lot — the best reviews are unofficial. The Long-Term Care Ombudsman program also serves assisted living residents in most states — call them about complaint patterns. (Print the tour checklists: page **80**.)

✔ DO THIS TODAY

If a move may be within a year: request contracts and FULL fee schedules from two facilities — before any deposit. How a facility handles that request tells you plenty.

✦ RED FLAGS

- "Sign this week to lock in the rate." Real communities don't need panic pricing.

- Vague answers about what forces a resident to leave. Vague now means shocking later.
- A beautiful memory care wing where staff can't describe their dementia training.

Chapter 29: Hiring & Managing In-Home Caregivers

Two roads, both legitimate — with very different responsibilities:

	Agency	Private hire
Cost	Higher hourly rate.	Often meaningfully cheaper.
Screening & backup	Agency handles background checks, training, and sends a substitute when someone is sick.	All on you — checks, references, AND the 6 a.m. no-show problem.
Taxes & liability	Agency is the employer; insurance and payroll are theirs.	You may legally become a household employer — payroll taxes, possibly workers' comp. "Paying cash under the table" creates real legal and injury-liability risk.
Control	Less choice over which caregiver arrives.	You pick the person — often the same trusted face every day.

Whichever road: manage it like the serious job it is.

- **Write a one-page duty sheet:** tasks, schedule, emergency contacts, house rules, and what to do if something feels wrong. (Interview questions for home care agencies: page **82**.)

- **Use a simple daily log:** meals eaten, meds prompted, mood, anything unusual. Patterns appear in writing that get missed in passing.
- **Check in unannounced sometimes.** Good caregivers don't mind; bad ones reveal themselves.
- **Build the backup roster BEFORE you need it:** a second agency's number, a respite option, one family fallback plan. The primary aide WILL eventually be sick, on vacation, or gone.
- **Protect the valuables and the financials quietly:** lock away checkbooks, jewelry, and card numbers. Not an insult — a standard practice that protects everyone, including the honest caregiver.

✔ DO THIS TODAY

Whether or not you're hiring yet: write down what a caregiver would actually need to DO in a typical week for your parent. That duty list is your interview sheet, your job post, and your reality check on hours and cost.

✦ RED FLAGS

- A caregiver who isolates your parent from family, resists unannounced visits, or becomes involved in finances. Act immediately.
- Missing items, unexplained withdrawals, or a new "loan" to a caregiver — classic exploitation signs. (Suspect abuse? Adult Protective Services — find your state's number via the Eldercare Locator, 1-800-677-1116.)
- No backup plan. One person, no roster, equals a crisis on their first sick day.

PHASE 7

Long-Term Management, Palliative Care & Family Protocols

Chapter 30: Palliative Care vs. Hospice — Two Doors, Not One

Say "palliative care" and many families hear "the end." That is the single most costly misunderstanding in serious illness. Learn the difference and you unlock help YEARS earlier:

	Palliative Care	Hospice
What it is	A specialist team focused on comfort, symptom relief, and quality of life — for anyone with serious illness, at ANY stage.	Comprehensive comfort-focused care when a doctor certifies a life expectancy of about six months or less if the illness runs its normal course.
Other treatment?	Yes — alongside curative treatment: chemo, surgery, everything.	Care shifts from cure to comfort for the terminal illness.
When to ask	At diagnosis of any serious illness — heart failure, COPD, cancer, dementia, Parkinson's.	When cure is no longer the goal — ideally months before the final weeks.

Ask early: **"Would a palliative care consult help manage her symptoms?"** It is a sign of good care, not surrender — and families consistently report better symptom control and support.

The Medicare hospice benefit is remarkably complete: the care team (nurses, aides, social worker, chaplain), medications for comfort, medical equipment, 24/7 on-call support, **respite care** (short inpatient stays that give exhausted family caregivers a break), and grief support for the family afterward. Two rights families forget: hospice can be **revoked at any time** if you change your mind, and you may **change hospice providers** if unhappy.

The biggest hospice mistake is lateness. Many families enroll in the final days and then say the same sentence afterward: "We wish we'd called months earlier." Signs it is time to ask: repeated hospitalizations, ongoing weight loss, "would you be surprised if…?" answered no by the doctor, and treatments that now take more than they give. (Interview questions for choosing a hospice: page **82**.)

SCRIPT: OPENING THE CONVERSATION WITH THE DOCTOR

"Doctor, honestly: would you be surprised if Mom were still with us a year from now? … If not, we want to focus on her comfort and her time. Can we talk about what palliative care — or hospice — would look like, while she can still enjoy the benefit of it?"

✔ DO THIS TODAY

If a parent has ANY serious chronic illness, ask at the next appointment whether a palliative care consult is available. You are not "giving up." You are adding a team.

✦ RED FLAGS

- Uncontrolled pain or breathlessness being treated as "just part of the disease." Comfort is a specialty — demand it.

- A hospice sales pitch that promises everything and documents nothing. Compare more than one provider; ask about nurse response times and weekend coverage.
- Waiting for the doctor to bring up hospice. Doctors often wait for the family. Someone has to go first — let it be you.

Chapter 31: Dementia Crisis Management & the Great Masqueraders

When a person with dementia suddenly gets much worse — more confused, agitated, sleepy, or "not themselves" — the single most important rule is: **sudden change is NOT the dementia.** Dementia moves in months and years. Overnight changes have a cause, and the cause is often fixable:

- **Urinary tract infections** — the classic masquerader; in seniors, a UTI can look like pure confusion with no complaint of pain.
- **Dehydration** — seniors lose the thirst signal; two low-fluid days can wreck cognition.
- **New medications or dose changes** — always the first suspect after any change.
- **Constipation, urinary retention, untreated pain** — a body screaming through behavior when words are gone.
- **Delirium from illness or hospitalization** (Chapter 12).

Say the sentence that changes the workup: "This is a sudden change from her baseline — last week she could ___. We need to look for a medical cause, not assume the dementia has progressed."

In the hospital, a person with dementia cannot self-report — so **the family becomes the reporting system**: pain often shows as grimacing, guarding, rocking, or aggression — tell staff how YOUR parent shows pain. Push for a family member or sitter present around the clock if possible; a familiar face is the best anti-delirium tool. Ask for the geriatric team where one exists, insist glasses and hearing aids stay in use, and question any sedating "behavior" medication: "What cause was ruled out first — pain, infection, bladder, bowel?"

✔ DO THIS TODAY

Write the **baseline page** for your parent NOW: what a good day looks like, what they can do, how they communicate discomfort. (Fill-in version: Appendix A4, page **77**.) In a crisis you will hand this to every new nurse and doctor — it is the most valuable page you can carry.

✦ RED FLAGS

- Any clinician attributing an overnight change to "the dementia progressing." Progression doesn't happen overnight — ask for the infection/ medication/dehydration workup.
- Sedatives or antipsychotics started in the hospital "for agitation" and never reviewed for stopping. Ask at discharge: "Which of these can come off now?"
- Weight loss and skipped meals at home — often the first quiet sign the current support level has been outgrown.

Chapter 32: The Sibling Alignment Protocol & Caregiver Burnout

First, the family. Nothing sabotages a parent's care faster than warring adult children. Alignment is built, not wished for:

- **Assign three roles** — medical lead, financial lead, communications lead. One voice talks to doctors. One tracks money. One updates the family. Roles can rotate; on any given day they must be clear.
- **Hold a standing family meeting** — even 30 minutes monthly by video. Agenda: what changed, decisions pending, money, who does what next. Boring meetings prevent explosive ones.
- **Write decisions down** in the shared file. Documentation prevents the "nobody told me" wars.
- **The distance rule:** the sibling who is not there does not get to overrule the sibling who is — but the local sibling must share real information, not filtered headlines. Criticism from afar buys no groceries; updates hidden from afar breed suspicion. Trade transparency for trust.
- **Deadlocked? Bring in a neutral:** a geriatric care manager or professional mediator can defuse in one session what siblings have fought about for a year.

Second, the caregiver. Caregiver collapse is the most predictable emergency in senior care — and the most ignored. If you are the primary caregiver, these are not luxuries; they are the maintenance schedule that keeps the whole system running:

- **Respite is a plan, not a wish.** Options: hourly in-home respite, adult day programs, short "respite stays" at facilities, and — for hospice families — the Medicare hospice respite benefit (Chapter 30). Your Area Agency on Aging can list local respite and support programs, many low-cost (Eldercare Locator: 1-800-677-1116).
- **Build the emergency backup file:** if YOU were hospitalized tomorrow, could anyone run Mom's care from a single page? Write that page: meds, routines, providers, quirks, keys. (The All About Me page and Med List — pages **72** and **74** — are most of the work already done.)
- **Set two boundaries and keep them:** one protected block of hours weekly that is yours, and one task you formally hand off (bills, groceries, one weekly shift). Small, kept boundaries beat grand, broken ones.
- **Watch your own red flags:** sleeplessness, constant irritability, dreading every phone ring, your own skipped checkups, thoughts like "I can't do this anymore." Those are medical symptoms of an unsustainable system — change the system. In a dark moment, the 988 Lifeline (call or text 988) is free and always open.

✔ DO THIS TODAY

Send one message to your siblings: "30-minute call Sunday — Mom's care, three topics: what's changed, what's pending, who does what." Attach this chapter if it helps.

✦ **RED FLAGS**

- One sibling silently doing 90% while "keeping the peace." That peace is borrowed against a breakdown.
- Old family roles running the show — the "baby" at 55, the "responsible one" drowning. Assign today's roles for today's crisis.
- A caregiver who hasn't seen their own doctor in over a year. Caregivers die of neglected health at alarming rates — the parent's care plan must include the caregiver's health.

Chapter 33: The Post-Crisis After-Action Review

The crisis passed. Dad is home, or settled at the facility, or the funeral is behind you. Everyone wants to stop thinking about it — which is exactly why families repeat the same chaos next time.

Within a month of any major health event, hold one family hour with four questions:

1. **What worked?** (The Digital Keyring saved the ER visit; the QIO appeal bought three days.)
2. **What failed?** (Nobody could reach the POA document; two pharmacies didn't talk; the sibling group chat melted down.)
3. **What needs updating NOW?** Refresh the medication Master List, upload new discharge summaries to the Keyring, update the baseline page, revisit POLST wishes after the health change, and review whether the POA/proxy choices still fit.

4. **What does next year's version of this family need?** If needs grew, revisit the care setting decision (Phase 6) BEFORE the next fall. If money got tight, book the SHIP benefits check-up and the elder law consult.

Then archive: request complete records from the hospital, store them in the Keyring, file every EOB and appeal letter, and write the one-page "story so far" summary a future ER doctor could read in 60 seconds. Future-you will be deeply grateful.

✔ DO THIS TODAY

Put a calendar reminder 30 days out titled "Family After-Action Hour." When it rings, run the four questions. One hour buys the next crisis down from chaos to checklist.

✦ RED FLAGS

- "Let's just not talk about it — it's over." The lessons evaporate in weeks; capture them now.
- Documents that no longer match reality — an outdated proxy, a POLST from before the health change, a med list frozen in time.
- The same near-miss twice. Once is a surprise; twice is a system that needs fixing.

Chapter 34: When Death Comes — The First Days

Nobody wants this chapter. But when the moment comes, the families who struggle least are the ones who knew the first three phone calls to make. Read it once, gently. Tab the page. Then go hug your parent.

In the first hours:

- **If your parent is on hospice: call the hospice nurse first — not 911.** Hospice staff handle the official steps, come to the home at any hour, and guide you minute by minute. This is what they are for.
- **If death is unexpected at home and there is no hospice:** call 911. Know in advance: if there is no POLST or out-of-hospital DNR, paramedics are required to attempt resuscitation (Chapter 4).
- **Call the funeral home when you are ready** — there is no clock. If your parent chose one in advance (write it on the All About Me page, page **72**), that decision is already made. If not, compare two; prices for the same service vary widely.

In the first days:

- **Death certificates:** order about **10 certified copies** through the funeral home. Banks, insurance, Social Security, titles — everyone asks for one, and reordering later is slower.
- **The funeral home usually reports the death to Social Security** — confirm it happened. Do not cash or spend benefit checks dated after the death; they must be returned.
- **The power of attorney ends at death.** Authority shifts to the executor named in the will. If there is no will, the court appoints someone — an elder law attorney can walk you through it.
- **Secure the home and the valuables,** kindly but promptly — house, car, checkbooks, jewelry. Not because family is untrustworthy; because this is the week confusion happens.

- **Do not rush** to distribute belongings, close accounts, or pay every bill that arrives. Creditors and real debts follow a legal process; grief-week snap decisions are how estates get tangled and scammers get paid.

In the first month:

- Notify: banks and mortgage holder, pension/employer, life insurance, Medicare plan or Part D supplement, credit cards, and the three credit bureaus (a "deceased alert" prevents identity theft).
- Ask about **VA burial benefits** if your parent was a veteran (1-800-827-1000), and the Social Security lump-sum death benefit for a surviving spouse.
- Then breathe. Most of this list waits safely for weeks.

And you: hospice programs offer free grief support to families for about a year afterward — use it even if "you're fine." Faith communities, senior centers, and your Area Agency on Aging know the local grief groups. Caregivers often crash after the mission ends; that is normal, and it is okay to get help for it. (The printable first-week checklist is on page **85**.)

✔ DO THIS TODAY

If a parent is seriously ill: put the funeral home's name and number, the hospice number, and a "who to call first" note in the Digital Keyring tonight. In the real moment, that one note is everything.

✦ RED FLAGS

- Phone callers demanding immediate payment of a deceased parent's "debt." Verify everything in writing — grief-week scams are an industry.

- Belongings quietly disappearing from the home before the estate is settled. Kind, clear, early conversations prevent permanent family damage.
- Anyone pressuring same-day decisions at the funeral home. You may take the price list home — by law, they must give it to you.

APPENDIX A

Fill-In Templates & Checklists

Print these pages. Write on them. Copy them freely. Every template also works as a phone note — but paper on the refrigerator saves lives, because paramedics and aides can see it. Free extra copies: goodstewardseniorcare.com

A1. All About Me — The One-Page Profile

Fill in for the senior (or yourself). Keep one copy on the refrigerator, one in the Digital Keyring (Chapter 7), and hand one to every new nurse, aide, or doctor. Update the date every time you change it.

Full name: _____ Goes by: _____

Date of birth: _____ Phone: _____

Address: _____

Lives: ☐ Alone ☐ With spouse/family ☐ Facility: _____

Emergency contact 1: _____ Phone: _____

Emergency contact 2: _____ Phone: _____

Main doctor (name & phone): _____

Pharmacy (name & phone): _____

Health plan(s): _____ Member ID #: _____

Hospital of choice: _____

Key conditions: _____

Past surgeries / hospital stays: _____

Implants & devices (pacemaker, hip, etc.): _____

Hearing / vision: ☐ Hearing aids ☐ Glasses ☐ Neither

Walking: ☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Needs hands-on help

ALLERGIES & BAD REACTIONS (make this LOUD):

_____

_____

What a good day looks like (one line — more on page **77**):

_____

How I show pain when I can't say it:

_____

What matters most to me:

_____

Faith / culture wishes, music, pets, people to call:

_____

My healthcare agent: _____ Phone:

_____

Backup agent: _____ Phone: _____

My papers live at (legal docs, POLST location):

_____

If I pass away — funeral home / plan to call first:

_____

My elder law attorney: _____ Phone:

_____

Filled in by: _____ Date updated: _____

A2. Universal Medication Master List

Every prescription, vitamin, supplement, cream, and over-the-counter pill — yes, ALL of them (Chapter 23). Update the same day anything changes. One copy on the fridge, one in the wallet/purse, one in the Digital Keyring. More than 13? Print a second page and staple it on.

ALLERGIES & BAD REACTIONS:

Our ONE pharmacy: _____ Phone: _____ Last updated: _____

Medication (brand / generic)	Strength / dose	When & how taken	What it's for	Prescribing doctor

A3. Doctor Visit Worksheet — Before, During & After

One page per visit. Ten minutes of prep changes what a 15-minute appointment can do (Chapters 20 & 25).

Doctor seeing: _____ Date: _____ Who's going along: _____

BEFORE — our top 3 concerns (pick three, no more)

1. _____
2. _____
3. _____

New symptoms since last visit (what / when it started / what helps / how bad, 0–10):

_____

_____

Anything changed at home the doctor can't see? (falls, appetite, sleep, mood, stairs):

_____

_____

Medication changes since last visit — bring the Master List!

_____

DURING — what the doctor said

_____

_____

New medicine(s) — name / why / side effects to watch:

_____

Test(s) ordered — and "When will results come, and who calls us?":

_____

_____

The three questions to end every visit

- [ ] What changed today?
- [ ] Who else needs to know? (Which specialist or family member do we tell?)
- [ ] What do we watch for — and what symptom means call the office vs. call 911?

The teach-back: "So I know I've got it right — let me say it back…"

_____

AFTER — locked in before we leave the parking lot

- [ ] Next appointment booked — date & time: _____
- [ ] New prescriptions sent to our one pharmacy — called to confirm
- [ ] Portal / message sent to the main doctor about today's changes (Chapter 25)
- [ ] Family group note updated (what changed / what we watch for)

Anything else the doctor said that we don't want to lose:

_____

_____

_____

A4. The Baseline Page — "What a Good Day Looks Like"

The most valuable page you can carry (Chapter 31). Write it on a calm day. In a crisis, hand it to every new nurse, doctor, or aide — it tells them what "normal" is for YOUR person, so they can spot "not normal" fast.

Name: _____ Date written: _____

Updated: _____

On a good day, my person can…

Walk / move: _____

Eat & drink: _____

Talk & understand:

_____

Wash, dress & toilet: _____

Remember & reason (examples — pays bills? tells stories?):

_____

The personal picture

Personality in three words: _____

How they show PAIN when they can't explain it (faces, rocking, guarding, anger):

_____

What calms them (music, hand-holding, certain show, prayer):

_____

What upsets them (noise, rushing, being cold, strangers):

_____

Habits the staff should know (early riser, naps at 2, hates baths):

_____

The sentence to say with this page

"This page is her normal. If she seems suddenly different from this, something medical is wrong — please look for the cause: infection, dehydration, medication, pain."

Anything else the nurse or aide should know:

A5. The ER Go-Bag Checklist

A tote bag in the closet, packed once, grabbed in seconds (Chapters 8 & 12). Check off what's inside, then hang the list on the bag.

The papers (in a big zip-top bag)

- ☐ Medication Master List (page **74**) — current, dated
- ☐ All About Me profile (page **72**)
- ☐ The Baseline Page (page **77**)
- ☐ Copies of insurance cards — front AND back
- ☐ Copies of legal papers: healthcare proxy, financial POA, POLST, HIPAA releases
- ☐ Master Contact Sheet (page **86**) — family & doctor numbers
- ☐ Notebook + two pens

The comfort kit

- ☐ Spare glasses + case ☐ Hearing aids + batteries + case
- ☐ Large-print clock ☐ Two family photos (re-orients a scared senior)
- ☐ Phone charger (long cord) ☐ Light sweater or throw (ERs are cold)
- ☐ Water bottle + non-messy snacks (visits run long)
- ☐ Lip balm, tissues, hand wipes
- ☐ One "busy" item: crosswords, knitting, tablet + headphones

For the caregiver (especially if you live far)

- ☐ Your own medications for 48 hours — caregiving doesn't pause because you're at a hospital
- ☐ Sweatshirt, phone battery pack, a protein bar, $20 in small bills (vending machines)
- ☐ The name and number of YOUR backup person — the one who takes over if you go down

Refresh twice a year: swap in the updated med list and baseline page when you change the clocks.

A6. Facility Tour Checklists — Rehab, Assisted Living & Memory Care

Print one per facility. Staffing and honesty beat chandeliers every time (Chapters 16 & 28). Facility: _____ Date: _____ Toured by: _____

Part 1: The 30-minute desk audit (before any visit)

- ☐ Care Compare (medicare.gov/care-compare): overall stars ____ staffing stars ____ weekend staffing ____ nurse turnover ____
- ☐ Inspection reports read — any serious (harm-level) deficiencies? Y / N
- ☐ Ombudsman called: "Patterns of complaints here?" Notes: _____
- ☐ Bed available AND our insurance accepted? Y / N Confirmed with: _____

Part 2: On the tour — eyes open (go unannounced at mealtime if you can)

- ☐ Hallway smell check: clean, or masked odors?
- ☐ Staff greet residents BY NAME? Watched: Y / N
- ☐ Call lights: counted ____ blinking over 5 minutes
- ☐ Asked a floor nurse: "How many residents per aide on nights?" Answer: _____
- ☐ Tour shows resident hallways — not just the gym and lobby? Y / N
- ☐ "How long has your director been here?" Answer: _____ (constant turnover = alarm)
- ☐ Talked to families in the parking lot. Said: _____

Part 3: Assisted living / memory care extras — the contract hunt

Facility: _____ Use alongside Part 2 — this page is where most families wish they had looked closer.

- ☐ Full fee schedule IN WRITING — every care level's price: received Y / N
- ☐ "What triggers a level change, and who decides?" Answer: _____
- ☐ Involuntary discharge rules reviewed — know exactly what forces a move-out: Y / N
- ☐ Community fee / deposit — refundable? on what timeline: _____
- ☐ Memory care: "What dementia training do floor staff get, and how many hours?" Answer: _____
- ☐ State inspection report pulled from the state licensing website: Y / N
- ☐ Contract taken HOME to read before any signature. (Always yes.)

Notes & gut feelings — write them the same day:

A7. Interview Questions — Hospice & Home Care Agencies

Interview at least two. The best agencies welcome these questions; the worst ones dodge them. Write answers in the margins.

Choosing a hospice (Chapter 30)

- [ ] Are you Medicare-certified? (Must be yes for the Medicare hospice benefit.)
- [ ] How fast does a nurse come when we call at 2 a.m.? Who answers — a nurse or an answering service?
- [ ] How many patients does each nurse carry? Weekend coverage — how does it actually work?
- [ ] What do you provide: nurses, aides, social worker, chaplain, medications, equipment, respite stays?
- [ ] What bereavement support do families get afterward — and for how long?
- [ ] If we're unhappy, how do we change providers? (We may — it's our right.)

Choosing home health / home care (Chapters 17 & 29)

- [ ] Are you Medicare-certified (for skilled home health)? What will our plan cover, and for how long?
- [ ] Who's coming: nurse, physical therapist, aide? How often, and who sets the schedule?
- [ ] How do you screen, train, and supervise your aides? Background checks?
- [ ] What happens when our aide is sick — same-day backup or a gap?
- [ ] Will we get the same caregiver each visit, or a rotation?
- [ ] Any costs to us? Get it in writing before services start.
- [ ] Who do we call after hours with a problem — name and number?

A8. Hospital Daily Log

Two minutes a day. This log wins arguments, catches handoff errors, and powers appeals (Chapters 9–15). Print 5 copies per hospital stay.

Date	Attending doctor today	Nurse today	Status: inpatient or observation?	What changed / what was promised

Today's one question for the team: _____

Who I told about the discharge appeal deadline (if any):

_____

A9. Discharge-Readiness Checklist

The golden rule: everything is in place BEFORE the front door — not "coming later this week" (Chapters 14 & 17). Any unchecked box = say the sentence: "I'm concerned this is an unsafe discharge — please document that."

- [ ] Written discharge plan received — and we actually understand it
- [ ] Status verified (inpatient days counted, if rehab is next — Chapter 10)
- [ ] I am listed in the chart as the designated family caregiver, and we've gotten discharge teaching on the tasks we'll do at home (CARE Act — Chapter 14)
- [ ] All equipment delivered TO THE HOME (bed, walker, oxygen, commode…)
- [ ] Home health agency named, first visit date confirmed — we have their number
- [ ] All prescriptions filled — old meds reconciled against the new list (Chapter 23)
- [ ] Which discharge meds can come OFF (anything started "for agitation," sleep, etc.)?
- [ ] Follow-up appointments booked — and rides arranged (they're not taxis; book vans ahead)
- [ ] Warning signs list: what symptom means "call the doctor" vs. "call 911"
- [ ] Family caregiver knows the plan and has all phone numbers
- [ ] The "Important Message from Medicare" is in the folder — QIO number saved in phones (Chapter 15)

A10. After a Death — The First Week Checklist

Chapter 34 has the full guidance. This page is for the week itself — keep it with the All About Me page.

First hours

- ☐ On hospice? Call the hospice nurse first — not 911. Number: _____
- ☐ No hospice, unexpected at home? Call 911.
- ☐ Called the funeral home: _____ (There is no clock. Breathe.)
- ☐ Immediate family & the faith leader notified

First days

- ☐ Ordered about 10 certified death certificates (through the funeral home)
- ☐ Confirmed the funeral home reported the death to Social Security
- ☐ Located: will/trust, insurance policies, bank info, the All About Me page
- ☐ Home & valuables secured — kindly, clearly
- ☐ Did NOT rush: no big money moves, no distributing belongings, no paying surprise "debts" by phone

First month — the notification round

- ☐ Banks / mortgage ☐ Pension or employer ☐ Life insurance
- ☐ Medicare plan / supplement / Part D ☐ Credit cards
- ☐ Three credit bureaus ("deceased alert" against identity theft)
- ☐ SSA lump-sum death benefit (surviving spouse) & VA burial benefits asked about
- ☐ Elder law / estate attorney contacted if needed: _____
- ☐ Grief support lined up (hospice bereavement, faith community, senior center)

A11. Master Contact Sheet

One sheet, everyone in the family has it, it lives in the Go-Bag and the Keyring. Update it the day anything changes.

Who	Name	Phone
Primary care doctor (quarterback)		
Specialist: (heart / kidney / etc.)		
Specialist:		
Pharmacy (one pharmacy only)		
Insurance plan (member services)		
Hospital & patient relations		
BFCC-QIO (discharge appeals)		
Home health / home care agency		
Healthcare agent & backup		
Siblings (medical / money / updates)		
Neighbor — local "eyes and ears"		
Elder law attorney		
Funeral home (Chapter 34)		
SHIP (free Medicare help) — shiphelp.org	1-877-839-2675	
Eldercare Locator (free local help)	1-800-677-1116	
Good Steward Senior Care — goodstewardseniorcare.com		**662-622-1831**

APPENDIX B

The Master Script Library

Every script from this guide, in one place, for the moment you need words fast:

1. **Verbal HIPAA consent** (bedside & phone) — Chapter 1
2. **Opening the legal-planning talk** with a resistant parent — Chapter 6
3. **The 30-second ER handoff** — Chapter 8
4. **Requesting a family care conference** — Chapter 9
5. **The daily inpatient/observation status check** — Chapter 10
6. **Challenging an unsafe discharge** — Chapter 14
7. **Filing the BFCC-QIO fast appeal** — Chapter 15
8. **Chasing a stuck prior authorization** — Chapter 19
9. **Requesting a deprescribing / Beers review** — Chapter 24
10. **Opening the palliative/hospice conversation** — Chapter 30
11. **Opening the Wishes Talk** — Chapter 5

And the five all-purpose power sentences worth memorizing:

1. "Please document my concern in the chart."
2. "Is my parent inpatient or under observation today?"
3. "I am not comfortable with this plan. What are our other options?"
4. "What would need to be true for insurance to approve this — and can we document exactly that?"

5. "This is a sudden change from her baseline. What medical cause are we ruling out?"

APPENDIX C

Plain-English Glossary

The word they use	What it actually means
ADLs / IADLs	Basic daily tasks (bathing, dressing, eating) / life-running tasks (cooking, bills, driving). The counts that decide care levels.
Advance directive	Umbrella term for documents stating your medical wishes — living will, healthcare proxy.
Attending physician	The doctor officially in charge of hospital care today.
Beers Criteria	The expert list of medications often unsafe for seniors (American Geriatrics Society).
BFCC-QIO	The independent Medicare review group that handles fast discharge appeals — free.
CARE Act	State law in most states: hospitals must record your family caregiver, notify them before discharge, and teach them the at-home care tasks.
Case manager / discharge planner	The hospital staffer who arranges what happens after the hospital. Befriend early.
Custodial care	Help with daily living (not medical treatment). The care Medicare does NOT pay for long-term.
Delirium	Sudden, severe confusion with a medical cause. Not dementia. Often preventable and reversible.
DME	Durable Medical Equipment — walkers, hospital beds, oxygen.

The word they use	What it actually means
EOB	Explanation of Benefits — the "this is not a bill" paper that explains what insurance did. Always compare it to the bill.
Hospitalist	A doctor who works only in the hospital and manages inpatient care in shifts.
Medicaid look-back	The five-year review of gifts/transfers before Medicaid long-term care eligibility.
Medical necessity	The documented justification insurers require before paying.
MOON	Medicare Outpatient Observation Notice — the paper telling you your parent is NOT admitted as inpatient.
Observation status	In a hospital bed but classified as outpatient — the status that can sink rehab coverage.
Ombudsman	Free, independent advocate for residents of nursing homes and assisted living.
Personal care agreement	A simple written contract when family gets paid to care for a parent — protects everyone, and Medicaid, later.
POLST / MOLST	A doctor-signed medical order for emergency treatment wishes that EMS can follow.
Prior authorization	Insurance permission required BEFORE a service, or the plan may not pay.
Representative Payee	The person Social Security appoints to manage someone's benefits — a POA is not enough.
Respite care	Short-term substitute care that gives the family caregiver a break.
SNF	Skilled Nursing Facility — where short-term rehab and long-term nursing care happen.

The word they use	What it actually means
4Ms	Age-friendly care framework: What Matters, Medication, Mentation (mind), Mobility.

APPENDIX D

The Red Flag Index — "This Is Happening. Where Do I Look?"

What's happening right now	Go to
"The hospital won't tell me anything — HIPAA."	Chapter 1
"Mom won't sign any legal papers."	Chapter 6
"We've signed papers — but I've never asked what Dad actually wants."	Chapter 5
"Dad's in the ER right now."	Crisis Day 1 Checklist + Chapter 8
"She's been in a hospital bed 3 days but they say she's not 'admitted.'"	Chapter 10
"Dad suddenly got confused in the hospital."	Chapters 12 & 31
"The hospital never wrote me down as the caregiver."	Chapter 14 (CARE Act box)
"They're discharging her tomorrow and it's not safe."	Chapters 14 & 15 — **act before midnight**
"We have to pick a rehab facility by tomorrow."	Chapter 16 + checklist A6
"Insurance denied the scan / rehab / equipment."	Chapters 19–21
"This bill can't be right."	Chapter 21

What's happening right now	Go to
"How will we ever afford a nursing home?"	Chapter 22
"Can I get paid for all the care I'm giving?"	Chapter 22 (gold box)
"She takes 14 medications and falls a lot."	Chapters 23–24
"Is it time for assisted living?"	Chapters 26–28
"Grandma got 10x more confused overnight."	Chapter 31 — look for the UTI
"My siblings and I can't agree on anything."	Chapter 32
"I'm the caregiver and I'm drowning."	Chapter 32 — today, not someday
"Should we be thinking about hospice?"	Chapter 30
"He just passed away. What do we do first?"	Chapter 34 + checklist A10

APPENDIX E

How Good Steward Senior Care Can Help

You have just read a book's worth of systems, scripts, and strategies. Here is the honest truth: knowing the playbook and running it alone at 2 a.m. are two different things. That is what we do.

Good Steward Senior Care is an independent senior care navigation and care coordination service — flat-fee, non-medical, and loyal only to your family. **We never take commissions or kickbacks from any facility.**

Package	Best for	What you get	Flat fee
1. The 72-Hour Senior Safety Roadmap	A sudden crisis — you need a plan NOW.	A 90-minute planning call, then a written plan within 72 hours: a step-by-step action checklist, key questions for doctors and providers, and a beginner's guide to public benefits your family may qualify for. Fully virtual — available nationwide.	**$597**
2. Senior Living Transition Plan	Choosing the right community — with facts, not sales pitches.	Everything in Package 1, PLUS deep research on 8–15 communities using official state inspection data: side-by-side comparison charts, red-flag summaries, verified pricing and openings, custom tour questions, and a family strategy meeting to get everyone on the same page. Fully virtual — available nationwide.	**$997**
3. Full Transition Support Plan	Wanting us hands-on, by your side.	Everything in Packages 1 & 2, PLUS in-person home safety triage (with coordinated CAPS assessment by a certified partner) and an in-person facility tour with a trained observer at your side. In-person services in DeSoto County, MS — Hernando, Olive Branch, Southaven, Horn Lake, Walls. Virtual support nationwide.	**$1,497**

Our promise: flat fees always — you know your exact cost upfront. Zero kickbacks — we never take commissions from facilities. Honest, plain-language guidance from someone in your corner during the most stressful season of family life.

Good Steward Senior Solutions, LLC DBA Good Steward Senior Care, Olive Branch, MS. Non-medical consultation, research, education, and care coordination services only. We do not provide medical advice, clinical diagnoses, or legal determinations, and our services do not replace the advice of qualified medical, financial, or legal professionals.

Ready for Help? It's Simple.

Start with a free, no-pressure conversation. Your consultation is scheduled within 24–48 hours of sign-up. Flat fees. Zero kickbacks. Someone in your corner.

Call today: 662-622-1831

goodstewardseniorcare.com/free-consultation

Serving DeSoto County, MS in person • Virtual support nationwide

Sources & Further Reading

This guide was built on publicly available, official guidance from: **Centers for Medicare & Medicaid Services (CMS)** — medicare.gov; **Administration for Community Living (ACL)** — acl.gov; **Social Security Administration (SSA)** — ssa.gov; **Consumer Financial Protection Bureau (CFPB)** — consumerfinance.gov; **National Academy of Elder Law Attorneys (NAELA)** — naela.org; **National Hospice and Palliative Care Organization (NHPCO)** — nhpco.org; **Medicare Rights Center** — medicarerights.org; **The National Consumer Voice for Quality Long-Term Care** — theconsumervoice.org; **American Geriatrics Society (AGS)** — americangeriatrics.org; **Aging Life Care Association** — aginglifecare.org; **Institute for Healthcare Improvement (IHI)** — ihi.org; **State Health Insurance Assistance Programs (SHIP)** — shiphelp.org; **National POLST** — polst.org; **Eldercare Locator** — eldercare.acl.gov, 1-800-677-1116. Phone numbers verified August 2026.

A Plain Promise: We Are Not Doctors — and This Is Not Medical Advice

Good Steward Senior Care is not a doctor, nurse, pharmacist, lawyer, or financial advisor. Nothing in this guide is medical advice, legal advice, or financial advice. We do not diagnose. We do not treat. We do not prescribe. We do not make decisions for your family.

What this guide IS: a plain-language resource to help you understand how the systems work, know which questions to ask, and see your options clearly — so you can make clear, informed decisions. **At the end of the day, every choice — about care, medication, housing, money, and legal documents — is up to you**, made with your parent and the licensed professionals who know your situation. When a decision carries real weight, bring it to the doctor, the elder law attorney, the SHIP counselor, or the pharmacist. This guide helps you walk into those conversations prepared and calm.

Disclaimer: This guide provides general education only. Laws and program rules change and vary by state — always verify current rules with the official agency, and consult licensed professionals for decisions about your family's specific situation. Good Steward Senior Solutions, LLC DBA Good Steward Senior Care, Olive Branch, MS — non-medical consultation, research, education, and care coordination only.

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