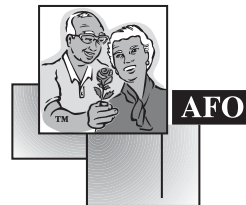


## ***Tips For Early Set Up Of Your Emergency Placement Directives***

- Plan with family, neighbors, friends, or case management services to decide who will take responsibility of the memory impaired patient in a crisis situation.
- Maintain a notebook for the responsible party who will be continuing the caregiving of your loved one. This notebook should contain emergency phone numbers, current problem behaviors and possible solutions, ways to calm the person suffering with memory impairment, assistance the patient needs such as toileting, feeding, or grooming, the patient's favorite activities or favorite food.
- Preview assisted living facilities to see if they meet the needs of your loved one.
- Consult an attorney regarding estate planning, power of attorney, and who will take the role of healthcare surrogate.
- Contact our office for a resource list of helpful contact information.

## ***Organization Services***

Respite Care Assistance Program  
Wanderer's Identification Program  
Support Groups  
Help-Line  
Legal Help (H.E.L.P.)  
Training  
Speakers Bureau  
Research  
Resource Lists  
Emergency Placement Directives  
Pardon My Companion Card  
Do Not Resuscitate Order (DNRO) Forms



## **Alzheimer's Family Organization**

*People Helping Families*

Mail To: P.O. Box 1939  
New Port Richey, FL 34656-1939  
Telephone: 727-848-8888 • 1-888-496-8004  
Fax: 727-849-7707  
Web: [www.alzheimersfamily.org](http://www.alzheimersfamily.org)  
E-Mail: [info@alzheimersfamily.org](mailto:info@alzheimersfamily.org)  
Blog: [www.afoblog.org](http://www.afoblog.org)



## **Alzheimer's Family Organization**

*People Helping Families*

## **Emergency Placement Program**

### *Serving Central Florida*

Office Location:  
7626 Congress St., New Port Richey, FL 34653

Mailing Address:  
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Telephone: 727-848-8888 • 1-888-496-8004  
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Blog: [www.afoblog.org](http://www.afoblog.org)



Alzheimer's Foundation of America



A United Way Agency

***People Helping Families***

# ***Emergency Placement Directives Program***

## **Who would take care of the person suffering from memory impairment if something happened to you, the caregiver?**

It is important to have a plan in case of your own illness, disability, or death. The Alzheimer's Family Organization has a service called the Emergency Placement Directives Program that allows the caregiver the opportunity to ensure that in the event of a calamity, the memory impaired patient will be cared for.

Pre-arrangements must be made with either an Adult Living Facility or a Nursing Facility. An alternate facility is also requested. If neither the primary nor alternate facility can accommodate the loved one, the organization will contact the Department of Children and Family Services for assistance with emergency placement. It is also important to list a transportation service and their phone number as well.

The Alzheimer's Family Organization relies solely on grants, United Way allocations, and donations to keep our services and programs available for the community, but we still need your help!

***Please donate generously.***

# ***Emergency Placement Questionnaire***

Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Doctor's Name (1st choice): \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor's Name (2nd choice): \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Facility (1st choice): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name of Facility (2nd choice): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## **Transportation Arrangements:**

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Name: \_\_\_\_\_ Contract Number: \_\_\_\_\_

Medicare Contract Number: \_\_\_\_\_ Medicaid Contract Number: \_\_\_\_\_

Pre-Need Funeral Plan with: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_