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Navigating Your Parent's Next Transition

A planning workbook for adult children and family caregivers

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Companion to the printable checklist *Your Parent's Next Transition: Family Checklist*

This workbook belongs to: _____

Started on: _____ **Parent's first name:** _____

Welcome

This workbook is for adult children and other family members who are helping a parent through a change in where they live or how much care they need. The change may be planned or sudden. Older adults are welcome to use it too. Read "your parent" as "you."

What is a transition?

A **transition** is a change in your parent's living situation or level of care. Examples include leaving the hospital, going to short-term rehab, adding help at home, moving to assisted living or memory care, and moving in with a family member.

Transitions are stressful. Decisions often come fast, and families work with doctors, insurance plans, and each other all at once. This workbook gives you a place to slow down, gather information, and make a plan.

How to use this workbook

1. Start with **Part 1** to see where things stand now.
2. Work through the parts in order, or jump to the one you need today. You do not have to fill in every page.
3. Use a pencil. Plans change, and rough answers are fine.
4. Share pages that help others, such as the contact sheet and "Getting to Know Me."
5. Come back and update it as your parent's needs change.
6. Keep it private. It may hold personal and health details, so store it safely. Do not write bank account numbers, passwords, or Social Security numbers in it.

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PART 1

Where You Are Now

Before you compare options or make calls, take a snapshot of what is happening. These worksheets help you name the change, see what help your parent needs, and sort out your worries.

Worksheet 1.1: Snapshot of the situation

Parent's name: _____ **Today's date:** _____

What is changing? (For example, leaving the hospital or moving to assisted living.)

_____

_____

What happened that led to this change?

_____

_____

Key dates I know about (discharge date, move-in date, lease or notice deadlines):

_____

_____

Where does my parent live now, and who else lives there?

_____

_____

Who is already helping, and how?

_____

_____

Who is the main family contact for the care team right now?

_____

_____

_____

Worksheet 1.2: What help does my parent need?

Doctors and therapists use **activities of daily living** (ADLs) for basic self-care tasks, such as bathing, dressing, eating, using the toilet, and moving around. Tasks that let a person live independently, such as cooking, shopping, and managing money, are sometimes called **instrumental** activities of daily living (IADLs).

Check the box that fits best right now. This is your observation, not a medical assessment. Share it with the doctor or care team, who can evaluate your parent's needs.

Task	No help	Some help	Lots of help	Not sure	Notes
Bathing or showering	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Using the toilet	☐	☐	☐	☐	
Getting in and out of bed or a chair	☐	☐	☐	☐	
Walking and balance	☐	☐	☐	☐	
Taking medicines correctly	☐	☐	☐	☐	
Preparing meals	☐	☐	☐	☐	
Housework and laundry	☐	☐	☐	☐	
Shopping and errands	☐	☐	☐	☐	
Driving or getting rides	☐	☐	☐	☐	
Managing money and bills	☐	☐	☐	☐	
Using the phone	☐	☐	☐	☐	
Remembering appointments and dates	☐	☐	☐	☐	
Being safe when alone, including overnight	☐	☐	☐	☐	

Worksheet 1.3: Concerns and priorities

It is normal to feel worried, rushed, or unsure. Writing your concerns down can make them easier to sort.

My three biggest worries right now:

_____

_____

What I think matters most to my parent (I will check this with them in Part 3):

_____

_____

What I most need to find out in the next few days:

_____

_____

Readiness check

Check one box for each statement. Every "Not yet" or "Not sure" is a good place to start your action plan.

Statement	Yes	Not yet	Not sure
I understand why this change is happening.	☐	☐	☐
I have talked with my parent about what they want.	☐	☐	☐
Our family has one main contact for the care team.	☐	☐	☐
I know what care my parent is likely to need.	☐	☐	☐
I know what insurance is likely to cover.	☐	☐	☐
I know how we will pay for the first three months.	☐	☐	☐
I can find my parent's legal papers, such as a health care power of attorney.	☐	☐	☐
We have a plan for the first week.	☐	☐	☐
I have someone I can lean on for support.	☐	☐	☐

PART 2

Understanding the Change

Different transitions bring different questions. This table explains the most common ones in plain language, so you know what to ask.

Common transitions and what families often overlook

Transition	What it usually means	Questions families often overlook
Hospital to home	Your parent goes home after a hospital stay. Care may include home health visits, equipment, and help from family.	Who is there the first days and nights? Is the home set up for safe walking? Who handles medicines and appointments?
Hospital to short-term rehab	A stay in a skilled nursing facility for nursing care and therapy while recovering. It is meant to be short-term.	Did the hospital stay count as inpatient care? How long will the plan pay? What is the plan for going home afterward?
Staying home with more help	Your parent stays home with added support, such as home health care, paid helpers, meal help, or an adult day program.	Who pays for each service? What happens at night or on weekends? What will we do if needs grow?
Home to assisted living	A home-like setting with meals and help with daily tasks, such as bathing, dressing, and medicines. Rules and services vary by state and by community.	What does the base price include? When would my parent need a higher level of care? What happens if money runs low?
Assisted living to memory care or a nursing home	A move to a setting with more nursing care, or care designed for people with memory loss.	Who decides that it is time? How will my parent be prepared? How does the cost compare with now?
Moving in with an adult child	Your parent moves into a family member's home. Space, routines, and roles change for everyone.	Is the home safe and accessible? What are each person's limits? Who covers care when the main caregiver is away or tired?

Words to know

You may hear these terms from doctors, social workers, and facility staff. It is always okay to ask someone to explain a term in plain language.

Term	What it means
Care plan	A written plan that lists a person's needs, goals, and the help they will receive.
Care conference	A meeting where staff, the resident, and family review the care plan.
Discharge planner or case manager	Hospital staff who help arrange care after a hospital stay.
Inpatient	Formally admitted to the hospital.
Observation status	Hospital care as an outpatient. A patient may stay overnight in a hospital bed and still be in observation.
Skilled nursing facility (SNF)	A Medicare-certified facility that gives nursing care and therapy, often after a hospital stay.
Home health care	Part-time skilled care at home, such as nursing visits and therapy, ordered by a doctor.
Assisted living	Housing with meals and help with daily tasks. Rules vary by state.
Memory care	A program or unit designed for people with dementia or other memory loss.
Geriatric care manager	A professional, often a nurse or social worker, who helps families assess needs and arrange care.
Long-Term Care Ombudsman	An advocate who helps residents of nursing homes and assisted living resolve problems.
Health care power of attorney	A legal document that names a person (an agent) to make medical decisions if your parent cannot. Also called a health care proxy.
Living will	A document that states which treatments your parent does or does not want.
Medigap	Private insurance that helps pay some costs that Original Medicare does not.
Quality Improvement Organization (QIO)	An outside reviewer hired by Medicare that can review a hospital discharge decision.

Medicare basics for hospital and rehab transitions

This section describes **Original Medicare**. Medicare Advantage plans have their own processes, so call your parent's plan to ask how it works. Costs and rules change, so check Medicare.gov or call 1-800-MEDICARE before you decide.

Inpatient or observation?

A hospital patient is either **admitted as an inpatient** or placed in **observation**, which counts as outpatient care. Observation care can look almost the same as inpatient care. Families often do not know which status their parent has, so ask.

The three-day rule

Original Medicare covers a skilled nursing facility stay only after a medically necessary inpatient hospital stay of at least three days in a row. The day of admission counts. The day of discharge does not. Time in observation or in the emergency room does not count, even if your parent stays overnight.

A doctor must also decide that your parent needs daily skilled nursing or therapy, and your parent generally must enter the facility within 30 days of leaving the hospital. Coverage is short-term, up to 100 days in a benefit period, and daily costs may apply after the first 20 days. Some Medicare Advantage plans, and some Accountable Care Organizations, can waive the three-day requirement. Ask your parent's plan or care team.

Home health care

Medicare may cover part-time skilled nursing, therapy, and some aide care at home. Your parent must need skilled care, be considered homebound, and have a doctor who ordered the care after seeing them in person. A Medicare-certified home health agency must provide it. Medicare does not cover 24-hour care at home, meal delivery, or homemaker services. It does not cover personal care, such as bathing and dressing, when that is the only care your parent needs.

If you think discharge is too soon

A hospital inpatient with Original Medicare should receive a notice called the **Important Message from Medicare**. It names the Quality Improvement Organization (QIO). You can ask the QIO to review the discharge decision. Contact the QIO no later than the planned discharge date and before your parent leaves the hospital. You can file any day of the week. The QIO decides within one day after it has the information it needs. Raising your concerns with the hospital team first is also a good step.

Worksheet 2.1: Hospital stay tracker

Use this page if your parent is in the hospital. Skip it if they are not.

Hospital and unit: _____

Date and time admitted: _____ **Planned discharge:** _____

Status right now:

- ☐ Inpatient (formally admitted)
- ☐ Observation (outpatient)
- ☐ I do not know yet. I will ask the nurse or case manager today.

Date status last changed: _____

Count the nights. Ask the hospital how each night is classified, and write it here as you learn it.

Night	Date	Status that night (inpatient, observation, or emergency room)
Night 1		
Night 2		
Night 3		
Night 4		

Notices and contacts:

- ☐ I received the Important Message from Medicare.
- ☐ I received a Medicare Outpatient Observation Notice (MOON).
- ☐ I called the plan to ask whether it waives the three-day rule.

QIO name and phone (from the notice): _____

Insurance plan name and phone: _____

Discharge planner name and phone: _____

Worksheet 2.2: Questions for the discharge planner or care team

Ask these early, not on the day of discharge. Write down the answers and the name of the person who gave them. If an answer is unclear, ask them to explain it another way.

Question	Answer and who gave it
What is my parent's status right now, inpatient or observation? When did it start?	
What is the planned discharge date? Who decides, and when will we know for sure?	
What care will my parent need after discharge, such as nursing, therapy, or help with daily tasks?	
Where is the safest place for that care: home, short-term rehab, or another setting? Why?	
If home: what help and equipment are needed, and can my parent manage with the help we have?	
Will Medicare or my parent's plan cover this care? Does anything need approval first?	
Which agencies or facilities are available? Can we get a list, and how fast could care start?	
Which medicines changed? Which new prescriptions must be filled?	
What follow-up appointments and tests are needed, and who will schedule them?	
What warning signs mean we should call, and who do we call, day or night?	
If we disagree with the discharge plan, what can we do?	

Hospital staff work with patients and families to prepare a safe discharge and arrange needed services. Ask to be part of the plan.

PART 3

Talking With Your Parent

Your parent is the expert on their own life. Even when time is short, how you start the conversation can shape how it goes. These tools help you listen first and plan second.

Before you talk

- Pick a calm time and a quiet place. If you can, avoid raising big topics in the middle of a crisis.
- Start with care and concern, not a decision you have already made.
- Ask open questions, such as "What worries you most?" Then listen without correcting.
- Expect strong feelings. Fear of losing independence and control is common.
- Take one topic at a time. You may need several short talks, not one long one.
- If your parent has memory loss, keep your words simple, calm, and short. Ask the doctor for advice on how to talk about changes.

Sample ways to start (examples, not scripts)

- "I have been thinking about how the last few weeks have gone. How are you feeling about what comes next?"
- "I am not trying to take over. I would like us to figure this out together."

Instead of this, try this

Instead of	Try
"You can't live alone anymore."	"I am worried about the falls. What ideas do you have to stay safe?"
"We already decided."	"Here are the options we found. What do you think of each one?"
"Don't worry about it."	"It makes sense that you are worried. Tell me more."
"You will love it there."	"Would you like to visit with me first and see what you think?"
"We have no choice."	"Here is what the doctor says is needed. Let's look at ways to meet it."

When your parent says no

A firm no often protects something important, such as independence, home, a pet, or money. Try these steps:

1. Ask what the no is about. "What is the hardest part of this for you?"
2. Ask what would make the plan work for them. This turns a debate into problem-solving.
3. Look for smaller first steps, such as help at home, a day program, or a short trial stay.
4. Invite someone your parent trusts, such as their doctor or a friend, to join.

Adults who can make their own decisions have the right to make choices their family does not agree with. If you worry that memory or thinking problems affect your parent's decisions, ask the doctor about an evaluation. For legal questions, see an elder law attorney.

Worksheet 3.1: What my parent says matters most

Ask these questions in your own words. Write what your parent says, not what you expect.

What would make this change feel okay to you?

_____

_____

What are you most worried about?

_____

_____

What are you willing to try?

_____

_____

What is not negotiable? Who do you want involved in decisions?

_____

_____

Worksheet 3.2: Getting to Know Me

Fill this out with your parent. Give a copy to the care team, home health agency, or facility staff. Knowing a person's routines and preferences helps staff give better care and helps your parent feel known.

About my parent	Notes
Name they like to be called	
Wake-up and bedtime routines	
Favorite foods and drinks. Foods they dislike or cannot eat	
Allergies or sensitivities (staff will also ask the doctor)	
What a good morning looks like	
What they enjoy: music, hobbies, shows, games, outdoors	
Important people and pets	
Faith, cultural, or family traditions that matter	
Things that upset or worry them	
What helps when they are upset	
Glasses, hearing aids, dentures, or walking aids	
Anything else staff should know	

PART 4

Building Your Family Team

No one should carry a transition alone. A clear team, with clear roles, protects your parent and protects you. A team can include siblings, a spouse, grandchildren, friends, neighbors, and members of a faith community.

Worksheet 4.1: Who is on the team?

Name	Relationship	Lives (distance)	Time and skills they can offer	Role

Family meeting guide

Hold one call or meeting before major decisions. Use this order:

1. **Facts first.** Share the same information from the doctor, discharge papers, and costs with everyone.
2. **Your parent's wishes.** Read aloud what your parent said in Worksheet 3.1.
3. **Options and costs.** Look at what is possible and what each choice would cost.
4. **What each person can do.** Time, money, travel, and limits. All contributions count.
5. **Decisions and tasks.** Write down who will do what, and by when.
6. **Next check-in.** Set the date for the next call.

Ground rules: one speaker at a time, focus on your parent's needs, no blaming about the past, and write down every decision.

Worksheet 4.2: Who does what?

Start with these common tasks. Add your own. Name a backup for every important task.

Task	Who	Backup	Due	Done
Main contact for the care team and facility				☐
Insurance and billing calls				☐
Paperwork, copies, and records				☐
Rides to appointments				☐
Medicines and pharmacy				☐
Visits and phone calls schedule				☐
Home setup or safety changes				☐
Packing and move day				☐
Old home: mail, bills, keys, and upkeep				☐
Giving the main caregiver a break				☐
				☐
				☐

How and when will we share updates? (For example, a group text each evening or a Sunday call.)

_____

_____

My own limits. What I can do, and what I cannot:

_____

_____

PART 5

Comparing Your Options

When you compare care options, look at more than price and appearance. Look at how care is given, how staff treat people, and what happens if needs change. If you can, visit more than once.

Tour checklist

Copy this page if you visit more than one place.

Before you go

- [ ] Write down your parent's top priorities from Worksheet 3.1 and bring them.
- [ ] Bring your questions from Worksheet 5.1.
- [ ] If your parent can come, bring them. Ask what they notice.

During the visit

- [ ] Note how staff speak to residents and to each other.
- [ ] Note how quickly staff respond when someone calls for help.
- [ ] Look at cleanliness, noise, odors, and lighting.
- [ ] Watch whether residents look comfortable, engaged, and well cared for.
- [ ] Try the food, or ask to see a menu.
- [ ] Ask to see a resident room and the common areas.
- [ ] Ask how the place handles emergencies and evacuations, and how families are notified.

Visit again

- [ ] Visit a second time, in the evening or on a weekend, when fewer staff may be working.
- [ ] Ask to speak with residents or family members, if they are willing.
- [ ] Ask for a copy of the contract or residency agreement to read at home.

After the visit

- [ ] Write your notes right away, while you remember them.
- [ ] Check inspection and quality information (see Part 10).
- [ ] Talk with your parent about what they liked and did not like.

Worksheet 5.1: Questions to ask and what you learn

Pick the questions that fit the type of place. Write the answer and who gave it.

Ask about	Answer
Staffing on each shift, including nights and weekends. Is there enough staff for the care residents need?	
Are the same staff assigned to the same residents most days? Does the place use temporary agency staff?	
How are families included in care planning? When are care conferences held?	
How is a complaint handled? Who do we contact?	
Is there a resident or family council? Can we get contact information for its leaders?	
What help does the place give with bathing, dressing, and medicines?	
What happens if my parent's needs increase? Does my parent have to move?	
What does the base price include? What costs extra?	
How and when can prices go up? What are the deposit and refund rules?	
Does the place accept Medicaid if my parent's money runs low? What happens then?	
How do you prevent the use of restraints? Why would they be used?	
What are the emergency and fire plans? How is staffing at night?	

Worksheet 5.2: Compare your options (page 1 of 2)

Write the name of each place or agency at the top. Fill in one column per option.

	Option A	Option B	Option C
Name of place or agency			
Type of care			
Address and distance from family			
Contact person and phone			
Date visited			
Base monthly cost			
What the base cost includes			
Extra fees			
Deposit and refund rules			
Accepts Medicaid if funds run low?			
Earliest move-in or start date			

Worksheet 5.2: Compare your options (page 2 of 2)

	Option A	Option B	Option C
Help with bathing, dressing, and medicines			
Staffing at night and on weekends			
Same staff most days?			
What happens if needs increase			
Meals and activities			
Cleanliness and atmosphere			
How staff treated my parent			
Inspection information checked (date and source)			
Ombudsman contacted? What did I learn?			
My overall impression	☐ Good ☐ Mixed ☐ Concerns	☐ Good ☐ Mixed ☐ Concerns	☐ Good ☐ Mixed ☐ Concerns

Inspection results and ratings are one piece of the picture. Check them, then confirm what you learn with your own visits and conversations.

Worksheet 5.3: Can we afford it?

Work with your parent, and ask a financial or elder law professional for advice before you make big money decisions. This worksheet only helps you see the numbers in one place.

Monthly income	**Amount**
Social Security	
Pension or retirement income	
Other income	
Total monthly income (A)	

Monthly care costs for the option you are weighing	**Amount**
Base rate or housing cost	
Extra fees (level of care, meals, laundry)	
Home health, aides, or other paid help	
Medicines and medical costs	
Insurance premiums	
Rides and other costs	
Total monthly costs (B)	

Monthly gap: B minus A = _____

Savings and other funds available for care: _____

Months the funds can cover the gap: funds divided by gap = _____

Other ways to help pay that we want to explore (for example, insurance, veterans benefits, Medicaid, or family help). Ask SHIP, the Eldercare Locator, or an elder law attorney for guidance:

PART 6

Paperwork and Records

When a transition is sudden, missing paperwork causes delays and stress. Gather these documents now. Know where they are, and who has copies.

A **health care power of attorney** (health care proxy) names who makes medical decisions if your parent cannot. A **living will** states which treatments they want or do not want. A **financial power of attorney** lets a named person manage money and property. Rules vary by state, so ask an elder law attorney about the forms and laws where your parent lives.

Worksheet 6.1: Document locator

Have it?	Document	Where the original is kept	Who has a copy
☐	Health care power of attorney (proxy)		
☐	Living will		
☐	Financial power of attorney		
☐	Will		
☐	Insurance cards (Medicare, Medigap or Medicare Advantage, drug plan)		
☐	Medicaid information (if any)		
☐	Long-term care insurance policy (if any)		
☐	Photo ID		
☐	Military discharge papers (if any)		
☐	Deed, lease, or rental agreement		
☐	List of accounts (where it is kept, not the numbers)		

Worksheet 6.2: Key contacts

Keep this page where the whole team can find it. Make copies for the care team.

Role	Name	Phone	Notes
Family point person			
Backup point person			
Health care agent (power of attorney)			
Primary care doctor			
Specialist			
Pharmacy			
Hospital discharge planner or case manager			
Social worker			
Home health agency			
Facility main contact			
Facility nurse or care manager			
Insurance plan and member services			
SHIP counselor			
Long-Term Care Ombudsman			
Elder law attorney			
Neighbor or friend with a key			

Worksheet 6.3: Medicines and appointments

Include prescriptions, over-the-counter products, vitamins, and supplements. After a hospital stay, ask the pharmacist or doctor to compare this list with any changes. Bring a copy to every appointment.

Allergies: _____

Pharmacy name and phone: _____

Medicine and dose	What it is for	When taken	Prescribed by	New or changed?
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Follow-up appointments

Date and time	Doctor and reason	Ride arranged?
		☐
		☐
		☐
		☐

PART 7

Preparing for the Move or the Return Home

Good preparation makes the first days easier. Use Worksheets 7.1 and 7.2 if your parent is moving to a new place. Use Worksheet 7.3 if your parent is returning home. Use Worksheet 7.4 for either.

Worksheet 7.1: Belongings and address changes

Let your parent make as many choices as possible about what comes along. Start with what is needed every day, then add what brings comfort.

Category	What to pack
Every day	☐ Glasses, hearing aids and batteries, dentures ☐ Walker, cane, or other aids ☐ Phone and charger
Clothes	☐ A week of easy-to-wear clothes, labeled ☐ Sturdy, non-slip shoes or slippers
Comfort	☐ Photos and a favorite blanket ☐ A familiar chair, clock, or radio ☐ Books, puzzles, or hobbies
Papers	☐ Copies of ID, insurance cards, and legal documents (keep originals safe) ☐ Current medicine list

Take photos of valuables, and keep valuables at home or in a safe place. Write down what you bring so nothing is lost.

Who needs the new address?

- ☐ Social Security
- ☐ Medicare
- ☐ Insurance plans
- ☐ Pharmacy
- ☐ Banks
- ☐ Doctors
- ☐ Post office (mail forwarding)
- ☐ Utilities and subscriptions
- ☐ Friends and family
- ☐ Other: _____

Worksheet 7.2: Move timeline

Adjust the timing to your situation. Some moves happen in days, not weeks.

When	Tasks
As soon as you know the date	☐ Confirm the move-in date and what the place provides. ☐ Measure the room and decide what to bring. ☐ Arrange movers or helpers. ☐ Tell doctors and the pharmacy about the move. ☐ Send medical records and legal documents.
One week before	☐ Label belongings with your parent's name. ☐ Fill prescriptions. ☐ Confirm transportation and parking. ☐ Copy "Getting to Know Me" for the staff.
The day before	☐ Pack a first-night bag with medicines, glasses, hearing aids, chargers, and comfortable clothes. ☐ Confirm the arrival time with staff. ☐ Plan a quiet evening and good rest.
Moving day	☐ Allow extra time and breaks. ☐ Set up the bed, photos, and favorite chair first. ☐ Introduce your parent to staff. Review the medicine list with the nurse. ☐ Agree on when you will call or visit next.
First week	☐ Visit or call as agreed. ☐ Look for missing items and fix small problems quickly. ☐ Ask staff how your parent is eating, sleeping, and joining in. ☐ Ask for the date of the first care conference.

Worksheet 7.3: Home safety walk-through

Walk through the home before your parent returns. If a therapist or home health nurse visits, ask them for advice made for your parent's needs.

Area	What to check
Entrance and paths	☐ A clear, well-lit path from the car to the door. ☐ Steps and railings are secure. ☐ Outdoor lights work.
Bedroom	☐ A clear path from bed to bathroom, with night lights. ☐ A lamp and phone are within reach of the bed. ☐ The bed height works for getting up safely.
Bathroom	☐ A non-slip mat or strips in the tub or shower. ☐ A shower chair, grab bars, or raised toilet seat if the therapist recommends them. ☐ Towels and supplies are within easy reach.
Kitchen	☐ Everyday items and easy-to-open food are within reach. ☐ Your parent can use the stove, microwave, and refrigerator safely.
Living areas and halls	☐ Loose rugs are removed. Cords are out of walkways. ☐ A sturdy chair with arms is available. ☐ There is room for a walker or wheelchair.
Stairs	☐ Handrails are secure, and lighting is good at the top and bottom. ☐ If stairs are hard, ask the therapist about setting up daily living on one floor.
Safety devices	☐ Smoke and carbon monoxide alarms work. ☐ Emergency numbers are posted near the phone. ☐ A plan for a spare key and for calling for help is in place.

Worksheet 7.4: First 30 days log

Notes help you spot patterns and make your case if you need to ask for changes. Write the date, what you noticed, and what you did. Notice eating, sleep, mood, confusion, pain, falls, and how staff respond.

Date	What I noticed	Who I told, and what happened	Follow-up

The 30-day review

Is the care plan being followed? What is working, and what is not?

Does my parent feel safe and respected? What did they tell me?

What needs to change, and who will ask for it?

PART 8

Practice Scenarios

These fictional examples help you practice before the pressure is on. Read each one, write what you would do, then read the considerations. There is no single right answer. The goal is to think it through.

Scenario 1: The Friday discharge

Fictional example. Maria's father, Walter, has been in the hospital for four days after a fall. On Wednesday, the nurse says he will go home on Friday. Walter still needs a walker and help getting out of bed. Maria lives two hours away and works full time.

What would you ask the hospital team today?

What would you do if you felt Friday was too soon?

Things to consider

Ask to meet with the discharge planner right away. Ask what care Walter will need and where it can be given safely.

Ask for the options, including home with home health care and short-term rehab, and what each would cost.

If the hospital gave Walter an Important Message from Medicare, read it. It explains how to ask for a review of the discharge decision. The call must be made no later than the planned discharge date and before he leaves.

While you wait, plan the first nights. Who can be with Walter? What equipment is needed? Who will handle medicines?

Scenario 2: The surprise about observation

Fictional example. Lena's mother, Rosa, spent three nights in the hospital after a fall. On the fourth day, the hospital says Rosa needs two weeks of rehab at a skilled nursing facility. Then a nurse mentions that Rosa has been in observation status the whole time.

What questions would you ask the hospital?

Who else could you call for help, and what would you ask?

Things to consider

Time in observation does not count toward the three inpatient days that Original Medicare usually requires before it covers skilled nursing facility care. Ask what Rosa's status is and when it began.

Ask whether Rosa's plan or program waives the three-day rule. Some Medicare Advantage plans and some other programs do.

Ask the team why Rosa has this status and whether it could change. Ask whether she received a Medicare Outpatient Observation Notice, and keep a copy.

Call SHIP for free, local help understanding coverage. Ask the facility about its private-pay cost and other ways to pay, so you know all your choices before you decide.

Scenario 3: "I'm staying in my house"

Fictional example. Frank has fallen twice this year. His daughter, Joy, believes assisted living would be safer. Frank says, "I'm staying in my house. Period."

What might be behind Frank's answer?

What would you say or do next?

Things to consider

Ask what he fears losing, such as independence, his home, a pet, or control. Fear often sits behind a firm no.

Ask what would make staying home work for him. This turns the talk from "no" to problem-solving.

Look for smaller steps first, such as a home safety review, home health therapy, help with chores, or a day program. A short trial can feel less final.

Frank's doctor can talk with him about fall risk. Some parents hear the doctor more easily than a child.

An adult who can make their own decisions has the right to make choices the family does not like. If you worry that memory or thinking problems affect his decisions, ask his doctor about an evaluation. For legal questions, talk with an elder law attorney.

Scenario 4: Three siblings, three opinions

Fictional example. Ana, Ben, and Chris share care of their mother. Ana lives nearby and does most of the work. Ben lives far away and wants the lowest-cost option. Chris avoids the conversation. A decision is needed this month.

What would you do to get everyone on the same page?

How would you divide tasks fairly?

Things to consider

Start with shared facts. Send the same notes from the doctor and the same cost information to everyone.

Ask each person what they can give in time, money, and travel. Contributions do not have to look the same.

Name roles. The person who lives nearby should not make every call. A sibling far away can handle insurance calls, paperwork, and bills.

Keep your mother's wishes at the center of the conversation.

If you are stuck, a neutral person such as a social worker, a geriatric care manager, or a counselor can help. Write down decisions and share them with everyone.

Scenario 5: "Please take me home"

Fictional example. Two days after moving into assisted living, Gloria calls her son, Marcus, in tears. She says, "Take me home. I hate it here." Marcus feels guilty and wants to bring her back right away.

What would you say to Gloria on the phone?

What would you do in the next few days?

Things to consider

Listen without arguing. You can say, "I hear that this is really hard." Avoid promises you may not be able to keep.

Call the staff after you hang up. Ask how Gloria is eating, sleeping, and joining in, and what they have noticed.

Look for things you can fix, such as a missing photo, a noisy room, or a meal she dislikes.

Visit at a time that works well for her. Bring a familiar item. Tell her when you will call or visit next.

Try to avoid big decisions in the first days. Keep notes. If her distress is severe or does not ease, tell the staff and her doctor.

Scenario 6: Something does not seem right

Fictional example. Two months after her father, Raj, moved into a nursing home, Priya notices that he has lost weight, his call light often goes unanswered, and he has a bruise no one can explain.

What would you do first?

How would you keep a record, and who would you tell?

Things to consider

If you believe your parent is in immediate danger, call 911.

Write down what you see, with dates, times, and the names of the people you talk to. Take photos of injuries if your parent agrees.

Talk with the nurse in charge or the manager. Ask for a care conference to review the care plan.

Tell Raj's doctor about the weight loss and the bruise.

If the problem continues, contact the Long-Term Care Ombudsman. The state survey agency, which inspects facilities, also takes complaints.

Scenario 7: The caregiver who is running on empty

Fictional example. Dana has been the main caregiver for her mother for a year. Since her mother came home from the hospital, Dana sleeps poorly, has missed work, and snaps at her family. Her brother says, "You're doing great."

What signs tell you Dana needs more support?

What help could Dana ask for, and from whom?

Things to consider

Caregiver stress is common, and it is a good reason to change the plan.

Ask for specific help. "Can you take Tuesday evenings?" is easier to say yes to than "I need help."

Respite care gives the main caregiver a break. The Eldercare Locator can connect caregivers with local respite and support services.

Talk with your own doctor or a counselor if you feel overwhelmed or hopeless. In the United States, you can call or text 988 at any time if you are in crisis.

PART 9

Your Personal Action Plan

Now bring it together. Look back at your snapshot, your readiness check, and your notes. Choose a few priorities, and turn each one into a small next step with a name and a date.

My top priorities

#	Priority	Why it matters	First step	Target date
1				
2				
3				
4				
5				

Next 7 days

Action	Who	By when	Done
			☐
			☐
			☐
			☐
			☐

Next 30 days

Action	Who	By when	Done
			☐
			☐
			☐
			☐
			☐

Next 90 days

Action	Who	By when	Done
			☐
			☐
			☐
			☐

Support for me

Who can I ask for help this week, and what will I ask them to do?

What will I do for myself this week, even for 15 minutes?

PART 10

Resources and Next Steps

These organizations are national, and most can point you to local help. Confirm hours, fees, and services when you call. The Medicare information in Part 2 comes from Medicare.gov and the Important Message from Medicare notice. Information checked October 2026.

Resource	How it can help, and how to reach it
Eldercare Locator	Connects older adults and caregivers with local services, such as meals, home care, transportation, and respite. A public service of the Administration on Aging. 1-800-677-1116 | eldercare.acl.gov
Medicare	Coverage questions and appeals. 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048 | medicare.gov Skilled nursing facility coverage: medicare.gov/coverage/skilled-nursing-facility-care Home health coverage: medicare.gov/coverage/home-health-services Important Message from Medicare (PDF): cms.gov
Medicare Care Compare	Compare Medicare-certified nursing homes, home health agencies, and other providers. medicare.gov/care-compare
State Health Insurance Assistance Program (SHIP)	Free, local, objective Medicare counseling for people with Medicare, their families, and caregivers. 1-877-839-2675 | shiphelp.org
Long-Term Care Ombudsman (through The Consumer Voice)	Advocates for residents of nursing homes, assisted living, and similar homes. Helps families find a facility and solve problems. Find your state: theconsumervoice.org/get-help Guide to choosing a nursing home (PDF): theconsumervoice.org
Caregiver Action Network	Education and support for family caregivers. caregiveraction.org
MedlinePlus: advance directives	Explains living wills, health care power of attorney, and do-not-resuscitate orders. medlineplus.gov/ency/patientinstructions/000472.htm

My local resources

Use the Eldercare Locator to find your local Area Agency on Aging, then fill in what you learn.

Resource	Name and phone	Notes
Area Agency on Aging		
Hospital social work or case management		
Local Long-Term Care Ombudsman		
Elder law attorney		
Respite or adult day program		

Your next steps

- ☐ Choose one action from your plan to finish in the next 24 hours.
- ☐ Share the contact sheet and the checklist, *Your Parent's Next Transition: Family Checklist*, with your family team.
- ☐ Set a date to review this workbook again.

You do not have to get everything right. Small, steady steps, taken with support, make a difference.

Important note. This workbook is for general education. It is not medical, legal, or financial advice. Needs, coverage, and rules vary by person, plan, and state. Check with your parent's doctor, insurance plan, and an attorney or other qualified professional before you make decisions. Using this workbook does not guarantee a safe move or any particular result. Coverage details were checked in October 2026 and can change.

LOOKING FOR MORE PRACTICAL RESOURCES?

Explore our collections of checklists and workbooks for aging in place, senior safety, and caregiving.

SeniorSafetyAdvice.com/products/

AgingInPlaceDirectory.com/products/