Your Vital Information

It is about you. We are engaged in a process to build your protective temple for you and those you love. More important however is for you to get maximum advantage from this PROCESS. It is a time to really understand what is important to you

To build your protective structure we must delve into your life and learn who are your loved and trusted persons. During this process we will guide you through some of the important issues you must address.

Our goal is to make this very personal process enlightening and beneficial. Since it is about *your* values, wishes and hopes, you may choose to put down as little or as much as you wish. Indeed feel free to skip any question that does not interest you. Make notes of questions you may have so that we will have a meaningful consultation when we meet.

In the end you will find this to have been one of those rare life experiences that really does make a difference to you and those you love. We are the builders, but it is *your* Testament and *your* Legacy we are constructing.

This checklist can be intimidating. If you feel that way we find the best approach is to answer the easy questions first and then go back for the more difficult ones.

We can best assist you if we address the very important questions:

- **What keeps you up at night?**
- What do you worry about for yourself?
- What do you worry about for your spouse?
- What do you worry about for your children?
- Who do you trust to take care of you if you need help?
  - Are you concerned that they do not know your wishes? Your needs?

Your Legacy: in addition to helping family and friends, is there a charitable organization or cause that you wish to remember in your Testament?

I. PERSONAL INFORMATION

YOU

Full name: _____

When you sign legal documents do you use your full middle name or initial?

No ____; Initial Only ____; Full Middle Name ____.

Birth date: _____

Home Telephone _____

YOUR SPOUSE

Spouse: (if applicable)_____

ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

YOUR CHILDREN

_____

_____

_____

_____

_____

YOUR SPECIAL OTHERS (partners, friends)

_____

_____

_____

PETS

Do you have a loved animal who you would like to provide for during sickness and after you pass away?

Name_____

Type of animal_____

Who would want to adopt your pet?_____

Special instructions_____

_____

_____

II. WILL

Your Will is central to your protective structure. For most people the Will is not the legal document for which that they have an immediate need. It only becomes effective after we die whereas the powers of attorney are immediately effective. However, the Will is central since it is *the* document that really states who you are and what is important to you.

In the legal sense the Will does basically two things. It says who gets your property after you die and who you trust to properly handle the "administration" of your estate. This person must fairly and completely carry out your instructions and be responsible enough to carry out all legal duties such as filing your final tax return.

We find that “Will contests” often reflect long buried fights between children. These surface during probate.

– Do you have any concerns about potential disagreements/fights between children?;
– Have they always gotten along?;
– Do any have special needs that would require them to receive more help?;
– Do you feel any child needs assistance and guidance after you are gone?

We need the following information to complete your will:

FIDUCIARY CHOICES (Personal Representative formerly known as "Executor")

Choice of *PERSONAL REPRESENTATIVE* (the Personal Representative is responsible for administering the probate estate. In other states this person is called the executor.) Please be aware that you may name as many Personal Representatives as you would like, we just ask that you list them in order and if extra space is needed, please use the back of this page.

First Choice: _____
Address: _____
Telephone: _____
Relationship: _____

Alternate: _____
Address: _____
Telephone: _____
Relationship: _____

Are you responsible for minor children? If so you may nominate a person who will be the Testamentary Guardian (The Testamentary Guardian is responsible for raising your children under the age of 18 if you die and your spouse does not survive you.)

First Choice: _____
Second Choice: _____

FUNERAL PLANS

Do you wish your funeral plan to be stated in your Will? If yes, please state.

_____

_____

SPECIFIC BEQUESTS (Gifts)

Do you have any specific bequests for children, relatives, friends etc.?

_____

_____

_____

_____

_____

RESIDUARY (The residue after specific gifts, if any are made)

Which persons, organizations, or charities do you want to receive the balance of your estate (residuary) if your spouse does not survive you?

_____

Are there any age requirements for the distribution of your residuary estate? If so, what?

UNEQUAL GIFTS or DISINHERITANCE

If you intend to make unequal gifts or intend to disinherit, please note your reasons:

JOINT ACCOUNTS/JOINT PROPERTY

IF you currently have accounts OR property held with one or more other people, do you wish those to become the property of the joint person upon your death, or do you want them distributed according to the language of your will?

II. DURABLE POWER OF ATTORNEY

What if you were out of town and there was some business at home that had to be taken care of? What if you were sick for an extended period, who would take care of your affairs? Who would the bank, the insurance company, the utilities, the tax agency talk to? How would you give that person recognized legal authority? By a Durable Power of Attorney you give your agent (or attorney in fact) authority to act for you.

Legal and Financial

If you were unable to carry out your financial business (for any reason - out of town visiting friends and family or serious illness) who would you want to take care of your legal, business, personal, and financial affairs? (List in order of priority) You may name as many Agents as you would like, we just ask that you list them in order and if extra space is needed, please use the back of this page.

First Choice: _____

Address: _____

Telephone: _____ Relationship: _____

Successor: _____

Address: _____

Telephone: _____ Relationship: _____

POWERS GIVEN: A general grant of power of attorney does not include certain transactions that families often wish to complete. Therefore, do you want to grant the

following additional powers?

Yes ___ No ___ Compensation. Unless the authority to receive payment is given, your agent may not be paid even if he or she has to lose time from work to act as your agent.

Yes ___ No ___ Employ Family Members. Under Michigan law your agent may employ third parties and pay them their rate but if family members do the same work they may not be paid unless you give the authorization.

Yes ___ No ___ Gifting. An Agent may not make a gift unless you so authorize. We often use gifting in tax matters and nursing home Medicaid cases.

Yes ___ No ___ Self Dealing. Your Agent has the power to sell your property. However she or he may not buy the property unless you so authorize. For example, if you wish to move and sell some property. Your Agent may wish to sell some of the items to your grandchild (the Agent's child) at a reduced rate. Your grandchild may need a car to drive to school or furniture for a college apartment.

FINANCIAL INSTITUTIONS/INVESTMENTS

NAME _____
ACCOUNT NO. _____

NAME _____
ACCOUNT NO. _____

NAME _____
ACCOUNT NO. _____

INSURANCE

NAME _____
POLICY/ ACCOUNT NO. _____

NAME _____
POLICY/ ACCOUNT NO. _____

PENSION PLAN

NAME _____
POLICY/ ACCOUNT NO. _____

PROPERTY

LEGAL DESCRIPTION (You may attach a tax bill or assessment) _____
_____
_____
_____
_____

PARCEL NO. _____

CREDIT CARDS

NAME _____
ACCOUNT NO. _____

IV(A). MEDICAL POWER OF ATTORNEY

The medical or "healthcare" power of attorney is the pillar of your protective structure that protects you from the impersonal healthcare system. What does this document do? By this document you empower a trusted person to guarantee you the best possible medical care according to your wishes. If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? If your doctor did not explain a medication or process such as surgery who would you trust to help you get the information you need?

A. Choice of HEALTHCARE AGENT ("PATIENT ADVOCATE")

Under Michigan law a Patient Advocate has the authority to make all decisions and to take all actions regarding one's care, custody and medical treatment including, but not limited to the following:

a. Having access to, obtaining copies of and authorizing release of medical and other personal information.

b. Employing and discharging physicians, nurses, therapists, and any other health care providers, and arranging to pay them reasonable compensation.

c. Consenting to, refusing or withdrawing any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, <u>including life-sustaining treatments</u>. Life sustaining treatment includes, but is not limited to breathing with the use of a machine and receiving food, water and other liquids through tubes. These decisions could or would allow one to die.

Please be aware that you may name as many Patient Advocates as you would like, we just ask that you list them in order and if extra space is needed, please use the back of this page.

First Choice: _____

Address: _____

Telephone: _____ Relationship: _____

Successor: _____

Address: _____

Telephone: _____ Relationship: _____

IV(B). ADVANCE DIRECTIVE ("LIVING WILL")

We recommend an advance directive be placed in your medical power of attorney. The directive states your instructions concerning end-of-life medical treatment. You may use the following three choices to guide you or write your own instructions. Choice one provides for broadest authority to terminate medical treatment. Choice two allows termination only for a coma or vegetative state. Choice three does not allow termination of treatment regardless of your condition or prognosis. Remember, your advocate will only make the decision if you are unable to communicate your wishes.

Please feel free to cross out or add anything you wish.

☐ Choice 1: **Life-sustaining treatment: I grant broad discretion to my Patient Advocate**

I do not want life-sustaining treatment (including artificial delivery of food and water) if **any** of the following medical conditions exists:

a. I am in an irreversible coma or persistent vegetative state that my doctor has reasonably concluded that I will remain unconscious for the rest of my life.
b. I am terminally ill, and life-sustaining procedures would only serve to artificially delay my death.
c. I have permanently lost cognitive function to the extent that I cannot communicate and I am dependent upon life-sustaining treatment to keep me artificially alive.
d. I am conscious but have irreversible brain damage, dependent upon life-sustaining treatment and will never regain the ability to make decisions and express my wishes.
e. I am suffering from the end stages of a degenerative condition, to the extent I cannot swallow or breathe without mechanical assistance.
f. My medical condition is such that the burdens of treatment outweigh the expected benefits. In making this determination, I want my Patient Advocate to consider relief of my suffering, the expenses involved, and the quality of my life, if prolonged.
g. I *optional* further state my preference to die in my own home and do not want any aggressive treatment plan that may only cause me to die in a hospital, prolong my suffering, death and reliance on life-sustaining treatment. I authorize my patient advocate in such circumstance to terminate life-sustaining treatment and remove me to a residential setting.
h. I express my desire for hospice and authorize my patient advocate to agree to hospice treatment, if my condition has been treated for at least 30 days. However, I waive the foregoing 30 day limitation if the doctor certifies that I have less than 30 days to live.

I expressly authorize my Patient Advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my

death.

<OR>

☐ Choice 2: **Life-sustaining treatment: withhold treatment only if I am in a <u>coma or persistent vegetative state</u>**

I want life-sustaining treatment (including artificial delivery of food or water) **unless** I am in a coma or vegetative state that my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.

I expressly authorize my Patient Advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death.

<OR>

☐ Choice 3: **Directive for maximum treatment**

I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of the procedures, and I direct life-sustaining treatment to be provided in order to prolong my life.

You may add instructions on a second sheet for: 1) Care you do want 2) Care you do <u>not</u> want

Mental Health Treatment Provisions

Please check Yes or No for each item.

☐ Yes ☐ No I authorize my patient advocate to obtain all information about my mental health treatment and I consent to the release of such information to my patient advocate.

☐ Yes ☐ No I authorize my patient advocate to make a petition for an Assisted Outpatient Treatment (AOT) as an alternative to hospitalization.

☐ Yes ☐ No I authorize my patient advocate to consent to forced inpatient hospitalization for mental health treatment.

☐ Yes ☐ No I authorize my patient advocate to consent to the administration of medication for mental health treatment.

☐ Yes ☐ No I waive my right to revoke this designation of my patient advocate for up to thirty days a permitted by Michigan statute.

☐ Yes ☐ No I nominate _____ as the physician and _____ as the mental health practitioner who would be asked to examine me and

determine whether I am able to give informed consent to mental health treatment.

□ Yes □ No My preferences for any medication to be administered for mental health treatment are:_____

_____

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent that my family, the medical or mental health facility, and any doctors, nurses, and other medical personnel involved in my care or mental health treatment shall have no civil or criminal liability for honoring my wishes expressed in this designation or for implementing the decisions of my patient advocate.

THE FIRST YEAR OF DOCUBANK IS A GIFT FROM ATTORNEY JIM SCHUSTER.

DocuBank® Enrollment Form (part 1 of 2)

A. Member Information:

Prefix (Mr/Ms/Dr): Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Email Address: DOB *(Optional)*:

Trust Name and Creation Date: (*Optional --57 character max, to appear on the face of the card.)*

B. Emergency Contacts: *(Optional)*

The names and phone numbers of three emergency contacts and physician will be provided to hospital staff when your directives are requested. If your living will, health care power of attorney, or other advance directive names people to make decisions for you, please list up to three of them here in the same order. If no one is listed in your document, please choose up to three people as emergency contacts and list them here. IF INFORMATION IS NOT AVAILABLE NOW, YOU CAN CALL US AT 1-866-DOCUBANK with updates any time after you receive your card.

First Emergency Contact: *(Optional*

Name: Relationship:

Home Phone: Work Phone:

Cell Phone: Email Address:

Second Emergency Contact: *(Optional)*

Name: Relationship:

Home Phone: Work Phone:

Cell Phone: Email Address:

Third Emergency Contact: *(Optional)*

Name: Relationship:

Home Phone: Work Phone:

Cell Phone: Email Address:

Primary Care Physician: *(Optional)*
Name: Dr. Phone:

THE FIRST YEAR OF DOCUBANK IS A GIFT FROM ATTORNEY JIM SCHUSTER.

DocuBank® Enrollment Form

E. Member Statement:

I have completed an advance directive document(s) (e.g. living will, health care power of attorney, HIPAA authorization, other advance directive, and/or organ donation information) of my own free will and have chosen to enroll in DocuBank® to help make my document(s) available when requested. To ensure prompt access, I authorize that my document(s), emergency contact information, and health information stored with DocuBank® be faxed to anyone who provides the member number and access code on my card. I will notify DocuBank® promptly of changes in my address, emergency contact information, and health information stored by DocuBank , and also of the revocation or replacement of my document(s). I understand that DocuBank® is not responsible for the validity or accuracy of any information stored by DocuBank®, including the health information that also appears on the face of my DocuBank® card. I further understand that by accepting my card I have verified and confirmed the accuracy of all information on the card before carrying the card. It is also my responsibility to ensure that all the information provided remains current and accurate. I also understand that DocuBank® does not provide legal advice, and that I may cancel this service in writing at any time by written request to DocuBank®. A charge for destruction of documents may apply.

F. OPTIONAL INFO that can appear on the front of the DocuBank Emergency Card.

(Can be completed now or added later via www.docubank.com or by calling 866-362-8226)

Allergies: *(Optional)*

Please number up to 4 selections in order of importance (1-4). (Due to space constraints, all items selected may not fit on your card.)

___ Penicillin	___ Beestings	___ Shellfish	___ _____
___ Sulfa	___ Latex	___ Nuts	___ _____

Permanent Medical Conditions: *(Optional)*

Please number up to 3 selections in order of importance (1-3). (Due to space constraints, all items selected may not fit on your card.) Do not list medications you're taking.

___ Alzheimer's	___ Cancer survivor	___ Low vision
___ Arthritis	___ Diabetes	___ Lung disease
___ Asthma	___ Hearing loss	___ Stroke history
___ Cancer (type)	___ Heart disease	___ _____
_____	___ High blood pressure	___ _____

Organ Donor / Anatomical Gift form is included with your directives? *(Optional - circle one)*

Yes **No**

Card Note: *(Optional - 45 character max.)* _____

Attorney:
Firm name:
Membership: