ESTATE PLANNING QUESTIONNAIRE

I. PERSONAL DATA

Full name: _____
Birth date: _____
Home Telephone _____

Spouse: (if applicable)_____

ADDRESS

Street: _____
City: _____ State: _____ Zip: _____

CHILDREN

_____
_____
_____
_____
_____

II. WILL

We need the following information to complete your will.

FIDUCIARY CHOICES

Choice of PERSONAL REPRESENTATIVE (the Personal Representative is responsible for administering the probate estate. In other states this person is called the executor.)

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

Alternate: _____
Address: _____
Telephone: _____

Relationship: _____

Choice of TESTAMENTARY GUARDIAN OF MINOR CHILDREN (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: _____
Address: _____
Telephone: _____
Relationship: _____

Second Choice: _____
Address: _____
Telephone: _____
Relationship: _____

SPECIFIC BEQUESTS

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

_____
_____
_____
_____
_____
_____
_____
_____

RESIDUARY

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

_____
_____
_____
_____
_____
_____
_____

III. **DURABLE POWER OF ATTORNEY**

By a durable power of attorney you give your agent (or attorney in fact) authority to act for you.

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 authorize. We often use gifting in tax matters and Medicaid - nursing home 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 may 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. _____

NAME _____
ACCOUNT NO. _____

NAME _____
ACCOUNT NO. _____

PROPERTY

LEGAL DESCRIPTION (You may attach an SEV) _____
_____
_____
_____
_____

PARCEL NO. _____

LEGAL DESCRIPTION (You may attach an SEV) _____
_____
_____
_____
_____

PARCEL NO. _____

LEGAL DESCRIPTION (You may attach an SEV) _____
_____
_____
_____
_____

PARCEL NO. _____

IV. MEDICAL POWER OF ATTORNEY

A. Choice of 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, including life-sustaining treatments. 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.

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

Successor: _____
Address: _____
Telephone: _____ Relationship: _____

V. LIVING WILL

Please make one choice from the following three. 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.
Please return this form to us.

☐ 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 end the stage 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