Name

Power of Attorney (Check Here if Same as Trustee ____)

Do You Want Your Agent to Manage Your Finances Independently: Yes____ No____

Do You Want Your Agents to Work Jointly Together: Yes____ No____
(If You Selected YES, Check Co-Agent Option on Each Agent's Name Below)

Primary Agent (Co-Agent: Yes_____ No_____)

Name

Address

City **State** **Zip Code**

Alternate Agent (Co-Agent: Yes_____ No_____)

Name

Address

City **State** **Zip Code**

Indicate Which Powers Your Agent is Authorized to Manage

Financial Transactions **Government Benefits**

Real Estate Transactions **Tax Returns**

Securitas/Bonds/Stocks **Conservator Estate**

Financial Loans **Healthcare**

Insurance **Business Interests**

List Any Special Instructions for Your Agent to Manage Your Financial Affairs

Advanced Healthcare & POA Intake Form

Spouse Name

Do You Want Your Agent to Manage Your Finances Independently: Yes____ No____

Do You Want Your Agents to Work Jointly Together: Yes____ No____
(If You Selected YES, Check Co-Agent Option on Each Agent's Name Below)

Primary Agent (Co-Agent: Yes_____ No_____)

Name

Address

City **State** **Zip Code**

Alternate Agent (Co-Agent: Yes_____ No_____)

Name

Address

City **State** **Zip Code**

Indicate Which Powers Your Agent is Authorized to Manage

Financial Transactions	**Government Benefits**
Real Estate Transactions	**Tax Returns**
Securitas/Bonds/Stocks	**Conservator Estate**
Financial Loans	**Healthcare**
Insurance	**Business Interests**

Special Instructions for Your Agent to Manage Your Financial Affairs

Advanced Healthcare Directive Second Spouse

If you were unable to make healthcare decisions for yourself, who would you want to manage those decisions?

Please check here if the person you are appointing is the same as your POA

Primary Agent (First Choice)

Full Name

Address

City **State** **Zip Code**

Phone **Relationship**

Alternate Agent (Second Choice)

Full Name

Address

City **State** **Zip Code**

Phone **Relationship**

Medical Directives

Select which of the following statements to be placed in your Advanced Directive.

I Do Want to be placed on machines or use artificial means or measures, if I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.
YES_____ NO_____

I Do Want life support if I am brain dead, without brain activity for more than 48 hours.
YES_____ NO_____

I Do Want all sustaining life support to be relinquished if there is no chance for full recovery.
YES_____ NO_____

I Do Want to be intubated or placed on a Ventilator or breathing machine if necessary to stay alive.
YES_____ NO_____

I Do Want medications to alleviate severe symptoms of pain and discomfort, even if it hastens my death.
YES_____ NO_____

I Do Want CPR, AED or other resuscitation procedures to be performed on me if my heart were to stop beating.
YES_____ NO_____

I Do Want a feeding tube or IV Procedures put in place, if I am not able to feed myself.
YES_____ NO_____

I Do Want an Autopsy performed at the time of my death.
YES_____ NO_____

I Do Want my organs and tissues to be made available for transplant purposes.
YES_____ NO_____

I Do Want my Medical Agent to take whatever steps are necessary to keep me in a Personal Residence rather than placing me into a Nursing Home Facility.
YES_____ NO_____

I Do Want my Medical Agent to obtain certification from a Physician if needed for psychological or substance treatments before my Agent may arrange for admission.
YES_____ NO_____

List Any Specific Requests for Relief of Pain Management:

List Any Other Special Instructions:

Primary Physician

Name

Address

Phone

Burial Instructions

Cremation _____ **Burial _____**

Distribution of Ashes **Burial Plans**