DURABLE POWER OF ATTORNEY AND HEALTHCARE DIRECTIVE QUESTIONNAIRE

Skip PERSONAL INFORMATION section if you have already completed a Will/Trust Questionnaire

PERSONAL INFORMATION SECTION:

YOUR PERSONAL INFORMATION	YOUR SPOUSE'S PERSONAL INFORMATION
Name	Name
Address	Address
City	City
State	State
Zip E-mail	Zip
County	County
Telephone # Cell#	Telephone # Cell#
Date of Birth	Date of Birth
S.S. #	S.S.#
Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female

DURABLE POWER OF ATTORNEY

Effective date of your Power of Attorney ☐ only when incapacitated ☐ immediately

My incapacity shall be determined by:

- ☐ One doctor chosen by my attorney-in-fact
- ☐ One doctor I name: _____
- ☐ Two doctors chosen by my attorney-in-fact
- ☐ Two doctors I name: _____

_____

My attorney in fact shall be: ☐ 1 person ☐ 2 people ☐ 3 people

Attorney-in-Fact (1) Name: _____

Address _____

Telephone: _____

Attorney-in-Fact (2) ☐ (check if only alternate for 1) Name: _____

Address: _____

Telephone: _____

Attorney-in-Fact (3) ☐ (check if only alternate for 2) Name: _____

Address: _____

Telephone: _____

Powers, Duties and Responsibilities granted to your Attorney-in Fact: (check applicable)

DESCRIPTION OF POWER GRANTED	Attorney-in-Fact	Alternate
1. To conduct real estate transactions for you (full power)?	☐	Same
2. To conduct real estate transactions for you but NOT SELL YOUR HOME? (limited)	☐	Same
3. Power over your tangible personal property?	☐	Same
4. To conduct security transactions for you?	☐	Same
5. To conduct banking transactions for you?	☐	Same
6. To make business decisions for you?	☐	Same
7. To handle insurance and annuity matters for you?	☐	Same
8. To conduct estate, trust and other beneficiary transactions for you?	☐	Same
9. To transfer assets and other items into your living trust (if you have one)?	☐	Same
10. To handle legal actions for you?	☐	Same
11. To spend money to take care of you and your family?	☐	Same
12. To conduct transactions involving your government benefits?	☐	Same

DURABLE POWER OF ATTORNEY AND HEALTHCARE DIRECTIVE QUESTIONNAIRE

13. To conduct retirement plan transactions for you?	☐	Same
14. To deal with your taxes?	☐	Same
15. To make gifts of your property to people/organizations? ☐ only that I choose Names_____ _____ _____ ☐ any chosen by my attorney-in-fact	☐	Same
16. To make gifts of your property to himself/herself? Max. amount: $_____	☐	☐
17. To be able to delegate tasks to others in his/her absence?	☐	Same
18. To benefit personally from actions taken on your behalf?	☐	☐
19. To commingle his/or her funds with yours?	☐	☐
20. To be paid for his/her services as your attorney-in-fact? ☐ a reasonable amount ☐ the specific amount of $_____	☐	Same

Do you require your attorney-in-fact to make periodic reports? ☐ No ☐ Yes. If yes, who should the reports be submitted to: _____

HEALTHCARE DIRECTIVE

If you are diagnosed as having a terminal condition and can no longer direct your medical care:
(Check one):

- ☐ I do not want any life-prolonging procedures and
  - ☐ DO ☐ DO NOT want food and water artificially administered
  - ☐ DO ☐ DO NOT want all pain reduction and/or comfort care
- ☐ I want some life-prolonging procedures, but not others (check all desired):
  - ☐ Blood and Blood products ☐ CPR ☐ Diagnostic tests ☐ Dialysis
  - ☐ Drugs ☐ Respirator ☐ Surgery
- ☐ I want all life-prolonging procedures

If you are diagnosed as being in a permanent coma and can no longer direct your medical care:
(Check one):

- ☐ I do not want any life-prolonging procedures and
  - ☐ DO ☐ DO NOT want food and water artificially administered
  - ☐ DO ☐ DO NOT want all pain reduction and/or comfort care
- ☐ I want some life-prolonging procedures, but not others (check all desired):
  - ☐ Blood and Blood products ☐ CPR ☐ Diagnostic tests ☐ Dialysis
  - ☐ Drugs ☐ Respirator ☐ Surgery
- ☐ I want all life-prolonging procedures

I desire the following representative to oversee my wishes: Attorney-in-Fact ☐ #1 ☐ #2 ☐ #3
I desire the following representative to act as an alternate: Attorney-in-Fact ☐ #1 ☐ #2 ☐ #3

FEMALES ONLY: If I am pregnant when my healthcare directive is considered:
☐ I direct it be given no effect during my pregnancy ☐ I direct that it be carried out

ACKNOWLEDGMENT AND AUTHORIZATION

I understand that the Legal Document Assistant (LDA) preparing my documents is NOT an attorney, cannot select forms and DOES NOT give legal advice. I hereby direct the Legal Document Assistant to type and perform certain services as outlined in the Contract for Services which we each executed regarding this matter. I further declare that the foregoing information which I have provided is, to the best of my knowledge, true and correct.

Dated:_____ _____
Signature