Life Care Guide

Life Care Guide

(Special Needs Adult)

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IMPORTANT NOTE TO USER:

As a reminder, this binder should be kept confidential because the information contained in here is highly personal to you and the special needs individual you care for. This should be made available only to those people who need to know to provide proper care for your special needs individual. If you have been directed by your attorney to complete the information in this binder, it may also be protected by the attorney client privilege and special care should be taken so as to avoid the inadvertent disclosure of this information to adverse parties or make any other disclosure which would destroy the privilege. If this applies to you, you should consult with your attorney about the proper maintenance of these records. [This generally applies in cases where the special needs individual has been involved in a lawsuit, but there are other situations which apply also, if you are uncertain, you are encouraged to consult with your attorney.]

DISCLAIMER

Use of this Life Care Guide does not create an attorney client relationship or any other professional client relationship with the Law Offices of Mark E. Biernath, P.C. or any of its attorneys. This is only done through a written retainer/engagement agreement entered into between the respective parties. This guide is provided for educational purposes to assist in understanding the complexities of estate planning for individuals with special needs. No promises or guarantees are made as to the fitness or usefulness of this guide for any purpose. If you have any questions or would like more information about the planning concepts addressed in this guide, the need for planning, or application of law to your specific situation you should seek the advice of competent legal counsel who focuses in this particular area of law. Estate planning involving individuals with special needs is a complex matter including many areas of law and life. If you feel you need additional counsel in this area you are encouraged to consult with an attorney of your choosing. You are welcome to call the Law Offices of Mark E. Biernath, P.C. to schedule an appointment.

It is our desire that this guide be useful to families with special needs, we welcome your comments and suggestions.

You may make as many copies of the pages you need for your personal use.

CONFIDENTIAL

Life Care Guide
For

_____

Maintained by:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Introduction

The goal of this guide is to serve as an essential tool in the event that the primary care giver of an individual with special needs is unable to provide care for him or her. This is a place for you to organize important information regarding the care of this person. In the unlikely event that a complete stranger must step in and provide proper care for this individual, this binder can be the primary source of information that person needs to know.

In the following pages, you can fill in detailed information concerning this person, including his or her medical, social, emotional, and spiritual needs as best you can describe them. This information should be kept confidential, but it is important that it is available when it is needed. This can be accomplished by keeping it up to date. Depending on the needs of this individual, a yearly review and revision may be sufficient, others may require a monthly or even a weekly review.

Please be aware that this guide, standing alone, is not legally enforceable for any purpose.

Life Care Guide

For: _____

1. Quick Reference

This section contains a quick overview of critical information that would be needed in the event that the primary caregivers were unavailable.

General Information

Full legal name of individual with special needs _____

Prefers to be called: _____

Home Address: _____

City, State, Zip: _____

Phone: _____

Is currently living at (name of facility): _____

Address: _____

City, State, Zip: _____

Names of Individuals living with person:	Relation to person
_____	_____
_____	_____
_____	_____
_____	_____

Does this individual require Home Health Aides/Nurse? Yes No (Circle one)

Name of person usually providing such care: _____

Name of Agency providing such care? _____

Specific Information

Attach recent photo here

Individual's Name: _____

Birth Date: _____

Social Security Number: _____

Medicaid Number: _____

Insurance (Health) Number: _____

Dental Insurance Number_____

General Description of individual (attach photo if one is available)

Height _____ Weight _____ Hair Color _____ Eye Color_____

_____

_____

Please identify disabling condition if known/diagnosed (medical or developmental):

_____

_____

General description of disabling condition: _____

_____

Prognosis: _____

_____

Please attach a copy or reference to a source of information you found helpful in learning about this individual's disability. This should be information that you consider important for someone caring for this individual.

Is this individual able to communicate in spoken English? Yes No

Is he or she able to communicate in a spoken language other than English? Yes No

If yes, What language(s)? _____

Is he or she able to communicate with a non-verbal language such as sign-language?
Yes No

If yes, what non-verbal language(s)? _____

Is he or she able to communicate his or her needs or desires to others? Yes No

How does this individual communicate his or her needs or desires to others?

_____

_____

_____

Does this individual understand when new people speak with him or her? Yes No

If someone had to explain bad news to this person, would he or she understand? Yes No

Who would you want to explain bad news to this individual if it were possible or practicable?

Name: _____ Phone: _____ Cell: _____

Relation to individual: _____

Please describe this person's current awareness of disability and self-advocacy skills:

_____

_____

_____

This section contains important information about the medications your special needs individual takes. It is critically important that this information be kept up to date. As you are aware, changes in medication routine can have troubling effects that can take a long time to correct. It is suggested that you maintain a record of all previous medications and reason for discontinuing so that important medical history is not lost.

If there have been adverse reactions to over the counter meds please add a sheet on that medication as well. Also, if some over the counter medications have been particularly useful, add them to this binder as well.

Cut this corner off when this medication is no longer used

Medications

Name of Medication: _____

Description: ☐ Tablet ☐ Capsule ☐ Oral Liquid ☐ Injection ☐ other: _____

Prescribing Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Dosage: _____ Frequency: _____ When Given? (Circle) AM PM With Food

How is medication administered: _____

Who administers medication: _____ At home/work? _____

Purpose of medication: _____

_____

Location medication is stored: _____

Side effects:

_____

_____

Date Started Med: _____ Date Stopped Med: _____

Reason for stopping medication:
☐ Doctor Directed ☐ Allergy ☐ Side effects too severe

Please describe: _____

_____

_____

3. Doctors/Professionals

This section contains important information about the doctors, therapists, social workers, and other professionals involved in the care of your special needs individual. This will help provided critical continuity of care as well as identify where important medical information can be located.

It is suggested to maintain a record of doctors and professionals who have been used in the past and for what reason, in case a similar need arises in the future, then your special needs individual can have the same care as before. Or, in the alternative, if a professional was discontinued and you do not want that professional used again in the future, you can indicate the reason and your desire that they not be consulted. Please understand however that this does not put a legal obligation on a future caregiver to follow, rather it provides them with information about what may be in the special needs individual's best interest.

Physicians

Physician's Name: _____ Primary Care? Y N

Practice Name: _____

Phone: _____ Fax: _____ Pager: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Affiliated Hospital: _____

Practice Area/Specialty: _____

Reason this individual sees this doctor: _____

_____

How often? ☐ Daily ☐ Bi-Weekly ☐ Weekly ☐ 2-weeks ☐ Monthly
☐ 3 months ☐ 4 months ☐ 6 months ☐ yearly ☐ other _____

Who usually takes this person to see this doctor? _____

How does he or she react to having to go to doctor? _____

_____

Tips or suggestions to help him or her with visiting this doctor: _____

_____

Date Started seeing Doctor: _____ Date stopped seeing Doctor: _____

Reason no longer seeing this doctor? _____

_____

Therapists

Therapist's Name: _____

Practice Name: _____

Phone: _____ Fax: _____ Pager: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Affiliated Hospital: _____

Practice Area/ Specialty: _____

Reason this person sees this therapist: _____

_____

How often? ☐ Daily ☐ Bi-Weekly ☐ Weekly ☐ 2-weeks ☐ Monthly
☐ 3 months ☐ 4 months ☐ 6 months ☐ yearly ☐ other _____

Who usually takes him or her to see this therapist? _____

How does he or she react to having to go to therapy? _____

_____

Tips or suggestions to help this individual with visiting this therapist: _____

_____

Date Started seeing therapist: _____ Date stopped seeing therapist: _____

Reason no longer seeing this therapist? _____

_____

Psychologists

Psychologist's Name: _____

Practice Name: _____

Phone: _____ Fax: _____ Pager: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Affiliated hospital or treatment facility: _____

Practice Area/Specialty: _____

Reason this individual sees this psychologist: _____

_____

How often? ☐ Daily ☐ Bi-Weekly ☐ Weekly ☐ 2-weeks ☐ Monthly
☐ 3 months ☐ 4 months ☐ 6 months ☐ yearly ☐ other

Who usually takes this person to see this psychologist? _____

How does he or she react to having to go to psychologist? _____

_____

Tips or suggestions to help this individual with visiting this psychologist: _____

_____

Date Started seeing psychologist: _____ Date stopped seeing psychologist: _____

Reason no longer seeing this psychologist? _____

_____

Other Professionals

Name: _____

Practice Name: _____

Phone: _____ Fax: _____ Pager: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Affiliated hospital or treatment facility: _____

Practice Area/Specialty: _____

Reason this individual sees this person: _____

_____

How often? ☐ Daily ☐ Bi-Weekly ☐ Weekly ☐ 2-weeks ☐ Monthly
☐ 3 months ☐ 4 months ☐ 6 months ☐ yearly ☐ other

Who usually takes him or her to see this person? _____

How does he or she react to having to go here? _____

_____

Tips or suggestions to help this person with visiting this person: _____

_____

Date started seeing person: _____ Date stopped seeing person: _____

Reason no longer seeing this person? _____

_____

4. Equipment

This section contains information about any special equipment that your special needs individual may require. Please include information about durable medical equipment as well as anything else that contributes to your special needs individual's ability to do things for themselves, brings them enjoyment, or has been simply helpful in his/her care.

By providing information about vendors and maintenance you make it easier for a future care giver to keep equipment in proper, safe working order.

Special Equipment

Equipment Name: _____ How does this individual refer to it: _____

Purpose: _____

_____

Can he or she use it independently? Yes No Eyes on Supervised Hands on Supervised

Who knows how to use it? _____ Phone: _____

Where is it kept? _____

Who supplied it (see provider list for contact information)? _____

Who maintains it? _____

Who paid for it? ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Private pay
Is it rented or owned? _____

How often is it needed?

☐ Daily ☐ Bi-Weekly ☐ Weekly ☐ 2-weeks ☐ Monthly

☐ 3 months ☐ 4 months ☐ 6 months ☐ yearly ☐ other

Please describe how this individual uses it: _____

_____

_____

5. Financial Information

This section contains important financial information regarding your special needs individual. Be as complete and through as possible. This will assist you or a future caregiver to appropriately provide for your special needs individual as well as assist in securing benefits for your special needs individual.

Government Benefits

Agency: _____

Location: _____

Contact Name: _____ Phone: _____

Case or File Number: _____

Location where ID card is kept (keep a photocopy of front and back of card in this manual):

_____

Amount of monthly benefit: _____

Where does this money go? (Bank, Check sent to home, etc): _____

Account Number: _____

Is there an annual case review? Yes No

If so, when is this annual review usually done? _____

Please indicate where previous copies of annual reviews and correspondence are kept, you may want to keep them in this binder. _____

Any other helpful or useful information?

_____

_____

_____

Current Private Benefits

Source of Private Benefit: _____

Location: _____

Contact Name: _____ Phone: _____

Case or File Number: _____

Location where ID card is kept (keep a photocopy of front and back of card in this manual):

_____

Amount of monthly benefit: _____

Where does this money go? (Bank, Check sent to home, etc)

Account Number: _____

Is there an annual case review? Yes No

If so, when is this annual review usually done? _____

Please indicate where previous copies of annual reviews and correspondence are kept, you may want to keep them in this binder.

What is the source of this benefit? _____

Was this a settlement to a lawsuit? Yes No

If so, please indicate case, location, and attorney representing this individual: _____

_____

Are these funds from an inheritance? Yes No

If so, please provide a copy of the instrument creating the funds: (Will, Certificate of Trust)

Current Private Medical Insurance

Source of Private Insurance: _____

Location: _____

Contact Name: _____ Phone: _____

ID Number: _____

Location where ID card is kept (keep a photocopy of front and back of card in this manual):

_____

Is this provided by an employer? Yes No

Name of Employer: _____

Contact Name: _____ Phone: _____

Who is primary card holder? _____ Social Sec No. _____

Is there an annual case review? Yes No

If so, when is this annual review usually done? _____

Please indicate where previous copies of annual reviews and correspondence are kept, you may want to keep them in this binder, If you have a summary of benefits, please include that here as well.

Under what circumstances will this coverage be terminated? _____

_____

Any other helpful or useful information? _____

_____

Assets Belonging to Special Needs Individual

Assets include personal property, cars, bank accounts in their name, any real property, any sources of income. Identifying the assets this individual has will help identify exempt assets under need based qualifying standards, as well as if this individual is in a residential facility this will alert a care giver to secure any personal property and assure that this person has access to their property. Please identify if any of the items have a strong personal or sentimental value.

Does special needs person own any land, house, building, real estate? Yes No

If yes please complete the following for each asset of this nature:

Description of Asset Location Contact person Phone

_____

How is this property titled? _____

How was this property acquired? _____ Insured? _____

Description of Asset Location Contact person Phone

_____

How is this property titled? _____

How was this property acquired? _____ Insured? _____

Description of Asset Location Contact person Phone

_____

How is this property titled? _____

How was this property acquired? _____ Insured? _____

Does special needs person own any vehicles (cars, trucks, vans, boats)? Yes No

If yes please complete the following:

Description of Asset Location Contact person Phone

_____

How is this vehicle titled? _____

How was this property acquired? _____ Insured? _____

Assets (continued)

Please identify important personal property:

Item Description Location Importance to Individual

_____

_____

_____

_____

_____

_____

Bank Accounts:

Description of Asset Location Contact person Phone

_____

How are accounts titled? _____

How was account acquired/what is source of funds? _____

_____

Description of Asset Location Contact person Phone

_____

How are accounts titled? _____

How was account acquired/what is source of funds? _____

_____

Description of Asset Location Contact person Phone

_____

How are accounts titled? _____

How was account acquired/ what is source of funds? _____

6. Life Activities and Routines

This section contains a wealth of information that will assist in maintaining continuity in routine for your special needs individual. This section should be reviewed by anyone who is charged with caring for your individual with special needs. It includes information about home, family, friends, social activities, pets, responsibilities, religious preferences, agencies and support groups, transportation needs, communication needs, eating, drinking, personal care, safety, mobility, sleeping habits, and social behaviors.

Home, Family, & Friends

Please list others who live with this individual and their relationships him or her.

_____ _____

_____ _____

_____ _____

_____ _____

Are there any interaction problems that this individual has with any family members or friends? If so please describe.

Does this person have any special family traditions?

Where does this person like to go for vacation? Check all that apply and add in your own.

- □ Mountains
- □ Big cities
- □ Camping
- □ Hiking
- □ Lake
- □ Snowy areas
- □ Boat
- □ _____
- □ _____
- □ _____
- □ _____

Recreation, Leisure, & Play activities

What activities or games does this individual enjoy most?

_____ _____

_____ _____

_____ _____

_____ _____

With whom does this person usually spend free time with?

Name: _____ Phone Number: _____
Address: _____

Name: _____ Phone Number: _____
Address: _____

Are there any relatives who visit him or her on a regular basis?

Name: _____ Phone Number: _____
Address: _____

What is this individual's favorite thing to do when it is raining?

What does he or she enjoy doing outside?

Responsibilities

What responsibilities does this person have at home? (chores, etc.)

_____

_____

_____

Does he or she enjoy cleaning? Y N

Explain:

_____

Does he or she enjoy cooking? Y N

Explain:

_____

Does he or she enjoy yard work? Y N

Explain:

_____

What types of housework does this individual enjoy the most?

_____

_____

_____

_____

Pets

Does this person enjoy being around animals?

Does this individual have any family pets? Y N

If yes, what kind and what are their names?

_____ _____

_____ _____

_____ _____

_____ _____

Does anyone bring their dog or pet to visit this individual? Y N

If yes, how often do they visit? _____

Contact information

Name: _____ Phone Number: _____

Address: _____

Agencies and Support Groups

Group Name: _____

Location: _____

Contact Name: _____ Phone: _____

Briefly describe how this individual or his or her family participates and what types of support this group provides: _____

_____

Group Name: _____

Location: _____

Contact Name: _____ Phone: _____

Briefly describe how this individual or his or her family participates and what types of support this group provides: _____

_____

Group Name: _____

Location: _____

Contact Name: _____ Phone: _____

Briefly describe how this individual or his or her family participates and what types of support this group provides: _____

_____

Religious Affiliation

Group Name: _____

Location: _____

Contact Name: _____ Phone: _____

Type of activities this individual usually participates in:

- ☐ Regular Worship Services
- ☐ Special Services
- ☐ Sunday School
- ☐ Weekday programs
- ☐ Music Programs
- ☐ Camping trips
- ☐ Sporting trips
- ☐ Evening programs
- ☐ Youth program

Briefly describe how this person participates and what types of accommodations are necessary:

_____

_____

_____

Are there any groups or activities that you do not want this person participating in?

_____

_____

_____

Community

Is this individual a member of any religious group? Y N

If yes, name of group: _____

Location of the Group: _____

Contact person: _____ Phone Number: _____

Does he or she participate in any community activities? (sports, etc)

Does he or she enjoy going shopping? Y N
Explain: _____

Are there any special affiliations with which this person is associated?

Transportation

Does this individual have any transportation needs? (van with a lift, special car or seat, community transportation)

Who maintains special equipment?

Company: _____

Contact: _____ Phone Number: _____

Community Transport: _____

Contact: _____ Phone Number: _____

How does this person usually get to where he or she needs to go?

Communication

How are the needs of this individual communicated? (verbal, gestures, pictures, sign language, special equipment)

Does this individual communicate:

□ Easily □ With Some Difficulty □ With Great Difficulty

Please explain:

On a scale of 1 to 5, how well are basic instructions understood?

1_____2_____3_____4_____5

Not understood at all Understands with little difficulty

Describe what happens when this individual becomes frustrated when trying to communicate.

Eating

Is this individual able to eat by his or herself? Y N

If no, please describe help needed: _____

_____

Have you created any special eating adaptations to make eating easier for him or her?

_____

_____

Does this individual have any special feeding equipment? Y N

Please describe: _____

_____

Who maintains and supplies equipment? _____

Contact: _____ Phone Number: _____

What is this person's eating schedule?: _____

_____

List this individual's favorite foods:

_____ _____

_____ _____

What types of food does this person dislike?

_____ _____

_____ _____

Does he or she have any food restrictions? _____

_____

Food allergies– List food and type of reaction (ex: choking/gagging, hives, etc.)

_____ _____

_____ _____

Drinking

Is this person able to drink by his or herself? Y N

If no, please describe help needed: _____

_____

Have you created any special drinking adaptations to make drinking easier for him or her?

_____

_____

_____

What are this person's favorite drinks

_____ _____

_____ _____

Least favorite drinks

_____ _____

_____ _____

Does this individual have any beverage restrictions? Y N

If yes, please explain: _____

_____

Personal Care

Is this person potty-trained? Y N

Does he or she need any help or special equipment using the toilet? Y N

Explain: _____

_____

How often (and when) do accidents happen?

_____

_____

_____

Does he or she need any help bathing?

_____

_____

_____

Describe this individual's grooming habits and any help he or she may need.

_____

_____

_____

_____

_____

Describe this individual's dressing habits and any help he or she may need.

_____

_____

_____

Safety

On a scale of 1 to 5, describe the level of supervision that this individual requires?

1_____2_____3_____4_____5
Needs very little supervision Must always be supervised

Please explain:_____

_____

How would this person react if he or she had a simple cut or minor burn?

_____

_____

_____

What would he or she do if there was a fire?

_____

_____

_____

Does this individual know how to dial 911? Y N

Are there safety issues you are concerned about in or around your home? Please explain

_____

_____

_____

Are there safety issues you are concerned about when in public? Please explain.

_____

_____

_____

Mobility

How much mobility does this individual have?

_____

_____

_____

Does he or she need any special equipment for mobility? Y N

If yes, please describe:

_____

_____

Product Information—please list any important information including model numbers and names of equipment needed and where you purchase equipment from

_____

_____

_____

If bed ridden, how often is this person re-positioned?

_____

_____

_____

What steps are taken to reduce or avoid bedsores?

_____

_____

_____

Sleeping Habits

Please describe this individual's bedtime routine (include usual bedtime)

_____

_____

_____

How often does he or she take a nap? _____

How long does he or she sleep? _____

Describe this person's sleeping habits

_____

_____

_____

How often does he or she wake up in the middle of the night? _____

Describe how to best deal with night awakenings. _____

_____

_____

Describe this individual's morning routine (include when he or she usually wakes up)

_____

_____

_____

Social Behavior

Describe this individual's general temperament.

_____

_____

Does he or she enjoy being in public places? Y N

What are this person's favorite places to go? _____

_____

_____

Describe how this individual responds to unfamiliar situations? _____

_____

_____

Describe any behaviors that you feel are dangerous to this individual or to others

_____

_____

Does he or she ever intentionally destroy things? Y N

If yes, please explain:

_____

_____

Are there any behaviors that must be dealt with? _____

_____

_____

Describe your current behavior support plan. _____

_____

_____

Does this individual have a BIP (Behavior Intervention Plan) at school? Y N

If yes, please include a copy of it here or write where it is located. _____

_____

Miscellaneous Information

Please use the space provided to add any additional information that is important for someone to know about this individual. Add additional pages if necessary

Likes & Dislikes

Fears

Social Activities

Behavior Management

7. Education and Employment

This section contains important information about the special needs individuals education and employment.

Education – Federal law provides significant safeguards to ensure a free, appropriate public education for individuals with disabilities. This is done in conjunction with the local school district and is usually specified in an Individualized Education Plan (IEP). Many IEPs are very thorough and occupy a separate binder. This section should either contain a copy of the current IEP and indicate where previous IEPs are located, or you should indicate where the IEP is kept so it can be located when needed. [NOTE: If you are unable to locate a copy of the current IEP, the local school district will have a copy on file, generally only a parent or guardian is able to access that information from the school system]

Employment – Many individuals with special needs are able to participate in a wide variety of occupational activities. There are numerous programs offered through the State and private companies. Often, a transition plan is developed in conjunction with the school system which includes work training and placement opportunities. This section will contain contact information if this applies to your special needs individual.

Education

Is this person currently enrolled in school? Y N Where? _____

_____

Does he or she go everyday? Y N If not, which days? _____

Is IEP Information included in this Binder? Y N

Please identify where any other IEP information is stored. _____

_____

Does he or she enjoy going to school? _____

_____

_____

What is his or her favorite subject in school? _____

_____

_____

What supports does this individual need during the school day? ڤ See IEP

_____

_____

How does he or she get to school? (bus, car, etc)? ڤ See IEP

_____

_____

Employment

What is this individual's current job placement?

How often does he or she work?

Does this person receive any employment supports? (job coach, employment counselor, transportation)
□ Y □ N

If yes, please list contact information
Name: _____ Phone Number: _____

Address: _____

Job title: _____

8. Guardianship

This section contains important information about any legally recognized or court established/supervised guardianships for the special needs individual.

This section should contain copies of the Order creating the guardianship, Letters of Guardianship, any reports filed with the court such as the annual inventory and personal status report.

Guardianship Information

Name of Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): Home: _____

Work: _____

Cell: _____

*Check all that apply, add additional sheets for additional guardians

ڤ Guardian of Person ڤ Guardian of Property

Identify court where guardianship was first established

Name of Court ڤ Probate ڤ Superior ڤ State

ڤ Common ڤ Other _____

Of _____ County

_____ State

Address of Court: _____

_____

Judge: _____

Clerk: _____

When is annual filing due: _____ (Anniversary date of original order)

Attorney who represented Guardian: _____

Address of attorney: _____

_____

Phone Number: _____ Fax Number: _____

Was an attorney appointed to represent ward? Y N

If yes, who? Name: _____

Address: _____

_____

Phone Number: _____

**Include copies of all court reports/correspondence

Miscellaneous Information

Please use the space provided to add any additional information that is important for someone to know about this individual. Add additional pages if necessary

Special Concerns

Any Other Useful Information

10. Care Giver's Estate Plan Overview

This section contains information about you (the caregiver) and your estate plan. This is important so that your wishes are followed and any future caregiver can assist with making sure those plans become effective.

This section only contains an overview and probably will not contain the actual documents that put the plan into effect. There is a place to indicate where the documents are kept. The information provided here does not have any legal force or effect, only properly drafted and executed documents have the legal binding effect to put your estate planning in place. This means generally the originals of the various documents would be required at such a time as it becomes necessary.

Estate Plan Overview for: _____

Please note that information here has no legal force or effect, only properly drafted and executed documents will have such. If there is a conflict between information here and what is in a properly drafted and executed document, the properly drafted and executed document prevails. Any mistakes are inadvertent and should not be constructed as an amendment or revocation of a previous document

I have a check all that apply:

- ☐ Will
- ☐ Trust (RLT)
- ☐ Durable Power of Attorney
- ☐ Durable Healthcare Power of Attorney
- ☐ Living Will
- ☐ HIPAA Authorization
- ☐ ILIT
- ☐ Other _____

The documents are located in a:

- ☐ Bank safe deposit box
- ☐ Safe
- ☐ Fire box
- ☐ Other _____

Answer any question that pertains to where the documents are located

The key is located: _____

The combination is: _____

The combination can be found at: _____

Persons who have access to them are:

Name: _____

Address: _____

_____

Phone Number: _____

General Durable Power of Attorney

Is this a springing Power of Attorney? Y N
Does it only come into effect upon disability or incapacity? Y N

	Name	Address	Phone Number
Agent	_____		
Joint/ Successor Agent	_____		

Estate Plan Overview Continued

Durable Medical Power of Attorney

Name Address Phone Number

1st Agent _____

Successor _____

Trust

Name Address Phone Number

1st Agent _____

Successor _____

Successor _____

Guardianship for Self

Determination by: ☐ Doctor ☐ Panel

Where is this nomination? ☐ DPOA ☐ Guardianship Nomination
☐ HCPOA ☐ Trust

Nominated Guardian:
Name Address Phone Number

_____

_____

_____

If a panel was used to determine incapacity or nominate guardian, who is on the panel?

_____ _____

_____ _____

_____ _____

Estate Plan Overview Continued

Who have you nominated as guardian for minor/dependant children?

Where is this nomination?

- ☐ Will
- ☐ Trust
- ☐ Guardianship Nomination

☐ Named Individuals

Names: _____

_____

_____

_____

_____

☐ Panel to Nominate

Panel members: _____

_____

_____

_____

_____