Western Mass Estate Planning

Kate Downes, Esq. **Deirdre Gleason, Esq.**
Of Counsel

NOMINATIONS FORM

Durable Power of Attorney and Health Care Documents

How my complete, legal name should appear in the documents (how I will be signing my name, as well as any "aka"):

_____

The information below will be used to prepare your estate planning documents. If, after you have returned this document to our office, you wish to make changes to any of the names or order of names, or any of the named individuals change addresses or telephone numbers, you must notify us no later than five (5) days prior to the date of the scheduled signing. It is extremely difficult to make changes at the signing. We will be sending you a summary of the documents in advance, reflecting the information below, which will give you another chance to review your decisions and make changes.

1. POWER OF ATTORNEY: This document names the individuals (called your Attorneys-in-Fact, or Agents) who you would trust to handle business transactions for you, whether you are incapacitated, on vacation, or just wanting/needing assistance with banking or other financial issues. Note that these individuals will each have equal authority to act (there is no hierarchy) which means we can call on each, as needed and appropriate. None may act, however, without access to the document, which gives you control over who can exercise the power. **Please name at least three (3) individuals who you would like to serve as your Attorneys-in-Fact to handle business matters for you:**

1. Name:_____ 2. _____

Relationship:_____ _____

Town/State: _____ _____

3. Name:_____

Relationship:_____

Town/State: _____

2. <u>HEALTH CARE PROXY</u>: This document designates the individuals (called your Health Care Agents) who may make medical decisions for you if your physician has declared that you are unable to make or communicate a medical decision. **<u>Please name three (3) individuals, in order of preference, who you would like to serve as your Health Care Agents:</u>**

	1.	2. First Alternate:
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____
Phone (H):	_____	_____
Phone (W):	_____	_____
Phone (cell):	_____	_____

3. Second Alternate:

Name: _____

Relationship: _____

Address: _____

_____

Phone (H): _____

Phone (W): _____

Phone (cell): _____

3. <u>HIPAA AUTHORIZATION FOR RELEASE</u> form: This form lists the individuals who you authorize to access your medical information and talk with your doctors. <u>We will list the same individuals who you listed as Health Care Agents</u> above. **In addition, <u>would you like anyone else listed?</u>**

<u>Full Name</u>	**<u>Relationship to You</u>**	**<u>Full Name</u>**	**<u>Relationship to You</u>**
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

4. <u>LIVING WILL</u>: This document says that you would not want to remain on life support indefinitely and gives your medical professionals and family members permission/encouragement to terminate life support if appropriate. **<u>Would you like a Living Will?</u>**

_____ YES _____ NO

5. <u>PRIMARY CARE PHYSICIAN</u>: Please provide the name and address of your Primary Care Physician, so that our office may send copies of your signed Health Care Proxy, Living Will, and HIPAA Authorization for Release form for your records:

Physician: _____

Practice: _____

Address: _____

_____

_____