Western Mass Estate Planning

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Of Counsel

NOMINATIONS FORM

Durable Powers of Attorney and Health Care Documents

How our complete, legal names should appear in the documents (how each of us will be signing our 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. POWERS OF ATTORNEY: These documents name 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 two (2) individuals, in addition to your spouse, who you would like to serve as your Attorneys-in-Fact to handle business matters for you:**

For husband:

1. Wife
2. Name: ______________________ 3. ______________________

   Relationship: ______________________ ______________________

   Address: ______________________ ______________________

   ______________________ ______________________

For wife:

1. Husband
2. Name: ______________________ 3. ______________________

   Relationship: ______________________ ______________________

   Address: ______________________ ______________________

   ______________________ ______________________

2. LIVING WILLS: These documents say 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. **Would you both like a Living Will?**

______ YES ______ NO

3. HEALTH CARE PROXIES: These documents designate 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. **Please name two (2) individuals, in addition to your spouse and in order of preference, who you would like to serve as your Health Care Agents:**

For husband:

1. Primary: wife

	2. First Alternate	3. Second Alternate:
Name:	______________________	______________________
Relationship:	______________________	______________________
Address:	______________________	______________________
	______________________	______________________
Phone (H):	______________________	______________________
Phone (W):	______________________	______________________
Phone (cell):	______________________	______________________

For wife:

1. Primary: husband

	2. First Alternate	3. Second Alternate:
Name:	______________________	______________________
Relationship:	______________________	______________________
Address:	______________________	______________________
	______________________	______________________
Phone (H):	______________________	______________________
Phone (W):	______________________	______________________
Phone (cell):	______________________	______________________

4. <u>HIPAA AUTHORIZATION FOR RELEASE</u> forms: These forms list 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>Husband</u>:	______________________	______________________
	______________________	______________________
	______________________	______________________
	______________________	______________________
<u>Wife</u>:	______________________	______________________
	______________________	______________________
	______________________	______________________
	______________________	______________________

5. <u>PRIMARY CARE PHYSICIAN(S)</u>: Please provide us with the name(s), practice(s), and address(es) of your Primary Care Physician(s), so that we may send copies of your signed Health Care Proxies, Living Wills, and HIPAA Authorization for Release forms for your records:

	<u>Husband's PCP</u>	<u>Wife's PCP</u>
	______________________	______________________
Practice:	______________________	______________________
	______________________	______________________
	______________________	______________________