FIVE STAR
ESTATE PLANS
—TRUSTS AND WILLS—

# FINANCIAL & HEALTHCARE POA INTAKE INFORMATION (Joint)

## Client Information

**Client's Full Name** _____

**Spouse Full Name** _____

**Address** _____

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

**Phone** _____ **Email** _____

## Power of Attorney

## 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_____ )**

**Full Name _____**

**Alternate Agent (Co-Agent: Yes_____ No_____ )**

**Full Name _____**

## Advanced Healthcare Directive

**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 the Trustee _____**

**Primary Agent (First Choice)**

**Full Name _____**

**Alternate Agent (Second Choice)**

**Full Name _____**

## Primary Physician

Name _____

Address _____ Phone _____

## Burial Instructions

**Cremation _____ Burial _____**

**Details _____**

**_____**

# 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 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 as long as a Full Recovery is Possible.
**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 as long as a Full Recovery is Possible.
**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** 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:**

_____

_____

## Power of Attorney

## Name:_____

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