MY FINAL WISHES

Guidelines to Help My Loved Ones Through a Difficult Time

In this packet, you will find:

- Personal Information Form
- Medical and Insurance Information
- Financial Information
- End of Life Instructions
- Funeral Arrangements Form
- Power of Attorney and Health Care Forms

Personal Information

Complete all relevant information about yourself, your loved one, or other:

1. Full Name

Given Name | Middle Name | Last Name

2. Date of Birth (DOB): Month | Day | Year

3. Address: Street | City | State | Zip

4. Home Telephone:

5. Cell Phone:

6. Social Security Number:

7. Medicare Number:

8. Military ID Number:

9. Driver's License:

10. Emergency Contact Person:

Street | City | State | Zip

Home Phone: | Cell: | Work:

Relationship:

11. Doctor (Primary Care Physician):

Street | City | State | Zip

Office Phone:

12. Hospital Name:

Street | City | State | Zip

Office Phone:

Personal Information (continued)

13. Person with Medical Power of Attorney:

Street | City | State | Zip

Office Phone:

14. Person with Financial Power of Attorney:

Street | City | State | Zip

Office Phone:

15. Person with Mental Health Power of Attorney:

Street | City | State | Zip

Office Phone:

16. Personal Attorney's Name:

Street | City | State | Zip

Office Phone:

17. I have a pet(s): named:

In case of emergency, I would like: to care for my pet(s).

Veterinarian's Name:

Firm Name/Title:

Street | City | State | Zip

Office Phone:

18. Family/Friends to notify in case of emergency:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Important Documents Locator

Critical Documents

	Location
Social Security Card	
Medicare Card	
HMO Card	
Primary Health Insurance Policy	
Long-Term Care Ins. Policy	
Secondary Health Ins. Policy	
Medicare Supplement Policy	
Life Insurance Policy	
Burial/Funeral Policy	
Deed to Burial Plot	
Homeowner's Policy	
Automobile Policy	
Living Will	
Medical Power of Attorney	
Financial Power of Attorney	
Mental Health Power of Attorney	
Pre-Hospital Advance Directive	

Personal Documents

	Location
Birth Certificates	
Marriage Certificates	
Divorce Decree	
Citizenship Papers	
Military Discharge Papers	
Other Personal Docs	

Financial Documents

	Location
Last Year's Tax Return	
Previous Year's Returns	
Will	
Trust Papers	
Credit Cards	
Previous Month's Bank Statement	
Annual SSI Award Letter	
Statements from Retirement/Pension	
Safe/Safety Deposit Boxes and Keys	
Most Current Bank Statements	

Property Information & Important Financial Contacts

Property Information

	Location
Deed to House	
Mortgage Papers	
Lease Agreements	
Rental Property Agreements	
Automobile Title	
Last Property Tax Statement	
Verification of HOA Fee	
Verification of Mobile Home Rent	

Important Financial Contacts

Attorney:

Name:

Firm:

Street | City | State | Zip

Office Phone:

Accountant:

Name:

Firm:

Street | City | State | Zip

Office Phone:

Tax Preparer:

Name:

Firm:

Street | City | State | Zip

Office Phone:

Banker:

Name:

Firm:

Street | City | State | Zip

Office Phone:

Medical and Personal Insurance Information

1. Primary Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Agent's name:

2. Medicare Supplement Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Agent's name:

3. Long-Term Care Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Agent's name:

4. Secondary Health Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Agent's name:

5. Life Insurance Company #1:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

6. Life Insurance Company #2:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

7. Burial Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

Medical and Personal Insurance Information (continued)

8. Auto Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

9. Homeowners Insurance Carrier:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

10. Other Insurance:

Street | City | State | Zip

Office Phone: | Type of Policy:

Policy #: | Face Value $: | Agent's name:

End of Life Instructions

This is a difficult time for my family; therefore I am making my final wishes known.

Name of Funeral Home:

Street | City | State | Zip

Office Phone:

Pre-paid? ◯ Yes ◯ No

If yes, paperwork/receipt location:

Spending limit (if no pre-payment): $

Do you want to be cremated? ◯ Yes ◯ No

If yes, how do you want the remains handled?

Would you like a funeral or memorial service? Where?

Open casket viewing prior to cremation? ◉ Yes ◯ No

Name of Person to Officiate:

Officiant Phone:

Alternate Officiant:

Alternate Officiant Phone:

Music selections, Vocal, or Instrumentals to be Played:

Poems, Spiritual Readings, Anecdotes to be Read or Told:

Readers or Speakers:

Casket open for viewing? ☐ Yes ☐ No If Yes, for whom? ☐ Family only ☐ Everyone

Clothing and Jewelry Choices:

Wedding ring on? ☐ Yes ☐ No Glasses on? ☐ Yes ☐ No

Memorial Information Questionnaire

Name of Cemetery:

Street | City | State | Zip

Office Phone:

Do you already own a burial plot? ☐ Yes ☐ No

If yes, what type of plot?

Do you want a headstone or other memorial marker? ☐ Yes ☐ No

If yes, what would you like the marker to say?

Have you already paid for the marker? ☐ Yes ☐ No

Special instructions or thoughts about your memorial:

Signature

Date

Health Care Power of Attorney — Designation Form

1. DESIGNATION OF HEALTH CARE AGENT

I, _____ , hereby appoint:

Agent's Name: _____

Agent's Address: _____

Phone - Home: _____ Work: _____ Mobile: _____

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent: _____

Phone - Home: _____ Work: _____ Mobile: _____

b. Second Alternate Agent: _____

Phone - Home: _____ Work: _____ Mobile: _____

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

Initial ONLY ONE of the following 3 options:

☐ GRANT OF DISCRETION TO AGENT — Agent decides based on burdens vs. benefits.

☐ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT — Do not prolong my life.

☐ DIRECTIVE FOR MAXIMUM TREATMENT — Prolong my life to the greatest extent possible.

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

Initial ONLY ONE of the following 3 options:

☐ GRANT OF DISCRETION TO AGENT — Agent decides based on burdens vs. benefits.

☐ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING — Do not prolong by tube.

☐ DIRECTIVE FOR PROVISION OF TUBE FEEDING — Provide tube feeding.

5. ORGAN DONATION

My agent ☐ may ☐ may not consent to donation of tissue/organs for transplantation.

I sign my name to this Health Care Power of Attorney on:

Day: _____ Month: _____ Year: _____

_____ Principal's Signature

_____ Print Name of Principal

Witness No. 1

_____ Signature

_____ Date

_____ Print Name

_____ Phone

The remaining pages of this document are not fillable. Below is the South Carolina Power of Attorney printable form.

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:
(Principal)

(Agent's Name) _____

(Agent's Address) _____

Telephone: home: _____ work: _____ mobile:_____

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:

Address: _____

Telephone: home:_____ work:_____ mobile:_____

b. Second Alternate Agent:

Address:_____

Telephone: home:_____ work:_____ mobile:_____

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Information Portability and

Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

_____

_____

_____

5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may ☐; may not ☐ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does

not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

(1) ☐ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) ☐ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) ☐ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Item 7, (INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS):

(a) ☐ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

(b) ☐ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(c) ☐ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN ITEM 8, YOUR AGENT WILL NOT

HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on

this _____ day of _____, 20 ____. My current home address is:

_____

Principal's Signature:_____

Print Name of Principal:_____

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1

Signature:_____

Date:_____

Print Name:_____

Telephone:_____

Address:_____

_____

Witness No. 2

Signature:_____

Date:_____

Print Name:_____

Telephone:_____

Address:_____

_____

(This portion of the document is optional and is not required to create a valid health care power of attorney.)

STATE OF SOUTH CAROLINA

COUNTY OF_____

The foregoing instrument was acknowledged before me by Principal on _____,

20 _____.

Notary Public for South Carolina_____

My Commission Expires:_____