



Ordering Our Steps with the **WRITE** Information

A Testimony of Knowledge

Presented by
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JUST THE FACTS

Full Name: _____
FIRST MIDDLE LAST

Birthplace: _____
CITY STATE COUNTY COUNTRY

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Current Full Address: _____
STREET NUMBER AND NAME CITY STATE

Name of Spouse or Significant Other: _____

Employer (or retired from): _____
COMPANY NAME

Current Full Address: _____
STREET NUMBER AND NAME CITY STATE

COUNTY COUNTRY

Father's Name: _____
FIRST MIDDLE LAST

Father's Birthplace: _____
CITY STATE COUNTY COUNTRY

Mother's Name: _____
FIRST MIDDLE LAST

Mother's Birthplace: _____
CITY STATE COUNTY COUNTRY

I have an advance Care Plan (or Living Will)?: YES NO

Location of Document: _____

Any Additional Remarks: _____

Birth Certificate is located: _____

Marriage Certificate if located: _____

Passport Number: _____ Location: _____

Religious Denomination: _____

Religious Services attended at: _____

Medicare Number: _____ Medicaid Number: _____

MEDICAL HISTORY: *I have had treatment for:*

Cancer:	Circulatory Problems:
Tuberculosis:	Heart:
Kidney Disorder:	Other:
Diabetes:	Other:

I am allergic to the following drugs: _____
(It is also suggested that you keep an updated copy of your medical records for your family, as physicians often ask for it.)

DOCTOR:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

DOCTOR:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

PHARMACY:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

LAWYER:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

ACCOUNTANT:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

FINANCIAL ADVISOR:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

IF YOU ARE A VETERAN, PLEASE COMPLETE PAGE 28.



FINANCIAL INFORMATION

“Even death is not to be feared by one who lives wisely.”
Buddha

IMPORTANT BANKING INFORMATION

- Don't let the location of your saving and checking accounts be a mystery.
- Don't let valuables in safe deposit boxes go unclaimed.
- It will be necessary to clean up unpaid bills and close out accounts before any distribution of funds can be made.
- Make it easy and efficient for your loved ones.

ACCOUNTS:

Bank/Credit Union Name: _____ Branch: _____

Address: _____

Phone: _____ Contact: _____

Checking Account #: _____ Savings Account #: _____

Checking Account #: _____ Savings Account #: _____

Bank/Credit Union Name: _____ Branch: _____

Address: _____

Phone: _____ Contact: _____

Checking Account #: _____ Savings Account #: _____

Checking Account #: _____ Savings Account #: _____

Money Market Account: _____ Money Market Account: _____

Money Market Account: _____ Money Market Account: _____

Certificate of Deposit: _____ Certificate of Deposit: _____

Certificate of Deposit: _____ Certificate of Deposit: _____

Safe Deposit Box? YES NO Key #: _____ Location: _____

Remember safe deposit boxes may be sealed upon death. It may be wise to place a trusted family member on the list for access to safe deposit box and let them know where the key is hidden. Please speak to your bank regarding your options. A safe deposit box can be accessed after death or to obtain wills and other important papers. If a person dies without will or descendants, the safe deposit box will be sealed and inventoried for probate and estate distribution.

INSURANCE POLICIES

INSURANCE COMPANY: _____

Address: _____

Phone Number and Contact: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

INSURANCE COMPANY: _____

Address: _____

Phone Number and Contact: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

INSURANCE COMPANY: _____

Address: _____

Phone Number and Contact: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

Account Type/Number: _____

Amount of Insurance: _____ Due Date: _____ Type of payment: _____

CHARGE CARD INFORMATION

(MasterCard, Visa, American Express, Discover, Department Stores)

CHARGE CARD:

Company: _____

Address: _____

Phone Number: _____

Account Number: _____

Company: _____

Address: _____

Phone Number: _____

Account Number: _____

Company: _____

Address: _____

Phone Number: _____

Account Number: _____

OTHER AGREEMENTS

Money: _____

Written Contract

Oral Agreement

Money: _____

Written Contract

Oral Agreement

Who: _____

Address: _____ City/State: _____ Zip: _____

County: _____ Country: _____ Phone Number: _____

Important Information: _____

Money: _____

Written Contract

Oral Agreement

Money: _____

Written Contract

Oral Agreement

Who: _____

Address: _____ City/State: _____ Zip: _____

County: _____ Country: _____ Phone Number: _____

Important Information: _____

INVESTMENTS: STOCKS, BONDS AND MUTUAL FUNDS

STOCK BROKER:

Name: _____ Phone: _____
Firm: _____
Address: _____

FINANCIAL ADVISOR:

Name: _____ Phone: _____
Firm: _____
Address: _____

PORTFOLIO:

RETIREMENT INVESTMENTS

Certificate of Deposit (CDs): (Company name Address, Account Number)

IRAs: (Company name Address, Account Number)

Annuities): (Company name Address, Account Number)

KEOGHS: (Company name Address, Account Number)

401(K) PLANS: (Company name Address, Account Number)

Employee Stock Option Plan (ESOP): (Company name Address, Account Number)

BENEFITS

SOCIAL SECURITY BENEFITS:

- Disability Benefits: _____

- Dependent Benefits: _____

- Retirement Benefits: _____

- Survivor's Benefits: _____

SOCIAL SECURITY OFFICE:

Contact: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

PENSION:

Civil Service: _____
Contact: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Beneficiary: _____

Veteran's Administration Benefits:

Contact: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Beneficiary: _____

Private Employer:

Contact: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Beneficiary: _____



THE MATERIAL WORLD

*“Has this world been so kind to you that you should leave with regret?
There are better things ahead than any we leave behind.”*

C. S. Lewis

REAL ESTATE:

Primary Residence:

Address: _____ City/State: _____ Zip: _____
OWN: _____ Deed is Located: _____

BANK/MORTGAGE:

Name: _____ Branch: _____ Account No.: _____
Address: _____ City/State: _____ Zip: _____
Contact: _____ Phone: _____

RENT

Landlord Name/Property Manager: _____
Company: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

OTHER (Time-Share, Vacation Home, Mobile Home, Condo, Co-op Commercial, Land, Business, etc.)

Type of Real Estate: _____
Address: _____ City/State: _____ Zip: _____
OWN: _____ Deed is Located: _____

BANK/MORTGAGE:

Name: _____ Branch: _____ Account No.: _____
Address: _____ City/State: _____ Zip: _____
Contact: _____ Phone: _____

RENT

Landlord Name/Property Manager: _____
Company: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

OTHER (Time-Share, Vacation Home, Mobile Home, Condo, Co-op Commercial, Land, Business, etc.)

Type of Real Estate: _____
Address: _____ City/State: _____ Zip: _____
OWN: _____ Deed is Located: _____

IMPORTANT HOME INFORMATION

- Very often, one person in the house handles the technical difficulties that may arise.
- Do you know the intimate details of the furnace, the toilet, the dishwasher?
- Share the Knowledge.

IMPORTANT NAMES AND NUMBERS

Plumber: _____ Phone: _____

Electrician: _____ Phone: _____

Well/Septic: _____ Phone: _____

Handy Man: _____ Phone: _____

Oil: _____ Gas Delivery: _____

Company: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Rubbish Removal: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

THE WELL BEING OF THE HOME

(HELPFUL HINTS WHEN DEALING WITH . . .)

Fuses/Circuit Breakers: _____

Where to turn off the water: _____

Furnace/Hot Water Heaters: _____

Lawn Mower: _____

Fireplace/Heat Source: _____

Where is the septic tank located: _____

Other things about the home that you know and others need to know: _____

It wouldn't hurt to take a tour of your house to see what and where it is and what in heaven's name does it do.

KEEPING THE YARD HAPPY

SPRING Chores regarding the lawn, trees, shrubs, flowers and vegetable garden:

SUMMER Chores regarding the lawn, trees, shrubs, flowers and vegetable garden:

AUTUMN Chores regarding the lawn, trees, shrubs, flowers and vegetable garden:

WINTER Chores regarding the lawn, trees, shrubs, flowers and vegetable garden:

LAWN CARE/LANDSCAPER:

Name: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

TOOLS/EQUIPMENT:

Type Tool: _____ Can Be Found: _____

Type Tool: _____ Can Be Found: _____

Type Tool: _____ Can Be Found: _____

Type Tool: _____ Can Be Found: _____

Type Tool: _____ Can Be Found: _____

Who has borrowed: _____

VEHICLE AND TRANSPORTATION

Car/Truck Recreational Vehicle Boat Motorcycle Other: _____

Year: _____ Make: _____ Model: _____

Description: _____ Located: _____

Own Title: _____

Leasing Company

Name: _____ Contact: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

*To whom it shall go:

Name: _____ Address: _____ Phone: _____

Car/Truck Recreational Vehicle Boat Motorcycle Other: _____

Year: _____ Make: _____ Model: _____

Description: _____ Located: _____

Own Title: _____

Leasing Company

Name: _____ Contact: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

*To whom it shall go:

Name: _____ Address: _____ Phone: _____

Car/Truck Recreational Vehicle Boat Motorcycle Other: _____

Year: _____ Make: _____ Model: _____

Description: _____ Located: _____

Own Title: _____

Leasing Company

Name: _____ Contact: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

*To whom it shall go:

Name: _____ Address: _____ Phone: _____

KEEPING THE VEHICLES SEASONALLY HAPPY

SPRING Duties regarding the well-being of the vehicles:

SUMMER Duties regarding the well-being of the vehicles:

AUTUMN Duties regarding the well-being of the vehicles:

WINTER Duties regarding the well-being of the vehicles:

Favorite Mechanic:

Name: _____

Address: _____ Phone: _____

The titles to the vehicles can be found: _____

Other important papers can be found: _____

Other information: _____



JUST BETWEEN YOU & ME

*“The best and most beautiful things in the world cannot
Be seen or even touched—they must be felt with the heart.”*

Helen Keller

STUFF & THE STORY BEHIND IT

- Your belongings are important to you.
- Some stuff has great meaning . . . some has little meaning . . . and some have no meaning at all.
- Nobody knows but you. But now here's the chance to share.
-

ITEM	DESCRIPTION	SPECIAL MEANING	TO WHOM SHALL IT GO

HIDING PLACES

Let someone know where to find those things that were hidden away and might be forgotten.

The keys to the safe deposit box(es) are: _____

The keys to automobile, mower, boat, etc.: _____

The combinations to the locks are: _____

Person(s) who know where you have put keys and/or combination information:

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

My Last Few Days On This Earth, I Would Like . . .

- If you could tell your caregiver what you would like during your last few months or days on earth, what would it be?
- Please list as many things you can think of (even if it's just whimsical):

What would you like your room to be like?

- Temperature of room: _____
- Color of your room: _____
- Sounds (ex. Music, TV, etc.): _____
- Dark/Light room (curtains opened or closed): _____
- Flowers, Posters, Pictures, etc.: _____

Do you want visitors?

- Family: _____
- Pets: _____
- Friends: _____

What type of food do you want (if any)?

- Favorite: _____
- Soft: _____

Do you want someone to read devotions to you?

- Religious: _____
- Bible: _____
- Other: _____

Any special instructions to professional staff that may be taking care of you?

THE CHILDREN

Child's Name: _____ Birth date: _____
Nickname: _____
Special Health Concerns: _____
Allergies/Medications: _____
Doctor's Name: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Dentist's Name: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Favorite Breakfast: _____
Favorite Lunch: _____
Favorite Dinner: _____
Favorite Snack: _____
Bedtime Rituals: _____
Hobbies/Interests: _____
Favorite Books: _____
Fears: _____
Other Things To Remember: _____

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Child's Name: _____ Birth date: _____
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Favorite Lunch: _____
Favorite Dinner: _____
Favorite Snack: _____
Bedtime Rituals: _____
Hobbies/Interests: _____
Favorite Books: _____
Fears: _____
Other Things To Remember: _____

A LETTER TO MY CHILD OR GRANDCHILD

- Children are always curious about the facts and feelings their parents had regarding their arrival into this world.
- Here's an opportunity to share your thoughts.

Dear: _____

I remember when I found out I was going to have you in my life . . .

The day you were born . . .

The things that make me smile when I look back . . .

What I want you to know for all time . . .

These are my hopes and dreams for you . . .

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The day you were born . . .

The things that make me smile when I look back . . .

What I want you to know for all time . . .

These are my hopes and dreams for you . . .



PREPARATION

"I am prepared for the worst, but hope for the best."

Benjamin Disraeli

PREPARING A LAST WILL & TESTAMENT

Take the time to leave written instruction in official legal form. Don't leave the probate court on your family with the burden of sorting out your affairs in the absence of a Will.

Choosing an Executor:

An executor is someone who will carry out wishes of the Will.

The person you choose as the executor of your Will should be someone who is willing and able to devote time and diligence in following through with all the paperwork that must be accurately completed. Often, the executor will work with a lawyer and/or an accountant. Also, it is important that your executor does not buckle under pressure that the family may apply in dealing with any questionable issue in the will.

The Executor of my Estate: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____

Where my Last Will and Testament is kept:

Areas to cover in the Will: _____

Questions to ask the lawyer:

SOCIAL SECURITY INFORMATION

Social Security Number: _____

Address of Nearest Social Security Office: _____

Phone: _____

A lump sum payment may be made when an eligible person dies. This payment can only be made if there is an eligible surviving widow, widower, or entitled child. Also, survivor's checks may go to certain members of a worker's family. To facilitate receiving Social Security benefits, you will need the following when you contact your Social Security office:

1. Social Security Number, as well as the deceased worker's
2. Marriage License
3. Your Birth certificate
4. Defendant children's birth certificate and SS#
5. W2 for previous two years
6. Proof of widow(er)'s age if 62 years or older
7. Certified Copy of the Death Certificate
8. Divorced/legal separation agreements, if you are applying as a divorced, widow, or widower
9. Deceased worker's W-2 forms of federal self-employment tax return or most recent year
10. The name of your bank and your account # so your benefits can be deposited.

An application for the lump sum death payments usually must be made within two years after the worker's death. Don't delay applying because you don't have all the proof of information. Social Security will help you get what you need. The people at the Social Security Office will tell you about the proof of information that can be used when you apply.

It's a good idea to check your record every three years to make sure the earnings are being correctly reported to your record.

SOCIAL SECURITY ADMINISTRATION TOLL FREE

1-800-772-1213

WWW.SOCIALSECURITY.GOV



ARMED FORCES INFORMATION

Branch of Service: _____

Service Serial Number: _____

Ranks Achieved: _____

Dates Served: _____

Wars/Conflicts/Primary Duty Area: _____

Medals/Honors/Citations:

Overall view of experience during service: _____

Reflections/Stories about service: _____

Location of Military Discharge Papers (DD214): _____

VETERANS' BURIAL BENEFITS

- To facilitate receiving veteran's military service (DD214)
- Service Serial Number: _____
- Marriage License (if applicable)
- Children's Birth Certificate (if applicable)
- Certified Copy of the Death Certificate

Veterans Administration Toll-Free Phone Number

1-800-8267-1000

www.va.gov

Can I get veteran pension benefits?

If you meet these basic requirements, it's worth applying.

1. If you are a veteran or widow of a veteran.
2. The veteran has an honorable discharge.
3. You are over 65 years old or permanently or totally disabled.
4. The veteran served at least one day during a war period (see chart below)

WARTIME Service Dates

<u>Mexican border period:</u> May 9, 1916 through April 5, 1917
<u>World War I:</u> April 6, 1917 through November 11, 1918. NOTE: veterans who served in Russia April 1917—April 1, 1920 (extended through July 1, 1921 for veterans who had at least one day service between April 6, 1917 and November 11, 1918)
<u>World War II:</u> December 17, 1941 through December 31, 1946
<u>Korean War:</u> June 27, 1950 through January 31, 1955
<u>Vietnam War:</u> August 5, 1964 through May 7, 1975. NOTE: veterans who served "in country" from February 28, 1961 to August 5, 1964 are considered Vietnam war veterans.
<u>Gulf War:</u> August 2, 1990 through a date to be set by or residential proclamation

2012 VA Improved Pension Rates (monthly) – (this is total combined monthly income)

Veteran	Regular	House bound	Aid and Attendance
Single veteran	\$1021.30	\$1248.16	\$1703.91
Married veteran	\$1377.00	\$1564.00	\$2019.00
Widow of a veteran	\$684.00	\$837.00	\$1094.00

Certain medical expenses can be deducted from income to help qualify.
Both the veteran and his/her dependents are counted.

Medicine cost both prescriptions and over the counter.
Cost of all health insurance (including Medicare Part B and D Medigap policies and cancer policies).
Cost of assisted living facilities.
Cost of in-home paid caregiver (can be a family member).
Mileage to and from all medical-related visits, such as M.D. appointment and trips to drug store to pick up medicines.

Information needed when applying for veteran Pension benefits

1. V.A. for DD-214 (discharge papers)
2. Marriage license on all marriages and divorce papers of all divorces
3. Death certificate of veteran
4. Proof on income (all sources)
5. Interest and net worth on all interest-bearing account
6. Net worth of all bank accounts
7. Proof of all out of pocket medical cost
8. V.S. Form 21-2680 (called examination for house bound status or permanent need for regular and attendance) this form to be filled out by your family M.D.

Your Veteran Service Representative is: _____

Phone Number is: _____



FUNERAL SERVICE INSTRUCTIONS

The following is an expression of my funeral service decisions.

Funeral Home/Mortuary/Crematorium Preferred: _____

Address: _____

Phone: _____

Prearrangement/Prepayment made: Yes No

Type of Service you prefer:

Graveside Service Location: _____ Plot Location: _____

Deed Located: _____

Wake/Reception Location: _____

Memorial Service Location: _____

Funeral Location: _____

Casket Open for viewing Open for service Closed for service

Cremation Ashes held by: _____ Scattered at: _____

Special Request: _____

Other: _____

Religious Preference: _____ Celebrant/Clergyman: _____

Religious Passages Selected: _____

Eulogy by: _____

Other Speakers: _____

Participating Organizations: _____ Contact person: _____

Participating Organizations: _____ Contact person: _____

Music/Organist: _____ Vocalist(s): _____

Musical Selections/Songs: _____

Obituaries for these newspapers _____

My Epitaph will read (or what I want other to say or remember about me):

FUNERAL SERVICE INSTRUCTIONS (continued)

Flag: N/A Draped Folded Presented to: _____

Floral Casket Blanket [type and color(s) preferred]: _____

Clothing Preference: New From Funeral Home Choices
 From current wardrobe (specify): _____

Personal Accessories: Wedding Band Stays on OR Return to: _____
 Eyeglasses Stays on OR Return to: _____
 Other Stays on OR Return to: _____

Suggested Pallbearers:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Honorary Pallbearers:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Floral bearers:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Memorial Donation Request: _____

Memorial donations may be made to: _____

Address: _____ Phone: _____



LEGACY INFORMATION

Experience/Stories/Tales

Early Childhood and upbringing: _____

Adolescent years: _____

Early adulthood: _____

Education:
High School: _____ Year Graduated: _____
College: _____
Other: _____

My proudest moments: _____

My proudest accomplishments: _____

Special Achievements/Awards/Office held/Additional point of interest and/or memories: _____
My proudest moments: _____



ADVANCE DIRECTIVE

The next pages contain copies of the (TN Advance Directives) forms.

These forms may be used to provide instructions for your medical care in the case that you are terminally ill and/or unable to speak for yourself. You may use either one of the forms to implement your end of life care choices. However, it may be best to utilize BOTH the Advance Care Plan form to carefully explain your wishes and the Appointment of Health Care Agent form to designate a person to ensure that your plans are carried out.

The Advance Care Plan expresses your wishes for the extent of your care you want, given your physical and mental condition at the time.

The Appointment of Health Care Agent additionally allows you to appoint a person of your choice to make your healthcare decisions in the event you become unable to do so. Be sure to discuss your wishes in advance with this person and ask their permission for the appointment. This person does not have to be a relative, although you need to choose someone who is close to you and willing to follow your instructions. You will need to appoint an alternate agent in the event your agent is unavailable or unable to serve. The form designates a space for the agent and the alternate.

The documents may either be witnessed by two adults (see direction on form as to who may not sign as a witness for you) or Notarized. Once you have completed these forms, keep the original in a secure place. Take a copy of your Advance Directives to your physician and the hospital that you generally use. Also, give a copy to the person you have appointed as your Health Care Agent and attach one to this booklet.

This is your way to be sure that your health care providers and loved ones know your wishes for care when you cannot speak for yourself.

If you have any questions or need assistance with completion of these forms, please contact New Direction Health Care Solution.



POST

Make your end of life treatment wishes known.

The POST (Physician Orders for Scope of Treatment) form is intended for people with serious health conditions. It is used to make a person's wishes for medical care known to doctors, nurses, and other health care staff.

If you have a serious health condition, you can help to make certain that your wishes for care in the future are known and respected. The POST form makes sure that your wishes are clear to people treating you. It provides a doctor's order for them to follow.

The POST form is a medical order form. Your doctor uses the POST form to write orders that indicate the treatment you want in the last stages of illness. The POST form asks for information about your preferences for CPR, medical conditions, and the use of antibiotics, a feeding tube, and intravenous fluids.

The POST form is voluntary and is intended to:

- Help you and your doctor discuss and develop plan to reflect your wishes.
- Assist doctors, nurses, health care facilities, and emergency personnel in honoring your wishes.
- Make sure that your wishes are followed as you are moved from one health care setting to another (for example, hospital or nursing home).

HEALTH CARE POWER OF ATTORNEY

The Power of Attorney is to be used for individuals to ensure that someone is designated to represent and speak for you in the event that you are unable to speak for yourself. It should be completed and copied. ***It does not have to be notarized, just have witness sign the form.***

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid. POST must be signed by a physician or, at discharge or transfer from a hospital or long-term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen “Do Not Attempt Resuscitation”.

Oral fluid and nutrition must always be offered, if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measure Only”, should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only”.

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment”.

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Review POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient’s health status, or
- (3) The patient’s treatment preferences change.

Draw a line through sections A through D and write “VOID” in large letters if POST is replaced or becomes invalid.

APPOINTMENT OF HEALTH CARE AGENT FORM

References:

In the checklist of life. "A Working Book", 2nd edition. (1997) McPhelimy, Lynn. AAIP Publishing Co. LLC, Rockfall, CT.

The reader is urged to consult legal counsel regarding any legal issues or questions that topics in this book may cover. No part of this book should serve as a legal document.