

Planning for the Grey Area of Incapacity: Using Advance Health Care Directives and Powers of Attorney



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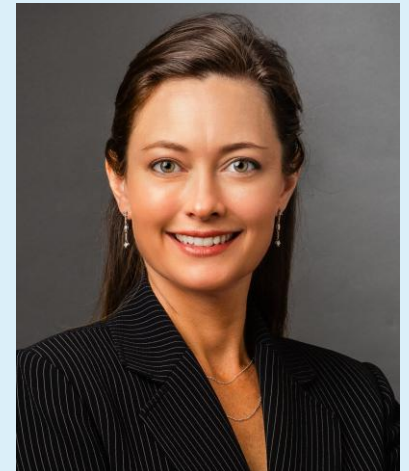
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- **B.A. IN PSYCHOLOGY - UNIVERSITY OF CALIFORNIA AT IRVINE**
- **JURIS DOCTORATE - CHAPMAN UNIVERSITY SCHOOL OF LAW**
- **EMPHASIS IN TAXATION - CHAPMAN UNIVERSITY SCHOOL OF LAW**
- **MEDIATION PROGRAM - STRAUSS INSTITUTE PEPPERDINE SCHOOL OF LAW**
- **WEALTH COUNSEL MEMBER**
- **YOUNG ATTORNEY OF THE YEAR,
SAN DIEGO DAILY TRANSCRIPT (2008)**
- **20 YEARS ESTATE PLANNING EXPERIENCE**
- **BACKGROUND IN LITIGATION**



Stephanie D. Winstead, Esq.



**If I'm not
able to
communicate
my wishes,
who will speak
for me?**

Planning for Incapacity

1. Health Care Power of Attorney
2. Advance Health Care Directive
3. HIPAA Authorization
4. Your Way
5. DNR and POLST
6. Durable Power of Attorney for Finances
7. Conservatorship



What is Incapacity?

Planning for Incapacity

Defined in California Probate Code Sections 810-813.

- Presumption of Capacity § 810
- Deficits in Mental Functions as examples of lack of capacity § 811
 - Alertness
 - Information processing
 - Thought process
 - Control of mood
- The mere diagnosis of a mental or physical disorder SHALL NOT be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act. § 811 (d)



What is Incapacity?

Planning for Incapacity

Defined in California Probate Code Sections 810-813.

- Capacity to Make Decisions § 812

They must be able to communicate their decisions and understand and appreciate:

- (a) The rights, duties, and responsibilities created by, or affect by the decisions.
- (b) The probable consequences for the decisionmaker and those affected by the decision, and
- (c) The significant risks, benefits, and reasonable alternatives involved in the decision.

- Capacity to Give/Withhold Informed Consent to Medical Treatment § 813

- Respond knowingly and intelligently
- Rational thought process re medical treatment
- Understand the seriousness of the illness, treatment risks/consequences



**Communication
is
Key!**



How Do You Plan for Incapacity?

1. It's a process.
 - a) Not an event!
 - b) Not a document!
2. Communicate your desires to:
 - a) Loved ones,
 - b) Physicians, and
 - c) Financial advisors.
3. Minimize court expense and involvement.
4. Guide for loved ones to follow.

Health Care Power of Attorney

Designates the person who has the authority to handle your medical affairs and convey your wishes to doctors upon your incapacity.

The person granting the authority (you) is called the “Principal.”

The person receiving the authority is called the “Agent.”

Agent’s Authority:

- Communicate with medical providers,
- Receive medical records,
- Admit and remove you from a hospital,
- Consent to administering and withdrawing life sustaining medical treatment,
- Donate organs, tissues, body parts,
- Direct disposition of your remains.

Who do you choose as your Health Care Agent?

Qualities to look for:

- Willingness to follow your wishes,
- Proximity/Availability/Ability to serve,
- Trustworthy,
- Experience, and
- Religious beliefs.

People commonly choose the following people as their Health Care Agent.

- Family member,
- Friend, and
- Alternate Agents.

Co-Agents are NOT recommended.

Health care providers and operators and employees of residential care facilities are NOT allowed.



ADVANCE HEALTH CARE DIRECTIVE FORM

PAGE 1 of 7

[Print Form](#)

[Reset Form](#)

Probate Code - PROB

DIVISION 4.7. HEALTH CARE DECISIONS [4600 - 4806] (Division 4.7 added by Stats. 1999, Ch. 658, Sec. 39.)

PART 2. UNIFORM HEALTH CARE DECISIONS ACT [4670 - 4743] (Part 2 added by Stats. 1999, Ch. 658, Sec. 39.)

CHAPTER 2. Advance Health Care Directive Forms [4700 - 4701] (Chapter 2 added by Stats. 1999, Ch. 658, Sec. 39.)

4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE (California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Donate your organs, tissues, and parts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues, and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Advance Health Care Directive

Document used to convey to
your Health Care Agent your
desires concerning life
sustaining treatment and
anatomical gifts.

Statutory form is found at
CA Probate Code § 4701.

Considerations:

- Health care goals and fears,
- Spiritual and religious beliefs,
- What does “quality of life” mean to you?
- Pain relief, even if it hastens death,
- Permanently unconscious,
- Completely dependent upon others,
- Flexibility: What to do in the grey area.

Communication:

- Talk to your Agent,
- Talk to your family and friends,
- Talk to your health care providers,
- Give copies to your physicians and Agent,
- Keep a copy in your car.

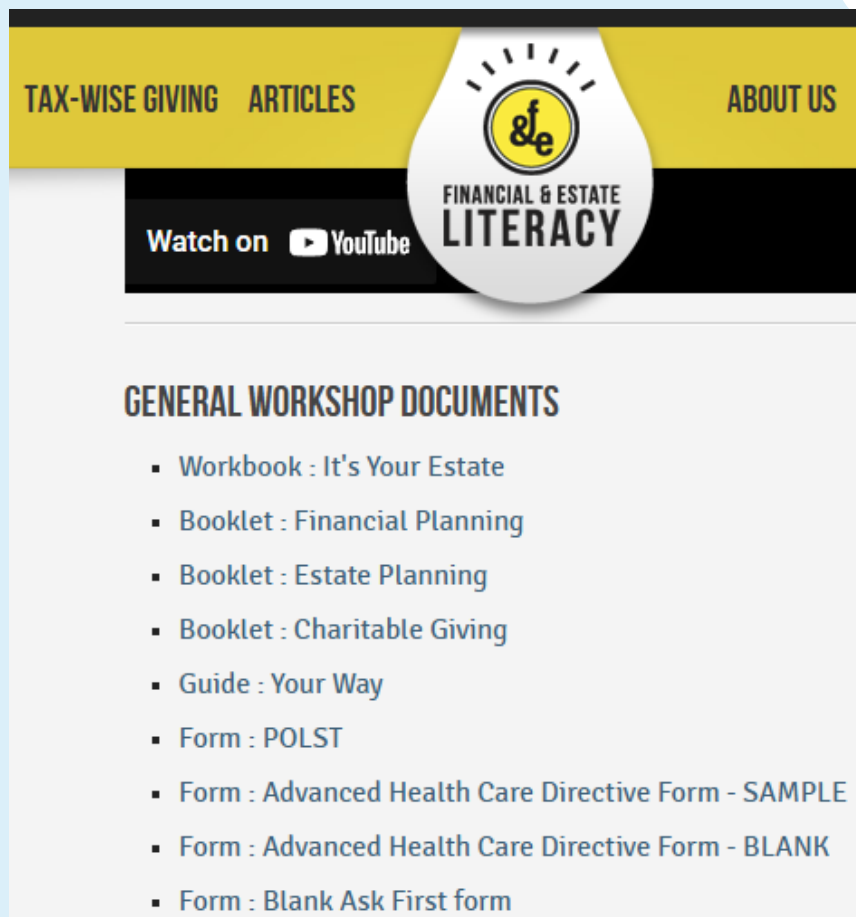
An invisible Advance Health Care Directive = NO Advance Health Care Directive.



HIPAA Authorization

Provides the Agents named in your Health Care Power of Attorney and General Durable Power of Attorney (discussed later) with access to your medical information.





TAX-WISE GIVING ARTICLES ABOUT US

Watch on YouTube

FINANCIAL & ESTATE LITERACY

GENERAL WORKSHOP DOCUMENTS

- Workbook : It's Your Estate
- Booklet : Financial Planning
- Booklet : Estate Planning
- Booklet : Charitable Giving
- Guide : Your Way
- Form : POLST
- Form : Advanced Health Care Directive Form - SAMPLE
- Form : Advanced Health Care Directive Form - BLANK
- Form : Blank Ask First form

<https://itsyourmoneyandestate.org/educate/its-your-estate-fall/>

Other “Non-Legal” Tools to Help Communicate Your Wishes

Your Way

DNR

POLST

Remembrance and
Services Memorandum



Your Way is a guide to help
you stay in charge of
decisions about your
medical care.

It will help you think about
what's important to you;
what kind of medical care
you want or don't want;
and what quality of life
means to you.



Prehospital Do Not Resuscitate (DNR)

Designed for use in a **prehospital setting** e.g., patient's home, long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals.

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

 **EMERGENCY MEDICAL SERVICES**
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM
An Advance Request to Limit the Scope of Emergency Medical Care

 **CMA**
California Medical Association

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this document will not prevent me from obtaining other emergency medical care by prehospital emergency medical caregivers, or from receiving medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or health care personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature Date _____

Legally Recognized Health Care Decisionmaker Relationship to Patient _____

By signing this form, the legally recognized health care decisionmaker acknowledges that the request for no resuscitative measures is consistent with the known or inferred wishes and best interest of the individual who is the subject of this form.

I affirm that the legally recognized health care decisionmaker is making an informed decision and that the directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiopulmonary medications are to be initiated.

Physician Signature Date _____

Print Name Telephone _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept by patient
Yellow Copy: To be kept in patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

**Audience =
First Responders
EMS
Personnel**



Prehospital Do Not Resuscitate (DNR)

Instructs EMS personnel what your decisions are concerning resuscitative measures in the event of cardiac arrest, including CPR, ventilation, intubation, defibrillation, and cardiotoxic drugs.

CMA PUBLICATIONS 1(800) 882-4262 WWW.CMA-NET.ORG

 **EMERGENCY MEDICAL SERVICES**
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM
An Advance Request to Limit the Scope of Emergency Medical Care

 **CMA**
California Medical Association

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this document will not prevent me from obtaining other emergency medical care by prehospital emergency medical caregivers, and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature Date _____

Legally Recognized Health Care Decisionmaker Relationship to Patient _____

By signing this form, the legally recognized health care decisionmaker acknowledges that the request for no resuscitative measures is consistent with the known wishes and wishes in the best interest of the individual who is the subject of this form.

I affirm that the legally recognized health care decisionmaker is making an informed decision and that the directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form will be placed in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature Date _____

Print Name Telephone _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY
PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept by patient
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Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

Audience =
First Responders
EMS
Personnel

Physician Orders for Life-Sustaining Treatment (POLST)

Executing a POLST gives seriously-ill patients more control over their end-of-life care, including medical treatment, extraordinary measures (such as a ventilator or feeding tube) and CPR.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

EMSA #111 B (Effective 4/1/2017)

Patent Last Name: _____ Form Prepared: _____
 Patient First Name: _____ Patient Date of Birth: _____
 Patient Sex: _____ Medical Record #: (optional) _____

A CARDIOPULMONARY RESUSCITATION *If patient has no pulse and is not breathing.*
If patient is NOT breathing, follow orders in Section A. If patient is breathing, follow orders in Sections B and C.
☐ Attempt Resuscitation/CPR (Resuscitation/CPR Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/CPR (Allow Natural Death)

B MEDICAL TREATMENT *If patient is found with a pulse and/or is breathing.*
☐ **Full Treatment** – primary goal of prolonging life by all medically effective means.
 In addition to treatment described in Selective Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation as indicated.
☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome treatments.
 In addition to treatment described in Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation as indicated. Do not use treatment described in Full Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**
☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort.
 Relieve pain and suffering with medication by any route as needed. Do not use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation. **Request transfer to hospital only if comfort needs cannot be met in current location.**
 Additional Orders: _____

C ARTIFICIALLY ASSISTED NUTRITION *Offer by _____ if feasible and desired.*
☐ Long-term artificial nutrition, including feeding tubes.
☐ Short-term artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

D INFORMATION AND SIGNATURES:
 Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker
☐ Advance Directive dated _____, available and reviewed by _____
☐ Advance Directive not available
☐ No Advance Directive
 Signature of Physician / Nurse Practitioner / Physician Assistant (Print Name, Title, and License #)
 My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.
 Print Physician/NP/PA Name: _____ Physician/NP/PA License #, NP Cert. #: _____
 Physician/NP/PA Signature: (required) _____ Date: _____
 Signature of Patient or Legally Recognized Decisionmaker
 I am aware that this form is voluntary and that I am a legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with my known desires and with the best interest of the individual who is the subject of the form.
 Print Name: _____ Relationship: (write self if patient) _____
 Signature: (required) _____ Date: _____
 Mailing Address (street/city/state/zip): _____ Phone Number: _____
 Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

Audience = First Responders EMS personnel

Physician Orders for Life-Sustaining Treatment (POLST)

Printed on bright pink paper, and signed by both a patient and physician, nurse practitioner or physician assistant.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

EMSA #111 B (Effective 4/1/2017)

A CARDIOPULMONARY RESUSCITATION *If patient has no pulse and is not breathing. If patient is NOT breathing, follow orders in Sections B and C.*

Check One

☐ Attempt Resuscitation/ CPR (Section A requires selecting Full Treatment in Section B)

☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B MEDICAL TREATMENT *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment** – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation as indicated.

☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome treatments. In addition to treatment described in Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation as indicated. Do not use treatment described in Full Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed, suctioning, and manual treatment of airway obstruction. Do not use treatment described in Full or Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C APPLY ARTIFICIAL NUTRITION: *Offer by artificial means if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes, and/or enteral nutrition.

☐ Short-term artificial nutrition, including feeding tubes, and/or enteral nutrition.

☐ No artificial means of nutrition, including feeding tubes.

D INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed by _____

☐ Advance Directive not available

☐ No Advance Directive

Signature of Physician / Nurse Practitioner / Physician Assistant (Print Name, Title, and License #)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: _____ Physician License # _____ Physician/PA License #, NP Cert. #: _____

Physician/NP/PA Signature: (required) _____ Date: _____

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary and that the Legally Recognized Decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires and with the best interest of the individual who is the subject of the form.

Print Name: _____ Relationship: (write self if patient) _____

Signature: (required) _____ Date: _____

Mailing Address (street/city/state/zip): _____ Phone Number: _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

Audience = First Responders EMS personnel

Physician Orders for Life-Sustaining Treatment (POLST)

POLST can prevent unwanted or ineffective treatments, reduce patient and family suffering, and ensure that a patient's wishes are honored.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

EMSA #111 B (Effective 4/1/2017)

A CARDIOPULMONARY RESUSCITATION *If patient has no pulse and is not breathing. If patient is NOT breathing, follow orders in Sections B and C.*

Check One

☐ Attempt Resuscitation/ CPR (Section C requires selecting Full Treatment in Section B)

☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B MEDICAL TREATMENT *If patient is found with a pulse and/or is breathing.*

Check One

☐ Full Treatment - primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiac resuscitation as indicated.

☐ Selective Treatment - goal of treating medical conditions while avoiding burdensome treatments. In addition to treatment described in Comfort-Focused Treatment, use mechanical ventilation, intubation, and IV fluids as indicated. Do not use non-invasive positive airway pressure. Generally requires intensive care.

☐ Comfort-Focused Treatment - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed. Do not use mechanical ventilation, intubation, or IV fluids. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders:

C APPLY ARTIFICIAL NUTRITION: *Offer by physician if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. (Section D requires)

☐ Short-term artificial nutrition, including feeding tubes.

☐ No artificial means of nutrition, including feeding tubes.

D INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed by _____

☐ Advance Directive not available

☐ No Advance Directive

Signature of Physician / Nurse Practitioner / Physician Assistant (Print Name, Title, and License #, NP Cert. #):

Physician/NP/PA Signature: (required) _____ Date: _____

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary and that the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires and with the best interest of the individual who is the subject of the form.

Print Name: _____ Relationship: (write self if patient)

Signature: (required) _____ Date: _____

Mailing Address (street/city/state/zip): _____ Phone Number: _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

Audience =
First Responders
EMS
personnel



Remembrance and Services Memorandum of Peter Kote

My Intent

This Memorandum provides guidance to my Trustee, Personal Representative, family, and friends with respect to handling of my remains and my desires for remembrance, if any. This memorandum is to be considered binding with the intent that my wishes should take precedence over those of any other person. However, I recognize that there may be circumstances that I cannot anticipate, so I request that all parties concerned act in accordance with my intent as set forth in this memorandum. I appoint my Trustee to carry out my last wishes and desires as expressed herein.

This state law utilizes a Revocable Living Trust, Pour-Over Will, and other documents. Should this memorandum conflict with any provision of my primary estate planning documents, i.e. my Revocable Living Trust or Pour-Over Will, my Revocable Living Trust shall take precedence followed by my Pour-Over Will.

Notices

I am providing the following information to my family, friends and organization with whom I am affiliated may be notified of my passing.

Upon my death, please notify the following friends and family members of my passing:

Remembrance and Services Memorandum

This document provides guidance to your Trustee, Personal Representative, Agents, family, and friends with respect to handling of your remains and your desires for remembrance, if any.



Types of Powers of Attorney (POA)

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
4. Immediate vs. Springing
5. Statutory vs. Attorney Drafted vs. Financial Institution Forms



Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
4. Immediate vs. Springing
5. Statutory vs. Attorney
Drafted vs. Financial
Institution Forms

Healthcare vs. Financial

Healthcare Power of Attorney

Authorizes the Agent to communicate on the Principal's behalf pertaining to healthcare decisions.

Financial Power of Attorney

Authorizes the Agent to communicate on the Principal's behalf pertaining to financial matters.



Financial POA Purpose & Definitions

Designates the person(s) who has(have) the authority to handle your financial affairs.

The person granting the authority (you) is called the “Principal.”

The person receiving the authority is called the “Agent” or “Attorney-in-Fact.”



Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
4. Immediate vs. Springing
5. Statutory vs. Attorney
Drafted vs. Financial
Institution Forms

General vs. Limited

General Power of Attorney

Authorizes the Agent to perform a variety of acts on the Principal's behalf.

Limited Power of Attorney

Authorizes the Agent to act on behalf of the Principal regarding a specific transaction.



Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
4. Immediate vs. Springing
5. Statutory vs. Attorney Drafted vs. Financial Institution Forms

Durable vs. Non-Durable

Durable Power of Attorney

Authority granted to the Agent remains effective even if/when the Principal becomes incapacitated.

Non-Durable Power of Attorney

Authority granted to the Agent expires when the Principal is incapacitated.



Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
4. Immediate vs. Springing
5. Statutory vs. Attorney Drafted vs. Financial Institution Forms

Immediate vs. Springing

Immediate POA

Effective immediately upon the Principal executing the document.

Springing POA

Springs into effect upon the occurrence of a specific event (typically incapacity).



Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
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4. Immediate vs. Springing
5. Statutory vs. Attorney Drafted vs. Financial Institution Forms

Statutory vs. Attorney Drafted vs. Financial Institution Forms

Uniform Statutory POA

Probate Code Section 4401

Attorney Drafted

Customized to client's goals and unique situation

Financial Institution Forms

Each institution has their own policies and may not honor statutory or attorney drafted POAs.



When Estate Plans go Wrong!

Don't let your poor planning lead to good ratings.



Watch Season 2 for free on Prime Video



When Estate Plans go Wrong!

Naming the wrong person as Agent and/or Successor Trustee

- Huge opportunity for abuse
- #1 perpetrators of financial elder abuse are family members
- Being an Agent/Successor Trustee is a job. Who has the skills needed to do the job?





When Estate Plans go Wrong!

**Choose your Agent and/or
Successor Trustee wisely.**

The legal authority to act on another's behalf is a significant responsibility that can be abused and mismanaged with potential disastrous consequences for the Principal's estate, or physical and mental well-being.





Choose your Agent and/or Successor Trustee wisely!

- The Agent owes a *Fiduciary Duty* to the Principal.
- The Agent is legally and ethically bound to act only in the best interests of the Principal.
- The Fiduciary Duty owed by an Agent to the Principal is one of the highest standards of care that exists under the law.
- Your Agent must be unquestionably trustworthy.



Choose your Agent and/or Successor Trustee wisely

The legal authority to act on another's behalf is a significant responsibility that can be abused and mismanaged with potential disastrous consequences for the Principal's estate, or physical and mental well-being.

Who do you choose as your Agent?

Qualities to look for:

- 1) Integrity/Humility
- 2) Reliability
- 3) Unbiased
- 4) Resolute
- 5) Organized
- 6) Financially Competent
- 7) Willingness
- 8) Time
- 9) Proximity
- 10) Age



Who do you choose as your Agent?

Qualities to look for:

- 1) Integrity/Humility
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- 4) Resolute
- 5) Organized
- 6) Financially Competent
- 7) Willingness
- 8) Time
- 9) Proximity
- 10) Age

People commonly choose the following people as their Agent:

- Family member or friend,
- Professional advisor (CPA),
- Fiduciary,
- Co-Agents, and
- Alternate Agents.

Pros & Cons

Prohibited Agents

PLANNING FOR INCAPACITY



Conservatorship

A court procedure giving another person the authority to act on behalf of an incapacitated adult when there is no advance legal planning.

Conservatee: The person who can't manage their financial or health care affairs.

Conservator: The person who is tasked with the duty of making the financial and health care decisions for the Conservatee.





Conservatorship

A court procedure giving another person the authority to act on behalf of an incapacitated adult when there is no advance legal planning.

Two Types

1. Conservatorship of the Estate,
2. Conservatorship of the Person.



Conservatorship of the Estate

A Conservator of the Estate is appointed by a court for an adult person who is unable to manage their financial affairs or resist fraud or undue influence.

Key Duties

- Makes an inventory of assets
- Protects the Conservatee's income and property
- Pays bills
- Required to provide regular accountings to the court and interested parties detailing how the financial resources are being managed.



Conservatorship of the Person

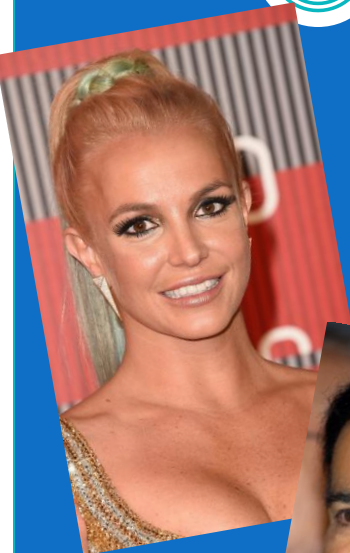
A Conservator of the Person is appointed by a court for an adult person who is unable to provide for their personal needs for food, clothing, shelter, or health care.

Key Duties

- Ensures the Conservatee's personal welfare and everyday living needs are met, e.g. housing, healthcare, personal care, and physical and mental well-being.
- Makes sure the Conservatee has access to food, clothing, shelter, transportation, and medical care.

BENEFITS OF CONSERVATORSHIPS

- Court supervision adds an extra layer of protection, ensuring transparency and accountability.
- Provides a structured mechanism for managing the Conservatee's affairs, offering protection against self-neglect or exploitation.
- The Conservator manages the Conservatee's finances, pays bills, and makes sound investments, ensuring financial stability and preventing financial hardship.



PROBLEMS WITH CONSERVATORSHIPS

- Court involvement
- Public record
- Time consuming
- Significant expense
- Emotionally trying
- Loss of control & civil liberties
- Indignity & intrusion
- Difficult to lift
- Potential for abuse





Planning for the Grey Area of Incapacity: Using Advance Health Care Directives and Powers of Attorney

PARTING THOUGHTS

- “By failing to prepare, you are preparing to fail.” *Benjamin Franklin*
- “A goal without a plan is just a wish.” *Antoine de Saint-Exupéry*
- “No plan ever failed due to good planning.” *Jury Nel*
- “Planning helps you to avoid potholes in the journey of life.” *Topsy Gift*
- “Yesterday’s the past, tomorrow’s the future, but today is a gift. That’s why it’s called the present.” *Bil Keane*

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Thank you!

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