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

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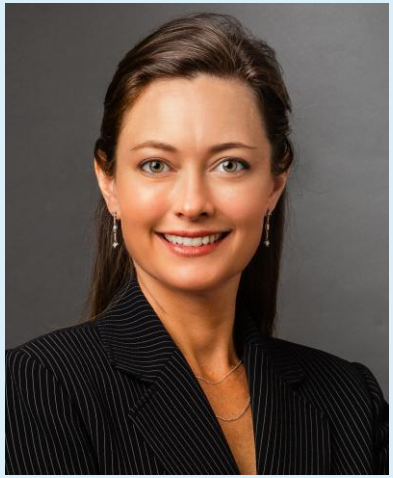
- 20 YEARS ESTATE PLANNING EXPERIENCE
- BACKGROUND IN LITIGATION



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

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Planning for Incapacity

What is 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)

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Planning for Incapacity

What is 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

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How Do You Plan for Incapacity?

Communication is Key!

1. It's a process.
   a) Not and 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.

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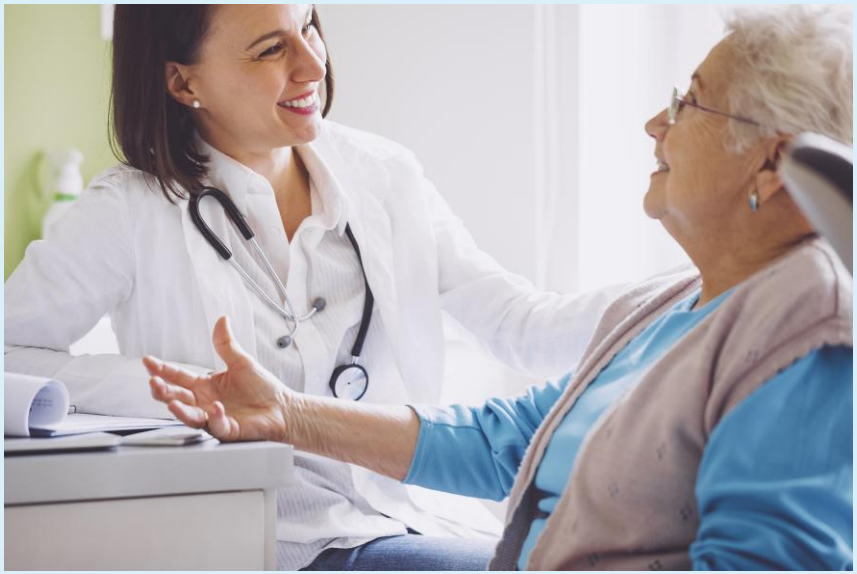

Health Care Power of Attorney

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."

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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.

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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.

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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.

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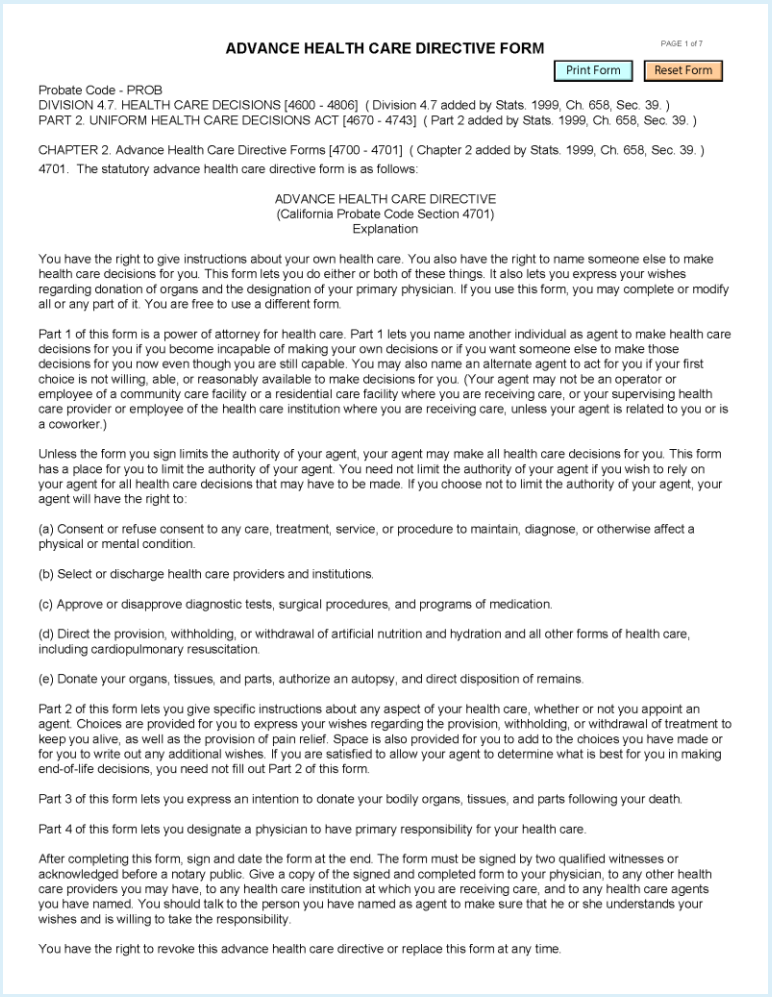

ADVANCE HEALTH CARE DIRECTIVE FORM

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.

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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.

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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.

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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.

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HIPAA Authorization

Hospitals generally will not release your medical information to anyone, including a spouse or close family member, unless they are provided with a HIPAA Authorization.

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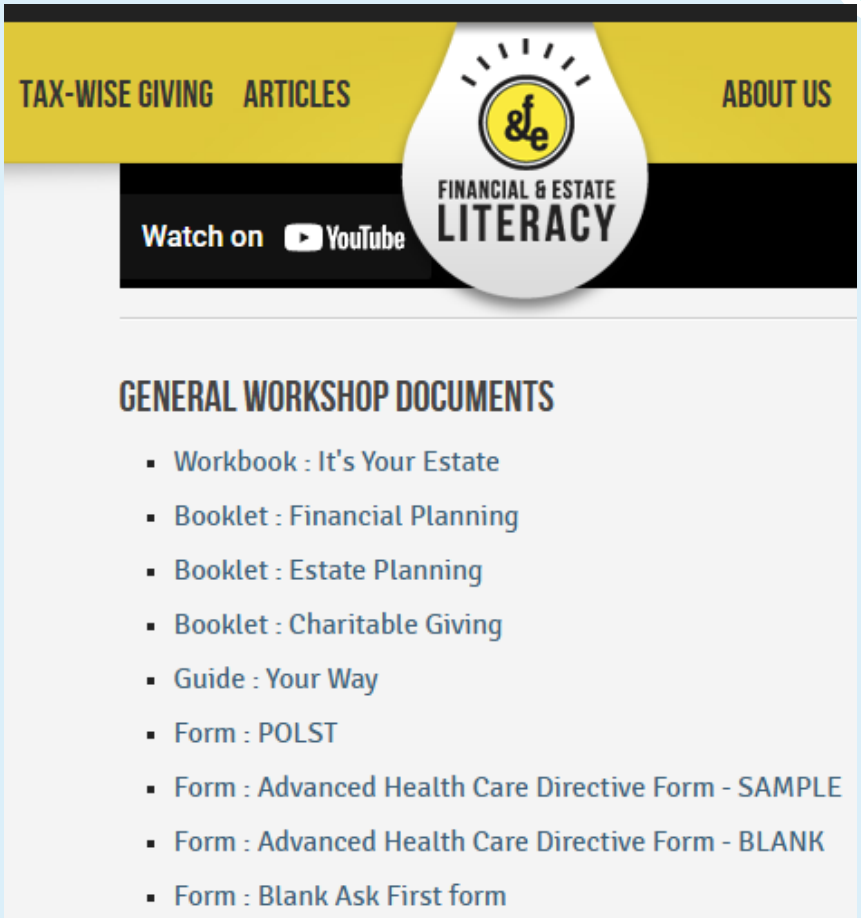

https://itsyourmoneyandestate.org/educate/its-your-estate-fall/

Other "Non-Legal" Tools to Help Communicate Your Wishes

Your Way

DNR

POLST

Remembrance and Services Memorandum

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Audience = Family Members Loved Ones

Your Way

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.

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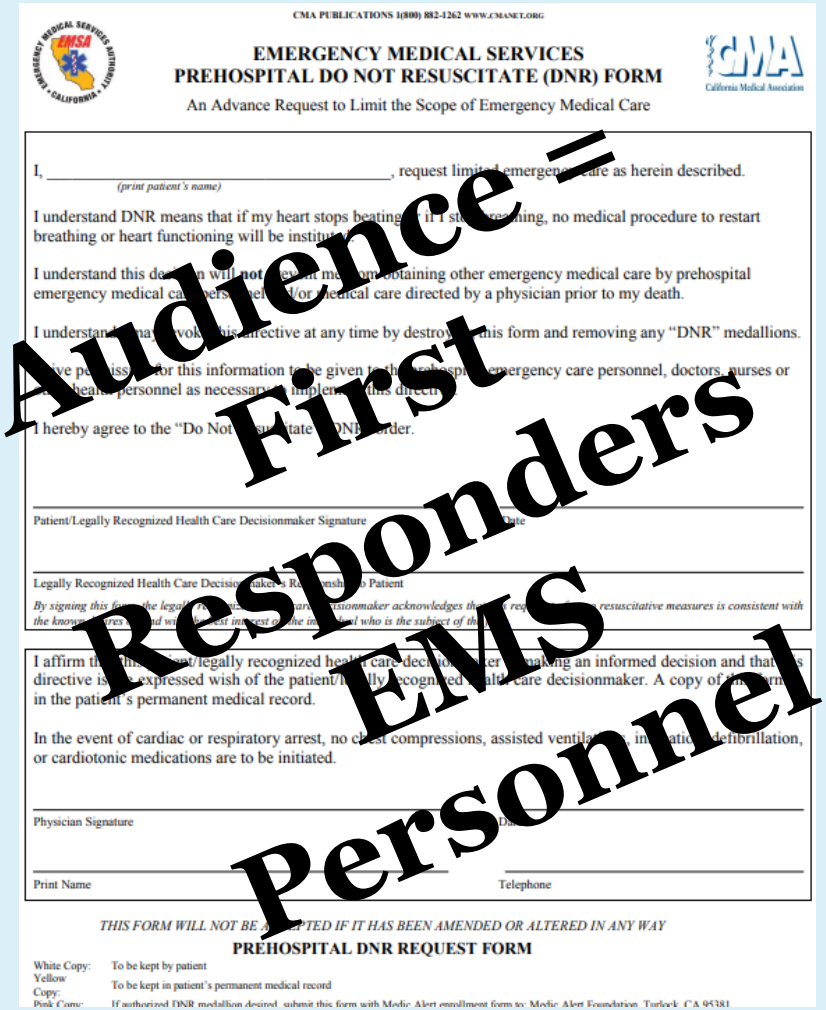

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

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

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

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

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel 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's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that the decision to forego resuscitative measures is consistent with the known desires of the patient and reflects the patient's best interest as the individual who is the subject of this form.

I affirm that this document legally recognized health care decisionmaker is making an informed decision and that this 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 cardiotonic 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)

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.

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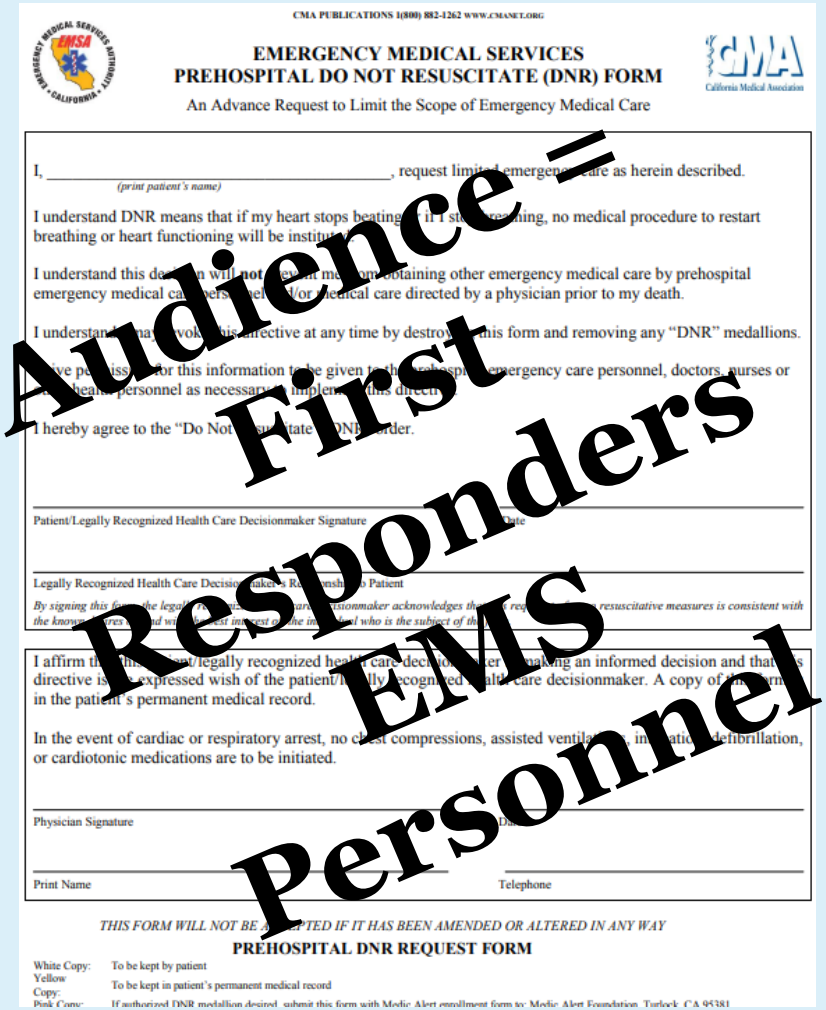

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I, _____, request limited emergency care as herein described.
(print patient's name)

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

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel 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's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that the request for limited resuscitative measures is consistent with the known desires of the patient and is in the best interest of the individual who is the subject of this form.

I affirm that this document is the patient's/legally recognized health care decisionmaker's directive after making an informed decision and that it 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 cardiotonic 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 cardiotonic drugs.

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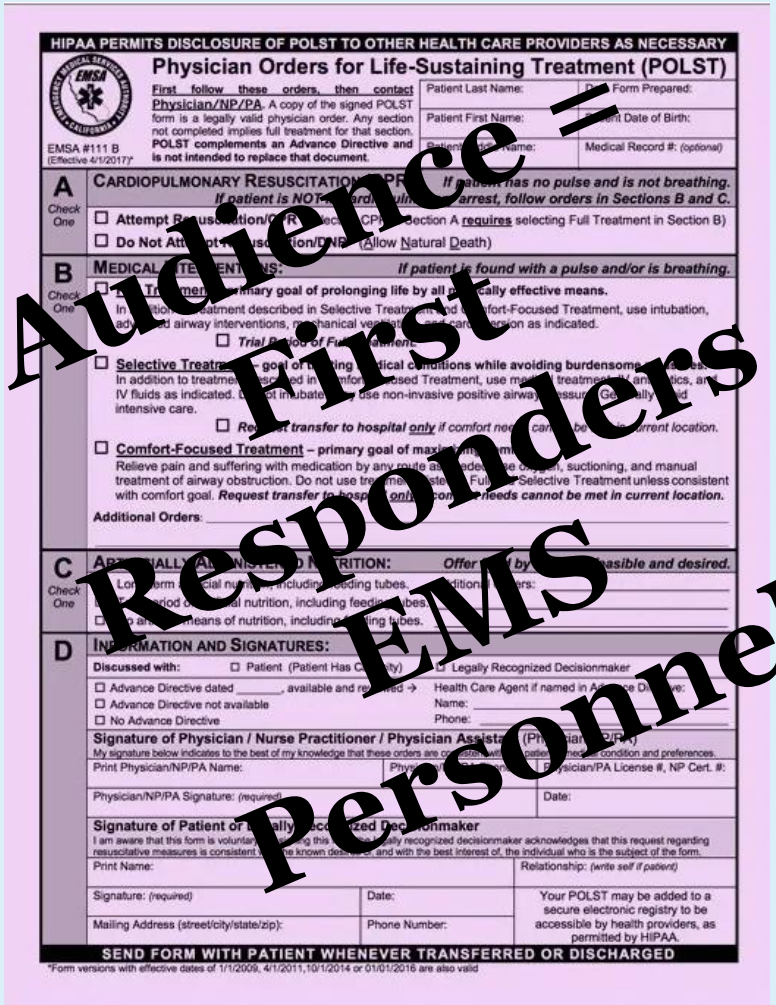

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

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.

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

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

A CARDIOPULMONARY RESUSCITATION (CPR) — If patient has no pulse and is not breathing. If patient is NOT in cardiac arrest, 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 INTERVENTIONS: — 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 and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ Trial Period of Full Treatment
☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome treatments.
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate, but use non-invasive positive airway pressure. Generally avoid intensive care.
☐ 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. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full Treatment 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 ARTIFICIALLY ADMINISTERED NUTRITION: — Offer by mouth if feasible and desired.
Check One
☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of 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 →
☐ Advance Directive not available
☐ No Advance Directive
Health Care Agent if named in Advance Directive:
Name:
Phone:

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with patient's medical condition and preferences.
Print Physician/NP/PA Name: | 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. I understand that a legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, 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)

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.

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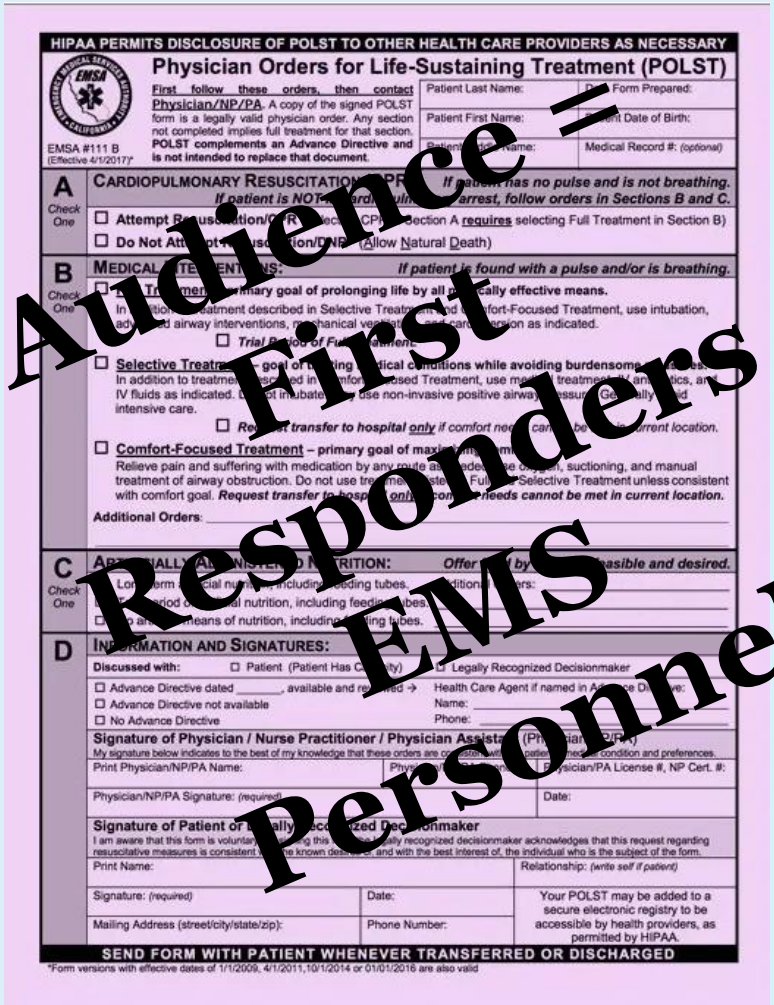

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Physician Orders for Life-Sustaining Treatment (POLST)

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.

Patient Last Name: | Form Prepared:

Patient First Name: | Date of Birth:

Patient Name: | Medical Record #: (optional)

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

A CARDIOPULMONARY RESUSCITATION (CPR) — If patient has no pulse and is not breathing. If patient is NOT in cardiac arrest, 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 INTERVENTIONS: — 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 and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ Trial Period of Full Treatment

☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome treatments.

In addition to treatment described in Comfort-Focused Treatment, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate, but use non-invasive positive airway pressure. Generally avoid intensive care.

☐ 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. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full Treatment 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 ARTIFICIALLY ADMINISTERED NUTRITION: Offer by mouth if feasible and desired.

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional orders:

☐ Trial period of 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 →

☐ Advance Directive not available

☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

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

Print Physician/NP/PA Name: | 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. Signing this form by a legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, 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.

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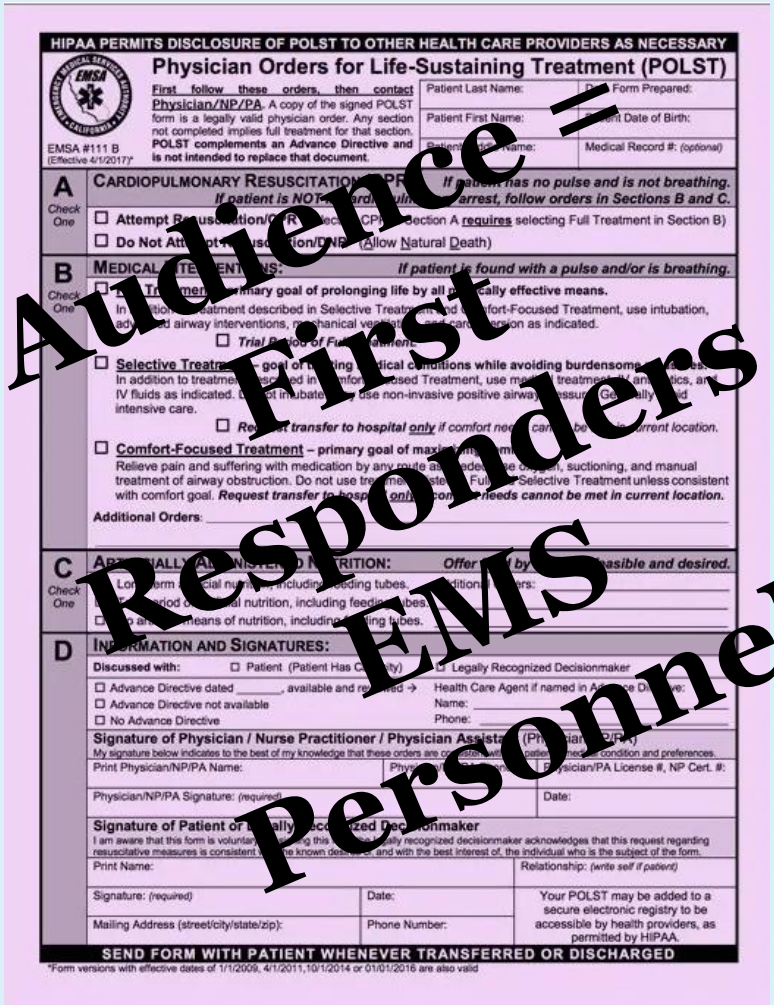

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Patient Last Name: | Form Prepared:
Patient First Name: | Date of Birth:
Patient Middle Name: | Medical Record #: (optional)

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

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

B Check One — MEDICAL INTERVENTIONS: 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 and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ Trial Period of Full Treatment
☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome treatments.
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate, but use non-invasive positive airway pressure. Generally avoid intensive care.
☐ 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. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full Treatment 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 Check One — ARTIFICIALLY ADMINISTERED NUTRITION: Offer by mouth if feasible and desired.
☐ Long-term artificial nutrition, including feeding tubes. Additional orders:
☐ Trial period of artificial nutrition, including feeding tubes.
☐ Other 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 →
☐ Advance Directive not available
☐ No Advance Directive
Health Care Agent if named in Advance Directive:
Name:
Phone:

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with patient's medical condition and preferences.
Print Physician/NP/PA Name: | 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. Signing this form by a legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, 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)

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

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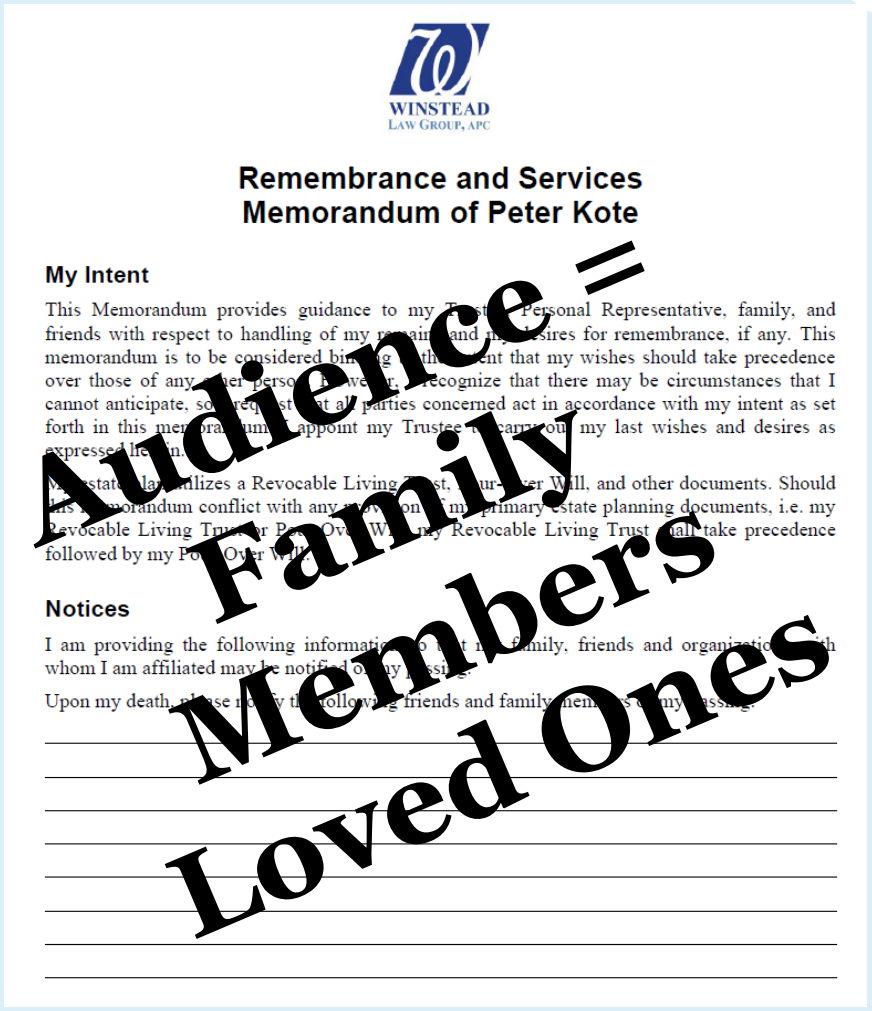
PLANNING FOR INCAPACITY



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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.

My estate plan 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 so that my family, friends and organizations 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:

Audience = Family Members Loved Ones

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.

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PLANNING FOR INCAPACITY

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

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PLANNING FOR INCAPACITY

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.

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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."

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PLANNING FOR INCAPACITY

Types of Powers of Attorney

1. Healthcare vs. Financial
2. General vs. Limited
3. Durable vs. Non-Durable
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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.

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PLANNING FOR INCAPACITY

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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.

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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).

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Types of Powers of Attorney

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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

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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?

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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.

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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.

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PLANNING FOR INCAPACITY

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

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PLANNING FOR INCAPACITY

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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

If I haven't documented an Agent and 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

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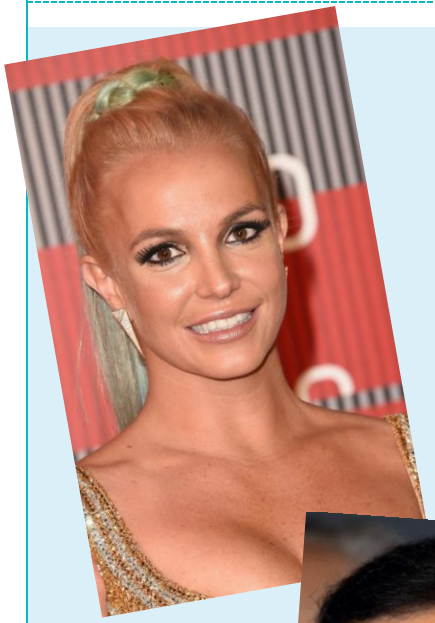

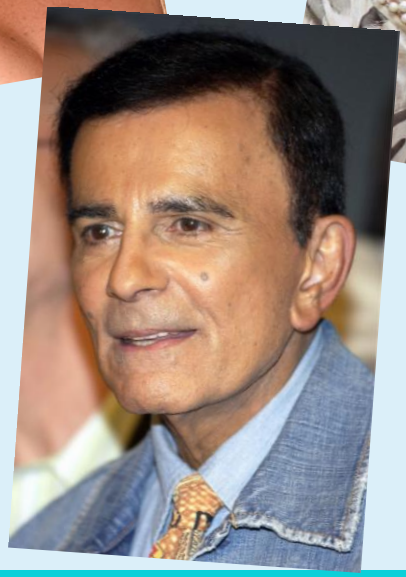

Conservatorship

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.

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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.

Two Types

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

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PLANNING FOR INCAPACITY

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.

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.

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PLANNING FOR INCAPACITY

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.

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PLANNING FOR INCAPACITY

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.

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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

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

Thank you!

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