HFRRF

A PLAN OR LIFE

Future Planning

Tool Kit

INTRODUCTION TO LIFE PLANNING

George S. Patton once said, "A good plan today is better than a perfect plan tomorrow

The process of making a life plan starts with creating a document to record your thoughts and ideas either with pen and paper or electronically. The plan is a living breathing document that includes several areas of life such as estate planning, long-term care, legacy planning and so forth that will require periodic attention to ensure it accurately reflects your life. The plan you create is your personal and your family's guide to how you want to live, what is important to you, and what action steps you take to achieve the goals you have.

Most of us find it nearly impossible to admit our own mortality, but once we are born, the "train has left the station" and we merely wait for its final destination. Although creating a Life Plan is not a one-size-fits-all, to help you begin this important process there are essential areas to include to create a comprehensive plan for your estate, your health, and your legacy.

In this two- part series we will discuss each of these areas and provide you tools to create an individualized plan that is right for you and your loved ones. To create a successful plan, it is important to begin by identifying your personal objectives, values, and desires. This foundation will help you build a strategy and navigate the decision-making process along the way.

SERIES ONE: Laying the Foundations for Estate, Health, and Legacy Planning

CREATE A VISION

Alan Lakein once said, "Planning is bringing the future into the present so that you can do something about it now." A life plan is a road map for your life that helps you prioritize what is important to you, make decisions based on your priorities and move toward the life you want. The plan should provide a clear path but be flexible. After all, as your life changes, your values and priorities may also change. For instance, I worked with a firefighter who at the beginning of his plan wanted total pain management for his terminal cancer. However, as his time drew nearer, he found that he didn't want to be pain-free if it meant he was sleeping all the time. Instead, he decided he could manage some pain if that meant he was awake and alert to spend time with wife and children.

Take some time to think about what you want your life to look like as you enter different stages. Some good questions to ask are:

- What are the three most important things to you and why? (The chart below can help clarify)
- What would you like to happen if you got very sick or had to manage a chronic medical condition? Have you discussed your choice with your spouse, children, or other family members to get their input on how those choices may affect them?
- What resources do you have as you age? (e.g. housing , health care, personal care, etc.)

- How do you want to be remembered?

IDENTIFY YOUR VALUES

Most important decisions are based on underlying values we hold. Families often experience conflict when values differ creating challenges when planning for estate settlements, long-term, care, end of life care and funeral arrangements.

Rate the following values in order of their importance to you from "Most Important" to "Least Important".

Feel free to leave blank any item you do not wish to rank.

	Most Important	Important	Neutral	Least Important
Cultural values such as art, music, travel.	☐	☐	☐	☐
Economic values such as financial responsibility, frugality, savings.	☐	☐	☐	☐
Educational values such as study, self-improvement, academic achievements, lifelong learning.	☐	☐	☐	☐
Emotional values such as compassion, kindness, generosity.	☐	☐	☐	☐
Ethical values such as honesty, fairness, justice.	☐	☐	☐	☐
Material values such as possessions, social standing, rank and title.	☐	☐	☐	☐
Personal values such as modesty, loyalty, independence.	☐	☐	☐	☐
Philanthropic values such as volunteer work donations (time and money).	☐	☐	☐	☐

Physical values such as health, relaxation, exercise, appearance.	☐	☐	☐	☐
Public values such as citizenship, community involvement, public service.	☐	☐	☐	☐
Recreational values such as sports, leisure time, hobbies, vacations.	☐	☐	☐	☐
Relationship values such as family, friends, colleagues.	☐	☐	☐	☐
Spiritual values such as faith, belief in God, inner peace.	☐	☐	☐	☐
Work values such as effort, competence, professional recognition, and success.	☐	☐	☐	☐

LAYING THE FOUNDATION

Personal Objectives

Most people engage in planning for both rational and emotional motivations. Commonly, individuals wish to provide for loved ones after death and ensure that their property is distributed in a timely manner. However, life planning is often guided by emotional motivations. It gives one a sense of comfort and security knowing that their loved ones will be provided for and that stress for those loved ones will be minimized because of pre-planning.

Take a minute to identify the reasons you would consider planning (select as many as you wish)

Preserve and Maximize Assets from your estate

- ☐ By minimizing taxes during your life (income taxes, capital gains taxes, estate taxes on inheritances you expect to receive)
- ☐ By minimizing or eliminating estate taxes upon your death
- ☐ By reducing estate administration costs through probate avoidance

- ☐ Avoid or limit Medicaid claims on your assets should you require long-term care
- ☐ Ensure that your family has enough life insurance to provide a comfortable lifestyle
- ☐ By ensuring that your assets are passed to your descendants and not given away to outsiders, such as creditors, the government, or spouses/ex-spouses

Protect Yourself (and Your Partner)

- ☐ From creditor claims
- ☐ From conservatorship proceedings ("living probate") if you or your partner become incapacitated
- ☐ From probate delays and stress upon your death (or the death of your partner)
- ☐ From hospital policies requiring life sustaining procedures when you would rather not endure them
- ☐ From healthcare decisions made by people other than those you trust most

Protect Your Children or other Beneficiaries

- ☐ From predators who can discover inheritance amounts and target young or vulnerable beneficiaries
- ☐ From claims of divorced spouses to take half of your child or beneficiary's inheritance
- ☐ From the stress and delays of the average (6 months to a year) process of probate
- ☐ From the financial immaturity resulting in a quick loss of an inheritance
- ☐ From sharing assets with heirs, you would rather disinherit
- ☐ From litigation claims by disinherited heirs
- ☐ *For parents only*: from relatives who would be poor, abusive or even dangerous guardians or from foster care
- ☐ *For parents only*: from acquaintances and relatives who should not be allowed to be alone with your children
- ☐ *For special needs beneficiary only*: from neglect in the government care system

Leave your Legacy

- ☐ Have clarity about your life purpose, goals, and dreams
- ☐ Benefit a charitable organization or activity
- ☐ Support a common family goal through coordinated planning
- ☐ *For parents only*: By providing guidelines for how your children should be supported while their assets are in trust

- *For special needs beneficiaries only*: By providing instructions, people, and assets to support your special needs beneficiaries about a poverty lifestyle
- *For business owners only*: By providing for the orderly continuation and transfer of family business interests rather than a distress sale.

Key Takeaways

Noah built the Ark when it wasn't raining. The same holds true for life planning. It brings the future into the present so you can do something about it. If you attempt to articulate some planning goals, these guidelines will give focus to the process. You are more likely to get good advice from professionals who have an idea of what you want to achieve. Documents will be properly drafted and assembled. And in the long run, it is more likely that all your goals are achieved and your wishes are carried out.

What's Next

The second part of our series we will discuss the "must have" documents you will want in your files. These documents are vital for estate planning and will legally ensure your guidelines are enforced and sample documents will be included.

SERIES TWO

Essential Estate Planning Documents

6 MUST-HAVE DOCUMENTS

Remember, you can always plan ahead, but you cannot plan behind!

SERIES TWO: Must Have Documents

IMPORTANT DOCUMENTS

One of the biggest financial mistakes people make is not having a defined estate plan in place. Developing an estate plans gives you mental peace of mind and financial protection to the greatest extent possible. An estate plan is not just about what happens when you die-it is also about what happens if you become incapacitated, incompetent, disabled or chronically ill. It is not just about death; it is about life and the legal implications as well.

Last will and testament

A Will is a legally binding statement directing who will receive your property at your death. It states who is going to be in control distribution of your assets (the "Executor"); who is going to receive your assets (the "Beneficiaries") and when; and, at death, it must be probated at your death for its terms to be legally fulfilled.

What happens if my family can't find my Last Will at my death?

According to attorney, Kurt Stanberry, upon your death, if your Will cannot be found, it will be presumed that it has been revoked, if it was last seen in your possession. Therefore, it would be prudent to keep your Will in a safe place and inform your Executor/Executrix of its location. Stanberry notes that if the ***original*** is not found, but a copy is found and offered into probate, although it may ultimately be admitted to probate, it is usually more complicated, burdensome, and costly than producing and filing the original Will. Additionally, if not even a copy of your Last Will is found, then your estate will be distributed as though you had no Will at all, i.e., "intestate". Then, rather than your assets being passed to those you indicate, they will be distributed pursuant to the Texas Laws of Descent and Distribution.

Can I change my Last Will?

A Will may be changed at any time by executing a new Will or a Codicil but only if with the formalities required by Texas Law. A new Will may be executed without destroying the original or any copy. However, an existing Will may not be amended by interlineation (marking through words, sentences, etc.) or by simply making handwritten changes to the original. Any changes must be undertaken with the formalities otherwise required for execution of a Will under the Laws of the State of Texas.

Is there a deadline for probating a Last Will?

According to the Texas Estates Code, there is a deadline and must be filed within a certain time from the date of death. If it is filed later than this, then extraordinary complications will likely arise with respect to probating the Will and may be quite costly.

Does the pension fund administer benefits based on my Last Will?

Houston Firefighters' Relief and Retirement Fund is responsible for administering the plan based on state statutes and therefore, in most cases, will override a will. Currently there are no "beneficiaries" for the monthly pension. Instead, we pay to eligible survivors at the time of your death. Other benefits such as DROP and PROP are paid out to eligible survivors and or whomever is listed as the beneficiary.

Financial power of attorney

What is a Power of Attorney?

A Financial Power of Attorney allows you to appoint someone to act for you, i.e., your "agent". It allows your agent to be able to step in and take care of your financial affairs. Typically, this includes things like buying or selling property, paying debts, investing money etc.

Without a FPOA, no one can represent you unless a court appoints a conservator or guardian. This process takes time, cost money and the judge may not choose the person you would prefer. In addition, under a conservatorship or guardianship, your representative may have to seek court permission to take steps that pertain to your care rather than being able to implement simple things at once.

Medical power of attorney and HIPPA release

Of great concern to many consumers is the medical treatment they will receive in case of a severe injury or illness (1 in 3 persons will have a disability in their lifetime). An advanced Health Care Directive, also known as a Durable Power of Attorney for Health Care, allows you to name someone to serve as your Attorney in Fact for health care matters and supplies extensive directions governing everything from what life support measures you want to whether you want to donate your organs.

To assure that your Medical Power of Attorney can access your health care information in case of your incapacity or to help with health care decisions, you and every other member of your family should execute a HIPAA Authorization form. Having someone legally authorized to make such decision for you will ensure that your wishes are conducted**.**

Living will

One tool commonly employed by individuals to describe in detail the kinds of treatments you do- and do not-want, *while you are still living*, should a life-threatening illness or injury befall you.

By planning, you can avoid unnecessary suffering and relieve caregivers of decision-making burdens during moments of crisis or grief. You can also help reduce confusion or disagreement about the choices you would want people to make on your behalf.

Medical directive

A Medical Directive otherwise known as a Living Will allows you to state your preferences as to whether you want Life-Sustaining Treatment to keep you alive if: i) you are in a hospital; and ii) with either a terminal condition or an irreversible condition. A Living Will is NOT legally binding (it is only expressing a wish) and does not apply if you are outside of a hospital or in a hospital but without a terminal condition or irreversible condition.

Letter of Instruction

A letter of last instruction is an organized way for you to give your family all the facts about your finances. It's a personal document (not a substitute for a will nor is it legally binding), which outlines the location of important documents, names, and numbers of persons to contact, information about your personal desires and can contain certain wishes for your children, pets or funeral.

While such a document may not be valid in the eyes of the law, it helps inform a probate judge your intentions and may help in the distribution of your assets if the will is deemed invalid for some reason.

Summary

Several famous people have died without a will. By not preparing an estate plan, the task of settling their affairs was made more complicated for their survivors. Procrastination is the biggest enemy of estate planning. While none of us likes to think about dying, improper or no planning can lead to long and sometimes expensive court litigation, assets getting into the wrong hands, excess money paid in taxes, or family disputes. Take action and choose a time to get started and find professionals such as attorneys, financial planners, tax advisors, elder care specialist, and so forth who can guide you through the process. You won't regret it.

A PERSONAL RECORD:

GET A HEAD START ON ESTATE PLANNING

ESTATE PLANNING WORKSHEET SAMPLES(your professional may use others)

Full Name of Dependent (Minors or disabled persons)	Relationship	Age

Full Name of Adult Child(ren)	Gender	Date of Birth

Full Name of Each Grandchild	Gender	Date of Birth

Real Property (Address, City, State)	Mortgage Balance	Current Value	Current Use

Bank Account	Type of Account (checking/savings)	Location/Contact info	Account holder/Beneficiaries (Transfer upon death or joint right of survivorship)

Type of Life Insurance	Face Amount	Location/Contact info	Beneficiaries

Type of Annuity	Annuity Amount	Location/Contact info	Beneficiaries

Type of Retirement (Pension, IRA, 401 K)	Amount Balance	Location/Contact info	Beneficiaries/Eligible Survivors

Brokerage Accounts, Stocks, Bonds, ETF's	Current Value	Location/Contact info	Transfer on death Beneficiaries

DISPOSITION OF ESTATE

1

To significant other

Descriptions of assets

2

To other beneficiaries

Descriptions of assets, plus names and relationships of beneficiaries

3

To charitable organizations

Descriptions of assets and names of charitable organizations

POWER OF ATTORNEY WORKSHEET

This information will be used when you complete your power of attorney. Note, each spouse should complete this form separately.

Name of Spouse	
County of Residence	
Agent #1 Name	
Address of Agent #1	
Phone number of agent #1	
Alternate agent name	
Address of alternate agent	
Phone number of alternate agent	
List the addresses of property owned	
Are you attaching deeds to properties owned?	
Do you have any special instructions? E.g. My power of attorney is prohibited from changing my beneficiaries	

STATUTORY DURABLE POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE DURABLE POWER OF ATTORNEY ACT, SUBTITLE P, TITLE 2, ESTATES CODE. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

You should select someone you trust to serve as your agent (attorney in fact). Unless you specify otherwise, generally the agent's (attorney in fact's) authority will continue until:

(1) you die or revoke the power of attorney;

(2) your agent (attorney in fact) resigns or is unable to act for you; or

(3) a guardian is appointed for your estate.

I, _____ (insert your name and address),

appoint _____ (insert the name and address of the person appointed) as my agent (attorney in fact) to act for me in any lawful way with respect to all of the following powers that I have initialed below.

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS LISTED IN (A) THROUGH (M).

TO GRANT A POWER, YOU MUST INITIAL THE LINE IN FRONT OF THE POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF THE POWER. YOU MAY, BUT DO NOT NEED TO, CROSS OUT EACH POWER WITHHELD.

____ (A) Real property transactions;
____ (B) Tangible personal property transactions;
____ (C) Stock and bond transactions;
____ (D) Commodity and option transactions;
____ (E) Banking and other financial institution transactions;
____ (F) Business operating transactions;
____ (G) Insurance and annuity transactions;
____ (H) Estate, trust, and other beneficiary transactions;
____ (I) Claims and litigation;
____ (J) Personal and family maintenance;
____ (K) Benefits from social security, Medicare, Medicaid, or other governmental programs or civil or military service;
____ (L) Retirement plan transactions;
____ (M) Tax matters;
____ (N) ALL OF THE POWERS LISTED IN (A) THROUGH (M). YOU DO NOT HAVE TO INITIAL THE

LINE IN FRONT OF ANY OTHER POWER IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

Special instructions applicable to gifts (initial in front of the following sentence to have it apply):

____ I grant my agent (attorney in fact) the power to apply my property to make gifts outright to or for the benefit of a person, including by the exercise of a presently exercisable general power of appointment held by me, except that the amount of a gift to an individual may not exceed the amount of annual exclusions allowed from the federal gift tax for the calendar year of the gift.

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

_____
_____
_____
_____
_____
_____
_____
_____

UNLESS YOU DIRECT OTHERWISE ABOVE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

CHOOSE ONE OF THE FOLLOWING ALTERNATIVES BY CROSSING OUT THE ALTERNATIVE NOT CHOSEN:

(A) This power of attorney is not affected by my subsequent disability or incapacity.

(B) This power of attorney becomes effective upon my disability or incapacity.

YOU SHOULD CHOOSE ALTERNATIVE (A) IF THIS POWER OF ATTORNEY IS TO BECOME EFFECTIVE ON THE DATE IT IS EXECUTED.

IF NEITHER (A) NOR (B) IS CROSSED OUT, IT WILL BE ASSUMED THAT YOU CHOSE ALTERNATIVE (A).

If Alternative (B) is chosen and a definition of my disability or incapacity is not contained in this power of attorney, I shall be considered disabled or incapacitated for purposes of this power of attorney if a physician certifies in writing at a date later than the date this power of attorney is executed that, based on the physician's medical examination of me, I am mentally incapable of managing my financial affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this power of attorney. A third party who accepts this power of attorney is fully protected from any action taken under this power of attorney that is based on the determination made by a physician of my disability or incapacity.

I agree that any third party who receives a copy of this document may act under it. Revocation of the durable power of attorney is not effective as to a third party until the third party receives actual notice of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.
If any agent named by me dies, becomes legally disabled, resigns, or refuses to act, I name the following (each to act alone and successively, in the order named) as successor(s) to that agent:

_____.

Signed this _____ day of _____, _____

_____
(your signature)

State of _____

County of _____

This document was acknowledged before me on _____(date) by _____
(name of principal).

_____
(signature of notarial officer)

(Seal, if any, of notary) _____

(printed name) _____

My commission expires: _____

IMPORTANT INFORMATION FOR AGENT (ATTORNEY IN FACT)

Agent's Duties

When you accept the authority granted under this power of attorney, you establish a "fiduciary" relationship with the principal. This is a special legal relationship that imposes on you legal duties that continue until you resign or the power of attorney is terminated or revoked by the principal or by operation of law. A fiduciary duty generally includes the duty to:

(1) act in good faith;
(2) do nothing beyond the authority granted in this power of attorney;
(3) act loyally for the principal's benefit;
(4) avoid conflicts that would impair your ability to act in the principal's best interest; and
(5) disclose your identity as an agent or attorney in fact when you act for the principal by writing or printing the name of the principal and signing your own name as "agent" or "attorney in fact" in the following manner:

(Principal's Name) by (Your Signature) as Agent (or as Attorney in Fact)

In addition, the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code) requires you to:

(1) maintain records of each action taken or decision made on behalf of the principal;
(2) maintain all records until delivered to the principal, released by the principal, or discharged by a court; and
(3) if requested by the principal, provide an accounting to the principal that, unless otherwise directed by the principal or otherwise provided in the Special Instructions, must include:

(A) the property belonging to the principal that has come to your knowledge or into your possession;
(B) each action taken or decision made by you as agent or attorney in fact;
(C) a complete account of receipts, disbursements, and other actions of you as agent or attorney in fact that includes the source and nature of each receipt, disbursement, or action, with receipts of principal and income shown separately;
(D) a listing of all property over which you have exercised control that includes an adequate description of each asset and the asset's current value, if known to you;
(E) the cash balance on hand and the name and location of the depository at which the cash balance is kept;
(F) each known liability;
(G) any other information and facts known to you as necessary for a full and definite understanding of the exact condition of the property belonging to the principal; and
(H) all documentation regarding the principal's property.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. An event that terminates this power of attorney or your authority to act under this power of attorney includes:

(1) the principal's death;
(2) the principal's revocation of this power of attorney or your authority;
(3) the occurrence of a termination event stated in this power of attorney;
(4) if you are married to the principal, the dissolution of your marriage by court decree of divorce or annulment;
(5) the appointment and qualification of a permanent guardian of the principal's estate; or
(6) if ordered by a court, the suspension of this power of attorney on the appointment and qualification of a temporary guardian until the date the term of the temporary guardian expires.

Liability of Agent

The authority granted to you under this power of attorney is specified in the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code). If you violate the Durable Power of Attorney Act or act beyond the authority granted, you may be liable for any damages caused by the violation or subject to prosecution for misapplication of property by a fiduciary under Chapter 32 of the Texas Penal Code.

THE ATTORNEY IN FACT OR AGENT, BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____ Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

_____

_____

DESIGNATION OF AN ALTERNATE AGENT:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of the document is kept at _____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior medical power of attorney.

DISCLOSURE STATEMENT

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

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself. It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time. You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or

declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

(1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;
(2) a person related to you by blood or marriage;
(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
(4) your attending physician;
(5) an employee of your attending physician;
(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ (date) by _____ (name of person acknowledging).

_____
NOTARY PUBLIC, State of Texas

Notary's printed name:

_____

My commission expires:

_____

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

SIGNATURE OF SECOND WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

TEXAS DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Instructions for completing this document

This is an important legal document, known as an *Advance Directive.* It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to help you complete your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may want to talk to your physician, family, hospital representative, or other advisers about them. You may also want to make a directive for organ and tissue donation.

You will need **two** witnesses to sign this Directive to acknowledge your signature. Both witnesses must be at least 18 years old, and competent (in good mental health).

"Witness 1" must not be:

- Someone you have asked to make health care decisions for you
- A person who is related to you by blood or marriage
- A person who has a right to any part of your estate (this person is not allowed to make claim against your estate).
- Your attending physician or an employee of your attending physician
- An officer, director, partner, or business office employee of the health care facility where you are being cared for, or an parent organization of the health care facility. (If witness 1 is an employee of a health care facility where you are being cared for, s/he must not be directly involved in your care).

In lieu of the two witnesses, you can sign the Directive before a notary public.

DIRECTIVE

I, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. **(This selection does not apply to hospice care.)**

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible.

OR

____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. **(This selection does not apply to hospice care.)**

Other requests: (After talking to your physician, you may want to list particular treatments in this space that you *do* or *do not* want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values: (You do not need to fill out this part if you already have a valid Medical Power of Attorney.)

1.

2.

If the people listed above are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Date:_____

Print Name:_____

Signature: _____

Your Address: (City, County, State):_____

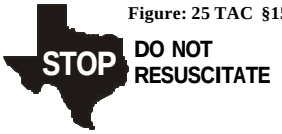

Figure: 25 TAC §157.25 (h)(2)

TEXAS DEPARTMENT OF HEALTH STANDARD OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER

This document becomes effective immediately on the date of execution. It remains in effect until the patient is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort measures will be given as needed.

All persons who sign the form must sign again under number 3.

1. _____ **Date of Birth:** _____ **Male/Female** (Circle One)

Patient's full legal name — printed or typed

2. COMPLETE **ONE** OF THE FOUR BOXES: **A**, **B**, **C**, or **D**. If using Box **A**, **B**, or **C**, Witnesses and Physician's Statement must be completed.

A. **Patient's Statement:** I, the undersigned, am an adult capable of making an informed decision regarding the withholding or withdrawing of CPR, including the treatments listed below, and I direct that none of the following resuscitation measures be initiated or continued: **Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.**

Signature _____ Date _____ Printed or Typed Name _____

B. **Only use this box if the order is being completed by a person acting on behalf of an adult patient who is incompetent or otherwise unable to make his or her wishes known.**

I am the patient's: ☐ legal guardian; ☐ agent under Medical Power of Attorney; ☐ or Qualified Relative (see back); **AND**:

☐ I attest to issuance of an Out-of-Hospital DNR by the patient by nonwritten means of communication; **OR**
☐ I am acting under the guidance of a prior Directive to Physicians; **OR**
☐ I am acting upon the known values and desires of the patient; **OR**
☐ I am acting in the patient's best interest based upon the guidance given by the patient's physician.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ Date _____ Printed or Typed Name _____

C. **Only use this box if the order is being completed by a person acting on behalf of a minor patient who has been diagnosed with a terminal or irreversible condition.**

I am the minor patient's: ☐ Parent; ☐ legal guardian; or ☐ managing conservator.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ **Date** _____ **Printed or Typed Name** _____

WITNESSES: (see qualifications on reverse) We have witnessed all of the above signatures.

Witness 1 Signature _____ Date _____ Witness Printed or Typed Name _____

Witness 2 Signature _____ Date _____ Witness Printed or Typed Name _____

PHYSICIAN'S STATEMENT: I, the undersigned, am the attending physician of the patient named above. I have noted the existence of this order in the patient's medical records, and I direct out-of-hospital health care professionals to comply with this order as presented.

Date _____ Physician's signature _____ Printed name _____ License number _____

D. **Only use this box if the order is being completed by two physicians acting on behalf of an adult who is incompetent or otherwise unable to make his or her wishes known, and who is without a legal guardian, agent, or qualified relative.**

☐ I attest to issuance of an Out-of Hospital DNR by the patient by nonwritten communication; **OR**:
☐ The patient's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgement, considered ineffective in these circumstances or are otherwise not in the best interest of the patient.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ Treating Physician _____ Date _____ Printed or Typed Name _____

Signature Second Physician who is not involved in treating the patient _____ Date _____ Printed or Typed Name _____

3. **ALL PERSONS WHO SIGNED MUST SIGN HERE (Pursuant to H&SC 166.083(b)(13). This document has been properly completed.**

Signature of Patient, Agent or Relative (A, B, or C) _____ Signature of Second Physician (D) _____ Signature of Attending Physician _____

Signature of Witness _____ Signature of Witness _____ Date _____

SHOULD TRANSPORT OCCUR, THIS DOCUMENT OR A COPY MUST ACCOMPANY THE PATIENT.

OUT-OF-HOSPITAL DNR INSTRUCTIONS

PURPOSE:
This form was designed to comply with the requirements as set forth in Chapter 166 of the Health and Safety Code (H&SC) relating to the issuance of Out-of-Hospital Do-Not-Resuscitate (DNR) orders for the purpose of instructing Emergency Medical Personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does NOT affect the provision of other emergency care including comfort care.

APPLICABILITY:
This form applies to all health care professionals operating in any out-of-hospital setting to include hospital outpatient or emergency departments and physician's offices.

IMPLEMENTATION:
A competent adult may execute or issue an Out-of-Hospital DNR Order. The patient's attending physician will document the existence of the directive in the patient's permanent medical record.

If an adult patient is capable of providing informed consent for the order, he/she will sign and date the out-of-hospital DNR order on the front of this sheet in Box A. In the event that an adult patient is unable to provide informed consent, his/her Legal Guardian, agent under Medical Power of Attorney, or Qualified Relative may execute the order by signing and dating the form in Box B. If an adult patient is unable to provide informed consent and none of the persons listed in Box B are available, the treating physician may execute the order using Box D with the consent of a second physician who is not treating the patient and/or is a member of the health care facility ethics committee or other medical committee.

The following persons may execute an out-of-hospital DNR order on behalf of a minor: the minor's parents, the minor's legal guardian or the minor's managing conservator. A person executing a DNR order on behalf of a minor may execute the order by signing and dating the form in Box C. **An out-of-hospital DNR order may not be executed unless the minor has been diagnosed by a physician as suffering from a terminal or irreversible condition.**

The form must be signed and dated by two witnesses except when executed by two physicians only (Box D).

The original standard Texas Out-of-Hospital DNR form must be completed and properly executed. Duplicates may be made by the patient, health care provider organization or attending physician as necessary. **Copies of this completed document may be used for any purpose that the original may be used and shall be honored by responding health care professionals.**

The presence of a Texas DNR identification device on a person is sufficient evidence that the individual has a valid Out-of-Hospital DNR Order. Therefore, either the original standard form, a copy of the completed standard form, or the device is sufficient evidence of the existence of the order.

For information on ordering identification devices or additional forms, contact the Texas Department of Health at (512) 834-6700.

REVOCATION:
The Out-of-Hospital Do-Not-Resuscitate Order may be revoked at ANY time by the patient **OR** the patient's Legal Guardian/Agent/Managing Conservator/Qualified Relative, Parent (if a minor), or physician who executed the order. The revocation may involve the communication of wishes to responding health care professionals, destruction of the form, or removal of all or any Do-Not-Resuscitate identification devices the patient may possess.

AUTOMATIC REVOCATION: This Out-of-Hospital DNR order is automatically revoked if the patient is known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS:
Attending Physician: The physician who is selected by or assigned to a patient who has primary responsibility for a person's treatment and care and is licensed by the Texas State Board of Medical Examiners or who is properly credentialed and holds a commission in the uniformed services of the United States and who is serving on active duty in this state**. (H&SC 166.002 (3) & (12))**

Qualified Relatives: Those persons authorized to execute or issue an out-of-hospital DNR order on behalf of a person who is comatose, incompetent, or otherwise mentally or physically incapable of communication under Section 166.088 H&SC Section 166.088 refers to 166.039; "One person, if available, from one of the following categories, in the following priority...: (1) The patient's spouse; (2) the patient's reasonably available adult children; (3) the patient's parents; or (4) the patient's nearest living relative."

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel; and, unless the context requires otherwise, includes hospital emergency department personnel. (H&SC 166.081 (5))

Witnesses: Two competent adult witnesses must sign the form acknowledging the signature of the patient or the person(s) acting on the patient's behalf (except when signed by two physicians in Section C). Witness One must meet the qualifications listed below. Witness Two may be any competent adult. Witness One (the "qualified" witness) may not be: (1) person designated to make a treatment decision for the patient; (2) related to the patient by blood or marriage; (3) entitled to any part of the estate; (4) be a person who has a claim against the estate of the patient; (5) the attending physician or an employee of the attending physician; (6) an employee of a health care facility in which the patient is being cared for, if he or she is involved in providing direct patient care to the patient; or (7) an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility.

Please report any problems with this form to the Texas Department of Health at (512) 834-6700.

Revised February 13, 2004
Texas Department of Health