



TRUST INTAKE INFORMATION (Joint)

Primary Trustee Information (Owner of the Trust)

Name of Trust _____

Client's Full Name _____

Spouse Full Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Successor Trustee Information (Designated Person to Manage the Trust)

Do You Want Your Trustee to Manage Your Trust Independently: Yes____ No____

Do You Want Your Co-Trustee's to Work Jointly Together: Yes____ No____
(If You Selected YES, Check Co-Trustee Option on Each Trustee Name Below)

Primary Successor Trustee (Co-Trustee: Yes____ No____)

Full Name _____

Relationship _____

Alternate Successor Trustee #1 (Co-Trustee: Yes____ No____)

Full Name _____

Relationship _____

Alternate/Successor Trustee #2 (Co-Trustee: Yes____ No____)

Full Name _____

Relationship _____

Beneficiaries (Individuals that will Inherent Your Assets thru the Trust)

Full Name	Relationship	Share %
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#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

#6 _____

Distribution Instructions/Additional Beneficiaries

[illegible]

Power of Attorney (Check Here if Same as Trustee ____)

Name: _____

Do You Want Your Agent to Manage Your Finances Independently: Yes____ No____

Do You Want Your Agents to Work Jointly Together: Yes____ No____

(If You Selected YES, Check Co-Agent Option on Each Agent's Name Below)

Primary Agent (Co-Agent: Yes____ No____)

Full Name _____

Alternate Agent (Co-Agent: Yes____ No____)

Full Name _____

Advanced Healthcare Directive

If you were unable to make healthcare decisions for yourself, who would you want to manage those decisions?

Please check here if the person you are appointing is the same as the Trustee ____

Primary Agent (First Choice)

Full Name _____

Alternate Agent (Second Choice)

Full Name _____

Primary Physician

Name _____

Address _____ **Phone** _____

Burial Instructions

Cremation ____ **Burial** ____

Details _____

Part 2
INSTRUCTIONS FOR HEALTH CARE

END OF LIFE DECISIONS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have marked below:

CHOICE NOT TO PROLONG LIFE

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

Initial

OR

CHOICE TO PROLONG LIFE

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Initial

RELIEF FROM PAIN

I direct that treatment for alleviation of pain or discomfort be provided as stated in the following;

OTHER WISHES:

Medical Directives

Select which of the following statements to be placed in your Advanced Directive.

I Do Want to be placed on machines or use artificial means or measures, if I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.

YES_____ NO_____

I Do Want life support if I am brain dead without brain activity for 48 hours.

YES_____ NO_____

I Do Want all sustaining life support to be relinquished if there is no chance for full recovery.

YES_____ NO_____

I Do Want to be intubated or placed on a Ventilator or breathing machine if necessary to stay alive and only if I am mentally intact.

YES_____ NO_____

I Do Want medications to alleviate severe symptoms of pain and discomfort, even if it hastens my death.

YES_____ NO_____

I Do Want CPR, AED or other resuscitation procedures to be performed on me if my heart were to stop beating.

YES_____ NO_____

I Do Want a feeding tube or IV Procedures put in place, if I am not able to feed myself and only if I am mentally intact.

YES_____ NO_____

I Do Want an Autopsy performed at the time of my death.

YES_____ NO_____

I Do Want my organs and tissues to be made available for transplant purposes.

YES_____ NO_____

I Do my Medical Agent to take whatever steps are necessary to keep me in a Personal Residence rather than placing me into a Nursing Home Facility.

YES_____ NO_____

I Do Want my Medical Agent to obtain certification from a Physician if needed for psychological or substance treatments before my Agent may arrange for admission.

YES_____ NO_____

List Any Specific Requests for Relief of Pain Management:

Power of Attorney (Check Here if Same as Trustee ____)

Name: _____

Do You Want Your Agent to Manage Your Finances Independently: Yes_____ No_____

Do You Want Your Agents to Work Jointly Together: Yes_____ No_____

(If You Selected YES, Check Co-Agent Option on Each Agent's Name Below)

Primary Agent (Co-Agent: Yes_____ No_____)

Full Name _____

Alternate Agent (Co-Agent: Yes_____ No_____)

Full Name _____

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Full Name _____

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Full Name _____

Primary Physician

Name _____

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