The Law Offices of Gabriel Lenhart

TRUST DATA SHEET
Supporting Documents

Date: _____

Name: _____ Date of birth: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Fax: _____

Email address: _____

FINANCIAL POWER OF ATTORNEY

The purpose of this document is for management of any assets that are not listed or held by the trust. Generally the individual you list here should be the same person(s) you selected as your trustee(s) of your trust.

Primary Agent

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

1st Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

2nd Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

WILL(S)

A special type of will, known as a pour over will, is provided with all revocable trusts to designate distribution of certain personal property not already transferred to the trust. Your executor of this will generally should be the same person as the primary trustee of your trust.

Primary Executor

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

1st Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

2nd Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

CONSERVATOR

Sometimes it is necessary to appoint a conservator for an incapacitated or incompetent person. Please identify the individual you would like as your conservator. That person should be someone familiar with your finances, wishes and desires, and has the time to manage your estate.

Primary Conservator

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

1st Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

2nd Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

ADVANCED HEALTH CARE DIRECTIVE

This document is used by all medical personnel and hospitals to determine how you want life support issues handled. You should appoint an agent who knows what your wishes are and will carry out those wishes. You should also consider one or two alternate agents in event your appointed agent cannot or will not so act. (Specific medical directives and burial wishes forms to follow below.)

Primary Agent

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

1st Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

2nd Alternate

Name/Relationship: _____

Address: _____

Phone: _____ Email: _____

INSTRUCTIONS FOR HEALTH CARE

2.A. END-OF-LIFE DECISIONS ("LIVING WILL"). I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. I understand that if there is a conflict between my agent's decision and this statement, this statement shall take precedence.

For purposes of this statement:

(A) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

(B) "An irreversible coma", means a coma from which the treating physicians have reasonably concluded I will never regain consciousness.

(C) "Persistent vegetative state" means a state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, is characterized by both of the following:

  (i) I am irreversibly unaware of myself and my environment, and

  (ii) There is a total loss of cerebral cortical functioning, resulting in my having no capacity to experience pain or suffering.

(D) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, both of the following apply:

  (i) There can be no recovery; and

(ii) Death is likely to occur within a relatively short time if life sustaining treatment is not administered.

_____
INITIALS

2.B. RELIEF FROM PAIN. Notwithstanding anything herein to the contrary, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. Notwithstanding the preceding paragraph, if withholding or withdrawing nutrition and/or hydration will cause me to experience substantial pain or discomfort, I want to be provided with nutrition and/or hydration.

_____
INITIALS

2.C. OTHER WISHES. In addition to the preceding paragraphs, I am making the following directives to my agent:

If I ever fall into a persistently vegetative state, you are directed to reduce my misery as painlessly as possible.

_____
INITIALS

If I become senile, you are directed to let me die naturally and without any extraordinary medical treatment.

_____
INITIALS

If I am in an irreversible coma or persistent vegetative state, I do not want any form of CPR.

_____
INITIALS

If I am already in an irreversible coma or persistent vegetative state and I develop some other illness or condition for which a course of treatment would be considered, I do not want any additional treatment to be initiated (for example, if I am in an irreversible coma and it is subsequently discovered that I have cancer, I do not want chemotherapy and/or radiation).

_____
INITIALS

Additional directives/instructions: