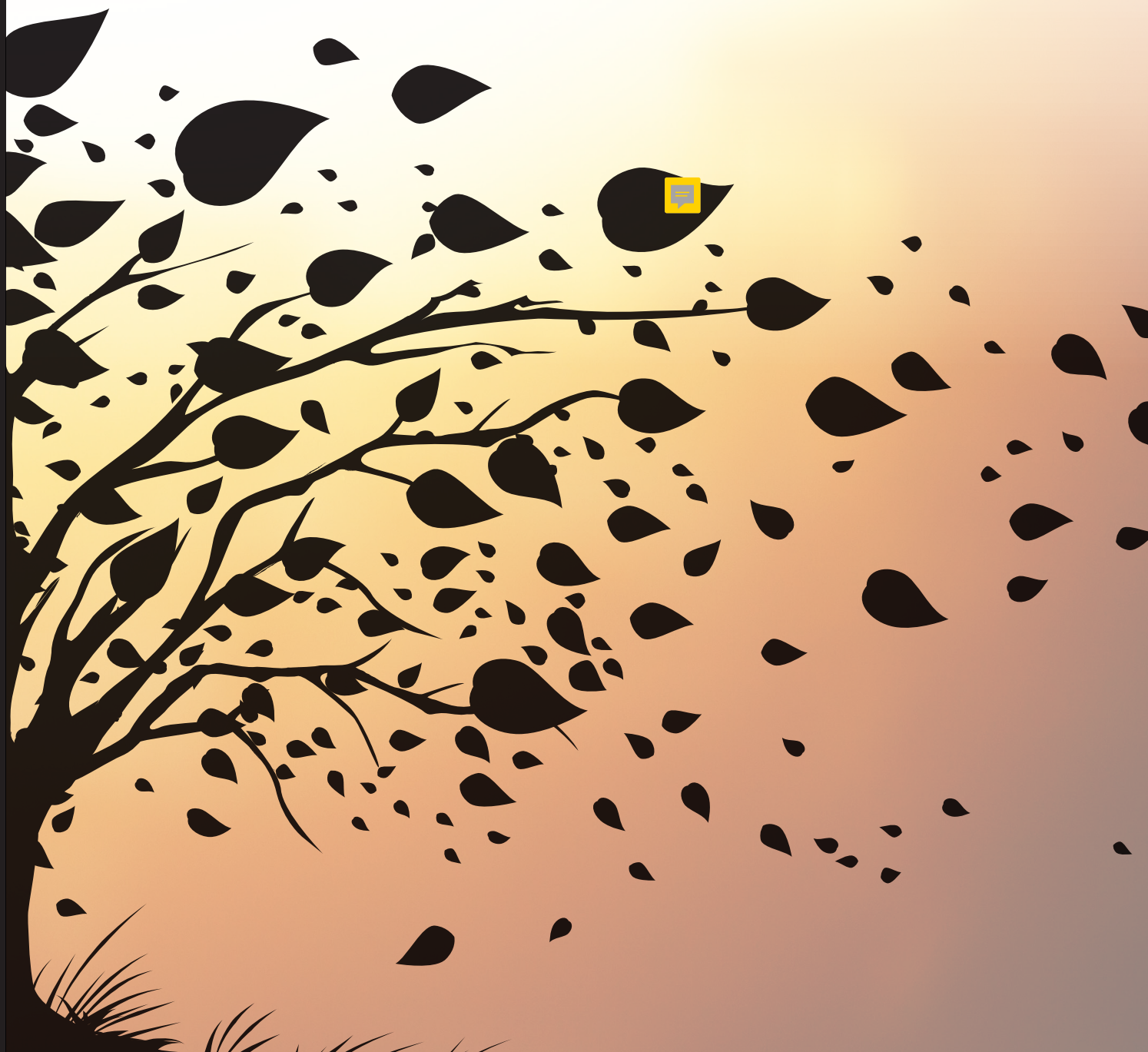
The Church Foundation

CHARTERED IN 1926

End-of-Life Planning



SOURCE MATERIAL FROM EPISCOPAL CHURCH FOUNDATION

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Table of Contents

For where your treasure is, there your heart will be also.

~ Luke 12:34

General Information

Planning for the future is essential if you want control of what happens to your family and loved ones after you're gone.

Appointing guardians for your children and dependents, appointing executors and trustees, and determining how you would like your earthly possessions distributed will afford peace of mind and relieve your loved ones from having to burden those decisions.

In the Episcopal Church we believe that your estate and end-of-life plans should reflect your values. That is why we suggest you consider the following three sections in the order presented:

1. "Medical Directive" appoints a Healthcare Proxy and gives instructions for how you would like to be treated if you are incapacitated.
2. "Funeral Planning." We suggest you design your funeral alongside writing your will. The funeral can then be a reflection of your life, a message to loved ones about your values and what was important to you.
3. "Estate Planning Once you have expressed your values through writing your funeral service, then write or amend your will so that it reflects those values.

Possessions—and how we use them—have a way of defining who we are. We hope this material will help you make important decisions to guide your friends and loved ones so they will know who you were and what was important to you.

Notes:

General Information

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Information collected in this booklet entered by:

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

Witness:

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

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Medical Directive

The Medical Directive comes into effect only if you become incompetent.

Complete the form in the context of a discussion with a physician.

Following is a general form of medical directive reprinted with the permission of the American Medical Association. Please note that many states have enacted legislation on advanced care directives. Please consult your attorney, healthcare provider, or state attorney general regarding requirements for healthcare directives in your state .~Episcopal Church Foundation*

INTRODUCTION

As part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during serious illness they are often unconscious or otherwise unable to communicate their wishes—at the very time when many critical decisions need to be made.

The Medical Directive allows you to record your wishes regarding various types of medical treatments in several representative situations so that your desires can be respected. It also lets you appoint a proxy, someone to make medical decisions in your place if you should become unable to make them on your own.

The Medical Directive comes into effect only if you become incompetent (unable to make decisions and too sick to make your wishes known). You can change it at any time until then. While you are fully competent, you should discuss your care directly with your physician.

I am undecided; I do not want this treatment should be indicated. If you choose a trial of treatment, you should understand that this indicates you want the treatment withdrawn if your physician and proxy believe that it has become futile.

The Personal Statement section allows you to explain your choices and say anything you wish to those who may make decisions for you concerning the limits of your life and the goals of intervention. For example, in situation B, if you wish to define "uncertain chance" with numerical probability, you may do so here.

Next you may express your preferences concerning organ donation. Do you wish to donate your body or some or all of your organs after your death? If so, for what purpose(s) and to which physician or institution? If not, this should also be indicated in the appropriate box.

In the final section you may designate one or more proxies who would be asked to make choices under circumstances in which your wishes are unclear.

Medical Directive

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COMPLETING THE FORM

You should, if possible, complete the form in the context of a discussion with your physician. Ideally, this should occur in the presence of your proxy. This lets your physician and your proxy know how you think about these decisions, and it provides you and your physician with the opportunity to give or clarify relevant personal or medical information. You may also wish to discuss the issues with your family, friends, or religious mentor.

The Medical Directive contains six illness situations that include incompetence. For each one, you consider possible interventions and goals of medical care. Situation A is permanent coma; B is near death; C is with weeks to live in and out of consciousness; D is extreme dementia; E is a situation you describe; and F is temporary inability to make decisions.

For each scenario you identify your general goals for care and specific intervention choices. The interventions are divided into six groups: 1) cardiopulmonary resuscitation or major surgery; 2) mechanical breathing or dialysis; 3) blood transfusions or blood products; 4) artificial nutrition and and hydration; 5) simple diagnostic tests or antibiotics; and 6) pain medications, even if they dull consciousness and indirectly shorten life. Most of these treatments are described briefly. If you have further questions, consult your physician.

Your wishes for treatment options: I want this treatment; I want this treatment tried but stopped if there is no clear improvement; You can indicate whether-or-not the decisions of the proxy should override your wishes if there are differences. Additionally, should you name more than one proxy, you can state who is to have the final say if there is disagreement. Your proxy must understand that this role usually involves making judgments that you would have made for yourself had you been able and making them by the criteria you have outlined. Proxy decisions should ideally be made in discussion with your family, friends and physician.

WHAT TO DO WITH THE FORM:

Once you have completed the form, you and two adult witnesses (other than your proxy) who have no interest in your estate need to sign and date it. Many states have legislation covering documents of this sort. To determine the laws in your state, you should call the state attorney general's office or consult a lawyer. If your state has a statutory document, you many wish to use the Medical Directive and append it to this form.

You should give a copy of the completed document to your physician. His or her signature is desirable but not mandatory. The directive should be placed in your medical records and flagged so that anyone who might be involved in your care can be aware of its presence. Your proxy, a family member, and/or a friend should also a copy. In addition, you may want to carry a wallet card noting that you have such a document and where it can be found.

Copyright © 1995 by Linda L. Emmanuel and Ezekiel J. Emmanuel. An earlier version of this form was originally published as part of an article by Linda L. Emmanuel and Ezekiel J. Emmanuel, "The Medical Directive: A New Comprehensive Advance Care Document," JAMA (1989), 261:3288843248. It does not reflect the official policy of the American Medical Association.

My Medical Directive

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This Medical Directive shall stand as a guide to my wishes regarding medical treatments in the event that illness should make me unable to communicate them directly. I make this directive, being 18 years or more of age, of sound mind, and appreciating the consequences of my decisions.

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

Witness:

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

Notes:

My Medical Directive

The Church Foundation
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Situation A

If I am in a coma or persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:
(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

Situation B

If I am near death and in a coma and, in the opinion of my physician and two consultants, have a small but uncertain chance of regaining higher mental functions, a somewhat greater chance of surviving with permanent mental and physical disability, and a much greater chance of not recovering at all, then my goals and specific wishes, if medically reasonable, for this and any additional illness would be:

(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

My Medical Directive

The Church Foundation
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Situation C

If I have a terminal illness with weeks to live, and my mind is not working well enough to make decisions for myself, but I am sometimes awake and seem to have feelings, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:

(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

Situation D

If I have brain damage or some brain disease that in the opinion of my physician and two consultants cannot be reversed and that makes me unable to think or have feelings, but I have no terminal illness, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:

(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

_____

_____

_____

My Medical Directive

The Church Foundation
CHARTERED IN 1926

Situation E

If I... (describe a situation that is important to you and/or your doctor believes you should consider in view of your current medical situation): _____

_____

(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

_____

_____

_____

Situation F

If in my current state of health (describe briefly): _____
I develop have an illness that, in the opinion of my physician and two consultants, is life threatening but reversible, and I am temporarily unable to make decisions, then my goals and specific wishes—if medically reasonable—would be:

(Please select one of the following options)

- ☐ Prolong life; treat everything
- ☐ Limit to less invasive and less burdensome interventions
- ☐ Other (please specify): _____
- ☐ Attempt to cure, but reevaluate often
- ☐ Provide comfort care only

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. **Cardiopulmonary Resuscitation** (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying.	☐	☐	☐	☐
2. **Major surgery** (for example, removing the gall bladder or part of the colon).	☐	☐	☐	☐
3. **Mechanical breathing** (respiration by machine, through tube in the throat).	☐	☐	☐	☐
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).	☐	☐	☐	☐
5. **Blood transfusions or blood products.**	☐	☐	☐	☐
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).	☐	☐	☐	☐
7. **Simple diagnostic tests** (for example, blood tests or x-rays).	☐	☐	☐	☐
8. **Antibiotics** (drugs used to fight infection).	☐	☐	☐	☐
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**	☐	☐	☐	☐

Notes:

My Medical Directive

The Church Foundation
CHARTERED IN 1926

Organ Donation

- ☐ I do not wish to make any anatomical gift from my
- ☐ I herby make this anatomical gift, to take effect after my death:

I GIVE:

- ☐ My body
- ☐ Any needed organs or parts
- ☐ The following parts: _____

TO:

- ☐ The following person/institution: _____
- ☐ The physician in attendance at my death
- ☐ The hospital in which I die

FOR:

- ☐ Any purpose authorized by law
- ☐ Therapy of another person
- ☐ Medical education
- ☐ Transplantation
- ☐ Research

Notes:

My Personal Statement

Please mention anything that would be important for your physician and your proxy to know. In particular, try to answer the following questions:

1. What medical conditions, if any, would make living so unpleasant that you would want life-sustaining treatment withheld? (Intractable pain? Irreversible mental damage? Inability to share love? Dependence on others? Another condition you would regard as intolerable?)
2. Under what medical circumstances would you want to stop interventions that might already have been started?
3. Why do you choose what you choose?

When I am dying, I would like—if my proxy and my healthcare team think it is reasonable— to be cared for:

☐ At a Home/Hospice ☐ In a Nursing Home ☐ In a Hospital

☐ Other _____

If there is any difference between my preferences detailed in the illness situations and those understood from my goals or from my personal statement, I wish my _____ to be given greater weight. (Choose one)

☐ Treatment Section ☐ Goals ☐ Personal Statement

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I appoint as my proxy and decision-maker(s): (Name & Address) _____

& (optional) (Name & Address) _____

I direct my proxy to make healthcare decisions based on his/her assessment of my personal wishes. If my personal desires are unknown, my proxy is to make healthcare decisions based on his/her best guess as to my wishes. My proxy shall have the authority to make all healthcare decisions for me, including decisions about life-sustaining treatment, if I am unable to make them myself. My proxy's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate healthcare decisions. My proxy is then to have the same authority to make healthcare decisions as I would if I had the capacity to make them, EXCEPT (list the limitations, if any, you wish to place on your proxy's authority).

I wish my written preference to be applied exactly as possible/with flexibility according to my proxy's judgment. (Delete as appropriate)

Should there be any disagreement between the wishes I have indicated in this document and the decisions favored by my above-named proxy, I wish my proxy to have authority over my written statements/I wish my written statements to bind my proxy. (Delete as appropriate)

If I have appointed more than one proxy and there is disagreement between their wishes, _____ shall have final authority.

Signed:

_____
Name (Sign & Print)

_____
Street Address, PO Box, and/or Apartment #

_____
City State Zip Code

_____
Signature Date

Notes:

My Medical Directive (Healthcare Proxy)

The Church Foundation
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Witness:

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

Witness:

Name (Sign & Print)

Street Address, PO Box, and/or Apartment #

City State Zip Code

Signature Date

Physician *(Optional):*

I am _____'s physician. I have seen this advance care document and have had an opportunity to discuss his/her preferences regarding medical intervention at the end of life.

If _____ becomes incompetent, I understand that it is my duty to interpret and implement the preferences contained in this document in order to fulfill his/her wishes.

Notes:

The Church Foundation
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Planning Funeral Services

"I am the resurrection and the life, he that believeth in me, though he were dead, yet shall he live; and whosoever liveth and believeth in me shall not die."

~John 11:25

Christian Faith Calls

The Christian faith calls us to witness, even in death, the new life that God gives in Christ through his death and resurrection.

We have prepared this booklet to help you and your family prepare in advance. It will enable your family and the parish clergy to understand your wishes and preferences. The clergy will help plan the service and will stand ready to assist in any way.

Christian burial is marked by three characteristics. First and foremost, it is an act of worship wherein we glorify God for the gift of eternal life in Jesus Christ, our Lord. Second, it is a time when members of the Body of Christ gather to comfort one another and to offer mutual assurance of God's abiding love. Third, it is a liturgy of celebration whereby we give thanks for a deceased loved one and commend that person to the care of Almighty God.

The earliest records of Christian burial tell us that the following elements were included:

- Prayer in the home before the burial
- A gathering of the community for a burial service, consisting of thanksgivings, psalms, hymns, readings from Scripture, and prayers for the departed and those who mourn
- Celebration of the Holy Eucharist
- A procession of lights and torches to the place of burial
- The interment of the remains

As part of preparation for Christian burial, it is suggested that you talk with your clergy. It is also of great benefit to read about the service in *The Book of Common Prayer* (BCP, 468–507). The rubrics on these pages are of particular interest. It is also recommended that people familiarize themselves with prayers for "Ministration at the Time of Death" (BCP, 462–467).

Planning Funeral Services
The Church Foundation
CHARTERED IN 1926

Final directions and instructions upon the death of:

Name (Sign & Print) _____ Date _____

Street Address, PO Box, and/or Apartment # _____

City State Zip Code _____

Date & Place of Birth _____

Date of Baptism _____

Occupation _____

Employer _____

Social Security Number _____

Date of Last Entered Will _____

Location of Will _____

Executor's Name & Address _____

Notes:

Family Information

Spouse's Name

Street Address, PO Box, and/or Apartment #

City State Zip Code

Spouse's Date & Place of Birth

Spouse's Date of Baptism

Mother's Full Name

Mother's Date & Place of Birth

Living: ☐ Yes ☐ No

Father's Full Name

Father's Date & Place of Birth

Living: ☐ Yes ☐ No

Notes:

Planning Funeral Services
The Church Foundation
CHARTERED IN 1926

Name, address and phone numbers of living siblings:

(Full Name) (Full Address) (Phone #)

Name, address and phone numbers of persons to notify upon my death:

(Full Name) (Full Address) (Phone #)

Notes:

Please fill out this form and return it to the parish secretary in the church office.

Name (Sign & Print)

(Street Address, PO Box, and/or Apartment #) (City/State/Zip)

The Episcopal tradition is that church members are normally buried from the church. The Prayer Book indicates the body is to be present, although a memorial service without the body may be held. The coffin is closed and is always covered by a pall, which the church will provide.

1. **I request** that my service be conducted at: _____
(Name, City and State of Church)

or at: _____

The rector or clergy of said congregation shall be in charge of the services.

2. The Burial of the Dead (the funeral service) is a series of psalms, lessons, and prayers. Holy Communion with special propers (i.e., Collect, Epistle, and Gospel) may be included.

I request (check one):

☐ **The Burial of the Dead with Holy Communion** (body or urn present)

Rite I (BCP, page 469) Rite II (BCP, page 491)

Rite I (BCP, page 323) Rite II (BCP, page 355)

☐ **The Burial of the Dead** (body or urn present)

Rite I (BCP, page 469) Rite II (BCP, page 491)

☐ **A Memorial Service** (body or urn not present)

Notes:

Planning Funeral Services
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3. Other arrangements as follows (Contact parish administrator):

Altar Flowers Musicians

Altar Flowers Musicians

Speakers (Optional)

4. I request that the following Scriptures be read:

Old Testament (choose one):

- ☐ Isaiah 25:6–9 (He will swallow up death in victory)
- ☐ Isaiah 61:1–3 (To comfort all that mourn)
- ☐ Lamentations 3:22–26, 31–33 (The Lord is good unto them that wait for him)
- ☐ Wisdom 3:1–5, 9 (The souls of the righteous are in the hand of God)
- ☐ Job 19:21–27a (I know that my Redeemer liveth)

Psalms: ☐ 42 ☐ 46 ☐ 90 ☐ 121 ☐ 130 ☐ 139

New Testament (choose one):

- ☐ Romans 8:14–19, 34–35, 37–39 (The glory that shall be revealed)
- ☐ 1 Corinthians 15:20–26, 35–38, 42–44, 53–58 (Raised in incorruption)
- ☐ 2 Corinthians 4:16–5:9 (Things which are not seen are eternal)
- ☐ 1 John 3:1–2 (We shall be like him)
- ☐ Revelation 7:9–17 (God shall wipe away all tears)
- ☐ Revelation 21:2–7 (Behold, I make all things new)
- ☐ Isaiah 25:6–9 (He will swallow up death in victory)

Psalms: ☐ 23 ☐ 27 ☐ 106 ☐ 116

Notes:

5. I request that the following Gospel verse be read
(Must be included if Holy Communion is celebrated):

- ☐ John 5:24–27 (He that believeth hath everlasting life)
- ☐ John 6:37–40 (All that the Father giveth me shall come to me)
- ☐ John 10:11–16 (I am the good shepherd)
- ☐ John 11:21–27 (I am the resurrection and the life)
- ☐ John 14:1–6 (In my Father's house are many mansions)

6. I request that the following hymns be sung:

Music should be confident and strong, expressing the hope and faith that Christians affirm in the presence of death. The congregation should participate fully by praying, singing the hymns ,and joining the responses. Easter hymns are especially appropriate. The Easter hymns are (#174–213) in the 1982 Hymnal. The hymns for Holy Communion (#300–347), the burial (#354–358), and #287, 376, 410, 556, 613-625, 637, 671, 680, and 688.

7. I prefer the following funeral home: _____ ; however, my family or attorney may make this decision.

- ☐ I wish to have my coffin open at the funeral home.
- ☐ I do not wish to have my coffin open at the funeral home.
- ☐ In lieu of flowers, I request that donations be made in my name to_____

Notes:

Planning Funeral Services
The Church Foundation
CHARTERED IN 1926

8. **Buried:** Location of cemetery plot deed, crypt deed, columbarium contract

Coffin specifications:

- ☐ Least expensive
- ☐ Mid-range
- ☐ Elaborate

Cremated:

- ☐ Before Funeral
- ☐ After Funeral

Donate entire body or certain organs (See Organ Donation Form on page 17):

- ☐ Arrangements have been made
- ☐ Please make appropriate arrangements

Please Return to Parish Administrator:

Name of Church

(Street Address, PO Box, and/or Apartment #) (City/State/Zip)

Phone Number

Signature Date

Notes:

Estate Planning

"Do not neglect to do good and to share what you have, for such sacrifices are pleasing to God."

Hebrews 13:16

Estate Planning

Writing a will is a loving and responsible act for the sake of your family. Here are a few helpful suggestions on how to prepare to write your will.

BEFORE SEEING AN ATTORNEY...

- Make a list of everyone for whom you are responsible.
- List everyone that you would like to remember in your will.
- List all of your material assets.
- After subtracting your debts, match the names with the assets or consider giving a portion of your total estate to each individual. Take care of your family first. This is also the time to consider special friends and your church.
- Consider establishing a trust if your estate is large enough.
- Ask your chosen estate administrator (sometimes called executor/executrix) if he or she is willing to serve.
- Consult with the people you select as guardians of your children (where minors and other dependents are involved).
- Talk with your priest to explore the ministries of the church that could best be funded with a gift from your will.

BEQUESTS IN YOUR WILL CAN TAKE SEVERAL FORMS ...

- An outright monetary bequest.
- A percentage of an estate.
- A specific asset, such as personal or real property.
- A testamentary trust created in a will.
- A contingent beneficiary, i.e., the church receives the assets if there are no surviving beneficiaries.
- Note: A bequest to the church is deductible from the value of your estate for tax purposes.

AFTER MAKING YOUR WILL ...

- Make sure someone knows where your will is located.
- Do not place funeral instructions in a safe- deposit box. Generally, services will be over by the time your administrator checks your bank box. Instead, leave a copy of your funeral plans and wishes with your priest and a member of your family.
- Review your will from time to time with your legal advisor. Laws, assets, and personal interests often change over time.

SAMPLE FORMS OF BEQUEST

Specific Amount:

I, _____ , hereby give, devise, and bequeath to the Rector, Wardens, and Vestry of Your Episcopal Church, 123 Main Street, Anywhere, MyState, 00000, the sum of $XX,XXX to be used at their discretion to assist in the ministries of the Church.

Percentage Amount:

I, _____ , hereby give, devise, and bequeath to the Rector, Wardens, and Vestry of Your Episcopal Church, 123 Main Street, Anywhere, MyState, 00000, XX% of the rest, residue, and remainder of my estate, to be used at their discretion to assist in the ministries of the Church.

Contingency Bequest:

In the event the beneficiaries of bequests and devises herein predecease me, or, in the case of institutions, cease to be organizations described in section 501(c)(3) of the Internal Revenue Code, I, _____ , hereby give, devise, and bequeath to the Rector, Wardens, and Vestry of Your Episcopal Church, 123 Main Street, Anywhere, MyState, the rest, residue and remainder of my estate, to be used at their discretion to assist in the ministries of the Church.

For more information on various types of bequests visit
The Church Foundation's Charitable Giving page:
www.tcfdiopa.org/charitable-bequest.

Notes:

_____

_____

_____

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Including a Christian Preamble

A Christian preamble to your will provides a significant opportunity to share your faith with family and friends. Through this personal statement of your faith, an important message will be delivered to those who love and know you best. This message of faith comes at a time of grief and loss and serves as a reminder to them to place their trust in Jesus Christ as you have. Remember, this may be the last document they read about you, their loved one.

As you, together with your attorney, prepare your will/estate plan, give prayerful consideration to adding a Christian preamble such as:

I _____, of the City _____ of _____, County of _____, and State of _____, being of sound mind and memory and being under no restraint, do make, declare and publish this my last will and testament, hereby revoking all wills and codicils heretofore made by me. In thanksgiving to God for the gifts of life given in baptism, and for the many blessings God has showered upon me; and in thanksgiving to God for the gifts of faith and hope through Jesus Christ; and in thanksgiving to God for the gifts of nurture and love through the Church where we have shared faith and fellowship; I now commend my loved ones to grow in this same faith, being true to their own baptisms, knowing that God will continue to provide for them in their lifetimes; I encourage them to place their faith and trust in our Lord and Savior.

(The particulars of the will would follow, leaving gifts to family and friends, but also an articulation of the gifts you might leave to the various ministries of the Church).

FOR ASSISTANCE, CONTACT:

The Church Foundation
23 East Airy Street
Norristown, PA 19401
Lori Daniels, Executive Director: lorid@diopa.org
Ryan Campbell, Operations Manager: rcampbell@diopa.org

A downloadable copy of this booklet is available at
www.tcfdiopa.org/end-of-life-planning/

Legal Name:

Name (Print)

Email

Social Security Number

(Street Address, PO Box, and/or Apartment #)

(City/State/Zip)

Country

Date of Military Service (If Applicable)

Discharge Location and Serial Number

Do you have a Will? ☐ **Yes** ☐ **No** *(If no, skip to "Family Information")*

Since making your last will, have you:

Moved to another state?	☐ Yes	☐ No
Sold or bought property?	☐ Yes	☐ No
Celebrated the birth of a child or grandchild?	☐ Yes	☐ No
Changed your mind about your executor?	☐ Yes	☐ No
Changed your mind about the guardian for your child?	☐ Yes	☐ No
Done family financial and charitable gift planning?	☐ Yes	☐ No

Marital Status:

- ☐ **Single**
- ☐ **Married**
- ☐ **Partner Civil Union**
- ☐ **Divorced**
- ☐ **Remarried**
- ☐ **Separated**
- ☐ **Widowed**

If the answer is yes to any of the above, your will may need to be updated. Complete the questions on the following pages.

Notes:

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Family Information

Spouse's Legal Name:

Spouse's Name (Print)

Spouse's Date of Birth

Spouse's Email

Spouse's Social Security Number

Spouse's Street Address, PO Box, and/or Apartment #

City, State, Zip Code

County

Children (Including those legally adopted)

(Full Name)	(Full Address)	(Date of Birth)

Notes:

Family Information

Other Dependants

(Full Name) (Full Address) (Date of Birth)

Other Loved Ones

(Full Name) (Full Address) (Date of Birth)

Notes:

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Person(s) to be the Guardian(s) of my Child(ren)

Full Name Phone Number

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Full Name Phone Number

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Executor(s) (Person(s) to be the personal representative of my estate):

Full Name Phone Number

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Full Name Phone Number

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Full Name Phone Number

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Notes:

Beneficiary Information: (Persons, Parish/Missions or charitable associations you wish to thank for being part of your life.)

Full Name

Full Name

Full Name

Residual Beneficiary (The final or residual beneficiary receives what is left over after all other bequests have been paid according to your will. Please consider naming your Parish/Mission or The Episcopal Diocese of Pennsylvania as a residual beneficiary.)

Location of Records

Will	Living Will
Birth Certificate	Social Security Card
Tax Records	Safe Deposit Box & Key
Insurance Policies	Funeral Directions
Durable Power of Attorney	Durable Power of Attorney (Healthcare)

Notes:

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Present Annual Income:

Salary $ _____ Investment Income $ _____

Other $ _____ Total $ _____

Property (Real Estate):

	Description & Location	Original Cost	Present Market Value	Mortgage Amount
1				
2				
3				
4				

Leases:

	Description & Location	Original Cost	Present Market Value	Mortgage Amount
1				
2				
3				

Stock:

	Description & Location	Original Cost	Present Market Value	Mortgage Amount
1				
2				
3				
4				
5				
6				

Bank & Retirement Accounts (IRA, etc.) / Other Income Producing Accounts:

	Name of Institution	Type	Account Number
1			
2			
3			
4			

Insurance Policies:

	Company	Policy Name	Face Value	Cash Value
1				
2				
3				

Other Assets:

	Description	Location	Present Market Value	Cost
1				
2				
3				
4				
5				
6				

Notes:

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Monthly Expenses:

House Repairs: $ _____ Auto Expense: $ _____ Clothing: $ _____

Personal Care: $ _____ Mortgage/Rent $ _____ Insurance $ _____

Utilities: $ _____ Taxes: $ _____ Medical/Dental: $ _____

Recreation: $ _____ Other: $ _____ Total:$ _____

Projected Retirement Income	Continues to Spouse		
Social Security: $_____	☐ Yes	☐ No	☐ Half
Pension Plans: $ _____	☐ Yes	☐ No	☐ Half
Retirement Accounts: $ _____	☐ Yes	☐ No	☐ Half
Charitable Trusts: $ _____	☐ Yes	☐ No	☐ Half
Stock Dividends: $ _____	☐ Yes	☐ No	☐ Half
Gift Annuities: $ _____	☐ Yes	☐ No	☐ Half
Pooled Income Fund: $ _____	☐ Yes	☐ No	☐ Half
Mortgages: $ _____	☐ Yes	☐ No	☐ Half
Royalties: $ _____	☐ Yes	☐ No	☐ Half
Other (Describe Below): $ _____	☐ Yes	☐ No	☐ Half

_____

_____

Notes:

Advisors

Accountant

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Attorney:

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Banker(s):

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Notes:

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Broker:

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Insurance Agent:

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Priest

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Trust Officer:

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Notes:

Other Advisors:

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Full Name | Phone Number/Email

Street Address, PO Box, and/or Apartment #, City, State, Zip Code

Additional Notes/Comments:

Signature | **Date**

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Additional Notes/Comments:

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End-of-Life Planning

Source Material From

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