UTAH LEGAL CLINIC

214 East 500 South ■ Salt Lake City, Utah 84111
PHONE: (801) 328-9531 ■ **FAX:** (801) 328-9533 ■ **WEB:** utahlegalclinic.com
ATTORNEY: Angela H. Elmore ■ **PARALEGAL:** Kate L. Andrus

WILL INTAKE FORM

Please fill out the following information prior to your appointment with our office. We will use this information to draft a Simple Will (distributing your assets, setting out burial requests, guardian for minor children, etc.), a Medical and Financial Power of Attorney (selecting someone to make medical and financial decisions for you in the event you are unable to do so yourself), and a Living Will/Advanced Health Care Directive (electing or declining life-prolonging heroic measures).

YOUR PERSONAL INFORMATION:

Name: _____

Address: _____

City: State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Email: _____

Marital Status: _____ Spouse's Name: _____

Children's Names and City of Residence (please include date of birth if the child is a minor):

_____

_____

Do you currently have a Safety Deposit Box? ☐ YES ☐ NO

If yes, where is it located? _____

On the following pages, you will designate various agents to carry out the administration of your estate, make health care decisions on your behalf if you are unable to communicate your wishes, and manage your financial affairs if you become incapacitated and are unable to do so for yourself.
Many people designate the same person to serve in each of these capacities. However, this is not required.

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YOUR PERSONAL REPRESENTATIVE / ADMINISTRATOR FOR YOUR WILL

Your Personal Representative is charged with carrying out your wishes regarding the distribution of your assets and property as specified in your will. Your Personal Representative must also complete any remaining personal business, such as paying bills and filing final tax returns. Your Personal Representative is responsible for administering your estate, including doing the following:

- *Collecting and inventorying the assets of the estate;*
- *Managing the assets of the estate during the probate process;*
- *Paying the bills of the estate*
- *Making distribution to the heirs or beneficiaries of the estate*
- *Closing the estate after all of the above responsibilities have been completed.*

Personal Representative Information:

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Alternate Personal Representative Information:

This person will serve as your Personal Representative if your primary Personal Representative, named above, is unable or unwilling to serve.

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

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Your Property:

Please indicate how and to whom you would like your property distributed:

Your Burial/cremation Requests:

Please indicate if you have any specific burial/cremation requests:

IF THERE ARE NO MINOR CHILDREN,
SKIP PAGES 4 AND 5 AND CONTINUE ON PAGE 6.

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SURVIVING MINOR CHILDREN

If both parents predecease your minor children you may specify in your will who you would like to have appointed by the court to physically care for them and manage their financial affairs. The formal Appointment of a Guardian and/or Conservator for your minor children will require additional legal action after your death. The court will only consider an appointment of a Guardian and/or Conservator, as designated in your will, if ***both*** *parents predecease the children.*

Trustee / Conservator Information:

This person manages money and assets on behalf of your surviving minor children (if any) after the death of both parents.

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

Alternate Trustee / Conservator Information:

This person manages money and assets on behalf of your surviving minor children (if any) after the death of both parents if the primary trustee/conservator designated above is unwilling or unable to serve.

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

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Guardian Information:

This person physically cares for your minor children (if any) after the death of both parents.

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

Alternate Guardian Information:

This person physically cares for your surviving minor children (if any) after the death of both parents if the Primary Guardian designated above if unable or unwilling to do so.

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

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YOUR ADVANCE HEALTH CARE DIRECTIVE
(HEALTH CARE WISHES)

An Advance Health Care Directive (also known as an "Advance Directive") is a document that helps others give you the medical care you would want under certain circumstances. It lets you designate a health care agent to make health care decisions when you are unable to communicate your wishes or make decisions on your own behalf. It also includes directions to your agent about how they should make end-of-life care decisions for you.

Primary Health Care Agent:

This person follows your instructions and makes sure your health care wishes are followed if you cannot communicate your wishes yourself.

☐ ***Check here if you would like this person to be the same person previously designated as your Personal Representative.***

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

Alternate Agent Information:

This person will serve as your health care agent if your agent, named above, is unable or unwilling to serve.

☐ ***Check here if you would like this person to be the same person previously designated as your Alternate Personal Representative.***

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

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Your Health Care Agent's Authority:

☐ YES ☐ NO I would like to authorize my agent to get copies of my medical records at any time, even when I can speak for myself.

☐ YES ☐ NO I would like to authorize my agent to admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

☐ YES ☐ NO I would like to place the limits or expansions on the powers of my health care agent. (*Specify below.*)

Limits/Expansions: _____

_____

☐ YES ☐ NO I would like to authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

☐ YES ☐ NO If I have not otherwise agreed to organ donation, I would like to authorize my agent to consent to the donation of my organs for the purpose of organ transplantation.

☐ YES ☐ NO I would like to nominate my agent or alternate agent to serve as my guardian in the event that I become incapacitated. *Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary.*

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LIVING WILL (ADVANCE HEALTH CARE DIRECTIVE) INFORMATION

A living will gives instructions to doctors and family members in the event you are terminally ill and unable to speak for yourself. A living will sets out your wishes with regard to life sustaining equipment and/or heroic action being used to prolong your life.

Please select ONE option from the following.

If at any time I should have an injury, disease, or illness, which is certified in writing to be a terminal condition or persistent vegetative state by two (2) physicians who have personally examined me, and in the opinion of those physicians the application of life-sustaining procedures would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process,

☐ OPTION 1: I choose to let my agent decide.

☐ OPTION 2: I choose to prolong life.

☐ OPTION 3: I choose not to receive care for the purpose of prolonging life.

If Option 3 is selected, please select either (A) or (B):

☐ (A) I put no limit on the ability of my health care provider or agent to withhold or withdraw life sustaining care.

☐ (B) My health care provider should withhold or withdraw life-sustaining care if at least one of the following conditions is met (check all that apply):

_____ I have a progressive illness that will cause death.

_____ I am close to death and am unlikely to recover.

_____ I cannot communicate and it is unlikely that my condition will improve.

_____ I do not recognize my family or friends and it is unlikely that my condition will improve.

_____ I am in a persistent vegetative state.

ADDITIONAL HEALTH CARE INSTRUCTIONS: _____

_____

_____

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YOUR FINANCIAL POWER OF ATTORNEY

A Durable Financial Power of Attorney allows you to appoint a person to manage your financial affairs if you become incapacitated and are unable to do so on your own behalf. It only becomes effective upon your becoming incapacitated and must be accompanied by a notarized written statement from your attending physician certifying that you are unable to give current directions as to the management of your financial affairs, property and related matters. The person designated to manage your financial affairs is called your "attorney-in-fact."

Primary Financial Decision Making Agent (Attorney-in-Fact):

☐ ***Check here if you would like this person to be the same person previously designated as your Personal Representative.***

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

Alternate Financial Decision Making Agent:

This person will serve as your financial decision making agent if your primary financial decision making agent, named above, is unable or unwilling to serve.

☐ ***Check here if you would like this person to be the same person previously designated as your Alternate Personal Representative.***

Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____

Relationship to You: _____

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FOR ATTORNEY TO COMPLETE

Additional Remarks/Instructions:

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PLEASE READ THE FOLLOWING

Your appointment today is to discuss our office drafting a Will, a Living Will, and a Medical and Financial Special Power of Attorney. The fee we charge for drafting those three (3) documents is $200.00.

Based upon the information that you have given us, we will draft a Will, a Living Will, and the Power of Attorney. We will mail those documents to you for review. You should receive those in the mail from us within fourteen (14) days of this appointment. If you do not receive them within that time, please call our office and ask when the documents will be completed.

After you have received and reviewed the documents, if there are changes necessary or if you have questions, please call our office. If the documents are correct and complete, please call our office and set an appointment to come in and sign your Wills. You must sign before a Notary Public and two (2) witnesses. Staff members in our office will serve as the Notary Public and as witnesses. Your appointment to sign the Wills will take at least twenty (20) minutes at our office.

After you have signed the final documents, we recommend that you keep the original documents in a safe place (a bank safety deposit box, etc.) that you and your Agent both have access to or have knowledge of. You should give copies of your Living Will and Medical Power of Attorney to your physician and relatives so that they know your wishes. Although we will keep a photocopy of these documents, you have the only signed valid formal originals. If you want to make changes in these documents in the future, you should consult an attorney to do so.

The policy of our office is to collect the fee and write you a receipt when you have completed this form, read this agreement, and before you talk to the attorney.

If you have any questions about this agreement, please ask one of our staff members before you sign.

I HAVE READ AND UNDERSTAND THE FOREGOING AGREEMENT AND AGREE TO THE TERMS OF THIS AGREEMENT. ALL OF THE INFORMATION AS SET FORTH ABOVE AND PROVIDED BY ME (THE CLIENT) IS TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

DATE CLIENT SIGNATURE

_____

PRINT CLIENT'S NAME

cc: Client (this page only)

UTAH LEGAL CLINIC
214 East 500 South Street
Salt Lake City, Utah 84111-3204
Telephone: (801) 328-9531

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****CLIENT COPY****

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XXXXXXXXX
DATE

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLIENT SIGNATURE

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PRINT CLIENT'S NAME

cc: Client (this page only)

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