



My plans - My gift to you

A checklist to help you honor my final wishes

We plan for college, marriage, a baby & retirement...
but we don't prepare for the end of life.
Let's change that!

www.gotplans123.org

Peace of mind is a precious gift. We can help.



Hospice & Palliative
CARE CENTER

Hospice & Palliative CareCenter
hospicecarecenter.org



Rowan
Hospice & Palliative CARE

Rowan Hospice & Palliative Care
rowanhospice.org

Hospice & Palliative CareCenter, Novant Health, Rowan Hospice & Palliative Care, and Wake Forest Baptist Health have come together to promote a common cause in the Piedmont Triad region of North Carolina. Along with other regional healthcare leaders, our coalition – The Community Partnership for Compassionate Care – works to encourage and facilitate the advance healthcare planning process. The partnership and its members have created “Got Plans?” and related resources to help promote decisions, discussions, and documentation related to the advance healthcare planning process. Our mission is to “encourage conversations about end of life care.”

The *future*
depends on what
we do in the
present

Mahatma Gandhi

Why should I complete this guide?

Death is an inevitable aspect of life, yet planning ahead can ease some of the challenges that often add stress and anxiety to those grieving your loss. Completing this guide will help bring peace of mind to you and your loved ones that want to honor your wishes and fulfill your life's legacy.

This packet was designed to help you think through, and make plans *now* for the many important decisions that will have to be carried out after your death. This packet will prompt thorough and detailed consideration of what is meaningful and

important to you. Making these decisions in advance is one of the most precious gifts you can provide to those you love.

By completing this packet, you are collecting vital information and organizing it into one simplified and convenient location.

This guide is a gift.

It is a gift for your family, friends, loved ones, and anyone who will be charged with funeral and burial arrangements, financial and legal organization and making a host of necessary decisions once you are gone. Like most people, your information may be dispersed in various locations. This packet is a tool you can use to organize that information, so that when the time comes, your loved ones are prepared to take on the responsibility of your affairs and honor your wishes.

Information and documents to consider as you complete this packet:

- Advance Directives
- Medical Information
- Birth Certificate
- Family Birth Certificates
- Family Death Certificates
- Social Security Card
- Marriage Certificates
- Divorce Decrees
- Guardianship Documents
- Insurance Policies
- Estate Plans
- Deeds and Titles to Property
- Automobile Title and Registration Papers
- Credit Card Accounts
- Bank Accounts
- Safety Deposit Boxes
- Retirement Accounts
- Stock Certificates
- Military Service and Veteran information
- Income Tax and W-2 Forms
- Loan and Installment Information
- Travel Documents
- Important Contact Information

The time to
repair the
roof is when
the sun is
shining.

John F. Kennedy

My Advance Directive

It's as simple as 1, 2, 3...

1 Decide

- ☐ Choose the type of care you would like to receive at the end of life
- ☐ Select your Health Care Agent

My Health Care Agent _____ Relationship _____

2 Discuss

- ☐ Discuss your wishes with your loved ones
- ☐ Discuss your wishes with your health care provider
- ☐ Discuss your wishes with your Health Care Agent

3 Document

- ☐ Fill out the Advance Directive forms according to your wishes
- ☐ Attend a **Got Plans? Workshop** if you have any concerns or questions about your forms
Date of workshop _____

- ☐ Get your forms notarized
Date of notarization _____

- ☐ Distribute your documents

- ☐ Send a copy to your doctor

Doctor's Name _____ Practice _____

Phone _____ Date _____

- ☐ Send a copy to the department of records at your hospital

Hospital _____ Date _____

- ☐ Give a copy to your Health Care Agent if you have one

Health Care Agent's Name _____

Phone _____ Date _____

- ☐ Give copies to your family and loved ones

Who has a copy?

Name _____ Relationship _____

Phone _____ Date _____

Name _____ Relationship _____

Phone _____ Date _____

- ☐ **Keep the original document in a safe and easily accessible place at all times**

My original document

Location _____ Date _____

My copies

Location _____ Date _____

Location _____ Date _____

- ☐ **Fill out your Notice of Advance Directive card and keep it with you at all times**

get organized.

It is important to note that some of the information in this guide may not apply to you. Only complete the sections you are comfortable with or you think are relevant to your life. You should also keep in mind that your own individual life circumstances are subject to change. The information you record in this guide should be updated as those changes occur.

About Me

My Full Name _____

My Date of Birth _____

My Address _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email Address** _____

Social Security Number _____

Driver's License Number _____ **State Issued** _____

- ☐ **I am married**

My Spouse's Full Name _____

Spouse's Home Phone _____ **Cell Phone** _____

Work Phone _____ **Email Address** _____

☐ **I am divorced**

Date _____

Location of my divorce decree or other important information

☐ **I am a United States citizen**

☐ **I was born in the United States**

☐ **I earned U.S. citizenship**

Location of my citizenship papers _____

☐ **I served in the military**

Years Served _____ My Company _____

My Rank _____

Decorations _____

Discharge Date _____ Location of my DD214 _____

Location of any other military service records _____

My VA Information _____

My Family

☐ **I have children**

Name

_____ Birthdate _____ Phone _____

Name

_____ Birthdate _____ Phone _____

Name

_____ Birthdate _____ Phone _____

Name

_____ Birthdate _____ Phone _____

☐ **My children are minors, and I have designated their legal guardian in case of emergency or my death**

Name of Legal Guardian _____ Phone _____

My Attorney _____ Phone _____ Date _____

Notes

☐ **My children are adopted**

Location of adoption papers

Date _____

☐ **I am the legal guardian of one or more individuals**

Name of Minor _____ Birth Date _____

Name of Minor _____ Birth Date _____

Location of Guardianship Papers

☐ **I am a caregiver**

Care Recipient's Name _____

Address _____

Home Phone _____ Cell Phone _____

My Responsibilities

Emergency Contact or Other Caregiver _____ Phone _____

☐ **I have other loved ones I wish to be notified in case of an emergency or my death**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Notes

☐ **I have one or more pets, and I have designated the circumstances of their guardianship in case of my death**

My Veterinarian _____ **Practice** _____

Practice Address _____ **Phone** _____

Pet's Name _____ Age _____ Breed _____

Designated Guardian _____ Phone _____

Notes: _____

Pet's Name _____ Age _____ Breed _____

Designated Guardian _____ Phone _____

Notes: _____

Pet's Name _____ Age _____ Breed _____

Designated Guardian _____ Phone _____

Notes: _____

Pet's Name _____ Age _____ Breed _____

Designated Guardian _____ Phone _____

Notes: _____

My Healthcare Information

My Primary Care Physician _____ Phone Number _____

Medical Practice _____ Date _____

☐

I have other physicians

Consider your eye specialists (optometrists, ophthalmologists), hearing specialists, podiatrists, neurologist, and any surgeons or oncologists.

Name	Specialty	Practice	Phone

☐

I have one or more specific health issues

Condition	Date Diagnosed	Attending Physician	Phone

☐

I take medications regularly

Medication	Date Started	Dosage	Frequency	Reason for Medication	Prescribing Physician	Date Discontinued

Medication	Date Started	Dosage	Frequency	Reason for Medication	Prescribing Physician	Date Discontinued

☐ **I have one or more allergies**

Please describe

☐ **I have completed a portable Do Not Resuscitate (DNR) form**

Date Completed _____

Location of my copy _____

Who else has a copy?

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

☐ **I have completed a MOST (Medical Orders for Scope of Treatment) form**

Physician who signed my form _____

Date Completed _____

Location of my copy _____

Who else has a copy?

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

☐ **I wish to donate my organs**

☐ I have discussed organ donation with my doctor, and my wishes have been documented in my medical records. Date _____

☐ I have registered for organ donation with North Carolina Donor Registry at www.donatelifenc.org
My username _____ Password _____ Date _____

☐ I have an organ donation card.
Location of my card _____ Date _____

☐ **I wish to donate my body to a medical school or other scientific institution**

☐ I have a preferred recipient _____

☐ I have made arrangements for the donation of my body with this recipient
Contact Name _____ Phone Number _____
Date _____

My Possessions

☐ **I have an income**

Consider your employers and any social security, retirement assets, retirement benefits, or disability payments

Source	Amount	Frequency	Contact

Location of related documents

☐ **I have a Last Will and Testament**

My Attorney _____ Phone Number _____

Executor of my will _____ Phone number _____

Location of my original copy _____ Date _____

Other copies

Location 1 _____ Date _____

Location 2 _____ Date _____

Location 3 _____ Date _____

☐ **I have a Trust**

Location of my original copy _____ Date _____

Other copies

Location 1 _____ Date _____

Location 2 _____ Date _____

Location 3 _____ Date _____

☐ **I have a codicil**

Location of my original copy _____ Date _____

Other copies

Location 1 _____ Date _____

Location 2 _____ Date _____

Location 3 _____ Date _____

☐ **I have included charities of my choice in my estate plans**

Charity Name _____ Date _____

Charity Name _____ Date _____

Charity Name _____ Date _____

☐ **I have designated an Attorney-in-Fact under a *durable* Power of Attorney (POA)**

Name of my attorney-in-fact _____ Phone Number _____

Address _____ Date _____

☐ **I have an annuity**

Recipient name _____ Phone _____

Term of annuity _____ Amount _____ Date _____

☐ **I have a mortgage**

Location of my documents _____ Date _____

My bank _____ My personal banker _____ Phone _____

☐ **I have a loan**

Location of my documents _____ Date _____

My bank _____ My personal banker _____ Phone _____

☐ **I am in the possession of a safety deposit box**

My Bank _____ My Financial Advisor _____

Contents _____

Lock Combination or Key Location _____ Date _____

☐ **I am in the possession of a personal safe**

Location _____ Lock Combination _____

Date _____

Contents _____

☐ **I am in the possession of a personal computer or laptop**

Location _____ Password _____ Date _____

Important Contents _____

☐ **I use a company-owned computer or laptop at my place of work**

Location _____ Password _____

Important contents _____

Name of employee to whom these contents may be relevant _____

Employee phone number _____ Date _____

☐ **I maintain personal or work-related websites, blogs, or social media accounts (Facebook, Twitter)**

Website Name _____ Username _____ Password _____

Website Name _____ Username _____ Password _____

Website Name _____ Username _____ Password _____

Website Name _____ Username _____ Password _____

Notes (eg. What would you like to happen with your accounts?)

☐ **I have one or more email accounts**

Email Address _____ Password _____

Email Address _____ Password _____

Email Address _____ Password _____

Email Address _____ Password _____

Email Address _____ Password _____

☐ **I have important travel documents (Passport, Visas, Identification Cards, etc.)**

☐ **I have a passport**

Issuing Country _____ Passport Number _____

Date Issued _____ Expiration Date _____

Location of my passport _____

☐ **I have one or more Visas**

Issuing Country _____ Type _____ Number _____
Date Issued _____ Expiration Date _____

Issuing Country _____ Type _____ Number _____
Date Issued _____ Expiration Date _____

Issuing Country _____ Type _____ Number _____
Date Issued _____ Expiration Date _____

☐ **I have other important travel documents**

Please describe

☐ **I have a Post Office (PO) Box**

My Post Office _____ PO Box Number _____

Location of my PO Box Key _____

☐ **I have one or more personal bank accounts**

Bank _____ Account Number _____ Password _____

Bank _____ Account Number _____ Password _____

Bank _____ Account Number _____ Password _____

☐ **I have one or more personal credit card accounts**

Provider _____ Account Number _____ Password _____

Provider _____ Account Number _____ Password _____

Provider _____ Account Number _____ Password _____

☐ **I am a stockholder**

Which companies? _____

Location of my stock certificates _____

☐ **I have employee benefits**

Please describe _____

Employer Name _____ Human Resources Contact _____

Phone Number _____ Date _____

☐ **I have an independent insurance policy**

Insurance company _____ My agent _____

Phone Number _____ Date _____

☐ **I have an automobile**

Registered Owner _____ Legal Owner _____

Outstanding Payments _____

Vehicle Identification Number _____ Make _____

Year Manufactured _____ License Number _____

Location of vehicle title and registration

☐ **I have automobile insurance**

Policy Holder _____ Policy Number _____

Insurance Company _____ Date _____

☐ **I am in possession of other important belongings, documents, and collateral in another non-disclosed location or on another technological device (consider your Social Security statement, birth certificates, marriage certificates, divorce decrees, death certificates, deeds, citizenship papers, etc., if you have not already listed their locations)**

Location 1 _____ **Lock Combination** _____

Contents _____

_____ **Date** _____

Location 2 _____ **Lock Combination** _____

Contents _____

_____ **Date** _____

[illegible]

My ideal setting for the end of life

In the event I need to be admitted to the hospital, my hospital preference would be

_____ Date _____

☐ **I have completed a Do Not Hospitalize form**

Location of my Do Not Hospitalize form

_____ Date _____

☐ **If possible, I would like to die at home**

☐ **If I become eligible, I would like to receive hospice care**

My preferred hospice is _____ Phone _____

Address of my preferred hospice _____ Date _____

☐ **I have preferences for pain relief**

☐ I would like enough medication to keep me as comfortable as possible, even if it makes me less aware of what is going on

☐ I prefer to be medicated for pain, but I want to be aware of my surroundings, even if this means that my pain may not be completely alleviated.

☐ Or, please provide your own instructions

☐ **In addition to medication, I would also benefit from non-medical comfort measures, such as healing therapy, massages, turning and repositioning, and all measures to keep me fresh and clean**

Please indicate any special request

☐ **I wish to have the support of those special to me**

Family members

Friends

Faith community members

Other special people or animals

☐ **I have other preferences for my setting at the end of life**

The following will bring me peace and comfort:

Music	Readings
Scripture	Prayers
Rituals	Flowers
Photographs	Artwork
Special Foods	Other

After my death

☐ **I have written my own obituary**

Location of my obituary _____

Date _____

☐ I have distributed copies of my obituary

Recipient _____ Date _____

Recipient _____ Date _____

Recipient _____ Date _____

☐ **I have not written my own obituary, but I have special instructions or guidelines and I have designated a writer**

Designated writer _____ Date _____

Special instructions or guidelines _____

Biographical Information to Guide My Obituary

Education

Social Activities

Military Service

Acts of Service

Employment

Special Achievements, Awards, or Recognition

Other

☐ **I have already contracted arrangements regarding my funeral**

Selected Funeral Service _____ Contact Name _____

Phone Number _____ Date _____

Selected Venue _____ Contact Name _____

Phone Number _____ Date _____

☐ **I have not already made arrangements, but I have special instructions regarding my funeral**

Preferred funeral service _____

Preferred venue _____ Date _____

☐ I wish to have a visitation prior to my funeral service: **Public** or **Private** (circle one)

☐ I wish to have a private funeral

☐ I would like to choose my funeral officiator

Preferred officiator _____

Phone Number _____ Date _____

☐ I would like to choose my pallbearers

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

- ☐ I want donations to be made to a specific charity

Charity Name _____

☐ **I have made arrangements for my burial or cremation**

- ☐ **I wish to be buried**

Location of my pre-purchased burial plot or crypt

Location of plot deed _____

Contact Phone Number _____ Date _____

- ☐ **I wish to be cremated**

Cremation Service _____

Contact Phone Number _____ Date _____

Instructions for my ashes _____

☐ **I have set aside funds to finance my funeral and burial/cremation**

Account Information _____

Personal Banker _____ Phone Number _____

Designated Amount _____ Date _____

☐ **I have other wishes regarding the funeral or memorial service**

- ☐ **In addition to my family, there are special individuals who I wish to be present at my funeral or memorial service**

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

[illegible]

Important Numbers

Name	Phone	Important Notes
My primary care physician		
My other doctors		
My dentist		
My faith community leader		
My pharmacy		
My attorney		
My CPA		
My bank		
My financial advisor		
My personal banker		
Executor of my will		
People listed in my will		
My insurance Agent		
My landlord		
Other		

[illegible]

[illegible]

Got Plans? has been endorsed by the North Carolina Partnership for Compassionate Care, the North Carolina Medical Society and the North Carolina Bar Association.



Got Plans? was created by the Community Partnership for Compassionate Care. Steering committee representatives from Hospice & Palliative CareCenter, Rowan Hospice & Palliative Care, Novant Health and Wake Forest Baptist Health work in collaboration to promote and facilitate advance care planning efforts throughout the region.

The Community Partnership for Compassionate Care is one of seven regional members of the North Carolina Partnership for Compassionate Care.