End-of-Life arrangements for:
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Note from the Fairmount Pastor

In life and in death we belong to God.

This affirmation from the Brief Statement of Faith testifies to the bedrock of Christian faith. God's love and care is eternal and unconditional. The fear that makes it easy to deny the reality of death is conquered by the love that overcame death. We can accept the certainty of our death because we trust in the certainty of God's presence and care even more.

The journey of our earthly life will be far more satisfying if we consider its end. This booklet is designed to help you reflect on end-of-life issues and decisions. You will have opportunity to put down in writing what your wishes are concerning advance medical directives, contact persons, location of important documents, disposition of your remains, funeral/memorial services, and other important information. We encourage you to talk with your family members about your wishes, both to let them know of these documents, but also to discuss any difference between your wishes and theirs.

Your ministers are happy to discuss end-of-life issues with you. Call on us at any time. We also invite you to leave a copy of your prepared documents on file with us, as an additional safeguard that your wishes will be fulfilled.

If you are looking for funeral or cremation services you may want to look at the Cleveland Memorial Society web site.

With believers in every time and place, we rejoice that nothing in life or in death can separate us from the love of God in Christ Jesus our Lord.

God's blessings on your journey,

Your Fairmount Pastors

Revised January, 2017
Note to my Survivors

Dear Loved Ones,

I have given a great deal of thought to my wishes concerning my final arrangements. I have tried to minimize the emotional strain and distress that you would face if these decisions were left to you with no indication of my wishes.

In this planning guide, I have recorded the information you will need to complete these arrangements. I have recorded information about financial and property matters and preferences for funeral or other arrangements at the time of my death. It has given me peace of mind to do so. I trust this guide will help you to avoid confusion, undue anxiety, and, hopefully, offer you some comfort.

This planning guide represents my wishes which I would like to have carried out at the time of my death. I understand that this document is not legally binding. I also realize that personal circumstances and preferences may make changes in my wishes desirable, and I entrust those decisions to my family.

With Abiding Love,


My Signature  


Date  

Biographical Data

Full Name ____________________________________________________________

Legal Address _________________________________________________________

Years at present address _______________________________________________

Prior Address _________________________________________________________

Telephone ___________________ Email Address ____________________________

Date of Birth ___________________ Place of Birth ________________________

Social Security # _______________ Citizen of ____________________________

Name of Father ________________ Place of Birth/Death ____________________

Date of Birth - ____________________________

Name of Mother ________________ Place of Birth/Death ____________________

Date of Birth____________________

Maiden name ______________________

Marital Status ____________________

Full name of Spouse or Partner (if applicable) _____________________________

Address and Phone if Different ___________________________________________

Date of Marriages __________________ Places _____________________________

Names of previous spouses or partner, if you wish to have them mentioned

_____________________________________________________________________

_____________________________________________________________________
Children: (if applicable)

1. Name ______________________________________________________
   Phone ______________________________________________________
   Address _____________________________________________________
   Date of Birth _______________________
   Place of Birth ______________________________________________

2. Name ______________________________________________________
   Phone ______________________________________________________
   Address _____________________________________________________
   Date of Birth _______________________
   Place of Birth ______________________________________________

3. Name ______________________________________________________
   Phone ______________________________________________________
   Address _____________________________________________________
   Date of Birth _______________________
   Place of Birth ______________________________________________
Living Brothers and Sisters:

1. Name _________________________ Phone _______________________
   Address ______________________________________________________
   Date of Birth _________________ Place of Birth_____________________

2. Name _________________________ Phone _______________________
   Address ______________________________________________________
   Date of Birth _________________ Place of Birth_____________________

Deceased Members of the Family:

1. Name ________________________________________________________
   Date of Birth _________________ Date of death_____________________

2. Name ________________________________________________________
   Date of Birth _________________ Date of death_____________________

3. Name ________________________________________________________
   Date of Birth _________________ Date of death_____________________
Personal information

Schools Attended

High School _____________________________   Degree date ______________

College ________________________________ Degree date ______________

Advanced Degree_________________________ Degree date ______________

Special Achievements or Recognition:

________________________________________________________________

________________________________________________________________

________________________________________________________________

Organization Affiliations

________________________________________________________________

________________________________________________________________

________________________________________________________________
Professional Statistics:

Company _______________________ Title __________________________
Dates __________________________

Company _______________________ Title __________________________
Dates __________________________

Company _______________________ Title __________________________
Dates __________________________

Professional Achievements:

Military Statistics

Branch Serial No.

Dates

Places of Service ________________________ Grade, Rank, Rating ______________________

Citations, Recognitions, Awards:

Arrangements for Care of Pets.

My animal(s) should go to:

Other information (e.g. friends important to you to note, items of interest not categorized here):

________________________________________________________________________________________

________________________________________________________________________________________
At the time of my death, contact the following immediately:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Physician</td>
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<tr>
<td>Clergy</td>
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<tr>
<td>Funeral Director</td>
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<tr>
<td>Relatives</td>
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<tr>
<td>Friends</td>
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<td>Executor</td>
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<td>Employer</td>
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<tr>
<td>Co-worker</td>
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Notify the following as soon as possible:

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<tr>
<th>Relationship</th>
<th>Name</th>
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<tbody>
<tr>
<td>Attorney</td>
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<tr>
<td>Banker</td>
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<tr>
<td>Insurance Agent</td>
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</table>
I have special medical considerations contained on a Medic Alert bracelet which state:

________________________________________________________________________

(e.g. Funeral Directors need to know if there is a pacemaker.)

I have contacted and signed forms with the following organizations:

________________________________________________________________________

(Note: Organ donation of all kinds requires contact with recipient groups well in advance in order to be carried out effectively.)

**Lifebank** (Cleveland Area) 216-752-5433 or 1-800-558-5433

Other (i.e. The Eye Bank)

Please be aware that there is time value involved, particularly regarding eye donation. I have informed my physician, funeral director and person handling arrangements of my wishes. It is advisable to confirm these plans with my funeral director, as soon as possible following my death.
Memorial or Funeral Service

If you would like to include a Fairmount pastor or have your service at Fairmount Presbyterian Church, please ensure that the church office is involved in the decision of the date and time of the service.

A funeral service occurs when a casket and body are present. A memorial service occurs when no body is present, though the ashes may be. Therefore a funeral is held very close to the death date, but a memorial service may be held at any time.

Type of Service: Memorial    Funeral

I wish the memorial service/funeral to be held at:

Clergy Preference:

Memorial gifts to:

I do_______ do not_______ want my picture on the front of the bulletin

Suggested hymns and music:

_______________________________________________

Suggested scripture:

_____________________________________________________

Reading selections:

______________________________________________________
Reception following service:

______________________________________________________________

Tone of service:

______________________________________________________________

Additional speakers  yes ____________  no  ____________

Names:

1.

2.

3.

Other requests:
Interment

Preferred care of body:
- Earth Burial
- Mausoleum Entombment
- Fairmount Church Columbarium
- Cremation

Calling Hours: Yes _____ No _____

Location: ________________________________

Preferred Committal:

Name:__________________________________________

Address: ________________________________________

Grave, Vault or Niche Number: _____________________________

I would like my name to read as follows: ______________________________

I have made the following arrangements with my funeral director, in brief:

Funeral Home                                    Funeral Director’s Name

_____________________________________________________________________

Address ____________________________________________

Phone ____________________________________________
My Life and Loves

Following my death, there will be people who wish to reflect during some special service or during private moments upon my life. I want to provide my loved ones with this information to be used as a valuable resource upon which to reflect later. (Feel free to add pages.)

Hobbies/Interests I enjoy...

Organizations/Activities that mean much to me...

Values and qualities for which I would like to be remembered...

Beliefs and truths I'd like to pass on to my loved ones...
I've noted below where records are located. (We suggest writing in pencil, since information may change.)

Will ____________________________________________________________

Living Will ______________________________________________________

Powers of Attorney _______________________________________________

Trust Agreement _________________________________________________

Deed to Cemetery Plot ____________________________________________

Military discharge record __________________________________________

Life insurance policies _____________________________________________

401k account ____________________________________________________

IRA/KEOGH account ______________________________________________

Investments ______________________________________________________

Stock plans ______________________________________________________

Stock options ____________________________________________________

Stock certificates _________________________________________________

Online investments (site)  User ID  Password

______________________________________________________________

______________________________________________________________

______________________________________________________________

Certificates of Deposit ____________________________________________

Bonds __________________________________________________________
Check book(s) ____________________________________________________________

Savings passbook(s) ______________________________________________________

Safe deposit box __________________________________________________________

Safe deposit box key ______________________________________________________

Persons with access to safe deposit box ____________________________________

Credit union account information __________________________________________

Home owner's insurance policy _____________________________________________

Birth certificate and/or baptismal record _____________________________________

Naturalization papers ______________________________________________________

Passport _________________________________________________________________

Marriage license __________________________________________________________

Divorce degree ____________________________________________________________

Children's birth certificates and/or baptismal records __________________________

Health (including dental) __________________________________________________

Death certificates of other family members ___________________________________

Renter's insurance policy __________________________________________________

Health insurance policy ____________________________________________________

Car insurance policy _______________________________________________________

Car title(s) ______________________________________________________________
Car maintenance records

Driver’s License

Title/deed to the following properties

House keys

Mortgage agreements

Credit accounts

Notes payable

Notes receivable

Social security card

Social security records

Most recent W-2

Most recent tax returns
### Whereabouts of my Records

**Internet information including passwords (Facebook, e-mail, etc.)**

<table>
<thead>
<tr>
<th>Site name</th>
<th>URL</th>
<th>Login ID</th>
<th>Password</th>
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<tbody>
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(Or list who also has the password if you don’t want to write it down here.)

**Professional organizations:**


**Volunteer or social organizations:**


**Other (such as records of tax deductible contributions, and/or valuables):**


We suggest you delete password information in copies of this document you share beyond your family.
Benefits

Benefits I've arranged for my survivors.

<table>
<thead>
<tr>
<th>Benefit source</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Employer life insurance</td>
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<tr>
<td>Other life insurance</td>
<td></td>
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<tr>
<td>Union</td>
<td></td>
</tr>
<tr>
<td>Veterans’ group</td>
<td></td>
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<tr>
<td>Religious group</td>
<td></td>
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<tr>
<td>Fraternal organization</td>
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<td>Other</td>
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Copies of this Planning Guide have been given to: (list name & address)

My Church

My Lawyer

Family Member

My Funeral Director (available 24/7)
### Possessions

I would like the following possessions, not specifically mentioned in my will, to be given to:

<table>
<thead>
<tr>
<th>Whom</th>
<th>Item</th>
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**Additional Instructions or Information**

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Declaration of ________________________________, (Name)

Date of Birth _____________________

I state that this is my Ohio Living Will Declaration. I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my wish that my dying not be artificially prolonged. If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

**Health Care if I am in a terminal condition. If I am in a terminal condition and unable to make my own health care decisions I direct that my physician shall:**

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a Do Not Resuscitate Order and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Health Care if I am in a Permanently Unconscious State. If I am in a permanently unconscious state, I direct that my physician shall:**

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph detailing Special Instructions, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Special instructions:** By placing my initials at number 3 below, I specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:

1. I am in a permanently unconscious state; and
2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
3. I have placed my initials on this line: ______________________________
In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify those designated by law (my guardian, spouse, adult children, parents or majority of adult siblings) or one of the following persons in the following order of priority (You are not required to name anyone. Please cross out any unused lines):

First Contact:                                        Second Contact:

Name ________________________________ Name ________________________________

Address: ________________________________ Address: ________________________________

Telephone: ________________________________ Telephone: ________________________________

This Living Will Declaration has no expiration date. However I may revoke it at any time. Copies of the document are the same as the original. Any person may rely on a copy of this document. I intend that this document be honored in any jurisdiction to the extent allowed by law.

I have completed a Health Care Power of Attorney: _____ Yes _____ No

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on _____________________________________, ____________,

(date)               (year)

At ______________________________________, Ohio.

(city)

Signature of Declarant: ________________________________

(You may either have this document witnessed by two people or by a Notary Public of the State of Ohio. YOU DO NOT NEED BOTH. Either one is sufficient to validate the document.)
Witnesses: I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in the Declarant’s Health Care Power of Attorney, I am not the attending physician or the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and I am an adult not related to the Declarant by blood, marriage or adoption.

Signature: ___________________________________________ Date: ______________
Address: ______________________________________________________________

Signature: ___________________________________________ Date: ______________
Address: ______________________________________________________________

OR

Notary Acknowledgment.
State of Ohio
County of ___________________, ss

On __________________________, _____________, before me, the undersigned (date)                                              (year)
Notary Public, personally appeared _______________________________________
(Declarant)
known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_______________________________________________
Notary Public

My Commission Expires: ____________________________
Ohio Legal Rights Service’s

Durable Power of Attorney for Health Care Form

This form helps you to direct your care should your doctor decide that you lack capacity to make your own medical decisions. It is not intended as a substitute for legal advice, and you should contact a lawyer if you have questions about this document or what it does.

Introduction

There are two types of advance directives for mental health treatment. One type is the Declaration for Mental Health Treatment under Revised Code chapter 2135. The second type is the Durable Power of Attorney for Health Care under Revised Code chapter 1337. The following form is an advance directive under Revised Code chapter 1337, a Durable Power of Attorney for Health Care form.

Ohio Legal Rights Service is partially funded by, and this form was prepared through, a grant under the Protection and Advocacy for Mentally Ill Individuals Act administered through the Center for Mental Health Services of the United States Department of Human Services.

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The express written permission of OLRS is required for any other use.

Instructions for filling out this form

In this document you name one or more people as your “agent” or “attorney-in-fact”. You authorize your agent to make all physical and mental health care decisions for you, but only if your attending physician determines that you have lost the capacity to make informed health care decisions for yourself. You should review each section of this form. You must fill in your name and county of residence; the section appointing an agent; and the signature and date. You must sign the form in the presence of the witnesses and/or notary public. The declarations should be filled out only if you want to provide specific instructions to your agent about your treatment.
I. Appointment of Agent

I, __________________________________________, am an adult of sound mind

who currently resides in __________________________ County, Ohio. After careful consider-
ation, I knowingly and voluntarily make this durable power of attorney for health care and declaration
of treatment preferences. I understand that this is a legally binding document.

I understand that this document will take effect only if my attending physician determines that my
ability to receive and evaluate information is impaired to such an extent that I have lost the capacity
to make informed health care decisions for myself. My agent can then begin making all physical and
mental health care decisions for me. My agent will continue making all health care decisions for me
until my attending physician determines that I have regained the capacity to make those decisions
for myself.

Designation of my agent

I appoint the following person(s) to act as my agent to make health care decisions for me if my at-
tending physician determines that I have lost the capacity to make informed health care decisions for
myself. My agent has authority to make all physical and mental health care decisions for me, includ-
ing the right to give, to refuse to give, or to withdraw informed consent to any health care treatment,
as allowed by law.

I instruct my agent to make health care decisions for me consistent with my wishes as expressed in
this document or, if not expressed here, as otherwise made known to my agent by me. If my agent
does not know and is not able to determine what I want, I instruct my agent to act in what my agent
believes to be my best interest.

I intend each of the individuals named below to succeed to the authority of and serve under this ap-
pointment, in the order named, if at any time the prior agent is not readily available or is unwilling to
serve or to continue to serve, or is removed by me.

First choice:

I appoint ____________________________________, address ______________________________________,

daytime phone ________________________, evening phone __________________________,

as my agent to make all health care decisions for me.

Second choice:

I appoint ____________________________________, address ______________________________________,

daytime phone ________________________, evening phone __________________________,

Third choice:

I appoint ____________________________________, address ______________________________________,

daytime phone ________________________, evening phone __________________________,
My ability to revoke this document

I understand that I can revoke this document at any time and in any manner merely by expressing my intention to revoke it. This can be done verbally or in writing. If I have given a copy of this document to a physician, my revocation will not be effective as to that physician until the fact of my revocation is communicated to that physician (or the physician’s staff) by me or by a witness to the revocation. I understand that if I execute a new durable power of attorney for health care, the new document will automatically replace this one.

Expiration date
(Initial one)

_____ This durable power of attorney for health care has no expiration date, and shall not be affected by my disability or by the passage of time.

_____ This durable power of attorney for health care shall expire at Midnight on the _____ day of _________________, 20___, but otherwise is not affected by my disability or by the passage of time.

Severability

If a court finds any provision of this document to be invalid or unenforceable, that provision shall be severed from this document without affecting any other power or provision of this document, or the appointment of my agent to make health care decisions for me.
II. Declaration of Treatment Instructions

You may provide your agent with specific instructions about the choices you want made for you should this POA take effect. If you do not instruct your agent, either in this document or otherwise, the agent will still make choices about your health care and will decide based on your best interests. If you wish to provide instructions about your care to your agent, then fill out those sections of the form below that provide the direction you want to give. If you do not wish to provide instructions to your agent, then go to the signature section at page 11 at the end of this document.

Attending physician

I name the following doctor as my “attending physician”. Under the law, this is the only physician who can make the determination as to whether I have lost the capacity to make informed health care decisions for myself for the purpose of this document.

Name: ___________________________________ Phone: ______________________________

Address: _______________________________________________________________________

Other physicians I choose to provide treatment to me

In addition to the attending physician named above, I prefer to be treated by the following doctors, and I instruct my agent to request medical services for me from the following doctors:

Name: ___________________________________ Phone: ______________________________

Address: _______________________________________________________________________

Specialty (if any):

Name: ___________________________________ Phone: ______________________________

Address: _______________________________________________________________________

Specialty (if any):

I do not want to be treated by the following doctors, psychiatrists, or other mental health professionals, and I instruct my agent not to consent to my treatment by these individuals:

Name: ___________________________________ Phone: ______________________________

Address: _______________________________________________________________________

Name: ___________________________________ Phone: ______________________________

Address: _______________________________________________________________________

Medical conditions

I may have the following medical condition(s), which may cause or contribute to, or may appear similar to, psychiatric symptoms. I instruct that my agent have these medical conditions ruled out prior to authorizing psychiatric care or treatment.

These medical conditions are:
Medication

If my physician proposes that I be given medication, I instruct my agent to (choose one and initial):

_____ consent to the medication proposed by my physician

_____ consent to medication, except for ________________________, which I do not take because

(you may wish to explain why you do not wish to take this medication).

_____ not consent to any medications

_____ (other) ____________________________________________________________.

Allergies, other physical conditions, health problems, or medications that I want my agent to know about and consider before giving informed consent to medication: ________________________________.

I understand that, if I have instructed my agent not to consent to medication, and if I am
involuntarily committed by a court order, it is possible that someone may file an application for
forced medication with the probate court and request a court hearing on the question of whether I
need to be medicated by court order. If there is a court hearing on the question of whether I am in
need of medication, I instruct my agent to inform the court of my instructions as expressed in
this document. However, I understand that the court is not required to follow my wishes as expressed in
this document.

Electroconvulsive therapy

Note that ECT is not available in any hospitals operated by the Ohio Department of Mental Health.

If my physician proposes that I be given electro-convulsive therapy (ECT), I instruct my agent to
(choose one and initial):

_____ not consent to ECT under any circumstances

_____ consent to ECT only after all other treatment options have been tried without success

_____ consent to ECT

_____ (other).

Restraint or seclusion

If it becomes necessary in the opinion of the hospital that I be placed in seclusion or restrained,
either physically or chemically, I instruct my agent to (choose one and initial):

_____ notwithstanding any other instructions about medication in this document, consent to
medication rather than allow me to be placed in physical restraint

_____ direct that I be secluded rather than medicated or restrained physically

_____ consent only to such seclusion or restraint as are necessary to prevent me from harming
myself or others, and this consent should be withdrawn at the point where I am no longer at such
risk

_____ (other) ____________________________________________________________.
Hospitalization

If it is determined that I need to be hospitalized, I instruct my agent as follows.

In a general medical hospital

If my physician determines that I need care or treatment in a general medical hospital, I instruct my agent to consent to my admission to the following general medical hospital(s):

First Choice: ___________________________ Second Choice: ___________________________

I instruct my agent not to consent to my admission to the following general medical hospital(s):

______________________________

In a psychiatric hospital (or licensed unit)

If my physician determines that I need care or treatment in a psychiatric hospital, I instruct my agent to consent to my admission to the following psychiatric hospital(s):

First Choice: ___________________________ Second Choice: ___________________________

I instruct my agent not to consent to my admission to the following psychiatric hospital(s):

______________________________

I understand that, by instructing my agent not to consent to my voluntary admission to the psychiatric hospital(s) named above, it is possible that someone may file with the probate court an affidavit of mental illness and request a court hearing on the question of whether I need to be admitted to a psychiatric hospital by court order, and if so, to which hospital. If there is a court hearing, I understand that the court is not required to follow my wishes as expressed in this document. If there is a court hearing on the question of whether I am in need of psychiatric hospitalization, I instruct my agent to inform the court of my instructions as expressed in this document.

Other directions to my agent

I instruct my agent to consider the following treatment preferences:

______________________________

I do not want the following treatments, and I instruct my agent not to consent to them:

______________________________

(Optional) The reason that I do not want these treatments is:

______________________________

(initial) _______ I wish to be treated by spiritual means through prayer alone, in accordance with a recognized religious method of healing. The recognized religious method of healing is: ___________________________

______________________________

I instruct my agent as follows concerning other medical or psychiatric care and treatment, or related issues:

______________________________
Withdrawal of nutrition and hydration when in a permanently unconscious state (required by law to be in capital letters).

[ ] ______ IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

Notification

If I am hospitalized, I request that my agent notify the following people of the fact of my hospitalization, and the hospital’s name, address and telephone number (for example, family members, friends and employer):

Name: ______________________, address ________________________________,

daytime phone ______________________, evening phone ________________________,

Name: ______________________, address ________________________________,

daytime phone ______________________, evening phone ________________________,

I instruct my agent not to contact the following people:

______________________________, ________________________________, ________________________________

Nomination of Guardian

If I need a guardian, I would like the following person to become my guardian, and I make this nomination pursuant to Revised Code Sec. 1337.09 and 2111.02. If there is a guardianship hearing, I instruct my agent to notify the court of my wishes, but I understand that the court is not required to follow my wishes.

Name: ______________________, address ________________________________,

daytime phone ______________________, evening phone ________________________,

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III. Principal’s Acknowledgement and Signature

If I have signed an earlier durable power of attorney for health care, it will be automatically revoked by this document. If I have signed a declaration under Revised Code Chapter 2133 (commonly called a “Living Will”), it will not be revoked by this document.

I understand that if I should execute a Declaration for Mental Health Treatment under Revised Code chapter 2135, that the Declaration for Mental Health Treatment will revoke any provisions for mental health treatment previously stated in a Durable Power of Attorney for Health Care. Any provisions previously stated in the Durable Power of Attorney for Health Care specifically for physical or medical (non-mental health) care will remain in effect.

I understand that I should give copies of this document to the agent and alternate agents I have named in this document. I may also give a copy to my physician, psychiatrist, or other health care provider. However, I understand that if I give a copy of this document to my physician or psychiatrist and later revoke this document, my revocation does not become effective as to the physician or psychiatrist until I or a witness to the revocation notifies him/her (or his/her staff) that I have revoked this document. I understand that both my revocation and notice of revocation to my physician or psychiatrist can be done either verbally or in writing. However, it may be easier to prove I revoked it if I do so in writing.

I can make changes to this document before I sign it, and I agree to write my initials beside those changes. I understand that I cannot make changes to this document after I have signed it. Instead I must execute a new document.

Ohio law requires that I be given the notice printed at the end of this document. I have read this notice before signing this document.

I understand that this document will not be valid unless I sign it in the presence of either a notary public or two witnesses who meet the law’s requirements.

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I understand the terms and purpose of this document, and I sign my name after carefully considering this matter on this _____ day of ___________________ 20__ , at __________________ County, Ohio.

_________________________ _______________________
Signature of Principal Principal’s typed or printed name

Witnesses

I attest that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and not subject to duress, fraud, or undue influence. I also attest that I am not an agent named in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult who is not related to the principal by blood, marriage or adoption.

_________________________ _______________________
Signature: __________________________ Date: __________________
Print name: __________________________ Residence Address: __________________________

_________________________ _______________________
Signature: __________________________ Date: __________________
Print name: __________________________ Residence Address: __________________________
Notary Acknowledgement

State of Ohio

County of ________________________________ss:

On this the ________ day of ________________________________, 200__,

______________________________________, who is known to me or who has
provided me with satisfactory proof of identity as the person whose name is subscribed above as the
principal, personally appeared before me and acknowledged that s/he executed this document for
the purposes described in the document. I attest that the principal appears to be of sound mind and
not under or subject to duress, fraud or undue influence.

My Commission Expires:_____________________

__________________________________________

Notary Public


IV. Statutory Notice

Ohio law requires Ohio Revised Code section 1337.17 (Use of printed form; notice to principle) to be
included in all Durable Power of Attorney for Health Care forms. The text of that statute follows:

1337.17. Use of printed form; notice to principal.

A printed form of durable power of attorney for health care may be sold or otherwise distributed in
this state for use by adults who are not advised by an attorney. By use of such a printed form, a prin-
cipal may authorize an attorney in fact to make health care decisions on the principal’s behalf, but
the printed form shall not be used as an instrument for granting authority for any other decisions.
Any printed form that is sold or otherwise distributed in this state for the purpose described in this
section shall include the following notice:
Notice to Adult Executing This Document (R.C. Sec. 1337.17)

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

1. Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:
   a. You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which
      i. there can be no recovery and
      ii. your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.
   b. You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

2. Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);

3. Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

4. REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:
   a. YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.
   b. (B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE
WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(i) including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(D) your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(C)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to him in another manner.

When acting pursuant to this document, the attorney in fact generally will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you cannot designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you cannot designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order. This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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Legacy Gifts To Support the Future Of
Fairmount Presbyterian Church

Fairmount Presbyterian Church is YOUR church. It defines, in part, who you are, who your family is, and what you stand for. Fairmount Presbyterian Church is also OUR church. This special statement speaks to our relationship with our church -- the impact it has on who we are and what we hold as dear to us. Whether we were brought up here, married here, had our children baptized here, or volunteer our time to the ministries that matter to us, Fairmount Presbyterian Church holds a special and central place in our life. We find Christ's love here and hope that in many ways we are able to share that love with others. We are defined by our church as it represents our best ethics, our best selves, and what we hold as dearest; our relationship with God.

And in our death, we have the opportunity to continue to be defined by our church. Through Legacy Giving, we are able to designate a portion of what we have acquired while living to our church. Just as our families have witnessed our faith and dedication to Fairmount Presbyterian Church while we are living, in death, our relationship with the church does not stop. And most importantly, legacy gifts ensure that future generations at Fairmount will always be defined, be nurtured, and find a relationship with Christ as we have. Through legacy giving, we are able to ensure that programs that have meant the most to us will continue into the future.

Planned Gifts
Building our Endowment for the Future

Planned or deferred gifts to Fairmount Presbyterian Church are one of the most important tools we have to build our endowment for our future, providing support for our many programs and services that benefit our families and our neighborhood. We hope you will consider a gift to the church in your estate plan. Please contact us to discuss the ways in which you might like to support Fairmount Presbyterian Church, or to request more information about any of the gifts described below. We look forward to working with you to structure a gift that benefits our church in a way you and your family will find most meaningful.

Bequests

A bequest is an ideal way to ensure that Fairmount Presbyterian Church will be there for the future of your family and your community. There are three different types of bequests you might consider:

You can make a **specific bequest** of cash or property. The decision to leave Fairmount Presbyterian Church a certain amount of money, stock, bonds, or real estate through your will or trust would fall into this category. Here is sample language for a specific bequest:

For a **specific bequest** of cash or property – I/we hereby give, devise and bequeath to Fairmount Presbyterian Church, Taxpayer ID # __________________, a charitable organization located in Cleveland Heights, Ohio, [the sum of $_________] or [insert description of specific item of property, or specific securities], to be added to its unrestricted endowment.

You can make a **residual bequest**. Through a residual bequest, you would leave Fairmount Presbyterian Church the remainder of your estate (or a percentage of the remainder), after all specific gifts have been distributed. Here is sample language for a residual bequest:
For a **residual bequest** – I/we hereby give, devise and bequeath to Fairmount Presbyterian Church, Taxpayer ID # _______________, a charitable organization located in Cleveland Heights, Ohio, [all of] or [______% of] the rest, residue and remainder of my/our estate, to be added to its unrestricted endowment.

You can create a **contingent bequest**. This type of bequest would provide for a gift to Fairmount Presbyterian Church should your designated beneficiaries, such as your spouse or children, not survive you. Here is sample language for a contingent bequest:

For a **contingent bequest** – If [insert names and relationships of primary beneficiaries or heirs] does/do not survive me/us, I/we hereby give, devise and bequeath to Fairmount Presbyterian Church, Taxpayer ID # _______________, a charitable organization located in Cleveland Heights, Ohio, [all of] or [______% of] the rest, residue and remainder of my/our estate, to be added to its unrestricted endowment.

It is not difficult to add a charitable bequest to your will or trust. A codicil or amendment drafted by your attorney can be used to make simple changes or additions to your current plan. Please be sure to consult with your own personal tax or financial advisor when forming or making changes to your estate plans.

**Life Insurance**

Gifts of life insurance allow you to give a gift larger than you might believe possible. Simply secure a policy in the usual manner and name Fairmount Presbyterian Church as the beneficiary and owner of the policy. Or, name Fairmount Presbyterian Church as beneficiary and owner of an existing policy you may no longer need. In either case, your annual premium, paid to Fairmount Presbyterian Church, is tax-deductible. You may also receive a charitable income tax deduction for a gift of an existing policy.

**Retirement Plan Assets**

Retirement plan assets often represent the major portion of an individual’s estate. For many reasons, retirement assets are an excellent source to fund a charitable gift from your estate. Under current tax law, retirement plan assets can be subject to both income and estate taxes if left to heirs. Designating other assets for children or family members and using retirement plan assets for your charitable gifts may help you maximize the value of your legacy, both to your family and to Fairmount Presbyterian Church. Consult with your financial advisor to see how using retirement assets for charitable gifts may benefit you.

**Other Beneficiary Designations**

Some states, including Ohio, permit Payable on Death accounts at banks, building and loan associations, savings banks, and credit unions. Depositors can indicate that their accounts, including certificates of deposit, be payable on death to an individual or a charity. Stocks, mutual funds, and other securities may also be designated Transfer on Death.
Supporting Fairmount Presbyterian Church
With Gifts that Pay You Back

Charitable Gift Annuities
A charitable gift annuity is a simple agreement providing that in exchange for your gift of cash or securities, you receive a fixed, guaranteed income for the rest of your life. Upon your death, or the death or an additional beneficiary if you choose, the remainder of your gift will benefit a charitable organization.

Fairmount Presbyterian Church offers charitable gift annuities through the Presbyterian Foundation. Individuals or couples age 60 or over can establish gift annuities for a minimum amount of $10,000. In return for your gift, you are assured a guaranteed stream of income for life, an immediate charitable income tax deduction in the year of your gift (with tax-favored income each year of the annuity), and an excellent rate of return. When you make your gift, Fairmount Presbyterian Church will receive an amount equal to the present value of the remainder of your gift, and the church will add that amount immediately to its endowment. Click here for an illustration of rates that may be available to you.

Sample Rates Based on a $10,000 Gift Annuity to Benefit One Person

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>Annual Payout</th>
<th>Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>4.8%</td>
<td>$480</td>
<td>$1,907.92</td>
</tr>
<tr>
<td>65</td>
<td>5.3%</td>
<td>$530</td>
<td>$2,367.20</td>
</tr>
<tr>
<td>70</td>
<td>5.8%</td>
<td>$580</td>
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<td>75</td>
<td>6.5%</td>
<td>$650</td>
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<td>7.5%</td>
<td>$750</td>
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<td>85</td>
<td>8.4%</td>
<td>$840</td>
<td>$5,242.41</td>
</tr>
<tr>
<td>90</td>
<td>9.8%</td>
<td>$980</td>
<td>$5,908.99</td>
</tr>
</tbody>
</table>

Charitable Remainder Trusts
Charitable remainder trusts involve the irrevocable transfer of property, usually cash or appreciated stocks, to a trust. In return, income is paid to you and one or more beneficiaries for life or for a term of years. You can choose to receive income based either on a fixed sum each year (an annuity trust) or a percentage of the trust’s assets valued annually (a unitrust). The percentage will be set by you and cannot be less than 5%.

In addition to estate tax benefits, a charitable trust established during your lifetime provides an immediate income tax charitable deduction based on the beneficiary’s age and the payout rate. At the end of the trust, the remaining assets will be added to Fairmount Presbyterian Church’s endowment or used to support a program or service you designate.

Additional Information and Confidential Gift Proposals
If you would like to receive a proposal illustrating how these gifts can benefit you with a lifetime income and useful tax benefits, please call our office.
Philanthropy for The Next Generation

Donor Advised Funds

A donor advised fund is a meaningful way to involve your family in your support of Fairmount Presbyterian Church. You and selected family members act as advisors to your fund, making recommendations as to what programs or missions of the church you want to support each year. A donor advised fund can be established with a gift as little as $2,500. Additional gifts can be made to the fund at any time, and each year you can distribute as much or as little of the fund as you like to support the areas you value most.

Donor advised funds to benefit Fairmount Presbyterian Church can be established through the Presbyterian Foundation or through any local foundation such as The Cleveland Foundation.

Fairmount Church Legacy Circle

We invite you to join this tradition of giving through membership in Fairmount Presbyterian Church’s Legacy Circle. The Legacy Circle is made up of individuals who have made a provision for Fairmount Presbyterian Church in their estate or financial plans.

Legacy Circle members are recognized in special ways for their deep commitment to Fairmount Presbyterian Church, including listing in our annual report and invitations to special events designed to bring you even closer to the church’s programs, services and missions.

If you are considering a planned gift to Fairmount Presbyterian Church, or if you have already included us in your plans, please let us know. Your willingness to be recognized will inspire others to consider this important support. Of course, if you would rather remain anonymous, we will keep your name and gift information completely confidential.

Find out how you can participate by contacting the church office at 216-321-5800.