This packet was created with one heartfelt purpose: to create a legacy of love for those who may care for you when you are ill or dying.

In times of uncertainty and grief, no one wants to feel doubt about how to carry out your wishes. By completing these documents, you can offer the clarity and guidance they'll need—so they can act with confidence, not guesswork, and remember your intentions with peace rather than regret.

Inside, you'll find some of the essential tools to help communicate your preferences in advance of a healthcare emergency or your passing. These documents are not just authorized forms – they are acts of love, designed to protect your quality of life and ease the burden on those who matter most.

For additional resources tailored to your unique healthcare or lifestyle needs, please visit knownwishes.com.

We are also available to help guide you through the planning process via in-person, phone, Zoom. Simply reach out at info@knownwishes.com.

Warmest regards,

The Known Wishes Team

End-of-Life Planning Checklist

Below is a list of actions you can take to have your wishes known by all who care for you and those that are left behind. For questions about which are essential or to be considered, contact us at info@knownwishes.com.

END-OF-LIFE ACTIONS	ESSENTIAL	TO CONSIDER
1. Complete an End-of-Life Values Worksheet		
Help clarify your perspective and beliefs about living and dying		
Use as a guide for conversations with those who support you to explain your choices		
2. Complete Advance Directives		
Select, complete and sign a Durable Power of Attorney for Healthcare		
Select, complete and sign a Healthcare Directive/Living Will		
Evaluate need for POLST and Dementia/Mental Health Directives		
Add addendum in writing or video as I see fit to share additional end-of-life wishes or reinforce choices		
3. Identify Supportive Primary Care Physician and Care Providers		
Talk to you physician and care providers about options you would want to consider regarding a Natural Death, Medical Aid in Dying, Voluntarily Stopping Eating and Drinking and Stopping Treatment		
Make sure they can and will support these choices		
4. Provide Copies of Advance Directives and Display POLST		
Share end-of-life documents with loved ones, healthcare agent, other support team members, and ask all medical providers to add a copy to		
Display copy of POLST prominently if you have one		
Consider medical alert jewelry or emergency contact cards and apps to ensure your wishes can be known		
5. Last Will & Testament, Financial Records, Digital Accounts, Insurance		
Create Will or Trust, Name Executor or Trustee, Fill our a Durable Power of Attorney for Finance		
Update insurance as needed as health status changes (medical updates can change coverage)		
Ensure updated financial and legal documents, and all digital account usernames and passwords, are accessible by the named individuals		
Designate beneficiaries of assets and sentimental items		
6. Final Disposition Arrangement and Designated Agent		
Decide how you want your body cared for after you die and who will be responsible. Complete After-Death Disposition Forms		
7. Shape Your Legacy		
Document and share anything you do or do not want for a remembrance, gathering, eulogy, obituary and after you die		
Consider letters, gifts, sentiments or designation of items to individuals and groups you choose		

Values Worksheet

VALUES WORKSHEET of _____

(Name)

Consider how important these values are to me.	**1 (Low – High) 5**				
Staying true to my values and traditions. (For example: decisions made about my healthcare are consistent with the way I've lived my life prior to becoming ill, even if it means I could lose quality of life, die sooner or not be in the best care.)	**1**	**2**	**3**	**4**	**5**
Following my spiritual and religious beliefs. (For example: I want my healthcare to be consistent with my spiritual and religious beliefs and the religious doctrine/teachings I follow.)	**1**	**2**	**3**	**4**	**5**
Letting nature take its course. (For example: I would or would not want life extending treatment or curative treatment to interfere with the natural dying process.)	**1**	**2**	**3**	**4**	**5**
Living as long as possible, regardless of quality of life. (For example: Provide me with all curative treatment to sustain my life, even if it impacts my health.)	**1**	**2**	**3**	**4**	**5**
Shortening the dying process rather than prolonging life if terminally ill or suffering. (For example: I would consider Medical Aid in Dying or Voluntarily Stopping Eating and Drinking.)	**1**	**2**	**3**	**4**	**5**
Having autonomy and making choices about my care. (For example: I want to remain in control of all healthcare decisions as long as I am capable. I do not have someone I trust to make decisions for me.)	**1**	**2**	**3**	**4**	**5**
Being independent. (For example: how important it is to me to care for myself vs allowing others to care for me if I were to lose cognitive or physical independence, and to what degree.	**1**	**2**	**3**	**4**	**5**

Being conscious, even if uncomfortable and experiencing pain. (For example: I want my pain medications balanced to allow for some cognitive capacity to make my own healthcare decisions or decisions with my Healthcare Proxy.)	**1**	**2**	**3**	**4**	**5**
Being slightly sedated, to avoid pain. (For example: I trust those I've named or healthcare professionals to make decisions for me so I can remain comfortable when/if experiencing pain.)	**1**	**2**	**3**	**4**	**5**
Being free of physical limitations or disabilities. (For example: how important is my physical ability and what limitations or disabilities would or would not be acceptable in relation to my quality of life.)	**1**	**2**	**3**	**4**	**5**
Being free of cognitive limitations and disabilities. (For example: how important is my mental capacity and ability to make my own decisions and live independently vs letting others make decisions for me.)	**1**	**2**	**3**	**4**	**5**
Remaining in my place of residence vs. moving for better care, safety, or cost.	**1**	**2**	**3**	**4**	**5**
Leaving good memories for my family and friends, saying goodbye. (For example: consider whether I would want loved ones to see me suffering or in a compromised state if I was ill and or in the dying process. Importance of letters, gestures, gifts you want to leave.)	**1**	**2**	**3**	**4**	**5**
Contributing to life-extension for others or medical research/teaching through organ and/or full body donation. (For example: how important it is to offer my full body, tissue or organs to provide sustained life for others or to medical research or teaching.)	**1**	**2**	**3**	**4**	**5**
Avoiding expensive care that doesn't extend quality of life. (For example: how important it is to avoid expensive extreme measures that would not extend quality of life vs doing everything possible regardless of the outcome.)	**1**	**2**	**3**	**4**	**5**
Leaving money and valuables to family, friends, and/or charity. (For example: how important it is to me to leave and designate valuable items or money to friends, family, loved ones or charity.)	**1**	**2**	**3**	**4**	**5**

Durable Power of Attorney for Health Care

My name is _____. My date of birth is _____.

1. **Agent.** I choose (*name*): _____ as my Agent with full authority to manage my health care.

   ☐ **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

   ☐ **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

2. **My Rights.** I keep the right to make health care decisions for myself if I am capable.

3. **Durable.** My Agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

4. **Start Date.** This power of attorney is effective on the day I sign it.

5. **End Date.** This power of attorney will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney will end if either of us files for divorce in court.

6. **Revocation.** I revoke any other power of attorney for health care documents I have signed in the past. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my Agent.

7. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to:

   ✓ Make health care decisions and give informed consent to my health care

   ✓ Refuse and withdraw consent to my health care

   ✓ Employ and discharge my health care providers

   ✓ Apply for and consent to my admission to a medical, nursing, residential, or other similar facility that is **not** a mental health treatment facility

   ✓ Serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended

   ✓ Visit me at any hospital or other medical facility where I reside or receive treatment

8. **Government Benefits.** My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

9. **Mental Health Treatment.** Unless I give my Agent power of attorney for mental health care **and** I have a Mental Health Advance Directive that specifically consents to these things:

   - ✓ My Agent is **not** authorized to arrange for my commitment to or placement in a mental health treatment facility.
   - ✓ My Agent is **not** authorized to consent to electroconvulsive therapy, psychosurgery, or other psychiatric or mental health procedures that restrict physical freedom of movement.

10. **Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.

11. **Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.

12. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (*date*) _____
by (*name*) _____.

▶ _____

Signature of Notary
Notary Public for the State of Washington.
My commission expires _____.

Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Durable Power of Attorney in my presence. I agreed to witness their signature at their request.

- I am not related to this person by blood, marriage, or state registered domestic partnership.
- I do not provide care for this person at home or in a long-term care facility.

Witness 1

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Durable Power of Attorney for Health Care
Attachment: Contact Info

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

✓ I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

My health care agent

Agent's name _____

Agent's relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Agent's phone number _____

Agent's email address _____

My alternate health care agent (if any)

Alternate's agent's name _____

Alternate agent's relationship to me (friend, partner, spouse, sister, etc.)

_____

Alternate agent's phone number _____

Alternate agent's email address _____

My 2nd alternate health care agent (if any)

2nd alternate's name _____

2nd alternate's relationship to me (friend, partner, spouse, sister, etc.)

_____

2nd alternate's phone number _____

2nd alternate's email address _____

Health Care Directive

My name is _____. My date of birth is _____.

I am a person with decision-making capacity. I voluntarily sign this directive. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any health care directives I have signed in the past.

1. **Health Care Values:** The following wishes and preferences should guide all decisions made about my care:

    a. **What makes my life worth living.**

    [ ] Some terminal or serious conditions may stop me from **ever** doing the things that make life worth living for me. In that situation, I want you to stop all treatment except comfort care, pain relief and palliative care if I **cannot ever again**:

    [ ] Recognize my close friends and family in any meaningful way

    [ ] Exercise

    [ ] Be outdoors

    [ ] Read

    [ ] Watch tv shows/movies

    [ ] Do the following: _____

    [ ] Other: _____

    _____

    _____

    [ ] Life is always worth living. Do everything you can to keep me alive.

    b. **My hopes**. In my last days, I hope to spend my time:

    [ ] With my close friends and family: _____

    _____

    [ ] With the following comfort items and/or pets: _____

    _____

    [ ] Eating/drinking the following items, if possible: _____

    _____

    [ ] Listening to the following music: _____

    _____

    [ ] Other: _____

    _____

c. Pain Management. Medications used to treat pain often come with the side effect of drowsiness and decreased mental clarity. In my last days, I hope to balance pain management and mental clarity in this way:

[ ] I hope to spend my time in as little pain as possible, even if I'm not mentally clear.

[ ] I am willing to tolerate the following level of pain in the hopes of having more mental clarity:

[ ] 1 = Pain I hardly notice

[ ] 2 = Pain I notice but does not interfere with activities

[ ] 3 = Pain that sometimes distracts me

[ ] 4 = Pain that distracts me, but I can do usual activities

[ ] 5 = Pain interrupts some activities

[ ] 6 = Pain is hard to ignore, I avoid usual activities

[ ] 7 = Pain is my focus of attention, prevents daily activities

[ ] 8 = Pain is awful, it's hard to do anything

[ ] 9 = Pain is unbearable, I'm unable to do anything

[ ] 10 = Pain as severe as I can imagine. Maximum mental clarity is the most important.

d. My fears. There are situations or treatments I am concerned about and want to prevent or avoid if possible.

[ ] I have a fear of (*examples:* shortness of breath, thirst, choking sensation, nausea, headaches) _____. Please do everything possible to relieve me of that feeling through comfort care.

[ ] I don't want to spend our life savings on my final illness. Please provide the least costly comfort care for my end-of-life care.

[ ] Other: _____

_____

e. Where I want to be. I would like to receive care in the following place/s if possible:

[ ] My home

[ ] Hospice care

[ ] An assisted living facility

[ ] An adult family home

[ ] A nursing home

[ ] A hospital

[ ] I know that it may not be possible for me to receive care where I want, given my needs and circumstances at the time. I trust my healthcare decision-maker/s and

know that they will make the best decisions for me after considering my values, and consulting with my loved ones and care providers.

[ ] Other: _____

_____

f. Other things to know about me:

[ ] I would like my friends and family to be notified of my condition and given an opportunity to visit me to say goodbye.

[ ] I would like to be kept alive for a short period of time if needed to allow friends and family time to travel and say goodbye.

[ ] If possible, I would like to be able to look out a window or see nature during my last days.

[ ] My religious or cultural traditions require the following practices around health care and end of life care:

_____

_____

[ ] Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Terminal Illness or Permanent Unconscious Condition. If my attending physician diagnoses me with a terminal condition or two physicians determine that I am in a permanent unconscious condition, and if my physician/s determine that life-sustaining treatment would only artificially prolong the process of dying, I want:

a. Comfort Care and Pain Medication (*check one*)

[ ] If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.

[ ] I **don't** want treatment and medications to make me comfortable if those treatments and medications might hasten my death. Do everything possible to keep me alive even if I am in pain. Please use pain management methods that will not hasten my death.

b. Artificial Life Support (*check one*)

[ ] Please use all treatment options to artificially prolong the process of dying or sustain me in a permanent unconscious condition.

[ ] The following treatment should be **withheld** or **withdrawn** from me after (*period of time*) _____ (*check all that apply*):

[ ] Artificial nutrition

[ ] Artificial hydration

[ ] Artificial respiration (ventilator)

[ ] Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure

[ ] Surgery to prolong my life or keep me alive

[ ] Blood dialysis or filtration for lost kidney function

[ ] Blood transfusion to replace lost or contaminated blood

[ ] Medication used to prolong life, not for controlling pain

[ ] Any other medical treatment used to prolong my life or keep me alive artificially

3. After Death

a. Organs, body parts, and tissues

[ ] I want to donate organs, body parts, and tissues.

(*Specific instructions, if any*): _____

_____

[ ] I **don't** want to donate organs, body parts, and tissues

b. Medical education or research

[ ] I consent to use all or part of my body for medical education or research.

[ ] I **don't** consent to use all or part of my body for medical education or research.

c. Autopsy

[ ] I consent to an autopsy.

[ ] I **don't** consent to an autopsy.

d. Releasing my body and remains

[ ] Upon my death, my body and remains can be released to the following person/s:

(*Name/s and contact information*): _____

_____

4. Health Care Institutions. If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.

5. Changes and Cancellation. I understand that I can change the wording of this directive before I sign it. I also understand that I can cancel this directive at any time.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington

County of _____

Signed or attested before me on (*date*) _____

by (*name*) _____.

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Health Care Directive in my presence. This person is personally known to me or provided proof of identity. I believe this person is capable of making health care decisions.

- I am not related to this person by blood or marriage.
- I am not eligible to inherit money or property from this person.
- I do not have a legal claim against this person.
- I am not this person's attending physician. I am not an employee of their physician, or of any health facility where they are a patient.

Witness 1

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

Health Care Directive
Attachment: Contact Info

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

[ ] I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

My health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My alternate health care agent (if any)

Name _____

Relationship to me (friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My 2nd alternate health care agent (if any)

Name _____

Relationship to me (friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

POLST Overview & Considerations

OVERVIEW OF PORTABLE ORDER FOR LIFE SUSTAINING TREATMENT (POLST)

A POLST is a medical order signed by a doctor that communicates to emergency responders what kind of life sustaining treatment a person would or would not want if they experienced a healthcare crisis outside of a hospital. It is used primarily when someone wants to limit emergency medical intervention to sustain life. A POLST is different than an Advance Directive which only requires a notary or two witnesses to become a viable representation of one's healthcare wishes.

A POLST is intended for those who are living with advanced serious illness, medical frailty or are at end of life to have with them outside of a hospital. It is most often posted on the refrigerator or freezer door to guide emergency personnel or caregivers to know what to do if 911 is called. One of the main goals of the POLST is to limit life sustaining measures where full emergency medical care could do more harm than good or the potential results from emergency medical treatment would not align with a person's personal quality of life values.

One of the most common reasons someone may have a POLST is to communicate to emergency caregivers outside of a hospital that a person's wishes are to not be resuscitated (referred to as DNR). This could be the case if a person is experiencing cardiac arrest or unconscious or not breathing and has no pulse. This DNR choice would represent that a person is requesting to be allowed a natural death and does not want medical intervention. The POLST can also communicate moderate medical interventions or selective treatment or a wish to avoid transfer to the hospital. These moderate interventions are best discussed with a doctor to understand the potential outcome of selective emergency measures on long term quality of life.

If one wants full medical intervention to sustain life, one does not need a POLST form. If 911 is called, emergency responders will apply all life sustaining measures needed. In many cases a person will then be transferred to a hospital depending on the severity of the healthcare crisis. It is recommended, however, to have an Advance Directive which names a Healthcare Proxy or Surrogate one trusts to communicate on their behalf if they cannot guide care for themselves in a hospital. This could be due to the side effects of pain medication or temporary loss of cognitive ability.

If you have questions about whether a POLST is right for you, it is best to communicate with your healthcare provider to discuss which of the full treatment, selective treatment or comfort measures only and a natural death may the right options for you. As your health may change over time, it is recommended to have this discussion annually to ensure you have the right orders in place to reflect your end-of-life values.

Values that might indicate a POLST is right for you:

- I am living with a degenerative disease, having trouble with the efficacy of my medications to ease my discomfort and am ready to die a natural death when my time comes.
- I am living with dementia and do not want to extend my life into the late stage of the disease.
- I have lived far beyond the age I thought I'd be alive. I want to die a natural death. I do not want to suffer the possible after effects of extreme measures taken to sustain my life in rehab or be moved to assisted living.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A — Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

CHECK ONE

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B — Level of Medical Interventions: When the individual has a pulse and/or is breathing.

CHECK ONE

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suctioning, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C — Signatures:

A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to those known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or intervention regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: Use this section to update and confirm order and preferences.

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

Durable Power of Attorney for Finances

My name is _____. My date of birth is _____.

1. **Agent.** I choose (*name*): _____ as my Agent with full authority to manage my finances.

   ☐ **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my finances.

   ☐ **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my finances.

2. **My Rights.** I keep the right to make financial decisions for myself if I am capable.

3. **Durable.** My Agent can use this power of attorney to manage my finances even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

4. **Start Date.** This power of attorney is effective (*check one*):

   ☐ Immediately.

   ☐ only if my medical provider signs a letter saying I cannot make decisions for myself.

5. **End Date.** This power of attorney will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney will end if either of us files for divorce in court.

6. **Revocation.** I revoke any power of attorney for finances documents I have signed in the past. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my Agent.

7. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to:

   ✓ Make deposits to, and payments from, any account in my name in any financial institution

   ✓ Open and remove items from any safe deposit box in my name

   ✓ Sell, exchange, or transfer title to stocks, bonds, or other securities

   ✓ Sell, convey, or encumber any real or personal property

   ✓ Apply for and manage governmental benefits, including Medicaid

8. **Special Powers.** My agent shall also have the following powers:

   ☐ Yes ☐ No – Give gifts of my money or property

☐ Yes ☐ No – Create, change, or cancel my rights of survivorship

☐ Yes ☐ No – Create, change, or cancel beneficiary designations

☐ Yes ☐ No – Give up my right to be the beneficiary of an annuity or retirement plan

☐ Yes ☐ No – Create, change, or cancel a trust

☐ Yes ☐ No – Tell a trustee to make distributions from a trust just as I could

☐ Yes ☐ No – Create, change, or cancel a community property agreement

☐ Yes ☐ No – Give authority granted in this document to someone else

9. **Accounting.** My Agent shall keep accurate records of my finances and show these records to me at my request.
10. **Nomination of Conservator.** I nominate my Agent as the conservator for consideration by the court if conservatorship proceedings become necessary.
11. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (*date*) _____
by (*name*) _____.

▶ _____

Signature of Notary
Notary Public for the State of Washington.
My commission expires _____.

Disposition Options and Directions

Cremation

- Body placed into rigid, leak resistant, combustible cremation container (like a casket) which is then placed into the crematory and exposed to heat and flame.
- When complete, everything except bone material is gone.
- Remaining bone material is then processed down to particulates and powder, referred to as ashes.
- Ashes are placed in a temporary urn to scatter or a permanent urn to display or bury in a cemetery.

Conventional Burial

- Body may or may not be embalmed.
- Placed into a casket, usually constructed of either wood, or steel.
- Casket transported to a cemetery for burial.
- Liner/vault is placed into the open grave by cemetery staff prior to the arrival of the casket.
- Casket is usually mechanically lowered into the liner/vault.
- After graveside ceremony, cemetery staff place a lid on the liner/vault and fill the grave back in with soil and replace the sod.
- Cemetery burials of both caskets and urns are commonly marked and memorialized with a headstone.

Green Burial

- Green burial takes place without embalming.
- Body is placed into a biodegradable container, which could be a casket made from wood or woven materials like willow branches, or it could be a cloth shroud.
- Body is transported in this container to a green cemetery, sometimes called a natural burial ground or conservation burial ground.
- Casket or shroud is lowered into the open grave either mechanically, or by hand, and is placed in direct contact with the earth.
- Soil and topsoil are returned in their order to close the grave.
- Conventional burial liners and vaults are prohibited in green burial, thereby facilitating an efficient return to natural cycles. In some cases, green burial is used to further ecological restoration and conservation goals.

Alkaline Hydrolysis (Aquamation, Flameless Cremation, Water Cremation)

- Body is placed unadorned, or in a shroud made of silk or wool, into a single stainless-steel vessel which is air and watertight.
- Approximately 95 gallons of water along with sodium hydroxide and/or potassium hydroxide is introduced into the chamber.
- Chamber may be pressurized and is heated to 200 - 300 degrees Fahrenheit. Over the course of 6 – 16 hours, depending on equipment used, the natural decomposition process that occurs in burial is dramatically sped up.
- Results are softened bone and a sterile liquid containing salts, sugars, amino acids and peptides. There is no tissue and no DNA left.
- Liquid is released to be recycled by the local wastewater treatment authority or diverted and used for fertilizer.
- After drying, the softened bone material is processed down to a powder similar to cremated remains.
- The hydrolyzed remains may be placed in an urn, kept at home, buried in a cemetery, or scattered.
- Uses significantly less energy than cremation and creates no emissions. The technology has been in use since 1888.

Natural Organic Reduction (Human Composting, Terramation)

- Body is placed into a vessel with straw, alfalfa, and wood chips or sawdust and stays in the vessel for 30 days while oxygen is gently moved through to stimulate the naturally occurring microbes to work with the biomass to transform the body to safe, sterile soil.
- Vessel is continually monitored with sensors and is gently turned at the appropriate times to facilitate the process.
- After composting, remains are screened for inorganic material such as prosthetic implants.
- Bones are processed to a powder and mixed back into the composted remains, which are then placed in a secondary vessel to rest and cool for another 30 days. During the cooling phase bone material composts completely.
- End result is approximately 250 - 300 pounds of topsoil, with a volume of approximately 1 cubic yard which can be released to the family or donated to an ecological restoration project or some of both.

Full Body Donation

- Pre-registration with a Willed Body Program is required to donate your body to medical science.
- University of Washington and Western Washington University both have programs.
- Not every body is accepted, even if registered, so it's important to have a back-up plan. If accepted, body is embalmed and remains are used in whole or in parts for research and instruction for approximately one year. At the end of that time their remains are cremated and returned to their family. There is typically no cost associated with cremation or any of this process.

TO BE PRESENTED TO FUNERAL HOME/REDUCTION FACILITY AT TIME OF DEATH

Designated Agent for Disposition
Washington State

I, _____designate the following agent(s) to act on my behalf for the sole purpose of directing my disposition arrangements.

Primary Agent's Full Name: _____

Primary Agent's Address: _____

Primary Agent's Phone(s): _____ Relationship: _____

If my Primary Agent is for any reason unable or unwilling to serve in this capacity or does not make contact with the disposition entity I've named within 5 business days of my death, I then name the following person.

Alternate Agent's Full Name: _____

Alternate Agent's Address: _____

Alternate Agent's Phone(s): _____ Relationship: _____

I direct that all of my family and survivors shall honor this authorization. I direct that any funeral home, cemetery, cremation authority, memorial society or designated agent shall be held harmless for arranging or handling the disposition of my remains, if done in reliance upon this authorization. If I have not executed a written disposition request or authorization, nor filed or prepaid my arrangements with a licensed funeral establishment or cemetery authority, then I authorize the designated agent(s) listed here to select appropriate disposition arrangements for me including the type, place and method. Neither my designated agent(s) nor my surviving relatives can alter any prearrangements I have made. **If I have not provided sufficient funds to cover my prearrangements, I direct my designated agent(s) to pay the remainder of the cost and my estate to promptly reimburse my designated agent(s) for any personal funds advanced to pay for my disposition arrangements.** My designated agent(s) have complete authority to act on my behalf and direct any and all details related to my disposition arrangements that I have not already prearranged or authorized, including but not limited to obituary, funeral or memorial service, cemetery, monument, memorialization, reception or other related matters.

Declarant's Signature: _____ Date: _____
(Only the Declarant may sign, not the POA or Spouse)

Printed Name of Declarant: _____Date of Birth: _____

UNDER WASHINGTON LAW, TO BE VALID, THIS FORM MUST BE SIGNED IN THE PRESENCE OF A WITNESS:

Witness Signature: _____Date: _____

Printed Name of Witness: _____ Phone:_____

Address of Witness: _____

Directions for the Disposition of my Body
Washington State

I, _____ hereby declare that it is my desire upon my death for my remains to be handled in the following manner: *(Initial your choice below)*

_____ **BURIAL**	_____ **ALKALINE HYDROLYSIS (Aquamation)**	_____ **CREMATION**
_____ **GREEN BURIAL**	_____ **NATURAL ORGANIC REDUCTION**	_____ **FULL BODY DONATION**

I may further direct the following funeral home, reduction facility or organization to manage my disposition.

_____ _____

(Name of funeral home, reduction facility or organization) (Phone number)

_____

(Address)

☐ **I HAVE** filled out the necessary disposition authorization forms and they are on file with the named entity above.
☐ **I HAVE** filled out the necessary organ donation or full body donation forms.
☐ **I HAVE** prearrangements where I have purchased a final expense whole life insurance policy with the named entity above.
☐ **I HAVE** prearrangements where I have placed funds into a master trust managed by the named entity above.
☐ **I HAVE** purchased (check all those purchased) ____cemetery property____headstone____opening/closing fee _____burial vault/liner with _____.
☐ **I HAVE NOT** purchased any of the above and need my designated disposition agent to do that on my behalf and be reimbursed from my estate where possible.

I may further direct that the funeral home or reduction facility release my remains in the following manner:

☐ **Release my remains to the following person(s):**

Name: _____ **Name:** _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City/State/Zip:_____ City/State/Zip:_____

Phone: _____ Phone: _____

☐ **Deliver or ship my remains to:**

Name: _____ Relationship: _____

Address: _____

City/State/Zip:_____ Phone: _____

I may further direct that my remains be buried at the following:

☐ **Cemetery/ Established Family Burial Ground**

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

☐ **Mausoleum**

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

I may further direct that my remains be scattered/spread in the following location:

Name/Address of Location: _____

Name/Address of Location: _____

Name/Address of Location: _____

Other: _____

Declarant's Signature: _____ **Date:** _____

Printed Name of Declarant: _____ Date of Birth: _____

Organ, Tissue and Full Body Donation
Washington State

I, _____ hereby declare that it is my desire upon my death for the following organ, tissue or full body donations to be made if determined to be eligible at time of death. If not eligible, please refer to disposition directions.

Eye/Cornia Donation

I ☐ do ☐ do not wish to donate my eyes at the time of my death to the eye bank.

☐ **I have chosen an organization** to work with on my donation like Sightlife, Donate Life Northwest, Eye Bank Association of America, etc.

_____

(Name of Organization) (City) (State) (Zip)

Organ/Bone/Tissue Donation

I ☐ do ☐ do not wish to donate such other organs, bone or tissue, at the time of death as may be considered medically useful. This also authorizes donation of pacemaker, if applicable.

☐ **I have chosen** an organization to work like LifeCenter Northwest, etc.

_____

(Name of Organization) (City) (State) (Zip)

Full Body Donation

I ☐do ☐do not wish to donate my full body to the University of Washington, Washington State University or other university willed body program for teaching or research purposes.

I have registered with the following program:

☐ **UW Willed Body Program** at (206) 543-1860 or wbp.biostr.washington.edu.

☐ **Washington State University Body Donation Program** at (509) 335-2602 or medicine.wsu.edu/give/willed-body-program.

☐ **Other:**_____

(Name of Organization) (City) (State) (Zip)

Declarant's Signature: _____ **Date:** _____

Printed Name of Declarant: _____Date of Birth: _____

Vital Statistics Form
Information Required for Death Certificate

Personal Information:

Full Legal Name: _____
(First) (Middle) (Last)

Other Names/(AKAs): _____
(First) (Middle) (Last)

Date of Birth: _____
(Month) (Date) (Year)

Birthplace: _____
(City) (County) (State or Country)

Marital Status: ☐ Single ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Registered Domestic Partner

Name of spouse or domestic partner: _____
(First) (Middle) (Last – *must use maiden name*)

Father's Name: _____
(First) (Middle) (Last)

Mother's Maiden Name: _____
(Before first marriage) (First) (Middle) (Last)

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary **Served in the US Armed Forces?** ☐ Yes ☐ No

Social Security Number _____-_____-_____ **Race(s) List all that apply:** _____

Hispanic Ethnicity: ☐ No ☐ Yes ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Residence:

_____
(Street Address, Apt. #) (City) (State) (Zip)

Resided at this address since: _____ **Residence Inside City Limits?** ☐Yes ☐ No ☐ Unknown
(Year)

Tribal Reservation Name:_____
(Name of Reservation)

Education/Occupation:

Education completed (highest degree earned): ☐ 8th Grade or Less ☐ 9 th-12th grade: no diploma ☐ High School Graduate or GED completed ☐ Some college credit, no degree ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate ☐ Unknown

Occupation (Kind of Work Done. Do not use "retired", give former occupation(s): _____
Industry (Do not use company name(s), i.e. "Education"): _____

My Wishes to Honor My Life
Instructions to Surviving Relatives and Designated Agents

I, _____ declare my wishes to have my life honored in the following manner after I die. I will look to my surviving relatives and/or designated agents to follow these directions where possible and only to make changes if and when my wishes can not be honored.

Declarant's Signature: _____ Date: _____

Type of gathering (Funeral, Memorial, Graveside Service, Celebration of Life, Wake, etc. Be as specific as possible):

_____

_____.

Location of gathering (Place of Worship, Home, Specific Location in Community, etc. Be as specific as possible):

_____

_____.

People I would like to speak/communicate at my gathering:

_____.

Gifts, gestures, mementos I would like given away to those who attend:

_____

_____.

Specific food, flowers, music, photos, or other items/wishes I would like represented:

_____

_____.

Notices: I ☐ do ☐ do not want notices of my death published.

Memorial Gifts: I ☐ do ☐ do not prefer memorial gifts or donations in lieu of flowers. If memorials requested, I ask that donations be sent to the following organization(s):

_____.

☐ A gathering to honor my life and all other decisions are up to surviving relatives and loved ones to decide.

Thoughts for My Obituary/Eulogy
Instructions of What to Include/What I Want Written About Me

The name in which I'd like to be referred to _____

Date and place of birth_____.

Parents names _____ _____
(Mother, Maiden Name) (Father)

Locations where I grew up and lived and when _____

_____

_____.

Education/military history (schools I went to and when I attended, graduated, degrees)_____

_____

_____.

Personal life highlights/mentions_____

_____

_____

_____.

Hobbies, interests, groups highlights/mentions _____

_____

_____

_____

_____.

Profession and career highlights/mentions_____

_____

_____

_____

_____.

Survivors I would like mentioned and relationship to me:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Predeceased by:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Other thoughts/mentions I would like included in my obituary and/or eulogy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you would like to <u>write your own obituary or eulogy</u>, simply staple or attach a document to this form.

After-Death Checklist

AFTER-DEATH CHECKLIST FOR: _____

(NAME)

NAME OF PERSON TO COORDINATE AND/OR MANAGE

First Steps Immediately After a Death

- _____ ☐ Determine if any after-death instructions/wishes were documented by deceased to guide decision about management of the body (look for disposition instruction forms)
- _____ ☐ Contact funeral home, reduction facility or organization to manage body after death
- _____ ☐ Identify who needs to be notified right away – family, friends, employer, caretakers/hospice/health care providers, power of attorney, executor of estate
- _____ ☐ Arrange care for minors, dependents, surviving spouse or partner who may need assistance, pets
- _____ ☐ Check that property and personal items are properly secured and protected - home, car, business, valuables in a home, etc. (Especially before obituary or death announcement is made public)

Day or Two After

- _____ ☐ Make appointment with funeral home or reduction facility (they will notify social security and order death certificates needed for finances, insurance, Veteran's Admin, etc.)
  - Copies of death certificate can often be used for official records if a certified original copy is shown in-person to verify its authenticity

Within a Week

- _____ ☐ Determine if there are recurring home delivery items that need to be canceled to avoid waste or theft
- _____ ☐ Contact attorney, accountant, executor or estate to discover/review what Will/Trusts/End-of-Life plans are in place
- _____ ☐ **Locate important financial and legal documents** →
- _____ ☐ Begin work on obituary/death announcement and plans for funeral/remembrance/gathering

Within Two Weeks

- _____ ☐ Forward mail to responsible party or to be held at post-office (as needed)
- _____ ☐ Identify financial matters that need immediate attention – review debts, pay bills, begin to close accounts or cancel payments
- _____ ☐ Contact insurance companies and file claim with life insurance company
- _____ ☐ Make appointment with social security office to switch benefits to qualified relations (payments stop when death is reported by funeral home)

Within a Month

- _____ ☐ Finish gathering and organizing personal and financial documents
- _____ ☐ Collect asset and liability information if not in a Last Will & Testament
- _____ ☐ If deceased did not have a Will or Trust, and meets a financial threshold, probate may be required for distribution of assets and management of debt
- _____ ☐ Change titles on assets - car, home, stocks, other property (as needed)
- _____ ☐ Decide how to manage social media accounts if no instructions were given (different platforms have different options for archive/cancel)
- _____ ☐ Notify any union or fraternal organizations where there may be benefits

Within Two Months

- _____ ☐ Begin to inventory and distribute personal belongings (as appropriate)

After Several Months

- _____ ☐ Begin process for filing federal and state income taxes
- _____ ☐ Follow up with settlement of assets and financial matters (as needed)

Important Documents (Examples)

- ✓ Wills/Trust Agreements
- ✓ Mortgage documents/Promissory Notes
- ✓ Deeds/Titles
- ✓ Vehicle titles and registrations
- ✓ Insurance Policies (funeral, life, heath, accident, long-term care, dental, property, vehicle)
- ✓ Financial Accounts (acct#, username and passwords for: bank, brokerage, stocks, bonds, annuities, credit and debit card, safety deposit box documents and keys)
- ✓ Other financial records (retirement, annuity, pension records, tax returns, financial statements, contracts, etc)
- ✓ Legal Papers (Power of Attorney, adoption and divorce papers, prenuptial/postnuptial agreements, military service papers, social security records, citizenship records, passports, proof of intent to donate organs, etc)
- ✓ Usernames, acct#s and passwords for devices, online apps and subscriptions
- ✓ List of bills, amount and due dates

Immediately After My Death

Please contact:

(name)	(Relationship)	(Phone Number)
(name)	(Relationship)	(Phone Number)
(name)	(Relationship)	(Phone Number)
(name)	(Relationship)	(Phone Number)
(name)	(Relationship)	(Phone Number)

Please take care of the following responsibilities for my home/residence/dependents:

My important documents are located in the following location(s):

Document	Location	Document	Location	Document	Location
Will/Trusts		Life Insurance		Adoption/Divorce Papers	
After-Death Wishes/ Arrangements		Health Insurance		Pre/Postnuptial Agreements	
Power of Attorney (Finance)		Long-Term Health Care Insurance		Marriage/Domestic Partnership Certificates	
Power of Attorney (Health Care)		Funeral Insurance		Passports/Citizenship Records	
Birth Certificate		Dental Insurance		Social Security/ Military Records	
Financial Statements/Records		Property Insurance		Mortgage/ Promissory Notes/Deeds/Titles	
Usernames, Passwords		Car Insurance		Vehicle Title and Registration	