

INTRODUCTION TO DYING, DEATH, AND BEREAVEMENT FORMS

The meeting can offer assistance around the process of death. The individual may ask the meeting for any level of assistance or none at all. It is very difficult for us to face the prospect of our own death so there may be reluctance to fill out these forms even if we would like the meeting to be involved. It is suggested that the meeting periodically bring Friends together to discuss end-of-life issues and to give Friends a chance to ask questions about the forms and to fill out the parts they find useful. The completed forms are retained by the meeting recorder, until such time as they are needed. It may happen that a Friend may not get around to filling out the forms until death is imminent. If a member of the meeting community is dying, it would be appropriate for someone from the meeting to make clear to the dying person what assistance the meeting can provide. The meeting recorder is responsible for having blank copies of these forms available to anyone in the meeting. Forms may also be available for downloading from the Southeastern Yearly Meeting website <www.seym.org>.

It is recommended that Friends prepare a Will, a Living Will, Designation of Health Care Surrogate, a Durable Power of Attorney, and a Living Trust. Such legal documents, of course, are drawn up with regard to the laws of the state the individual lives in. Instructions and sample forms are available at your local Hospice office and at Aging with Dignity, P.O. Box 1661, Tallahassee, Florida 32302-1661, 1-888-594-7437, <www.agingwithdignity.org>. The Advanced Directives from Aging with Dignity are called Five Wishes.

It would be well for meetings to note that the laws and customs in the end-of-life area are constantly changing. These forms are as good as we can make them now, but changes are bound to occur. Individuals are encouraged to file a Living Will with their primary care doctor and their hospital and verify that the doctor and hospital will follow it.

Legal resources within SEYM are available for those Gay, Lesbian, Bi-sexual, Transgender and Queer persons who face special problems in preparing for their death.

Requests to the Monthly Meeting About Incapacity or Death

REQUESTS REGARDING MY POSSIBLE INCAPACITY

Name _____ Date filled out _____

Address _____

Phone _____ E-mail _____

I request _____ Monthly Meeting to do the following things for me if I become incapacitated.

1. To notify these persons of my incapacity. Yes _____ No _____

If yes, **Attach a List** including: name, address, phone number, e-mail, and relationship.

2. To notify my health care surrogate and the person who has a durable power of attorney for my financial affairs. Yes _____ No _____

If yes, **Attach a List** including: name, address, phone number, e-mail, function and relationship.

3. I have a Living Will? Yes _____ No _____

If yes, what is the location of the document? **Attach Instructions.**

Signature of person making request Date Dates reviewed

Received for _____ Monthly Meeting Date _____

Clerk or Recorder's Signature _____ Date _____

Requests to the Monthly Meeting About Incapacity or Death

| | |
|---|-----------------------|
| <u>REQUESTS REGARDING MY DEATH</u> | |
| Name _____ | Date filled out _____ |
| Address _____ | |
| Phone _____ | E-mail _____ |

I request _____ Monthly Meeting to do the following things for me at the time of my death.

1. To notify these persons at the time of my death. Yes _____ No _____

If yes, **Attach a List** including: name, address, phone number, e-mail, and relationship.
You may include the executor of your will if you wish.

2. If I have minor children or other dependents and there is no surviving parent or guardian, I ask the meeting to notify those responsible for their care. Yes _____ No _____

If yes, **Attach a List** with the necessary information.

3. To oversee the disposal of my body in the manner I request. Yes _____ No _____

If yes, complete, sign and attach the corresponding form provided in this packet, including your financial arrangements to carry this out.

4. To plan and carry out a memorial meeting for me. Yes _____ No _____

If yes, complete, sign and attach the corresponding form provided in this packet.

5. To provide information, if necessary, for the completion of the Death Certificate. Yes _____ No _____

If yes, complete, sign and attach the corresponding form provided in this packet.

6. I have a Will and a Living Will? Yes _____ No _____

If yes, what is the location of these documents? **Attach Instructions**

Signature of person making request Date _____ Dates reviewed _____

Received for _____ Monthly Meeting Date _____

Clerk or Recorder's Signature _____ Date _____

Requests to the Monthly Meeting About Incapacity or Death

REQUESTS REGARDING DISPOSAL OF MY BODY

Name _____ Date filled out _____

Address _____

Phone _____ E-mail _____

I request _____ Monthly Meeting to notify my next of kin/significant other of my wishes for disposal of my body as follows at the time of my death. In the event of no surviving next of kin/significant other, I authorize _____ Monthly Meeting to carry out my wishes and have made financial arrangements to do so. **Attach Instructions.**

1. Burial Cremation Medical Research Organ Donations Eye Bank
If you have decided to donate your body to Medical Research, Organ Donations or Eye Bank, please designate a second choice of Burial or Cremation in the event your wishes are unable to be carried out.

2. Do you own a plot for your interment? Cemetery _____
City _____ State _____ Plot _____
Location of deed to cemetery plot _____

3. If your body is to be cremated, what do you wish done with your ashes? Please provide enough detail so that the meeting can carry out your wishes. **Attach Instructions.**

4. If your body is to be given for medical use, who needs to be contacted? **Attach Instructions.**

5. Member of a Memorial Society _____
Address _____ Phone _____

6. Undertaker preferred _____ Phone _____

7. Burial insurance company _____
Policy number _____ Location of Policy _____

If no insurance, expenses are to be met as follows: **Attach Instructions.**

8. Special instructions if death is distant from home: **Attach Instructions.**

Signature of person making request Date Dates reviewed

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Requests to the Monthly Meeting About Incapacity or Death

REQUESTS REGARDING MY MEMORIAL MEETING

Name _____ Date filled out _____

Address _____

Phone _____ E-mail _____

Unless otherwise specified the usual practice would be a memorial meeting for worship as described in the *Faith and Practice* in the Dying, Death , and Bereavement Section. Please indicate any specific requests.

Special requests: _____

Flowers accepted? Yes _____ No _____ Where? _____

In lieu of flowers, contributions may be made to: _____

Do you wish the meeting to put an obituary in the paper? Yes _____ No _____
(Funeral homes will provide a simple notice without extra cost and might offer to submit your obituary for you at the newspaper's rate.)

Do you have an obituary you wish the meeting to use? Yes _____ No _____
Please attach the obituary or information about your life.

Signature of person making request Date Dates reviewed _____

Received for _____ Monthly Meeting Date _____

Clerk or Recorder's Signature _____ Date _____

Requests to the Monthly Meeting About Incapacity or Death

INFORMATION FORM FOR DEATH CERTIFICATE

Name _____ Date filled out _____

Address _____

Phone _____ E-mail _____

ONLY FILL THIS FORM OUT IF YOU ARE ASKING THE MEETING TO FILE YOUR DEATH CERTIFICATE

Information must agree with legal records and policies

Full legal name _____

Other names on legal documents _____

Address _____

County you live in _____ Social Security Number _____

Date of Birth _____ Birthplace _____

Citizenship _____ Present Employer _____

Occupation _____ Kind of business or industry _____

Marital Status _____ Surviving Spouse (Partner) _____

Address of surviving spouse (partner) _____

Education _____ 10 – 12, _____ college 1 – 4, _____ college 5 + _____ Race _____

Father's full name _____

Mother's full name including maiden name _____

Surviving children _____

Address of surviving children _____

Signature of person making request Date Dates reviewed

Received for _____ Monthly Meeting Date _____

Clerk or Recorder's Signature _____ Date _____

Requests to the Monthly Meeting About Incapacity or Death

FORMS FOR MY LIVING WILL

Name _____ Date filled out _____

Address _____

Phone _____ E-mail _____

Included are sample forms for a Living Will and a Designation of Health Care Surrogate, circa 2003. Friends are urged to find current forms applicable to your situation.

Definitions useful in understanding Living Will and Designation of Health Care Surrogate forms.

“Health care decision” means:

- A. Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures.
- B. The decision to apply for private, public, government, or veterans’ benefits to defray the cost of health care.
- C. The right of access to all records of the principal that are reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.
- D. The decision to make an anatomical gift pursuant to Part X of Chapter 732, Florida Statutes, or the corresponding statutes in other states.

“Incapacity” or “incompetent” means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

“Life-prolonging procedure” means any medical procedure, treatment, antibiotics or intervention, including artificially provided sustenance and hydration, or other which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of a medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

“Terminal condition” means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

“End-stage condition” means a condition caused by injury, disease, or illness which has resulted in severe and permanent deterioration, indicated by incapacity and complete physical dependency, and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

“Persistent vegetative state” means a permanent and irreversible condition of unconsciousness in which there is:

- A. the absence of voluntary action or cognitive behavior or any kind; or
- B. an inability to communicate or interact purposefully with the environment.

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Requests to the Monthly Meeting About Incapacity or Death

SAMPLE – LIVING WILL

Declaration made this _____ day of _____, 20__,

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated

And (initial one or more of the following three conditions)

_____ (initial) I have a terminal condition

or _____ (initial) I have an end-stage condition

or _____ (initial) I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

_____ Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

Signed: _____ Date: _____

Witnesses' signature, address, and phone number:

1 . _____ 2. _____

Requests to the Monthly Meeting About Incapacity or Death

SAMPLE – DESIGNATION OF HEALTH CARE SURROGATE

Name: (Last) _____ (First) _____ (Middle Initial) _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____

Address: _____

_____ Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____

Address: _____

_____ Phone: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional): _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____

Name: _____

Name: _____

Signed: _____ Date: _____

Witnesses' signature, address, and phone number:

1. _____ 2. _____
