

Below is a list of documentation required prior to admission:

1. Signed Physical — dated within the last 6 months (FORM ATTACHED)
2. Psychiatric Evaluation dated within the last 6 months
3. Identifying Documents
 - a. Valid Photo ID and
 - b. Insurance Card and
 - c. Birth Certificate and
 - d. Social Security Card
4. Medication List (FORM ATTACHED)
5. "About the Member" form (FORM ATTACHED)
6. Consent/s (FORMS ATTACHED)
7. Authorization and Understanding Statement/consent to run a background check (FORM ATTACHED)
8. Completed apartment rental application; this is required by the apartment complexes, complete only the areas marked in yellow (FORM ATTACHED)
9. Labs (required if presently taking Clozaril, Depakote, Lithium or Tegretol, dated within 30 days prior to admission)

Consents must be fully complete for:

- Any family members or other positive supports with whom we may release information/speak with
- Parole or probation officer
- Rep Payee (if the member receives Social Security benefits)
- ICM or other external supports
- Current and any previous treatment provider in the last two years

If the Member needs help in gathering any of the required documents, please contact us for support. You can reach our entire team by e-mailing us at admissions@projecttransition.com or calling 215-997-9959 and asking for Admissions.

Thank you!

Benji Holmes

Victoria Ernst

The Project Transition Admissions Team

Patient Information

First Name: _____ Last Name: _____

Member Phone: _____ Date of Birth: _____

Social Security Number: _____

Health Insurance Provider Name: _____

Member ID: _____ RX Bin: _____

PCN: _____ Group #: _____

Member Permanent Address: _____

For members who are homeless and do not have a permanent address that is viable to use, please let us know and we will provide an alternative.

This address is where mail is sent and retrieved. This address must continue be used after admission. The Project Transition program address cannot be used. Members need to maintain their permanent address to maintain benefits.

Check boxes below that apply to the patient

A history of fire setting YES NO

A history of harm to animals YES NO

A history of aggressive/violent behavior to property or people YES NO

A diagnosis of an Intellectual Developmental Disability (including Autism spectrum or Asperger's Syndrome) YES NO

Traumatic Brain Injury YES NO

Currently on probation YES NO

Currently on parole YES NO

Currently incarcerated YES NO

A history of sexually challenging behavior YES NO

Emergency Contact Information

1. Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

2. Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

Referring Provider

Referring Facility/Agency:

Current Level of Care (*Acute inpatient, Sub Acute, Rehab, DHS, OP, other, etc.*):

Referring Agency Contact Name:

Referring Agency Contact Title:

Referring Contact Phone:

Referring Contact Fax:

Referring Contact E-mail:

Who to Contact to Start Preadmission Process:

Phone:

E-mail:

Medical Contacts

Primary Care Provider Name:

Provider Phone:

Provider Address:

Dentist Name:

Dentist Phone Number:

Dentist Address:

Rep Payee for Social Security (*if not applicable, write N/A*)

Rep Payee Name (*if applicable*):

Rep Payee Phone:

Relationship:

Legal Contacts

Probation or Parole Officer Name

PO Phone Number:

PO E-mail Address:

County:

Case Manager Contact

Name:	Company Name:
ICM Phone:	ICM Email:

Family and Other Supports Contact Information

1. Name:	Relationship:
Phone:	
Address:	

2. Name:	Relationship:
Phone:	
Address:	

Pre-Admission Packet

Authorization and Understanding Statement



Name: _____ Social Security Number: _____

Driver's License Number: _____ Driver's License State: _____

Date of Birth: _____

Permanent Address: _____

I authorize Project Transition and its designated security agent to contact either orally or in writing any third parties to obtain any information they deem necessary and appropriate in verifying my application. I specifically authorize this company or its designated agent to obtain from any state or local law enforcement agency to include US Military authorities concerning my conduct, including any criminal history record information and motor vehicle reports.

Member Signature _____ Date _____

Member Name Print _____

Signature of witness who has validated applicants ID _____ Date _____



2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682 | admissions@projecttransition.com

Consent for Release of Information

I, _____, hereby give my permission to the staff of Project Transition to
(print name)

obtain from _____

(Organization/Name and Title)

(Phone #)

(Address)

(City)

(State)

(Zip Code)

the following specific information (please check next to the lines you consent release of):

- Psychiatric Evaluation, Medical History, including physical examination, Biopsychosocial Assessment, Authorization of Services (Clinical Reviews), Treatment Planning, Program Status, Discharge Planning, Discharge Summary (from past treatment episodes), Other

for the purpose(s) of (please check next to the items purpose):

- Admission planning, Permanent Address Verification, Legal Background Check, Authorization of Services, Benefits Information, Emergency Contact, Other

- I understand the nature of this authorization. I understand that my authorization shall remain effective until (date to be no longer than one year).
I understand that all information released will be handled confidentially, in compliance with the Federal Privacy Act (PL92-282).
I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by verbal or written communication to the releasing agency.
I have been informed of my right (subject to RULES OF TENNESSEE DEPARTMENT OF HEALTH AND MENTAL RETARDATION CHAPTER 0940-05-06 MINIMUM PROGRAM REQUIREMENTS FOR ALL FACILITIES) to inspect the material to be released.

Member Signature

Date

Project Transition Staff/Witness Signature

Date

NOTICE TO RECIPIENT OF INFORMATION

This information had been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. D and A - all QI 8/2016

Pre-Admission Packet

Physician Recommendation (Level 1)

To Whom It May Concern:

My signature on this document serves as my recommendation that _____ needs
(Printed Member name)

Project Transitions Level 1- Orientation- Independent Living Level of Care.

Sincerely,

(Treating Medical Doctor signature)

Date

(Treating Medical Doctor Printed Name)

Pre-Admission Packet

Physician Recommendation (24/7 Supportive Housing)

To Whom It May Concern:

My signature on this document serves as my recommendation that _____ is in
(Printed member name)
need of 24/7 Supportive Housing Level of Care.

Sincerely,

(Treating Medical Doctor Signature)

Date

(Treating Medical Doctor Printed Name)

Project Transition Treatment Informed Consent

I, _____, hereby acknowledge that I have been informed of and have an understanding of the services that I am to receive at Project Transition.

I, _____, hereby consent to being admitted to Project Transition, where I will receive:

Telehealth Assessment and/or Telehealth Session

Member Signature

Date

Project Transition Staff Signature

Date

APPLICATION FOR RESIDENCE

Amount due at move in \$ _____ Rental Amount _____ Move in date _____
 Unit Type _____ Apt. # _____ Building # _____ Lease Term _____

First Name _____ Middle Name _____ Last Name _____
 Date of Birth _____ Social Security Number _____ Male _____ Female _____
 Driver's License Number _____ State _____ Single _____ Married _____ Other _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Email Address _____ U.S. Citizen (If unchecked, additional forms are required)

PRESENT ADDRESS

Street Address _____
 City _____ State _____ Zip Code _____
 Community Name/Landlord _____ Phone Number _____
 At this Address: From _____ To _____ Monthly Rent \$ _____

PREVIOUS ADDRESS (if less than 3 years at present address)

Street Address _____
 City _____ State _____ Zip Code _____
 Community Name/Landlord _____ Phone Number _____
 At this Address: From _____ To _____ Monthly Rent \$ _____

Have you ever been evicted? _____ Where _____ Why _____
 Have you ever broken a lease? _____ Where _____ Why _____

EMPLOYMENT

Applicant Employer _____ Phone Number _____
 Address _____ City _____ State _____ Zip Code _____
 Position _____ Supervisor _____
 Employed here from _____ To _____ Monthly Gross Salary \$ _____

VEHICLE INFORMATION

Make _____ Model _____ Year _____ Color _____ Lic. No. _____ State _____
 Make _____ Model _____ Year _____ Color _____ Lic. No. _____ State _____

PERSONS TO OCCUPY APARTMENT

Name _____ Relationship _____ Social Security # _____ D/O/B _____
 Name _____ Relationship _____ Social Security # _____ D/O/B _____
 Name _____ Relationship _____ Social Security # _____ D/O/B _____
 Name _____ Relationship _____ Social Security # _____ D/O/B _____
 Name _____ Relationship _____ Social Security # _____ D/O/B _____

PETS

Do you have a pet? _____ YES or _____ NO (check one)
 If yes, How Many? _____ Kind(s) of Pet _____ Breed/Weight(s) _____

EMERGENCY CONTACT – Please fill out in its entirety

Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Email Address _____

ADDITIONAL INFORMATION

Have you ever been arrested and/or convicted of any misdemeanor or felony or do you have knowledge of anyone who will be occupying the apartment ever being arrested and/or convicted of any misdemeanor or felony? _____ YES or _____ NO (check one)
 If yes, Who? _____ When? _____ Type of arrest/conviction _____
 Have you ever filed bankruptcy or are you presently involved in an active bankruptcy case? _____ YES or _____ NO (check one)
 If yes, when was the bankruptcy filed? _____
 Do you currently have a security freeze placed on your credit information? _____
 Are you, or anyone who will be occupying the apartment home, a smoker? _____
 How did you hear about our community? _____

The applicant hereby authorizes Brookside Properties Inc./ Brookside Agent to conduct a credit check that includes, but does not limit to, obtaining a credit report and interviewing the applicant's references and previous landlords. The applicant hereby consents to the credit check process and authorizes any individual listed in this application to speak with Brookside Properties Inc./ Brookside Agent regarding the applicants present or previous credit performance. Applicant further release any and all individuals who provide information to Brookside Properties Inc./ Brookside Agent from any and all claims which the applicant may have resulting from information provided to Brookside Properties Inc. / Brookside Agent. The applicant also authorizes the release of information based upon reliance of either photocopies or facsimiles of the authorization. The undersigned applicant certifies that the above information is true and correct and hereby authorizes verification of same. Any false information in the application shall result in immediate denial of application and or termination of any lease resulting from acceptance of this application. If accepted as a resident, this application is to become a part of the lease file. All information provided will be kept in confidence.

Application Fee (non-refundable) \$ _____ Date rec. _____ Payment Type Check / Credit / Certified Funds Document # _____ received or waived
 Administration Fee: \$ _____ Date rec. _____ Payment Type Check / Credit / Certified Funds Document # _____ received or waived

If for any reason the management denies this application, this Administration fee will be refunded. Once this application is approved this fee is non-refundable. Administration Fee is hereby acknowledged as a non-refundable fee. We are an equal opportunity housing provider. We do not discriminate on the basis of race, color, sex, national origin, religion, handicap, familial status (presence of children under age of 18,) marital status or age.

Applicant's Signature _____ Date _____

Office Use Only: Application Taken By _____ Date Received _____ Approved or Rejected By _____ Date _____

Physical Evaluation Form

Please answer every question on this form and be sure to sign the last page.

First Name: _____ Last Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure/Pulse: _____

Review of Systems/History

- | | | | |
|---------------------------------|--|-------------------------|--|
| Loss of Vision | <input type="checkbox"/> YES <input type="checkbox"/> NO | Loss of Side Vision | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Distorted Vision (Halos) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mucous Discharge | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Double Vision | <input type="checkbox"/> YES <input type="checkbox"/> NO | Sandy or gritty feeling | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Redness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Burning | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Itching | <input type="checkbox"/> YES <input type="checkbox"/> NO | Excess tearing/watering | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Foreign body sensation | <input type="checkbox"/> YES <input type="checkbox"/> NO | Glare/light sensitivity | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Occasional tearing | <input type="checkbox"/> YES <input type="checkbox"/> NO | Styes, Chalazion | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Eye pain or soreness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Other | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chronic infection of eye or lid | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Blurred Vision | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

If answered yes to any of the above please explain:

Respiratory

- | | | | |
|--------------------|--|---------------------|--|
| Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Chronic Cough | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bronchitis | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Seasonal Allergies | <input type="checkbox"/> YES <input type="checkbox"/> NO | Shortness of Breath | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pneumonia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Other | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Smoking History | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Emphysema/COPD | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

If answered yes to any of the above please explain:

Physical Evaluation Form

Review of Systems/History

High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chest Pain/Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Congestive Heart Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Irregular Heart Beat	<input type="checkbox"/> YES <input type="checkbox"/> NO	Migraines	<input type="checkbox"/> YES <input type="checkbox"/> NO
Slow or Fast Heart Rate	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bleeding Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stroke/TIAs	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Blood or lymphatic	<input type="checkbox"/> YES <input type="checkbox"/> NO

If answered yes to any of the above please explain:

Respiratory

Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Intestinal/Bowel Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hepatitis/Yellow Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Musculoskeletal	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsions/Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Skin Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blackouts	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Neurological	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hiatal Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Eyes, Nose, Throat	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stomach Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Gastrointestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Genitourinary	<input type="checkbox"/> YES <input type="checkbox"/> NO

If answered yes to any of the above please explain:

If answered yes to any of the above please explain:

If answered yes to any of the above please explain:

Physical Evaluation Form

Review of Drug and Alcohol History

Does the member have a history of substance abuse? YES NO

If yes, please explain including substance/s used, frequency of use and relapse profile:

Medications

Does the member have any allergies to any Medications (if so please list each medication and type of reaction)?

List all medications the member is currently on:

List medication history of member (physical and psychotropic):

Are you prescribing/recommending any new medication? YES NO

If yes, please list below:

Have you reviewed this member's list of medications? YES NO

Does this patient have any mobility issues that would prevent them from living successfully in an apartment and participating in a residential treatment program?

Physical Evaluation Form

Recommendations

Does member present with identified breathing and/or cardiovascular problems

Are there any physical limitations that would prevent/restrict the member from following a physical fitness regime of:

Moderate aerobic exercise (30 min/day)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Running	<input type="checkbox"/> YES <input type="checkbox"/> NO
Strength training	<input type="checkbox"/> YES <input type="checkbox"/> NO	Karate/Martial Arts	<input type="checkbox"/> YES <input type="checkbox"/> NO
Yoga stretching	<input type="checkbox"/> YES <input type="checkbox"/> NO	Biking	<input type="checkbox"/> YES <input type="checkbox"/> NO
Water aerobics/therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Walking	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Are there any nutritional/dietary needs?

What is member's BMI? _____

Is BMI in a healthy range? YES NO If no, what is healthy range? _____

Weight loss recommended? YES NO If yes, what is goal weight? _____

Is member up-to-date with immunizations/tetanus? YES NO

Does member use tobacco regularly? YES NO

Is smoking cessation program recommended? YES NO

Referrals or follow-up appointments:

Physical Examination

General: _____

Vital Signs: _____

HEENT: _____

Signature of Physician: _____ Date of Evaluation: _____

Printed Name of Physician: _____

Reviewed by Project Transition Psychiatrist: _____ Date: _____

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1 Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 Other instructions, such as hospice care, burial arrangements, etc.: _____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue My entire body Only the following organs/tissues: _____
- No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- 1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form. _____
Signature of witness number 1
- 2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form. _____
Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.