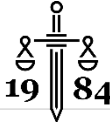

CHILDS
LAW FIRM

20 Center Street, Travelers Rest SC 29690
864-242-9997 • 864-242-9914 (fax) • Robert@LawyerChilds.com

WE'RE HERE TO HELP!

The Childs Law Firm is general service law provider with a current emphasis in the following areas: Automobile Accidents, Civil Litigation, Criminal Defense, Family Law, Mediation, Slip & Fall, and Workers Compensation. Mr. Robert C. Childs, III has been practicing law since 1984 and has served as the Public Defender for Aiken County, Deputy Solicitor for the 13th Judicial Circuit and the Greenville County Attorney

We provide Wills and Durable Powers of Attorney far below market costs as a service to our community. We have also attached a FREE Health Care Powers of Attorney/Living Will. You can fill these out yourself according to the instructions and have them witnessed.

A Will or Durable Power of Attorney is **$250.00 each.** We recommend that you have both a Will and Durable Power of Attorney. A Health Care Power of Attorney is provided free with instructions and is attached to this document.

INSTRUCTIONS

1. Fill out each of the forms and return to us in one of following means;

   Mail to: P.O. Box 1519, Travelers Rest SC 29690

   Email to: Receptionist@LawyerChilds.com

   Drop off: Childs Law Firm, 20 Center Street, Travelers Rest SC 29690

2. Once received, we will prepare the documents and either mail or email them back for you to review.

3. Once you've approved the documents, we will call to schedule you an appointment to execute the documents. Payment for these services will be due upon the completion of the execution.

IMPORTANCE OF A WILL

Wills are extremely important to your family. You need a will in order to put your wishes into effect in the event of your death. Without a will, your property and your surviving family's affairs will be governed by the choices reflected in the statute law of the state of South Carolina. Those choices may not be your choices.

First, your will may dispose of your property in accordance with your wishes, you may choose people and the shares that each will take. Without a will, your property will go to your heirs in shares pre-determined for you by the state's law of intestacy. Dying without a will is called dying "intestate." Roughly summarized: the intestacy law favors your relatives, the closer the relation the greater the share.

Your husband or wife takes one-half of your property if you leave a spouse and child(ren). If you leave a spouse and no child(ren), your spouse will receive all. If you leave no spouse, but children, then your child(ren) will receive your property.

Generally, if a child of yours does not survive you, then their child(ren) receives the share your child would have received if they had survived you. If neither spouse nor child(ren) or grandchild(ren) survive(s) you, then your parents would receive the share. If no parents survive then your brother(s) and/or your sister(s) receives your property under the state's law of intestacy.

- With a will, you may determine which of your heirs will share in your property, and in what order of priority, and just exactly what their respective shares will be. You may leave them fractional shares of your choice, or you may leave specific items of property to specific people.

- With a will, you may leave shares of your property to more distant relatives, friends, charities, churches, to whomever you wish to benefit, and in the shares that you desire.

- With a will, you may make gifts to people and require that the beneficiary who survives you, or perhaps survives to a more mature age, or surviving some other person's death before receiving any such gift.

- With a will, you may make gifts into a trust, appointing a trustee to administer your property for the benefit of your survivors. A trust may be very flexible and can keep someone from doing something foolish with their inheritance.

- With a will, you may even provide for the final disposition of property held by you and your spouse in joint names with right of survivorship. It is true that on the death of the first spouse the property passes to the surviving spouse without need of a will. But, that leaves the death of the second spouse to be planned for. Your will is the way to handle that problem.

Your will may designate a person of your choice to act as personal representative of your estate. The will may go further and may specify your personal representative's duties and powers with

respect to your estate. Your will may tailor to make your estate administration fit your wishes and the needs of your survivors.

If you have minor children or a family member who cannot look after their own affairs, your will may nominate someone to act as guardian to care for the child or infirm family member. It may also be wise to name someone to act as conservator of the property of such persons.

Finally, your will may be drafted with an eye to the United States and South Carolina tax laws. It may include provisions set up to minimize and, perhaps, entirely to avoid the payment of estate taxes at your death and afterward.

These are some reasons why you need a will. There may be others. But they will all have this in common: **you need a will in order to dispose of your property and provide for your family in accordance with your own wishes.**

IMPORTANT CONSIDERATIONS CONCERNING WILLS AND ESTATES

ESTATE TAXES

An estate tax is a tax on your right to transfer property after your death. South Carolina has no estate taxes and probate fees are nominal. The threshold value of an estate for federal estate taxes is more than $12,000,000.00. If your estate is approaching that amount you should consult with an Estate Planner/Tax Attorney before doing a will.

AVOIDING PROBATE

Many people rightfully want to keep their family from having to probate parts of their estate. Be mindful that Probate Fees are a very small percentage of the overall value of an estate and really shouldn’t be a major consideration in taking measures to avoid probate. Major considerations should be given to transferring and encumbering your party before death since it limits your ability to liquidate or transfer those assets in the future. Also keep in mind that the attorney’s fees for preparing a Deed of Distribution for an estate are about the same as those for preparing a Deed to transfer your interest in real estate while you are still alive.

MEDICAID FIVE YEAR LOOK-BACK

One of the most important considerations is the “Five-Year Look-Back” on Medicaid. Starting the day you apply to Medicaid, there is a five-year look-back period on any asset transfers you make. If you give away assets and don't receive fair value, you will be penalized. The penalty is calculated based on the value of the transferred assets and leads to a ban on benefits for a certain period of time. Therefore, if you transfer or encumber your property in that five-year period and need Medicaid for a nursing home you may be disqualified for a period of time. You should consult a Medicaid Planning Attorney to learn more.

IMPORTANCE OF A DURABLE POWER OF ATTORNEY

Whether you are in a coma after a car accident, or your mental ability is simply deteriorating due to old age, a Durable Power of Attorney ("DPOA") can help to ensure that your business and financial affairs are taken care of, even if you cannot personally oversee those parts of your life. It is important to address these issues by having a DPOA in place prior to your incapacity. Otherwise, you would have to rely on a court to appoint a guardian or conservator to handle your affairs if you were to become incapacitated—a process that can be very slow, tedious, and expensive. Since incapacities often occur close to the end of one's life, a DPOA can effectively bridge the gap between the onset of the person's incapacity and the person's death.

A durable power of attorney allows the person designated to handle your affairs (You are the "principal" and they are the "agent" or "attorney-in-fact") to conduct business on behalf of the principal and handle the financial affairs of the principal, with limits that are specified in the document.

Agents or Attorneys-in-Fact commonly use DPOAs for the principal to:

- Pay the principal's bills,
- Manage the principal's bank accounts,
- Buy or sell the principal's property,
- Enter into contracts or agreements for services for the principal,
- Provide or obtain childcare services or homecare services for the principal, or
- Engage in healthcare planning on behalf of the principal.

Note that an agent who holds a DPOA is a fiduciary – they owe a duty of trust to the principal to make decisions and take actions using the DPOA solely for the benefit of the principal. It is illegal for the agent to use the DPOA for their own personal benefit or to the detriment of the principal's interests.

DURABLE POWERS OF ATTORNEY ARE EFFECTIVE IMMEDIATELY BUT MUST BE FILED WITH THE DEEDS OFFICE TO BE USED.

A DPOA is effective upon execution even if it is not recorded. Upon the incapacity of the Principal, however, a DPOA must be recorded in the Deeds Office for the particular county in which the Principal is domiciled in order for the DPOA to remain effective. Since a DPOA cannot be used until it is filed at the Deeds Office but is effective on execution most clients do not file them right away and they advise their Attorney-in-Fact (The person receiving the DPOA) of the location of the original with instructions to file it only when they become incapacitated.

IMPORTANCE OF A HEALTH CARE POWER OF ATTORNEY

We recommend using the form for a Health Care Power of Attorney and Declaration of Desire to Die a Natural Death ("HCPOA") attached to this document rather than a Living Will. There are differences between the HCPOA and the Living Will. The two documents are not interchangeable. Different rules, which may conflict, govern their interpretation and application. The HCPOA contains important elements of the Living Will, but the reverse is not the case. For this reason, many attorneys no longer use the Living Will.

The person creating a Living Will is called the "Declarant." The person creating a HCPOA is the "Principal." Both Declarants and Principals must be at least 18 years old. The major difference is scope. The HCPOA gives someone the authority to make all health care decisions for the Principal, including end-of-life decisions, if the Principal is unable to make them. The Living Will only addresses end-of-life decisions and directs the health care provider to withhold certain "life-sustaining procedures" if the Declarant has a "terminal condition" or is in a state of "permanent unconsciousness" (these terms are defined in the acts).

The HCPOA is recommended because you can both state your desire's concerning dying a natural death, nutrition and hydration in the case of terminal illness or permanent unconsciousness and designate a person to make all your other medical decisions if you unable to do so.

THINGS TO DO NOW

1. Do a Will.

2. Make bank, retirement and investment accounts payable on your death to the person you designate. These transfers are automatic on your death.

3. Do a Durable Power of Attorney.

4. Do a Health Care Power of Attorney.

5. Other more complicated things you can do are to put real estate in joint tenancy with rights of survivorship (Still possible Medicaid issues.), Create a living trust (Still possible Medicaid issues) and gifting your assets (Tax implications). Consult an Estate Planning/Tax Attorney for these more complicated preparations.

INFORMATION NEEDED TO PREPARE YOUR WILL AND DURABLE POWER OF ATTORNEY.

PLEASE RETURN TO CHILDS LAW FIRM

Check Box: ____Will only or ____ Will and Durable Power of Attorney

YOUR WILL

Please fill out the information requested below to the best of your ability.

Full name of person requesting Will:

____

Full address of person requesting will:

____

____

County:______________________________ phone no.____________________________

Email________________________________

Whom do you wish to give your estate (property) to? (In most cases with married couples they leave their estate to each other and in case, they die in a common disaster then to their children or their issue [Your children's children]. This is just an example, and you can designate whomever you wish.)

Full name:____Relationship ____________________

Percentage of estate they are to receive:__________

Full name:____ Relationship ____________________

Percentage of estate they are to receive:__________

Full name:____Relationship ____________________

Percentage of estate they are to receive:__________

If the person(s) you wish to give your estate to dies at the same time or before you, who do you wish to give your estate to then? (This is usually your children or their issue, but this is only an example, and you may designate whomever you wish.)

Full name:____ Relationship ____________________

Percentage of estate they are to receive:__________

Full name:____Relationship ____________________

Percentage of estate they are to receive:__________

Full name:____Relationship ____________________

Percentage of estate they are to receive:__________

Who do you want to be appointed personal representative of your estate? (This is who handles your estate in Probate Court. This is often your spouse or the person who is receiving most of your estate. This is just an example, and you can designate whomever you wish.)

Full name:____________________________ relationship __________________________

Who do you wish to be your alternate personal representative? (This is in case your appointed personal representative is unable to serve for any reason)

Full name:____________________________ relationship __________________________

If you have minor children, who do you want appointed to be guardian over them? (This is normally designated in most wills as the person serving as the personal representative but can be a different person)

Full name:____________________________ relationship __________________________

Please list full names and ages of your children:

____

____

____

____

____

Please list below any special conveyances of property of other matters that you would like to address in your will:

YOUR DURABLE POWER OF ATTORNEY

Please fill out the information requested below to the best of your ability.

Who do you want to be appointed as your Attorney-In-Fact?

Full name:______________________________ relationship ____________________________

Address:____

County:________________________________ phone no.______________________________

Who do you want to be appointed as your alternate Attorney-In-Fact?

Full name:______________________________ relationship ____________________________

Address:____

County:________________________________ phone no.______________________________

YOUR HEALTH CARE POWER OF ATTORNEY

Attached is the State Health Care Power of Attorney form with instructions. This document is provided free and you may fill this out at home and have it witnessed by two disinterested parties (See Instructions) and it will be effective without anything further. You do not need to have this document notarized or executed at our office but if you wish we can witness it while you are here for execution of your other documents.

IMPORTANT INFORMATION ABOUT HCPOA

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

1. This document gives the person you name as your agent the power to make health care decisions for you if you cannot make the decision for yourself. This power includes the power to make decisions about life-sustaining treatment. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have.

2. This power is subject to any limitations or statements of your desire that you include in this document. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent will be obligated to follow your instructions when making decisions on your behalf. You may attach additional pages if you need more space to complete the statement.

3. After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. After you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

4. You have the right to revoke this document, and terminate your agent's authority, by informing either your agent or your health care provider orally or in writing.

5. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

6. This power of attorney will no be valid unless two persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgement that the signature on the power of attorney is yours.

7. The following persons may not act as witnesses:

    a. Your spouse, your children, grandchildren, and other lineal descendants; your parents, grandparents, and other lineal ancestors; your siblings and their lineal descendants; or a spouse of any of these persons.

    b. A person who is directly financially responsible for your medical care.

    c. A person who is named in your will, or if you have no will, who would inherit your property by intestate succession.

    d. A beneficiary of a life insurance policy on your life.

    e. The persons named in the health care power of attorney as your agent or successor agent.

    f. You physician or an employee of your physician.

    g. Any person who would have a claim against any portion of your estate (persons to whom you owe money).

    h. If you are a patient in a health facility, no more than one witness may be an employee of that facility.

8. Your agent must be a person who is 18 years old or older and of sound mind. It may not be your doctor or any other health care provider that is now providing you with treatment; or an employee of your doctor or provider; or a spouse of the doctor, provider, or employee; unless the person is a relative of yours.

9. You should inform the person that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. If you are in a health care facility or a nursing care facility, a copy of this document should be included in your medical record.

HEALTH CARE POWER OF ATTORNEY

(South Carolina Statutory form, Code of Laws Section 62-5-504)

1. DESIGNATION OF HEALTH CARE AGENT

I, ____, hereby appoint.

____

(Agent)

____

(Agent's address)

__________________ __________________ ________________________

(Agent's home phone) (Agent's work phone) (Agent's mobile phone)

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disables resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorce or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:____

address:____

Telephone: home_______________, work____________, mobile___________

b. Second Alternate Agent:____

address:____

Telephone: home_______________, work____________, mobile___________

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. **EFFECTIVE DATE AND DURABILITY**

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. **HIPAA AUTHORIZATION**

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in event that I revoke the authority in writing and deliver it to my health care provider.

4. **AGENT'S POWERS**

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority my agent shall follow my desires as stated in this document, otherwise expressed by me, or known to my agent. In making any decision my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desire is intended to be as broad as possible except for any limitations I may state below.

Accordingly, unless specifically limited by Section E below, my agent is authorized as follows:

a. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

b. To authorize or refuse to authorize any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

c. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

d. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice; and pursuing any legal action in my name and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

e.

f. The powers granted above do not include the following powers or are subject to the following rules or limitations: ___________________________________

____

____

____

5. **ORGAN DONATION (INITIAL ONLY ONE)**

My agent may __________ or may not __________ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. **EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)**

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

7. **STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT**

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

a. ______ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

b. ______ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

1.) if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time;

or

2.) if I am in a state of permanent unconsciousness.

OR

c. ______ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

8. **STATEMENT OF DESIRES REGARDING TUBE FEEDING**

With respect to nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Item 7, (INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS.)

a. ______ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of the tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

b. ______ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life to be prolonged by tube feeding

OR

c. ______ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL EITHER OF THE ABOVE STATEMENTS IN ITEM 8, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT, CARE, OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. **ADMINISTRATIVE PROVISIONS**

a. I revoke any prior Health Care Power of Attorney and any provisions relating to health-care of any other prior power of attorney.

b. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this ______________________ day of ________________________ 20______.

My current home address is:____

____

Signature:____

Print Name:____

I declare on the basis of information and belief that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his/her decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1.:________________________________

Signature:_______________________________________ Date:_________________________

Print Name:_____________________________________ Telephone:_____________________

Address:____

____

Witness No. 2.:____________________________________

Signature:_______________________________________ Date:________________________

Print Name:_____________________________________ Telephone:_____________________

Address:____

____