

Date instructions received: _____, 20__.

Quote:

****CHEQUE, CASH, and ETRANSFER ONLY****

INSTRUCTIONS FOR REPRESENTATION AGREEMENT FOR HEALTH CARE

Your Full Legal Name:	
Aliases:	
Occupation:	
Your Address:	
Telephone No:	
Date of Birth and Place of Birth:	
Marital Status:	
Name of Spouse:	
Aliases:	
Date of Birth and Place of Birth:	

Do you have a Representation Agreement? Yes ☐ No ☐

Are you revoking that Representation Agreement? Yes ☐ No ☐

[**If not revoking that Representation Agreement, a copy of that Representation Agreements is to be provided to our office**]

Some things you should know before getting started:

- The Representation Agreement is no longer valid if the Representative, dies, becomes incompetent or resigns;
- The Representative can make health care and personal care decisions for you, or assist you with those decisions.

- The Representative must act in the best interests of the Adult and use any instructions or known beliefs or wishes as a guide as far as practicable. (those instructions, when in writing, are often referred to as a Health Care Directive, or Instructions for my Representative)
- Some people may want to give their Representative(s) authority to override their decisions, especially those with bi-polar conditions or schizophrenia. Please let us know if you want this authority in your agreement.
- A Power of Attorney can only be used for financial and business purposes.
- An enhanced Representation Agreement can only be used for health care and personal care decisions.
- A Standard Representation Agreement is for **ROUTINE** management of financial matters and **ROUTINE** health care decisions, and is generally used for people who may not have capacity to do a Power of Attorney. The Notary will interview you and help you decide which agreement is best suited to your needs.

The person(s) who will be your Representative:

Full Legal Name:

Occupation:

Relationship to you:

Address, Tel No:

DOB:

If you wish to appoint more than one Representative, please indicate the person's information below:

2nd Representative's

Full Legal Name:

Occupation:

Relationship to you:

Address, Tel No:

DOB:

3rd Representative's Full
Legal Name:

Occupation:

Relationship to you:

Address, Tel No:

DOB

Do you want multiple Representatives to be able to act separately / must act together (tick one box)?

Bear in mind if they must act together, if one of them becomes incapable or dies, the document would then be void and you might not be competent at the time to make a new Representation Agreement.

If they must act together, under what circumstances would one Representative be authorized to act alone (tick applicable boxes)

- ☐ One of the Representatives dies
- ☐ One of the Representatives becomes incapable or very ill
- ☐ One of the Representatives moves away
- ☐ If one refuses to act

Where there are multiple Representatives, indicate how you would like your Representatives to resolve a conflict?

- ☐ Consult a notary or lawyer
- ☐ Consult a family friend (name) _____
- ☐ Consult another professional (name) _____

Do you want your Representative to be able to act during any subsequent mental infirmity on your part? Yes ☐ No ☐

Do you want the Representative to have the power to give or refuse consent to health care necessary to preserve life? Yes ☐ No ☐

Do you want the Representative to be able to interfere with your religious practices?
Yes ☐ No ☐

Do you want the Representative to be able to help make decisions or make decisions about where you might live if you cannot remain in your home. Yes ☐ No ☐

Sometimes the duties of the Representative can be a heavy load and can require many hours of visits, consultations with medical professionals, taking you to the doctor and other appointments and keeping records. Do you want your Representative(s) to be paid for this time? Yes ☐ No ☐

If yes indicate:

- ☐ Out of Pocket expenses only (ferries, airfares, long distance, etc)
- ☐ A reasonable hourly rate for time spent on your behalf (currently \$____)
- ☐ A fee arrangement (generally for professionals) based on Capital fee of ____% of value of trust property, and
An annual income fee of ____% of income earned, and
An annual care and management fee of ____% calculated on the average value of the trust property.

Are there any restrictions or conditions that you would like to add to this document?

YES ☐ NO ☐

If yes please specify:

Location of Representation Agreement:

Where will it be kept? _____

Please drop off, email or fax this form to our office and we will contact you for an appointment.

NOTES:
