Aging Facilitation Guidance

 *As we age, we are all presented with numerous challenges. Some of these challenges are physical, but others are cognitive. As your advisory firm, we believe it is our responsibility to protect both your wealth and your health. We would like to take this opportunity to ask for your guidance on how we may best do so.*

In the unlikely event that I exhibit behavioral changes due to cognitive decline, particularly the inability to make financial decisions, I authorize ***\*insert firm name\**** to:
(write 1, 2, and 3 in order of preference)

\_\_\_\_\_\_\_ Speak to me directly about any concerns.

\_\_\_\_\_\_\_ Contact one or more of the following individuals to discuss any concerns.
(Consider family, friends, or medial, legal, or financial professionals).

\_\_\_\_\_\_\_\_\_ (Yes/No) If deemed necessary by one of more of these individuals, shall ***\*insert firm name\**** assist in arranging for a consultation with an elder care specialist or your personal physician for a professional evaluation?

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Email | Phone # |
|  |  |  |  |
|  |  |  |  |
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\_\_\_\_\_\_\_ Contact the person or persons I have named in my Durable Power of Attorney and proceed as they direct.

I understand that the sole purpose of this document is to provide guidance to ***\*insert firm name\**** during periods of uncertainty. This document does not supersede or replace any other legal documents I have executed. By signing below, I agree to hold ***\*insert firm name\**** harmless for either acting or failing to act on the preferences stated in this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature* *Print Name* *Date*

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*Witness* *Print Name* *Date*

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*Firm Representative Print Name Date*