

# Lasting Powers of Attorney Health and Welfare



## ABOUT YOU

Confidential

Title	
Full name (including maiden name and any former names)	
Date of Birth	
Social Security Number	
Address	
	Post Code
Telephone	Email address
Are you currently in receipt of benefits, including Long Term Care benefits?    Yes <input type="checkbox"/> No <input type="checkbox"/>	

## YOUR ATTORNEY(S)

You can appoint one or more individuals as your attorney. Your attorney can be a friend, family member or professional individual (a corporation cannot act).

<b>Attorney 1 Name</b>	
Date of Birth	Social Security Number
Address	
	Post Code
Telephone	Email address
Relationship to you	
Authority to give or refuse consent to life sustaining treatment?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
If your marriage / civil partnership ends would you like Attorney 1 to continue to act?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Attorney 2 Name</b>	
Date of Birth	Social Security Number
Address	
	Post Code
Telephone	Email address
Relationship to you	
Authority to give or refuse consent to life sustaining treatment?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
If your marriage / civil partnership ends would you like Attorney 2 to continue to act?    Yes <input type="checkbox"/> No <input type="checkbox"/>	

If you would like to appoint more than two attorneys please complete additional copies of this page.

## HOW SHOULD YOUR ATTORNEYS MAKE DECISIONS?

☐ **Jointly (always together)** OR ☐ **Jointly and Severally (they can act together but can also act separately).**

If you are appointing more than one attorney, please detail any specific decisions which you wish only to be made by one or all of them (i.e. a move into a care home may need agreement of all attorneys or can only be made by "Attorney 1")

## REPLACEMENT ATTORNEY

Replacement attorneys will act as your attorney in the event that one of your above nominated attorneys is unable to act. If you wish to appoint a replacement attorney please complete their details below:

### Replacement Attorney 1 Name

Date of Birth

Social Security Number

Address

Post Code

Telephone

Email address

Relationship to you

Authority to give or refuse consent to life sustaining treatment? Yes ☐ No ☐

If your marriage / civil partnership ends would you like Replacement Attorney 1 to continue to act? Yes ☐ No ☐

### Replacement Attorney 2 Name

Date of Birth

Social Security Number

Address

Post Code

Telephone

Email address

Relationship to you

Authority to give or refuse consent to life sustaining treatment? Yes ☐ No ☐

If your marriage / civil partnership ends would you like Replacement Attorney 2 to continue to act? Yes ☐ No ☐

If you would like to appoint more than two replacement attorneys please complete additional copies of this page.

## YOUR ATTORNEY(S) POWERS

### INSTRUCTIONS

These are things that your attorney(s) **must or must not** do when making decisions for you. If you leave this section blank then your attorneys will be free to make decisions they think are right.

Please outline any instructions in the box below:

## PREFERENCES

These are things you **would like** your attorneys to consider when making decisions for you, (e.g. your wishes, beliefs and values).

Please outline any preferences in the box below:

## NOTIFICATION RECIPIENTS

You can choose up to 5 people who the Judicial Greffe will inform when you apply to register your LPA. These people could be family members or close friends, who will be able to raise concerns (if they have any) when your LPA is registered.

<b>Person 1 to be notified</b>	
Name	
Address	
	Post Code
Telephone number	Email address
Relationship to you	
<b>Person 2 to be notified</b>	
Name	
Address	
	Post Code
Telephone number	Email address
Relationship to you	

If you would like more than two people to be notified please complete additional copies of this page.

Please complete this form and return to **Kylie Young** or **Eliana Lennon** at [probate@voisinlaw.com](mailto:probate@voisinlaw.com)



VOISIN LAW

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**Voisin Law** is a law firm regulated by the Law Society of Jersey

# Lasting Powers of Attorney Health and Welfare Guidance



VOISIN LAW

## INSTRUCTIONS

These are things that your attorney(s) **must or must not do** when making decisions for you. If you leave this section blank then your attorneys will be free to make decisions they think are right and in your best interests.

Instructions will use words such as *"must"*, *"will"* and *"have to"*.

Examples of Instructions:

- My attorney(s) must ensure that I am fed a vegan diet with no animal products.
- My attorney(s) must refer to my Advance Decision to Refuse Treatment involving blood products. This is against my religion.
- My attorney(s) must not decide that I am to move into a care home, unless my doctor says that I can no longer live alone without a lot of extra help.

## PREFERENCES

These are things you would like your attorneys **to consider** when making decisions for you, (e.g. your wishes, beliefs and values). These are words such as *"prefer"* or *"would like"*.

Examples of Preferences:

- I would like to remain living in St Ouen where I have lived all my life.
- I would like to take exercise at least 3 times a week if I am physically able to do so.
- I prefer a west facing room if possible as I suffer from Seasonal Affective Disorder.
- If I am to live in a care home then I would like to live in one which will accept any pet that I may have.



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