

Aging with Grace: The Paperwork Part

Estate Planning and Administration



Breakwater Law

Presented By: Taylor Kittell

General Overview

- **Why estate planning matters**
- **Planning for Incapacity**
 - Guardianship and Conservatorship
 - Advance Directive
 - Durable Power of Attorney
 - Revocable Living Trust
- **Planning for Death**
 - Probate
 - Will
 - Revocable Living Trust
- **TAXES!**

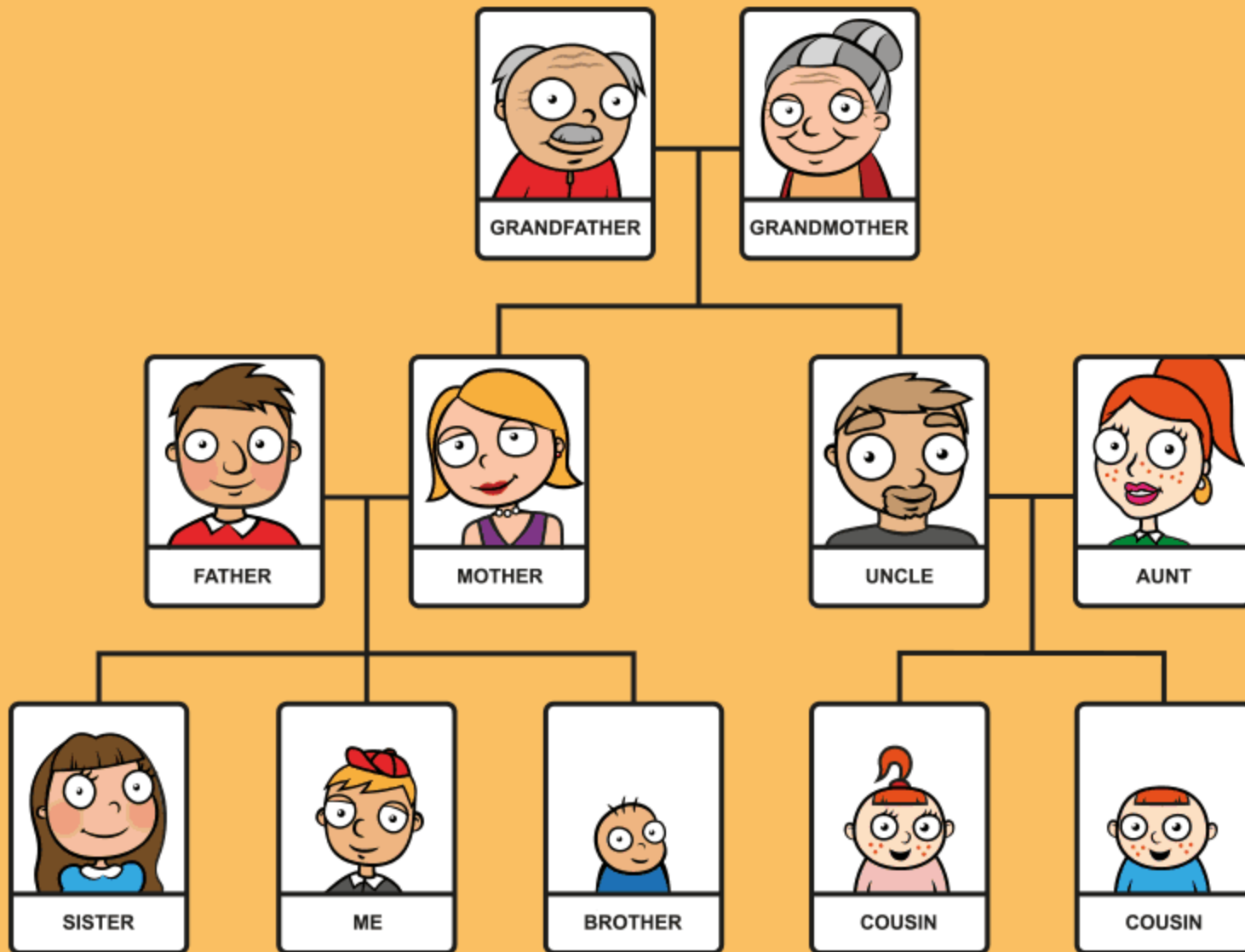
Alan and Betty



Allan and Betty



- Own primary residence valued at \$500K
- Total of retirement accounts is \$1M
- Other assets are jewelry, cash, and investments worth about \$500K
- All assets are jointly owned between A&B (or name spouse as beneficiary)



Why do they need an estate plan?

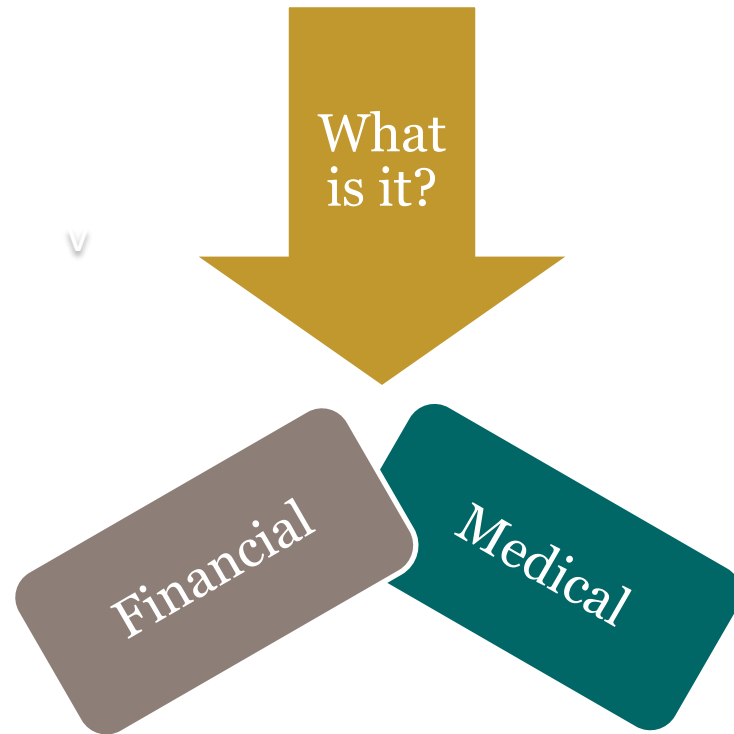
- Different heirs at law
- What money will be used to pay administrative expenses and estate taxes?
- Who will be in charge?
- Who will receive which assets?



Incapacity

Temporary or permanent loss of ability to make decisions for yourself

Fluid - not black and white



Issues and Options

- Issues
 - Who makes decisions?
 - Do they know what you want?
 - Do they have the legal tools to do it?



* Planning

- * Personalized
- * Can Limit Powers
- * Flexible
- * Update as needed

Power of
Attorney

Advance
Directive

* No planning

- * Court-supervised process
- * Stressful for loved ones
- * Wishes may not be known or carried out

Guardianship & Conservatorship



- **Guardian** = control over the **person**
- **Conservator** = control over the **estate**
- Necessary if:
 - there are no estate planning documents
 - the EP documents aren't enough (the person objects to receiving help or revokes their documents)
- Court supervised! Must account for every dollar in and every dollar out, for the duration of that person's incapacity
- Inventory and accountings are publicly available

General Durable Power of Attorney

- Appoints an **Agent** to make financial decisions
- Revocable!
- Powers can be limited or general
- Can be effective immediately or only upon incapacity (with a letter from your doctor)
- Does NOT take away principal's power to manage his or her own finances



Advance Directive

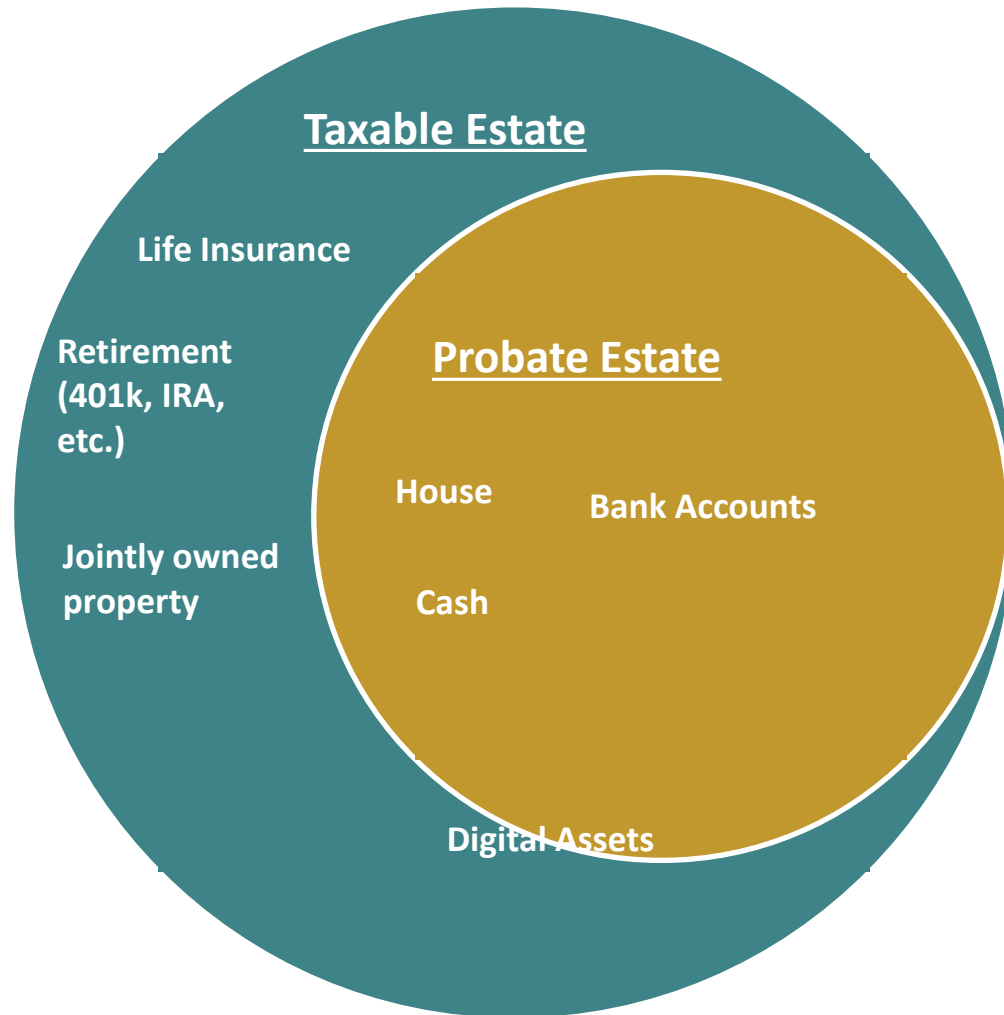
- Appoints a **Health Care Representative** to make medical decisions
- Directs life support and tube feeding
- Also can be called a Living Will or Power of Attorney for Health Care
- Different from **POLST** (Physician's Order for Life Sustaining Treatment)
- Different from **DNR** (Do Not Resuscitate)

You do not need an attorney to complete an advance directive – do it today! See example at end of slides as a guide for the simplest way to complete it.

Link for Oregon Health Authority – Form for Advance Directive:
<https://www.oregon.gov/oha/ph/about/pages/adac-forms.aspx>



What is an Estate?



Taxable
VS.
Probate

Will and Revocable Trust



- Names who will administer your estate
 - Will: **Personal Representative** (sometimes called Executor)
 - Trust: **Trustee**
- Directs distribution of your assets upon death
- Authorizes payment of your expenses and debts
- Incorporates tax-planning objectives
- Personalized for your values and your family

Will vs. Revocable Trust

Will:

- Probate
- Public; Court Supervised; formal rules
- Simple; assets stay in your name

Revocable Trust:

- Avoids probate
- Private; can be less formal
- Benefits during lifetime/incapacity
- Assets are owned by the Trust

Probate vs. Trust Administration

Probate*

- Court supervised (public)
 - Varies by county
- Formal pleadings required (some increase in attorney fees)
- Court/publication costs
- Most take 6-12 months
- Must give creditors 4+ months to file claims; claims may then be barred (more protective)
- Notice is given to all heirs (regardless of who gets what)

Trust Administration*

- No court supervision (private)
 - Consistent across the state
- No formal pleadings required (can reduce attorney fees)
- No court/publication costs
- Timeline depends on assets and people involved – can be very fast
- Creditors must still be paid; claims may surface years later
- Notice is only given to beneficiaries

***TAXES ARE THE SAME!**

Other Transfer Upon Death Tools



- Joint Ownership with Survivorship Rights
- Beneficiary Designation
- TOD/POD – “Transfer on Death” or “Payable on Death”

Benefits:

- ✓ Avoids probate or trust administration
- ✓ Quick and easy

Drawbacks:

- **Overrides your estate plan!**
- Unintended consequences (minors, unequal distributions, outdated beneficiaries)
- May cause more stress for estate administration (no cash in the estate)
- Still subject to estate taxes, but hard to gather information
- Does not address incapacity or debts





The Math Part (Estate Taxes)

Oregon's Estate Tax

- \$1 million exemption per person
- 10% to 16% of amount over \$1 million
- Due 12 months after date of death

Oregon Estate Tax Rate Table			
<i>Equal to or more than</i>	<i>Less than</i>	<i>Tax rate on taxable estate amount more than column one</i>	<i>Base amount from prior column</i>
\$1,000,000	\$1,500,000	10.00%	\$ -
\$1,500,000	\$2,500,000	10.25%	\$ 50,000
\$2,500,000	\$3,500,000	10.50%	\$ 152,500
\$3,500,000	\$4,500,000	11.00%	\$ 267,500
\$4,500,000	\$5,500,000	11.50%	\$ 367,500
\$5,500,000	\$6,500,000	12.00%	\$ 482,500
\$6,500,000	\$7,500,000	13.00%	\$ 602,500
\$7,500,000	\$8,500,000	14.00%	\$ 732,500
\$8,500,000	\$9,500,000	15.00%	\$ 872,500
\$9,500,000	and up	16.00%	\$ 1,022,500

Example Calculations:

<i>Adjusted Gross Value</i>	<i>Estate Tax Due</i>
\$ 2,000,000	\$ 101,250
\$ 5,000,000	\$ 425,000
\$ 8,000,000	\$ 802,500
\$ 10,000,000	\$ 1,102,500
\$ 15,000,000	\$ 1,902,500



Questions?

THANK YOU

Taylor Kittell

(503) 878-8948

Taylor@Breakwater-Law.com

Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive will replace any older directive.

You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

Advance Directive Form

1. About me		
Name (first, middle, last): Marge Simpson		Date of birth: March 19, 1958
Telephone numbers: Home 123-45-6789	Work	Cell
Address: 742 Evergreen Terrace, Springfield, OR		E-mail: margeluvshomer@simpsons.com

2. My health care representative		
I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.		
Name (first, middle, last): Homer Simpson		Relationship: Spouse
Telephone numbers: Home 123-45-6789	Work	Cell
Address: 742 Evergreen Terrace, Springfield, OR		E-mail: Homerluvsduff@simpsons.com

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me, or if I cancel the first healthcare representative's appointment.

First alternate health care representative		
Name (first, middle, last): Lisa Simpson		Relationship: Daughter
Telephone numbers: Home 123-45-6789	Work	Cell
Address: 742 Evergreen Terrace, Springfield, OR		E-mail:

Second alternate health care representative		
Name (first, middle, last): Maggie Simpson		Relationship: Daughter
Telephone numbers: Home 123-45-6789	Work	Cell
Address: 742 Evergreen Terrace, Springfield, OR		E-mail:

3. My health care instructions

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.

You can provide guidance on your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. My health care decisions

There are three situations below for you to express your wishes. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

a. Terminal condition

This is what I want if:

- I have an illness that cannot be cured or reversed

AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only	
<input type="checkbox"/>	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
<input type="checkbox"/>	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
<input type="checkbox"/>	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
<input checked="" type="checkbox"/>	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced progressive illness

This is what I want if:


- I have an illness that is in an advanced stage.

AND

- My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

- My health care providers believe I will never be able to:
 - » Communicate
 - » Swallow food and water safely
 - » Care for myself
 - » Recognize my family and other people

Initial one option only	
_____	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
_____	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
_____	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. Permanently unconscious

This is what I want if:

- I am not conscious.
- AND**
- If my health care providers believe it is very unlikely that I will ever become conscious again.

Initial one option only	
_____	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
_____	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
_____	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

	<p>I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.</p>
<p>You may write in the space below or attach pages to say more about what kind of care you want or do not want.</p>	
<p>B. What matters most to me and for me</p> <p>This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.</p>	
<p>This is what you should know about what is important to me about my life:</p>	
<p>This is what I value the most about my life:</p>	
<p>This is what is important for me about my life:</p>	

I do not want life-sustaining procedures if I can not be supported and be able to engage in the following ways:

Initial all that apply

- Express my needs
- Be free from long-term severe pain and suffering
- Know who I am and who I am with
- Live without being hooked up to mechanical life support
- Participate in activities that have meaning to me, such as:

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in...)

I want my health care representative to decide

C. My spiritual beliefs

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in the space below or attach pages to say more about your spiritual or religious beliefs.

4. More information

Use this section if you want your health care representative and health care providers to have more information about you.

A. Life and values

Below you can share about your life and values. This can help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system and more.

You may write in the space below or attach pages to say more about your life, beliefs and values.

B. Place of care

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)

You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

C. Other

You may attach to this form other documents you think will be helpful to your health care representative and health care providers. What you attach will be part of your Advance Directive.

You may list documents you have attached in the space below.

D. Inform others

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

5. My signature


My signature

10/25/23
Date

6. Witness

Complete either A or B when you sign

A. Notary

State of _____

County of _____

Signed or attested before me on _____ by _____
Date

Notary Public State of Oregon

B. Witness Declaration

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Ned Flanders
Witness name (print)

Ned Flanders
Signature

10/25/23
Date

Moe
Witness name (print)

Moe
Signature

10/25/23
Date

7. Acceptance by my health care representative

I accept this appointment and agree to serve as health care representative.

Health care representative:

Homer Simpson

Printed name



Signature or other verification of acceptance

10/25/23

Date

First alternate health care representative:

Lisa Simpson

Printed name



Signature or other verification of acceptance

10/25/23

Date

Second alternate health care representative:

Maggie Simpson

Printed name



Signature or other verification of acceptance

10/25/23

Date

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhscha.state.or.us.