COLORADO RIVER INDIAN TRIBES LEGAL AID DEPARTMENT
APPLICATION FOR SERVICES

Applicant Information (must be enrolled, or eligible to be enrolled with CRIT):

Name: _____ DOB: _____

Mailing Address: _____ Day Phone: _____

_____ Eve. Phone: _____

Physical Address: _____ Fax: _____

_____ Cell Phone: _____

E-Mail: _____ Enrollment No.: _____

SSN: XXX-XX-_____

Applicant is seeking assistance with: (please mark which box(es) applies)

- ☐ Child Support (Defense)
- ☐ Child Support (Seeking)
- ☐ Child Custody (Defense)
- ☐ Child Custody (Seeking)
- ☐ Guardianship of a Minor
- ☐ Conservatorship of Adult
- ☐ Paternity (for Enrollment)
- ☐ Child In Need of Care
- Power of Attorney:
  - ☐ Durable
  - ☐ Healthcare
  - ☐ Parental

- ☐ Estate Planning (Writing a Will)
- ☐ Probate of an Estate
- ☐ Grievance
- ☐ Small Claims
- ☐ Personal Injury
- ☐ Restraining Orders/Injunctions
- ☐ Dissolution of Marriage (no kids)
- ☐ Dissolution of Marriage (with kids)
- ☐ Property Dispute
- ☐ Housing Dispute
- ☐ Name Change
- ☐ Other: _____

In order to determine whether there are conflicts, please provide as many details as possible:

Please list the full names and approximate ages of each person involved in your issue:

1 _____

2 _____ Approximate Age: _____

3 _____ Approximate Age: _____

4 _____ Approximate Age: _____

5 _____ Approximate Age: _____

Approximate Age: _____

Please describe any previous services you have received from Legal Aid:

_____

_____

_____

_____

For Office Use Only:

Referral Required? Yes No

Office File No.: _____

DURABLE HEALTHCARE POWER OF ATTORNEY SUPPLEMENTAL (2)

This application is for a Durable Healthcare Power of Attorney. A Durable Healthcare Power of Attorney is a grant of authority to another person of all authority and rights to make medical decisions on your behalf an "Attorney-In-Fact." It lasts until either (1) it is revoked by the Principal/You, or (2) it is revoked by a Court. A Durable Healthcare Power of Attorney does not have to be approved by a court; the Principal and one witness needs to sign the document and have it notarized. The Witness should be someone other than the Attorney-In-Fact.

Please complete the following information about the PRINCIPAL (if the Principal is not the Applicant):

Name: _____ **DOB:** _____

Mailing Address: _____ **Day Phone:** _____

_____ **Eve. Phone:** _____

Physical Address: _____ **Fax:** _____

_____ **Cell Phone:** _____

E-Mail: _____ **Enrollment No.:** _____

SSN: XXX-XX- _____

Please complete the following information about the AGENT/ATTORNEY-IN-FACT:

Name: _____ **DOB:** _____

Mailing Address: _____ **Day Phone:** _____

_____ **Eve. Phone:** _____

Physical Address: _____ **Fax:** _____

_____ **Cell Phone:** _____

E-Mail: _____ **Enrollment No.:** _____

SSN: XXX-XX- _____

Information about an ALTERNATE AGENT/ATTORNEY-IN-FACT (optional):

Name: _____ **DOB:** _____

Mailing Address: _____ **Day Phone:** _____

_____ **Eve. Phone:** _____

Physical Address: _____ **Fax:** _____

_____ **Cell Phone:** _____

E-Mail: _____ **Enrollment No.:** _____

SSN: XXX-XX- _____

DURABLE HEALTHCARE POWER OF ATTORNEY SUPPLEMENTAL (3)

Effective Date of your Durable Healthcare Power of Attorney: _____

A Durable Healthcare Power of Attorney authorizes your agent to make medical decisions for you. Examples of the types of medical decisions that the Agent can make for you include: refusing or authorizing care/disgnosis/surgery/therapy/etc., use funds from your estate to pay for medical services, approve or deny admission into hospitals/clinics/nursing homes/assisted living centers/behavioral health facilities, and having access and control of your medical records. If you are able to be consulted, the agent is obligated to discuss decisions with you. You may expressly limit certain types of decisions if you decide.

Are there any specific types of decisions that you wish to limit your agent from making? If so, please describe below:

_____

_____

_____

_____

_____

What are your desires about having an autopsy performed on you? (Check one)

☐ You **DO** consent to (or want) an autopsy.
☐ You **DO NOT** consent to (or want) an autopsy.
☐ You want to leave it to your Agent to approve or deny an autopsy.

What are your desires about organ donation? (Check one/Elaborate where appropriate)

☐ You **DO NOT** want to make an organ or tissue donation.
☐ You **DO** want to make an organ or tissue donation, and your specific instructions:

Please describe what organs/tissues you choose to donate:

☐ Any needed parts or organs.
☐ These specific organs or parts:

_____

_____

_____

_____

Please specify (if any) the purpose(s) of your organ/tissue donation:

☐ Any legally authorized purpose.
☐ Transplant or therapeutic purposes only.
☐ Other specific purposes:

_____

_____

_____

_____

DURABLE HEALTHCARE POWER OF ATTORNEY SUPPLEMENTAL (4)

Please specify (if any) any organization or person to whom you wish to donate your organ(s)/tissue:

☐ You authorize your Agent to make this decision.

☐ You would like your organ/tissue donation to go do the following individual/institution:_____

_____

_____

_____

☐ You have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

_____

_____

_____

Funeral and Burial Choices (optional):

(Below, you can check what funeral and burial desires you have. This is optional.)

☐ Upon your passing, you direct your body to be buried.

☐ Upon your passing, you direct your body to be buried at:

☐ Upon your passing, you direct your body to be cremated.

☐ Upon your passing, you direct your body to be cremated, and your ashes to be:

_____

_____

_____

☐ Upon your passing, you leave it to your Agent to make funeral and burial decisions.

Do-Not-Resuscitate Directives:

<u>Important information</u>: A Pre-Hospital Medical Care Directive (also known as a Do-Not-Resuscitate or "D.N.R." Directive) is instructions regarding any directives for a hospital or EMT's to take or not take to prolong your life. If you wish to have a D.N.R. drawn up, it should be done at your Primary Care Physician's Office because it requires their signature, and it has to be printed on ORANGE paper. If you have a D.N.R. Directive already, you should attach a copy of it to this Durable Healthcare Power of Attorney.

Living Wills:

<u>Important information</u>: A Living Will is another healthcare directive that has a legally-prescribed form on the website of the Arizona Attorney General. The difference between a D.N.R. and a Living Will is that the Living Will talks about certain standards of care you desire if you have an incurable disease. When you come to our office to review your Durable Healthcare Power of Attorney for signature, we can review the Living Will form, and if you decide to execute one, we can do that.

DURABLE HEALTHCARE POWER OF ATTORNEY SUPPLEMENTAL (5)

Do you grant your Agent the ability to obtain and control your healthcare records, and thereby waive your confidentiality under the Health Insurance Portability and Accountability Act of 1996? (Also known as a "HIPAA Waiver").

☐ Yes
☐ No

Be advised that in order to revoke a Durable Healthcare Power of Attorney, you are required to execute a new formal "revocation" document in the same manner as the Durable Healthcare Power of Attorney, and deliver copies to any person or institution that knows about the original Durable Healthcare Power of Attorney. Until those persons or institutions receive a copy of the "revocation," those persons or institutions may continue to act and are immune from liability until you deliver a copy of the "revocation" to them.

By signing this form, you are requesting services by the Legal Aid Department and waiving privacy to any third-party for the purposes of that service; you promise to update the Legal Aid Department of any change of contact information during the period of representation. The Legal Aid Department does not charge C.R.I.T. community members for services, but any fees (i.e., court filing fees) are the responsibility of the applicant. There are no court fees for a Power of Attorney. If Legal Aid cannot take you on as a client for conflicts, we may seek approval for a referral.

Applicant Signature: _____ Date: _____