Triage Cancer Estate Planning Toolkit: Arkansas

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Arkansas probate courts accept written wills and holographic wills. To make a valid written will in Arkansas:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Arkansas. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Due to the COVID-19 pandemic, Arkansas now allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Arkansas:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written entirely in your handwriting and you must sign it.
3. Three disinterested witnesses, or witnesses not related to you or named in your will, must verify your handwriting.

However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Arkansas's power of attorney statutory form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate

otherwise in the "special instructions" section, your agent is entitled to reasonable compensation for their help. This document goes into effect when you sign it, unless you indicate otherwise in the "special instructions" section. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to make decisions for yourself. In Arkansas, most people over 18 years old, and emancipated minors, can complete an advanced health care directive called "Health Care Decision Forms."

This document contains two parts.

Advance Care Plan: You can state your wishes about your health care in advance, in case you become unconscious or unable to make them. In Arkansas, this form allows you to:

1. Choose a health care agent to make health care decisions for you
2. Indicate what quality of life outcome would be unacceptable to you, and that you want doctors to help maintain your acceptable quality of life, , including pain management
3. Indicate what treatment you would like and not like if your quality of life becomes unacceptable as defined by you above
4. Choose if you would like to make an organ donation
5. Other directions for your care

There are limits to this document. If you are pregnant and your declaration would interfere with facilitating life-sustaining treatment to the fetus, then it will not be honored.

Appointment of a Health Care Agent: allows you to choose your health care agent to make medical decisions for you if you are unable to. You can also name an alternate.

To make your Health Care Decision Forms legal, you must:

1. Be at least 18 years old, or an emancipated or married minor
    - Sign the document in front of two witnesses (who are at least 18 years old) or have it notarized. Additionally, one witness must: Not be related by blood, marriage or adoption and
    - Not benefit from your estate

You can change the directions in your advance health care directive at any time, by notifying your doctor or other health care professional.

You can change or take back your proxy's power by creating a new durable power of attorney for health care, or by indicating you want to take back their power in writing.

Part III includes documents for the Arkansas Durable Power of Attorney for Health Care.

State Laws About POLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You can complete a POLST form with your doctor. In Arkansas, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)

- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes. You can request alternative treatment or revoke a POLST at any time, as long as you are still capable of making your own decisions.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

A 2009 Arkansas law protects your right to having your funeral wishes honored. With Arkansas's Right of Disposition Form, you can specify an agent to make all decisions about the disposal of your remains, or provide directions for how they should do so. To be valid, this document must be signed by you and two witnesses.

Once you complete this document, your wishes cannot be overridden by the wishes of your family. Part III includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Arkansas does not have a death with dignity law. But, you can indicate other preferences for end-of-life care through an advanced health care directive or POLST.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: Arkansas

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Health Care Decision Forms
- Physician Order for Life-Sustaining Treatment (POLST)
- Right of Disposition Form
- HIPAA Authorization Form

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

ARKANSAS
STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68.

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

IF YOU HAVE QUESTIONS ABOUT THE POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT, YOU SHOULD SEEK LEGAL ADVICE BEFORE SIGNING THIS FORM.

DESIGNATION OF AGENT

I, _____, name the following person as my agent:

Name of Agent: _____
Agent's Address: _____
Agent's Telephone Number: _____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____
Successor Agent's Address: _____
Successor Agent's Telephone Number: _____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial “All Preceding Subjects” instead of initialing each subject.)

(___) Real Property
(___) Tangible Personal Property
(___) Stocks and Bonds
(___) Commodities and Options
(___) Banks and Other Financial Institutions
(___) Operation of Entity or Business
(___) Insurance and Annuities
(___) Estates, Trusts, and Other Beneficial Interests
(___) Claims and Litigation
(___) Personal and Family Maintenance
(___) Benefits from Governmental Programs or Civil or Military Service
(___) Retirement Plans
(___) Taxes
(___) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: **Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.** INITIAL ONLY the specific authority you WANT to give your agent. If you DO NOT want to give any of these powers to your agent, do not initial anything.)

(___) Amend, revoke, or terminate an inter vivos trust
(___) Make a gift, subject to the limitations of § 28-68-217 of the Uniform Power of Attorney Act and any special instructions in this power of attorney
(___) Create or change rights of survivorship
(___) Create or change a beneficiary designation
(___) Authorize another person to exercise the authority granted under this power of attorney
(___) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(___) Exercise fiduciary powers that the principal has authority to delegate

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____
_____
_____
_____
_____
_____

EFFECTIVE DATE

Please indicate when you want your Power of Attorney to become effective:

_____ This power of attorney is effective immediately unless I have stated otherwise.

_____ This power of attorney shall become effective only upon my disability or incapacity and shall endure through such events.

For purposes of determining my incapacity, I shall be deemed to be incapacitated in the event my agent shall come into possession of either of the following:

(1) A valid court order appointing a guardian or conservator of my person or estate, or otherwise holding me to be legally incapacitated to act on my own behalf; or

(2) A duly executed and acknowledged written certificate of a licensed physician certifying that such physician has examined me and has concluded that by reason of accident, physical or mental illness, deterioration, or other similar cause, I have become incapacitated and unable to act rationally and prudently in financial matters.

Such incapacity shall be deemed to continue until such court order or certificate have become inapplicable or have been revoked. A physician's certificate may be revoked by a similar certificate to the effect that I am no longer incapacitated, executed either (i) by the originally certifying physician or (ii) by another licensed physician.

I hereby authorize the physician(s) who examine me for the purposes of determining my incapacity to disclose my physical or mental condition to the person(s) named herein as my agent and attorney-in-fact. This authorization is intended to comply with the requirements of the Health insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.]

_____ This power of attorney is only effective from _____ to _____.

_____ Other. Please specify. _____
_____
_____

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for guardian of my estate: _____
Nominee's Address: _____
Nominee's Telephone Number: _____
Name of Nominee for guardian of my person: _____
Nominee's Address: _____
Nominee's Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

_____ _____
Signature Date

_____
NAME

_____ _____
ADDRESS PHONE NUMBER

_____
ADDRESS

ACKNOWLEDGMENT

STATE OF ARKANSAS)
COUNTY OF _____)

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the individual, _____. The individual personally appeared before me and signed above or acknowledged the signature above as his or her own on the _____ day of _____, 20___. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:
(1) do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) act in good faith;
(3) do nothing beyond the authority granted in this power of attorney; and
(4) disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as “agent” in the following manner:

(Principal's Name) by (Your Signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:
(1) act loyally for the principal's benefit;
(2) avoid conflicts that would impair your ability to act in the principal's best interest;
(3) act with care, competence, and diligence;
(4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and
(6) attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:
(1) death of the principal;
(2) the principal's revocation of the power of attorney or your authority;
(3) the occurrence of a termination event stated in the power of attorney;
(4) the purpose of the power of attorney is fully accomplished; or
(5) if you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68. If you violate the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

ARKANSAS
STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68.

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

IF YOU HAVE QUESTIONS ABOUT THE POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT, YOU SHOULD SEEK LEGAL ADVICE BEFORE SIGNING THIS FORM.

Commented [O1]: Depending on the instructions you include in your power of attorney, you could be giving someone the authority to sell your home, add their name to your bank account, sell your investments or take other meaningful steps that could harm you financially. Consider limiting the powers you give away to what is actually necessary and seek legal advice if you are at all confused.

DESIGNATION OF AGENT

I, _____, name the following person as my agent:

Name of Agent: _____
Agent's Address: _____
Agent's Telephone Number: _____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____
Successor Agent's Address: _____
Successor Agent's Telephone Number: _____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(___) Real Property
(___) Tangible Personal Property
(___) Stocks and Bonds
(___) Commodities and Options
(___) Banks and Other Financial Institutions
(___) Operation of Entity or Business
(___) Insurance and Annuities
(___) Estates, Trusts, and Other Beneficial Interests
(___) Claims and Litigation
(___) Personal and Family Maintenance
(___) Benefits from Governmental Programs or Civil or Military Service
(___) Retirement Plans
(___) Taxes
(___) Gifts
(___) All Preceding Subjects

Commented [O2]: Fill in your name. The person making the form should be the person who wants to designate powers to someone else.

Commented [O3]: The agent is the person who will act on your behalf regarding your finances.

Commented [O4]: The successor agent is the person who will make financial decisions for you if your agent can't act for you.

Commented [O5]: If you don't want to name anyone, just leave blank.

Commented [O6]: All of the options in this list are specifically defined by Arkansas law and are referenced if you check the box. For example, real property includes selling, mortgaging, managing, giving away and insuring real property among other things. Carefully consider if you want to provide all of the powers that are described when you click on the link before initialing.

Commented [O7]: You won't be able to manage Social Security benefits from a POA. Your agent could try to become a representative payee to manage these benefits.

Commented [O8]: You can initial just this one if you want your agent to do all of the above.

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: **Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.** INITIAL ONLY the specific authority you WANT to give your agent. If you DO NOT want to give any of these powers to your agent, do not initial anything.)

(___) Amend, revoke, or terminate an inter vivos trust
(___) Make a gift, subject to the limitations of § 28-68-217 of the Uniform Power of Attorney Act and any special instructions in this power of attorney
(___) Create or change rights of survivorship
(___) Create or change a beneficiary designation
(___) Authorize another person to exercise the authority granted under this power of attorney
(___) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(___) Exercise fiduciary powers that the principal has authority to delegate

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____
_____
_____
_____
_____
_____

Commented [O9]: Most people do not mark the boxes in this section because they give away great powers that may be unintended or that are not in line with the rest of your estate plan.

Commented [O10]: This is a trust that is established during your lifetime that can designate how your property should be managed for you or other beneficiaries you name.

Commented [O11]: This could allow your agent to rename the beneficiary in your life insurance policy.

Commented [O12]: This would give your agent the right to have anyone else they choose to act as your agent, even if that wasn't your original intent.

Commented [O13]: This statement says that your agent should not use his or her power to personally benefit from being named as an agent. Your agent owes you a fiduciary duty to put your interests above their own.

Commented [O14]: You can add in special instructions in these lines. For example, you might want your successor agent to have fewer powers than your original agent. You might want to try to avoid financial abuse by stating that your agent must provide an annual accounting to you and/or another trusted individual you name, that your agent must get your permission before conducting a transaction over a certain dollar amount that you specify or that gives Adult Protective Services the power to revoke this POA if it is determined that your agent was abusing the authority.

EFFECTIVE DATE

Please indicate when you want your Power of Attorney to become effective:

_____ This power of attorney is effective immediately unless I have stated otherwise.

_____ This power of attorney shall become effective only upon my disability or incapacity and shall endure through such events.

For purposes of determining my incapacity, I shall be deemed to be incapacitated in the event my agent shall come into possession of either of the following:

(1) A valid court order appointing a guardian or conservator of my person or estate, or otherwise holding me to be legally incapacitated to act on my own behalf; or

(2) A duly executed and acknowledged written certificate of a licensed physician certifying that such physician has examined me and has concluded that by reason of accident, physical or mental illness, deterioration, or other similar cause, I have become incapacitated and unable to act rationally and prudently in financial matters.

Such incapacity shall be deemed to continue until such court order or certificate have become inapplicable or have been revoked. A physician's certificate may be revoked by a similar certificate to the effect that I am no longer incapacitated, executed either (i) by the originally certifying physician or (ii) by another licensed physician.

I hereby authorize the physician(s) who examine me for the purposes of determining my incapacity to disclose my physical or mental condition to the person(s) named herein as my agent and attorney-in-fact. This authorization is intended to comply with the requirements of the Health insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.]

_____ This power of attorney is only effective from _____ to _____.

_____ Other. Please specify. _____
_____
_____

Commented [O15]: Check one of these four boxes.

Commented [O16]: This section basically says that the POA is "springing," meaning that it only springs into effect IF you become incapacitated. Incapacity is determined by a judge in a guardianship proceeding or other legal action making this finding or a licensed physician writing a certificate to this effect.

Commented [O17]: You can fill in dates.

Commented [O18]: For certain purposes or timeframes, such as only if I am out of the country or only for the transaction to sell my home, etc.

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for guardian of my estate: _____
Nominee's Address: _____
Nominee's Telephone Number: _____
Name of Nominee for guardian of my person: _____
Nominee's Address: _____
Nominee's Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

_____ _____
Signature Date

_____
NAME

_____ _____
ADDRESS PHONE NUMBER

_____
ADDRESS

Commented [O19]: You can NOMINATE a guardian in this section. A guardian is someone who would potentially be able to make decisions about you and your property if you were found to be incapacitated. You are not giving anyone guardianship by filling out this section. You are just saying who you would choose if you could. The proposed guardian would have to petition

Commented [O20]: The person who can make important decisions about your property.

Commented [O21]: The person who can make important decisions about your day-to-day life, such as where you live and what type of medical treatment you receive

Commented [O22]: This says that the bank, creditor, etc. can rely on this form without needing a separate court order.

ACKNOWLEDGMENT

STATE OF ARKANSAS)
COUNTY OF _____)

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the individual, _____. The individual personally appeared before me and signed above or acknowledged the signature above as his or her own on the _____ day of _____, 20___. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

IMPORTANT INFORMATION FOR AGENT

Commented [O23]: Make a copy of your signed POA and give it to your agent. Be sure they read these back pages. Give anyone else who might need a copy to them if you have made the agent's powers effective immediately.

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:
(1) do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) act in good faith;
(3) do nothing beyond the authority granted in this power of attorney; and
(4) disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal's Name) by (Your Signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:
(1) act loyally for the principal's benefit;
(2) avoid conflicts that would impair your ability to act in the principal's best interest;
(3) act with care, competence, and diligence;
(4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and
(6) attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:
(1) death of the principal;
(2) the principal's revocation of the power of attorney or your authority;
(3) the occurrence of a termination event stated in the power of attorney;
(4) the purpose of the power of attorney is fully accomplished; or
(5) if you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68. If you violate the Uniform Power of Attorney Act, Arkansas Code Title 28, Chapter 68, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ ☐ Yes No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ ☐ Yes No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ ☐ Yes No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ ☐ Yes No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT

(Arkansas)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
(_____) _____ Area Code Home Phone Number	(_____) _____ Area Code Home Phone Number
(_____) _____ Area Code Work Phone Number	(_____) _____ Area Code Work Phone Number
(_____) _____ Area Code Mobile Phone Number	(_____) _____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____ Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of witness number 2

Block B Notarization

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____ Signature of Notary Public

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Full Name	Date of Birth	Gender

Physician

Printed Name	Phone Number

Patient's Additional Contact

Printed Name	Phone Number

Directions for Physician Completing POLST Form

Completing the POLST Form

- **No patient is required to complete a POLST form.** The patient (or legal representative) signs the form to indicate the voluntary nature of the form and that the contents of the form are consistent with the patient's desires and values.
- **Upon arrival at or admission to a hospital or other facility, the POLST establishes initial treatment of the patient.** After evaluation of the patient in the hospital or other facility, additional appropriate orders may be issued consistent with the patient's preferences.
- **POLST does not replace a living will or other advance directive.** When available, review the advance directive and POLST form to ensure consistency and update forms appropriately to resolve any conflicts.
- **POLST must be completed by a physician based on patient preferences and values and medical indications.**
- **The legal representative of a patient may sign the POLST form if the patient lacks capacity.** A legal representative may include a court-appointed guardian, an agent designated in an advance directive, a spouse, an adult child, an adult sibling, an adult relative, or another surrogate whom the physician believes has exhibited special care and concern for the patient, is familiar with the patient's values, and will make decisions according to the patient's wishes and values.
- **To be valid, a POLST form must be signed by a physician and the patient or legal representative.** Both signatures are required.
- **If a translated POLST form is used with the patient or legal representative, attach the translation to the signed English POLST form.**
- **It is recommended that the POLST form be printed on bright pink paper, so it can be easily recognized among the patient's paperwork.** Use of the original POLST form is encouraged, but photocopies and faxes are legal and valid under Arkansas law.
- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**

Using POLST

- An incomplete section of the POLST form implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment." If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."

Section C:

- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**
- Depending on local EMS protocol, "Additional Orders" written in Section C may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. In addition, review is recommended when:

- The patient is transferred from one care setting or care level to another; or
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means indicating intent to revoke.
- It is recommended that revocation be documented by drawing a line through Sections A through C, writing "VOID" in large letters, and signing and dating this line. A legal representative of a patient who lacks capacity may request to modify the orders after consulting with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or a copy of the POLST form, visit www. healthy.arkansas.gov.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Arkansas Department of Health

5800 West Tenth Street Suite 400 ● Little Rock, Arkansas 72205-3867 ● Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer
http://www.healthy.arkansas.gov

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

First follow these orders, then contact **Physician**. A copy of the executed POLST form is a legally binding, valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**	Patient Last Name:	Date form Prepared:
	Patient First Name:	Patient Date of Birth:
	Patient Middle Name:	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing.***
NOTE … If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B *Check One*

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort Treatment, use medical treatment and IVs as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

C

ADDITIONAL ORDERS:

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legal Representative

☐ Advance Directive dated _____, available and reviewed
☐ Advance Directive not available.
☐ No Advance Directive.

Signature of Physician My signature below indicates to the best of my knowledge these orders are consistent with the patient's intentions and medical condition.

Print Physician Name:	Physician Phone Number:	Physician License #:
Physician Signature: *(required)*		Date:

Signature of Patient or Legal Representative I am aware my consent to this form is voluntary. By signing this form, a legal representative acknowledges this request regarding resuscitative measures is consistent with the known wishes of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: *(write self if patient)*
Signature: *(required)*	Date:
Mailing Address:	Phone:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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Part III: Your State's Estate Planning Forms

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Funeral Designation Form

State of Arkansas
Directions for the Disposition of My Body at Death

as authorized by statute number § 20-17-102

This law gives your wishes the highest legal priority, and those may not be overridden by kin. You may also appoint a person to carry out your funeral wishes, and this person will have sole legal authority to do so. If you appoint a person to carry out the disposition of your body, you may either a) allow him or her to make all decisions regarding the disposition of your body ***or*** *b) give him or her specific instructions to carry out.*

OPTIONAL (you may describe your funeral wishes below without appointing an agent to carry them out, though it is wise to appoint a person you trust to do so)

I appoint _____ to act as my agent in

carrying out the disposition of my body. My agent:

(Check only one option)

_____ May make any and all decisions about the disposition of my body

OR

_____Shall follow the instructions I have written below

I direct that my body be disposed of in the following manner:

_____

_____

_____

_____

_____

_____ _____
(signature) (date)

_____ _____
(signature of first witness- REQUIRED) (date)

_____ _____
(signature of second witness- REQUIRED) (date)

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524