Triage Cancer Estate Planning Toolkit: Utah

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.

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

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 have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

Due to the COVID-19 pandemic, Utah now allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). 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 Utah:

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 in your handwriting and you must sign it

If you make a holographic will, it does not need to be signed by witnesses. 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.

Utah's power of attorney statutory form allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose an alternate agent, who can act if the first person cannot act. 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 until you die or revoke this document, unless you indicate otherwise in the "special instructions" section

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

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 communicate.

In Utah, this form is called a **Utah Advance Health Care Directive.** You can sign Part I, Part II, or both. But, you must sign Part IV to make the document valid.

- **Part I:** You can choose someone (an agent) to make decisions about your medical care for you, including life-prolonging care, any time your doctor determines you can no longer make these decisions. You can also choose an alternate person if the first person you appoint is not available. You can limit your agent's authority, consent to participate in medical research, and indicate your preferences for organ donation. This document takes effect when your doctor determines you can no longer understand or communicate your preferences for health care.
- **Part II:** Sometimes called a "living will," this document lets you indicate your preferences for health care if you become unable to speak for yourself and are suffering from a terminal illness or condition. You can clarify your preferences for treatments including surgery or other invasive procedures, cardiopulmonary resuscitation (CPR) to restart your heart or breathing, antibiotics, dialysis, chemotherapy, and artificially supplied nutrition and hydration. If you like, you can indicate that you want your agent to make these decisions. You can also indicate whether or not you would like to make an organ donation.
- **Part III:** This section provides instructions for revoking your advance health care directive. You can do this by writing "void" across the form, or destroying it in some other way; signing a written revocation; stating your desire to revoke your advance health care directive in front of an adult witness; or signing a new directive.
- **Signing and Witnessing Provisions:** You must sign your advance health care directive in front of an adult witness. Your witness cannot be:
    - The person who signed the directive for you, if you could not sign it yourself
    - Your agent or alternate agent
    - Related to you by blood or marriage
    - Your doctor or an employee of your doctor
    - Directly financially responsible for your health care
    - Included in your will or entitled to your estate by any other law
    - A beneficiary of your life insurance policy, trust, or other pay on death account
    - Your health care provider or an administrator at your health care facility

If you are pregnant and the decisions you make in this document would interfere with facilitating life-sustaining treatment to the fetus, then it will not be followed.

Part III of this toolkit includes a sample advance health care directive.

State Laws About POLST/MOLST

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 directive. You can complete a POLST form with your doctor.

This form lets you indicate your preferences for:

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

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- 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
- Medically assisted nutrition and hydration, or food and water offered through surgically-placed tubes
- Advance health care directives, if you have one in place, and your preferences

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.

Part III of this toolkit includes a sample form.

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.

Utah's **Funeral Planning Form** and **Appointment of Agent to Control Disposition of Remains** form allow you to express detailed preferences for these processes. The funeral planning form allows you to explain your wishes for the disposition of your remains and funeral arrangements, including music, your final resting place, and favorite flowers for memorials. The appointment of agent form lets you choose someone to oversee the disposition of your remains.

Part III of this toolkit includes sample forms.

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.

Utah does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

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.

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Triage Cancer Estate Planning Toolkit: Utah

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- Funeral Planning Form
- Appointment of Agent to Control Disposition of Remains
- HIPAA Authorization Form

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Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

Power of Attorney for Financial Affairs

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UTAH STATUTORY FORM POWER OF ATTORNEY
Utah Code Sections 75-9-101 et seq.

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 Title 75, Chapter 9, Uniform Power of Attorney Act.

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 co-agent in the Special Instructions.

Co-agents 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 of Principal)
name the following person as my agent:

Name of Agent: ____

Agent's Address: ____

Agent's Telephone Number: ____

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: ______________________________________

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

Name of Second Successor Agent: ____

Second Successor Agent's Address: ____

Second 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 Title 75, Chapter 9, Uniform Power of Attorney Act:

(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.

[ ] Create, amend, revoke, or terminate an inter vivos trust

[ ] Make a gift, subject to the limitations of Section 75-9-217, 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
[ ] Disclaim or refuse an interest in property, including a power of appointment

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:

____
____
____
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____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

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

Name of Nominee for conservator 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 AND ACKNOWLEDGMENT

Your Signature: ______________________________

Date: ______________________________

Your Name Printed: ______________________________

Your Address: ______________________________

Your Telephone Number: ______________________________

On this date, I certify that ______________________________ (name) who is known to me or who presented satisfactory identification, in the form of ______________________________ (form of identification), has, while in my presence and while under oath or affirmation, voluntarily signed this document and declared that it is true.

______________________ Sign here ► ______________________

Date

Typed or printed name (Notary Public) ______________________

Notary Seal

[This document prepared by: ____]

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 shall:

(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 Title 75, Chapter 9, Uniform Power of Attorney Act. If you violate Title 75, Chapter 9, Uniform Power of Attorney Act, 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.

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

Advance Health Care Directive

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Print Form

Utah Advance Health Care Directive

*(Pursuant to Utah Code Section 75-2a-117, effective 2009)**

Part I:	***Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.***
Part II:	***Allows you to record your wishes about health care in writing.***
Part III:	***Tells you how to revoke or change this directive.***
Part IV:	***Makes your directive legal.***

My Personal Information

Name: ____________________

Street Address: ____________________

City, State, Zip Code: ____________________

Telephone: (_______) ____________________ Cell Phone: (_______) ____________________

Birth Date: ____________________

Part I: My Agent (*Health Care Power of Attorney)*

A. No Agent

If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.

[ ] **I do not want to choose an agent.**

B. My Agent

Agent's Name: ____________________

Street Address: ____________________

City, State, Zip Code: ____________________

Home Phone: (_______) ____________________ Cell Phone: (_______) ____________________

Work Phone: (_______) ____________________

C. My Alternate Agent

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Alternate Agent's Name: ____________________

Street Address: ____________________

City, State, Zip Code: ____________________

Home Phone: (_______) ____________________ Cell Phone: (_______) ____________________

Work Phone: (_______) ____________________

D. Agent's Authority

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority

My agent has the powers below only if I initial the "***yes***" option that precedes the statement. I authorize my agent to:

____YES ____ NO Get copies of my medical records at any time, even when I can speak for myself.

____YES ____ NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F. Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent as follows:

____

____

____

G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

____YES ____ NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H. Consent to Participate in Medical Research

____YES ____ NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Organ Donation

____YES ____ NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one *of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

Option 1	
________ Initial	**I choose to let my agent decide.** I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.
Additional comments:	

Option 2	
________ Initial	**I choose to prolong life.** Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.
Additional comments:	

Option 3		
________ Initial	**I choose not to receive care for the purpose of prolonging life,** including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.	
If you choose this option, you must also choose either (a) or (b), below		
________ Initial	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.	
________ Initial	(b) My health care provider should withhold or withdraw life-sustaining care if ***at least one*** of the initialed conditions is met:	
If you selected (a), above, do not choose any options under (b).		I have a progressive illness that will cause death
		I am close to death and am unlikely to recover
		I cannot communicate and it is unlikely that my condition will improve
		I do not recognize my friends or family and it is unlikely that my condition will improve
		I am in a persistent vegetative state
Additional comments:		

Option 4	
________ Initial	I do not wish to express preferences about health care wishes in this directive.
Additional comments	

Part II: My Health Care Wishes (*continued*)

Additional instructions about your health care wishes:

____

____

____

If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. (***If you sign more than one Advance Health Care Directive, the most recent one applies.)***

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

______________________________ ____

Date Signature

____

City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

______________________________________ ______________________________________

Signature of Witness Printed Name of Witness

______________________________________ ____________________ __________ ____________

Street Address City State Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

____

____

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

Physician Orders for Life Sustaining Treatment (POLST)

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Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.1 February 2019 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name		First Name/Middle Initial		Effective Date of this Order	
Date of Birth		Last 4 of SS#		Address (street/city/state/zip)	
Medical Provider's Name (MD/DO/PA/APRN)		Medical Provider's Phone			

Brief description of patient's medical condition

Patient's stated goals for medical care

A. CARDIOPULMONARY RESUSCITATION (CPR)

Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

- ☐ Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
- ☐ Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
- ☐ I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS

Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

☐ **FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.

☐ **LIMITED ADDITIONAL INTERVENTIONS:** *Treating medical conditions while avoiding burdensome measures.* Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.

☐ **COMFORT MEASURES:** *MAXIMIZING comfort and dignity.* Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.

☐ **NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other Instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

C. ARTIFICIAL NUTRITION

- ☐ Long term artificial nutrition with feeding tube
- ☐ Trial period of artificial nutrition with feeding tube
- ☐ No artificial nutrition
- ☐ I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

- ☐ Advance Directive available, reviewed and confirmed without conflicts
- ☐ No Advance Directive available

Health care agent named in Advance Directive | Phone Number

- ☐ I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
- ☐ I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name		Relationship: (write self if patient)		Signature	

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

UTAH POLST UTAH POLST UTAH POLST UTAH POLST UTAH POLST

Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.1 February 2019 (http://health.utah.gov/hflcra/forms.php)

DIRECTIONS FOR HEALTHCARE PROVIDERS

COMPLETING POLST

- This form is intended for both adult and pediatric patients.
- The POLST is not an Advance Directive and does not replace it. The POLST is a Medical Order.
- When available, review the Advance Directive and POLST form to ensure consistency.
- The POLST must be completed by a medical provider (MD/DO/PA/APRN) based on patient preferences and medical indications.
- The entire form should be completed. A patient may indicate that they “do not wish to express a preference” rather than leaving a section of the form blank.
- Section D, which indicates the degree of leeway the patient would like to grant their surrogate, must be completed by the individual patient and only if the patient has medical decision-making capacity.
- The POLST must be signed by the patient or surrogate decision maker AND by a medical provider (MD/DO/PA/APRN) to be valid. In the case of pediatric patients, signatures from two different medical providers are required.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid.

USING POLST

Section A:

- If a patient has selected “Do Not Attempt Resuscitation” and is **found pulse less and not breathing**, no defibrillator (including automated external defibrillators) or chest compressions should be used.

Section B:

- A person may chose “DNR” in Section A and “Full Treatment” in Section B, recognizing in Section A the setting refers to where there are no signs of life (palpable pulse) and Section B refers to the setting where there are signs of life.
- Choosing “Attempt to resuscitate” in Section A requires “Full treatment” in Section B as an attempt at resuscitation may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, and/or vasopressors.
- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort Measures,” may be transferred to the hospital to provide comfort (e.g., treatment of hip fracture).
- If a patient has indicated that he/she would not want to return to the hospital, this should be written in the “other instructions and clarifications” section of the form.
- IV antibiotics and fluids are generally not considered “Comfort Measures” and may prolong life. A person who desires IV fluids or IV antibiotics should indicate “Limited Additional Interventions” or “Full Treatment.”
- Some IV medications (e.g. medication for pain, nausea, delirium, etc.) may be appropriate for a patient who has chosen “Comfort Measures.”

REVIEWING POLST

This form should be reviewed periodically (consider at least annually). Review is also recommended when:

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

MODIFYING AND VOIDING POLST

- The POLST form can be modified at any time if a patient changes his/her mind about his/her treatment preferences by completing a new POLST form.
- If a patient has given sufficient leeway to his/her surrogate to modify the POLST form, any modifications made should be consistent with patient preferences and in collaboration with the medical provider.
- It is recommended that revocation of the form be documented by drawing a line through sections A through D, writing “VOID” in large letters, and signing/dating the form.
- The most recently dated POLST is considered the valid POLST. The most recently dated POLST orders supersede all prior POLST directives.

Place this form in a prominently visible part of the patient’s record or home. A copy of this form must accompany the patient when transferred or discharged (including transfers to hospital emergency departments).

UTAH POLST UTAH POLST UTAH POLST UTAH POLST UTAH POLST

Triage Cancer Estate Planning Toolkit

Part III: Your State’s Estate Planning Forms

Funeral Designation Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Final Arrangements of _______________

(I **Rated** my preferences 1st 2nd 3rd… or **Circled** or **Checked them) Today's date**______________
In a phrase, the basic over-all vision for my ceremony and body disposition (examples: "Traditional but shorter" or "family-only graveside" or "simple and cheap", etc): ____

WHO

1. Person responsible for making arrangements: Next of kin **or** Appointed Agent (a copy assigning the person is attached) name, address and phone:____
(Make sure he/she has a copy of this plan and knows how to get the money to carry it out)
2. Executor for my estate is (name, address, and phone):
____ and knows where I keep my acct #s, deeds, property, safe deposit box key, computer passwords, stocks & bonds certificates, ins. policies, and family jewels. OR I'm not telling___. OR located ______________________.
3. Final disposition should be handled by: ___Mortuary ___My Family ___Appointed Agent ___A Funeral Committee ___Name and phone:____
4. To find contact info of my family and friends see my: ___Computer ___Address book ___Day-planner ___Other Located: ______________________________________ or Ask (name):_______________________

FIRST THING

5. If possible **donate my organs** or tissues: ___ Yes ___No Only: eyes/ tissue/ organs/ bone/ any
(Mortuaries are not to charge extra for servicing a donor. Survivors call 1-800-366-6744 if charged)
6. Donation of body to Science or Education (pre-registration with the U of U is attached.)

NEXT DECISIONS AFTER I'M GONE

7. Within 24 hrs a body must be (I prefer): ___Refrigerated (40 degree room or ice packs)___ Buried ___Embalmed ___Cremated
8. ___Embalm me no matter what ___Don't embalm ___Only Embalm if: ______________________________
9. Body Disposition, I prefer: ___**Whole Body Burial** ___**Cremation (___**I have attached an advance authorization) ___I have a Pacemaker or other implanted device which must be removed before cremation.

10. **Hold a viewing**
I prefer: ___Public ___Private ___Two viewings **Location**: ___home ___chapel ___Mortuary
10a. **Hold a visitation** ___a closed casket ___body not present at all ___Ashes in an urn
I prefer: ___Public ___Private ___Two Visitations **Location**: ___home ___chapel ___ Mortuary

11. Dress me in: ___clothing I own. OR ___new clothing.
What:____
I want to wear my glasses: __________________ Jewelry: __________________________________
Please donate my medical devices/glasses. List:____

THE CASKET

12. I prefer: ___the casket I built (located:___________________) ___buy cheapest ___buy best ___rental ___homemade ___plywood wood ___solid wood ___Steel ___Simple alternative (cardboard) ___Shroud (transported on a bier) Other:__________________ **If lining inside** casket, Color and Type: _______________
Outside of casket, Color?________ A pal (cloth covering over top)?______ Carvings?_______
If Military, Veteran flag will cover casket? Yes__ No__

THE SERVICE

13. Religious Affiliation: ____
14. I prefer: ___**F**uneral with whole body present ___**F**uneral with ashes present ___**M**emorial (A funeral or a social gathering without body present) ___**N**o Service
15. Location: ___Church ___Mortuary ___Home ___Graveside ___Other:______________________
16. Officiate: __Congregation leader __funeral director __family member __other (name):
17. Invited: ___**Public or** ___**Private**
18. Desired Pallbearers:
19. Transport casket by: ___Funeral coach/hearse ___Van ___Truck ___Any

(Note: Family can transport a covered body themselves with a burial transit permit & death certificate)

20. If I die out of state/country, changes?:____
21. Specify any preferences for printed programs:____
22. ___Assigned Speakers ____Open mike ____Both If assigned, names:

22a. Length: __short (under 30min) __medium (30min -60min) __long (over 1hr) __painful (over 1½)

23. Other instructions for speakers: ____
24. Musical numbers or song(s): ____

Person(s) to perform:____

Hymn(s):____

25. Scriptures or readings (such as journal entries or favorite poems): __________________________________

____

FINAL RESTING PLACE

26. I prefer final interment be: ___Cemetery ___Mausoleum/vault ___Scattering ___ A loved one's property ___Niche **Location:**
27. Any special Interment ceremonial instructions:____
28. ____Grave Marker ___Flat Headstone ___Raised Headstone ___Something Natural Special requests:
29. Color Guard? Yes__ No__

MEMORIALS

30. Favorite flowers: ____

I prefer: ___Cut flowers ___Live plants ___Memorial gifts **in lieu of flowers**

My favorite charities are: ____

____

31. **Obituary: N**one (a death notice is published free of charge upon request) **OR I**'ve written my own obituary (attached). **OR I**'d like (name)______________________to write one for me. I'd like included (mark choices): age, birthplace/date, cause of death, marital status, partner's name, parent's names, occupations, college degrees, places lived, memberships held, military service, outstanding work, immediate survivors and the towns or states they live in, #'s of descendants, time and location of funeral or memorial service, preferred charities for memorial contributions, and also:

____

____

____

____

____

____

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

I, the designator, ____being of sound mind, willfully and voluntarily make known my desire that, upon my death, the control of the disposition of my dead body, including the location, manner and conditions of the disposition, and arrangements for funeral goods and services shall be controlled by____, and with respect to that subject only, I hereby appoint the above named person as my "agent to control the disposition of my remains." My designated agent has complete authority to act on my behalf and direct any and all details related to my funeral arrangements that I have not already pre-arranged or authorized, including but not limited to obituary, funeral, or memorial service, cemetery, monument, memorialization, reception, or other related matters.

If I have not executed a written disposition authorization, nor filed or prepaid my arrangements with a licensed funeral establishment or cemetery authority, then I authorize my designated agent to select appropriate funeral arrangements for me including the type, place, and method of the final disposition.

If I have not provided sufficient funds to cover my pre-arrangements, the designated agent is responsible for the balance of my funeral and cemetery costs.

I direct that my estate promptly reimburse my designated agent for any personal funds advanced to pay for my funeral arrangements.

DURATION: This appointment becomes effective upon my death.

PRIOR APPOINTMENTS REVOKED: I hereby revoke any prior appointment of any person to control the disposition of my remains, including (if a different person) a personal representative named in my will (according to Utah code 75-3-701).

RELIANCE: I hereby agree that any cemetery organization, business operating a crematory or columbarium or both, funeral director, embalmer, dispositioner, funeral committee or mortuary, Vital Records Registrar, or Care Facility who receives a copy of this document may act under it. Any modification or revocation of this document is not effective until that business or government agency receives notice of the modification or revocation. No business or agency shall be liable because of reliance on a copy of this document.

ASSUMPTION: THE AGENT BY ACCEPTING THIS APPOINTMENT, ASSUMES THE OBLIGATIONS PROVIDED IN, AND IS BOUND BY THE PROVISIONS OF, UTAH SECTION 58-9-602 which states that a person designated in writing has the first right and duty to control the disposition and funeral arrangements of a deceased person.
All decisions made by my agent with respect to the disposition of my remains shall be binding.
Signatures below as per UTAH SECTIONS 58-9-602(1)(a) and 75-2-502(1)(a)(b)(c)

Designated Agent acceptance of appointment:
Signature
Print Name Date:

Alternate Agent in case Designated Agent can not fulfill assignment:
Signature Date:
Print Name

DESIGNATOR affirms stipulations stated above
Signature Date:
Print Name

Signature Witness 1: Date:
Print Name

Signature Witness 2: Date:
Print Name

Or Notarized:

In the STATE OF UTAH, COUNTY OF

The foregoing instrument was acknowledged before me this______________________(date) by

____(person acknowledging).
(Seal)

Notary Public Printed Name:

My Commission Expires:

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

HIPAA Authorization Form

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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