Triage Cancer Estate Planning Toolkit: District of Columbia

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.

The District of Columbia probate courts accept written and holographic wills. To make a valid written will in DC:

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)
    - Free from coercion or outside pressure
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are not included in your will.

You do not need to have your will notarized for it to be valid in DC.

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

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)
    - Free from coercion or outside pressure
2. Your will must be written entirely 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 their validity 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.

The District of Columbia's statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. 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, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated 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 communicate. In the District of Columbia, this document includes two parts.

District of Columbia Durable Power of Attorney for Health Care: The durable power of attorney for health care lets you chose someone (a proxy) to make medical decisions for you any time you can't. You can also appoint an alternate person to make these decisions if the first person you chose isn't available. If there are directions you want your proxy to follow, you can share those in the "other directions" section.

District of Columbia Declaration: You can state your wishes about your end-of-life health care, in case you become unconscious or unable to make decisions for yourself. It is recommended that you designate the same person as the proxy on your power of attorney for health care to avoid confusion. In DC, this form allows you to:

- Indicate if you would like treatments that would only prolong the process of dying without alleviating pain
- Choose a health care proxy to decide if you should receive life-sustaining treatment
- Indicate if you would like nutrition or hydration withheld on the recommendation of your physician
- Other directions for your care

There are limits to this document. Your proxy does not have the power to authorize abortion, sterilization, psycho-surgery, or convulsive therapy or behavior modification involving averse stimuli, unless authorized by a court.

If would like to make an organ or tissue donation upon your death, you can also complete the Organ Donor Form included in this document.

To make your advance health care directive legal, you must be at least 18 years old and have each document signed by two adult witnesses. None of these documents need to be notarized. Each has its own requirements for witnesses.

- Durable Power of Attorney for Health Care: At least one witness may not be related to you by blood, marriage, or adoption, or inherit anything in your estate. Witnesses cannot:
    - Be your proxy
    - Be your health care provider or an employee of your health care provider
- Declaration: If you are a patient in an intermediate care or skilled care facility, one of your witnesses must be a patient advocate. Witnesses cannot:
    - Be person signing on your behalf (if you are unable to sign yourself)
    - Be related to you by blood, marriage, or adoption
    - Inherit anything in your will
    - Be financially responsible for your care
    - Be your attending doctor of an employee of your health care facility
- Organ Donation Form: At least one of your witnesses must be "disinterested," or not entitled to your organs or anything in your will.

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

You can change the directions in your declaration at document at any time, by destroying the document, creating a dated and signed revocation, or orally revoking this document in front of a witness at least 18 years old, who will sign a statement confirming your revocation.

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

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. In the District of Columbia, this form is called a DC Medical Order for Scope of Treatment, or MOST. The MOST does not replace an advance health care directive. You can complete a MOST 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)
- 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, or food and hydration offered through surgically-placed tubes
- 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.

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.

In the District of Columbia, the **Designation of Agent for Body Disposition After Death** form allows you to designate someone to make decisions about the disposition of your remains and your funeral arrangements. You can also attach specific instructions for these processes for the person you choose to follow.

Part III of this toolkit 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.

DC's Death with Dignity Act of 2016 allows certain adults with terminal illnesses to voluntarily request medication that would hasten death. Qualified patients must:

- Be 18 years or older
- Reside in the District of Columbia
- Be under the care of a physician licensed in the District of Columbia
- Be able to make and communicate medical decisions for yourself
- Be diagnosed with an incurable terminal illness with a prognosis of less than six months to live, confirmed by two physicians (your primary physician and a consulting physician)
- Voluntarily ask for the medication

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 15 days apart.

- Submit a written request for the medication using the required form. This request should come before your second verbal request. There must be two witnesses to the written request. One witness cannot be:
    - A relative by blood, marriage, or adoption
    - A recipient of your estate
    - A part of the health care facility where you are receiving treatment
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis. If this other doctor confirms your information, your primary physician will administer the medication.

Taking aid-in-dying medications will not affect any life, health or accident insurance policies you might have. If you pass away after taking an aid-in-dying medication, your death certificate will indicate that you died naturally from an underlying illness.

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: District of Columbia

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- District of Columbia Durable Power of Attorney for Health Care and Declaration
- DC Medical Order for Scope of Treatment (MOST)
- Designation of Agent for Body Disposition After Death Form
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

Code of the District of Columbia

You Are Here

- ↪ D.C. Law Library
- ↪ Code of the District of Columbia
- ↪ Title 21. Fiduciary Relations and Persons with Mental Illness. [Enacted title]
- ↪ Chapter 21. Uniform General Power of Attorney.
- ↪ § 21–2101. Statutory form of power of attorney.

Previous

Chapter 21. Uniform General Power of Attorney.

Next

§ 21–2102. Durable power of attorney.

Publication Information

Current through July 29, 2021

Last codified D.C. Law:
Law 24-9 effective June 24, 2021
Last codified Emergency Law:
Act 24-312 effective July 29, 2021
Last codified Federal Law:
Public Law approved Jan. 1, 2021

§ 21–2101. Statutory form of power of attorney.

(a) The following statutory form of power of attorney is legally sufficient:

STATUTORY POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT OF 1998. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I _____ (insert your name and address) appoint _____ (insert the name and address of the person appointed) as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

INITIAL ____ (A) Real property transactions, except transactions subject to D.C. Official Code § 42-101.

____ (B) Tangible personal property transactions.

____ (C) Stock and bond transactions.

____ (D) Commodity and option transactions.

____ (E) Banking and other financial institution transactions.

____ (F) Business operating transactions.

____ (G) Insurance and annuity transactions.

____ (H) Estate, trust, and other beneficiary transactions.

____ (I) Claims and litigation.

____ (J) Personal and family maintenance.

____ (K) Benefits from social security, medicare, medicaid, or other governmental programs, or military service.

____ (L) Retirement plan transactions.

____ (M) Tax matters.

____ (N) ALL OF THE POWERS LISTED ABOVE.

YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS: ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT:

UNLESS YOU DIRECT OTHERWISE ABOVE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

This power of attorney will continue to be effective even though I become disabled, incapacitated, or incompetent.

STRIKE THE PRECEDING SENTENCE IF YOU DO NOT WANT THIS POWER OF ATTORNEY TO CONTINUE IF YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this ____ day of _____, ____

_____

(Your Signature)

_____

(Your Social Security Number)

District of Columbia

This document was acknowledged before me on _____ (Date)

by _____ (name of principal)

_____

(Signature of notary public)

(Seal) _____

[My commission expires: _____]

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

(b) A statutory power of attorney is legally sufficient under this chapter if the wording of the form complies substantially with subsection (a) of this section, the form is properly completed, and the signature of the principal is acknowledged.

(c) If the line in front of line (N) of the form under subsection (a) of this section is initialed, an initial on the line in front of any other power does not limit the powers granted by line (N).

(Sept. 18, 1998, D.C. Law 12-147, § 2, 45 DCR 3853; Apr. 12, 2000, D.C. Law 13-91, § 143(b), 47 DCR 520.)

Prior Codifications

1981 Ed., § 21-2101.

Section References

This section is referenced in § 21-2103.

Effect of Amendments

D.C. Law 13-91 validated a previously made technical amendment.

Editor's Notes

Uniform Law: This section is based upon § 1 of the Uniform Statutory Form Power of Attorney Act.

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 1 OF 4

INTRODUCTION

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

This document gives the person you name as your attorney in fact the power to make health-care decisions for you if you cannot make the decisions for yourself.

After you have signed this document, you have the right to make health-care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.

You have the right to take away the authority of your attorney in fact, unless you have been adjudicated incompetent, by notifying your attorney in fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney in fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.

If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney in fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE ATTORNEYS IN FACT

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,_____, of
(name)
_____, hereby appoint:
(home address)

_____
(name of attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment, or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information, and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person(s) to serve in the order listed below:

1. _____
(name of first alternate attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

2._____
(name of second alternate attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

PRINT THE DATE AND YOUR LOCATION AND SIGN THE DOCUMENT

YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 3 OF 4

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

Statement of directives concerning life-prolonging care, treatment, services, and procedures:

_____
_____
_____
_____
_____

Special provisions and limitations:

_____
_____
_____
_____
_____

By my signature I indicate that I understand the purpose and effect of this document.

I sign my name to this form on _____
(date)

at: _____
(address of location)

_____
(signature)

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 4 OF 4

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND DATE THE DOCUMENT AND PRINT THEIR NAMES AND ADDRESSES

WITNESS #1

WITNESS #2

AT LEAST ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT AND SIGN BELOW

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal, or an employee of the health-care provider of the principal.

First Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

Second Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare that I am not related to the principal by blood, marriage, adoption, or domestic partnership, and that I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law. Signature:

Signature: _____ Date _____

Signature: _____ Date _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

DISTRICT OF COLUMBIA DECLARATION – PAGE 1 OF 2

Declaration made this _____ day of _____.
(date) (month, year)

I, _____
(name)

being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Other directions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DISTRICT OF COLUMBIA DECLARATION — PAGE 2 OF 2

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed _____Date_____

Address _____

WITNESSING PROCEDURE

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood, marriage, or domestic partnership, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

TWO WITNESSES MUST SIGN AND DATE HERE

Witness _____Date_____

Witness _____Date_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

DISTRICT OF COLUMBIA ORGAN DONATION FORM

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under District of Columbia law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to District of Columbia law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name_____

Declarant signature_____Date_____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HIPAA PERMITS DISCLOSURE OF THIS DOCUMENT TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

DC Medical Orders for Scope of Treatment (MOST)

Patient Last Name / First Name / Middle Initial

Address

City/State/Zip Code

_____/_____/_____ Date of Birth (MM/DD/YYYY)

_____ _____ _____ _____ Last 4 Digits of SSN (optional)

☐ Male ☐ Female ☐ Transgender ☐ Other

Medical Conditions/Patient Goals:

_____

_____

Instructions for Responding Providers:

FIRST follow these orders, **THEN** contact physician or nurse practitioner. The MOST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a MOST form is always voluntary. Everyone shall be treated with dignity and respect. **PLEASE keep the original or a copy of this MOST form in the patient's medical record. To print the DC MOST form, go to**: dchealth.dc.gov/most

A Check One — Cardio-Pulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

When not in cardiopulmonary arrest, go to part B.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation (DNAR) / Allow Natural Death (AND)**
Choosing **DNAR** will include appropriate comfort measures.

B Check One — Medical Interventions: Person has pulse and/or is breathing.

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures**. Includes care described below. Use medical treatment, IV fluids and cardiac care as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer**: EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional Orders: *(e.g. dialysis)* _____

C Check One — Medical Treatment Preferences:

Medically-assisted Nutrition:
(Always offer food and liquids by mouth if feasible.)

☐ Trial period of medically-assisted nutrition by tube.
(Goal:_____)

☐ No medically-assisted nutrition by tube.

☐ Long-term medically-assisted nutrition by tube.

Antibiotics:

☐ Use antibiotics for prolongation of life.

☐ Do not use antibiotics except when needed for symptom management

Additional orders: *(e.g. dialysis, blood products, implanted cardiac devices. Attach additional orders if necessary.)*

DC HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

D Signatures:

The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by an authorized representative, the patient must be mentally incapacitated and the person signing is the legal authorized representative.

Discussed with:	PRINT — MD/DO/APRN Name ***(required)***	Phone Number
☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Domestic Partner ☐ Health Care Agent (Durable Power of Attorney for Healthcare) ☐ Adult child of patient	X MD/DO/APRN Signature ***(required)***	Date ***(required)***
	MD/DO/APRN License Number ***(required)***	
PRINT — Patient or Legal Authorized Representative Name		Phone Number
X Patient or Legal Authorized Representative Signature ***(required)***		Date ***(required)***

Person has: ☐ Health Care Directive (Living Will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany MOST

KEEP ORIGINAL DC MOST FORM WITH PATIENT'S MEDICAL RECORDS

Health Care Professional Information:

NOTE: A person with capacity may always consent to or refuse medical care interventions, regardless of information represented on any document, including this one.

Completing MOST

- Completing a MOST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their authorized representative and medical provider based on the person's preferences and medical condition.
- MOST must be signed by a MD/DO/APRN and patient, or their authorized representative, to be valid. Verbal orders are acceptable with follow-up signature by a MD/DO/APRN in accordance with facility/community policy.

Using MOST

- Any incomplete section of MOST implies full treatment for that section.
- This MOST is valid in all care settings including hospitals until replaced by new physician orders.
- The MOST is a set of medical orders.
- The MOST does not replace an advanced directive.
- An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name an authorized representative decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A, B and C:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation"
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment".
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment".
- Oral fluids and nutrition must always be offered if medically feasible.

SECTION D:

- Patient/Authorized Representative and MD/DO/APRN signatures.

Reviewing MOST

This MOST should be reviewed periodically whenever:

1. The person is transferred from one care setting or care level to another,
   or
2. There is a substantial change in the person's health status,
   or
3. The person's treatment preferences change.

To void this form, draw a line through "Medical Orders" and write "VOID" in large letters. Any changes require a new MOST.

Review of this MOST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

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Photocopies and faxes of signed MOST forms are legal and valid. May make copies for records.

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Funeral Designation Form

DISTRICT OF COLUMBIA
DESIGNATION OF AGENT FOR BODY DISPOSITION AFTER DEATH
As authorized by DC Code: §3-413

I, _____, do hereby designate

_____ as the sole person who will have the right to determine and decide the disposition of my remains upon my death and the arrangements for funeral goods and services. I:

____have

____have **not**

attached specific directions concerning the disposition of my remains. If I have attached specific directions, the designee shall substantially comply with the specific directions, provided the directions are lawful and there are sufficient resources in my estate to carry out the directions.

_____ _____
(sign your name) (date)

_____
(print your name)

Witness *(optional)*

_____ _____
(sign your name) (date)

_____

Triage Cancer Estate Planning Toolkit

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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