Triage Cancer Estate Planning Toolkit: Massachusetts

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.

Massachusetts probate courts accept written and handwritten wills. To make a valid written will in Massachusetts:

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 or authorize someone to do so for you, 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 Massachusetts, but you might want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

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

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 in front of two witnesses who are not included in your will.

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.

In Massachusetts, a general durable power of attorney allows you to appoint someone (your "attorney-in-fact") to manage all of your property, access your tax records, enter safety deposit boxes on your behalf, and take any other actions they think are appropriate for your well-being. This document should include the words "This power of attorney shall not be affected by subsequent disability or incapacity of the principal, or lapse of time,'' or ''This power of attorney shall become effective upon the disability or incapacity of the principal.'' The first statement indicates that you want this document to go into effect upon you signing. Alternatively, the second indicates that your agent should take over if you become incapacitated at some point.

Part III 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 Massachusetts, this document is called a Massachusetts Health Care Proxy.

Massachusetts Health Care Proxy: This document allows you to appoint someone (your "proxy") to make any and all health care decisions for you, including decisions about life-prolonging care, if your doctor determines you can no longer make or communicate these decisions yourself. You can also choose an alternate person if the first person you appoint is not available.

To make this document legal, you need to sign it (or direct someone to sign it for you) in front of two adult witnesses who believe you are at least 18 years old, of sound mind, and not acting under constraint or undue influence (under pressure). Your proxy cannot act as a witness.

You can revoke this document at any time by:

- Notifying your agent or doctor, either orally or in writing
- Destroying the document
- Creating another Health Care Proxy

If you designate your spouse as your proxy and you later get divorced, your health care proxy is automatically revoked.

Part III includes a sample form.

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 Massachusetts, this form is called a medical order for scope of treatment (MOST). The MOST does not replace an advance directive. You can complete a MOST form with your doctor. This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation after cardiac and/or pulmonary arrest (also known as a "Do not resuscitate," or DNR order)
- Invasive Intubation and artificial ventilation
- Hospital transfers
- Non-invasive ventilation
- Artificially-administered fluids and nutrition
- Dialysis

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 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.

Massachusetts does not currently have a funeral designation 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.

Massachusetts 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.

Triage Cancer Estate Planning Toolkit: Massachusetts

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Massachusetts Health Care Proxy
- Medical Order for Scope of Treatment (MOST)
- HIPAA Authorization Form

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Power of Attorney for Financial Affairs

GENERAL DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS that I, _____ of _____, County of _____, State of _____, do hereby make, constitute and appoint _____ of _____, County of _____, State of _____, my true and lawful attorney for me and in my name, place and stead, generally to act as my agent or attorney in fact in relation to all matters in which I may be interested or concerned, not including matters about which I have authorized my Health Care Agent to make decisions, and as such to do all acts and things and to execute all instruments as fully and effectually in all respects as I myself could do if personally present, excepting only such acts and things as the law of the place where they are to be done (including the conflicts of law rules) or their nature would make impossible, it being my intention, regardless of the mention hereafter of any powers which may be specifically included in this general power, to make this a full, complete and general power of attorney. This power of attorney shall not be affected by my subsequent disability or incapacity.

I give unto my said attorney in fact full authority and power to do whatsoever is requisite and necessary to be done in the foregoing, as fully as I could if personally present, with full power of substitution, hereby ratifying and confirming all that my said attorney or his substitute shall lawfully do, or cause to be done by virtue hereof.

It is my specific intent that the attorney appointed under this power take whatever actions he may deem necessary or desirable to provide for my wellbeing, including without limitation my housing. I also include in the aforesaid general power, without in any way limiting its generality, the power to exercise general control and supervision over all my property, both real and personal, wherever situated; to collect all dividends, interest, rents and other income; and to deposit and withdraw monies in any accounts at any bank or trust company.

I covenant for myself, my heirs, executors, and assigns to hold said attorney harmless from any liability for any acts, otherwise proper, performed under this power after my death or other incapacity may have revoked it, so long as such acts are performed by said attorney in good faith and in the belief that this power is still in effect and my said attorney shall not be deemed to have acted in bad faith merely because of doubts raised by unconfirmed reports of my death or other incapacity.

Specifically, and without in any way limiting the generality of the foregoing, I give my said attorney the authority:

- To transfer, convey and deliver any and all of my property, real and personal, and to do all things necessary or convenient to accomplish the same, including without limitation the power to sign, seal, execute and deliver deeds, bills of sale, and stock powers;

- To receive, endorse, collect, negotiate and deposit checks payable to my order, including Social Security checks and other checks drawn on the Treasurer of the United States, and

to give full discharge for the same, and to draw checks and withdrawal orders on any checking or savings account or certificate standing in my name;

- To collect any and all claims and demands of every nature and description which I may now or hereafter have and to prosecute and defend any lawsuits involving me or my property and to adjust by compromise or arbitration any claims in my favor or against me;

- To execute and file any and all income and other tax returns and declarations of estimated tax required to be filed by me, to receive any tax refund due me, to receive any communications with respect to any tax, and to appear for me and represent me before the United States Treasury Department and any state or municipal or other agency in connection with any matter involving federal, state or local taxes;

- To enter any safe deposit box standing in my name alone or jointly with any other person, to remove any or all of the contents thereof, and to close any such box;

- To assign or surrender any life insurance policies I may own;

- To make charitable gifts on my behalf; and

- To take any other actions which my said attorney may, in her sole discretion, deem necessary or appropriate for the management of my financial affairs or for the financial well-being of me or my family.

I hereby give my said attorney-in-fact full authority and power to do everything whatsoever requisite or necessary to accomplish the foregoing, as fully as I could or might do if personally present, and ratify and confirm all that said attorneys-in-fact shall lawfully do by virtue hereof, it being my intention to make this power as general and complete as possible.

Wherever in the above document the pronoun "he" or "his" is used it shall apply to the feminine gender where appropriate.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____ day of _____, 20___.

_____

COMMONWEALTH OF MASSACHUSETTS

County of _____, ss.

On this _____day of _____, 20___, before me, _____, the undersigned notary public, personally appeared _____ (name of document signer), proved to me though satisfactory evidence of identification, which was _____, to be the person whose name was signed on the preceding attached document in my presence.

_____
Official Signature of Notary Public

_____
Printed Name of Notary

My Commission Expires:_____

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Advance Health Care Directive

MASSACHUSETTS HEALTH CARE PROXY – PAGE 1 OF 4

APOINTMENT OF AGENT

PRINT YOUR NAME

(1) I, _____, hereby appoint

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

_____

_____

(name, home address and telephone number of proxy)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise below.

This Health Care Proxy shall take effect in the event that a determination is made by my attending physician that I lack the capacity to make or to communicate my own health care decisions. My attending physician shall make such determination in writing, and shall include his or her opinion regarding the cause and nature of my incapacity, as well as its extent and probable duration.

(OPTIONAL) PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

(2) Name of alternate agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent (optional):

_____

_____

(name, home address and telephone number of alternate agent)

(3) I direct my agent to make health care decisions in accord with my wishes and limitations as may be stated below, or as he or she otherwise knows. If my wishes are unknown, I direct my agent to make health care decisions in accord with what he or she determines to be my best interest.

INSTRUCTIONS

(OPTIONAL) 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

(4) Other directions (optional):

(Attach additional pages, if needed.)

DONATION OF ORGANS (OPTIONAL)

DONATION OF ORGANS (OPTIONAL)

Initial the line next to the statements below that best reflect your wishes. If you do not complete this section, your spouse, adult children, parents, adult siblings, or health care agent, in that order of priority, will have the authority to make a gift of a part of your body pursuant to law unless you give them notice orally or in writing that you do not want a gift made. The donation elections you make below survive your death.

I hereby make this organ and tissue gift, if medically acceptable, to take effect upon my death. The words and marks (or notations) below indicate my desires:

(7) Upon my death, I wish to donate:
_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes;

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

I authorize the use of my organs, tissues, or eyes:
_____For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

Limitations or special wishes, if any, list below:

LIST ANY LIMITAITONS OR SPECIAL WISHES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Attach additional pages, if needed.)

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

EXECUTION

(5) Signature: _____

Name: _____

Date: _____

Address: _____

_____

Statement by Witnesses

I declare that the person who signed this document appears to be at least eighteen years of age, of sound mind, and under no constraint or undue influence. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as agent or alternate agent by this document.

Witness 1 Signature: _____

Name: _____

Address: _____

_____

Date: _____

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 2 Signature: _____

Name: _____

Address: _____

_____

Date: _____

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

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Physician Orders for Life Sustaining Treatment (POLST)

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT

(MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A — Mark one circle ➔

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

0 Do Not Resuscitate 0 Attempt Resuscitation

B — Mark one circle ➔

VENTILATION: for a patient in respiratory distress

0 Do Not Intubate and Ventilate 0 Intubate and Ventilate

Mark one circle ➔

0 Do Not Use Non-invasive Ventilation (e.g. CPAP) 0 Use Non-invasive Ventilation (e.g. CPAP)

C — Mark one circle ➔

TRANSFER TO HOSPITAL

0 Do Not Transfer to Hospital (*unless needed for comfort*) 0 Transfer to Hospital

PATIENT or patient's representative signature

D *Required*

Mark one circle and fill in every line for valid Page 1.

Mark one circle below to indicate who is signing Section D:

o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

X _____ _____

Signature of Patient (or Person Representing the Patient) Date of Signature

_____ _____

Legible Printed Name of Signer Telephone Number of Signer

CLINICIAN signature

E *Required*

Fill in every line for valid Page 1.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

X _____ _____

Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature

_____ _____

Legible Printed Name of Signer Telephone Number of Signer

Optional Expiration date (if any) and other information

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____

Health Care Agent Printed Name _____ Telephone Number _____

Primary Care Provider Printed Name _____ Telephone Number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable_____

F — Statement of Patient Preferences for Other Medically-Indicated Treatments

INTUBATION AND VENTILATION			
Mark one circle ➔	O Refer to Section B on Page 1	O Use intubation and ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
Mark one circle ➔	O Refer to Section B on Page 1	O Use non-invasive ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
DIALYSIS			
Mark one circle ➔	O No dialysis	O Use dialysis O Use dialysis, but short term only	O Undecided O Did not discuss
ARTIFICIAL NUTRITION			
Mark one circle ➔	O No artificial nutrition	O Use artificial nutrition O Use artificial nutrition, but short term only	O Undecided O Did not discuss
ARTIFICIAL HYDRATION			
Mark one circle ➔	O No artificial hydration	O Use artificial hydration O Use artificial hydration, but short term only	O Undecided O Did not discuss

Other treatment preferences specific to the patient's medical condition and care _____

_____

_____

PATIENT or patient's representative signature — G — *Required*

Mark one circle and fill in every line for valid Page 2.

Mark one circle below to indicate who is signing Section G:

o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

X _____ _____

Signature of Patient (or Person Representing the Patient) | Date of Signature

_____ _____

Legible Printed Name of Signer | Telephone Number of Signer

CLINICIAN signature — H — *Required*

Fill in every line for valid Page 2.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.

X _____ _____

Signature of Physician, Nurse Practitioner, or Physician Assistant | Date and Time of Signature

_____ _____

Legible Printed Name of Signer | Telephone Number of Signer

Additional Instructions For Health Care Professionals

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.

→ Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*

→ Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

Massachusetts Medical Orders for Life-Sustaining Treatment

IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.

- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.

- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.

- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients.

- Listen to *MOLST Overview for Health Professionals* at: http://www.molst-ma.org/molst-training-line.

- Access the MOLST website at: http://www.molst-ma.org periodically for MOLST form updates.

- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit http://www.molst-ma.org.

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* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at http://www.staples.com, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at http://www.officedepot.com.

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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