# Triage Cancer Estate Planning Toolkit: Maryland

## 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.

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

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.
3. Your will does not need to be notarized to be legal in Maryland. However, you can 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.

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

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

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 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.

Maryland'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. You can also appoint up to three successor agents, in case your first choice is not available. 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. If you do not set a specific time period for your power of attorney, it will remain in effect until you die, revoke your power of attorney, or a court revokes your power of attorney.

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 Maryland, this document contains three parts. You can complete part one and/or part two, but you must sign part three to make the document valid.

1. **Selection of Health Care Agent:** You can appoint someone (your "agent") to make any and all health care decisions for you, including decisions about life-prolonging care, any time your doctor determines you can no longer make these decisions yourself. You can include instructions for specific situations, including if you are pregnant. You can also choose an alternate person if the first person you appoint is not available, and a second alternate.
2. **Treatment Preferences:** Also called a "living will," you can use this document to express your preferences for life-sustaining care in case you become seriously ill or permanently unconscious. This includes specific situations, including administering or withholding life-prolonging procedures, artificially administered nutrition (food offered through surgically-placed tubes), choices for life-prolonging care while pregnant, and any other instructions you would like to include.
3. **Execution:** You must sign your advance health care directive in front of two witnesses to make it valid. Your witnesses cannot be your agent, and one of your witnesses cannot knowingly inherit anything from your will or benefit from your death. Attached to this form is the "After my Death" form, where you can indicate your preferences for funeral arrangements, your remains, and organ donation. This must be signed by you and two witnesses.

You can revoke all or part of your advance health care directive at any time by:

- Signing a written revocation
- Telling your doctor you are revoking the document
- Destroying the document
- Creating a new advance health care directive

Part III of this toolkit 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 Maryland, 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)
- Efforts to prevent cardiac and/or pulmonary arrest, including comfort or palliative care
- Intubation and artificial ventilation
- Blood transfusion
- Hospital transfer
- Medical workup (medical tests for diagnosis and treatment)
- Antibiotics

- Artificially-administered fluids and nutrition
- Dialysis and other directions not captured by other sections

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.

Maryland's advance health care directive includes an "After my Death" form, where you can indicate your preferences for the disposal of your remains and organ donation.

**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.

Maryland 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: Maryland

**Part III: Your State's Estate Planning Forms**

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Scope of Treatment (MOST)
- 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

**Article - Estates and Trusts**

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§17–202.

"MARYLAND STATUTORY FORM

PERSONAL FINANCIAL POWER OF ATTORNEY

IMPORTANT INFORMATION AND WARNING

You should be very careful in deciding whether or not to sign this document. The powers granted by you (the principal) in this document are broad and sweeping. 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.

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.

You need not grant all of the powers listed below. If you choose to grant less than all of the listed powers, you may instead use a Maryland Statutory Form Limited Power of Attorney and mark on that Maryland Statutory Form Limited Power of Attorney which powers you intend to delegate to your attorney–in–fact (the Agent) and which you do not want the Agent to exercise.

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

You should obtain competent legal advice before you sign this power of attorney if you have any questions about the document or the authority you are granting to your agent.

DESIGNATION OF AGENT

This section of the form provides for designation of one agent.

If you wish to name coagents, skip this section and use the next section ("Designation of Coagents").

I, _____ ,

(Name of Principal)

Name the following person as my agent:

Name of Agent: _____

Agent's Address: _____

Agent's Telephone Number: _____

DESIGNATION OF COAGENTS (OPTIONAL)

This section of the form provides for designation of two or more coagents. Coagents are required to act together unanimously unless you otherwise provide in this form.

I, _____ ,

(Name of Principal)

Name the following persons as coagents:

Name of Coagent: _____

Coagent's Address: _____

Coagent's Telephone Number:_____

Name of Coagent: _____

Coagent's Address: _____

Coagent's Telephone Number:_____

Special Instructions Regarding Coagents: _____

_____

_____

_____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

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

Name of Successor Agent:_____

Successor Agent's
Address: _____

Successor Agent's
Telephone Number: _____

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 ("the principal") grant my agent and any successor agent, with respect to each subject listed below, the authority to do all acts that I could do to:

(1) Contract with another person, on terms agreeable to the agent, to accomplish a purpose of a transaction and perform, rescind, cancel, terminate, reform, restate, release, or modify the contract or another contract made by or on behalf of the principal;

(2) Execute, acknowledge, seal, deliver, file, or record any instrument or communication the agent considers desirable to accomplish a purpose of a transaction;

(3) Seek on the principal's behalf the assistance of a court or other governmental agency to carry out an act authorized in this power of attorney;

(4) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to a claim existing in favor of or against the principal or intervene in litigation relating to the claim;

(5) Engage, compensate, and discharge an attorney, accountant, discretionary investment manager, expert witness, or other advisor;

(6) Prepare, execute, and file a record, report, or other document to safeguard or promote the principal's interest under a statute or regulation and communicate with representatives or employees of a government or governmental subdivision, agency, or instrumentality, on behalf of the principal; and

(7) Do lawful acts with respect to the subject and all property related to the subject.

SUBJECTS AND AUTHORITY

My agent's authority shall include the authority to act as stated below with regard to each of the following subjects:

Real property – With respect to this subject, I authorize my agent to: demand, buy, sell, convey, lease, receive, accept as a gift or as security for an extension of credit, or otherwise acquire or reject an interest in real property or a right incident to real property; pledge or mortgage an interest in real property or right incident to real property as security to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal, including a reverse mortgage; release, assign, satisfy, or enforce by litigation or otherwise a mortgage, deed of trust, conditional sale contract, encumbrance, lien, or other claim to real property that exists or is asserted; and manage or conserve an interest in real property or a right incident to real property owned or claimed to be owned by the principal, including: (1) insuring against liability or casualty or other loss; (2) obtaining or regaining possession of or protecting the interest or right by litigation or otherwise; (3) paying, assessing, compromising, or contesting taxes or assessments or applying for and receiving refunds in connection with them; and (4) purchasing supplies, hiring assistance or labor, and making repairs or alterations to the real property.

Stocks and bonds – With respect to this subject, I authorize my agent to: buy, sell, and exchange stocks and bonds; establish, continue, modify, or terminate an account with respect to stocks and bonds; pledge stocks and bonds as security to borrow, pay, renew, or extend the time of payment of a debt of the principal; receive certificates and other evidences of ownership with respect to stocks and bonds; exercise voting rights with respect to stocks and bonds in person or by proxy, enter into voting trusts, and consent to limitations on the right to vote.

Banks and other financial institutions – With respect to this subject, I authorize my agent to: continue, modify, transact all business in connection with, and terminate an account or other banking arrangement made by or on behalf of the principal; establish, modify, transact all business in connection with, and terminate an account or other banking arrangement with a bank, trust company, savings and loan association, credit union, thrift company, brokerage firm, or other financial

institution selected by the agent; contract for services available from a financial institution, including renting a safe deposit box or space in a vault; deposit by check, money order, electronic funds transfer, or otherwise with, or leave in the custody of, a financial institution money or property of the principal; withdraw, by check, money order, electronic funds transfer, or otherwise, money or property of the principal deposited with or left in the custody of a financial institution; receive statements of account, vouchers, notices, and similar documents from a financial institution and act with respect to them; enter a safe deposit box or vault and withdraw or add to the contents; borrow money and pledge as security personal property of the principal necessary to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal; make, assign, draw, endorse, discount, guarantee, and negotiate promissory notes, checks, drafts, and other negotiable or nonnegotiable paper of the principal or payable to the principal or the principal's order, transfer money, receive the cash or other proceeds of those transactions; and apply for, receive, and use credit cards and debit cards, electronic transaction authorizations, and traveler's checks from a financial institution.

Insurance and annuities – With respect to this subject, I authorize my agent to: continue, pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract procured by or on behalf of the principal that insures or provides an annuity to either the principal or another person, whether or not the principal is a beneficiary under the contract; procure new, different, and additional contracts of insurance and annuities for the principal and select the amount, type of insurance or annuity, and mode of payment; pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract of insurance or annuity procured by the agent; apply for and receive a loan secured by a contract of insurance or annuity; surrender and receive the cash surrender value on a contract of insurance or annuity; exercise an election; exercise investment powers available under a contract of insurance or annuity; change the manner of paying premiums on a contract of insurance or annuity; change or convert the type of insurance or annuity with respect to which the principal has or claims to have authority described in this section; apply for and procure a benefit or assistance under a statute or regulation to guarantee or pay premiums of a contract of insurance on the life of the principal; collect, sell, assign, hypothecate, borrow against, or pledge the interest of the principal in a contract of insurance or annuity; select the form and timing of the payment of proceeds from a contract of insurance or annuity; pay, from proceeds or otherwise, compromise or contest, and apply for refunds in connection with a tax or assessment levied by a taxing authority with respect to a contract of insurance or annuity or the proceeds or liability from the contract of insurance or annuity accruing by reason of the tax or assessment.

Claims and litigation – With respect to this subject, I authorize my agent to: assert and maintain before a court or administrative agency a claim, claim for relief, cause of action, counterclaim, offset, recoupment, or defense, including an action to recover

property or other thing of value, recover damages sustained by the principal, eliminate or modify tax liability, or seek an injunction, specific performance, or other relief; act for the principal with respect to bankruptcy or insolvency, whether voluntary or involuntary, concerning the principal or some other person, or with respect to a reorganization, receivership, or application for the appointment of a receiver or trustee that affects an interest of the principal in property or other thing of value; pay a judgment, award, or order against the principal or a settlement made in connection with a claim or litigation; and receive money or other thing of value paid in settlement of or as proceeds of a claim or litigation.

Benefits from governmental programs or civil or military service (including any benefit, program, or assistance provided under a statute or regulation including Social Security, Medicare, and Medicaid) – With respect to this subject, I authorize my agent to: execute vouchers in the name of the principal for allowances and reimbursements payable by the United States or a foreign government or by a state or subdivision of a state to the principal; enroll in, apply for, select, reject, change, amend, or discontinue, on the principal's behalf, a benefit or program; prepare, file, and maintain a claim of the principal for a benefit or assistance, financial or otherwise, to which the principal may be entitled under a statute or regulation; initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation concerning a benefit or assistance the principal may be entitled to receive under a statute or regulation; and receive the financial proceeds of a claim described above and conserve, invest, disburse, or use for a lawful purpose anything so received.

Retirement plans (including a plan or account created by an employer, the principal, or another individual to provide retirement benefits or deferred compensation of which the principal is a participant, beneficiary, or owner, including a plan or account under the following sections of the Internal Revenue Code: (1) an individual retirement account under Internal Revenue Code Section 408, 26 U.S.C. § 408; (2) a Roth individual retirement account under Internal Revenue Code Section 408A, 26 U.S.C. § 408A; (3) a deemed individual retirement account under Internal Revenue Code Section 408(q), 26 U.S.C. § 408(q); (4) an annuity or mutual fund custodial account under Internal Revenue Code Section 403(b), 26 U.S.C. § 403(b); (5) a pension, profit–sharing, stock bonus, or other retirement plan qualified under Internal Revenue Code Section 401(a), 26 U.S.C. § 401(a); (6) a plan under Internal Revenue Code Section 457(b), 26 U.S.C. § 457(b); and (7) a nonqualified deferred compensation plan under Internal Revenue Code Section 409A, 26 U.S.C. § 409A) – With respect to this subject, I authorize my agent to: select the form and timing of payments under a retirement plan and withdraw benefits from a plan; make a rollover, including a direct trustee–to–trustee rollover, of benefits from one retirement plan to another; establish a retirement plan in the principal's name; make contributions to a retirement plan; exercise investment powers available under a retirement plan; borrow from, sell assets to, or purchase assets from a retirement

plan. I recognize that granting my agent the authority to create or change a beneficiary designation for a retirement plan may affect the benefits that I may receive if that authority is exercised. If I grant my agent the authority to designate the agent, the agent's spouse, or a dependent of the agent as a beneficiary of a retirement plan, the grant may constitute a taxable gift by me and may make the property subject to that authority taxable as a part of the agent's estate. Therefore, if I wish to authorize my agent to create or change a beneficiary designation for any retirement plan, and in particular if I wish to authorize the agent to designate as my beneficiary the agent, the agent's spouse, or a dependent of the agent, I will explicitly state this authority in the Special Instructions section that follows or in a separate power of attorney.

Taxes – With respect to this subject, I authorize my agent to: prepare, sign, and file federal, state, local, and foreign income, gift, payroll, property, federal insurance contributions act, and other tax returns, claims for refunds, requests for extension of time, petitions regarding tax matters, and other tax–related documents, including receipts, offers, waivers, consents, including consents and agreements under Internal Revenue Code Section 2032(A), 26 U.S.C. § 2032(A), closing agreements, and other powers of attorney required by the Internal Revenue Service or other taxing authority with respect to a tax year on which the statute of limitations has not run and the following 25 tax years; pay taxes due, collect refunds, post bonds, receive confidential information, and contest deficiencies determined by the Internal Revenue Service or other taxing authority; exercise elections available to the principal under federal, state, local, or foreign tax law; and act for the principal in all tax matters for all periods before the Internal Revenue Service, or other taxing authority.

Digital assets – With respect to this subject, in accordance with the Maryland Fiduciary Access to Digital Assets Act, my agent shall have authority over and the right to access: (1) the content of any of my electronic communications; (2) any catalogue of electronic communications sent or received by me; and (3) any other digital asset in which I have a right or interest.

## SPECIAL INSTRUCTIONS (OPTIONAL)

YOU MAY GIVE SPECIAL INSTRUCTIONS ON THE FOLLOWING LINES:

_____
_____
_____
_____
_____
_____
_____
_____

## EFFECTIVE DATE

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

## TERMINATION DATE (OPTIONAL)

This power of attorney shall terminate on _____ ,
20 _____ .
(Use a specific calendar date)

## NOMINATION OF GUARDIAN (OPTIONAL)

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

Name of nominee for guardian of my property:_____
Nominee's address:_____
Nominee's telephone number: _____
Name of nominee for guardian of my person:_____
Nominee's address:_____
Nominee's telephone number: _____

## SIGNATURE AND ACKNOWLEDGMENT

_____ _____
Your Signature Date

_____
Your Name Printed

_____
_____
Your Address

_____
Your Telephone Number

STATE OF MARYLAND
(COUNTY) OF_____

This document was acknowledged before me on

_____

(Date)

By _____ to be his/her act.
(Name of Principal)

_____ (SEAL, IF ANY)
Signature of Notary
My commission expires: _____

WITNESS ATTESTATION

The foregoing power of attorney was, on the date written above, published and declared by

_____
(Name of Principal)

in our presence to be his/her power of attorney. We, in his/her presence and at his/her request, and in the presence of each other, have attested to the same and have signed our names as attesting witnesses.

_____
Witness #1 Signature

_____
Witness #1 Name Printed

_____

_____
Witness #1 Address

_____
Witness #1 Telephone Number

_____
Witness #2 Signature

_____
Witness #2 Name Printed

_____

_____
Witness #2 Address

_____
Witness #2 Telephone Number"

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# Triage Cancer Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

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# Advance Health Care Directive

PRINT YOUR NAME AND THE DATE

## Maryland Advance Directive:

Planning for Future Health Care Decisions

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

## PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR PRIMARY AGENT

Name: _____

Address: _____

_____

Telephone Numbers:_____
(home and cell)

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR FIRST BACK-UP AGENT

Name: _____ Address:

_____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR SECOND BACK-UP AGENT

Name: _____ Address:

_____

Telephone Numbers: _____
(home and cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank)

_____

_____

_____

_____

_____

PRINT INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S POWERS

D. How My Agent Is To Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive, if I have filled out Part II, that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s):

PRINT THE NAMES

AND TELEPHONE NUMBERS OF ANYONE YOU WANT YOUR AGENT TO CONSULT WITH IN MAKING DECISIONS FOR YOU

PRINT ANY INSTRUCTIONS IN THE EVENT YOU ARE PREGNANT

WHEN A DECISION MUST BE MADE

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

_____

_____

_____

_____

_____

_____

G. Access to My Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of This Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

INITIAL ONLY ONE

_____ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

**((or))**

_____ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

I. Waiver of Right to Revoke Appointment of Agent

INITIAL ONLY IF YOU WISH TO WAIVE YOUR RIGHT TO REVOKE THE APPOINTMENT OF YOUR AGENT IN

THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

(Read this section carefully. Then, initial only if you wish to waive your right to revoke the appointment of your agent upon certification of incapacity.)

_____I wish to waive my ability to revoke the appointment of my agent during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.



If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate "After my Death" form for that.

## PART II: TREATMENT PREFERENCES ("LIVING WILL")

USE THIS SPACE TO DISCUSS YOUR ADVANCE PLANNING GOALS AND VALUES ATTACH ADDITIONAL PAGES IF NEEDED

A. Statement of Goals and Values

(Optional; form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

_____

_____

_____

(attach additional pages if needed)

B. Preference in Case of Terminal Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A TERMINAL CONDITION

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. Preference in Case of Persistent Vegetative State

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

D. Preference in Case of End-Stage Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

INITIAL YOUR PREFERENCE IN THE EVENT YOU DEVELOP AN END-STAGE CONDITION

INITIAL ONLY ONE PREFERENCE

_____1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**((or))**

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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

E. Additional Instructions:

(You may add additional instructions, if any, here. This section may be useful to you if you have crossed through the sections above, or if your concerns are not otherwise addressed by this form.)

F. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

G. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

ADD INSTRUCTIONS HERE IF YOU WANT DIFFERENT TREATMENT IN THE EVENT YOU ARE PREGNANT

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

_____

_____

H. Effect of Stated Preferences

INITIAL ONLY ONE, DEPENDING ON HOW STRICTLY YOU WANT YOUR TREATMENT PREFERENCES FOLLOWED

(Read both of these statements carefully. Then, initial one only.)

_____1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

**((or))**

_____ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

I. Waiver of Right to Revoke Treatment Preferences ("Living Will")

(Read this section carefully. Then, initial only if you wish to waive your right to revoke your stated treatment preferences upon certification of incapacity.)

INITIAL ONLY IF YOU WISH TO

WAIVE YOUR RIGHT TO REVOKE YOUR STATED TREATMENT PREFERENCES IN THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

_____I wish to waive my ability to revoke my stated treatment preferences ("Living Will") during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.

## PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

SIGN AND DATE YOUR DOCUMENT

_____

(Signature of Declarant) (Date)

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

YOUR WITNESSES MUST SIGN AND DATE AND LIST THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

ONE WITNESS MUST NOT KNOWINGLY INHERIT ANYTHING FROM YOU OR OTHERWISE KNOWLINGLY BENEFIT FROM YOUR DEATH

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the declarant or otherwise knowingly gain a financial benefit from the declarant's death. Maryland law does not require this document to be notarized.)

## AFTER MY DEATH

(This form is optional. Fill out only what reflects your wishes.)

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

## PART I: ORGAN DONATION

(Initial the ones that you want.)

Upon my death I wish to donate:

INITIAL ONLY ONE

_____Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____

_____

I authorize the use of my organs, tissues, or eyes for the purpose of:

INITIAL ALL THAT APPLY

_____ Research and education
_____ Transplantation and therapy

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

## PART II: DONATION OF BODY

INITIAL HERE IF YOU WANT YOUR BODY DONATED FOR MEDICAL STUDY

_____ After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

## PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

INITIAL ONLY ONE

_____ The health care agent who I named in my advance directive.

**((or))**

_____ This person:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU WANT TO MAKE DECISIONS REGARDING DISPOSITION OF YOUR BODY

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

PRINT ADDITIONAL INSTRUCTIONS HERE, IF ANY

_____

_____

_____

_____

## PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

SIGN AND DATE YOUR DOCUMENT HERE

_____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing this donation document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

HERE YOUR WITNESSES SIGN AND DATE AND PRINT THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s) _____

_____

(Signature of Witness) (Date)

Telephone Number(s) _____



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

# Triage Cancer Estate Planning Toolkit

⌘

# Part III: Your State's Estate Planning Forms

⌘

# Physician Orders for Life Sustaining Treatment (POLST)

# Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

| Patient's Last Name, First, Middle Initial | Date of Birth | ☐ Male ☐ Female |
|---|---|---|

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

**1**

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ Attempt CPR: If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

---

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation.

_____ Option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

---

_____ No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

| Practitioner's Signature | Print Practitioner's Name | |
|---|---|---|
| Maryland License # | Phone Number | Date |

| Patient's Last Name, First, Middle Initial | Date of Birth | Page 2 of 2<br>☐ Male ☐ Female |
|---|---|---|

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest.
Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

**2 ARTIFICIAL VENTILATION**

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

**3 BLOOD TRANSFUSION**

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

**4 HOSPITAL TRANSFER**

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

**5 MEDICAL WORKUP**

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

**6 ANTIBIOTICS**

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

**7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION**

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

**8 DIALYSIS**

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

**9 OTHER ORDERS** _____
_____
_____
_____
_____

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

| Practitioner's Signature | Print Practitioner's Name | |
|---|---|---|
| Maryland License # | Phone Number | Date |


# Triage Cancer Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

⌘

# 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