Triage Cancer Estate Planning Toolkit: Nevada

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.

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

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. If your only witnesses are included in your will, they will forfeit anything you leave to them in the will.
3. Your will does not need to be notarized to be legal in Nevada. 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, Nevada 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 Nevada:

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 and date 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.

In Nevada, a general 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 a successor agent, and a second successor

agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a guardian in advance, in case a court decides one is necessary. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance 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 Nevada, this document contains four parts. You can complete part one and/or part two, but you must sign part three to make the document valid. If you reside in a hospital, residential facility, facility for skilled nursing, or home for individual residential care when you complete your directive, you need to complete part four.

1. **Nevada Power of Attorney for Health Care:** You can choose someone (your "agent") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can appoint an alternate person to make these decisions if the first person you chose isn't available. This section also allows you to express your preferences for advance planning decisions to help guide your agent. If there are additional directions you want your agent to follow, you can share those in the "other directions" section.

2. **Nevada Declaration:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. This document goes into effect if your doctor determines you have become terminally ill or entered a vegetative state. If you complete part one and record these advance planning preferences there, you may choose to leave your declaration blank.

3. **Signature and Witnessing Provisions:** You must sign your advance health care directive to make it legal. For part one, you need to have your signature witnessed by a notary public or two witnesses. Your witnesses may not be the person you chose to make health care decisions for you, a health care provider, an employee of your health care provider, or an operator or employee of a health care facility. One of your witnesses may not be related to you by blood, adoption, or marriage, or entitled to any portion of your estate. For part two, you should sign the document in front of two witnesses.

4. **Certification of Competency:** If you reside in a hospital, residential facility, facility for skilled nursing, or home for individual residential care when you complete your directive, you need to complete this section. An advance practice registered nurse, physician, psychologist, or psychiatrist will fill out this form to certify you are competent of making these decisions.

At the end of your AHCD, you can indicate if you would like to make an organ donation upon death.

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

You can indicate that you would like to change any other instruction included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up this directive. But, you have to tell your attorney-in-fact, physician, or treating health care provider that you revoked this person's powers for it to be effective.

If you appoint your spouse as your attorney-in-fact, this will be automatically revoked if your marriage dissolves.

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

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance directive. You can complete a POLST form with your doctor. In Nevada, 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
- Life-sustaining antibiotics
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Other limitations (like dialysis or IVs) or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

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

State Laws About Funeral Designation Forms

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

Nevada does not have a dedicated funeral designation form, but you can include instructions for your remains in your advance health care directive.

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.

Nevada does not have a death with dignity law.

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: Nevada

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

Form

NRS 162A.620 Power of attorney. A document substantially in the following form may be used to create a statutory form power of attorney that has the meaning and effect prescribed by NRS 162A.200 to 162A.660, inclusive:

STATUTORY FORM POWER OF ATTORNEY

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE DECISIONS CONCERNING YOUR PROPERTY FOR YOU. 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.
2. THIS POWER OF ATTORNEY BECOMES EFFECTIVE IMMEDIATELY UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.
3. THIS POWER OF ATTORNEY DOES NOT AUTHORIZE THE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.
4. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.
5. 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.
6. YOUR AGENT IS ENTITLED TO REASONABLE COMPENSATION UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.
7. THIS FORM PROVIDES FOR DESIGNATION OF ONE AGENT. IF YOU WISH TO NAME MORE THAN ONE AGENT YOU MAY NAME A CO-AGENT IN THE SPECIAL INSTRUCTIONS. CO-AGENTS ARE NOT REQUIRED TO ACT TOGETHER UNLESS YOU INCLUDE THAT REQUIREMENT IN THE SPECIAL INSTRUCTIONS.
8. IF YOUR AGENT IS UNABLE OR UNWILLING TO ACT FOR YOU, YOUR POWER OF ATTORNEY WILL END UNLESS YOU HAVE NAMED A SUCCESSOR AGENT. YOU MAY ALSO NAME A SECOND SUCCESSOR AGENT.
9. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT.
10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY.
11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF AGENT.

I, ...
(insert your name) do hereby designate and appoint:

Name: .....
Address: .....
Telephone Number: .....

as my agent to make decisions for me and in my name, place and stead and for my use and benefit and to exercise the powers as authorized in this document.

2. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same decisions as the agent designated above in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If my agent is unable or unwilling to act for me, then I designate the following person(s) to serve as my agent as authorized in this document, such person(s) to serve in the order listed below:

A. First Alternative Agent

Name:.....
Address:.....
Telephone Number:.....

B. Second Alternative Agent

Name:.....
Address:.....
Telephone Number:.....

3. OTHER POWERS OF ATTORNEY.

This Power of Attorney is intended to, and does, revoke any prior Power of Attorney for financial matters I have previously executed.

4. NOMINATION OF GUARDIAN.

If, after execution of this Power of Attorney, proceedings seeking an adjudication of incapacity are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

5. GRANT OF GENERAL AUTHORITY.

I grant my agent and any successor agent(s) general authority to act for me with respect to the following subjects:

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

[.....] Real Property
[.....] Tangible Personal Property
[.....] Stocks and Bonds
[.....] Commodities and Options
[.....] Banks and Other Financial Institutions
[.....] Safe Deposit Boxes
[.....] Operation of Entity or Business
[.....] Insurance and Annuities
[.....] Estates, Trusts and Other Beneficial Interests
[.....] Legal Affairs, Claims and Litigation
[.....] Personal Maintenance
[.....] Benefits from Governmental Programs or Civil or Military Service
[.....] Retirement Plans
[.....] Taxes
[.....] All Preceding Subjects

6. GRANT OF SPECIFIC AUTHORITY.

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

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

[.....] Create, amend, revoke or terminate an inter vivos, family, living, irrevocable or revocable trust
[.....] Make a gift, subject to the limitations of NRS and any special instructions in this Power of Attorney
[.....] Create or change rights of survivorship
[.....] Create or change a beneficiary designation

[.....] Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
[.....] Exercise fiduciary powers that the principal has authority to delegate
[.....] Disclaim or refuse an interest in property, including a power of appointment

7. EXPRESSION OF INTENT CONCERNING LIVING ARRANGEMENTS.

[.....] It is my intention to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

[.....] It is my intention to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

[.....] I desire for my agent to take the following actions relating to my care:

.....

.....

.....

8. LIMITATION ON AGENT'S AUTHORITY.

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

9. SPECIAL INSTRUCTIONS OR OTHER OR ADDITIONAL AUTHORITY GRANTED TO AGENT:

10. AUTHORITY OF PRINCIPAL.

Except as otherwise expressly provided in this Power of Attorney, the authority of a principal to act on his or her own behalf continues after executing this Power of Attorney and any decision or instruction communicated by the principal supersedes any inconsistent decision or instruction communicated by an agent appointed pursuant to this Power of Attorney.

11. DURABILITY AND EFFECTIVE DATE. (INITIAL the clause(s) that applies.)

[.....] DURABLE. This Power of Attorney shall not be affected by my subsequent disability or incapacity.

[.....] SPRINGING POWER. It is my intention and direction that my designated agent, and any person or entity that my designated agent may transact business with on my behalf, may rely on a written medical opinion issued by a licensed medical doctor stating that I am disabled or incapacitated, and incapable of managing my affairs, and that said medical opinion shall establish whether or not I am under a disability for the purpose of establishing the authority of my designated agent to act in accordance with this Power of Attorney.

[.....] I wish to have this Power of Attorney become effective on the following date: .....

[.....] I wish to have this Power of Attorney end on the following date: .....

12. THIRD PARTY PROTECTION.

Third parties may rely upon the validity of this Power of Attorney or a copy and the representations of my agent as to all matters relating to any power granted to my agent, and no person or agency who relies upon the representation of my agent, or the authority granted by my agent, shall incur any liability to me or my estate as a result of permitting my agent to exercise any power unless a third party knows or has reason to know this Power of Attorney has terminated or is invalid.

13. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information, by any government agency, business, creditor or third party who may have information pertaining to my assets or income, to my agent named herein.

14. SIGNATURE AND ACKNOWLEDGMENT. YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I sign my name to this Power of Attorney on ..... (date) at ..... (city), ... (state)

.....
(Signature)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada }
}ss.
County of..... }

On this ..... day of ....., in the year ....., before me, ... (here insert name of notary public) personally appeared ..... (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL .....
(Signature of Notary Public)

IMPORTANT INFORMATION FOR AGENT

1. Agent's Duties. When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(a) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

(b) Act in good faith;

(c) Do nothing beyond the authority granted in this Power of Attorney; and

(d) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:
(Principal's Name) by (Your Signature) as Agent

2. Unless the Special Instructions in this Power of Attorney state otherwise, you must also:

(a) Act loyally for the principal's benefit;

(b) Avoid conflicts that would impair your ability to act in the principal's best interest;

(c) Act with care, competence, and diligence;

(d) Keep a record of all receipts, disbursements and transactions made on behalf of the principal;

(e) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and

(f) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

3. Termination of Agent's Authority. You must stop acting on behalf of the principal if you learn of any event that terminates this Power of Attorney or your authority under this Power of Attorney. Events that terminate a Power of Attorney or your authority to act under a Power of Attorney include:

(a) Death of the principal;

(b) The principal's revocation of the Power of Attorney or your authority;

(c) The occurrence of a termination event stated in the Power of Attorney;

(d) The purpose of the Power of Attorney is fully accomplished; or

(e) If you are married to the principal, your marriage is dissolved.

4. Liability of Agent. The meaning of the authority granted to you is defined in NRS 162A.200 to 162A.660, inclusive. If you violate NRS 162A.200 to 162A.660, inclusive, or act outside the authority granted in this Power of Attorney, you may be liable for any damages caused by your violation.

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

(Added to NRS by 2009, 193; A 2019, 421, 1738, 3503)

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

Part I. Nevada Durable Power of Attorney For Health Care Decisions

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

STATUTORY WARNING

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR OR ADVANCED PRACTICE REGISTERED NURSE NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE

GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO DECIDE WHERE YOU LIVE, EVEN AS YOU AGE. DECISIONS ABOUT WHERE YOU LIVE ARE PERSONAL, SOME PEOPLE LIVE AT HOME WITH SUPPORT, WHILE OTHERS MOVE TO ASSISTED LIVING FACILITIES OR FACILITIES FOR SKILLED NURSING. IN SOME CASES, PEOPLE ARE MOVED TO FACILITIES WITH LOCKED DOORS TO PREVENT PEOPLE WITH COGNITIVIE DISORDERS FROM LEAVING OR GETTING LOST OR TO PROVIDE ASSISTANCE TO PEOPLE WHO REQUIRE A HIGHER LEVEL OF CARE. YOU SHOULD DISCUSS WITH THE PERSON DESIGNATED IN THIS DOCUMENT YOUR DESIRES ABOUT WHERE YOU LIVE AS YOU AGE OR IF YOUR HEALTH DECLINES. YOU HAVE THE RIGHT TO DETERMINE WHETHER TO AUTHORIZE THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE DECISIONS FOR YOU ABOUT WHERE YOU LIVE WHEN YOU ARE NO LONGER CAPABLE OF MAKING THAT DECISION. IF YOU DO NOT PROVIDE SUCH AUTHORIZATION TO THE PERSON DESIGNATED IN THIS DOCUMENT, THAT PERSON MAY NOT BE ABLE TO ASSIST YOU TO MOVE TO A MORE SUPPORTIVE LIVING ARRANGEMENT WITHOUT OBTAINING APPROVAL THORUGH A JUDICIAL PROCESS.

STATUTORY WARNING (CONTINUED)

7. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

8. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, ADVANCED PRACTICE REGISTERED NURSE, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

9. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

STATUTORY WARNING (CONTINUED)

12. YOU MAY REQUEST THAT THE NEVADA SECRETARY OF STATE ELECTRONICALLY STORE WITH THE NEVADA LOCKBOX A COPY OF THIS DOCUMENT TO ALLOW ACCESS BY AN AUTHORIZED PROVIDER OF HEALTH CARE AS DEFINED IN NRS 629.031.

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR AGENT

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, do hereby designate and appoint:
(name)

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

as my Agent to make health care decisions for me as authorized in this document.

Insert the name and address of the person you wish to designate as your agent to make health care decisions for you. Unless the person you designate is your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, or (4) an employee of a health care facility.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the agent named above full power and authority: to make health care decisions for me before, or after my death, including consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility, and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISION AND LIMITATIONS.

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on his or her authority, you should list them in the space below. If you do not write any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.

In exercising the authority under this durable power of attorney for health care, the authority of my agent is subject to the following special provisions and limitations:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE SCOPE OF YOUR AGENT'S AUTHORITY

_____

_____

_____

_____

_____

_____

_____

_____

5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

PRINT THE EXPIRATION DATE (OPTIONAL)

I wish to have this power of attorney end on the following date:

_____

6. STATEMENT OF DESIRES.
(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the line next to the statement.)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES (OPTIONAL)

A. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

Initial _____

B. If I am in a coma which my doctors or advanced practice registered nurses have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments **not** be used.

Initial _____

ANY INSTRUCTIONS ON THE USE OF LIFE-SUSTAINING OR PROLONGING TREATMENTS SHOULD BE CONSISTENT WITH INSTRUCTIONS PROVIDED IN YOUR NEVADA DECLARATION (PART II), IF ANY

C. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments **not** be used.

Initial _____

D. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.

Initial _____

E. I do **not** desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

Initial _____

(*If you wish to change your answer, you may draw an "X" through the answer you do not want, circle the answer you prefer, and initial the changes)*

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

Other or Additional Statements of Desires:

(Attach additional pages if needed)

7. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS.

INITIAL THE RESPONSES THAT REFLECT YOUR WISHES (OPTIONAL)

A. I desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

Initial _____

B. I desire to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

Initial _____

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR LIVING ARRANGEMENTS.

(If you wish to change your mind, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternate agent but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 3 in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1, is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my agent is unable to make health care decisions for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR FIRST ALTERNATE AGENT

A. First Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR SECOND ALTERNATE AGENT

B. Second Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

9. PRIOR DESIGNATIONS REVOKED.
I revoke any prior durable power of attorney for health care.

10. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

11. CHALLENGES.

If the legality of any provision of this durable power of attorney for health care is questioned by my physician, my advanced practice registered nurse, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. The durable power of attorney for health care must be construed and interpreted in accordance with the laws of the State of Nevada.

This section is not required, and you may cross it out if you desire.

12. NOMINATION OF GUARDIAN.

If, after execution of this durable power of attorney for health care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

Part II: Declaration Relating to the Use of Life-Sustaining Treatment

PART II ONLY APPLIES TO WITHHOLDING OR WITHDRAWING OF LIFE-SUSTAINING TREATMENTS IF YOU ARE TERMINALLY ILL

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

INITIAL ONLY ONE

ADD ADDITIONAL INSTRUCTIONS, IF ANY, IN THE EVENT YOU HAVE A TERMINAL CONDITION

ATTACH ADDITIONAL PAGES IF NEEDED

If I should lapse into an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time (a terminal condition) and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Nevada Uniform Act on the Rights of the Terminally Ill, to:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other 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 any life-sustaining treatment or other 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 life-sustaining treatment or other medical 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.

Any questions regarding how to interpret or apply my declaration shall be resolved by my agent appointed under a durable power of attorney for health care (Part I), if I have appointed one.

I further direct that:

_____

_____

_____

_____

(Attach additional pages if needed)

PART III: EXECUTION

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:
   - the person you name as your agent,
   - a health care provider,
   - an employee of a health care provider,
   - an operator of a health care facility, or
   - an employee or an operator of a health care facility.

   At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

   Signing your document in this way will also make Part II legal.

   OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (i.e., Part II needs an additional witness besides the notary).

You should retain an executed copy of this document and give one to your agent. The power of attorney should be available so a copy may be given to your providers of health care.

IF YOU FILLED OUT PART II, YOU MUST HAVE YOUR DOCUMENT WITNESSED

Alternative No. 1: Sign before witnesses.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility or an employee of an operator of a health care facility.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

REQUIRED STATEMENT BY ONE OF THE ABOVE WITNESSES IF YOU FILLED OUT PART I

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY AN OPTION IF YOU DID NOT FILL OUT PART II

Alternative No. 2: Sign before a notary public.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

On this _____ day of _____, in the year _____, before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(signature of notary public)

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

ASK YOUR TREATING ADVANCED PRACTICE REGISTERED NURSE, PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST TO FILL THIS OUT

PART IV: CERTIFICATION OF COMPETANCY

If you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, Nevada requires that you include a certification of competency from an advanced practice registered nurse, physician, psychologist, or psychiatrist along with your power of attorney:

The undersigned treating (advanced practice registered nurse/physician/psychologist/psychiatrist) of _____ states as follows:

PRINT YOUR NAME HERE

1. That I am a licensed (advanced practice registered nurse/physician/psychologist/psychiatrist) practicing in the State of _____, and I have been a licensed (advanced practice registered nurse/physician/psychologist/psychiatrist) for ____ years. My present address is _____.

PRINT YOUR NAME HERE

2. That I have examined _____ and have concluded as a result of that examination that the he/she is mentally competent to understand the nature of the Durable Power of Attorney for Health Care proceedings and the delegation of authority to an agent.

_____

(Signature of certifying advanced practice registered nurse/physician/psychologist/psychiatrist) (Date)

_____

(Name of certifying advanced practice registered nurse/physician/psychologist/psychiatrist)

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

NEVADA ORGAN DONATION FORM – PAGE 1 OF 1

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 Nevada 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 Nevada 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

INSERT YOUR NAME

INSERT YOUR ADDRESS

PRINT THE NAME OF YOUR AGENT

THIS FORM SHOULD ONLY BE USED FOR ADULTS WITH INTELLECTUAL DISABILITIES[1]

PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

My name is: _____
(insert your name)

and my address is: _____
(insert your address).

I would like to designate _____
(insert the name of the person you wish to designate as your agent for health care decisions for you) as my agent for health care decisions for me if I am sick or hurt and need to see a doctor or an advanced practice registered nurse or go to the hospital. I understand what this means.

If I am sick or hurt, my agent should take me to the doctor or an advanced practice registered nurse. If my agent is not with me when I become sick or hurt, please contact my agent and ask him or her to come to the doctor's or advanced practice registered nurse's office. I would like the doctor or advanced practice registered nurse to speak with my agent and me about my sickness or injury and whether I need any medicine or other treatment. After we speak with the doctor or advanced practice registered nurse, I would like my agent to speak with me about the care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor or advanced practice registered nurse about our decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who work at the hospital to try very hard to care for me. If I am able to communicate, I would like the doctor or advanced practice registered nurse at the hospital to speak with me and my agent about what care or treatment I should receive, even if I am unable to understand what is being said about me. After we speak with the doctor or advanced practice registered nurse, I would like my agent to help me decide what care or treatment I should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate because of my illness or injury, I would like my agent to make decisions about my care or treatment based on what he or she thinks I would do and what is best for me.

[1] "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see or have copies of my medical records, please allow him or her to see or have copies of the records.

I understand that my agent cannot make me receive any care or treatment that I do not want. I also understand that I can take away this power from my agent at any time, either by telling him or her that they are no longer my agent or by putting it in writing.

If my agent is unable to make health care decisions for me, then I designate_____ (insert the name of another person you wish to designate as your alternative agent to make health care decisions for you) as my agent to make health care decisions for me as authorized in this document.

INSERT THE NAME OF ANOTHER PERSON YOU WISH TO DESIGNATE AS YOUR ALTERNATIVE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE.

Signature: _____

THE HEALTH CARE AGENT MUST COMPLETE THIS PORTION.

2. AGENT SIGNATURE.

THE AGENT MUST WRITE IN THE NAME OF THE PRINCIPAL (THE PERSON WHO IS CREATING THIS ADVANCE DIRECTIVE).

As agent for_____(insert name of principal), I agree that a physician, advanced practice registered nurse, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, advanced practice registered nurse, health care facility or other provider of health care that in good faith accepts an acknowledged power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration Contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

THE AGENT MUST COMPLETE THIS PORTION.

I also agree that:

1. I have a duty to act in a manner consistent with the desires of_____(insert name of principal) as stated in this document or otherwise made known by _____ (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.

2. If _____ (insert name of principal) revokes this power of attorney at any time, either verbally or in writing, I have a duty to inform any persons who may rely on this document, including, without limitation, treating physicians, advanced practice registered nurses, hospital staff or other providers of health care, that I no longer have the authorities described in this document.

3. The provisions of NRS 162A.840 prohibit me from being named as an agent to make health care decisions in this document if I am a provider of health care, an employee of the principal's provider of health care or an operator or employee of a health care facility caring for the principal, unless I am the spouse, legal guardian or next of kin of the principal.

4. The provisions of NRS 162A.850 prohibit me from consenting to the following types of care or treatments on behalf of the principal, including, without limitation:

(a) Commitment or placement of the principal in a facility for treatment of mental illness;

(b) Convulsive treatment;

(c) Psychosurgery;

(d) Sterilization;

(e) Abortion;

(f) Aversive intervention, as it is defined in NRS 449.766;

(g) Experimental medical, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program; or

(h) Any other care or treatment to which the principal prohibits the agent from consenting in this document.

THE AGENT MUST COMPLETE THIS PORTION.

5. End-of-life decisions must be made according to the wishes of _____ (insert name of principal), as designated in the attached addendum. If his or her wishes are not known, such decisions must be made in consultation with the principal's treating physicians or advanced practice registered nurses.

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

Alternative No. 1: Agent signs before witnesses.

THE AGENT MUST SIGN AND PRINT HERE

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) THE PRINCIPAL'S HEALTH CARE PROVIDER;
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____,
before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(signature of notary public)

PART II. END–OF–LIFE DECISIONS ADDENDUM STATEMENT OF DESIRES

You can, but are not required to, state what you want to happen if you get very sick and are not likely to get well. You do not have to complete this form, but if you do, your agent must do as you ask if you cannot speak for yourself.

_____(insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or to stop your medicine, even if it means you might not live_____(insert name of agent) will talk to you to find out what you want to do, and will follow your wishes.

If you are not able to talk to_____(insert name of agent), you can help him or her make these decisions for you by letting your agent know what you want.

Here are your choices. Please circle yes or no to each of the following statements and sign your name below:

FOR EACH QUESTION CIRCLE YES OR NO (CIRCLE ONLY ONE CHOICE)

1. I want to take all the medicine and receive any treatment I can to keep me alive regardless of how the medicine or treatment makes me feel. YES NO

2. I do not want to take medicine or receive treatment if my doctors or advanced practice registered nurses think that the medicine or treatment will not help me. YES NO

3. I do not want to take medicine or receive treatment if I am very sick and suffering and the medicine or treatment will not help me get better. YES NO

4. I want to get food and water even if I do not want to take medicine or receive treatment. YES NO

YOU MUST SIGN AND DATE THIS END-OF-LIFE DECISIONS ADDENDUM

I sign my name to this End-of-Life Decisions Addendum on

_____ at _____,_____.
(date) (city) (state)

Signature: _____

THE AGENT MUST SIGN AND PRINT HERE

(THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

Alternative No. 1: Agent signs before witnesses.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) THE PRINCIPAL'S HEALTH CARE PROVIDER;
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____,

before me, _____, personally

appeared

(name of notary public)

_____

(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____

(signature of notary public)

COPIES: You should retain an executed copy of this document and give one to your agent. The End-of-Life Decisions Addendum should be available so a copy may be given to your providers of health care.

PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

INSERT YOUR NAME

My name is:

_____
(insert your name)

INSERT YOUR ADDRESS

and my address is:

_____
(insert your address).

PRINT THE NAME OF YOUR AGENT

I would like to designate

_____
(insert the name of the person you wish to designate as your agent for health care decisions for you) as my agent for health care decisions for me if I am sick or hurt and need to see a doctor or go to the hospital. I understand what this means.

If I am sick or hurt, my agent should take me to the doctor. If my agent is not with me when I become sick or hurt, please contact my agent and ask him or her to come to the doctor's office. I would like the doctor to speak with my agent and, if I have the capacity to understand, me about my sickness or injury and whether I need any medicine or other treatment. After we speak with the doctor, if I have the capacity to understand, I would like my agent to speak with me about the care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor about our decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who work at the hospital to try very hard to care for me. If I am able to communicate, I would like the doctor at the hospital to speak with me and my agent about what care or treatment I should receive, even if I am unable to understand what is being said about me. After we speak with the doctor, I would like my agent to help me decide what care or treatment I should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate because of my illness or injury, I would like my agent to make decisions about my care or treatment based on what he or she thinks I would do and what is best for me.

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see or have copies of my medical records, please allow him or her to see or have copies of the records.

I understand that my agent cannot make me receive any care or treatment that I do not want. I also understand that I can take away this power from my agent at any time, either by telling by telling my agent that he or she is no longer my agent or by putting it in writing.

INSERT THE NAME OF ANOTHER PERSON YOU WISH TO DESIGNATE AS YOUR ALTERNATIVE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

If my agent is unable to make health care decisions for me, then I designate _____ (insert the name of another person you wish to designate as your alternative agent to make health care decisions for your) as my agent to make health care decisions for me as authorized in this document.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____,_____.
(date) (city) (state)

Signature: _____

AGENT SIGNATURE:

THE HEALTH CARE AGENT MUST COMPLETE THIS PORTION.

THE AGENT MUST WRITE IN THE NAME OF THE PRINCIPAL (THE PERSON WHO IS CREATING THIS ADVANCE DIRECTIVE).

As agent for _____ (insert name of principal), I agree that a physician, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, health care facility or other provider of health care that in good faith accepts an acknowledge power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

I also agree that:

1. I have a duty to act in a manner consistent with the desires of _____ (insert name of principal) as stated in this document or otherwise made known by _____ (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.

2. If _____ (insert name of principal) revokes this power of attorney at any time, either verbally or in writing, I have a duty to inform any persons who may rely on this document, including, without limitation, treating physicians, hospital staff or other providers or health care, that I no longer have the authorities described in this document.

3. The provisions of NRS 162A.840 prohibit me from being named as an agent to make health care decisions in this document if I am a provider of health care, an employee of the principal's provider of health care or an operator or employee of a health care facility caring for the principal, unless I am the spouse, legal guardian or next of kin of the principal.

4.The provisions of NRS 162A.850 prohibit me from consenting to the following types of care or treatments on behalf of the principal, including, without limitation:

(a) Commitment or placement of the principal in a facility for treatment of mental illness;

(b) Convulsive treatment;

(c) Psychosurgery;

(d) Sterilization;

(e) Abortion;

(f) Aversive intervention, as it is defined in NRS 449.766;

(g) Experimental medical, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program; or

(h) Any other care or treatment to which the principal prohibits the agent from consenting in this document.

5. End-of-life decisions must be mde according to the wishes of _____ (insert name of principal), as designated in the attached addendum. If his or her wishes are not known, such decisions must be made in consultation with the principal's treating physicians.

THE AGENT MUST SIGN AND PRINT HERE

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) A HEALTH CARE PROVIDER
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

Alternative No. 1: Agent signs before witnesses.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____,
before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(signature of notary public)

Note: You should retain an executed copy of this document and give one to your agent. The power of attorney should be available so a copy may be given to your providers of health care.

PART 2. END-OF-LIFE DECISIONS ADDENDUM STATEMENT OF DESIRES.

You can, but are not required to, state what you want to happen if you get very sick and are not likely to get well. You do not have to complete this form, but if you do, your agent must do as you ask if you cannot speak for yourself.

_____(insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or to stop your medicine, even if it means you might not live_____(insert name of agent) will talk to you to find out what you want to do, and will follow your wishes.

If you are not able to talk to_____(insert name of agent), you can help him or her make these decisions for you by letting your agent know what you want.

Here are your choices. Please circle yes or no to each of the following statements and sign your name below:

FOR EACH QUESTION CIRCLE YES OR NO (CIRCLE ONLY ONE CHOICE)

1. I want to take all the medicine and receive any treatment I can to keep me alive regardless of how the medicine or treatment makes me feel. YES NO

2. I do not want to take medicine or receive treatment if my doctors or advanced practice registered nurses think that the medicine or treatment will not help me. YES NO

3. I do not want to take medicine or receive treatment if I am very sick and suffering and the medicine or treatment will not help me get better. YES NO

4. I want to get food and water even if I do not want to take medicine or receive treatment. YES NO

YOU MUST SIGN AND DATE THIS END-OF-LIFE DECISIONS ADDENDUM.

I sign my name to this End-of-Life Decisions Addendum on

_____ at _____,_____.
(date) (city) (state)

Signature: _____

THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE; OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

Alternative No. 1: Agent signs before witnesses.

THE AGENT MUST SIGN AND PRINT HERE

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) A HEALTH CARE PROVIDER
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this End-of-Life Decisions Addendum in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____,
before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(signature of notary public)

Note: You should retain an executed copy of this document and give one to your agent. The End-of-Life Decisions Addendum should be available so a copy may be given to your providers of health care.

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

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

⌘

Physician Orders for Life Sustaining Treatment (POLST)

NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

SIDE 1: Medical Orders

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA. Any section not completed implies full treatment for that section.	Last Name/First/Middle Initial		
	Date of Birth (mm/dd/yyyy)	Last 4 SSN	Gender
	/ /	__ __ __ __	M F

A — Choose 1

CARDIOPULMONARY RESUSCITATION (CPR) – *Patient/resident has no pulse and is not breathing*

☐ Attempt Resuscitation (CPR) ☐ Do Not Resuscitate (Allow Natural Death)_____

When not in cardiopulmonary arrest, follow orders in Section B and C

B — Choose 1

MEDICAL INTERVENTIONS – Check only one – *Patient/resident has pulse and/or is breathing.*

☐ **Full Treatment.** ***Goal - prolong life by all medically effective means***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention in addition to treatment described in Comfort-Focused Treatment and Selective Treatment. Transfer to hospital/admit to ICU as indicated.
*Other Instructions:*_____

☐ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
In addition to Comfort-Focused Treatment, use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally, avoid ICU.
*Other Instructions:*_____

☐ **Comfort-Focused Treatment.** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medication by *any route* as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location**.
*Other Instructions:*_____

C

ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – *offer food & fluids by mouth if feasible or desired*

☐ Long-term artificial nutrition or feeding tube
☐ Artificial nutrition/feeding tube trial no longer than_____
☐ No artificial nutrition or feeding tube
☐ IV fluids trial no longer than _____
☐ No IV fluids
*Other Instructions:*_____

D — Required

CAPACITY DETERMINATION – Completion required by Provider (MD, APRN or PA)

At the time of completion of this medical order, the patient:
☐ **Has decisional capacity** ☐ **Lacks decisional capacity**
to understand and communicate their health care preferences for options in this medical order.

E — Bolded Items Required

VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate Information on Side 2

Date (Required)	**Physician/APRN/PA Signature (Required)**	**Physician/APRN/PA License # (Required)**

Physician/APRN/PA Name (Printed, Required)	Physician/APRN/PA Phone

Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian (circle one)
I have discussed this form, its treatment options and their implications for sustaining life with my/the patient's health care provider. This form reflects my wishes/the patient's best-known wishes.

Signature_____ Print Name _____Date_____

OR if the patient lacks capacity *and* has no known Agent (DPOA-HC) or guardian, complete the following:

Health Care Surrogate Authorization *Also Requires Completion of Side 2, #1.C.*

Signature_____Date_____

Send original with patient when discharged or transferred

NEVADA POLST (Provider Order for Life-Sustaining Treatment)

Patient Name: _____ **DOB:** _____

SIDE 2: Supplementary Information

1. Representative/Surrogate Information – The following may have further information regarding patient's preferences:

A. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney for Health Care (DPOA-HC) ☐ NO ☐ YES

AD filed with Living Will Lockbox: ☐ NO ☐ YES - Registration #, if known:_____

Other AD location: _____

DPOA-HC – This information must be taken directly from the patient's valid DPOA-HC, not verbally

Appointed agent #1: _____ Telephone No: _____

Appointed agent #2: _____ Telephone No: _____

B. Court-Appointed Guardian ☐ NO ☐ YES Name: _____ Phone: _____

C. Health Care Surrogate: Name (printed): _____

Relationship: _____ Phone: _____

2. PREPARER: Preparer's Name (print): _____ Title/Position (MSW, RN, etc.) _____

3. REGISTRY: Provider initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox at: www.LivingWillLockbox.com

4. ORGAN DONATION

☐ I have documented on my license or state-issued ID that I would like to donate my organs

Terms of Use

- The POLST is ALWAYS VOLUNTARY and may not be mandated for a patient.
- The POLST is intended for the seriously ill or frail, and for whom a health care professional would not be surprised if they died within a year; others should be offered an AD with DPOA-HC designation.
- This medical order is to be honored in all care settings. In-patient order sets should reflect these POLST orders. The POLST is to be followed until replaced by new orders.
- Should a patient have both a DNR Identification and POLST, the most recent order should be followed.
- Photocopied, faxed or electronic versions are valid as long as required signatures (Section E) are included.
- When comfort cannot be achieved in the current setting, the patient should be transferred to a setting that is able to provide comfort.

Completing a POLST

- If a patient lacks decisional capacity, their legal representative (DPOA-HC, guardian or parent of a minor) may complete a POLST. If the patient has no legal representative *and* lacks decisional capacity, then a surrogate may complete a POLST for the patient. Surrogates are (in this order): a spouse, the majority of adult child(ren), parent(s), a majority of adult sibling(s), the nearest other adult relative of the patient by blood or adoption who is reasonably available, or "an adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient."
- A POLST does not replace an Advance Directive. An AD may designate a decision-maker (DPOA-HC) in the event the patient becomes incapacitated, documents additional treatment preferences and should be encouraged to be completed. Always check for inconsistencies between End-of-Life documents and make corrections as appropriate.
- Completion of a POLST should follow a discussion of the patient's goals, values and how their treatment preferences will impact both their longevity and quality of life.
- Any section not completed creates no presumption about the patient's preferences for treatment for that section.
- Patients discharged home should place the POLST next to their bed or on their refrigerator where EMS is trained to look.

POLST Review - This POLST should be reviewed periodically, and if:

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

Voiding POLST

- If the patient has decisional capacity, only the patient may void a POLST.
- Without decisional capacity, the patient's legal representative may revoke a POLST, or the patient's surrogate may revoke the POLST *only* if the POLST was completed by the patient's surrogate (see Completing a POLST, first bullet, above).

Send original with patient when transferred or discharged

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