Triage Cancer Estate Planning Toolkit: New Jersey

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.

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

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 adult witnesses.
3. Your will does not need to be notarized to be legal in New Jersey. 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, New Jersey 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 New Jersey:

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.

In New Jersey, a durable 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, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you revoke your power of attorney.

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

1. **New Jersey Proxy Declaration:** This is also known as durable power of attorney for health care directives. This document lets you chose someone (your "health care representative") 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.
2. **New Jersey Instruction 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. You can also indicate if you would like to make an organ donation with this document.
3. **Signature and Witnessing Provisions:** You must sign your advance health care directive in front of a notary public or two witnesses. Your witnesses must be at least 18 years old, and cannot be your health care representative or alternate representative.

Your advance health care directive takes effect when your doctor and another doctor determine, in writing, that you can no longer understand or make health care decisions.

You can revoke your AHCD by:

- Announcing your revocation in writing or orally to your health care provider
- Doing anything else to demonstrate you want to revoke this document (e.g., destroying or tearing up the document)
- Creating a new advance health care directive

If you appoint your spouse or domestic partner as your representative, this will be automatically revoked if your marriage/partnership dissolves, unless you specify differently in the "further instructions" section.

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 New Jersey, this form lets you indicate your preferences for:

- Goals of care (e.g., better quality of life, longevity, spending time with family)
- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Other 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.

New Jersey's Appointment of Agent to Control the Funeral and Disposition of Remains form lets you appoint a Funeral and Disposition Agent (your "agent") to organize your funeral arrangements and the disposition of your remains after your death. You can also appoint a successor agent if the first person you choose is not available. You must sign this form in front of two witnesses and a notary public.

Part III of this toolkit includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

As of 2019, New Jersey's Aid in Dying for the Terminally Ill Act gives certain patients the right to request compassionate, safe aid in dying. Qualified patients must:

- Be 18 years or older
- Be a New Jersey resident
- Be diagnosed with an incurable terminal illness with a prognosis of six months or less to live
- Be able to make medical decisions for yourself
- Be able to take (eat, drink, swallow, or inject) the aid-in-dying medication by yourself

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

- Verbally ask for the medication twice, at least 15 days apart.
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- 48 hours after receiving all three requests, your doctor will provide you with the medication

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place.

If your doctor refuses to administer an aid-in-dying medication, you may transfer to another health care provider or facility. The provider or facility refusing to provide the aid-in-dying medication must facilitate your transfer to another health care professional at your request.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one. If you pass away after taking an aid-in-dying medication, your death certificate will indicate that you died naturally from an underlying illness.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: New Jersey

Part III: Your State's Estate Planning Forms

- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- Appointment of Agent to Control the Funeral and Disposition of Remains
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

PROXY DIRECTIVE--(Durable Power of Attorney for Health Care)
Designation of Health Care Representative

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, _____, hereby designate _____,
of _____
_____,
(home address and telephone number of health care representative)

as my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

B) ALTERNATE REPRESENTATIVES: If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

1. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

2. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

_____

_____

_____

_____

D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

1. *name* _____
   address _____
   city _____ *state* _____ *telephone* _____
2. *name* _____
   address _____
   city _____ *state* _____ *telephone* _____

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20_____.

signature _____

address _____

city _____ *state*_____

F) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. *witness*_____
   address _____
   city _____ *state* _____
   signature _____
   date _____

2. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, _____, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

Part One: Statement of My Wishes Concerning My Future Health Care

*In **Part One**, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.*

*In **Section B and C**, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use **Section D**, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part One before completing your directive**.*

B) GENERAL INSTRUCTIONS: To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

Initial ONE of the following two statements with which you agree:

1. _____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition

2. _____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:

a. _____ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

In the space provided, write in the bracketed phrase with which you agree:

To me, terminal condition means that my physicians have determined that:

_____

[I will die within a few days] **[I will die within a few weeks]**
[I have a life expectancy of approximately _____ or less *(enter 6 months, or 1 year)***]**

b. _____ If there should come a time when I come **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all my medically appropriate care necessary to provide for my personal hygiene and dignity.

c. _____ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph **c.** covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section D** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

_____

_____

_____

_____

C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). *On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

In the space provided, write in the bracketed phrase with which you agree:

1. In the circumstances I initialed on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

_____

[be withheld or withdrawn and that I be allowed to die]
[be provided to the extent medically appropriate]

2. In the circumstances I initialed on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

_____

[not be provided and that I be allowed to die]
[be provided to preserve my life, unless medically inappropriate or futile]

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

_____

_____

_____

D) ADDITIONAL INSTRUCTIONS: *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

_____

_____

_____

E) BRAIN DEATH*: (The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

Initial the following statement only if it applies to you:

_____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

F) AFTER DEATH - ANATOMICAL GIFTS: *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

Initial the statements which express your wishes:

1. _____ **I wish** to make the following anatomical gift to take effect upon my death:

   A. _____ any needed organs or body parts
   B. _____ only the following organs or parts

_____

for the purposes of transplantation, therapy, medical research or education, or

   C. _____ my body for anatomical study, if needed.
   D. _____ special limitations, if any:

_____

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

_____

_____

_____

2. _____ **I do not wish** to make an anatomical gift upon my death.

Part Two: Signature and Witnesses

G) COPIES: The original or a copy of this document has been given to the following people *(NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.):*

1. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

2. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

H) SIGNATURE: By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20_____.

signature _____

address _____

city _____ *state*_____

I) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

2. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

PERSON NAME (LAST, FIRST, MIDDLE) _____ DATE OF BIRTH _____

A

GOALS OF CARE

(See reverse for instructions. This section does not constitute a medical order.)

B

MEDICAL INTERVENTIONS: *Person is breathing and/or has a pulse*

❑ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.

❑ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.

- ❑ Transfer to hospital for medical interventions.
- ❑ Transfer to hospital only if comfort needs cannot be met in current location.

❑ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders:_____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:

Always offer food/fluids by mouth if feasible and desired.

❑ No artificial nutrition.

❑ Defined trial period of artificial nutrition.

❑ Long-term artificial nutrition.

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

❑ Attempt resuscitation/CPR

❑ Do not attempt resuscitation/DNAR

Allow Natural Death

AIRWAY MANAGEMENT

Person is in respiratory distress with a pulse

❑ Intubate/use artificial ventilation as needed

❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort.

❑ Additional Order (for example defined trial period of mechanical ventilation) _____

E

If I lose my decision-making capacity, I authorize my surrogate decision maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN in keeping with my goals: ❑ Yes ❑ No

❑ Health care representative identified in an advance directive ❑ Other surrogate decision maker

_____

Print Name of Surrogate (address on reverse) Phone Number

F

SIGNATURES:

I have discussed this information with my physician/APN.

Print Name_____

Signature_____

❑ Person Named Above

❑ Health Care Representative/Legal Guardian

❑ Spouse/Civil Union Partner

❑ Parent of Minor

❑ Other Surrogate

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

_____

PRINT - Physician/APN Name Phone Number

_____

Physician/APN Signature (Mandatory) Date/Time

_____

Professional License Number

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Print Person's Name (last, first, middle) | Date of Birth

Print Person's Address

CONTACT INFORMATION

Print Surrogate Health Care Decision Maker | Address | Phone Number

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician or advance practice nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

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

MODIFYING AND VOIDING POLST - *An individual with decision making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

Section A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.

Section B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

Section C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

Section D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

Section E

This section is applicable in situations where the person has decision making capacity when the POLST form is completed. A surrogate may only void or modify an existing POLST form, or execute a new one, if named in this section by the person.

Section F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

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Funeral Designation Form

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Cemetery Board
124 Halsey Street, 6th Floor, P.O. Box 45036
Newark, New Jersey 07101
(973) 504-6553

Appointment of Agent to Control the Funeral and Disposition of Remains

In accordance with N.J.S.A. 45:27-22

General Directions For This Form

- This form creates a Funeral and Disposition Agent ("Agent") who you appoint to authorize your funeral arrangements and the final disposition of your remains after your death. The appointed Agent will have **sole authority** to make decisions regarding your funeral and the final disposition of your remains.

- If you have executed a Last Will and Testament in which a person to control your funeral and disposition is already named, execution of this form will revoke that appointment in favor of the appointment made here. You may appoint as your Agent the same person named as Executor in your Will.

- This form must be signed by you in the presence of two (2) witnesses and a Notary. Both witnesses must sign the completed form, and the Notary must notarize it where indicated.

- You may **NOT** appoint as your Agent any owner, employee, or representative of the funeral home, cemetery or crematory you have chosen/will choose to provide any goods or services related to your funeral and/or the disposition of your remains, unless said person is your relative.

- You may name a successor agent on this form. If your designated Agent(s) is unable or unwilling to act, and no successor agent is named (or the named successor is unable/unwilling to act), the right to control the funeral and disposition of your remains is determined by N.J.S.A. 45:27-22(a). The statute lists the order of priority for the right to control as surviving spouse, then adult children, then parents, then siblings and other next of kin.

Copies of this executed form should immediately be given to the named Agent and any other person who should be informed of the appointment of the Agent, such as the successor agents (if any), funeral home, cemetery or crematory, family members, estate attorney, etc.

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Cemetery Board
124 Halsey Street, 6th Floor, P.O. Box 45036
Newark, New Jersey 07101
(973) 504-6553

Appointment of Agent to Control the Funeral and Disposition of Remains

I, _____,
(Your name, mailing address, telephone number, email address)

being an adult of sound mind, hereby willfully and voluntarily appoint _____
(Name of Designated Funeral and Disposition Agent)

to serve as my Funeral and Disposition Agent ("Agent"), who, upon my death, shall have authority and power to control and carry out the arrangements for my funeral and the disposition of my remains.

Prior Arrangements:

I ☐ **have** ☐ **have not** entered into a pre-need agreement for funeral services and/or merchandise pursuant to N.J.S.A. 45:7-82 et seq.

_____
_____
(Name and address of funeral home with which you entered into a pre-need funeral arrangement to provide merchandise and/or services)

I ☐ **do** ☐ **do not** own an interment space within the cemetery below. Title to the interment space is currently located at: _____

_____
_____
(Name and address of cemetery where you own an interment space)

Preferences:

Set forth below are my preferences regarding funeral arrangements and the disposition of my remains. My Agent is not bound by the preferences stated below and may ultimately authorize arrangements and/or final disposition that conflict with any preference listed:

Preferred Funeral Arrangements	Preferred Disposition of Remains

Designated Funeral and Disposition Agent:

Name:_____
Address:_____
Telephone Number: _____
(include area code)
Email Address: _____

Successor Agent Optional:

Name:_____
Address:_____
Telephone Number: _____
(include area code)
Email Address: _____

☐ I choose **not** to name a Successor Agent. I understand that if my designated Agent is unable or unwilling to act, the right to control the funeral and disposition of my remains shall be governed by N.J.S.A. 45:27-22.

This form has been approved by the New Jersey Cemetery Board in accordance with N.J.S.A. 45:27-22.

Authorization:

This appointment becomes effective upon the completion and proper execution of this entire document (witnessed and notarized). At such time, and in so doing, any previous appointment of a person to control the funeral and disposition of my remains is hereby revoked.

In executing this form appointing a Funeral and Disposition Agent, I warrant that all representations and statements contained in this document are true and correct and that all of the statements and signatures are made in order to appoint a Funeral and Disposition Agent. I understand that this appointment supersedes all other priority classes outlined in N.J.S.A. 45:27-22.

Signature of person appointing the Funeral and
Disposition Agent:

_____

Signed this _____ day of _____, 20 _____

Witnesses:

I declare that the person who executed this document above is personally known to me and appears to be of sound mind and acting of his/her free will. He/She signed this document in my presence.

Witness #1:

Name:_____

Address: _____

City:_____ State_____ Zip _____

Signature:_____

Signed this _____ day of _____, 20_____

Witness #2:

Name:_____

Address: _____

City:_____ State_____ Zip _____

Signature:_____

Signed this _____ day of _____, 20_____

Acknowledgement by Notary:

State of New Jersey, County of _____

I certify that the persons named above personally appeared before me, were confirmed and acknowledged to my satisfaction to be the persons identified in this Appointment of Agent to Control the Funeral and Disposition of Remains, and personally signed this document in my presence.

Signed and sworn to before me on this _____ day of _____ , _____

Notary Signature: _____

Notary Name: _____

Expiration of Notary Commission: _____

Affix Seal Here

Triage Cancer Estate Planning Toolkit

⌘

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