Triage Cancer Estate Planning Toolkit: Delaware

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.

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

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 and disposing mind and memory" (meaning you know what you're doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses (in Delaware, these people can be included in your will, although that may not be true in other states). Your witnesses also need to sign your will in front of you.
3. Your will does not need to be notarized to be legal in Delaware. But, 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 will sign an affidavit affirming the will in front of a notary.

A holographic will is one that is handwritten by you. Holographic wills can also be used in Delaware, as long as they are written entirely in your handwriting and meet the conditions above. 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.

Delaware's statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint one or more successor agents to act if the first person you appointed resigns, dies, becomes incapacitated, isn't qualified to serve, or declines to serve. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated until you die, unless you or a court revokes your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) 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 Delaware, this form has three parts:

1. **Power of Attorney for Health Care:** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, if you become unable. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care. Unless they are related to you, your agent cannot be the operator or an employee of a community care or residential care facility where you are receiving care.
2. **End of Life Decisions:** Sometimes called a "living will," this document lets you indicate your preferences for end-of-life health care if you become unable to speak for yourself. You can provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include. In Delaware, you can select decisions based on various conditions you may be in (e.g., permanently unconscious versus having a serious illness).
3. **Anatomical Gift Declaration:** Here you can indicate whether or not you would like to make an organ or tissue donation, what type of donation you would like to make, what organization or person would receive that gift, and what the gift can be used for.

To make your advance health care directive valid, you must sign and date the document, or ask someone to do so for you. Your signature must be witnessed by a notary public or two witnesses. Your witnesses must be at least 18 years old, and may not be:

- Related to you be blood, marriage, or adoption
- Entitled to anything in your will
- Have a claim against any portion of your estate
- Financially responsible for your health care, or
- Your health care provider or an employee of your provider

If you are executing your advance health care directive while a resident of a mental health facility, rest home, nursing home, or related institution, one of your witnesses must be a designated patient advocate.

You can revoke all or part of your AHCD in a number of ways, but this decision should be documented in writing:

- Through a signed statement
- By creating a new AHCD
- In any way that expresses your intent in front of two people, if one of them is a health care provider

Under Delaware law, life-sustaining procedures will not be withheld or withdrawn from a pregnant patient, regardless of their AHCD, if continuing treatment will likely lead to the continued development of the fetus.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Delaware, this is called a Delaware Medical Order for Scope of Treatment, or DMOST. The DMOST does not replace an advance health care directive. You can complete a DMOST form with your doctor. This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

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

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.

Delaware does not have a funeral designation form. However, by statute it allows for a "Declaration of Disposition of Last Remains" form and requires that your declaration follow a specific format. You are able to indicate what you want to happen to your body, what ceremonial arrangements should be made, and any special instructions.

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.

Delaware is considering an aid-in-dying law, but it hasn't passed yet. However, you can indicate other decisions related to end-of-life care through an advance health care directive and/or DMOST.

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 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: Delaware

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Delaware Medical Order for Scope of Treatment (DMOST)
- HIPAA Authorization Form

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Power of Attorney for Financial Affairs

Delaware Durable Personal Power of Attorney

Notice to Principal

As the person signing this durable power of attorney, you are the Principal. The purpose of this power of attorney is to give the person you designate (your "Agent") broad powers to handle your property, which may include powers to sell, dispose of, or encumber any real or personal property without advance notice to you or approval by you.

This power of attorney does not authorize your Agent to make health-care decisions for you.

Unless you specify otherwise, your Agent's authority will continue even if you become incapacitated, or until you die or revoke the power of attorney, or until your Agent resigns or is unable to act for you. You should select someone you trust to serve as your Agent.

This power of attorney does not impose a duty on your Agent to exercise granted powers, but when powers are exercised, your Agent must use due care to act for your benefit and in accordance with this power of attorney.

Your Agent must keep your funds and other property separate from your Agent's funds and other property.

A court can take away the powers of your Agent if it finds your Agent is not acting properly.

The powers and duties of an Agent under a durable power of attorney are explained more fully in Delaware Code, Title 12, Chapter 49A, Section 49A-114 and Sections 49A-201 through 49A-217.

If there is anything about this form that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

I have read or had explained to me this notice and I understand its contents.

_____ _____

Principal Date

Durable Personal Power of Attorney Form

As the person completing this form, you are the Principal. This form gives another person the power to act on your behalf. The other person is your Agent.

This form allows you to designate:

(1) one Agent at a time and up to two Agents in succession;
(2) two or more Agents who may act independently of each other (Concurrent Agents); or
(3) two or more Agents who must act together (Joint Agents).

If your Agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor Agent(s).

IF YOU HAVE QUESTIONS ABOUT THIS POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT(S), YOU SHOULD SEEK LEGAL ADVICE BEFORE COMPLETING AND SIGNING THIS FORM.

Designation of Agent

I, _____, name the following person(s) as my
(Name of Principal)

Agent(s):

Name of Agent:_____

Agent's Address:_____

Agent's Telephone Number:_____

DESIGNATION OF ADDITIONAL OR SUCCESSOR AGENTS (OPTIONAL)

Name of Agent:_____

Agent's Address:_____

Agent's Telephone Number:_____

Name of Agent:_____

Agent's Address:_____

Agent's Telephone Number:_____

If more than one Agent has been named above, I intend for those Agents to:

_____ Act successively, one after the other.
_____ Act concurrently, independent of each other.
_____ Act jointly, such that neither may act alone.

You must sign ONE of these two choices:

_____ Sign here if this is your choice — This power of attorney is effective immediately, and shall not be affected by my subsequent incapacity.

_____ Sign here if this is your choice — This power of attorney is effective only if and while I am incapacitated as determined under 12 Del. C. § 49A-109(c).

Grant of General Authority

You should READ the terms of each category of power or authority listed below before granting any of them to your Agent(s). A full explanation of each power or authority is in the Delaware Code. The Delaware Code is available online.

Search: Delaware Code, Title 12, Chapter 49A, and then go to the number next to the category. Example: Real Property, Section (§) 49A-204. The Delaware Code may also be available at your local library.

I grant my Agent(s) general authority to act for me with respect to the following categories of powers. INITIAL each category you want to include in the Agent's general authority. CROSS OUT each category you do not want to include in the Agent's general authority.

If you do not initial a category listed below, powers associated with that category will NOT be included as part of your Agent's general authority.

_____ Real Property § 49A-204
_____ Tangible Personal Property § 49A-205
_____ Stocks and Bonds § 49A-206
_____ Commodities and Options § 49A-207
_____ Banks and Other Financial Institutions § 49A-208
_____ Operation of Entity or Business § 49A-209
_____ Insurance and Annuities § 49A-210
_____ Estates, Trusts, and Other Beneficial Interests § 49A-211
_____ Claims and Litigation § 49A-212
_____ Personal and Family Maintenance § 49A-213
_____ Benefits from Governmental Programs or Civil or Military Service § 49A-214
_____ Retirement Plans § 49A-215
_____ Taxes § 49A-216
_____ Gifts § 49A-217

Grant of Specific Authority

Giving your Agent(s) any of the following powers will give your Agent(s) the authority to take actions that could significantly reduce your property or change how and to whom your property is distributed at your death.

You should READ the terms describing each power before granting any of them to your Agent(s). INITIAL each power you want to include in the Agent's authority. CROSS OUT each power you do not want to include in the Agent's authority.

If you do not initial a power listed below, it will NOT be included as part of your Agent's specific authority.

_____ Create, amend, revoke, or terminate an inter vivos trust

_____ Make a gift in excess of the limitations provided in the Durable Personal Power of Attorney Act, 12 Del. C. § 49A-217

_____ Create or change rights of survivorship

_____ Create or change a beneficiary designation

_____ Delegate authority granted under the power of attorney when all successor Agents have resigned, died, become incapacitated, are no longer qualified to serve, or have declined to serve

_____ Exercise fiduciary powers that the Principal has authority to delegate

_____ Reject, renounce, disclaim, release, or consent to a reduction in or modification of a share in or payment from estate, trust, or other beneficial interest

Any person, including my Agent(s), may rely upon this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

Revocation of Prior Power of Attorney

If you have previously executed a power of attorney granting authority covered in this document, indicate below whether or not you wish to revoke the prior power of attorney. **Initial** your selection below:

_____All my previously executed powers of attorney are hereby revoked.

_____My previously executed powers of attorney hereby remain in effect.

_____Other. Explain._____

_____

_____

IF YOU HAVE QUESTIONS ABOUT THIS POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT(S), YOU SHOULD SEEK LEGAL ADVICE BEFORE SIGNING THIS FORM.

IN WITNESS WHEREOF, I have hereunto set my Hand and Seal this _____ day of _____, 20_____ .

_____
Principal's Signature

_____
Print Principal's Name

SIGNED, SEALED, AND DECLARED by the Principal, _____,
as his/her Durable Personal Power of Attorney in the presence of the following witness, who has signed in the presence of and at the request of the Principal on the day and year appearing above.

I, the witness, swear that I am not related to the Principal by blood, marriage, civil union, or adoption; and that I am not entitled to any portion of the estate of the Principal under the Principal's current will or codicil, or under any current trust instrument of the Principal.

_____ of _____
(Seal) Witness Signature

_____
Print name

STATE OF DELAWARE :: SS.

COUNTY OF _____ :

This Durable Power of Attorney was signed by the Principal, witnessed by the person aforesaid, and acknowledged before me, the Subscriber, a Notary Public, this _____ day of _____ 20_____.

_____
Notary Public

Statement to Agent

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:

(1) 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;
(2) act in good faith;
(3) do nothing beyond the authority granted in this power of attorney;
(4) 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

and

(5) to the extent reasonably practicable under the circumstances, keep in regular contact and communication with the principal.

Except as otherwise provided in the power of attorney, you must also:

(1) not act for your own benefit;
(2) avoid conflicts that would impair your ability to act in the Principal's best interest;
(3) act with care, competence, and diligence;
(4) keep a record of all receipts, disbursements, and transactions made on behalf of the Principal;
(5) cooperate with any person who has authority to make health-care decisions for the Principal; and
(6) not act in a manner inconsistent with the Principal's testamentary plan.

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 this power of attorney or your authority to act under it include:

(1) death of the Principal;
(2) the Principal's revocation of the power of attorney or your authority;
(3) the occurrence of a termination event stated in the power of attorney;
(4) the purpose of the power of attorney is fully accomplished; or
(5) an action is filed with a court for your separation, annulment, or divorce from the Principal, unless the Principal otherwise provided in the power of attorney that such action will not terminate your authority.

Liability of Agent

The authority granted to you is specified in the Durable Personal Power of Attorney Act, Delaware Code, Title 12, Chapter 49A. If you violate the Act, or act outside the scope of the authority granted, you may be liable for any damages caused by your violation.

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

Agent's Certification

I, _____, have read the attached durable power of attorney and the foregoing statement, and I am the person identified as the Agent for the Principal. To the best of my knowledge, this power has not been revoked. I hereby acknowledge that, in the absence of a specific provision to the contrary in the durable power of attorney, when I act as Agent:

I shall exercise my powers for the benefit of the Principal.
I shall keep the assets of the Principal separate from my assets.
I shall exercise reasonable caution and prudence.
I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the Principal.
I shall, to the extent reasonably practicable under the circumstances, keep in regular contact with the Principal and communicate with the Principal.

_____ _____

Agent Signature Date

Effective October 1, 2010

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Advance Health Care Directive

ADVANCE HEALTH-CARE DIRECTIVE OF

_____

ABOUT THIS FORM

This form is a legal document that lets you name another individual or individuals as your "agent(s)" to make health-care decisions for you if you become incapable of making your own decisions (**Part 1**). It also allows you to communicate your wishes – ahead of time – regarding your care near the end of life (**Part 2**). If desired, you may also make choices about being an organ donor (**Part 3**). You can complete all of these parts, but each part can stand alone so you do no have to complete every part unless you choose.

IMPORTANT: Your agent will not be asked to make any decisions as long as you are capable and can communicate for yourself. You always have the right to give instructions about your own health care if you are able. However, if you do not write down your wishes about your health care in advance, and if you later become unable to understand, make, or communicate those wishes, they may not be honored because they may remain unknown to others.

USING THIS FORM

Part 1 of this form is a power of attorney for health care. You can name one or more persons as your agent(s) to make health-care decisions and you can decide if they may act together or one after the other.

Part 2 of this form provides you with the ability to give specific instructions regarding whether or not you wish to receive life-sustaining medical measures if you are ever declared "terminally ill" or "permanently unconscious" or "seriously ill or frail." There is also additional space in Part 2 for you to write out any additional instructions regarding your medical care.

Part 3 of this form lets you express an intention to donate your body, organs and/or tissues following your death, if you so choose.

HOW TO SIGN THIS FORM CORRECTLY SO THAT IT IS VALID

After you have finished filling this form out, sign and date it in front of two (2) qualified witnesses as described under "About the Witnesses" below. It does not need to be notarized to be effective. You will find the signature page following Part 3. Your witnesses will also have to sign this form on the last page, following your signature.

ABOUT THE WITNESSES:

- They cannot be related to you in any way (blood, marriage, or adoption).
- They cannot be a beneficiary of your estate.
- They cannot have a claim (actual or potential) against your estate.
- They cannot have direct financial responsibility for your medical care.
- If you are a resident in a long-term-care facility when you are signing, the witnesses cannot be owners, operators, or employees of the facility, and one of the witnesses must be a patient advocate or Ombudsman designated by the Delaware Department of Health and Social Services or the Delaware Public Guardian.
- They must be over 18 years old.

IF YOU HAVE QUESTIONS ABOUT THIS FORM,
YOU SHOULD SEEK LEGAL ADVICE BEFORE COMPLETING AND SIGNING IT.

ADVANCE HEALTH-CARE DIRECTIVE

I, _____ (*Your Full Name*), of _____ (*Name of County You Live In*) County, Delaware, declare this to be my Advance Health-Care Directive and revoke all previous Advance Health-Care Directives, Powers of Attorney for Health-care, Living Wills and similar documents made by me.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(OPTIONAL—If you DO NOT wish to appoint someone to make health-care decisions for you when you are unable, cross out all of Part 1 and skip to Part 2)

About your Agent: If you are a resident in a long-term care facility, the agent or agents designated below may not have a controlling interest in nor be the operator or employee of the long-term care facility in which you reside, unless the agent or agents are related to you by blood, marriage or adoption

(1) DESIGNATION OF AGENT: I designate the following individual as my Agent to make health-care decisions for me:

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

OPTIONAL: I hereby designate additional or successor Agent(s):

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

If more than one Agent has been designated above, I intend for these Agents to (**initial ONE only**):

_____ Act in succession (if one is not available, the next shall serve)
_____ Act independently (any available Agent may serve solely and independently)
_____ Act jointly (all Agents must act together, not independently)

(2) AUTHORITY OF AGENT(S): My Agent(s) is authorized to (**initial ALL that apply**):

_____ Provide for my admission to, or discharge from, a medical, nursing, residential, mental health or similar facility

_____ Enter into agreements for my care at home or in a facility

_____ Employ and discharge medical personnel, including physicians, psychiatrists, dentists, nurses, and therapists

_____ Approve medical and surgical procedures, including administration of drugs

_____ Consent to and arrange for the administration of pain-relieving drugs

_____ Consent to psychiatric treatment

_____ Sign medical releases for medical personnel who provide treatment to me pursuant to instructions given by my Agent

_____ Sign, authorize or revoke a Delaware Medical Orders for Scope of Treatment ("DMOST") or similar document under the laws of other States unless prohibited by the terms of the DMOST or other document.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My Agent's authority becomes effective when my primary care physician or my currently treating physician determines I lack the capacity to make my own health-care decisions. When I want my agent to make decisions about providing, withholding or withdrawing a life-sustaining procedure, my agent's authority shall become effective only upon a determination that I lack capacity and am in a qualifying condition. I am in a qualifying condition if I am permanently unconscious or terminally ill or suffer from a serious illness or frailty that may cause me to die within the next year. When the condition in question is "permanently unconscious," the determination of qualifying condition must be made by my attending physician and by at least 1 other physician who shall be a board-certified neurologist and/or neurosurgeon.

(4) AGENT'S OBLIGATION: My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes, to the extent they are known to my Agent. To the extent that my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

(5) AUTHORIZATION TO RELEASE MEDICAL INFORMATION: Effective:

(Initial ONE only)

____ effective immediately notwithstanding the provisions of paragraph (3) above,

____ effective when my agent's authority becomes effective under the provisions of paragraph 3 above,

and continuously until my death or revocation by a writing signed by me or someone authorized to make health-care decisions for me, I authorize and request any physician, health-care professional, health-care provider, and medical care facility (collectively, "health-care providers") to provide to my Agent information, oral or written, relating to my physical and mental condition and the diagnosis, prognosis, care, and treatment thereof upon the request of my Agent I have appointed under this instrument, including, but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024, generally referred to as "HIPAA"), the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a health-care provider may be redisclosed and may no longer be subject to the privacy rules provided by Section 164 of Title 45 of the Code of Federal Regulations. It is my intent by this authorization for my Agent to be considered a personal representative under privacy regulations related to protected health information and for my Agent to be entitled to all health information in the same manner as if I personally were making the request. This authorization and request shall also be considered a consent to the release of such information under current laws, rules, and regulations as well as under future laws, rules, and regulations and amendments to such laws, rules, and regulations to include but not be limited to the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy laws and regulations.

PART 2: END – OF – LIFE DECISIONS

(OPTIONAL—If you DO NOT wish make known your wishes, at this time, regarding end-of-life treatment, cross out all of Part 2 and skip to Part 3)

If you do not complete any part of Part 2, the agent appointed under Part 1, if any, will have the power to make all medical decisions for your benefit.

This form offers you ability to specify how you wish to be treated if you are diagnosed with one or more of three "Qualifying Conditions."

"Qualifying condition" means the existence of one or more of the following conditions in the patient, certified in writing in the patient's medical record by the attending physician and by at least one other physician who, when the condition in question is "permanently unconscious" shall be a board-certified neurologist and/or neurosurgeon:

(1) "Permanently unconscious" or "permanent unconsciousness" means a medical condition that has existed for at least 4 weeks and that has been diagnosed in accordance with currently

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.

(2) "Terminal condition" means any disease, illness or condition sustained by any human being for which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of such human being regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life or the life processes.

(3) "Serious illness or frailty" means a condition based on which the health-care practitioner would not be surprised if the patient died within the next year.

About your options: It is important to read each option fully before **choosing**. Please note that you **may** to choose only one option under each qualifying condition but you may choose a different option under a different qualifying condition. You will also have the opportunity to write-in any other medical instructions.

Qualifying Condition: Terminally Ill.

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select one option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I become **terminally ill** and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I become **terminally ill** and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments – if any – you do not want, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

_____ **Option 3: Do not Prolong Life:** In the event I become **terminally ill** and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments – if any – you do want, even if they could sustain your life):

I **DO WANT** the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

Qualifying Condition: Permanently Unconscious

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select **ONE** option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I become **permanently** unconscious and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I become **permanently unconscious** and am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you do not want, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

_____ **Option 3: Do Not Prolong Life:** In the event I become **permanently unconscious** and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

I DO WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

Qualifying Condition 3: Serious Illness or Frailty.

Note. Whether you elect to complete this section of Part 2 or not, when you develop a "serious illness or frailty" as defined at the beginning of this Part 2, you or if you are unable, your agent under Part 1, can meet with your qualified health-care provider and execute a Delaware Medical Order for Life Sustaining Treatment which will create a medical order specifying your wishes for life sustaining treatment.

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select **ONE** option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I have a "**serious illness or frailty"** and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I have a "**serious illness or frailty**" and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you **do not want**, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotic

_____ **Option 3: Not to Prolong Life:** In the event I have a "**serious illness or frailty**" and I am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

I **DO WANT** the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

COMFORT CARE

Regardless of the option I chose above regarding end of life decisions. (Initial ONE choice below)

_____I wish to be treated to relieve pain or provide comfort, and I understand that such treatment might shorten my life or suppress my appetite or breathing.

_____I do not wish to be treated to relieve pain or provide comfort.

Other Medical Instructions: If you wish to add to the instructions you have given in this Part 2 of your Advance Health-Care Directive, you should do so in the space below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

PART 3: ANATOMICAL GIFT DECLARATION

(OPTIONAL—If you DO NOT wish to make anatomical gifts at this time, cross out all of Part 3 and skip to the ADMINISTRATIVE PROVISIONS section below.)

If you wish to make anatomical gifts of your body, organs and/or tissues upon your death, you may indicate your specific desires here I hereby make the following anatomical gift(s) to take effect upon my death.

I give (**initial ONE only**)

_____ my body
_____ any needed organs, tissues, or parts
_____ the following organs, tissues or parts (write in on the line below):

_____

to (**initial ONE only**)

_____ the physician in attendance at my death
_____ the hospital in which I die
_____ the following named physician, hospital, storage bank or other medical institution:

_____

for the following purpose(s) (**initial ALL that apply**)

_____ any purpose authorized by law
_____ transplantation
_____ therapy
_____ research
_____ medical education

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

ADMINISTRATIVE PROVISIONS

REVOCATION, REMOVAL, AMENDMENT, OR RESIGNATION: I understand that, if I am mentally competent, I may revoke all or part of this document by writing down my revocation instructions and signing them. I do not need an attorney, health care provider or witnesses to do so, although I understand that it is best to have two witnesses sign after my signature. I further understand that it is best to give a copy of such written revocation instructions to my agents and health care providers. (Note: while you can revoke all or part of this document as described above, adding to your Advance Heath Care Directive requires completing a new form or writing signed by two qualified witnesses.)

I understand that I may also revoke this health care directive in any manner that communicates an intent to revoke done in the presence of two competent persons, one of whom is a health care provider. I further understand that any revocation that is not in writing shall be memorialized in writing and signed and dated by both witnesses, and made a part of my medical record.

I understand that, if I have designated my spouse as my agent, a decree of annulment, divorce, dissolution of marriage or a filing of a petition for divorce revokes that designation unless otherwise specified in the decree or in a power of attorney for health care.

I understand that the initiation of emergency treatment shall be presumed to represent a suspension of an advance health-care directive while receiving such emergency treatment.

Also, I understand that, upon written notification to me or to anyone who is caring for me or has custody of me, one or more of my health-care Agents may resign.

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE

Having carefully read this document, I understand its purpose and effect, and hereby sign and date below:

_____ _____

(*Date*) (*Sign your name*)

_____

(*Print your name*)

_____

(*Street*)

_____

(*City, State, Zip Code*)

STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del. C. §§ 2502,2503, in our presence, who in his/her presence at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. The Declarant is mentally competent.

B. That neither of us is prohibited by § 2503 of Title 16 of the Delaware Code from being a witness. Neither of us:

1. Is related to the declarant by blood, marriage, or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health-care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health-care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive, a patient advocate or ombudsman designated by the Department of Health and Social Services or the Public Guardian.

Witness	Witness
_____	_____
(*Print name*)	(*Print name*)
_____	_____
(*Address*)	(*Address*)
_____	_____
(*City, State, Zip Code*)	(*City, State, Zip Code*)
_____	_____
(*Signature of Witness*) (*Date*)	(*Signature of Witness*) *(Date)*

You do not need to have this form notarized, but notarization may enhance its effectiveness in other states.

(Optional Notarization)

Sworn and subscribed to me this _____ day of _____, 20_____.

My term expires: _____ _____

(*Notary*)

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Physician Orders for Life Sustaining Treatment (POLST)

DELAWARE MEDICAL ORDERS FOR SCOPE OF TREATMENT (DMOST)

- FIRST, follow the orders below. THEN contact physician or other health-care practitioner for further orders, if indicated.
- The DMOST form is voluntary and is to be used by a patient with serious illness or frailty whose health care practitioner would not be surprised if the patient died within next year.
- Any section not completed requires providing the patient with the full treatment described in that section.
- Always provide comfort measures, regardless of the level of treatment chosen.
- The Patient or the Authorized Representative has been given a plain-language explanation of the DMOST form.
- The DMOST form must accompany the patient at all times. It is valid in every health care setting in Delaware.

_____ / / _____

Print Patient's Name (last, first, middle) Date of Birth last four digits of SSN Gender

_____ _____

Patient's Address Phone Number

A **Goals of Care** (see reverse for instructions. This section does not constitute a medical order.)

B **Cardiopulmonary Resuscitation (CPR)** *Patient has no pulse and/or is not breathing*

☐ Attempt resuscitation/CPR. ☐ Do not attempt resuscitation/DNAR.

C **Medical Interventions:** *Patient is breathing and/or has a pulse.*

☐ **Full Treatment**: Use all appropriate medical and surgical interventions, including intubation and mechanical ventilation in an intensive care setting, if indicated to support life. Transfer to a hospital, if necessary.

☐ **Limited Treatment**: Use appropriate medical treatment, such as antibiotics and IV fluids, as indicated. May use oxygen and noninvasive 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 setting.

☐ **Treatment of Symptoms Only/Comfort Measures:** Use any medications, including pain medication, by any route, positioning, wound care, and other measures to keep clean, warm, dry, and comfortable. 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.

☐ **Other Orders**:_____

D **Artificially Administered Fluids and Nutrition:** *Always offer food/fluids by mouth if feasible and desired.*

☐ Long-term artificial nutrition

☐ Defined trial period of artificial nutrition: Length of trial: _____Goal:_____

☐ No artificial nutrition ☐ hydration only ☐ none (check one box)

E **Orders Discussed With:** ☐ Patient _____ph.#_____

Printed Name & phone number

☐ Guardian ☐ Surrogate (per DE Surrogacy Statute)

☐ Other ☐ Agent under healthcare POA/or AHCD _____

Signature

☐ Parent of a minor

-

_____

Print Name of Authorized Representative Relation to Patient Address Phone #

If I lose capacity, my Authorized Representative may / may not change or void this DMOST _____

Patient Signature

F **SIGNATURES:** Patient/Authorized Representative/Parent (mandatory) *I have discussed this information with my Physician / APRN / PA*

_____

Signature Date

If authorized representative signs, the medical record must document that a physician has determined the patient's incapacity & the authorized representative's authority, in accordance with DE law.

Physician / APRN / PA

_____

Signature Date Time

_____

Print Name

_____

Print Address

_____

License Number Phone #

DIRECTIONS FOR HEALTH-CARE PROFESSIONALS

COMPLETING A DMOST FORM

- Must be signed by a Licensed Physician, Advance Practice Registered Nurse, or Physician's Assistant.
- Use of original form is highly encouraged. Photocopies and faxes of signed DMOST forms are legal and valid.
- Any incomplete section of a DMOST form indicates the patient should get the full treatment described in that section.

REVIEWING A DMOST FORM -- It is recommended that a DMOST form be reviewed periodically, especially when:

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

MODIFYING AND VOIDING INFORMATION ON A COMPLETED DMOST FORM

A patient with decision-making capacity can void a DMOST form at any time in any manner that indicates an intent to void.

Any modification to the form voids the DMOST form. A new DMOST form may be completed with a health care practitioner. Forms are available online at www.delaware.gov/.

SECTION A This section outlines the specific goals that the patient is trying to achieve by this treatment plan. Health care professionals shall share information regarding prognosis with the patient in order to assist the patient in setting achievable goals. Examples may include:

- Longevity, cure, remission or better quality of life
- To live long enough to attend an important event (wedding, birthday, graduation)
- To live without pain, nausea, shortness of breath or other symptoms
- Eating, driving, gardening, enjoying time with family, or other activities

SECTION B This is a medical order. Mark a selection for the patient's preferences regarding CPR.

SECTION C This is a medical order. When "limited treatment" is selected, also indicate whether the patient prefers or does not prefer transfer to a hospital for additional care.

- IV medication to enhance comfort may be appropriate treatment for a patient who has indicated "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP).
- The patient will always be provided with comfort measures.
- Patients who are already receiving long-term mechanical ventilation may indicate treatment limitations on the "Other Orders" line.

SECTION D This is medical order. Mark a selection for the patient's preferences regarding nutrition and hydration. Check one box.

- Oral fluids and nutrition should always be offered if feasible and consistent with the goals of care.

SECTION E This section documents with whom the medical orders were discussed, the name of any healthcare professional who assisted in the completion of the Form, the name of any authorized representative and if the authorized representative may not modify/void the Form.

SECTION F To be valid, all information in this section must be completed.

HIPAA PERMITS DISCLOSURE OF DMOST FORMS TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT.

SEND FORM WITH PATIENT WHENEVER MOVED TO A NEW SETTING

Faxed, Copied, or Electronic Versions of the Form are legal and valid.

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