Triage Cancer Estate Planning Toolkit: North Dakota

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.

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

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, in front of two witnesses who watched you sign the will.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

North Dakota 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 North Dakota:

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.

While a holographic will is better than no will at all, 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 North Dakota, the durable power of attorney form allows you to appoint someone (your "attorney-in-fact") to oversee your finances and transactions, including buying and selling, managing and repairing personal property, and

making payments for you. You can either set a specific date for the general durable power of attorney to take effect, or indicate you want it to take effect if you become incapacitated. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (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 North Dakota, this form includes five parts.

1. **Power of Attorney for Health Care:** You can choose someone (your "agent") to make any and all health care decisions for you (including life-sustaining care), if your doctor determines you can no longer make these decisions yourself for any reason. This can be as broad as to include life-sustaining care, or you can limit the powers of your agent. You can also choose an alternate person if the first person you appoint is not available.
2. **Instructions for Health Care:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. This also allows you to include information on beliefs and values about your health care.
3. **Organ Donation:** You can choose whether or not you would like your organs to be given to someone after your death.
4. **Your Signature:** This is where you sign your advance health care directive to make it legal. You can either sign it in front of a notary public, or two witnesses. Neither can be:
    - Your agent or alternate agent
    - Your spouse
    - Someone related to you by blood, marriage, or adoption
    - Someone included in your will
    - Someone with a claim against your estate (e.g. someone suing you)
5. **Your agent's signature:** In this section, your agent must sign to accept their power of attorney.

Your AHCD goes into effect once your doctor determines you are unable to communicate your health care decisions.

If you change your mind about instructions in your directive, you can revoke any part of these instructions (except the appointment of your agent) at any time by telling your agent or doctor, orally or in writing, of your intent to revoke your document, or by executing a new health care directive.

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

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. 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 hydration and 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.

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.

North Dakota does not have a funeral designation form, but you can indicate other preferences for end-of-life care in an advance health care directive.

State Laws About Death with Dignity

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

North Dakota does not have a death with dignity law.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to 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.

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Part III: Your State's Estate Planning Forms

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

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Power of Attorney for Financial Affairs

READ BEFORE COMPLETING THE POWER OF ATTORNEY FORM

CAUTION!

All ND Legal Self Help Center forms and information are provided as a general guide to a legal process and are not intended as legal advice.

As a self-represented individual, you must independently determine if the forms and information are legally sufficient for North Dakota and for your specific circumstances. Use at your own risk.

Any user of the forms or information is hereby advised that all forms and information are provided "as is." The forms and information provided may be subject to errors or omissions. The ND Legal Self Help Center IS NOT responsible for any consequences that may result.

If you are unsure if you should use this form, consult a lawyer.

A Durable Power of Attorney is a document authorizing a person to act as the Attorney in Fact of the Principal. A Durable Power of Attorney does not end if the Principal becomes unable to make their own decisions. A Durable Power of Attorney remains in effect even if the Principal becomes disabled or incapacitated.

A Durable Power of Attorney is for financial or other decisions. Heath care decisions are not authorized in a Durable Power of Attorney. There is a different document for health care decisions called a Health Care Directive.

The Durable Power of Attorney may 1) take effect upon the signature of the Principal and remain effective if the Principal becomes disabled or incapacitated; or 2) take effect only when the Principal becomes disabled or incapacitated.

A Durable Power of Attorney does not require a court order. The Principal may revoke the Durable Power of Attorney at any time, as long as they are legally competent. The revocation must be in writing.

A Durable Power of Attorney is not a guardianship and is not a conservatorship. Guardianships and conservatorships are court processes where a court appoints a guardian, conservator, or both for an adult, if legal requirements are met.

GENERAL DURABLE POWER OF ATTORNEY

I, _____, the Principal, whose mailing address is:

_____,

designate and appoint _____, whose mailing address is:

_____,

as my Attorney-in-Fact and agent in my name and for my benefit:

1) General Grant of Power: To exercise or perform any act, power, duty, right or obligations that I now have, or may acquire in connection with, arising from or relating to any person, item, transaction, business, real or personal property, tangible or intangible thing or any matter whatsoever;

a) Powers of Collection and Payment: To request, ask, demand, sue for, recover, collect, receive, hold, and possess all such sums of money, debts, dues, commercial paper, checks, drafts, accounts, dividends, certificates of deposit, annuities, pension and retirement benefits, insurance benefits and proceeds, documents of title, real and personal property which I now have or should subsequently become owned by, or due, owing, payable or belonging to me, or in which I have or may subsequently acquire interest, to have, use and take all lawful means and equitable and legal remedies, procedures and writs in my name for their collection and recovery;

b) Power to Acquire and Sell: To lease, purchase, exchange, grant options to sell, sell, and convey real or personal property, tangible or intangible, including homestead property and under such covenants, as the attorney-in-fact shall deem proper;

c) Management Powers: To maintain, repair, improve, invest, manage, insure, rent, lease, encumber, and in any manner deal with any real or personal property, tangible or intangible rights or interests, that I now own or may subsequently acquire, in my behalf, and in my name under such terms and conditions as the attorney-in-fact shall deem proper; and

d) Instruments: To sign, seal, execute and deliver all instruments in writing of whatsoever kind and nature as may be necessary and proper.

2) This document is to be construed and interpreted as a general durable power of attorney. The listing of specific items, rights, acts or powers is not intended to, nor does it, limit or restrict, and is not to be construed or interpreted as limiting or restricting, the general powers granted to the Attorney-in-Fact.

3) The rights, powers, and authority of the Attorney-in-Fact granted shall begin and be in full force and effect on _____, 20_____ (*date document is signed*).

4) **CHECK ONE**:

❑ This General Durable Power of Attorney shall not be affected by any subsequent disability or incapacity of the principal or by lapse of time. The rights, powers, and authority of the Attorney-in-Fact shall begin and be in effect on _____ _____, 20_____ (*date document is signed*).

OR

❑ This General Durable Power of Attorney becomes effective upon the disability or incapacity of the principal.

5) This General Durable Power of Attorney may be revoked by the Principal at any time that the Principal has the capacity to do so. Any revocation must be in writing and delivered to the named Attorney-in-Fact.

Dated this _____ day of _____, 20____

_____ (*Signature*)

_____(*Printed Name*)

_____

(*Address*) (*City, State, Zip Code*) (*Telephone Number*)

Signed and sworn to before me on _____, 20_____ by

_____.

_____

(*Notary Public or Clerk of Court*)
If Notary, my commission expires: _____

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Advance Health Care Directive

HEALTH CARE DIRECTIVE

http://www.legis.nd.gov/cencode/t23c065.pdf

I_____ , understand this document allows me to do ONE OR ALL of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to make and communicate health care decisions for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or my agent must act in my best interest if I have not made my health care wishes known. AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make and communicate decisions for myself. AND/OR

PART III: Allows me to make an organ and tissue donation upon my death by signing a document of anatomical gift.

PART I: APPOINTMENT OF HEALTH CARE AGENT THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II and/or Part III. None of the following may be designated as your agent:

- your treating health care provider, a nonrelative employee of your treating health care provider,
- an operator of a long-term care facility, or a nonrelative employee of a long-term care facility.

When I am unable to make and communicate health care decisions for myself, I trust and appoint _____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: _____
Telephone number of my health care agent: _____
Address of my health care agent: _____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

Relationship of my alternate health care agent to me: _____
Telephone number of my alternate health care agent: _____
Address of my alternate health care agent: _____

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF (I know I can change these choices). My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. Whenever I am unable to make and communicate health care decisions for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive and deciding about mental health treatment.
(B) Choose my health care providers.
(C) Choose where I live and receive care and support when those choices relate to my health care needs.
(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

_____
_____
_____

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

____(1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.
____(2) To decide what will happen with my body when I die (burial, cremation). If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

_____
_____
_____

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete, at a minimum, Part II (B) if you wish to make a valid health care directive. These are instructions for my health care when I am unable to make and communicate health care decisions for myself. These instructions must be followed (so long as they address my needs).

(A) THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:
My goals for my health care:

_____
_____
_____

My fears about my health care:

_____
_____
_____

My spiritual or religious beliefs and traditions:

My beliefs about when life would be no longer worth living:

My thoughts about how my medical condition might affect my family:

(B) THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help. I have these views about my health care in these situations: (Note: You can discuss general feelings, specific treatments, or leave any of them blank).

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want:

If I were dying and unable to make and communicate health care decisions for myself, I would want:

If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want:

If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want:

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

_____
_____
_____

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor:

_____
_____
_____

Where I would like to live to receive health care:

_____
_____
_____

Where I would like to die and other wishes I have about dying:

_____
_____
_____

My wishes about what happens to my body when I die (cremation, burial):

_____
_____
_____

Any other things:

_____
_____
_____

PART III: MAKING AN ANATOMICAL GIFT

I would like to be an organ donor at the time of my death. I have told my family my decision and ask my family to honor my wishes. I wish to donate the following (initial one statement):

[ ] Any needed organs and tissue.
[ ] Only the following organs and tissue:_____

PART IV: MAKING THE DOCUMENT LEGAL

PRIOR DESIGNATIONS REVOKED. I revoke any prior health care directive.

DATE AND SIGNATURE OF PRINCIPAL (YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)

I sign my name to this Health Care Directive Form on

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

_____
(You Sign here)

(THIS HEALTH CARE DIRECTIVE WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS HEALTH CARE DIRECTIVE.)

NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care. None of the following may be used as a notary or witness:

1. A person you designate as your agent or alternate agent;
2. Your spouse;
3. A person related to you by blood, marriage, or adoption;
4. A person entitled to inherit any part of your estate upon your death; or
5. A person who has, at the time of executing this document, any claim against your estate.

Option 1: Notary Public

In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

_____
(Signature of Notary Public)

My commission expires _____ , 20_____.

Option 2: Two Witnesses

Witness One:

(1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [ ].

I certify that the information in (1) through (3) is true and correct.

_____ _____
(Signature of Witness One) (Address)

Witness Two:

(1) In my presence on_____(date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [ ].

I certify that the information in (1) through (3) is true and correct.

_____ _____
(Signature of Witness Two) (Address)

ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY.
I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make health care decisions, I must notify the principal's physician.

_____
(Signature of agent/date)

_____
(Signature of alternate agent/date)

PRINCIPAL'S STATEMENT
I have read a written explanation of the nature and effect of an appointment of a health care agent that is attached to my health care directive.

Dated this _____ day of _____ , 20 _____.

_____
(Signature of Principal)

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth (mm/dd/yyyy)

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION** ☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

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

B Check One

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

Comfort Measures always provided regardless of level of care chosen.

☐ **COMFORT MEASURES ONLY -** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

- ☐ Avoid calling 911, call _____ instead (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS -** Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

☐ **FULL TREATMENT -** Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C Check One

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

Check One

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Artificial nutrition and hydration unless it provides no benefit.
- ☐ Long-term artificial nutrition by tube.

Additional Orders:

D Must fill out

DOCUMENTATION OF DISCUSSION (Required)

☐ Patient (if patient has capacity)

If patient lacks capacity:

- ☐ A Health Care Directive
- ☐ Health Care Agent
- ☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name Relationship

E

PATIENT or Health Care Agent/Legal Representative (Required)

Signature (Form Does Not Expire) Date of signature

F

ATTESTATION OF MD/DO/APRN/PA (Required)

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Name of MD/DO/APRN/PA Name Signer Phone Number Signer License Number

MD/DO/PRN/PA Signature: required Date: required Time: required

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Patient's Name			Patient's Date of Birth
Health Care Agent/Legal Representative Name	**Relationship**	**Phone Number**	**Address**
Name of Health Care Professional Preparing Form	**Preparer Title**	**Phone**	**Date Prepared**

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

North Dakota Century Code section 23-12-13 authorizes the following persons to give informed consent for an incapacitated patient in the following order of priority:

a: A health care agent;
b: The appointed guardian or custodian of the patient, if any;
c: The patient's spouse who has maintained significant contacts with the incapacitated person;
d: Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;
e. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person;
f. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person;
g. Grandparents of the patient who have maintained significant contacts with the incapacitated person;
h. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person; or
i. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Completing POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
- POLST must be signed and dated by a physician, advanced practice registered nurse, or physician assistant if delegated, to be valid. Verbal orders are acceptable with follow-up signature by physician, advanced practice registered nurse, or physician assistant if delegated in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- A automatic external defibrillator (AED) should not be used on a patient who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."
- A patient with capacity or the health care representative (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Clarifying POLST

- **Comfort Measures Only:** At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life.
- **Limit Interventions and Treat Reversible Conditions:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective. Comfort Measures will be offered.
- **Full Treatment:** The goal at this level is to preserve life by providing all available medical treatment and advanced life support measures when reasonable and indicated. For patient's designated DNR status in section A above, medical care should be discontinued at the point of cardio and respiratory arrest. Comfort Measures will be offered.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change.
4. The ND POLST form does not expire.

Additional copies of the ND POLST are available here: www.honoringchoicesnd.org/

Faxed copies and photocopies of this form are valid.
To void this form, draw a line across Sections A - D and write "VOID " in large letters.

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524