# Triage Health Estate Planning Toolkit: Alabama

## 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.

Alabama probate courts accept written wills. To make a valid written will in Alabama:

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)
    - Acting without the "improper" or coercive influences of other people (e.g., you don't feel your beneficiaries are forcing you to leave certain property to them)
2. You need to sign the will, in front of two witnesses
3. Your will does not need to be notarized to be legal in Alabama. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Alabama 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.

**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.

Alabama's power of attorney statutory form 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 tasks, like filing your taxes or banking. Unless you indicate otherwise in the "special instructions" section, your agent is entitled to reasonable compensation for their help. This document goes into effect when you sign it, unless you indicate otherwise in the "special instructions" section. 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 are unable to make decisions for yourself. The Alabama Natural Death Act provides the right to express what medical treatment you do or do not want through an Advance Directive for Health Care (ADHC). An individual must be at least 19 years old. This document has six sections:

1. **Living Will:** You can express your wishes for life-sustaining care if you become unconscious or can no longer make your own medical decisions. 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.
2. **Health Care Proxy:** You can appoint someone to make any and all health care decisions for you, including decisions about life-prolonging care, if your doctor determines you can no longer make these decisions yourself for any reason. You can also choose an alternate person if the first person you choose is not available.
3. **Section 3:** This section explains some of the limitations of this document, and allows you to list people you would like your attending physician to speak to if the time comes for you to stop receiving life-sustaining treatment.
4. **Your Signature:** This is where you sign your advance health care directive, in front of two witnesses.
5. **Witnesses:** This is where your two witnesses sign.
6. **Proxy Signature:** Alabama law requires your proxy, or the person you appointed in section two, to accept their role by signing the document.

There are limits to ADHCs in Alabama:

- Doctors and hospitals do not have to follow your directions. If the provider will not follow your directions, they have to refer you to someone who will.
- If you are pregnant or become pregnant, your choices will not be followed until after the birth of the baby.
- Permission for nutrition and hydration must be explicitly stated in order for your agent to have the authority to make those decisions.

To make your ADHC valid in Alabama, you have to sign the document, or ask someone to do so for you, in front of two witnesses (who are also at least 19 years old). Your witnesses cannot be:

- Your health care proxy, or the person you have chosen to make health care decisions for you if you become unable
- Related to you by blood, adoption, or marriage
- Included in your will or entitled to your estate through interstate succession
- Directly financially responsible for your medical care
- The person who signed the document for you

You do not need to notarize your AHDC for it to be legal in Alabama.

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. Additionally, you can change your mind and revoke your AHCD by destroying the document, writing and signing a revocation, or informing your health care team.

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

**State Laws About POLST**

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Alabama, 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 and fluids 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. This form cannot be modified, so if changes are necessary it is important for you and your physician to complete a new form.

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.

In 2011, Alabama passed a law to allow adults over the age of 18 to sign an affidavit authorizing a trusted person to make these decisions. You can attach specific directions to the form. For this form to be valid, you have to sign this document, be of sound mind, and have it notarized.

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

**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.

Alabama does not yet have a death with dignity law. But, you can indicate other preferences for end-of-life care through an advanced health care directive or POLST.

**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 Health Estate Planning Toolkit: Alabama

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

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

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# Part III: Your State's Estate Planning Forms

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# Power of Attorney for Financial Affairs

ALABAMA POWER OF ATTORNEY FORM (in accordance to Alabama Code Section 26-1A-301)

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Alabama Uniform Power of Attorney Act, Chapter 1A, Title 26, Code of Alabama 1975.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by other applicable law.

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

Your agent is entitled to reimbursement of reasonable expenses and reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a co-agent in the Special Instructions. Co-agents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

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

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I_____

(Name of Principal)

name the following person as my agent:

Name of Agent:_____

Agent's Address:_____

Agent's Telephone Number:_____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

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

Name of Successor Agent:_____

Successor Agent's Address:_____

Successor Agent's Telephone Number:_____

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

Name of Second Successor Agent:_____

Second Successor Agent's Address:_____

Second Successor Agent's Telephone Number:_____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Alabama Uniform Power of Attorney Act, Chapter 1A, Title 26, Code of Alabama 1975:

If you wish to grant general authority over all of the subjects enumerated in this section you may SIGN here:

_____

(Signature of Principal)

OR

If you wish to grant specific authority over less than all subjects enumerated in this section you must INITIAL by each subject you want to include in the agent's authority:

_____Real Property as defined in Section 26-1A-204

_____Tangible Personal Property as defined in Section 26-1A-205

_____Stocks and Bonds as defined in Section 26-1A-206

_____Commodities and Options as defined in Section 26-1A-207

_____Banks and Other Financial Institutions as defined in Section 26-1A-208

_____Operation of Entity or Business as defined in Section 26-1A-209

_____Insurance and Annuities as defined in Section 26-1A-210

_____Estates, Trusts, and Other Beneficial Interests as defined in Section 26-1A-211

_____Claims and Litigation as defined in Section 26-1A-212

_____Personal and Family Maintenance as defined in Section 26-1A-213

_____Benefits from Governmental Programs or Civil or Military Service as defined in Section 26-1A-214

_____Retirement Plans as defined in Section 26-1A-215

_____Taxes as defined in Section 26-1A-216

_____Gifts as defined in Section 26-1A-217

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

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

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

_____Create, amend, revoke, or terminate an inter vivos trust, by trust or applicable law

_____Make a gift to which exceeds the monetary limitations of Section 26-1A-217 of the Alabama Uniform Power of Attorney Act, but subject to any special instructions in this power of attorney

_____Create or change rights of survivorship

_____Create or change a beneficiary designation

_____Authorize another person to exercise the authority granted under this power of attorney

_____Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

_____Exercise fiduciary powers that the principal has authority to delegate

LIMITATIONS ON AGENT'S AUTHORITY

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

Limitation of Power. Except for any special instructions given herein to the agent to make gifts, the following shall apply:

(a) Any power or authority granted to my Agent herein shall be limited so as to prevent this Power of Attorney from causing any Agent to be taxed on my income or from causing my assets to be subject to a "general power of appointment" by my Agent as defined in 26 U.S.C. §2041 and 26 U.S.C. §2514 of the Internal Revenue Code of 1986, as amended.

(b) My Agent shall have no power or authority whatsoever with respect to any policy of insurance owned by me on the life of my Agent, or any trust created by my Agent as to which I am a trustee.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines. For your protection, if there are no special instructions write NONE in this section.

_____

_____

_____

_____

_____

_____

_____

EFFECTIVE DATE

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

NOMINATION OF [CONSERVATOR OR GUARDIAN] (OPTIONAL)

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

Name of Nominee for [conservator or guardian] of my estate:_____

Nominee's Address:_____

Nominee's Telephone Number:_____

Name of Nominee for [guardian] of my person: _____

Nominee's Address: _____

Nominee's Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____

(Signature of Principal)

Your Signature Date:_____

Your Name Printed:_____

Your Address:_____

Your Telephone Number:_____

State of_____

[County] of_____

I, _____, a Notary Public, in and for the County in this State, hereby certify that _____, whose name is signed to the foregoing document, and who is known to me, acknowledged before me on this day that, being informed of the contents of the document, he or she executed the same voluntarily on the day the same bears date.

Given under my hand this the ___ day of _____, 2____. _____(Seal, if any)

Signature of Notary

My commission expires: _____

[This document prepared by:

_____]

IMPORTANT INFORMATION FOR 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; and

(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

Unless the Special Instructions in this power of attorney state otherwise, you must also:

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

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

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(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) if you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Alabama Uniform Power of Attorney Act, Chapter 1A, Title 26, Code of Alabama 1975. If you violate the Alabama Uniform Power of Attorney Act, Chapter 1A, Title 26, Code of Alabama 1975, or act outside the authority granted, you may be liable for any damages caused by your violation.

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

# Triage Health Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

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# Advance Health Care Directive

# ADVANCE DIRECTIVE FOR HEALTH CARE

### (Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

## Section 1. Living Will

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

### If I become terminally ill or injured:

*Terminally ill or injured* is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

*Life sustaining treatment* – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

*Place your initials by either "yes" or "no"*:

I want to have life sustaining treatment if I am terminally ill or injured. ____ Yes ____ No

*Artificially provided food and hydration* (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either "yes" or "no"*:

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

____ Yes ____ No

## If I Become Permanently Unconscious:

*Permanent unconsciousness* is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

*Life sustaining treatment* – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

*Place your initials by either "yes" or "no"*:

I want to have life-sustaining treatment if I am permanently unconscious. ____ Yes ____ No

*Artificially provided food and hydration* (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either "yes" or "no"*:

I want to have food and water provided through a tube or an IV if I am permanently unconscious.

____ Yes ____ No

**Other Directions**: Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

_____

_____

_____

_____

*If you do not have other directions, place your initials here:*

____ No, I do not have any other directions.

## Section 2. If I need someone to speak for me.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

*Place your initials by only one answer*:

_____ I **do not** want to name a health care proxy. *(If you check this answer, go to Section 3)*

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

**First choice for proxy**: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

**If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:**

**Second choice for proxy: _____**

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

**Instructions for Proxy**

*Place your initials by either "yes" or "no"*:

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. ____ Yes ____ No

*Place your initials **by only one** of the following*:

____ I want my health care proxy to follow **only** the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form **and** to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

## Section 3. The things listed on this form are what I want.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.
- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

  _____

  _____

## Section 4. My signature

Your name: _____

The month, day, and year of your birth: _____

Your signature: _____

Date signed: _____

## Section 5. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

## Section 6. Signature of Proxy

I, _____, am willing to serve as the health care proxy.

Signature: _____ Date: _____

**Signature of Second Choice for Proxy:**

I, _____, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: _____ Date: _____

# Triage Health Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

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# Physician Orders for Life Sustaining Treatment (POLST)

National POLST
www.polst.org

## ***NOTICE***

**This is the National POLST Form and can only be *completed* in states that have adopted it (it is valid in most states). Check with your POLST Program (www.polst.org/map) to determine if your state uses this version.**

## National POLST Form

The National POLST Form is a portable medical order. Health care professionals should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

This form should be obtained from a health care provider.
It should not be provided to patients or individuals to complete.

## Printing the National POLST Form

1. **Do not alter this form**.

2. This national form must be adopted by the state before it can be completed in that state as a valid POLST form. Find your POLST Program contact at www.polst.org/map – this is because some states have added information on page 2, have added a border, or have requirements about the color of the form.

3. Print BOTH pages as a double-sided form on a single sheet of paper.

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

# National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

**Patient Information.** **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed:_____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

**A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.**

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

**B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.**

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

**D. Medically Assisted Nutrition** (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

**E. SIGNATURE: Patient or Patient Representative** (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | **Authority:**

**The most recently completed valid POLST form supersedes all previously completed POLST forms.**

**F. SIGNATURE: Health Care Provider** (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required / / | **Phone # :** ( )

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

**Patient Full Name:**

## Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

| Full Name: | ☐ Legal Representative<br>☐ Other emergency contact | Phone #:<br>Day: ( )<br>Night: ( ) |
|---|---|---|
| Primary Care Provider Name: | | Phone:<br>( ) |
| ☐ Patient is enrolled in hospice | Name of Agency:<br>Agency Phone: ( ) | |

## Form Completion Information (Optional but helpful)

| Reviewed patient's advance directive to confirm no conflict with POLST orders:<br>(A POLST form does not replace an advance directive or living will) | ☐ Yes; date of the document reviewed:_____<br>☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)<br>☐ Advance directive not available<br>☐ No advance directive exists |
|---|---|

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

| Professional Assisting Health Care Provider w/ Form Completion (if applicable):<br>Full Name: | Date (mm/dd/yyyy):<br>/ / | Phone #:<br>( ) |
|---|---|---|

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

## Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

| State Specific Info | For Barcodes / ID Sticker |
|---|---|

# Triage Health Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

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# Funeral Designation Form

## ALABAMA BOARD OF FUNERAL SERVICE

# AUTHORIZING AGENT AFFIDAVIT

***AFFIDAVIT MUST BE EXECUTED BEFORE A NOTARY PUBLIC.

State of Alabama

County of _____

I, _____designate _____ to control the disposition of my remains upon my death. I [ ] HAVE [ ] HAVE NOT attached specific directions concerning the disposition of my remains.

If specific directions are attached, the designee shall substantially comply with those directions, provided the directions are lawful and there are sufficient resources in my estate to carry out those directions.

_____
SIGNATURE

SUBSCRIBED TO AND SWORN BEFORE ME THIS _____ DAY OF _____, 20_____.

_____
SEAL NOTARY

My Commission Expires: _____

Pursuant to Section 34-13-11(2b) of the *Code of Alabama, 1975*, any person at least 18 years of age and of sound mind, may authorize another person to control the disposition of his or her remains pursuant to this affidavit.

# Triage Health Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

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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