# Triage Health Estate Planning Toolkit: Colorado

## 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.

Colorado probate courts accept written wills, electronic wills, and holographic wills. To make a valid written will in Colorado:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses or a notary. The will must also be signed by the two witnesses.
3. Your will does not need to be notarized to be legal in Colorado, but you might want to 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.

An electronic will is a will that is made and stored electronically. To make a valid electronic will in Colorado:

1. Your will must be in a record that is readable at the time of signing
2. You need to sign the will or authorize someone to do it for you, in the physical or electronic presence of two witnesses (who are U.S. residents and located in the U.S. at the time) or a Colorado notary (who is in Colorado at the time.)
3. Your electronic will may be made self-proving. To do this, you and your witnesses must sign an affidavit in the physical presence of an officer authorized to administer oaths under Colorado law, or in the physical or electronic presence of a Colorado notary (who is in Colorado at the time.)

A holographic will is one that is handwritten by you. To make a valid holographic will in Colorado:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. Your will must be written entirely in your handwriting and you must sign it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove their validity 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.

Colorado'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 an alternate agent, who can act jointly with the first person you appoint, or separately if the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Your agent is entitled to reasonable compensation for their help if you do not specify otherwise in the "special instructions" section. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you specify a specific date to terminate, or revoke your power of attorney.

Part III of this toolkit includes a sample form.

**State Laws About Advance Directives for Health Care**

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 Colorado, this document includes:

- **Colorado Medical Durable Power of Attorney:** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, any time you become unable to communicate. You can also choose an alternate person if the first person you appoint is not available. On this form you can indicate your medical wishes, including life-sustaining procedures and general care and services.
- **Advance Health Care Directive for Surgical/Medical Treatment:** Sometimes called a "living will," this document lets you indicate your preferences for end-of-life care if your doctor determines you can no longer make medical decisions for yourself. **Execution:** You must sign and date the document in front of two witness or a notary public to validate the AHCD. Your witnesses must be at least 18 years old, and may not be:
    - Your agent (if you have appointed one)
    - Your health care provider or an employee of your provider
    - A beneficiary in your will
- **Behavioral Health Orders for Scope of Treatment**: You can use this form to appoint someone to make behavioral health decisions on your behalf. You can also use it to indicate your wishes for behavioral health treatment, medication, and alternative treatment decisions. Unlike a medical directive, this form expires after 2 years.
- **Organ Donation:** This section lets you indicate if you would like to make an organ or tissue donation at the time of your death.

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.

If you change your mind about the decisions you made in this document, you can revoke it orally, in writing, or by destroying the document. You must also notify your doctor and your agent you have revoked your AHCD.

**State Laws About POLST/MOLST**

In Colorado, patients can use the Colorado medical order for scope of treatment (MOST) to express their wishes for end-of-life care. The MOST does not replace an advance health care directive. You can complete a MOST form with your doctor. In Colorado, 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.

Part III includes a sample form.

**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.

Colorado does not have a funeral designation form. Colorado law will recognize your funeral wishes if they are written down, signed, and dated by you. The document must be witnessed by at least one adult or notarized.

**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.

Colorado's Proposition 106, Access to Medical Aid-in-Dying Medication allows certain adults with terminal illnesses to voluntarily request medication that would hasten death. Qualified patients must:

- Be 18 years or older and a Colorado resident
- Be able to make and communicate medical decisions for yourself
- Be diagnosed with an incurable terminal illness with a prognosis of less than six months to live, confirmed by two physicians (your primary physician and a consulting physician)
- Voluntarily ask for the medication

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

- Verbally ask for the medication twice, at least 15 days apart.
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis.

If your doctor refuses to administer an aid-in-dying medication, you can transfer your care to another provider. The health care provider then has to transfer your records to the new provider at your request.

Taking aid-in-dying medications will not affect any life, health or accident insurance policies you might have. If you pass away after taking an aid-in-dying medication, your death certificate will indicate that you died naturally from an underlying illness.

**Federal Law About HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the

privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care 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: Colorado

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

- Power of Attorney for Financial Affairs
- Colorado Medical Durable Power of Attorney
- Advance Health Care Directive for Surgical/Medical Treatment
- Colorado Medical Order for Scope of Treatment (MOST)
- 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

**STATE OF COLORADO STATUTORY FORM**
**POWER OF ATTORNEY**
***(effective January 1, 2010)***

## 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 Uniform Power of Attorney Act, part 7 of article 14 of title 15, Colorado Revised Statutes.

This power of attorney does not authorize the agent to make health care decisions for you.

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 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 Uniform Power of Attorney Act, part 7 of article 14 of title 15, Colorado Revised Statutes:

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

(___) Real property
(___) Tangible personal property
(___) Stocks and bonds
(___) Commodities and options
(___) Banks and other financial institutions
(___) Operation of entity or business
(___) Insurance and annuities
(___) Estates, trusts, and other beneficial interests
(___) Claims and litigation
(___) Personal and family maintenance
(___) Benefits from governmental programs or civil or military service
(___) Retirement plans
(___) Taxes
(___) All preceding subjects

## 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 ONLY the specific authority you WANT to give your agent.)

(___) Create, amend, revoke, or terminate an inter vivos trust
(___) Make a gift, subject to the limitations of the Uniform Power of Attorney Act set forth in section 15-14-740, Colorado Revised Statutes, and 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
(___) Disclaim, refuse, or release an interest in property or a power of appointment
(___) Exercise a power of appointment other than: (1) The exercise of a general power of appointment for the benefit of the principal which may, if the subject of estates, trusts, and other beneficial interests is authorized above, be exercised as provided under the subject of estates, trusts, and other beneficial interests; or (2) the exercise of a general power of appointment for the benefit of persons other than the principal which may, if the making of a gift is specifically authorized above, be exercised under the specific authorization to make gifts
(___) Exercise powers, rights, or authority as a partner, member, or manager of a partnership, limited liability company, or other entity that the principal may exercise on behalf of the entity and has authority to delegate excluding the exercise of such powers, rights, and authority with respect to an entity owned solely by the principal which may, if operation of entity or business is authorized above, be exercised as provided under the subject of operation of the entity or business

## LIMITATION 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.

## SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____

_____

## 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 of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of nominee for conservator 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

_____ _____

Your signature Date

_____

Your name printed

_____

_____

Your address

_____

Your telephone number

STATE OF COLORADO )
) ss.
_____ COUNTY OF _____)

The foregoing instrument was acknowledged before me this ____ day of _____, 20___, by _____, principal.

Witness my hand and official seal.

My commission expires: _____.

_____
Notary Public

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 Uniform Power of Attorney Act, part 7 of article 14 of title 15, Colorado Revised Statutes. If you violate the Uniform Power of Attorney Act, part 7 of article 14 of title 15, Colorado Revised Statutes, 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.

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# Part III: Your State's Estate Planning Forms

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# Advance Health Care Directive

# MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS (MDPOA)

NAME OF
DECLARANT_____DOB_____

ADDRESS_____ PHONE#_____

## 1. Appointment of Agent and Alternates

I, the Declarant, hereby appoint:

_____

***Name of Agent- Relationship***

_____

*Agent's Best Contact Telephone Number*

_____

*Agent's Home Address*

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, refuse, or stop any healthcare, treatment, service or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____

***Name of Alternate Agent #1- Relationship***

_____

*Agent's Best Contact Telephone Number*

_____

*Agent's Home Address*

_____

***Name of Alternate Agent #2- Relationship***

_____

*Agent's Best Contact Telephone Number*

_____

*Agent's Home Address*

## 2. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines to be in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

*Optional: State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:*

_____

_____

_____

_____

My signature below indicates that I understand the purpose and effect of this document. I do hereby revoke and cancel any and all prior Medical Powers of Attorney that I may have previously done and executed:

_____

*Signature of Declarant* *Date*

## 3. Signature of Witnesses and Notary (Optional)

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

**Notary (Optional)**

State of _____

County of _____

SUBSCRIBED and sworn to before me by _____, the Declarant, as the voluntary act and deed of the Declarant this_____ day of _____, 20_____

Notary Public_____

My commission expires: _____

# Advance Directive for Surgical / Medical Treatment (Living Will)

*On completion, give copies to your physician, family members, and Healthcare Agent.*
*If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.*
*If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.*

## I. DECLARATION

I, _____ , am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

**A. Terminal Condition** If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

### 1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

### 2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

**B. Persistent Vegetative State** If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

### 1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

### 2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

## II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) *(initial one)*:

_____ (*Initials*) Yes, I have attached other directions.

_____ (*Initials*) No, I do not have any other directions.

## III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (*initial one*)

_____ (*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

## Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

### IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

*Name* *Relationship*

_____

_____

_____

_____

_____

### V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

*Name* *Telephone number or email*

_____

_____

_____

_____

_____

### VI. ANATOMICAL GIFTS

_____ (*Initials*) I wish to donate my (check one or both)
☐ organs and/or ☐ tissues, if medically possible.

_____ (*Initials*) I do not wish donate my organs or tissues.

### VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _____, 20____.

_____

*Declarant signature*

### VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

### Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____ , the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____

Notary Public
My commission expires: _____

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# Part III: Your State's Estate Planning Forms

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# Physician Orders for Life Sustaining Treatment (POLST)

**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

# Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

| Legal Last Name | | |
|---|---|---|
| Legal First Name/Middle Name | | |
| Date of Birth | | Sex |
| Hair Color | Eye Color | Race/Ethnicity |

***In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.*** *(See additional instructions on page 2.)*

## A — Check one box only

**CARDIOPULMONARY RESUSCITATION (CPR)** ******Person has no pulse and is not breathing.******

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

***NOTE:*** *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
*When not in cardiopulmonary arrest, follow orders in Section B.*

## B — Check one box only

**MEDICAL INTERVENTIONS** ******Person has pulse and/or is breathing.******

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

***Additional Orders:*** _____

## C — Check one box only

**ARTIFICIALLY ADMINISTERED NUTRITION** ***Always offer food & water by mouth if feasible.***

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

***Additional Orders:*** _____

## D

**DISCUSSED WITH** (check all that apply):

☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other:_____

**SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)**

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

***If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.***

| ***Patient/Legal Decision Maker Signature*** *(Mandatory)* | ***Name*** *(Print)* | ***Relationship/ Decision maker status*** *(Write "self" if patient)* | ***Date Signed*** *(Mandatory; Revokes all previous MOST forms)* |
|---|---|---|---|
| | | | |

| ***Physician / APN / PA Signature*** *(Mandatory)* | ***Print Physician / APN / PA Name, Address, and Phone Number*** | ***Date Signed*** *(Mandatory)* |
|---|---|---|
| **Colorado License #:** | | |

**HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY**

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**ADDITIONAL INFORMATION:** *Please provide contact information below, in case follow up or more information needed.*

| ***Patient Legal Last Name*** | ***Patient Legal First Name*** | ***Patient Middle Name (if any)*** | ***Patient Date of Birth*** |
|---|---|---|---|
| | | | |

| *Primary Contact Person for the Patient* | *Relationship and/or MDPOA, Proxy, Guardian* | *Phone Number/email/Other contact information* |
|---|---|---|
| | | |

| *Healthcare Professional Preparing Form* | *Preparer Title* | *Phone Number/Email* | *Date Prepared* |
|---|---|---|---|
| | | | |

| ***Patient Primary Diagnosis*** | *Hospice Program (if applicable) /Address* | *Hospice Phone Number* |
|---|---|---|
| | | |

## DIRECTIONS FOR HEALTH CARE PROFESSIONALS

### For more information, please refer to the "Getting the MOST Out of the Medical Orders for Scope of Treatment: Guidelines for Healthcare Professionals," www.ColoradoMOST.com

***Completing the MOST form:***

- MOST form master may be downloaded from www.ColoradoMOST.com and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper suppliers.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

***Following the Medical Orders:***

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

***Reviewing the Medical Orders:***

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

## REVIEW OF THIS COLORADO MOST FORM

| Review Date | Reviewer | Location of Review | Review Outcome |
|---|---|---|---|
| | | | ☐ No Change ☐ New Form Completed |
| | | | ☐ No Change ☐ New Form Completed |
| | | | ☐ No Change ☐ New Form Completed |
| | | | ☐ No Change ☐ New Form Completed |

**HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY**

# Triage Health Estate Planning Toolkit

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# Part III: Your State's Estate Planning Forms

⌘

# HIPAA Authorization Form

**Sample HIPAA Right of Access Form for Family Member/Friend**

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

*Name:* *Relationship:*

_____ _____

Contact information: _____

_____

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

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

    _____
    _____

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

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

This authorization shall be effective until (Check one):

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

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

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

_____ _____
Signature of the Individual Giving this Authorization Date

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