Triage Health Estate Planning Toolkit: Georgia

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.

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

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 14 years old
    - Have "testamentary capacity," or a decided and rational desire to dispose of your property
2. Your will must be written and signed in front of two witnesses who are at least 14 years old. Your witnesses must also sign your will in front of you. If a witness is benefitting from your will, that gift will be void unless there are two other witnesses to the will who will not benefit from the will.
3. Your will does not need to be notarized to be legal in Georgia. But 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.

Georgia does not accept holographic (handwritten) or oral wills.

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.

Georgia's statutory form for power of attorney allows you to appoint someone to manage your finances for you, including your property, taxes, and government benefits. You can also appoint a successor agent or co-agent in the "special instructions" section. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking.

You can also use this document to nominate a conservator in advance, in case a court decides one is necessary. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it. The document will remain in effect until you die, unless you revoke your power of attorney.

Part III 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 Georgia, this document includes four parts:

1. **Health Care Agent:** You can appoint someone to make health care decisions for you, including decisions about life-prolonging care, organ donation, and the final disposition of your body. This document will go into effect any time your doctor determines you can no longer make these decisions yourself. You can also choose an alternate person if the first person you appoint is not available. A physician or health care provider directly involved in your care cannot serve as your health care agent.

2. **Treatment Preferences:** You can use a living will to express your wishes for your medical care in the event you become seriously ill or unconscious. You can also 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. If you are pregnant and your treatment preferences would interfere with facilitating life-sustaining treatment for a viable fetus, then they will not be honored.

3. **Guardianship:** This form lets you choose someone as your guardian in the event a court decides one should be appointed for you.

4. **Effectiveness and Signatures:** You must sign your AHCD in front of two witnesses to make it valid. Your witnesses must be of "sound mind" (meaning they know what they're doing) and at least 18 years old. Your witnesses cannot be your health care agent or back-up agent, inherit anything in your will, or be directly involved in your health care. Only one witness can be an employee, agent, or medical staff member of your hospital or other health care facility. The witnesses do not have to see you sign or see each other sign.

If you change your mind about the instructions in your advance health care directive, you can revoke this document at any time by destroying the document, signing a written revocation, orally expressing that you would like to revoke the document in front of one adult witness (who within 30 days confirms your intent to revoke the document in writing), or executing a new advance health care directive.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

Part III of this toolkit includes a sample form.

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 health care directive. You can complete a POLST form with your doctor. In Georgia, 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
- Decisions regarding antibiotics
- Medically assisted nutrition, or food and hydration 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 of this toolkit 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.

Georgia does not offer a funeral designation form. However, Georgia law provides the right to indicate the location, manner, and condition of the disposition of your body and funeral arrangements. If you would like to authorize another individual to control the disposition of your remains, you can complete an affidavit and sign with a notary public. You can also allow your health care agent to handle the disposal of your remains in your health care agent form.

State Laws About Death with Dignity

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

Georgia does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

Federal Law About HIPAA

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

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

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

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

Triage Health Estate Planning Toolkit: Georgia

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

Triage Health Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Power of Attorney for Financial Affairs

State of Georgia

County of

STATUTORY FORM POWER OF ATTORNEY

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 O.C.G.A. Chapter 6B of Title 10.

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. If you revoke the power of attorney, you must communicate your revocation by notice to the agent in writing by certified mail and file such notice with the clerk of superior court in your county of domicile.

Your agent is not entitled to any compensation unless you state otherwise in the Special Instructions. Your agent shall be entitled to reimbursement of reasonable expenses incurred in performing the acts required by you in your power of attorney.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a successor agent or name a coagent in the Special Instructions. Coagents will not be 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 shall be durable unless you state otherwise in the Special Instructions.

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

This Durable Power of Attorney shall revoke all powers of attorney previously executed by me, including any powers of attorney previously executed by me for a specific or limited purpose. It shall revoke any power executed as part of a contract signed by me or for the management of any bank or securities account.

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 AND COAGENT

I, _____, name the following persons as my agents:

Name of agent: _____
Agent's address: _____
Agent's telephone number: _____
Agent's e-mail address: _____

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: _____
Successor agent's e-mail address: _____

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: _____
Second successor agent's e-mail address: _____

GRANT OF GENERAL AUTHORITY

I grant my agents, acting together, general authority to act for me with respect to the following subjects as defined in O.C.G.A. Chapter 6B of Title 10:

(INITIAL each subject you want to include in the agents' 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 agents SHALL 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 agents 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 agents. You should give your agents specific instructions in the Special Instructions when you authorize your agent to make gifts.)

(☐) Create, amend, revoke, or terminate an inter vivos trust

(☐) Make a gift, subject to the limitations of O.C.G.A. § 10-6B-56 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

(☐) Access the content of electronic communications

(☐) Exercise fiduciary powers that the principal has authority to delegate

(☐) Disclaim or refuse an interest in property, including a power of appointment

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant SHALL 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 (you may add lines or place your special instructions in a separate document and attach it to the power of attorney):

EFFECTIVE DATE

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

NOMINATION OF CONSERVATOR (OPTIONAL)

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

Name of nominee for conservator of my estate: _____
Nominee's address: _____
Nominee's telephone number: _____
Nominee's e-mail address: _____

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 has actual knowledge it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____
Your signature Date

_____
Your name printed

Your address:

_____
_____

This document was signed in my presence on _____,
(Date)

by: _____
(Name of principal)

_____
(Witness's signature)

_____
(Witness's name printed)

_____
Witness's address

_____
(Witness's signature)

_____
(Witness's name printed)

_____
Witness's address

State of Georgia

County of

This document was signed in my presence on _____, 2020, by _____.

_____(Seal)
Signature of notary

My commission expires:

This document prepared by:

IMPORTANT INFORMATION FOR AGENTS

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:

By _____ as Agent.

_____ _____
(Your signature)

By as Successor Agent.

_____ _____
(Your signature)

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 your authority or the power of attorney so as long as the revocation of the power of attorney is communicated to you in writing by certified mail and provided that such notice is filed with the clerk of superior court in the county of domicile of the principal;

(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 O.C.G.A. Chapter 6B of Title 10. If you violate O.C.G.A. Chapter 6B of Title 10 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

⌘

Part III: Your State's Estate Planning Forms

⌘

Advance Health Care Directive

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

Revised March 2016

Purpose:

In recognizing the right of individuals to (1) control all aspects of his or her personal care and medical treatment, (2) insist upon medical treatment, (3) decline medical treatment, or (4) direct that medical treatment be withdrawn, the General Assembly has in the past, provided statutory forms for both the living will and durable power of attorney for health care. To help reduce confusion, inconsistency, out-of-date terminology, and confusing and inconsistent requirements for execution, and to follow the trend set by other states to combine the concepts of the living will and health care agency into a single legal document, the efforts of a significant number of individuals representing the academic, medical, legislative, and legal communities, state officials, ethics scholars, and advocacy groups produced the development of a consolidated advance directive for health care. This newly created form using understandable and everyday language is meant to encourage more citizens of Georgia to voluntarily execute advance directives for health care to make their wishes more clearly known.

The General Assembly takes note that the clear expression of individual decisions regarding health care, whether made by the individual or an agent appointed by the individual, is of critical importance not only to citizens but also to the health care and legal communities, third parties, and families. In furtherance of these purposes, the General Assembly enacted a new Chapter 32 of Title 31. This Chapter sets forth general principles governing the expression of decisions regarding health care and the appointment of a health care agent, as well as a form of advance directive for health care.

Guide to Contents

INSTRUCTIONS

The effect of the Georgia Advance Directive for Health Care Act on the Georgia Living Will and Georgia Durable Power of Attorney for Health Care Laws.

Georgia's laws on advance directives changed significantly on July 1, 2007.

- The Georgia Advance Directive for Health Care Act replaced the Georgia Living Will as the new Chapter 32 of Title 31 of the Official Code of Georgia.
- Chapter 36 of Title 31 of the Official Code of Georgia creating the Durable Power of Attorney for HealthCare was repealed and that chapter reserved, meaning that for now, no law will be found in Chapter 36, but the space and the Chapter number will be reserved for future use.
- The Living Will and Durable Power of Attorney for Health Care will no longer be available as options for advance directives in Georgia.
- Validly executed Living Wills created between March 28, 1986 and June 30, 2007 remain valid until revoked.
- Validly executed Durable Powers of Attorney for Health Care created before June 30, 2007 remain valid until revoked.

To know if your current Living Will and/or Durable Power of Attorney for Health Care is valid, find a copy of the old code sections to confirm the witnessing requirements or consult an attorney who can compare it with the law in effect prior to July 1, 2007.

If one chooses to complete a Georgia Advance Directive for Health Care, it will replace any other advance directive for health care, durable power of attorney for health care, health care proxy, or living will that currently is in place. One may choose not to complete this form and his/her current Living Will and/or Durable Power of Attorney for Health Care form, if valid now, remains valid.

A Georgia Advance Directive for Health Care is Never Required

Definitions:

(1) 'Advance directive for health care' means a written document voluntarily executed by a declarant in accordance with the requirements of Code Section 31-32-5.

(2) 'Attending physician' means the physician who has primary responsibility at the time of reference for the treatment and care of the declarant.

(3) 'Declarant' means a person who has executed an advance directive for health care authorized by this chapter.

(4) 'Durable power of attorney for health care' means a written document voluntarily executed by an individual creating a health care agency in accordance with Chapter 36 of this title; as such chapter existed on and before June 30, 2007.

(5) 'Health care' means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for a declarant´s physical or mental health or personal care.

(6) 'Health care agent' means a person appointed by a declarant to act for and on behalf of the declarant to make decisions related to consent, refusal, or withdrawal of any type of health care and decisions related to autopsy,

anatomical gifts, and final disposition of a declarant´s body when a declarant is unable or chooses not to make health care decisions for himself or herself. The term 'health care agent' shall include any back-up or successor agent appointed by the declarant.

(7) 'Health care facility' means a hospital, skilled nursing facility, hospice, institution, home, residential or nursing facility, treatment facility, and any other facility or service which has a valid permit or provisional permit issued under Chapter 7 of this title or which is licensed, accredited, or approved under the laws of any state, and includes hospitals operated by the United States government or by any state or subdivision thereof.

(8) 'Health care provider' means the attending physician and any other person administering health care to the declarant at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

(9) 'Life-sustaining procedures' means medications, machines, or other medical procedures or interventions which, when applied to a declarant in a terminal condition or in a state of permanent unconsciousness, could in reasonable medical judgment keep the declarant alive but cannot cure the declarant and where, in the judgment of the attending physician and a second physician, death will occur without such procedures or interventions. The term 'life-sustaining procedures' shall not include the provision of nourishment or hydration but a declarant may direct the withholding or withdrawal of the provision of nourishment or hydration in an advance directive for health care. The term 'life-sustaining procedures' shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

(10) 'Living will' means a written document voluntarily executed by an individual directing the withholding or withdrawal of life-sustaining procedures when an individual is in a terminal condition, coma, or persistent vegetative state in accordance with this chapter, as such chapter existed on and before June 30, 2007.
(11) 'Physician' means a person lawfully licensed in this state to practice medicine and surgery pursuant to Article 2 of Chapter 34 of Title 43; and if the declarant is receiving health care in another state, a person lawfully licensed in such state.
(12) 'Provision of nourishment or hydration' means the provision of nutrition or fluids by tube or other medical means.
(13) 'State of permanent unconsciousness' means an incurable or irreversible condition in which the declarant is not aware of himself or herself or his or her environment and in which the declarant is showing no behavioral response to his or her environment.
(14) 'Terminal condition' means an incurable or irreversible condition which would result in the declarant´s death in a relatively short period of time.

Certification of a terminal condition or state of permanent unconsciousness

Before any action can be taken to withdraw or withhold life sustaining procedures or to withdraw or withhold nourishment or hydration for a declarant in a state of permanent unconsciousness or is in a terminal condition, that condition must be certified in writing. The attending physician and one other physician must personally examine the declarant and certify in writing based upon the declarant's condition found during the course of their examination and in accordance with current accepted

medical standards that the declarant does meet the criteria for terminal condition or state of permanent unconsciousness as defined above.

No limitation on the use of other advance directives forms

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care that substantially comply with this form may be used in Georgia.

This includes using forms from other states.

The difference between this advance directive form and the Living Will and Durable Power of Attorney for Health Care

The Georgia Advance Directive for Health Care is an attempt to combine the best features of the Living Will and Durable Power of Attorney for Health Care into one written document. An effort has also been made to make the execution (signing and witnessing) of this document easier and more convenient. The effect of this new document still does not constitute suicide, physician assisted suicide, homicide or euthanasia. Completing one has no affect on insurance, annuities or anything else contingent on the life or death of the person making the advance directive (hereafter, "the declarant").

Three parts of the Georgia Advance Directive for Health Care

Part One: allows an agent to be appointed to carry out health care decisions (formerly the Durable Power of Attorney for Health Care)

Part Two: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration (formerly the Living Will)

Part Three: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

Requirements for the person making an advance directive for health care

- Must be of sound mind
- Must be 18 years of age or older ***Or*** An emancipated minor

Executing the advance directive for health care

1) the declarant must sign or expressly direct someone else do it for him/her
2) two witnesses required, who are
    - of sound mind
    - 18 years of age or older
        - Witnesses do not have to see the declarant sign
        - Witnesses do not have to see each other sign the advance directive
3) the declarant must see both witnesses sign
4) Restriction on witnesses
    - Not the health care agent

- Not knowingly be in line to inherit anything from or benefit from the death of the declarant
- Not directly involved in the health care of the declarant
- Only one of the two witnesses can be an employee, agent or on the medical staff of the health care facility where the declarant is receiving his/her health care

Restrictions on the health care agent

A physician or health care provider directly involved in the care of the declarant may not serve as health care agent.

Duty of the health care agent to act

- A health care agent has no duty to act, even if named.
- If the health care agent does choose to act, s/he must not make decisions that are different or that contradict the decisions of the declarant.
- All of the health care agent's actions must be consistent with the intentions and desires of the declarant.
- If those intentions and desires are not clear, the health care agent's actions must be in the best interests of the declarant considering all of the benefits, burdens, risks and treatments options.

Authorized responsibilities/duties of the health care agent related to the necessary care of the declarant

1) Consent to, authorize, withdraw consent from, refuse, withhold, any and all types of medical/surgical care, treatment, programs and/or procedures
2) Sign and deliver all instruments (documents)

3) Negotiate and enter into all agreements and contracts binding the declarant
4) Accompany him/her in an ambulance or air ambulance
5) Admit to or discharge the declarant from any health care facility
6) Visit and consult with the declarant as necessary
7) Examine, copy and consent to disclosure of all the declarant's medical records deemed relevant
8) Do all other acts reasonably necessary and carry out duties and responsibilities in person or through those employed by the health care agent; **this does not include delegating the authority to make health care decisions**
9) Consent to an anatomical gift of the declarant´s body, in whole or part, an autopsy and direct the final disposition of declarant´s remains, including funeral arrangements, burial, or cremation (*Note: the law states that the agent can bind the declarant to pay but does not expressly mention binding the estate of the declarant. It may be a good idea to make all arrangements prior to the death of the declarant.*)

Prohibited actions by the health care agent

The health care agent may not consent to psychosurgery, sterilization, or involuntary hospitalization or treatment under the Mental Health Code, Title 37.

When the attending physician, health care provider and/or health care facility refuse to honor the advance directive for health care

The law states:

For health care decisions with which health care providers are unwilling to comply, after this decision is communicated with the agent, the agent is responsible for arranging for the declarant's transfer to another health care provider. [O.C.G.A. §31-32-8(2)] This section of the law does not expressly include life-sustaining procedures, nourishment or hydration in "health care decisions."

For a declarant's decision to withhold or withdraw life-sustaining procedures or withhold or withdraw the provision of nourishment or hydration, attending physicians who fail or refuse to comply are responsible for making a good faith attempt to effect the transfer of the declarant to *another physician* who will comply or must permit the agent, next of kin or legal guardian to obtain another physician who will comply. [O.C.G.A. §31-32-9 (d) (1-2)]

If it is the health care facility that refuses to comply with the declarant's decision to withhold or withdraw life-sustaining procedures or nutrition or hydration, the law does not expressly state whose responsibility it is to ensure the declarant is transferred to another health care facility.

Revoking this advance directive for health care

The Georgia Advance Directive for Health Care may be revoked at any time, regardless of the declarant´s mental state or competency. **It remains effective even if a Guardian is appointed for the declarant unless a court specifically orders otherwise.**

Revocation can occur in any of the following ways:

- By completing a new advance directive for health care
- By burning, tearing up, or otherwise destroying the existing advance directive for health care
- By writing a clear statement expressing the intent to revoke the advance directive for health care
- By orally expressing the intent to revoke the advance directive for health care in the presence of a witness 18 years of age or older who confirms this in writing within 30 days. The revocation is effective when the treating physician documents it in the medical record.
- Marrying after executing an advance directive for health care revokes any agent other than the declarant´s spouse
- Divorcing or otherwise dissolving a marriage after the execution of an advance directive for health care revokes the designation of the spouse as the health care agent

What to do with the completed form

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still

reflects your preferences. If your preferences change, complete a new advance directive for health care.

This information was revised March 2016

Copies of this form and its instructions are available at no cost from the Georgia Department of Human Services Division of Aging Services, 2 Peachtree Street NW, Suite 33.384, Atlanta, GA 30303-3142. For additional information, call the Division at 1-866-552-4464.

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: _____Date of Birth: _____
(Print Name) (mm/dd/yyyy)

This advance directive for health care has four parts:

PART ONE **HEALTH CARE AGENT.** *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART TWO **TREATMENT PREFERENCES.** *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART THREE **GUARDIANSHIP.** *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART FOUR **EFFECTIVENESS AND SIGNATURES.** *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.* ***This document may be signed by you or signed by someone else for you in your presence and at your express direction.***

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

PART ONE: HEALTH CARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address:_____

_____

_____

Telephone Numbers:

_____

(Home)

_____

(Work)

_____

(Mobile/Cell)

E-Mail Address: _____

(2) BACK-UP HEALTH CARE AGENT

[This section is optional. PART ONE will be effective even if this section is left blank.]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

First Back-up Agent

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____

_____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

Second Back-up Agent

Name: _____

Address: _____

_____

_____

Telephone Numbers:_____

_____

(Home, Work, and Mobile/Cell)

E-Mail Address:_____

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes the following powers:

- To authorize my admission to or discharge (including transfers) from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- To request, consent to, withhold, or withdraw any type of health care; and to
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent, acting in this official capacity, will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records. <u>This includes the Health Insurance Portability and Accountability Act (HIPAA) of 1996.</u> My health care agent will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am

in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, developmental disability, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Revised Uniform Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body **unless** I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____

_____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

I wish for my body to be:

_____ (Initials) Buried OR _____ (Initials) Cremated

PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) *Try to extend my life for as long as possible*, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) *Allow my natural death to occur.* I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _____ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial each statement that you want to apply to option (C).]

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

_____

_____

_____

(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

[**PART THREE is optional.** This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____

_____

(Home, Work, and Mobile/Cell)
E-Mail Address: _____

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

Completing this form revokes and replaces any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) This advance directive for health care will become effective on or upon _____ and will terminate on or upon

(*Optional: Specify a date or event*)

_____.

(*Optional: Specify a date or event*)

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.]

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____

(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____ _____

(Signature of First Witness) (Date)

Print Name: _____

Address: _____

_____

_____ _____

(Signature of Second Witness) (Date)

Print Name: _____

Address: _____

_____

[This form does not need to be notarized and a copy of a validly executed advance directive for health care carries the same meaning and effect as the original document.]

Triage Health Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Physician Orders for Life Sustaining Treatment (POLST)

Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ **Gender**: Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** *** Signature of a concurring physician is needed for this section to be valid **if** this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible**
	☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders:
	☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):

☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

GUIDANCE FOR COMPLETING THE POLST FORM

1. Completion of a POLST form is always voluntary**.**
2. Any section of a POLST form which is not completed implies full treatment for interventions discussed in that section.
3. A POLST form may be executed/created:
   a. when a patient has a serious illness or condition and the attending physician's reasoned judgment is that the patient will die within the next 365 days OR
   b. at any time if a person has been diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking, and behavior.
4. **If the patient has decision making capacity**, that patient chooses whether to complete and sign the POLST form with his or her physician. An authorized person may NOT sign the POLST form for a patient who has decision making capacity.
5. **If the patient lacks decision making capacity**, the POLST form may be signed by an "authorized person", which includes, in the following order of priority:
   a. the agent named on the patient's durable power of attorney for health care or a health care agent named on the patient's advance directive for health care
   b. a spouse
   c. a court-appointed guardian
   d. son or daughter (age 18 or older)
   e. parent
   f. brother or sister (age 18 or older)
6. If an authorized person completes and signs the POLST form, treatment choices should be based in good faith on what the patient would have wanted if the patient understood his or her current circumstances.

ADDITIONAL GUIDANCE FOR HEALTH CARE PROFESSIONALS

I. When a POLST form is signed by the Patient and Attending Physician**,** all orders may be implemented without restriction.

II. When a POLST form is signed by the patient's Health Care Agent and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). However, a concurring physician signature is NOT required per Georgia Code Section 31-92-4(c).
   ii. Orders in Sections B, C and D may be implemented without restriction.

III. When a POLST form is signed by an Authorized Person (other than the patient's Health Care Agent) and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). A concurring physician signature is REQUIRED per Georgia Code Section 31-39-4(c).
   ii. Orders in B, C, or D may be implemented when patient is:
      a. in a terminal condition OR
      b. state of permanent unconsciousness OR
      c. diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking and behavior.

IV. The status of resuscitation orders during surgery or other invasive procedures should be reviewed by the physician with the patient or patient's "authorized person" (as defined above).

V. Copies of the original POLST form are valid.

VI. The POLST form shall remain effective unless revoked by the attending physician upon the consent of the patient or the patient's authorized person.

VII. An attending physician who issues an order using the POLST form and who transfers the patient to another physician shall inform the receiving physician and the health care facility, if applicable, of the order**.**

VIII. A health care facility may impose additional administrative or procedural requirements regarding a patient's end of life care decisions, including the use of a separate order form. If the patient is in a health care facility, the attending physician should check with the facility to ensure these orders are valid.

***** Georgia Code Section 31-92-2(4) defines a "candidate for non-resuscitation" to mean a patient who, based on a reasonable degree of medical certainty:

(A) has a medical condition which can reasonably be expected to result in the imminent death of the patient;
(B) is in a non-cognitive state with no reasonable possibility of regaining cognitive functions; or
(C) is a person for whom CPR would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely experience repeated need for CPR over a short period of time or that such resuscitation would be otherwise medically futile.

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient's health status, or (iv) the patient's treatment preferences change. If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A though D, write "VOID" in large letters with date and time, and sign by the line. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			☐ **No Change** ☐ **Form Voided, new form completed** ☐ **Form Voided, no new form**	
			☐ **No Change** ☐ **Form Voided, new form completed** ☐ **Form Voided, no new form**	

Triage Health Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

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

Name: *Relationship:*

_____ _____

Contact information: _____

_____

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

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

    _____
    _____

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

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

This authorization shall be effective until (Check one):

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

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

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

_____ _____
Signature of the Individual Giving this Authorization Date

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