Triage Health Estate Planning Toolkit: Minnesota

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.

Minnesota probate courts accept written and electronic wills. To make a valid written will in Minnesota:

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)
    - Not under any constraint or undue influence (outside pressure)
2. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. Your will does not need to be notarized to be legal in Minnesota. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

An electronic will is one that is created, signed, or maintained in a digital format. There must be a way to show that the electronic will has not been changed after it is signed. To make a valid electronic will in Minnesota:

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)
    - Not under any constraint or undue influence (outside pressure)
2. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing. The signing can occur in various ways, such as:
    - Signing separate printed signature pages while watching each other via a remote audio-visual call and sending the signed pages to an attorney to verify and to create a complete document;
    - Electronically signing in separate locations while watching each other via a remote audio-visual call; or
    - Electronically signing while physically together.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In Minnesota, you can use this document to appoint someone (an "attorney-in-fact") to make all financial decisions (including managing property, bank accounts, and paying bills) for you. This can mean all transactions and decisions, or you can indicate which specific powers you would like your attorney-in-fact to have (e.g., designating someone only to handle family maintenance and banking transactions). You can also appoint two successors, or people to take over if the first person you choose is not available. This document takes effect right when it is signed and notarized, not when you become sick or unable to make decisions for yourself.

If you want to make this document durable, meaning it would stay in effect if you become unable to make decisions for yourself, add the phrase "This power of attorney shall not be affected by incapacity of the principal" to the document.

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. A Minnesota Health Care Directive has three parts. You can complete the Appointment of Health Agent and/or the Health Care Instructions.

1. **Appointment of Health Agent:** You can appoint someone (your "agent") to make any and all health care decisions for you, including decisions about life-prolonging care, any time your doctor determines you can no longer make these decisions yourself (or immediately, if you want). If you like, you can also give this person the power to dispose of your remains, and you can indicate your preference for organ donation, burial, or cremation. You can also choose an alternate person if the first person you appoint is not available.
2. **Health Care Instructions:** Also called a "living will," you can use this document to express your preferences for health care in case you become seriously ill or unconscious. This includes specific directions including, where you receive care, who you would like to be your doctor, what happens to your body after you die, pain management, and any other instructions you would like to include.
3. **Execution:** This is where you sign your advance health care directive. You can either sign it in front of two adult witnesses, or in front of a notary public. Your witnesses cannot be your agent, and one of your witnesses cannot be your health care provider or their employee.

There are limits to this document. If you are pregnant and the decisions you make in this document would interfere with facilitating life-sustaining treatment to the fetus, it may not be honored unless you specifically indicate how you would like pregnancy to affect health care decisions made on your behalf or there is other clear and convincing evidence of your wishes regarding the pregnancy and life-sustaining treatment.

You can revoke all or part of your advance health care directive at any time by:

- Signing a written revocation
- Saying you would like to revoke the document in front of two witnesses
- Destroying the document
- Creating a new advance health care directive

If you appoint your spouse or domestic partner as your health care agent, that decision will be automatically revoked if your marriage or partnership 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 directive. You can complete a POLST form with your

doctor. In Minnesota, this form is known as Provider Orders for Life-Sustaining Treatment. It 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
- Additional orders or instructions for your care, including medically assisted nutrition, or food and hydration offered through surgically-placed tubes, antibiotics, and any additional preferences

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

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

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Minnesota does not have a dedicated funeral designation form, but you can express these preferences in an advance health care directive.

State Laws About Death with Dignity

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

Minnesota 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: Minnesota

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Michigan Patient Advocate Designation
- Provider Orders for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

Powers of Attorney

What is a power of attorney?

A power of attorney is written permission for someone to take care of property or money matters for you, in the way you want. In a power of attorney document, you are called the "principal" (person giving the power). The person who takes care of things for you is called the "attorney-in-fact." This person doesn't have to be a lawyer.

Who should I pick as my attorney-in-fact?

Any competent person over the age of 18 can be your attorney-in-fact. This includes family members. Many people choose a spouse or child. It is important to pick someone you trust deeply. Remember they will have control of things like your bank accounts or property.

You can list more than one attorney-in-fact. **But remember**, each of them can do things in your name without asking permission from the other, unless you write out that you want it to be different.

You can also name a "successor attorney-in-fact." This is someone who takes over if the first one can't or won't do it anymore.

How much power does my attorney-in-fact have?

If an attorney-in-fact takes legal action in your name, it is the same as if you had done it yourself. With a power of attorney, you can still act for yourself when you want to, but the attorney-in-fact can **also** act for you.

The attorney-in-fact is not your guardian. You can't be forced to move or forced to do anything you don't agree to. You don't lose the right to control property or money. You don't lose the right to make decisions about your life like where you live and how you spend your time. You can revoke (take back) the power of attorney at any time.

Usually, you give a power of attorney so someone else can sign papers about property and money matters. The power can be limited to a certain thing, like selling a property, or it can be very broad, such as handling all property and money matters. It depends on what you write on the power of attorney form.

What else does the attorney-in-fact have to do?

The attorney-in-fact is responsible for keeping records of all the transactions they do for you. This is called "accounting." Ask to see these records on a regular basis. Even if you trust someone, getting regular accountings on a quarterly or monthly basis is a good idea. It is also a good idea to have the accountings go to you AND someone else like a family member or friend who can help keep track of things.

Legally, the attorney-in-fact is supposed to do things only in your best interest.

How do I make a power of attorney?

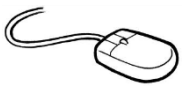
A power of attorney must be written, dated, and signed by you in front of a notary public. If you want the power to end at a certain time, list the day, month, and year when it ends.

Important: the power of attorney form is effective as soon as it is signed and notarized. It gives powers to the attorney in fact right away- not only if you become sick or incapacitated.

The power of attorney form was updated in January 2014. The current form has more instructions and warnings about the roles and responsibilities of an Attorney-in-Fact.

If you did a Power of Attorney form in the past it is still okay. You don't need to do a new one. If you are making a Power of Attorney form **now,** use the form attached. Make sure you read the "Important Notice to the Principal" page after the form. You need to initial it to show you have read it and keep it as part of the form.

Or, create a Power of Attorney online at www.lawhelpmn.org/forms.



→ Look under "Health Care and Power of Attorney"

→ Click on "Power of Attorney"

This is a step-by-step interview that lets you print out a completed form when done.

Can anyone make a power of attorney?

You must be mentally competent and able to make decisions on your own. Mentally competent means that you are "of sound mind." Some people who have a dementia diagnosis or other disability may still be mentally competent even with that diagnosis. If there is a question of competence you may want to talk to your doctor or health care provider before signing a power of attorney form.

If a person is not mentally competent, or incompetent, it is too late to make a power of attorney. In that situation, a guardianship or conservatorship may need to be created.

For more information on these, see our fact sheet, *Guardianships and Conservatorships*.

What is a durable power of attorney?

"Durable" means lasting. Normally, if you become mentally incompetent, the power of attorney is not good any more. But you can write that you want to continue the power even if you become incompetent. Then it is called a durable power of attorney. If you say on it "This power of attorney shall not be affected by incapacity of the principal" it would be a durable power of attorney.

On the attached form, selecting "This power of attorney continues to be effective if I become incapacitated or incompetent" makes the document "durable."

If you do become mentally incompetent, a durable power of attorney can only be ended by a court-appointed conservator.

Do I need a lawyer to help make my power of attorney?

No. But it is a good idea to use a lawyer. The courts watch over the things that guardians or conservators do, but they do not watch over what an attorney-in-fact does. **An attorney-in-fact could take advantage of you.** A lawyer can help you put things in your power of attorney papers that limit the actions of the attorney-in-fact or make them have to show what they do with money and property.

How does the power of attorney work and who should have copies?

Both the principal and the attorney-in-fact should have a copy of the document. If you are giving a power to sell land, you need to file a signed original at the county recorder's office. If the power deals with money matters, file a copy with the bank.

When the attorney-in-fact acts for you, they sign their own name and then write:

(their signature) **As attorney-in-fact for** (*your name*).

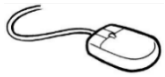
Can I stop a power of attorney?

Yes. A competent person can revoke (take back) a power of attorney at any time. You must put in writing that you revoke the power of attorney, and sign and date this in front of a notary. Send copies to the attorney-in-fact and to any person, office or bank the attorney-in-fact dealt with for you. If you don't send out copies of the revocation, the businesses won't know, and your attorney-in fact could still try to do business in your name.

You should also get the original power of attorney back.

There is a Revocation of Power of Attorney form attached.

Or you can create a Revocation of Power of Attorney online at www.lawhelpmn.org/forms.



→ Click on "Health Care and Other Powers"

→ Click on "Power of Attorney Revocation"

This is a step-by-step interview that lets you print out a completed form when done.

NOTE: Powers of attorney automatically end when the principal dies. If you give a power of attorney to your spouse, it ends if either of you start a divorce, separation, or annulment case.

STATUTORY SHORT FORM POWER OF ATTORNEY
MINNESOTA STATUTES, SECTION 523.23

Before completing and signing this form, the principal must read and initial the IMPORTANT NOTICE TO THE PRINCIPAL that appears after the signature lines in this form. Before acting on behalf of the principal, the attorney(s)-in-fact must sign this form acknowledging having read and understood the IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT that appears after the notice to the principal

---

PRINCIPAL (Name and address of person granting the power)

_____

_____

_____

ATTORNEY(S)-IN-FACT

(Names and Addresses)

_____

_____

_____

_____

NOTICE: If more than one attorney-in-fact is designated to act at the same time, make a check or "x" on the line in front of one of the following statements:

_____ Each attorney-in-fact may independently exercise the powers granted.

_____ All attorneys-in-fact must jointly exercise the powers granted.

SUCCESSOR ATTORNEY(S)-IN-FACT

(Optional) To act if any named attorney-in-fact dies, resigns or is otherwise unable to serve.

(Name and Address)

First Successor

_____

_____

_____

Second Successor

_____

_____

_____

EXPIRATION DATE (Optional)

_____

Use specific month, day and year only

I (the above-named Principal), appoint the above named Attorney(s)-in-fact to act as my attorney(s) in fact:

FIRST: To act for me in any way I could act with respect to the following matters, as each of them is defined in Minnesota Statutes, section 523.24:

(To grant the attorney-in fact any of the following powers, make a check or "x" on the line in front of each power being granted. You may, but need not, cross out each power not granted. Failure to make a check or "x" on the line in front of the power will have the effect of deleting the power unless the line in front of the power (N) is checked or x-ed.)

Check or "x"

_____ (A) Real property transactions;

I choose to limit this power to real property in _____ County, MN described as follows: (use legal description. Do not use address.)

_____

_____

_____

(If more space is needed, continue on the back or on an attachment.)

_____ (B) Tangible personal property transactions;

_____ (C) Bond, share, and commodity transactions;

_____ (D) Banking transactions;

_____ (E) Business operating transactions;

_____ (F) Insurance transactions;

_____ (G) Beneficiary transactions;

_____ (H) Gift transactions;

_____ (I) Fiduciary transactions;

_____ (J) Claims and litigations;

_____ (K) Family maintenance;

_____ (L) Benefits from military service;

_____ (M) Records, reports, and statements;

_____ (N) All of the powers listed in (A) through (M) above and all other matters other than health care decisions under a health care directive that complies with Minnesota Statutes, chapter 145C.

SECOND: (you must indicate below whether or not this power of attorney will be effective if you become incapacitated or incompetent. Make a check or "x" on the line in front of the statement that expresses you intent.)

_____ This power of attorney shall continue to be effective if I become incapacitated or incompetent.

_____ This power of attorney **shall not** be effective if I become incapacitated or incompetent.

THIRD: My attorney(s)-in-fact MAY NOT make gifts to the attorney(s)-in-fact, or anyone the attorney-in-fact is legally obligated to support, UNLESS I have made a check or an "x" on the line in front of the second statement below and I have written in the name(s) of the attorney(s)-in-fact. The second option allows you to limit the gifting power to only the attorney(s)-in-fact you name in the statement. Minnesota Statutes, section 523.24, subdivision 8, clause (2), limits the annual gift(s) made to my attorney(s)-in-fact, or to anyone the attorney(s)-in-fact are legally obligated to support, to an amount, in the aggregate, that does not exceed the federal annual gift tax exclusion amount in the year of the gift.

_____ I **do not** authorize any of my attorney(s)-in-fact to make gifts to themselves or to anyone the attorney(s) in fact have a legal obligation to support.

_____ I authorize _____ (write in names), as my attorney(s)-in-fact, to make gifts to themselves or to anyone the attorney(s)-in-fact have a legal obligation to support.

FOURTH: (you may indicate below whether or not the attorney-in-fact is required to make an accounting. Make a check or "x" on the line in front of the statement that expresses your intent.)

_____ My attorney-in-fact need not render an accounting unless I request it or the accounting is otherwise required by Minnesota Statutes, section 523.21.

_____ My attorney-in-fact must render _____ (Monthly, Quarterly, Annual) accountings to me, or _____

_____ *(Name and Address)*

during my lifetime, and a final accounting to the personal representative of my estate, if any is appointed, after my death.

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____ 20 _____

_____

(Signature of Principal)

(Acknowledgment of Principal)

STATE OF MINNESOTA)

) ss.

COUNTY OF _____)

_____

The foregoing instrument was acknowledged before me this _____ day of _____ 20 _____ , by _____

(Insert name of principal)

_____

Signature of Notary Public or other official

Acknowledgment of notice to attorney(s)-in-fact and specimen signature of attorney(s)-in-fact.

By signing below, I acknowledge that I have read and understand the IMPORTANT NOTICE TO ATTORNEY(S)-IN-FACT required by Minnesota Statutes, section 523.23, and understand and accept the scope of any limitations to the powers and duties delegated to me by this instrument.

(Notarization not required)

Specimen signature(s) of Attorney(s)-in-Fact:

(Notarization not required)

Specimen signature(s) of Attorney(s)-in-Fact:

(Notarization not required)

This instrument was drafted by:

IMPORTANT NOTICE TO THE PRINCIPAL

READ THIS NOTICE CAREFULLY. The power of attorney form that you will be signing is a legal document. It is governed by Minnesota Statutes, chapter 523. If there is anything about this form that you do not understand, you should seek legal advice.

PURPOSE: The purpose of the power of attorney is for you, the principal, to give broad and sweeping powers to your attorney(s)-in-fact, who is the person you designate to handle your affairs. Any action taken by your attorney(s)-in-fact pursuant to the powers you designate in this power of attorney form binds you, your heirs and assigns, and the representative of your estate in the same manner as though you took the action yourself.

POWERS GIVEN: You will be granting the attorney(s)-in-fact power to enter into transactions relating to any of your real or personal property, even without your consent or any advance notice to you. The powers granted to the attorney(s)-in-fact are broad and not supervised. THIS POWER OF ATTORNEY DOES NOT GRANT ANY POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. TO GIVE SOMEONE THOSE POWERS, YOU MUST USE A HEALTH CARE DIRECTIVE THAT COMPLIES WITH MINNESOTA STATUTES, CHAPTER 145(C).

DUTIES OF YOUR ATTORNEY(S)-IN-FACT: Your attorney(s)-in-fact must keep complete records of all transactions entered into on your behalf. You may request that your attorney(s)-in-fact provide you or someone else that you designate a periodic accounting, which is a written statement that gives reasonable notice of all transactions entered into on your behalf. Your attorney(s)-in-fact must also render an accounting if the attorney-in-fact reimburses himself or herself for any expenditure they made on behalf of you.

An attorney-in-fact is personally liable to any person, including you, who is injured by an action taken by an attorney-in-fact in bad faith under the power of attorney or by an attorney-in-fact's failure to account when the attorney-in-fact has a duty to account under this section. The attorney(s)-in-fact must act with your interests utmost in mind.

TERMINATION: If you choose, your attorney(s)-in-fact may exercise these powers throughout your lifetime, both before and after you become incapacitated. However, a court can take away the powers of your attorney(s)-in-fact because of improper acts. You may also revoke this power of attorney if you wish. This power of attorney is automatically terminated if the power is granted to your spouse and proceedings are commenced for dissolution, legal separation, or annulment of your marriage.

This power of attorney authorizes, but does not require, the attorney(s)-in-fact to act for you. You are not required to sign this power of attorney, but it will not take effect without your signature. You should not sign this power of attorney if you do not understand everything in it, and what your attorney(s)-in-fact will be able to do if you do sign it.

Please place your initials on the following line indicating you have read this IMPORTANT NOTICE TO THE PRINCIPAL:

_____

IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT

You have been nominated by the principal to act as an attorney-in-fact. You are under no duty to exercise the authority granted by the power of attorney. However, when you do exercise any power conferred by the power of attorney, you must:

1) act with the interests of the principal utmost in mind;

2) exercise the power in the same manner as an ordinarily prudent person of discretion and intelligence would exercise in the management of the person's own affairs;

3) render accountings as directed by the principal or whenever you reimburse yourself for expenditures made on behalf of the principal;

4) act in good faith for the best interest of the principal, using due care, competence, and diligence;

5) cease acting on behalf of the principal if you learn of any event that terminates this power of attorney or terminates your authority under this power of attorney, such as revocation by the principal of the power of attorney, the death of the principal, or the commencement of proceedings for dissolution, separation, or annulment of your marriage to the principal;

6) disclose your identity as an attorney-in-fact whenever you act for the principal by signing in substantially the following manner: Signature by a person as "attorney-in-fact for (name of principal)" or "(name of principal) by (name of the attorney-in-fact) the principal's attorney-in-fact";

7) acknowledge you have read and understood this IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT by signing the power of attorney form.

You are personally liable to any person, including the principal, who is injured by an action taken by you in bad faith under the power of attorney or by your failure to account when the duty to account has arisen.

The meaning of the powers granted to you is contained in Minnesota Statutes, chapter 523. If there is anything about this document or your duties that you do not understand, you should seek legal advice.

REVOCATION OF POWER OF ATTORNEY
Minnesota Statutes, § 523.11

TO WHOM IT MAY CONCERN:

I _____ revoke and declare null and void the

POWER OF ATTORNEY I granted to _____

which is dated _____ 20 _____

Please be advised that the above-named person no longer has power to act as my attorney-in-fact in any way.

Date: _____ _____

(Principal)

STATE OF MINNESOTA

County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20 _____

by _____

_____

_____

Notary Public

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

MINNESOTA STATUTE § 145C
HEALTH CARE DIRECTIVE
OF

_____

(Your Name)

I, _____, understand this document allows me to do ONE OR BOTH of the following:

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

AND/OR

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

Part I: Appointment of Health Agent

This is who I want to make health care decisions for me if I am unable to decide or speak for myself (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent). NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

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

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

(Optional) Appointment of Alternate Health Care Agent: If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

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

THIS IS WHAT I WANT MY HEALTH CARE AGENT
TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

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

_____

_____

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

(1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

(2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

_____

_____

_____

Part II: Health Care Instructions

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part 11 if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs). THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE (I know I can change these choices or leave any of them blank)

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

1. My goals for my health care:_____

   _____

   _____

2. My fears about my health care:_____

   _____

   _____

3. My spiritual or religious beliefs and traditions:_____

   _____

   _____

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

   _____

   _____

5. My thoughts about how my .medical condition might affect my family:_____

   _____

   _____

6. (For a woman of childbearing age) My thoughts about how my health care should be handled in the event I am pregnant: _____

   _____

   _____

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

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

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:
(NOTE: You can discuss general feelings, specific treatments, or leave any of them blank)

1. If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:_____
   _____
   _____

2. If I were dying and unable to decide or speak for myself, I would want: _____
   _____
   _____

3. If I were permanently unconscious and unable to decide or speak for myself, I would want: __
   _____
   _____

4. If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:_____
   _____
   _____

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

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

1. Who I would like to be my doctor:_____
   _____
2. Where I would like to live to receive health care: _____
   _____
3. Where I would like to die and other wishes I have about dying:_____
   _____
   _____
4. My wishes about donating parts of my body when I die:_____
   _____
   _____
5. My wishes about what happens to my body when I die (cremation, burial):_____
   _____
   _____
6. Any other things:_____
   _____

Part III: Making The Document Legal

This document must be signed by me. It also must be verified either by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

Iam thinking clearly, I agree with everything that is written in this document, and Ihave made this document willingly.

_____ _
My signature

If I cannot sign my name, I can ask someone to sign this document for me.

Date signed:_____ Date of birth:_____

Address:_____

_____

_____

_____ _____

Signature of person who I asked to sign this document for me

Printed name of person who I asked to sign this document for me

Option 1: Notary Public

In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

Subscribed and sworn to before me this _____ day of _____, _____.

_____

Notary Public

Option 2: Two Witnesses

Two witness must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

_____
(Signature of Witness One)

Address:_____

_____

_____

Witness Two:

(i) In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

_____
(Signature of Witness Two)

Address:_____

_____

_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

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

CHECK ONE

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE (NOTE REQUIREMENTS)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

TREATMENT PLAN: Maximize comfort through symptom management.

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

☐ **Patient** (*Patient has capacity*) ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**

☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ***(STRONGLY RECOMMENDED)*** | NAME *(PRINT)* | DATE

RELATIONSHIP *(IF YOU ARE THE PATIENT, WRITE "SELF")* | PHONE *(WITH AREA CODE)*

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D SIGNATURE OF PHYSICIAN / APRN / PA

ALL ITEMS REQUIRED

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME *(PRINT)* | CREDENTIALS (MD, DO, APRN, PA) | PHONE *(WITH AREA CODE)*

SIGNATURE | DATE

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

INFORMATION FOR

PATIENT NAMED ON THIS FORM

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

OPTIONAL SECTION. IF COMPLETED, CHECK ONE FROM EACH CATEGORY

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- ☐ **Long-term artificial nutrition by tube.**
- ☐ **Defined trial period of artificial nutrition by tube.**
- ☐ **No artificial nutrition by tube.**

ANTIBIOTICS

- ☐ **Use IV/IM antibiotic treatment.**
- ☐ **Oral antibiotics only (no IV/IM).**
- ☐ **No antibiotics. Use other methods to relieve symptoms when possible.**

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

F HEALTH CARE PROFESSIONAL WHO PREPARED DOCUMENT

REQUIRED: CHECK BOX OR COMPLETE ALL ITEMS

☐ **Same as signing provider (see Section D)**

NAME *(PRINT)* TITLE PHONE *(WITH AREA CODE)*

SIGNATURE DATE

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a health care agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, health care agent designated in a Health Care Directive, or a person who the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a spouse, domestic partner, adult child, sibling, parent of a minor, other relative or close friend, or closest available relative.

Reviewing POLST

This POLST should be reviewed periodically, and if:

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

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through F and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

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

Name: *Relationship:*

_____ _____

Contact information: _____

_____

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

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

    _____
    _____

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

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

This authorization shall be effective until (Check one):

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

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

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

_____ _____
Signature of the Individual Giving this Authorization Date

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