Triage Health Estate Planning Toolkit: Missouri

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.

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

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, or an emancipated minor (by court order, marriage, or by entry into active military duty)
   - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Missouri. 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.

Missouri allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

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

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, or an emancipated minor
   - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign it.

If you make a holographic will, it needs to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

Oral wills are only valid in Missouri if you are in "imminent peril of death" and die shortly after creating the will. These wills can only distribute $500 worth of assets. To create an oral will:

1. Declare that this statement is your will in front of two witnesses not included in your will
2. One witness should write down your will within 30 days of your declaration
3. Someone must submit the will for probate within six months after your death

While oral wills are useful for extreme circumstances, experts recommend creating a written will if you can.

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 Missouri, a general durable power of attorney allows you to appoint someone (your “attorney-in-fact”) to manage all of your property, access your tax records, enter safety deposit boxes on your behalf, and take any other actions they think are appropriate for your well-being. This document should include the words “This power of attorney shall not be affected by subsequent disability or incapacity of the principal, or lapse of time,'' or ''This power of attorney shall become effective upon the disability or incapacity of the principal.'' The first statement indicates that you want this document to go into effect upon your signing, and the second indicates that your agent should take over if you become incapacitated.

Part III includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive 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 Missouri, this document contains four parts. You can sign part one, part two, or both. But, you must sign part four to make the document valid.

1. **Durable Power of Attorney for Health Care:** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, including life-prolonging care and the disposition of your remains, if your doctor determines you can no longer make these decisions. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care, or immediately, depending on how you fill out the form.
2. **Health Care Directive:** Sometimes called a “living will,” this document lets you indicate your preferences for health care if you become unable to speak for yourself and are suffering from a terminal illness or condition. You can clarify your preferences for treatments including surgery or other invasive procedures, cardiopulmonary resuscitation (CPR) to restart your heart or breathing, antibiotics, dialysis, chemotherapy, and artificially supplied nutrition and hydration. You can also indicate whether or not you would like to make an organ donation.
3. **Relationship Between Health Care Choices Directive and Durable Power of Attorney for Health Care Choices:** This section clarifies the relationship between part I and part II. It explains that if you have both documents, your agent should follow the instructions in your health care choices directive.
4. **Signing and Witnessing Provisions:** You must sign your advance health care directive to make it valid. Your durable power of attorney for health care should be signed in front of a notary, and your health choices directive should be signed by two adult witnesses. If you filled out both documents, your signature should be notarized and witnessed.

If you are pregnant and the decisions you make in this document would interfere with facilitating life-sustaining treatment to the fetus, then it will not be honored.

You can indicate that you would like to change any other instruction included in your advance health care directive at any time. You can simply tell your physician you would like to revoke or change your advance health care directive, do so in writing, or just tear up this directive. But, you have to tell your agent, physician, or treating health care provider that you revoked your agent’s powers for it to be effective.

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. In Missouri, this is called a transportable physician order for patient preferences, or TPOPP. The TPOPP does not replace an advance directive. You can complete a TPOPP form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Use of antibiotics, whether to preserve life, for trial periods, or to relieve pain and discomfort
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

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

Missouri does not yet have a form available statewide, but it is available at some medical facilities and you need to complete it with your health care provider.

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.

Missouri does not have a dedicated funeral designation form, but you can appoint someone to dispose of your remains and indicate your 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.

Missouri 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: Missouri

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Transportable Physician Order for Patient Preferences (TPOPP)
- HIPAA Authorization Form

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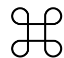
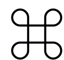
Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

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MISSOURI DURABLE POWER OF ATTORNEY

KNOW EVERYONE BY THESE PRESENTS, which are intended to constitute a Durable General Power of Attorney, **THAT I**, ___________________________, having an address at ___________________________, hereby make, constitute and appoint ___________________________, my agent having an address at ___________________________, or if agent is unable, unwilling or unavailable to act, then ___________________________, successor agent having an address at ___________________________, as my attorney-in-fact TO ACT in my name, place and stead in any way which I could do, if I were personally present, to the extent that I am permitted by law to act through an agent:

(a) to ask, demand, sue for, recover and receive all manner of goods, chattels, debts, rents, interest, sums of money and demands whatsoever, due or to become due, that are thought to be owing, belonging or payable to me in my own right or otherwise, and to execute, acknowledge and deliver acquittances, receipts, releases, satisfactions or other discharges for the same;

(b) to sell, transfer, exchange, convert, abandon, or otherwise dispose of, or grant options with respect to, real and personal property, at public or private sale, with or without security, in such manner, at such times, for such prices, and upon such terms and conditions as my attorney-in-fact may deem necessary or appropriate;

(c) to buy, sell, exchange, invest and reinvest in common or preferred stocks, bonds, commodities, options, limited liability companies, investment trusts, mutual funds, regulated investment companies and other types of securities and financial instruments, foreign or domestic, including any undivided interest in any one or more common trust funds, whether or not such investments be of the character permissible for investments by fiduciaries under any applicable law, and without regard to the effect any such investment may have upon the diversity of investments; to demand, receive and obtain any money or other things of value to which I am or may become or may claim to be entitled in connection with any stocks, bonds or other financial instruments; to cause securities or other property to be held or registered in the name of a nominee or nominees or unregistered or in any other form; to vote in person at meetings of stock or security holders and adjournments thereof, to enter into voting trusts, and to vote by general or limited proxy with respect to any stock or securities;

(d) to make, execute, endorse, accept and deliver in my name or in the name of my attorney-in-fact all checks, notes, drafts, warrants, securities, stock certificates, certificates of deposit, bonds, acknowledgments, and any other agreements, certificates or instruments of any nature, as my attorney-in-fact may deem necessary or appropriate;

(e) to deposit and withdraw any sums to or from any bank, savings or similar account maintained by me alone or jointly; to open, continue, modify or terminate any account or banking arrangement in my name or jointly with others; to borrow

money at such interest rates and upon such terms and conditions as my attorney-in-fact may deem necessary or appropriate, and to provide security therefor from my assets; to pay, renew or extend the time of payment of any note given by me or on my behalf; to prepare financial statements concerning my assets and liabilities or income and expenses, and deliver them to financial institutions; to receive statements, notices and other documents from financial institutions; to open or cause to be opened any safe deposit box in my name and to examine and remove any or all of the contents of such box; and to conduct such other banking transactions as my attorney-in-fact may deem necessary or appropriate;

(f) to take possession of, recover, obtain and hold any tangible personal property belonging to me or to which I may be entitled, and to receive and take for me and in my name any rents, issues and profits of any such property; to purchase, invest in, reinvest in, accept as a gift, sell, exchange, lease, grant options upon, assign, transfer, abandon, pledge, encumber or otherwise dispose of any personal property of any nature and wherever situate; to store property for hire or on a gratuitous bailment; to make repairs and alterations; and to execute, acknowledge and deliver all contracts, leases, notes, security agreements, guarantees, bills of sale, assignments, extensions, releases, waivers, consents, and any other agreements, writings and instruments of any nature affecting any personal property, as my attorney-in-fact may deem necessary or appropriate;

(g) to possess, recover, manage, hold, control, develop, subdivide, partition, mortgage, lease or otherwise deal with any real property belonging to me or to which I may be entitled; to purchase, invest in, reinvest in, accept as a gift, sell, exchange, lease, sublease, grant options upon, convey with or without covenants, quitclaim, assign, transfer, abandon, encumber or otherwise dispose of any real property of any nature and wherever situate; to borrow money at such interest rates and upon such terms and conditions as my attorney-in-fact may deem necessary or appropriate, and to provide security therefor by mortgage, deed of trust or similar instrument or pledge of any property; to satisfy, discharge, release or extend the term of any mortgage, deed of trust or similar instrument; to apply for zoning, rezoning or other governmental permits; to make repairs, replacements and improvements, structural or otherwise; to pay, compromise or contest real estate taxes, assessments, water charges and sewer rents; to abstain from the payment of real estate taxes, assessments, water charges and sewer rents, repairs, maintenance and upkeep of the same; to abandon property if deemed to be worthless or not of sufficient value to warrant keeping or protecting; to permit property to be lost by tax sale, foreclosure or other proceeding or to convey property for a nominal consideration or without consideration; and to execute, acknowledge and deliver all contracts, deeds, leases, mortgages, notes, security agreements, guarantees, transfers to trusts, bills of sale, assignments, extensions, satisfactions, releases, waivers, consents, and any other agreements, writings and instruments of any nature affecting any real property, as my attorney-in-fact may deem necessary or appropriate;

(h) to commence any actions or proceedings for the recovery of any real or personal property or for any other purpose; to appear in, answer and defend any actions or proceedings commenced against me; and to prosecute, maintain, appeal, discontinue, compromise, arbitrate, mediate, settle and adjust all actions, proceedings, accounts, dues and demands that now or hereafter may exist, as my attorney-in-fact may deem necessary or appropriate;

(i) to create, amend or terminate one or more trusts, partnerships, corporations, limited liability companies, co-tenancies or any other form of ownership or entity for the purpose of dealing with any property or property interest of any nature that I may have or hereafter acquire, under such terms and with such provisions as my attorney-in-fact may deem necessary or appropriate; to transfer any or all property in which I have an interest into any trusts, partnerships, corporations, limited liability companies, co-tenancies or other entities, whether created by me or my attorney-in-fact or otherwise (and, in this regard, that my attorney-in-fact may be a remainderman, partner, shareholder, member, co-tenant or beneficiary of any such entity shall not affect the validity of any action hereunder, and shall not, by itself, constitute a breach of fiduciary duty); to remove property from any such entity; and to give to any such entity, or to any person acting as agent or trustee under any instrument executed by me or on my behalf, such instructions or authorizations as I may have the right to give;

(j) to join or become a party to, or to oppose, any reorganization, readjustment, recapitalization, foreclosure, merger, voting trust, dissolution, consolidation or exchange, and to deposit any securities with any committee, depository or trustee, and to pay any fees, expenses and assessments incurred in connection therewith, and to charge the same to principal, and to exercise conversion, subscription or other rights, and to make any necessary payments in connection therewith, or to sell any such privileges;

(k) to deal with all matters relating to all forms of insurance and annuities, including the procurement, maintenance and termination thereof; however, notwithstanding the powers given my attorney-in-fact in this and other provisions of this power of attorney, my attorney-in-fact shall have no incidents of ownership in any life insurance policy in which I own an interest and which insures the life of my attorney-in-fact;

(l) to do all acts necessary to maintain my customary standard of living and that of my family and other persons customarily supported by me, including without limitation the power to pay for medical, dental and surgical care, living quarters, usual vacation and travel expenses, shelter, clothing, food, education, organizational fees and contributions, and other living costs;

(m) to act for me in all matters which affect my right to government benefits and assistance, including without limitation Social Security, Medicare, Medicaid, qualified state tuition programs, and other governmental benefits and benefits relating to civil or military service; to file, prosecute, submit to arbitration or settle any claim for benefits or assistance; to establish new residency and domicile; and to receive the proceeds of claims and conserve, invest, disburse and use them on my behalf;

(n) to take all steps and remedies necessary or appropriate for the conduct and management of any business in which I may have an interest; to exercise in person or by proxy any right, privilege or option which I may have with respect to any business; to continue, modify, negotiate, renegotiate, extend and terminate any and all contracts or agreements heretofore or hereafter made with respect to the business; to pay, compromise or contest business taxes or other claims or obligations; to determine the policies of the business as to the location, methods and manner of its operations including its financing, accounting, and insurance; and to add or remove capital from the business;

(o) to employ such agents, attorneys, accountants, investment counsel, trustees, caretakers and other persons and entities providing services or advice, irrespective of whether my attorney-in-fact may be associated therewith, and to rely upon information or advice furnished thereby or to ignore the same, and to delegate duties hereunder and pay such compensation, as my attorney-in-fact may deem necessary or appropriate; and

(p) to do, execute, perform and finish for me and in my name all things which my attorney-in-fact shall deem necessary or appropriate in and about or concerning my property or any part thereof.

THIS POWER OF ATTORNEY IS A DURABLE POWER OF ATTORNEY, AND THE AUTHORITY OF MY ATTORNEY-IN-FACT SHALL NOT TERMINATE IF I BECOME DISABLED, INCOMPETENT OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

It may be necessary for my attorney-in-fact to have access to my medical records to establish whether medical bills are valid and appropriate or for other purposes. I grant to my attorney-in-fact the authority and power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, the regulations in 45 C.F.R. Sec. 160 et seq., and any other applicable federal, state or local laws or regulations (collectively "HIPAA"), including the authority to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under HIPAA. I understand that health and medical records can include information relating to

subjects such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my attorney-in-fact to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

Subject to limitations in this document, my agent and attorney-in-fact shall have all the power and authority necessary to do all the following:

(a) authorize an autopsy;
(b) make a disposition of a part or parts of my body; and
(c) direct the disposition of my remains

It is my desire and request that no guardian or conservator of my person or property be appointed in the event of my disability or incapacity. If, however, a guardian or conservator of my person or property is to be appointed for me, I hereby nominate and appoint my attorney-in-fact hereunder to serve as guardian and conservator without bond.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this power of attorney may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party. I, for myself and my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied upon the provisions of this power of attorney.

I hereby revoke any prior general powers of attorney which I have executed (but not any powers of attorney related to health care).

This power of attorney shall be governed by Missouri law, although I request that it be honored in any state or other location in which I or my property may be found. If any provisions hereof shall be unenforceable or invalid, such unenforceability or invalidity shall not affect the remaining provisions of this power of attorney.

IN WITNESS WHEREOF, I have executed this power of attorney this ____ day of **__________________________, 20______.**

____
**
SSN:

STATE OF MISSOURI)
) ss.
COUNTY OF _____________)

On this ___________________________ day of ___________________________, 20____, before me personally came ___________________________, to me known to be the individual described in and who executed the foregoing power of attorney, and acknowledged that he executed the same as his free and voluntary act and deed.

IN WITNESS WHEREOF I hereunto set my hand and official seal in said County and State on the date first above written.

____

Notary Public
Commissioned in ___________ County, Missouri

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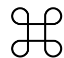
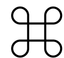


Part III: Your State's Estate Planning Forms



Advance Health Care Directive

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

(Print full name here) ______________________________

(Address, City, State, Zip)______________________________

PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part II.)

1. **Selection of Agent**. I, ______________________________, currently a resident of ____________ County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: ______________________________

Address: ______________________________

____

Phone(s): 1st ______________ 2nd ______________

2. **Alternate Agent**. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: ______________________________

Address: ______________________________

____

Phone(s): 1st ______________________________

2nd ______________________________

Second Alternate Agent:

Name: ______________________________

Address: ______________________________

____

Phone(s): 1st ______________________________

2nd ______________________________

3. **Durability**. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date as to Health Care Decision Making**. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by ***(check one of the following boxes):*** ☐ one physician **OR** ☐ two physicians.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

A. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization ***(initial one of the following boxes to indicate your choice):***

______ **Initials** I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

______ **Initials** OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to Other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers ***(initial your desired choices):***

______ **Initials** Determine what happens to my body after my death (authority for right of sepulcher);

______ **Initials** Give consent after my death to an autopsy or postmortem examination of my remains;

______ **Initials** Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent;

With respect to anatomical gifts of my body or any part (i.e., organs or tissues), please initial your desired choice below:

______ **Initials** **AUTHORIZATION OF ANATOMICAL GIFTS**. I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check one)	GIFT SPECIFICATIONS: (check one)
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	I would like to donate ☐ Any needed organs and tissues, as allowed by law. ☐ Any needed organs and tissues as allowed by law, with the following restrictions:

______ **Initials** **PROHIBITION OF ANATOMICAL GIFTS**. I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

7. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

PART II. HEALTH CARE DIRECTIVE

(If you *DO NOT WISH* to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part I on pages 1 & 2, mark an "X" through Part II on pages 2 & 3 and continue to Part III.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

_______ Initials **artificially supplied nutrition and hydration (including tube feeding of food and water)**

_______ Initials **surgery or other invasive procedures**

_______ Initials **heart-lung resuscitation (CPR)**

_______ Initials **antibiotics**

_______ Initials **dialysis**

_______ Initials **mechanical ventilator (respirator)**

_______ Initials **chemotherapy**

_______ Initials **radiation therapy**

_______ Initials **other procedures specified by me (insert)** ____

_______ Initials **all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

PART III. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive . If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*

C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive. I revoke any prior living will, declaration or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE DIRECTIVE (PART II), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on ____________________(month, date),______(year).

____
Signature
Printed Name: ______________________________

WITNESSES: The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature	___________________________	Signature	___________________________
Print Name	___________________________	Print Name	___________________________
Address	___________________________	Address	___________________________
	___________________________		___________________________

NOTARY ACKNOWLEDGMENT
(Only required if Part I or entire document completed.)

STATE OF MISSOURI)
) SS
COUNTY OF _______________)

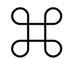
On this ______ day of _________________ (month), ______ (year), before me personally appeared _________________________ _____________, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

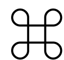
____

____, Notary Public
(Name Printed)

Triage Health Estate Planning Toolkit



Part III: Your State’s Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

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FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

Last Name:	First Name:	Middle Initial:	FOR EDUCATIONAL USE ONLY
Date of Birth:	Last 4 SSN:	*(For Patient Identifiers)*	

A. CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. If patient is not in cardiopulmonary arrest, follow orders in B and C.

☐ **Attempt Resuscitation/CPR**
(Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation**
(DNAR/no CPR/Allow Natural Death)

B. CHECK ONE

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

☐ **Full Treatment.**
In addition to treatment described in **Comfort Measures Only** and **Selected Additional Interventions** *(see below)*, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.

☐ **Selected Additional Interventions.**
In addition to treatment described in **Comfort Measures Only** *(see below)*, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.

☐ **Comfort Measures Only.**
Treat with dignity and respect. Keep clean, warm, and dry. 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. Transfer to hospital only if comfort needs cannot be met in current location.

TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.

Additional Orders: ______________________________

C. CHECK ONE

MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

☐ Long term medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: ______________________
☐ No medically administered nutrition, including feeding tubes.

Additional Orders: ______________________________

D. CHECK ALL THAT APPLY

INFORMATION AND SIGNATURES

Discussed with:
☐ Patient ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: ______________________

Signature of patient or recognized decision maker *(All fields required)*
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name:	Signature: FOR EDUCATIONAL USE ONLY	Relationship:
Address:		Phone:

Signature of authorized healthcare provider *(All fields required)*
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print name of authorized provider and Physician:	Phone:
Signature of authorized provider: FOR EDUCATIONAL USE ONLY	Date:

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

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Last Name:	First Name: FOR EDUCATIONAL USE ONLY	Middle Initial:
Date of Birth:	Last 4 SSN:	

E. ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

Healthcare Directive or other Advance Directive ☐ No ☐ Yes
Durable Power of Attorney for Healthcare Decisions document* ☐ No ☐ Yes
*Name of Agent: ______________________ Phone: ______________________

Health Care Providers Assisting with Form Preparation

Name:	Title:	Phone:
Name:	Title:	Phone:

Instructions for Completing TPOPP

- Completing a TPOPP form is always voluntary. TPOPP is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- TPOPP is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- TPOPP must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA; and patient *(or representative)* in compliance with scope of practice, regulation, and state law to be valid.
- Use of original form is strongly encouraged. Photocopies and Faxes of signed TPOPP forms are valid. A copy shall be retained in patient's medical record and accompany the patient to all settings.

Using TPOPP

- Any incomplete section of TPOPP implies full treatment for that section.

SECTION A:

– If found pulseless and not breathing, no defibrillator *(including automated external defibrillators)* or chest compressions should be used on a person if "Do Not Attempt Resuscitation" is selected.

SECTION B:

– When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort *(e.g., treatment of a hip fracture)*.

– Non-invasive positive airway pressure includes continuous positive airway pressure *(CPAP)*, bi-level positive airway pressure *(BiPAP)*, and bag valve mask *(BVM)* assisted respirations.

Reviewing TPOPP

TPOPP form should be reviewed when:

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

Modifying and Voiding TPOPP

- A patient with capacity can, at any time, request alternative treatment or revoke a TPOPP by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or to obtain more forms: TPOPP@practicalbioethics.org

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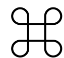
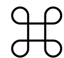
Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization Form

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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