Triage Health Estate Planning Toolkit: North Carolina

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.

North Carolina probate courts accept written and holographic wills, and oral wills under certain circumstances. To make a valid written will in North Carolina:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. You need to sign the will, in front of two witnesses who watched you sign the will.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

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

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. Your will must be written entirely in your handwriting and you must sign it.
3. It must be found after your death among your valuable papers or effects, or other safe place or person for safekeeping

If you make a holographic will, it does not need to be signed by witnesses.

To make a valid nuncupative (oral) will in North Carolina, you must be in "imminent peril of death," from illness or some other condition. In this condition, you can declare your will in front of two witnesses.

Estate planning experts do not recommend relying on holographic or oral wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

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

In North Carolina, the power of attorney statutory short form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "additional provisions" section, your agent is entitled to reasonable compensation for their help. This document goes into effect when you sign it. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive 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 North Carolina, this document contains three parts.

1. **North Carolina Health Care Power of Attorney:** You can choose someone (your "proxy") to make health care decisions for you (including decisions about life-sustaining care, organ donation, and funeral arrangements) any time your doctor determines that you cannot make them yourself. You can choose an alternate person to make these decisions if the first person you chose isn't available. This section also allows you to express your preferences for advance planning decisions to help guide your agent, and limit their powers in certain situation (e.g., authority for mental health decisions).
2. **North Carolina Advance health care directive for a Natural Death:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. At the end of this document, you can indicate if you would like your living will to override your proxy's decisions.
3. **Signature and Witnessing Provisions:** You must sign your advance health care directive in front of a notary public and two witnesses. Your witnesses must be at least 18 years old, and cannot:
    - Be related within the third degree to you or your spouse (e.g., grandparents or in-laws)
    - Know or have reason to believe that they are included in your will or entitled to your estate
    - Have any claim against you or your estate at the time you sign the document
    - Be your doctor or mental health treatment provider or a licensed health care their employee
    - Be an employee of your health care facility, or an employee of your residential nursing home or group-care home.

Your advance health care directive takes effect when your doctor determines you can no longer make or communicate your health care decisions.

You can revoke part one of your advance health care directive by telling your health care provider your decision in a written statement. You can also revoke your advance health care directive by doing anything else to demonstrate you want to revoke this document (e.g., destroying or tearing up the document), or by creating a new advance health care directive. This becomes effective when you notify your proxy, doctor, or psychologist.

If you appoint your spouse as your proxy for part one, this will be automatically revoked if your marriage dissolves, unless you specify differently in the "additional instructions" section.

You can revoke part two in any way you are able to communicate this decision, regardless of your mental or physical condition (e.g., destroying the document or telling your doctor).

Part III of this toolkit includes a sample advance health care directive.

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 North Carolina, this form is called a medical order for scope of treatment (MOST). The MOST does not replace an advance directive. You can complete a MOST 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
- Medically assisted hydration and nutrition, or food and water offered through surgically-placed tubes
- Antibiotics
- Additional orders or instructions for your care

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

Part III includes a sample form.

State Laws About Funeral Designation Forms

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

North Carolina does not have a dedicated funeral designation form.

State Laws About Death with Dignity

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

North Carolina does not have a death with dignity law.

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 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: North Carolina

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Scope of Treatment (MOST)
- HIPAA Authorization Form

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

⌘

Power of Attorney for Financial Affairs

Article 3.

Statutory Forms.

§ 32C-3-301. Statutory form power of attorney.

As a nonexclusive method to grant a power of attorney, a document substantially in the following form may be used to create a statutory form power of attorney that has the meaning and effect prescribed by this Chapter:

"NORTH CAROLINA

STATUTORY SHORT FORM POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN CHAPTER 32C OF THE NORTH CAROLINA GENERAL STATUTES, WHICH EXPRESSLY PERMITS THE USE OF ANY OTHER OR DIFFERENT FORM OF POWER OF ATTORNEY DESIRED BY THE PARTIES CONCERNED.

IMPORTANT INFORMATION

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

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

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

Your agent is entitled to reasonable compensation unless you state otherwise in the Additional Provisions and Exclusions.

This form provides for designation of one agent, successor agent, and second successor agent. If you wish to name more than one agent, successor agent, and second successor agent, you may name a coagent, successor coagent, or second successor coagent in the Additional Provisions and Exclusions. Coagents, successor coagents, or second successor coagents are not required to act together unless you include that requirement in the Additional Provisions and Exclusions.

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

This power of attorney becomes effective immediately.

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

DESIGNATION OF AGENT

I, _____, name the following person as my agent:
Name of Agent:

_____ (Name of Principal).

DESIGNATION OF SUCCESSOR AGENT(S)
(OPTIONAL)

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

Name of Successor Agent:

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

Name of Second Successor Agent:

INITIAL below if you want to give an agent the power to name a successor agent.

(_____) I give to my acting agent the full power to appoint another to act as my agent, and full power to revoke such appointment, if no agent named by me above is willing or able to act.

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the North Carolina Uniform Power of Attorney Act, Chapter 32C of the General Statutes:

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

(_____) Real Property
(_____) Tangible Personal Property
(_____) Stocks and Bonds
(_____) Commodities and Options
(_____) Banks and Other Financial Institutions
(_____) Operation of Entity or Business
(_____) Insurance and Annuities
(_____) Estates, Trusts, and Other Beneficial Interests
(_____) Claims and Litigation
(_____) Personal and Family Maintenance
(_____) Benefits from Governmental Programs or Civil or Military Service

(_____) Retirement Plans
(_____) Taxes
(_____) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY
(OPTIONAL)

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

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

(_____) Make a gift, subject to the limitations provided in G.S. 32C-2-217
(_____) Create or change rights of survivorship
(_____) Create or change a beneficiary designation
(_____) Authorize another person to exercise the authority granted under this power of attorney
(_____) Waive my right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(_____) Exercise fiduciary powers that I have authority to delegate
(_____) Disclaim or refuse an interest in property, including a power of appointment
(_____) Access the content of electronic communications.

EXERCISE OF SPECIFIC AUTHORITY IN FAVOR OF AGENT
(OPTIONAL)

(_____) UNLESS INITIALED, an agent MAY NOT exercise any of the grants of specific authority initialed above in favor of the agent or an individual to whom the agent owes a legal obligation of support.

ADDITIONAL PROVISIONS AND EXCLUSIONS
(OPTIONAL)

(_____) _____

_____

EFFECTIVE DATE

This power of attorney is effective immediately.

NOMINATION OF GUARDIAN
(OPTIONAL)

INITIAL below ONLY if you WANT your acting agent to be your Guardian.

(_____) If it becomes necessary for a court to appoint a guardian of my estate or a general guardian, I nominate my agent acting under this power of attorney to be the guardian to serve without bond or other security.

RELIANCE ON THIS POWER OF ATTORNEY

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

MEANING AND EFFECT

The meaning and effect of this power of attorney shall for all purposes be determined by the law of the State of North Carolina.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

_____

Your Name Printed

State of _____, County of _____.

I certify that the following person personally appeared before me this day, acknowledging to me that he or she signed the foregoing document: _____.

Date: _____ _____

Signature of Notary Public

(Official Seal)

_____, Notary Public

Printed or typed name

My commission expires:_____

"IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or your authority is terminated or the power of attorney is terminated or revoked. You must:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) Act in good faith;
(3) Do nothing beyond the authority granted in this power of attorney; and
(4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: (Principal's Name) by (Your Signature) as Agent.

Unless the Additional Provisions and Exclusions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;
(2) Avoid conflicts that would impair your ability to act in the principal's best interest;
(3) Act with care, competence, and diligence;
(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects, or if you do not know the principal's expectations, to act in the principal's best interest; and
(6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

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

(1) Death of a principal;
(2) The principal's revocation of the power of attorney or the termination of your authority;
(3) The occurrence of a termination event stated in the power of attorney;
(4) The purpose of the power of attorney is fully accomplished; or

(5) If you are married to the principal, your divorce from the principal, unless the Additional Provisions and Exclusions in this power of attorney state that your divorce from the principal will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the North Carolina Uniform Power of Attorney Act. If you violate the North Carolina Uniform Power of Attorney Act or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice." (2017-153, s. 1; 2018-142, s. 30(b).)

§ 32C-3-302. Agent's certification.

The following optional form may be used by an agent to certify facts concerning a power of attorney:

"AGENT'S CERTIFICATION AS TO THE VALIDITY OF
POWER OF ATTORNEY AND AGENT'S AUTHORITY
(G.S. 32C-3-302)

I, _____ (Name of Agent), do hereby state and affirm the following under penalty of perjury:

(1) _____ (Name of Principal) granted me authority as an agent or successor agent in a power of attorney dated _____.

(2) The powers and authority granted to me in the power of attorney are currently exercisable by me.

(3) I have no actual knowledge of any of the following:

(a) The principal is deceased.

(b) The power of attorney or my authority as agent under the power of attorney has been revoked or terminated, partially or otherwise.

(c) The principal lacked the understanding and capacity to make and communicate decisions regarding his estate and person at the time the power of attorney was executed.

(d) The power of attorney was not properly executed and is not a legal, valid power of attorney.

(e) (Insert other relevant statements)
_____
_____
_____
_____

(4) I agree not to exercise any powers granted under the power of attorney if I become aware that the principal is deceased, that the power of attorney has been revoked or terminated, or that my authority as agent under the power of attorney has been revoked or terminated.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Agent's Signature Date

_____

Agent's Name Printed

_____

Agent's Address

_____

Agent's Telephone Number

COUNTY OF _____, STATE OF _____.

Sworn to or affirmed and subscribed before me this day by:

Date: _____ _____

Signature of Notary Public

(Official Seal)

_____, Notary Public

Printed or typed name

My commission expires: _____"

(2017-153, s. 1.)

§ 32C-3-303. Limited power of attorney for real property.

While no particular phrasing is required for a limited power of attorney for transactions involving the purchase, sale, or financing of real property or tangible personal property related to real property, the following form may be used to create a limited power of attorney for transactions involving the purchase, sale, or financing of designated real property or tangible personal property related to the designated real property. The following form has as the meaning and effect prescribed by this Chapter:

"Return to:

NORTH CAROLINA

LIMITED POWER OF ATTORNEY FOR REAL PROPERTY

I, _____, name the following person as my agent:

(Name of Principal)

Name of Agent: _____

For purposes of this power of attorney, the "Property" is all of that real property located in _____ County, North Carolina, and known or identified as follows:

GRANT OF AUTHORITY

I grant my agent general authority to act for me with respect to the Property, all tangible personal property related to the Property, and all financial transactions relating to the Property. The authority granted to my agent pursuant to this power of attorney expressly includes the following:

(1) The authority to act with respect to real property as set forth in Section 32C-2-204 of the North Carolina General Statutes;

(2) The authority to act with respect to tangible personal property as set forth in Section 32C-2-205 of the North Carolina General Statutes; and

(3) The authority to act with respect to banks and other financial institutions as set forth in Section 32C-2-208 of the North Carolina General Statutes.

The authority granted to my agent pursuant to this power of attorney may be exercised by my agent even though the exercise of that authority may benefit the agent or a person to whom the agent owes an obligation of support.

EFFECTIVE DATE; AUTOMATIC EXPIRATION

This power of attorney is effective immediately. The authority of my agent to act on my behalf pursuant to this power of attorney will automatically expire on _____ (or, if no date is specified, one year from the date of this power of attorney). Actions taken by my agent on my behalf pursuant to this power of attorney while this power of attorney remains in effect shall continue to bind me even after my agent's authority expires.

RELIANCE ON THIS POWER OF ATTORNEY

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

MEANING AND EFFECT

The meaning and effect of this power of attorney shall for all purposes be determined by the law of the State of North Carolina.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

_____

Your Name Printed

State of _____, County of _____.

I certify that the following person personally appeared before me this day, acknowledging to me that he or she signed the foregoing document: _____.

Date: _____ _____

Signature of Notary Public

(Official Seal)

_____, Notary Public

Printed or typed name

My commission expires: _____

(2017-153, s. 1; 2018-142, s. 32.)

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

STATE OF NORTH CAROLINA

COUNTY OF _____

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

This document gives the person you designate as your health care agent ***broad powers*** *to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* https://www.sosnc.gov

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ *(Physician)*

2. _____ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations to your agent's authority.)

	A. <u>Limitations about Artificial Nutrition or Hydration</u>: In exercising the authority to make health care decisions on my behalf, my health care agent:
_____ (Initial)	Shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
_____ (Initial)	Shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
	NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.

_____ (Initial)	B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):
	NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ (Initial)	donate any needed organs or parts; or
_____ (Initial)	donate only the following organs or parts: _____
	NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.
_____ (Initial)	donate my body for anatomical study if needed.
_____ (Initial)	In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.) _____
	NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____(SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of signer)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date: _____ _____
(Official Seal) *Signature of Notary Public*

_____, Notary Public
Printed or typed name

My commission expires: _____

I signed this notarial certificate on _____ according to the emergency video notarization
Date
requirements contained in G.S. 10B-25.

Notary Public location during video notarization: _____ County
Stated physical location of principal during video notarization: _____ County

STATE OF NORTH CAROLINA

ADVANCE DIRECTIVE FOR A
NATURAL DEATH ("LIVING WILL')

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: *You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.*

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Registry maintained by the North Carolina Secretary of State: https://www.sosnc.gov

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ (Initial)	may withhold or withdraw life-prolonging measures.
_____ (Initial)	shall withhold or withdraw life-prolonging measures.

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ (Initial)	I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.**
_____ (Initial)	I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.**
_____ (Initial)	I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.**

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

_____ (Initial)	Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life.
_____ (Initial)	Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE:* DO NOT INITIAL BOTH BLOCKS. *IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

_____
Signature of Declarant

_____
Type/Print Name

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health

care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of declarant)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date _____ _____
(Official Seal) *Signature of Notary Public*

_____, Notary Public
Printed or typed name

My commission expires: _____

I signed this notarial certificate on _____ according to the emergency video notarization
Date

requirements contained in G.S. 10B-25.

Notary Public location during video notarization: _____ County

Stated physical location of principal during video notarization: _____ County

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)

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

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

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C**, and **D**.

Section B *Check One Box Only*

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

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** 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. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information			
Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS
112

North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/ems.htm
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Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

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

Name: *Relationship:*

_____ _____

Contact information: _____

_____

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

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

    _____
    _____

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

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

This authorization shall be effective until (Check one):

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

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

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

_____ _____
Signature of the Individual Giving this Authorization Date

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