



Triage Health Estate Planning Toolkit: Pennsylvania

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.

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

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 at the end of the document.
 - If you sign the will yourself, your signature does not have to be witnessed.
 - If you cannot write your name, you can make a mark on a will in your name, in the presence of two witnesses that sign their names to the will in your presence.
 - If you cannot sign or make a mark for yourself, you can direct an individual to sign the will for you in the presence of two witnesses that sign their names to the will in your presence.
3. You might also want to make your will “self-proving,” or accepted in probate court without the court needing to prove your signature or contact your witnesses. To do this, ask your witnesses to sign a notarized statement that it was your intention to make the will and you did so without undue or coercive influence. A self-proving affidavit can also be signed after the will's execution if necessary.

Pennsylvania allows you to notarize a self-proving will remotely.

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 Pennsylvania, a financial power of attorney must be witnessed by two people and signed before a notary public or other person authorized to take acknowledgments. The general durable power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. This document goes into effect when you sign it, even after you become incapacitated, unless you specify otherwise in the “special instructions” section. 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 (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate.

The Pennsylvania Advance Care Directive includes three parts. You can include a durable health care power of attorney, a living will, or both, depending on your advance planning needs. You must sign Part IV to make the directive valid.

- **Part I - Introduction:** This section introduces the uses and requirements for an advance health care directive in Pennsylvania.
- **Part II - Durable Health Care Power of Attorney:** This form lets you choose someone (your “health care agent”) to make medical decisions for you any time you cannot make them yourself, including decisions about life-sustaining care, organ donation, and funeral arrangements. You can also appoint an alternate person to make these decisions, if the first person you chose isn’t available. If there are other directions you want your agent to follow, you can share those in the “other directions” section. The Durable Health Care Power of Attorney takes effect if your doctor determines you are unable to make or communicate health care decisions.
- **Part III - Living Will:** This is where you state your wishes about your end-of-life health care in advance, in case you become unconscious or unable to make them. This includes decisions about life-sustaining care, artificial nutrition or hydration, dialysis, and organ donation. You can also indicate if you would like your health care agent to make these decisions for you, or follow these instructions.
- **Part IV - Signature and Witnessing Provisions:** You must sign your AHCD in front of two adult witnesses. If you ask someone to sign this document on your behalf, they cannot act as a witness. Notarization of the advance health care directive is not required, but it is recommended.

You can change the directions in your AHCD at any time. This could include destroying the document, creating a dated and signed revocation, or orally revoking this document to your doctor.

Unless life-sustaining treatment would prevent the fetus from growing to term, harm the pregnant person, or cause pain that cannot be alleviated by medication, a pregnant person’s advance health care directive will not be followed.

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.

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
- Antibiotics
- Medically assisted nutrition, or hydration and food offered through surgically-placed tubes
- Your overall goals or preferences for life-sustaining 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.

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

State Laws About Funeral Designation Forms

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

Pennsylvania does not have a dedicated funeral designation form, but you can use your advance health care directive to designate someone to oversee your end-of-life care.

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.

Pennsylvania 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 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: Pennsylvania

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

PENNSYLVANIA GENERAL DURABLE POWER OF ATTORNEY

**THE POWERS YOU GRANT BELOW ARE EFFECTIVE
EVEN IF YOU BECOME DISABLED OR INCOMPETENT**

NOTICE

THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO HANDLE YOUR PROPERTY, WHICH MAY INCLUDE POWERS TO SELL OR OTHERWISE DISPOSE OF ANY REAL OR PERSONAL PROPERTY WITHOUT ADVANCE NOTICE TO YOU OR APPROVAL BY YOU.

THIS POWER OF ATTORNEY DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS, BUT WHEN POWERS ARE EXERCISED, YOUR AGENT MUST USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS POWER OF ATTORNEY.

YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME INCAPACITATED, UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THESE POWERS OR YOU REVOKE THESE POWERS OR A COURT ACTING ON YOUR BEHALF TERMINATES YOUR AGENT'S AUTHORITY.

YOUR AGENT MUST KEEP YOUR FUNDS SEPARATE FROM YOUR AGENT'S FUNDS.

A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS YOUR AGENT IS NOT ACTING PROPERLY.

THE POWERS AND DUTIES OF AN AGENT UNDER A POWER OF ATTORNEY ARE EXPLAINED MORE FULLY IN 20 PA.C.S. CH. 56.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER OF YOUR OWN CHOOSING TO EXPLAIN IT TO YOU.

I HAVE READ OR HAD EXPLAINED TO ME THIS NOTICE AND I UNDERSTAND ITS CONTENTS.

DATE:

(SIGNATURE OF PRINCIPAL)

(PRINT NAME OF PRINCIPAL)

PENNSYLVANIA GENERAL DURABLE POWER OF ATTORNEY

**THE POWERS YOU GRANT BELOW ARE EFFECTIVE
EVEN IF YOU BECOME DISABLED OR INCOMPETENT**

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I _____

_____ [insert your name and address] appoint
_____ [insert the name and address of the person
appointed] as my Agent (attorney-in-fact) to act for me in any lawful way with respect to the following
initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE
THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE
LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT,
CROSS OUT EACH POWER WITHHELD.

**Note: If you initial Item A or Item B, which follow, a notarized signature will be required on behalf of
the Principal.**

INITIAL

_____ **(A) Real property transactions.** To lease, sell, mortgage, purchase, exchange, and acquire, and
to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept,
take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and
under such covenants, as my Agent shall deem proper; and to maintain, repair, tear down, alter, rebuild,
improve manage, insure, move, rent, lease, sell, convey, subject to liens, mortgages, and security deeds,
and in any way or manner deal with all or any part of any interest in real property whatsoever, including
specifically, but without limitation, real property lying and being situated in the Commonwealth of
Pennsylvania, under such terms and conditions, and under such covenants, as my Agent shall deem proper
and may for all deferred payments accept purchase money notes payable to me and secured by mortgages
or deeds to secure debt, and may from time to time collect and cancel any of said notes, mortgages, security
interests, or deeds to secure debt.

_____ **(B) Tangible personal property transactions.** To lease, sell, mortgage, purchase, exchange,
and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of,
and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or
interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper;
and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens or mortgages, or
to take any other security interests in said property which are recognized under the Uniform Commercial
Code as adopted at that time under the laws of the Commonwealth of Pennsylvania or any applicable state,
or otherwise hypothecate (pledge), and in any way or manner deal with all or any part of any real or personal
property whatsoever, tangible or intangible, or any interest therein, that I own at the time of execution or may
thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem
proper.

_____ **(C) Stock and bond transactions.** To purchase, sell, exchange, surrender, assign, redeem, vote
at any meeting, or otherwise transfer any and all shares of stock, bonds, or other securities in any business,
association, corporation, partnership, or other legal entity, whether private or public, now or hereafter
belonging to me.

_____ **(D) Commodity and option transactions.** To buy, sell, exchange, assign, convey, settle and
exercise commodities futures contracts and call and put options on stocks and stock indices traded on a
regulated options exchange and collect and receipt for all proceeds of any such transactions; establish or
continue option accounts for the principal with any securities or futures broker; and, in general, exercise all
powers with respect to commodities and options which the principal could if present and under no disability.

_____ **(E) Banking and other financial institution transactions.** To make, receive, sign, endorse,
execute, acknowledge, deliver and possess checks, drafts, bills of exchange, letters of credit, notes, stock
certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of
deposit of banks, savings and loans, credit unions, or other institutions or associations. To pay all sums of
money, at any time or times, that may hereafter be owing by me upon any account, bill of exchange, check,
draft, purchase, contract, note, or trade acceptance made, executed, endorsed, accepted, and delivered by
me or for me in my name, by my Agent. To borrow from time to time such sums of money as my Agent may

deem proper and execute promissory notes, security deeds or agreements, financing statements, or other security instruments in such form as the lender may request and renew said notes and security instruments from time to time in whole or in part. To have free access at any time or times to any safe deposit box or vault to which I might have access.

_____ **(F) Business operating transactions.** To conduct, engage in, and otherwise transact the affairs of any and all lawful business ventures of whatever nature or kind that I may now or hereafter be involved in. To organize or continue and conduct any business which term includes, without limitation, any farming, manufacturing, service, mining, retailing or other type of business operation in any form, whether as a proprietorship, joint venture, partnership, corporation, trust or other legal entity; operate, buy, sell, expand, contract, terminate or liquidate any business; direct, control, supervise, manage or participate in the operation of any business and engage, compensate and discharge business managers, employees, agents, attorneys, accountants and consultants; and, in general, exercise all powers with respect to business interests and operations which the principal could if present and under no disability.

_____ **(G) Insurance and annuity transactions.** To exercise or perform any act, power, duty, right, or obligation, in regard to any contract of life, accident, health, disability, liability, or other type of insurance or any combination of insurance; and to procure new or additional contracts of insurance for me and to designate the beneficiary of same; provided, however, that my Agent cannot designate himself or herself as beneficiary of any such insurance contracts.

_____ **(H) Estate, trust, and other beneficiary transactions.** To accept, receipt for, exercise, release, reject, renounce, assign, disclaim, demand, sue for, claim and recover any legacy, bequest, devise, gift or other property interest or payment due or payable to or for the principal; assert any interest in and exercise any power over any trust, estate or property subject to fiduciary control; establish a revocable trust solely for the benefit of the principal that terminates at the death of the principal and is then distributable to the legal representative of the estate of the principal; and, in general, exercise all powers with respect to estates and trusts which the principal could exercise if present and under no disability; provided, however, that the Agent may not make or change a will and may not revoke or amend a trust revocable or amendable by the principal or require the trustee of any trust for the benefit of the principal to pay income or principal to the Agent unless specific authority to that end is given.

_____ **(I) Claims and litigation.** To commence, prosecute, discontinue, or defend all actions or other legal proceedings touching my property, real or personal, or any part thereof, or touching any matter in which I or my property, real or personal, may be in any way concerned. To defend, settle, adjust, make allowances, compound, submit to arbitration, and compromise all accounts, reckonings, claims, and demands whatsoever that now are, or hereafter shall be, pending between me and any person, firm, corporation, or other legal entity, in such manner and in all respects as my Agent shall deem proper.

_____ **(J) Personal and family maintenance.** To hire accountants, attorneys at law, consultants, clerks, physicians, nurses, agents, servants, workmen, and others and to remove them, and to appoint others in their place, and to pay and allow the persons so employed such salaries, wages, or other remunerations, as my Agent shall deem proper.

_____ **(K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service.** To prepare, sign and file any claim or application for Social Security, unemployment or military service benefits; sue for, settle or abandon any claims to any benefit or assistance under any federal, state, local or foreign statute or regulation; control, deposit to any account, collect, receipt for, and take title to and hold all benefits under any Social Security, unemployment, military service or other state, federal, local or foreign statute or regulation; and, in general, exercise all powers with respect to Social Security, unemployment, military service, and governmental benefits, including but not limited to Medicare and Medicaid, which the principal could exercise if present and under no disability.

_____ **(L) Retirement plan transactions.** To contribute to, withdraw from and deposit funds in any type of retirement plan (which term includes, without limitation, any tax qualified or nonqualified pension, profit sharing, stock bonus, employee savings and other retirement plan, individual retirement account, deferred compensation plan and any other type of employee benefit plan); select and change payment options for the principal under any retirement plan; make rollover contributions from any retirement plan to other retirement plans or individual retirement accounts; exercise all investment powers available under any type of self-directed retirement plan; and, in general, exercise all powers with respect to retirement plans and retirement plan account balances which the principal could if present and under no disability.

_____ **(M) Tax matters.** To prepare, to make elections, to execute and to file all tax, social security, unemployment insurance, and informational returns required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, to execute, and to file all other papers and instruments which the Agent shall think to be desirable or necessary for safeguarding of me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, to compromise, or to contest or to apply for refunds in connection with any taxes or assessments for which I am or may be liable.

_____ **(N) ALL OF THE POWERS LISTED ABOVE.** YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

THIS POWER OF ATTORNEY SHALL BE CONSTRUED AS A GENERAL DURABLE POWER OF ATTORNEY AND SHALL CONTINUE TO BE EFFECTIVE EVEN IF I BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

(YOUR AGENT WILL HAVE AUTHORITY TO EMPLOY OTHER PERSONS AS NECESSARY TO ENABLE THE AGENT TO PROPERLY EXERCISE THE POWERS GRANTED IN THIS FORM, BUT YOUR AGENT WILL HAVE TO MAKE ALL DISCRETIONARY DECISIONS. IF YOU WANT TO GIVE YOUR AGENT THE RIGHT TO DELEGATE DISCRETIONARY DECISION-MAKING POWERS TO OTHERS, YOU SHOULD KEEP THE NEXT SENTENCE, OTHERWISE IT SHOULD BE STRICKEN.)

Authority to Delegate. My Agent shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my Agent may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(YOUR AGENT WILL BE ENTITLED TO REIMBURSEMENT FOR ALL REASONABLE EXPENSES INCURRED IN ACTING UNDER THIS POWER OF ATTORNEY. STRIKE OUT THE NEXT SENTENCE IF YOU DO NOT WANT YOUR AGENT TO ALSO BE ENTITLED TO REASONABLE COMPENSATION FOR SERVICES AS AGENT.)

Right to Compensation. My Agent shall be entitled to reasonable compensation for services rendered as agent under this power of attorney.

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAME(S) AND ADDRESS(ES) OF SUCH SUCCESSOR(S) IN THE FOLLOWING PARAGRAPH.)

Successor Agent. If any Agent named by me shall die, become incompetent, resign or refuse to accept the

office of Agent, I name the following (each to act alone and successively, in the order named) as successor(s) to such Agent:

Choice of Law. THIS POWER OF ATTORNEY WILL BE GOVERNED BY THE LAWS OF THE COMMONWEALTH OF PENNSYLVANIA WITHOUT REGARD FOR CONFLICTS OF LAWS PRINCIPLES. IT WAS EXECUTED IN THE COMMONWEALTH OF PENNSYLVANIA AND IS INTENDED TO BE VALID IN ALL JURISDICTIONS OF THE UNITED STATES OF AMERICA AND ALL FOREIGN NATIONS.

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my Agent.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this _____ day of _____, 20____

[Your Signature]

STATEMENT OF WITNESS

On the date written above, the principal declared to me in my presence that this instrument is his general durable power of attorney and that he or she had willingly signed or directed another to sign for him or her, and that he or she executed it as his or her free and voluntary act for the purposes therein expressed.

[Signature of Witness #1]
[Printed or typed name of Witness #1]
[Address of Witness #1, Line 1]
[Address of Witness #1, Line 2]

[Signature of Witness #2]
[Printed or typed name of Witness #2]
[Address of Witness #2, Line 1]
[Address of Witness #2, Line 2]

A Note About Selecting Witnesses: The agent (attorney-in-fact) may not also serve as a witness. Each witness must be present at the time that principal signs the Power of Attorney in front of the notary. Each witness must be a mentally competent adult. Witnesses should ideally reside close by, so that they will be easily accessible in the event they are one day needed to affirm this document's validity.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF _____

On this, the _____ day of _____, 20____, before me
_____, the undersigned officer, personally appeared
_____,
known to me (or satisfactorily proven) to be the person(s) whose name(s) is/are subscribed to the
within instrument, and acknowledged that _____ executed
the same for the purposes therein contained.

In witness whereof, I hereunto set my hand and official seals.

[Notary Seal, if any]:

(Signature of Notarial Officer)

Notary Public for the Commonwealth of
Pennsylvania

My commission expires: _____

ACKNOWLEDGMENT EXECUTED BY AGENT

I, _____ [name of agent], have read the attached
power of attorney and am the person identified as the agent for the principal. I hereby acknowledge that in
the absence of a specific provision to the contrary in the power of attorney or in 20 Pa.C.S. when I act as
agent:

I shall exercise the powers for the benefit of the principal.

I shall keep the assets of the principal separate from my assets.

I shall exercise reasonable caution and prudence.

I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

Agent's Signature

Agent's Printed Name

Date

PREPARATION STATEMENT

This document was prepared by the following individual:

[Typed or Printed Name]

[Signature]



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Advance Health Care Directive

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PENNSYLVANIA

DURABLE HEALTH CARE POWER OF ATTORNEY
AND HEALTH CARE TREATMENT INSTRUCTIONS
LIVING WILL
PART I
INTRODUCTORY REMARKS ON
HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want. Should you become unable to understand, make, or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

- (1) naming a health care agent to decide treatment for you; and
- (2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding, or withdrawal of life-sustaining treatment and other specific instructions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. **THIS COMBINED FORM GIVES YOUR HEALTH CARE AGENT THE POWER TO SPEAK FOR YOU ONLY WHEN YOU ARE UNABLE TO SPEAK FOR YOURSELF.**

A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make, and communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make, or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family

members, and others whom you expect would likely attend to your needs if you become unable to understand, make, or communicate decisions about medical care.

If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician, or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment.

The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements. You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious.

If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. You should also use a different form if you wish to express your preferences in more detail than this form allows or if you wish for your health care agent to be able to speak for you immediately. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) will be physically harmful to you; or
- (3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant. Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

PART II DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____, of _____ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as

verified by my attending physician. My health care agent may not delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART III (Cross out any powers you do not want to give your health care agent):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Work _____

E-MAIL: _____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT, UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative Health Care Agent: _____
(Name and relationship)

Address: _____
—

Telephone Number: Home _____ Work _____

E-MAIL: _____

Second Alternative Health Care Agent: _____
(Name and relationship)

Address: _____
—

Telephone Number: Home _____ Work _____

E-MAIL: _____

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

GOALS

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.)

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome.

I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials _____ I agree

Initials _____ I disagree

PART III

HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)
 - heart-lung resuscitation (CPR) _____
 - mechanical ventilator (breathing machine) _____
 - dialysis (kidney machine) _____
 - surgery _____
 - _____
 - chemotherapy radiation treatment _____

- antibiotics
-

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(Initial only one statement.)

TUBE FEEDINGS

_____ I want tube feedings to be given.

OR

NO TUBE FEEDINGS

_____ I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(INITIAL ONE OPTION ONLY.)

_____ My health care agent must follow these instructions.

OR

_____ These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any

claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

ORGAN DONATION (INITIAL ONE OPTION ONLY.)

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_____ I do not consent to donate my organs or tissues at the time of my death.

Having carefully read this document, I have signed it this _____ day of _____, 20__, revoking all previous health care powers of attorney and health care treatment instructions.

SIGNED: _____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this ____ day of _____, 20 ____, before me personally appeared the aforesaid declarant and principal, 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 of _____, State of _____ the day and year first above written.

Notary Public

My commission expires _____



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Introduction to the POLST Form

Pennsylvania – Orders for Life Sustaining Treatment (POLST) is a medical order that gives patients more control over their end-of-life care. The POLST form specifies the types of medical treatment that a patient wishes to receive towards the end of life. These medical orders are signed by both a patient’s physician, physician’s assistant, or certified registered nurse practitioner and the patient or the patient’s surrogate. The POLST form travels with the patient to help assure that treatment preferences are honored across settings of care (hospital, nursing home, assisted living facility etc.).

Completion of a POLST form is an entirely voluntary process and is only a small step in the process of a patient’s decision-making, and it is critical that this form be used as part of a program for end of life decisions that includes educational support and other aspects of planning for providers and patients.

This form was developed by the Pa. Department of Health’s Patient Life Sustaining Wishes Committee and was designed to be consistent with Pennsylvania law. There are significant advantages to using a form that contains standardized language and is produced in a distinctive and easily recognizable format. In order to maintain continuity throughout Pennsylvania, please follow these printing instructions:

***** Print POLST form on Pulsar Pink card stock (65#) *****

See additional instructions on the POLST form related to completing and using the form. As additional educational materials are developed for the POLST form and for POLST programs in Pennsylvania, they will be added to this introduction.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
 To follow these orders, an EMS provider must have an order from his/her medical command physician



Pennsylvania Orders for Life- Sustaining Treatment (POLST)

Last Name

First/Middle Initial

Date of Birth

FIRST follow these orders, **THEN** contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

A

Check One

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

- CPR/Attempt Resuscitation DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

B

Check One

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

COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.**

LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

Transfer to hospital if indicated. Avoid intensive care if possible.

FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Transfer to hospital if indicated. Includes intensive care.

Additional Orders _____

C

Check One

ANTIBIOTICS:

- No antibiotics. Use other measures to relieve symptoms.
- Determine use or limitation of antibiotics when infection occurs, with comfort as goal
- Use antibiotics if life can be prolonged

Additional Orders _____

D

Check One

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

Always offer food and liquids by mouth if feasible

- No hydration and artificial nutrition by tube.
- Trial period of artificial hydration and nutrition by tube.
- Long-term artificial hydration and nutrition by tube.

Additional Orders _____

E

Check One

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

- Discussed with
- Patient
- Parent of Minor
- Health Care Agent
- Health Care Representative
- Court-Appointed Guardian
- Other:

Patient Goals/Medical Condition:

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Physician /PA/CRNP Printed Name:

Physician /PA/CRNP Phone Number

Physician/PA/CRNP Signature (Required):

DATE

Signature of Patient or Surrogate

Signature (required)

Name (print)

Relationship (write "self" if patient)

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Other Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. www.health.pa.gov or www.papolst.org

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary

Using POLST

If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation"

Oral fluids and nutrition must always be offered if medically feasible.

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).

A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

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

Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write "VOID" in large letters across the form, and sign and date the form.



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