



Triage Health Estate Planning Toolkit: Texas

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.

Texas probate courts accept written and holographic wills. To make a valid written will in Texas:

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, lawfully married, or a member of the U.S. armed or maritime services
 - Of “sound mind” (meaning you know what you’re doing)
2. You need to sign the will in front of two witnesses who have watched you sign or authorize someone else to sign the will. Your witnesses must be at least 14 years old and must sign the will in your presence.
3. Your will does not need to be notarized to be legal in Texas. However, you can make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

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

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)
2. Your entire will must be written in your handwriting and you must sign and date it
3. If you like, you can attach an affidavit to your holographic will to make it self-proving

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

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.

Texas’s statutory form for general power of attorney allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose an alternate agent, who will take charge separately if the first person cannot act, or can oversee your finances jointly if you indicate this preference in the “special instructions” section. This person can make all financial decisions for you, or you can limit

their powers to specific areas, like filing taxes or banking. A power of attorney is valid once you have signed it and gotten it notarized.

Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it, however, it must include language such as “This power of attorney is not affected by subsequent disability or incapacity of the principal” or “This power becomes effective on the disability or incapacity of the principal” in order for it to remain in effect if you become incapacitated. This document will remain in effect until you die unless you specify a date to terminate or revoke your power of attorney. Note that if you select your spouse as your agent, their authority will automatically terminate if your marriage dissolves, unless you specify otherwise.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Texas, this form contains four parts. You can sign part one, part two, or both, depending on your advance planning needs. But, you must sign part four to make the document valid.

1. **Texas Medical Power of Attorney Designation of a Health Care Agent:** You can use this form to choose someone (an agent) to make decisions about your medical care for you, including life-prolonging care, any time your doctor determines you can no longer make these decisions. There is a place for you to limit the decision-making authority of your agent. You can also choose an alternate person if the first person you appoint is not available. If you appoint a health or residential care provider (e.g., your doctor or someone who works for your doctor or for your residential care facility who is not your relative) as your agent, then that person must choose between acting as your agent or as your health or residential care provider. This document takes effect when your doctor determines you can no longer understand or communicate your preferences for health care.
2. **Directive to Physicians and Family or Surrogates:** Sometimes called a “living will,” this document lets you indicate your preferences for health care if you become unable to speak for yourself and are suffering from a terminal illness or condition. You can clarify your preferences for treatments including surgery or other invasive procedures, cardiopulmonary resuscitation (CPR) to restart your heart or breathing, antibiotics, dialysis, chemotherapy, and artificially-supplied nutrition and hydration in the additional requests section.
3. **Explanation of Terms:** This section clarifies important terms used in your advance health care directive, including “irreversible condition” and “life-sustaining treatment.”
4. **Signing and Witnessing Provisions:** You must sign your advance health care directive in front of two adult witnesses who also sign the document, or you must have the AHCD notarized. One of your witnesses cannot be:
 - Your agent or alternate agent
 - Related to you by blood or marriage
 - Your doctor or an employee of your doctor
 - An officer, director, partner, or business office employee of your health care facility or of any parent organization of your health care facility, if you are currently a patient or resident
 - Included in your will or entitled to your estate by any other law
 - Someone with a claim against your estate upon your death (e.g. someone to whom you owe money)

If you are pregnant and the decisions you make in this document would interfere with facilitating life-

sustaining treatment to the fetus, then it will not be followed.

You can revoke part one of your AHCD by telling your health care provider your decision in a written or oral statement, or by creating a new advance health care directive.

If you appoint your spouse as your proxy for part one, their authority will automatically terminate if your marriage dissolves, unless you specify differently in the “additional instructions” section.

You can revoke part two by destroying the document or telling your doctor orally or in a written statement.

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 Texas, 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 nutrition and hydration, or food and fluids offered through surgically-placed tubes

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 change or revoke your MOST verbally or in writing at any time.

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.

Texas’s Appointment for Disposition of Remains form allows you to designate an agent to make decisions about the disposition of your remains and your funeral arrangements. The document must be signed by you and your agent. You can also include instructions to guide your agent. If your agent was a spouse, unless you specifically say otherwise, your agent’s appointment is automatically revoked in the case of divorce.

Part III of this toolkit includes a sample 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.

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

Federal Law About HIPAA

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

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

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

Part III of this toolkit includes a sample HIPAA authorization form. For more information:

www.cdc.gov/php/publications/topic/hipaa.html.



Triage Health Estate Planning Toolkit: Texas

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Colorado Medical Durable Power of Attorney
- Advance Health Care Directive for Surgical/Medical Treatment
- Colorado Medical Order for Scope of Treatment (MOST)
- HIPAA Authorization Form



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

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STATUTORY DURABLE POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE DURABLE POWER OF ATTORNEY ACT, SUBTITLE P, TITLE 2, ESTATES CODE. 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. IF YOU WANT YOUR AGENT TO HAVE THE AUTHORITY TO SIGN HOME EQUITY LOAN DOCUMENTS ON YOUR BEHALF, THIS POWER OF ATTORNEY MUST BE SIGNED BY YOU AT THE OFFICE OF THE LENDER, AN ATTORNEY AT LAW, OR A TITLE COMPANY.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until:

- (1) you die or revoke the power of attorney;
- (2) your agent resigns, is removed by court order, or is unable to act for you; or
- (3) a guardian is appointed for your estate.

I, _____ (insert your name and address), appoint
_____ (insert the name and address of the person appointed) as my agent to act for me in any lawful way with respect to all of the following powers that I have initialed below. (YOU MAY APPOINT CO-AGENTS. UNLESS YOU PROVIDE OTHERWISE, CO-AGENTS MAY ACT INDEPENDENTLY.)

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

TO GRANT A POWER, YOU MUST INITIAL THE LINE IN FRONT OF THE POWER YOU ARE GRANTING.

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

- _____ (A) Real property transactions;
- _____ (B) Tangible personal property transactions;
- _____ (C) Stock and bond transactions;
- _____ (D) Commodity and option transactions;
- _____ (E) Banking and other financial institution transactions;
- _____ (F) Business operating transactions;
- _____ (G) Insurance and annuity transactions;
- _____ (H) Estate, trust, and other beneficiary transactions;
- _____ (I) Claims and litigation;
- _____ (J) Personal and family maintenance;
- _____ (K) Benefits from social security, Medicare, Medicaid, or other governmental

- _____ programs or civil or military service;
- _____ (L) Retirement plan transactions;
- _____ (M) Tax matters;
- _____ (N) Digital assets and the content of an electronic communication;
- _____ (O) ALL OF THE POWERS LISTED IN (A) THROUGH (N). YOU DO NOT HAVE TO INITIAL THE LINE IN FRONT OF ANY OTHER POWER IF YOU INITIAL LINE (O).

SPECIAL INSTRUCTIONS:

Special instructions applicable to agent compensation (initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to compensation that is reasonable under the circumstances):

_____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf and to compensation that is reasonable under the circumstances.

_____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf but shall receive no compensation for serving as my agent.

Special instructions applicable to co-agents (if you have appointed co-agents to act, initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to act independently):

_____ Each of my co-agents may act independently for me.

_____ My co-agents may act for me only if the co-agents act jointly.

_____ My co-agents may act for me only if a majority of the co-agents act jointly.

Special instructions applicable to gifts (initial in front of the following sentence to have it apply):

_____ I grant my agent the power to apply my property to make gifts outright to or for the benefit of a person, including by the exercise of a presently exercisable general power of appointment held by me, except that the amount of a gift to an individual may not exceed the amount of annual exclusions allowed from the federal gift tax for the calendar year of the gift.

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

UNLESS YOU DIRECT OTHERWISE BELOW, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT TERMINATES.

CHOOSE ONE OF THE FOLLOWING ALTERNATIVES BY CROSSING OUT THE ALTERNATIVE NOT CHOSEN:

(A) This power of attorney is not affected by my subsequent disability or incapacity.

(B) This power of attorney becomes effective upon my disability or incapacity.

YOU SHOULD CHOOSE ALTERNATIVE (A) IF THIS POWER OF ATTORNEY IS TO BECOME EFFECTIVE ON THE DATE IT IS EXECUTED.

IF NEITHER (A) NOR (B) IS CROSSED OUT, IT WILL BE ASSUMED THAT YOU CHOSE ALTERNATIVE (A).

If Alternative (B) is chosen and a definition of my disability or incapacity is not contained in this power of attorney, I shall be considered disabled or incapacitated for purposes of this power of attorney if a physician certifies in writing at a date later than the date this power of attorney is executed that, based on the physician's medical examination of me, I am mentally incapable of managing my financial affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this power of attorney. A third party who accepts this power of attorney is fully protected from any action taken under this power of attorney that is based on the determination made by a physician of my disability or incapacity.

I agree that any third party who receives a copy of this document may act under it. Termination of this durable power of attorney is not effective as to a third party until the third party has actual knowledge of the termination. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney. The meaning and effect of this durable power of attorney is determined by Texas law.

If any agent named by me dies, becomes incapacitated, resigns, or refuses to act, or is removed by court order, or if my marriage to an agent named by me is dissolved by a court decree of divorce or annulment or is declared void by a court (unless I provided in this document that the dissolution or declaration does not terminate the agent's authority to act under this power of attorney), I name the following (each to act alone and successively, in the order named) as successor(s) to that agent:

Signed this _____ day of _____, _____.

(your signature)

State of _____
County of _____

This document was acknowledged before me on _____ (date) by

(name of principal)

(Seal, if any, of notary)

(signature of notarial officer)

(printed name)

My commission expires: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, you establish a “fiduciary” relationship with the principal. This is a special legal relationship that imposes on you legal duties that continue until you resign or the power of attorney is terminated, suspended or revoked by the principal or by operation of law. A fiduciary duty generally includes the duty to:

- (1) act in good faith;
- (2) do nothing beyond the authority granted in this power of attorney;
- (3) act loyally for the principal's benefit;
- (4) avoid conflicts that would impair your ability to act in the principal's best interest; and
- (5) disclose your identity as an agent when 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

In addition, the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code) requires you to:

- (1) maintain records for each action taken or decision made on behalf of the principal;
- (2) maintain all records until delivered to the principal, released by the principal, or discharged by a court; and
- (3) if requested by the principal, provide an accounting to the principal that, unless directed by the principal or otherwise provided in the Special Instructions, must include:
 - (A) the property belonging to the principal that has come to your knowledge or into your possession;
 - (B) each action taken or decision made by you as agent;
 - (C) a complete account of receipts, disbursements, and other actions of you as agent that includes the source and nature of each receipt, disbursement or action, with receipts of principal and income shown separately;
 - (D) a listing of all property over which you have exercised control that includes an adequate description of each asset and the asset's current value, if known to you;
 - (E) the cash balance on hand and the name and location of the depository at which the cash balance is kept;
 - (F) each known liability;
 - (G) any other information and facts known to you as necessary for a full and definite understanding of the exact condition of the property belonging to the principal; and
 - (H) all documentation regarding the principal's property.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn or any event that terminates or suspends this power of attorney or your authority under this power of attorney. An event that terminates this power of attorney or your authority to act under this power of attorney includes:

- (1) the principal's death;
- (2) the principal's revocation of this power of attorney or your authority;
- (3) the occurrence of a termination event stated in this power of attorney;

- (4) if you are married to the principal, the dissolution of your marriage by court decree of divorce or annulment or declaration that your marriage is void, unless otherwise provided in this power of attorney;
- (5) the appointment and qualification of a permanent guardian of the principal's estate unless a court order provides otherwise; or
- (6) if ordered by a court, your removal as agent (attorney in fact) under this power of attorney. An event that suspends this power of attorney is the appointment and qualification of a temporary guardian unless a court order provides otherwise.

Liability of the Agent

The authority granted to you under this power of attorney is specified in the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code). If you violate the Durable Power of Attorney Act or act beyond the authority granted, you may be liable for any damages caused by the violation or subject to prosecution for misapplication of property by a fiduciary under Chapter 32 of the Texas Penal Code.

THE AGENT, BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Advance Health Care Directive

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MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____ Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE
AS FOLLOWS:

DESIGNATION OF AN ALTERNATE AGENT:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of the document is kept at _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior medical power of attorney.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself. It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time. You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or

declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

- (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
- (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____
(month, year) at

(City and State)

(Signature)

(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ (date) by _____
(name of person acknowledging).

NOTARY PUBLIC, State of Texas

Notary's printed name:

My commission expires:

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on _____ day of _____ (month, year)
at

(City and State)

(Signature)

(Print Name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____



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Part III: Your State's Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

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MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

Follow this MOST and patient preferences first, then contact a physician. This MOST may only be changed by a physician or revoked by the patient or surrogate/proxy below. Send this MOST with patient for all transfers between treatment sites. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name: _____ First Name _____ DOB: _____

Primary Care Provider: _____ Provider Phone: _____

A Choose ONLY one	PHYSICIAN RESUSCITATION ORDER: No pulse and not breathing
	<input type="checkbox"/> Attempt Resuscitation (CPR) Tube in the windpipe, electrical shocks to the chest, chest compression, and IV tubes for fluids/medications. <input type="checkbox"/> Do Not Attempt Resuscitation/ Allow Natural death (DNAR/AND) Provide physical comfort, emotional, and respectful spiritual support to patient and family. OOH DNR completed <input type="checkbox"/>

B Choose ONLY one	MEDICAL INTERVENTION SCOPE: Unstable, has pulse and is breathing Per physician order, use appropriate interventions for the scope of treatment preferences noted below. If this section is not completed, then provide full treatment for this section.
	<input type="checkbox"/> COMFORT INTERVENTIONS ONLY: <u>Avoid hospitalization unless needed to provide comfort care.</u> Focus on symptom control, dignity, and allowing gentle, natural death should it occur. Use comfort interventions like oral, subcutaneous, or intravenous medications (e.g., opioids), comfort foods/liquids, oxygen, and emotional/spiritual support.
	<input type="checkbox"/> INTERMEDIATE INTERVENTIONS: <u>If necessary, transfer to a hospital.</u> In addition to comfort measures, may add interventions like intravenous antibiotics, non-invasive breathing support (BiPAP/CPAP), and fluid resuscitation. <input type="checkbox"/> FULL INTERVENTIONS: <u>Transfer to a hospital, and if necessary to ICU.</u> Use comfort and intermediate measures, and may add medically appropriate ICU interventions such as, but not limited to, intubation/ventilator support, ICU-only medications, and dialysis.
ADDITIONAL ORDERS: _____	

C Choose all that apply	MEDICALLY ASSISTED NUTRITION Offer nutrition and hydration by mouth at all intervention levels if feasible. Per physician order, use additional interventions noted below. If this section is not completed, then provide full treatment for this section.
	<input type="checkbox"/> No medically assisted nutrition. <input type="checkbox"/> Unless medically contra-indicated*, defined trial of medically assisted nutrition. Length of trial _____ Goal _____ <input type="checkbox"/> Long-term medically assisted nutrition. *In some circumstances including, but not limited to, heart, lung, liver or kidney failure, assisted nutrition or hydration may increase suffering or hasten death, and is therefore medically contraindicated.

D Choose all that apply	This MOST is based upon the patient's medical condition and preferences expressed in:
	<input type="checkbox"/> OOH-DNR; <input type="checkbox"/> Living Will (Directive to Physicians and Family or Surrogates); <input type="checkbox"/> MPOA <input type="checkbox"/> Direct conversation with patient with decision-making capacity <input type="checkbox"/> Direct conversation with surrogate decision-maker/proxy for incapacitated patient Surrogate/Proxy designated in: <input type="checkbox"/> MPOA <input type="checkbox"/> Living Will <input type="checkbox"/> Texas Statutory Surrogate Attached: <input type="checkbox"/> OOH DNR <input type="checkbox"/> MPOA <input type="checkbox"/> Living Will Surrogate/Proxy name and phone contact: _____ Relationship to patient: _____ NTRC Facilitator (Print Name/Sign/Date) _____

E Choose ONLY one	DOCUMENTATION OF DISCUSSION:
	<input type="checkbox"/> Patient (Patient has capacity) <input type="checkbox"/> Health Care Representative or legally recognized surrogate, family member <input type="checkbox"/> Parent of minor <input type="checkbox"/> Surrogate for patient with developmental disabilities or significant mental health condition <input type="checkbox"/> Court-Appointed Guardian (Note: Special requirements for completion. See reverse side.) <input type="checkbox"/> Other _____

Patient or Patient's Designee Signature:

Physician Signature: My signature certifies both the order and preferences above and the basis for them.

Patient or Patient's Designee Name: (Print)

Print Name and License Number:

Date/Time Completed:

Date/Time Completed:

Legend: **MPOA** = medical power of attorney; **OOH-DNR** = Out of Hospital-Do Not Resuscitate; **ICU** = Intensive Care Unit; some other terms are **BiPAP** = bilevel positive airway pressure; **CPAP**- continuous positive airway pressure; **G-tube** = gastrostomy tube, **J-tube** = jejunostomy tube, **PEG** = percutaneous endoscopic gastrostomy.

Instructions for MOST Form

(Form Provided by North Texas Specialty Physicians version 1.2.14)

Purpose and scope: explains the conversation and MOST form intent to honor the current wishes of our patients and improve communication between providers. This MOST form is intended to improve communication between health care professionals in hospitals and nursing homes about scope (intensity) of treatment for patients who are seriously ill and unable to communicate. The order and treatment preferences should be based upon:

- The patient's medical condition as determined by a physician; and
- The patient's verbal preferences, or if the patient is unable to verbally express preferences, preferences stated in the patient's Living Will or the decision of a surrogate/proxy acting with knowledge of what the patient would want and/or acting in the patient's best interests.

When the need occurs, health care professionals should first follow this form, and then contact a physician for further orders. Health care professionals should honor a patient's preferences when it is medically appropriate to do so. Physician orders should be followed by all health care professionals until new orders are written by a physician or the patient or surrogate/proxy named on the MOST revokes or changes a treatment preference. If any section of this MOST is not completed or if a section is revoked by a patient or a patient's surrogate/proxy, then full treatment should be provided for that section as appropriate for the patient's medical condition (e.g., ICU transfer and organ support machines or drugs as medically indicated).

Review reminds that physicians should review the form annually with patient and surrogate or upon changes in condition. Physicians should review this form with the patient or surrogate/proxy at least yearly or upon a major change in care setting, medical condition, or patient treatment preferences.

Section A: Section A translates patient preferences regarding resuscitation into a physician order. It applies when a patient does not have a pulse and is not breathing. If a patient is not in cardiopulmonary arrest, then go to Sections B, C, D. At all times, health care professionals should remember that a DNAR/AND order does not mean that other health problems should go untreated.

Information Regarding Cardio-Pulmonary Resuscitation (CPR): CPR is sometimes helpful but other times can be harmful. It is most effective when a patient dies unexpectedly. CPR is rarely effective in advanced cancer, organ failure, other advanced illness, or advanced age when death would not be a surprise. CPR started in the nursing home almost never leads to survival. If CPR is initially successful in resuscitating a patient, the patient will be on a breathing machine in the ICU. Patients should discuss with their physician the potential to benefit from CPR based on their medical condition.

Section B and C: Section B and C provide guidance for more specific orders which a treating physician may issue according to the patient's medical condition, medical appropriateness, and local medical and nursing facility policy. These sections apply when a patient has a pulse and is breathing.

Section D: Section D indicates the basis for completing Sections A, B and C. A copy of the patient's Living Will, Medical Power of Attorney (MPOA), or Out of Hospital-Do Not Resuscitate (OOH-DNR) Order should be attached to this MOST and sent with it when possible, but those are not required for this MOST to be effective.

Living Will, MPOA, and OOH-DNR Order: MOST is vital but does not replace these documents. EMS should honor and execute an OOH-DNR order or device [Tex. H&S Code, 166.102(b)] Although this MOST conveys important information about a patient's treatment preferences, it does not replace a Living Will, MPOA, or OOH-DNR Order. A patient's Living Will, MPOA, or OOH-DNR Order controls over this MOST. Health care professionals should be aware that when responding to a call for assistance, EMS personnel shall honor only a properly executed or issued OOH-DNR Order or identification device. [Tex. H&S Code, §166.102(b)].

Copy of MOST and HIPAA: A copy of a completed MOST is as valid as the original. HIPAA permits disclosure of a completed MOST to other health care providers as necessary for treatment. The complete MOST and associated documents will also be available to your treating physicians electronically via a secure local health information exchange.

SEND the MOST FORM ON ALL TRANSFERS BETWEEN HEALTHCARE SITES



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Funeral Designation Form

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.

DURATION:

This appointment becomes effective upon my death.

PRIOR APPOINTMENTS REVOKED:

I hereby revoke any prior appointment of any person to control the disposition of my remains.

RELIANCE:

I hereby agree that any cemetery organization, business operating a crematory or colombarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document may act under it. Any modification or revocation of this document is not effective as to any such party until that party receives actual notice of the modification or revocation. No such party shall be liable because of reliance on a copy of this document.

ASSUMPTION:

THE AGENT, AND EACH SUCCESSOR AGENT, BY ACCEPTING THIS APPOINTMENT, ASSUMES THE OBLIGATIONS PROVIDED IN, AND IS BOUND BY THE PROVISIONS OF, SECTION 711.002, HEALTH AND SAFETY CODE.

SIGNATURES:

This written instrument and my appointments of an agent and any successor agent in this instrument are valid without the signature of my agent and any successor agents below. Each agent, or a successor agent, acting pursuant to this appointment must indicate acceptance of the appointment by signing below before acting as my agent.

Signed this _____ day of _____, 20_____.

(your signature)

State of _____

County of _____

This document was acknowledged before me on _____ (date)

by _____ (name of principal).

(signature of notarial officer)

(Seal, if any, of notary)

_____ (printed name)

My commission expires: _____

ACCEPTANCE AND ASSUMPTION BY AGENT:

I have no knowledge of or any reason to believe this Appointment for Disposition of Remains has been revoked. I hereby accept the appointment made in this instrument with the understanding that I will be individually liable for the reasonable cost of the decedent's interment, for which I may seek reimbursement from the decedent's estate.

Acceptance of Appointment: _____
(signature of agent)

Date of Signature: _____

Acceptance of Appointment: _____
(signature of first successor)

Date of Signature: _____

Acceptance of Appointment: _____
(signature of second successor)

Date of Signature: _____



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