Triage Health Estate Planning Toolkit: West Virginia

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.

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

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. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. Your will does not need to be notarized to be legal in West Virginia. 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.

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

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

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 it

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.

West Virginia's power of attorney statutory form allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose a successor agent, and a second

successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, your agent is entitled to reasonable compensation for their help. This document goes into effect when you sign it, unless you indicate 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. In West Virginia, this form is called a **West Virginia Combined Medical Power of Attorney and Living Will.**

- **Part I - Medical Power of Attorney:** You can choose someone (a "representative") 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. You can also choose an alternate person if the first person you choose is not available. This document takes effect when your doctor determines you can no longer understand or communicate your preferences for health care.
- **Part II - Living Will:** This document lets you indicate your preferences for life-sustaining care if you become unable to speak for yourself and are suffering from a terminal illness or condition. You can indicate wishes for hospice care, but also other advance planning issues, like preferences for burial in the special directives or limitations section of the form.
- **Part III - Signing and Witnessing Provisions:** You must sign your advance health care directive in front of two adult witnesses and a notary public. Your witnesses cannot be:
    - Someone signing this document on your behalf
    - Your representative or successor representative
    - Related to you by blood or marriage
    - Your doctor or an employee of your doctor
    - Directly financially responsible for your health care
    - Included in your will or entitled to your estate by any other law
- **Organ Donation Form:** You can attach an optional organ donation form to indicate if you would like to make an organ/tissue donation. You can also express preferences about organ donation in the Special Directives or Limitations section of your living will.

You can change the directions in your AHCD at any time by destroying the document, creating a dated and signed revocation, or orally revoking this document in front of a witness at least 18 years old, who will sign a statement confirming your revocation. You should inform your representative and attending physician when you change your AHCD so they can destroy the document that was revoked and replace it with your new form.

Part III of this toolkit includes a sample AHCD.

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 West Virginia, this document is called a physician order for scope of treatment (POST). The POST does not replace an advance directive. You can complete a POST 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
- Antibiotics
- Medically assisted nutrition and hydration, or food and fluids offered through surgically-placed tubes
- Additional orders or instructions for your care

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

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.

West Virginia does not have a dedicated funeral designation form, but you can use your advance health care directive to designate someone to oversee the disposal of your remains.

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.

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

Federal Law About HIPAA

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

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

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

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: West Virginia

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- West Virginia Combined Medical Power of Attorney and Living Will
- Physician Order for Scope of Treatment (POST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

State of West Virginia

STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act located at W.Va. Code §39B-3-101, et seq.

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

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

Your agent is entitled to reasonable compensation unless you state otherwise in the special instructions. This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions. If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

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

DESIGNATION OF AGENT

I _____ name the following person as my agent:
(Name of Principal)

Name of Agent:_____

Agent's Address:_____

Agent's Telephone Number:_____

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

Name of Successor Agent:_____

Successor Agent's Address:_____

Successor Agent's Telephone Number:_____

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

Name of Second Successor Agent:_____

Second Successor Agent's Address:_____

Second Successor Agent's Telephone Number:_____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act [insert citation]:

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

(___) Real Property

(___) Tangible Personal Property

(___) Stocks and Bonds

(___) Commodities and Options

(___) Banks and Other Financial Institutions

(___) Operation of Entity or Business

(___) Insurance and Annuities

(___) Estates, Trusts, and Other Beneficial Interests

(___) Claims and Litigation

(___) Personal and Family Maintenance

(___) Benefits from Governmental Programs or Civil or Military Service

(___) Retirement Plans

(___) Taxes

(___) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

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

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your

property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

(___) Create, amend, revoke, or terminate an inter vivos trust

(___) Make a gift, subject to the limitations of the West Virginia Uniform Power of Attorney Act and any special instructions in this power of attorney

(___) Create or change rights of survivorship

(___) Create or change a beneficiary designation

(___) Authorize another person to exercise the authority granted under this power of attorney

(___) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

(___) Exercise fiduciary powers that the principal has authority to delegate

(___)Disclaim or refuse an interest in property, including a power of appointment

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____
_____
_____
_____
_____
_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the special instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a conservator or guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator or guardian of my estate:

_____

Nominee's Address:_____

Nominee's Telephone Number:_____

Name of Nominee for guardian of my person:_____

Nominee's Address:_____

Nominee's Telephone Number:_____

RELIANCE ON THIS POWER OF ATTORNEY

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

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

Your Name Printed_____

Your Address_____

Your Telephone Number_____

State of _____

[County] of_____

This document was acknowledged before me on _____,
(Date)

by_____.
(Name of Principal)

_____ (Seal, if any)

Signature of Notary

My commission expires: _____

This document prepared by: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

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

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest; act in good faith;

(2) Do nothing beyond the authority granted in this power of attorney; and

(3) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

_____ by _____
(Principal's Name) (Your Signature) as Agent

Unless the special instructions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;

(2) Avoid conflicts that would impair your ability to act in the principal's best interest;

(3) Act with care, competence and diligence;

(4) Keep a record of all receipts, disbursements and transactions made on behalf of the principal;

(5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

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

(1) Death of the principal;

(2) The principal's revocation of the power of attorney or your authority;

(3) The occurrence of a termination event stated in the power of attorney;

(4) The purpose of the power of attorney is fully accomplished; or

(5) If you are married to the principal, a legal action is filed with a court to end your marriage or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act located at W.Va. Code §39B-3-101, et seq. If you violate the Uniform Power of Attorney Act located at W.Va. Code §39B-3-101, et seq or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

AGENT'S CERTIFICATION AS TO
THE VALIDITY OF POWER OF ATTORNEY
AND AGENT'S AUTHORITY

State of West Virginia,
County of _____, to-wit:

I, _____, certify under penalty of perjury that _____ granted me authority as an agent or successor agent in a power of attorney dated ___ _____.

I, further certify that to my knowledge:

(1) The Principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney and the power of attorney and my authority have not terminated;

(2) If the power of attorney was drafted to become effective upon the happening or an event or contingency, the event or contingency has occurred.

(3) If I was named as a successor agent, the prior agent is no longer able or willing to serve; and

Date: _____

_____

Agent's Signature

_____

Agent's Name Printed

Address: _____

_____

Telephone Number: _____

This document was acknowledged before me on ____ day of _____, 2012 by _____.

_____
Notary Public

My commission expires: _____

This document was prepared by: _____

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 1 OF 4

PART I. Medical Power of Attorney

PRINT THE DATE

Dated: _____, 20___

PRINT YOUR NAME

I, _____, hereby appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself.

The person I choose as my representative is:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR REPRESENTATIVE AND SUCCESSOR REPRESENTATIVE

Name: _____Telephone: _____
Address: _____.

If my representative is unable, unwilling, or disqualified to serve, then I appoint as my successor representative:

Name: _____Telephone: _____

Address: _____.

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

When making health care decisions for me, my representative should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my representative should make decisions for me that my representative believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I give these additional instructions as further guidance for my representative:

(attach additional pages if needed)

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

PART II. Living Will

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative, if I have appointed one, shall act consistently with my special directives or limitations as stated below. If I have not appointed a representative, this document shall be binding on any surrogate appointed to make health care decisions on my behalf.

I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments).

1. If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

2. Other directives: _____

_____

_____

_____

_____

_____

_____

_____

_____

(attach additional pages if needed)

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DISAGREE

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 4 OF 4

PART III. Execution

SIGN, DATE, AND PRINT YOUR NAME

Signature:_____Date:_____

Printed Name:_____

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES

Witness #1 _____DATE _____

Print Name_____

Witness #2 _____DATE _____

AND

Print Name_____

STATE OF _____

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

COUNTY OF _____

I, _____, a Notary Public of said _____county, do certify that_____, as principal, and _____and_____, as witnesses, whose names are signed to the writing above bearing date on the _____ day of _____, 20___, have this day acknowledged the same before me.

Given under my hand this _____ day of _____, 20___.

My commission expires:_____

_____Signature of Notary Public

WEST VIRGINIA ORGAN DONATION FORM - PAGE 1 OF 1

ORGAN DONATION (OPTIONAL)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under West Virginia law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

ADD NAME OR INSTITUTION (IF ANY)

Name of individual/institution:_____

_____ Pursuant to West Virginia law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____

For (initial one):
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: _____

Declarant signature: _____

Date: _____

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____
Address _____

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____
Address _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

West Virginia POST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

West Virginia POST Form

Adapted from the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Health care providers should complete this form only after a conversation with the patient or the patient's Medical Power of Attorney (MPOA) representative or surrogate. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. https://polst.org/guidance-appropriate-patients-pdf

Patient Information. **Having a POST form is always voluntary.**

THIS IS A MEDICAL ORDER, NOT AN ADVANCE DIRECTIVE.
Review and revise advance directives to be consistent with POST.

Patient First Name:_____ Middle Initial:_____

Last Name:_____ Suffix (Jr, Sr, etc): _____

Preferred Name:_____ DOB (mm/dd/yyyy): _____/_____/_____

Last 4 Social Security Number: xxx-xx-_____ _____ _____ _____ Gender (circle one): M F X

Address: _____ Zip code: _____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.
(Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation.
(May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and is breathing.

Reassess and discuss interventions with patient or MPOA representative/surrogate regularly to ensure treatments are meeting patient's care goals. Consider a time-limited trial of interventions based on goals.

Pick 1

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
EMS protocols may limit emergency responder ability to act on orders in this section.

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe, and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Time-limited trial of _____ days but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Discussed but no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative/Surrogate/Guardian (eSigned documents are valid)

Authorization ☐	Indicate in this box if you agree with the following statement: If I lose decision-making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new POST form in accordance with my expressed wishes for such a condition or if these wishes are unknown or not reasonably ascertainable, my best interests.
Opt-In ☐	Indicate in this box if you agree to have your POST and other forms submitted to the WV e-Directive Registry and released to treating health care providers to ensure your wishes are known. **FAX 844-616-1415**

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's MPOA representative/surrogate, the treatments are consistent with the patient's expressed wishes or, if unknown, their best interests.

Patient/Patient MPOA representative/surrogate signature (required)	Date (mm/dd/yyyy)	The most recently completed, valid POST form supersedes all previously completed POST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or the patient's MPOA representative/surrogate. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only providers with MD, DO, APRN, or PA license may sign this order]

MD/DO/APRN/PA signature (required)	Date (mm/dd/yyyy): Required / /	Phone # :
Printed Full Name: required		License/Cert. #:

Send original form with patient. A copied, faxed, or electronic version of this form is a valid medical order. This form does not expire.
WV Center for End-of-Life Care: 1-877-209-8086. **WV e-Directive Registry FAX: 844-616-1415** 2021

West Virginia POST
Physician Orders for Scope of Treatment
A Participating Program of National POLST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

WV POST form: A Portable Medical Order

Consistent with the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Patient Full Name:

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative.)

Full Name:	☐ MPOA Representative/surrogate ☐ Other emergency contact	Phone #:

Primary Care Provider Name: Phone: ( )

☐ Patient is enrolled in hospice

Name of Agency:
Agency Phone: ( )

Reviewed patient's advance directive to confirm no conflict with POST orders:
(A POST form does not replace an advance directive or living will)

☐ Yes; date of the document reviewed:_____
☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)
☐ Advance directive not available
☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court-Appointed Guardian ☐ Parent of Minor ☐ MPOA representative/Surrogate ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - MPOA representative/surrogate may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
  - **FAX completed form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Using a POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care, and other measures to relieve pain and suffering.
- **Reviewing a POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes their treatment preferences or goals of care.
- **Modifying a POST form:** This form cannot be modified. If changes are needed, void form (see below) and complete a new POST form. **FAX new POST form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Voiding a POST form:**
  - **If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.
  - **For health care providers**: destroy copy (if possible), note in patient record form is voided and notify the WV e-Directive Registry.
  - *If no new form is completed, note that full treatment and resuscitation may be provided.*
- **Additional Forms.** Can be obtained by going to www.wvendoflife.org/ or by calling 877-209-8086.
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.
- **Submitting a POST form (or any form) to the WV e-Directive Registry (if Opt-In Box is initialed)**
  - With the permission of patients or their legal agents, the WV e-Directive Registry houses and makes available to treating health care providers advance directive forms, do not resuscitate (DNR) cards, Physician Orders for Scope of Treatment (POST) forms, etc. The Registry makes patients' treatment wishes known to their physicians so that they can be respected. By submitting forms to the e-Directive Registry, the patient can ensure their forms are available in the event of a health care emergency in order for medical wishes to be translated into patient care. More information is available at www.wvendoflife.org/wv-e-directive-registry. FAX a copy of the POST form to the WV e-Directive Registry at 844-616-1415. Ensure the form is readable prior to faxing the form to the Registry. For questions, call 877-209-8086.

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

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

Name: *Relationship:*

_____ _____

Contact information: _____

_____

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

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

    _____
    _____

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

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

This authorization shall be effective until (Check one):

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

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

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

_____ _____
Signature of the Individual Giving this Authorization Date

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