Triage Health Estate Planning Toolkit: Wyoming

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.

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

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 Wyoming, but you might want to 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.

Wyoming allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing).

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

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 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.

Wyoming's statutory form for 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. Your agent is entitled to reasonable compensation for their help if you

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do not specify otherwise in the “special instructions” section. Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die or 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 **Wyoming Advance Health Care Directive** contains five parts. You can fill out part one, part two, or both, depending on your advance planning needs. Parts three and four are optional, but you must sign part five to make the document valid.

1. **Wyoming Power of Attorney for Health Care:** You can use this form to choose someone (your “agent”) to make decisions about your health care for you, including life-prolonging, if your doctor determines you can no longer make these decisions for any reason. You can also choose an alternate person if the first person you choose is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care, or immediately, depending on how you fill out the form.
2. **Wyoming Instructions for Health Care:** 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 cardiopulmonary resuscitation (CPR) to restart your heart or breathing and artificially supplied nutrition and hydration.
3. **Organ Donation**: This section lets you indicate if you would like to make an organ or tissue donation at the time of your death.
4. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care.
5. **Execution:** You must sign your advance health care directive in front of a notary public, or two adult witnesses. Your witnesses cannot be:
    - Your agent
    - Your health care provider or their employee
    - the operator or employee of a community care facility
    - the operator or employee of a residential care facility

You can change your agent by creating a signed, dated, written statement revoking their authority.

You can indicate that you would like to change any other instruction included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD or just tear up any existing directive. Once you have indicated you want to revoke your AHCD, this should be documented in writing as soon as possible.

If you choose your spouse as your agent, this will be automatically revoked if your marriage dissolves.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Wyoming, this form is called a WyoPOLST. The WyoPOLST does not replace an advance directive. You can complete a WyoPOLST 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
- Goals for treatment

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.

Wyoming 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.

Wyoming 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.

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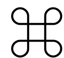
Triage Health Estate Planning Toolkit: Wyoming

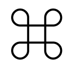
Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (WyoPOLST)
- 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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STATE OF WYOMING
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, W.S. 3-9-101 through 3-9-403.

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 (1) agent. If you wish to name more than one (1) 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 of principal) name the following person as my agent:

Name of Agent: ____

Agent's Address: ____

Agent's Telephone Number: ____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

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

Name of Successor Agent: ____

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, W.S. 3-9-101 through 3-9-403:

(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 Uniform Power of Attorney Act, W.S. 3-9-217, 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 of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator 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 and 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:__________________________

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 shall:

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

(2) Act in good faith;

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

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

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

Unless the Special Instructions in this power of attorney state otherwise, you shall also:

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

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

(3) Act with care, competence and diligence;

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

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

(6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

You shall 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 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, W.S. 3-9-101 through 3-9-403. If you violate the Uniform Power of Attorney Act, W.S. 3-9-101 through 3-9-403, 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: ___________________________

County of: _________________________

I, ______________________________(Name of Agent), certify under penalty of perjury that

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

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 to act under the Power of Attorney have not terminated;

(2) If the Power of Attorney was drafted to become effective upon the happening of 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

(4) (Insert other relevant statements)

____

____

____

SIGNATURE AND ACKNOWLEDGMENT

Agent's Signature:

Date:

Agent's Name Printed:

Agent's Address:

Agent's Telephone Number:

This document was acknowledged before me on ______________________(Date), by

____(Name of Agent).

(Seal, if any)

Signature of Notary:

My commission expires:

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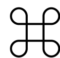
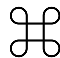


Part III: Your State's Estate Planning Forms



Advance Health Care Directive

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PRINT YOUR NAME AND THE DATE

I, ____(print name), make

this Advance Health Care Directive on ____________________(print date).

PART 1

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

PRINT NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

____
(name of individual you choose as agent)

____
(address, city, state, zip code)

____
(home phone and work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

PRINT NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

____
(name of individual you choose as agent)

____
(address, city, state, zip code)

____
(home phone and work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

PRINT NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

____
(name of individual you choose as agent)

____
(address, city, state, zip code)

____
(home phone and work phone)

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ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

____
____
____
____
____
____
____
____
____
____
____

____
____
____
____
____
____
____

(Add additional sheets if needed.)

INITIAL THE BOX ONLY IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician or supervising health care provider determines that I lack the capacity to make my own health care decisions unless I initial the following box. If I initial this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3 OR 4 THAT DO NOT REFLECT YOUR WISHES.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

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(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please initial one of the following):

INITIAL ONLY ONE

[ ] I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

[ ] I nominate the following to be guardian in the order designated:

____

(name, address and phone of individual designated as guardian)

____

____

(name, address and phone of second alternate designated as guardian)

[ ] I do not nominate anyone to be guardian.

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PART 2

STRIKE THROUGH AND INITIAL ANY LANGUAGE THAT DOES NOT REFLECT YOUR WISHES

PART 2: INSTRUCTIONS FOR HEALTH CARE

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my health care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

INITIAL ONLY ONE

[   ] (a) **Choice Not to Prolong Life** – I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time,

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or

(iii) the likely risks and burdens of treatment would outweigh the expected benefits.

OR

[   ] (b) **Choice to Prolong Life** – I want my life to be prolonged as long as possible within the limits of generally accepted health care standards

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I initial the following box. If I initial this box [   ], artificial hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

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(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times:

____

____

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

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____

(Add additional sheets if needed.)

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PART 3

IF YOU DO NOT WISH TO DONATE ORGANS, DO NOT COMPLETE PART 3

OTHERWISE INITIAL THE STATEMENTS THAT REFLECT YOUR INTENT AND CROSS OUT ANY STATEMENTS THAT DO NOT REFLECT YOUR INTENT

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) UPON MY DEATH (initial applicable box):

[ ] (a) I give my body; or

[ ] (b) I give any needed organs, tissues or parts; or

[ ] (c) I give the following organs, tissues or parts only:

____

____

(d) My gift is for the following purpose (strike and initial any of the following you do NOT want)

(i) Any purpose authorized by law;
(ii) Transplantation;
(iii) Therapy;
(iv) Research;
(v) Medical education.

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PART 4

IF YOU DO NOT WANT TO NAME A PRIMARY PHYSICIAN, DO NOT COMPLETE PART 4.

OTHERWISE, PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN AND ANY ALTERNATE PRIMARY PHYSICIAN.

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

(11) PRIMARY PHYSICIAN: I designate the following physician as my primary physician:

____
(name, address and phone of primary physician)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following as my primary physician:

____
(name, address and phone of alternate primary physician)

****

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

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PART 5

SIGN AND DATE AND PRINT YOUR NAME AND ADDRESS

PART 5. EXECUTION

Sign: ________________________________Date: _____________

Print Name: ____

Residence Address: ____

____

WITNESS STATEMENT

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility or an employee of an operator of a residential care facility.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND PRINT THEIR NAME AND ADDRESS HERE

WITNESSES

Witness #1:

Sign: ________________________________Date: _____________

Print Name: ____

Residence Address: ____

Witness #2:

Sign: ________________________________Date: _____________

Print Name: ____

Residence Address: ____

—OR—

HAVE A NOTARY PUBLIC FILL OUT THIS SECTION

SIGNATURE OF NOTARY PUBLIC IN LIEU OF WITNESSES

The State of Wyoming

County of _____________

Subscribed, sworn to, and acknowledged before me by

____, the principal, this

____ day of _______________, 20___.

(SEAL) ____________

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

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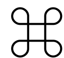

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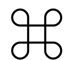

Physician Orders for Life Sustaining Treatment (POLST)

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WyoPOLST

Providers Orders for Life Sustaining Treatment

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

FIRST follow these orders, **THEN** contact the Physician, PA, or APRN. This is a Provider Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Every patient shall be treated with dignity and respect.

Last / First / Middle Name (Place ID Sticker Here if Applicable):

Date of Birth: ____/_____/_____

Last 4 SSN: ___ ___ ___ ___

Gender: M / F

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 and C**

B Check One

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

☐ **FULL TREATMENT:** Use intubation, advanced airway interventions, mechanical ventilation and defibrillation/cardioversion as indicated. Includes care described below.
Transfer *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT:** Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BIPAP). Includes treatments listed below. Includes care described below.
Transfer *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED THERAPY:** 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.
Patient prefers no transfer*: Transfer if comfort needs cannot be met in current location.*

Additional Orders (e.g. dialysis, etc) ____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Oral fluids and nutrition must always be offered if medically feasible.*

☐ Long-term artificial nutrition by tube
☐ Trial period of artificial nutrition by tube
☐ No artificial nutrition by tube

Additional Orders/Patient Goals: ____

D

MEDICAL CONDITION / PATIENT GOALS:

E

___ In initialing this line, I indicate that my instructions on this POLST form may not be changed by my next of kin or medical decision maker if I am incapacitated.

SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences, and best known information.

Discussed with:
☐ Patient
☐ Parent of a minor
☐ Legal Guardian
☐ Health Care Agent (DPOAHC)
☐ Spouse
☐ Other: __________________

Print Primary Health Care Provider Name and Address:	Phone #:
Primary Health Care Provider Signature:	Date:
Patient (or Legal Representative):	Date:

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged, however photocopies and faxes of signed POLST forms are legal and valid.

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

WyoPOLST – Providers Orders for Life Sustaining Treatment

Patient Name (Last, First Middle)	Date of Birth:	Gender:

Additional Contact Information (optional)

Name of Next of Kin, Guardian, Surrogate, or Patient Contact:	Relationship:	Phone Number:

Patient has: ☐ Advanced Directive (or Living Will) ☐ DPOAHC ☐ Organ Donor

Encourage all advance care planning documents to accompany POLST

Directions for Health Care Professional

Completing WyoPOLST

- Completion of WyoPOLST form is VOLUNTARY.
- WyoPOLST is recommended for patients with advanced illness or frailty.
- Must be completed by Wyoming Licensed Health Care Professional based on patient preferences and medical indications.
- WyoPOLST must be signed by a licensed provider and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by licensed provider in accordance with facility/community policy.
- Use of original form is strongly encouraged. Original form should be printed on yellow card-stock, and orignal form should accompany patient. Photocopies and FAXes of signed WyoPOLST forms are legal and valid.
- Additional copies of the WyoPOLST form can be obtained by contacting the Wyoming Department of Health, Aging Division, Community Living Section at 1-800-442-2766.

Using WyoPOLST

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

Section A:

- No defibrillator (including AED) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- Comfort-Focused therapies must always be offered to any patient regardless of level of care selected.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Focused Therapy" should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Focused Therapy"
- Non-invasive airway techniques includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Selective Treatment" or "Full Treatment."

Section C:

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

Reviewing WyoPOLST

It is recommended that WyoPOLST be reviewed periodically. Review is recommended when:

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

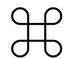
Modifying and Voiding WyoPOLST

- A person with capacity can, at any time, void the WyoPOLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new WyoPOLST form.
- To void WyoPOLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.

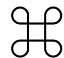
Review of WyoPOLST:

Review Date	Reviewer Name/Signature	Reason for Review	Review Outcome
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ No Change ☐ Form Voided ☐ New Form Completed
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ Change in Patient Status ☐ Transfer ☐ Annual Review

Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization 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.

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