

UTAH
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Utah Advance Directive

This packet contains a legal document, the Utah Advance Health Care Directive, that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. The document is divided into four parts:

1. **Part I** allows you to appoint a surrogate decision maker to make medical treatment decisions on your behalf. Your appointment of a surrogate decision maker acting on your behalf goes into effect whenever your attending physician certifies that you are unable to make an informed decision about receiving or refusing healthcare.
2. **Part II** lets you state your wishes about medical care in the event that your attending physician certifies that you are unable to make an informed decision about receiving or refusing healthcare.
3. **Part III** tells you how to revoke or change your Directive.
4. **Part IV** makes your Directive legal.

Note: These documents will be legally binding only if the person completing them is at least 18 years old.

Completing Your Utah Advance Health Care Directive

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you should become unable to do so. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of completing a Directive for you. Your agent may be a family member or a close friend whom you trust to make serious decisions. (An agent may also be called an “attorney-in- fact” or “proxy.”)

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as your agent is unable, unwilling or unavailable to act for you.

Who cannot be your agent?

An agent may not be a healthcare provider for you, or an owner, operator, or employee of a healthcare facility at which you are receiving care unless the agent is related to you by blood, marriage, or adoption.

How do I make my Directive legal?

Utah allows your Directive to be oral or written. In order to make your Directive legally binding, it must be witnessed by a disinterested adult. If you are physically unable to sign the Directive, you may arrange for someone to sign it in your presence at your direction.

Your witness **cannot** be:

- The person who signed the directive on your behalf,
- Related to you by blood or marriage,
- Entitled to any portion of your estate according to the laws of intestate succession of Utah or under any will or codicil,
- The beneficiary of your life insurance policy, trust, qualified plan, a pay on death account or transfer on death deed,
- Entitled to benefit financially from your death,
- Entitled to a right to or interest in your personal property upon your death,
- Directly financially responsible for your medical care,
- A healthcare provider who is providing care to you or an administrator at a healthcare facility in which you are receiving care, or
- The appointed agent or alternate agent.

Note: you do not need to notarize your Utah Directive.

Can I add personal instructions to my Directive?

Yes. You can add personal instructions under Part II of your document.

Completing Your Utah Advance Health Care Directive (continued)

What if I change my mind?

You may revoke your Directive to Physicians in the following ways:

- writing “void” across your Directive or obliterating. Burning, tearing or otherwise destroying or defacing your Directive or asking another person to do the same on your behalf,
- signing and dating a written revocation of the Directive (or having a written revocation signed and dated by an adult acting on your behalf and at your direction),
- orally expressing your intention to revoke the Directive in the presence of a witness 18 years of age or older (individual must not be disqualified as a witness), and who will not be appointed as agent or become a default surrogate when the Directive is revoked, or
- signing a new Directive

What other important facts should I know?

- A pregnant patient’s Utah Directive to Physicians will not be honored due to restrictions in the state law.
- A decree of annulment, divorce, dissolution of marriage, or legal separation revokes the designation of a spouse as an agent, unless otherwise specified or you affirm intent to retain the spouse as your agent.

INSTRUCTIONS

PRINT YOUR NAME, ADDRESS, TELEPHONE NUMBERS, AND BIRTH DATE

INITIAL THIS PARAGRAPH IF YOU DO NOT WANT TO NAME AN A AGENT

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR AGENT

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

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UTAH Advance Health Care Directive - PAGE 1 OF 7

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____ Cell Phone: _____

Birth Date: _____

Part I: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.

A. No Agent

If you do not want to name an agent: initial the box below, then go to Part II; do not name an agent below. No one can force you to name an agent.

_____ I do not want to choose an agent.

B. My agent (Health Care Power of Attorney)

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

C. My Alternate Agent

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Alternate Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

D. Agent's Authority

If I cannot make decisions or speak for myself (in other words, after my physician or APRN finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E and F of part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority

My agent has the powers below ONLY IF I initial the "yes" option that precedes the statement. I authorize my agent to:

Yes _____ No _____ Get copies of my medical records at any time, even when I can speak for myself.

Yes _____ No _____ Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other congregate facility for long-term placement other than convalescent or recuperative care, unless I agree to be admitted at that time.

F. I wish to limit or expand the powers of my healthcare agent as follows:

INITIAL THE
STATEMENT THAT
REFLECTS YOUR
WISHES

CHECK THE
STATEMENT THAT
REFLECTS YOUR
WISHES

G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary, Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternative agent, to serve as your guardian, if a guardianship is ever necessary.

YES _____ NO _____

I being of sound mind and not under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H. Consent to Participate in Medical Research

YES _____ NO _____ I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Organ Donation

YES _____ NO _____ If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

J. Agent's Authority to Override Expressed Wishes

Yes _____ No _____ My agent may make decisions about health care that are different from the instructions in Part II of this form.

Part II: My Health Care Wishes (Living Will)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.

Option 1: _____ **I choose to let my agent decide.** I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.

Additional Comments:

Option 2: _____ **I choose to prolong life.** Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.

Other: _____

INITIAL THE
STATEMENT THAT
REFLECTS YOUR
WISHES

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

IF YOU SELECTED (A) ABOVE, DO NOT CHOOSE ANY OPTIONS UNDER (B)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

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Option 3: _____ I choose not to receive care for the purpose of prolonging life. Including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong life.

If you choose this option, you must also choose either (a) or (b), below.

(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.

(b) My health care provider should withhold or withdraw life-sustaining care if at least one of the following initialed conditions is met:

_____ I have a progressive illness that will cause death

_____ I am close to death and am unlikely to recover.

_____ I cannot communicate and it is unlikely that my condition will improve.

_____ I do not recognize my friends or family and it is unlikely that my condition will improve.

_____ I am in a persistent vegetative state.

Other: _____

Option 4: _____ I do wish to express preferences about health care wishes in this directive.

Other: _____

ORGAN DONATION
(OPTIONAL)

INITIAL THE
STATEMENT THAT
REFLECTS YOUR
WISHES

Option 5: _____ Organ Donation (optional)

_____ I want to be an organ donor. In the event of my death I request that my agent inform my family/next of kin of my desires to be an organ and tissue donor if possible. My wishes are indicated below.

I wish to give:

_____ any organs/tissues: or

_____ only the following organs/tissues: _____

Additional instructions about your health care wishes:

If you do not want emergency medical services providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking My Directive

I may revoke or change this directive by:

1. Writing "void" across the form, or burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
2. Signing a written revocation of the directive, or directing another person to sign a written revocation on my behalf;
3. Stating that I wish to revoke the directive in the presence of a witness who is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement;
4. Signing a new directive. (If you sign more than one Advance Health Care Directive, the most recent one applies.)

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Part IV: Making my Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form, naming a health care agent, that I have completed in the past.

DATE AND SIGN

Date: _____

Signature: _____

City, County, and State of Residence: _____

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant;
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer on death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declareant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

HAVE YOUR WITNESS SIGN

Signature of Witness: _____

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

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You Have Filled Out Your Advance Directive, Now What?

1. Your Utah Directive to Physicians and Providers of Medical Services and Utah Special Power of Attorney are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Utah documents.
6. Be aware that your Utah documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**