UTAH
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CaringInfo, 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.

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. 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.

4. 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, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR UTAH ADVANCE DIRECTIVE

This packet contains a legal document, a **Utah Advance Health Care Directive**, that protects 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. You may complete Part I, Part II, or both, depending on your advance-planning needs. You must complete Part IV.

Part I lets you name someone, your "agent," to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. This part is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part II lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill.

Part III tells you how to revoke or change your Directive.

Part IV contains the signature and witnessing provisions so that your document will be effective.

Your Utah Advance Health Care Directive goes into effect when your doctor, physician assistant, or advance practice registered nurse ("APRN") determines you are no longer able to make an informed decision about receiving or refusing health care.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.

Completing Your Utah Advance Health Care Directive

How do I make my Advance Health Care 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, which means your witness can have no interest in your estate or benefit from your death. 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,
- 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 health care provider who is providing care to you or an administrator at a health care facility in which you are receiving care, or
- Your appointed agent or alternate agent.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

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

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

Can I add personal instructions to my Advance Health Care Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

Paragraph J in Part I allows you to decide whether your agent can override instructions you give in Part II or be strictly bound by your directions.

What if I change my mind?

You may revoke your Advance Health Care Directive in the following ways:

- Writing "void" across your Directive or obliterating it or asking another person to do the same on your behalf.
- Burning, tearing, or otherwise destroying or defacing your Directive in any manner indicating an intent to revoke 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 who would be qualified to witness your Directive, but cannot be the person who will become your agent or default surrogate after the revocation.
- Signing a new Directive.

A decree of annulment, divorce, dissolution of marriage, or legal separation revokes the designation of your spouse as an agent, unless otherwise specified or you affirm your intent to retain the spouse as your agent.

What other important facts should I know?

Directions to withhold or withdraw life sustaining care will not be honored during a patient's pregnancy.

If you object, your agent does not have the authority to admit you to a licensed health care facility for long-term custodial placement other than for assessment, rehabilitative, or respite care.

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

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____ Cell Phone: _____

Birth Date: _____

PART I

PART I: Appointment of Agent (Health Care Power of Attorney)

This part 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

INITIAL THIS PARAGRAPH IF YOU DO NOT WANT TO NAME AN 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 on can force you to name an agent.

_____ I do not want to choose an agent.

B. My agent

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR AGENT

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: ( )_____Cell Phone: ( ) _____Work Phone: ( ) _____

C. My Alternate Agent

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR 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, physician assistant, or advance practice registered nurse ("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:

GENERAL STATEMENT OF AGENT'S AUTHORITY

- 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:

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

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.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT OR

EXPAND YOUR AGENT'S AUTHORITY

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

_____

_____

_____

_____

_____

G. Nomination of Guardian

INITIAL WHETHER YOU WANT TO NOMINATE YOUR AGENT AS YOUR GUARDIAN IF YOU NEED ONE

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 herby 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

INITIAL WHETHER YOU WANT YOUR AGENT TO CONSENT TO 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

INITIAL WHETHER YOU WANT YOUR AGENT TO DONATE YOUR ORGANS

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

INITIAL WHETHER YOUR AGENT MAY OVERRIDE YOUR INSTRUCTIONS OR STRICTLY ABIDE BY THEM

Yes_____ No_____ My agent may make decisions about health care that are different from the instructions in Part II of this form.

PART II

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.

INITIAL ONLY ONE OF OPTIONS 1-4

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.

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.

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 INITIAL OPTION 3, INITIAL YOUR WISHES REGARDING YOUR HEALTH CARE PROVIDER'S ABILITY TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING CARE

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.

Option 4: _____ I do NOT wish to express preferences about end-of-life health care wishes in this Directive.

Organ Donation (optional)

INITIAL ONLY ONE

_____I do not want to be an organ donor.

_____ 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:

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

(attach additional pages if needed)

PART III

REVOCATION

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.)

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

PART IV

PART IV: Making my Directive Legal

PRINT YOUR NAME

I _____ (your name), 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 AND PRINT RESIDENCE INFORMATION

Date: _____

Signature: _____

City, County, and State of Residence: _____

RESTRICTIONS OR LIMITATIONS

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 AND DATE AND PRINT NAME HERE

Signature of Witness:_____, Date, _____

Witness printed name:_____

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

_____

_____

_____

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

You Have Filled Out Your Health Care Directive, Now What?

1. Your Utah Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Utah document.

7. Be aware that your Utah document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop. In addition, Utah authorizes a special type of order called a "Life with Dignity Order" that may be used in a similar manner. We suggest you speak to your physician if you are interested in obtaining one of these orders. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

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