

# UTAH

## Advance Directive

### Planning for Important Healthcare Decisions

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **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, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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 HEALTH CARE 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.

**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 healthcare 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.

You may complete Part I, Part II, or both, depending on your advance-planning needs. **You must complete Part IV.**

### **How do I make my Utah 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 healthcare 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 healthcare 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.

## **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

## **When does my agent's authority become 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.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

## **Agent Limitations**

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.

Directions to withhold or withdraw life sustaining care will not be honored during a patient's pregnancy and your agent will be bound by the current laws of Utah as they regard pregnancy and termination of pregnancies.

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.

## **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.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state’s psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician’s order, which are typically called “prehospital medical care directives” or “do not resuscitate orders.” DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

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**

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**

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: ( ) \_\_\_\_\_

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

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBERS OF YOUR  
AGENT

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

**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:

- 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.

GENERAL  
STATEMENT OF  
AGENT'S  
AUTHORITY

INITIAL THE  
STATEMENT THAT  
REFLECTS YOUR  
WISHES

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:**

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

**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 \_\_\_\_\_

INITIAL WHETHER  
YOU WANT YOUR  
AGENT TO  
CONSENT TO  
MEDICAL RESEARCH

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.

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

**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.

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Palliative Care  
Organization  
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**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

**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.

**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 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.**

INITIAL ONLY ONE OF OPTIONS 1-4

IF YOU INITIAL OPTION 3, INITIAL YOUR WISHES REGARDING YOUR

HEALTH CARE PROVIDER'S ABILITY TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING CARE





PART III

**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.)

REVOCATION

**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

PRINT YOUR NAME

DATE AND SIGN AND PRINT RESIDENCE INFORMATION

RESTRICTIONS OR LIMITATIONS

HAVE YOUR WITNESS SIGN AND DATE AND PRINT NAME HERE

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**PART IV: Making my Directive Legal**

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: \_\_\_\_\_

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.

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.

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