CONCEPTS TO AVOID GUARDIANSHIP

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The material provided herein is for educational purposes only and is not to be construed as legal advice. Any person concerned with the matters contained herein should consult with his/her attorney

5. DIRECTION TO EXECUTE A NEVADA POLST FORM.

I have reviewed the Nevada POLST form attached hereto as Exhibit 1. If in the future, I have not executed a POLST form and my physician determines execution of a POLST is appropriate then my agent is authorized to execute a POLST on my behalf in accordance with my wishes stated in this my Durable Power of Attorney for Health Care.

(2) DESIRE FOR PALLIATIVE CARE. It is my desire to be comfortable.

(a) I want my care to be provided in a manner that promotes palliative care.

(b) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. When the circumstances are appropriate, and in accordance with my wishes as I have expressed them, such pain relief may be authorized even though its use may lead to physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death.

Principal ________

12. DIRECTION FOR LIMITED GUARDIANSHIP.

If a guardian of my person is sought, I request that a limited guardianship of my person or a protective arrangement, whether temporary or permanent, be established and that my agent's authority granted herein as to any matter not included in the guardianship or protective arrangement be reserved to my agent to act on my behalf.

13. ALTERNATIVE TO GUARDIANSHIP

This document is intended to minimize the necessity of intervention by a court in providing any necessary directions through its order for carrying out my wishes stated herein or contained in my estate plan. Therefore, as an alternative to guardianship the court may grant additional powers to my agent by its order or provide for a protective arrangement of my person and appoint my agent as an administrator or representative thereof.

A protective arrangement means:

1) A court order authority a transaction to meet my needs, or
2) A court order authorizing a particular medical treatment, or
3) A court order confirming a refusal of medical treatment, or
4) A court order moving me to a specified location, or
5) Authorizing visitation between another person and myself,
6) Other arrangements of a limited basis that are appropriate and consistent with my stated wishes, or
7) A court order granted pursuant to NRS 123.259 to protect my spouse.

My nominated agents are also nominated to carry out any protective arrangement for me and such person may be designated as my personal administrator or representative.

14. ADVOCATE COUNSEL DIRECTIVE.

My advocate counsel, whether nominated and retained by me or a free legal service attorney appointed by the court, shall follow "my known wishes" contained herein and in my estate planning documents or other directives, if any.

15. NOMINATION OF COURT INVESTIGATOR.

In a guardianship proceeding if a geriatric / elder care coordinator is a presenter of evidence as to my needs or incapacity in the petition then I nominate/appoint said person as my court investigator.

16. THIS DOCUMENT IS SELF EXECUTING AND IS ALSO A DELEGATION OF POWER.

It is my intention that this instrument serve both as a self-executing document and as a delegation of power to my agent. If my agent or my alternate attorney(s) in fact is unavailable, I nevertheless request that my instructions and preferences in this document be observed.

17. MY STATED DESIRES ARE PRIMARY IN RELATION TO THE VIEWS OF OTHERS.

I desire that my wishes be carried out through the authority given to my agent by this document despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends.

18. RIGHT TO TERMINATE DOCUMENT RESERVED TO PRINCIPAL.

This document shall not be terminated by anyone other than myself and it shall not be terminated by a governmental entity including a court. Any such attempt would violate my right to self-determination.

19. PROTECTION OF CONSTITUTIONAL RIGHTS.

I have certain constitutional rights in regards to my health care decision making. This document shall be deemed an exercise of all of the rights that I have under the United States Constitution. Among those are the right to self-determination, the right to privacy, the right to be maintained in the least restrictive environment, subject to the provisions stated herein, the right to due process of law, and the protections of the privileges and immunities clause. What process is due me in a guardianship proceeding shall be those processes set forth herein. The State is not to terminate this document for the convenience of a guardian or based upon any statutory provision. If I am impaired and a guardian of my person is appointed for me, or a protective arrangement is implemented by the court,

Exhibit 1

NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

SIDE 1: Medical Orders

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA. Any section not completed implies full treatment for that section.	Last Name/First/Middle Initial		
	Date of Birth (mm/dd/yyyy)	Last 4 SSN	Gender
	/ /		M F

A — Choose 1

CARDIOPULMONARY RESUSCITATION (CPR) – *Patient/resident has no pulse and is not breathing*

☐ Attempt Resuscitation (CPR) ☐ Do Not Resuscitate (Allow Natural Death)__________

When not in cardiopulmonary arrest, follow orders in Section B and C

B — Choose 1

MEDICAL INTERVENTIONS – Check only one – *Patient/resident has pulse and/or is breathing.*

☐ **Full Treatment.** ***Goal - prolong life by all medically effective means***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention in addition to treatment described in Comfort-Focused Treatment and Selective Treatment. Transfer to hospital/admit to ICU as indicated.
*Other Instructions:*______________________________

☐ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
In addition to Comfort-Focused Treatment, use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally, avoid ICU.
*Other Instructions:*______________________________

☐ **Comfort-Focused Treatment.** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medication by *any route* as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location.**
*Other Instructions:*______________________________

C

ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – *offer food & fluids by mouth if feasible or desired*

☐ Long-term artificial nutrition or feeding tube
☐ Artificial nutrition/feeding tube trial no longer than________
☐ No artificial nutrition or feeding tube
☐ IV fluids trial no longer than _______
☐ No IV fluids
*Other Instructions:*______________________________

D — Required

CAPACITY DETERMINATION – Completion required by Provider (MD, APRN or PA)

At the time of completion of this medical order, the patient:

☐ **Has decisional capacity** ☐ **Lacks decisional capacity**

to understand and communicate their health care preferences for options in this medical order.

E — Bolded Items Required

VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate Information on Side 2

Date (Required)	**Physician/APRN/PA Signature (Required)**	**Physician/APRN/PA License # (Required)**

Physician/APRN/PA Name (Printed, Required)	Physician/APRN/PA Phone

Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian (circle one)
I have discussed this form, its treatment options and their implications for sustaining life with my/the patient's health care provider. This form reflects my wishes/the patient's best-known wishes.

Signature______________________ Print Name ______________________Date__________

OR if the patient lacks capacity *and* has no known Agent (DPOA-HC) or guardian, complete the following:
Health Care Surrogate Authorization *Also Requires Completion of Side 2, #1.C.*

Signature______________________________Date____________

Send original with patient when discharged or transferred

NEVADA POLST (Provider Order for Life-Sustaining Treatment)

Patient Name: ______________________________ **DOB:** ____________________

SIDE 2: Supplementary Information

1. Representative/Surrogate Information – The following may have further information regarding patient's preferences:

A. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney for Health Care (DPOA-HC) ☐ NO ☐ YES

AD filed with Living Will Lockbox: ☐ NO ☐ YES - Registration #, if known:______________

Other AD location: ______________________________

DPOA-HC – This information must be taken directly from the patient's valid DPOA-HC, not verbally

Appointed agent #1: ______________________ Telephone No: ____________________

Appointed agent #2: ______________________ Telephone No:____________________

B. Court-Appointed Guardian ☐ NO ☐ YES Name: ________________ Phone: ______________

C. Health Care Surrogate: Name (printed): ____________________________

Relationship: ______________________ Phone: ____________________

2. PREPARER: Preparer's Name (print):______________________ Title/Position (MSW, RN, etc.) __________

3. REGISTRY: Provider initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox at: www.LivingWillLockbox.com

4. ORGAN DONATION

☐ I have documented on my license or state-issued ID that I would like to donate my organs

Terms of Use

- The POLST is ALWAYS VOLUNTARY and may not be mandated for a patient.
- The POLST is intended for the seriously ill or frail, and for whom a health care professional would not be surprised if they died within a year; others should be offered an AD with DPOA-HC designation.
- This medical order is to be honored in all care settings. In-patient order sets should reflect these POLST orders. The POLST is to be followed until replaced by new orders.
- Should a patient have both a DNR Identification and POLST, the most recent order should be followed.
- Photocopied, faxed or electronic versions are valid as long as required signatures (Section E) are included.
- When comfort cannot be achieved in the current setting, the patient should be transferred to a setting that is able to provide comfort.

Completing a POLST

- If a patient lacks decisional capacity, their legal representative (DPOA-HC, guardian or parent of a minor) may complete a POLST. If the patient has no legal representative *and* lacks decisional capacity, then a surrogate may complete a POLST for the patient. Surrogates are (in this order): a spouse, the majority of adult child(ren), parent(s), a majority of adult sibling(s), the nearest other adult relative of the patient by blood or adoption who is reasonably available, or "an adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient."
- A POLST does not replace an Advance Directive. An AD may designate a decision-maker (DPOA-HC) in the event the patient becomes incapacitated, documents additional treatment preferences and should be encouraged to be completed. Always check for inconsistencies between End-of-Life documents and make corrections as appropriate.
- Completion of a POLST should follow a discussion of the patient's goals, values and how their treatment preferences will impact both their longevity and quality of life.
- Any section not completed creates no presumption about the patient's preferences for treatment for that section.
- Patients discharged home should place the POLST next to their bed or on their refrigerator where EMS is trained to look.

POLST Review - This POLST should be reviewed periodically, and if:

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

Voiding POLST

- If the patient has decisional capacity, only the patient may void a POLST.
- Without decisional capacity, the patient's legal representative may revoke a POLST, or the patient's surrogate may revoke the POLST *only* if the POLST was completed by the patient's surrogate (see Completing a POLST, first bullet, above).

Send original with patient when transferred or discharged

AMENDMENT NO. ONE TO MY DURABLE POWER OF ATTORNEY FOR FINANCIAL AFFAIRS DATED ___________________

PARAGRAPH 6. is amended by adding the following provision:

(Caution: Granting any of the following will give your agent the authority to take actions that could effect where you live and the level of care you receive. Any authority granted could significantly reduce your property or necessitate the selling of your home. Initial only the specific authority you want to give your agent.)

Additional possible grants of authority:

__________ to make or consent to a placement in assisted care (N.R.S. 442.3962);

__________ to make or consent to a placement in a skilled care facility for long term care (N.R.S.449.0039)

__________ to make or consent to a placement in an intermediate care facility for long term care (N.R.S.449.0038)

__________ to make or consent to placement in a secured facility for long term care (N.R.S.15

Notice to providers: The authority of my agent to make a placement for me is subject to the provisions of Attachment No.1 which is incorporated herein by reference in its entirety. My agent may, if necessary, pursuant to N.R.S.162A.330, file a petition to construe my power of attorney, or to confirm a transaction, or for other judicial relief.

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I sign my name to this Amendment No. One To My Durable Power of Attorney for Financial Affairs on this ______day of ________________, 20____.

Signature: ____

Print Name: ____

Address: ____

Town, State, Zip: ____

Telephone Number: ____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada }
}ss.
County of }

On this________ day of _________________________, in the year______ before me, ___________________________________ (here insert name of notary public) personally appeared______________________________________ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

(Signature of Notary Public)

____

DIRECTION IN REGARDS TO PLACEMENT DECISIONS:

(1) AUTHORITY TO MAKE PLACEMENT DECISIONS. I authorize my agent to make placement decisions for me if I cannot live in my own home. The person having control of my estate is to cooperate with my agent so that the cost of my care is paid for out of my estate if insurance or public benefits aren't available.

____

(2) PLACEMENT SAFEGUARDS. If I become disabled and or incapacitated, then I suggest that my agent obtain an individualized care plan for me which is to be prepared by a geriatric/ elder care coordinator, who is a licensed social worker. The plan is to consider how I can be maintained in the least restrictive environment subject to the provisions of paragraph (3), (4) and (5) below. In developing a care plan under this provision (3), (4) and (5) below are to be considered by the geriatric/elder care coordinator, as well as my overall well-being and safety. A physician's letter of instruction or care plan is mandatory if I am to be placed outside of my home. The instruction/plan shall consider my needs, safety and the level of care which is best for me whether in: 1)assisted care (NRS 442.3962); 2) a skilled care facility for long term care (NRS 449.0039); 3) an intermediate care facility (NRS 449.0038); or 4) a secure facility for long term care (NRS 159.0255). Any subsequent placement changes shall be based upon a physician's instruction or care plan. A secure facility placement shall only be made based upon two physicians' instructions or one physician's instruction and a care plan. The instructions-care plan shall state the reasons requiring said level of care. Any objection by my family to any secured placement should be made via negotiation and or mediation based upon good cause.

____

(3) DIRECTION IN REGARDS TO NEED FOR A PLACEMENT OUTSIDE OF MY HOME I have been married to my spouse for____ years. I do not want to be a burden on my spouse if my personal care needs and/or my behaviors are

Principal

____

such that my care cannot be reasonably maintained at home. In this regard if my spouse, individually or as my agent, and my physician, concur in writing that my needs cannot be met in my own home because of the level of my needs being a burden on my spouse than that decision shall be binding on my family and any court that has jurisdiction over me in a guardianship/protective arrangement matter. My spouse's interests are to be considered before my own self-interest, to what care is appropriate for me. Any report submitted to a Court by my nominated guardian prepared by my treating physician or by a geriatric/elder care coordinator shall be admitted into evidence by said Court. If appropriate I give my agent authority to consider locating me to a common place of residence with my spouse if physical barriers in our home create difficulty, for both of us.

(4) Placement to Take into Account Cost of Care. Any placement of me, whether in my own home shall take into account the cost of my care, the likelihood of my recovery and my need for custodial care.

Any placement made while I am married shall be done in a manner that considers my spouse's support needs and in no event shall a placement be made that would jeopardize my spouse's right to obtain a Maximum Federal Community Spouse Resource Allowance and/or a Maximum Federal Community Spousal Minimum Monthly Maintenance Needs Allowance. My right to be maintained in the lease restrictive environment is subject to this provision and paragraph (3) above.

(5) The provisions in section 9(3) and (4) above are to be binding on my family and/or any Court in which a guardianship or protective arrangement proceeding is brought seeking to make me a protected person, whether of my person, my estate or both.

REQUEST FOR SUPPORTIVE DECISION MAKING BY FIDUCIARIES

I, ____________________________, have executed various estate planning documents and a durable power of attorney for health care and a durable power of attorney for financial matters.

It is my request that any fiduciary or agent that is carrying out her/his responsibilities to me under said document does so in a manner that fosters supportive decision making to the extent possible.

In this context supportive decision-making means:

> The assistance from one or more other persons of a principal's choosing in understanding the nature and consequences of potential personal and financial decisions, which enables the principal to make the decisions, and in communicating a decision once made if consistent with the principal's wishes.