Preparing for Death/Dying Empowerment and Education

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How do I begin thinking about my eventual death?

Starting to think about your end-of-life care preferences may initially feel uncomfortable, but preparing for your eventual death, how much medical intervention you want, and how you want to be honored during and after the dying process is important, as is planning for your inevitable demise. Planning ahead not only empowers you, it also educates and provides comfort and guidance to those that you love so that they can honor your wishes and have instructions and support during a difficult time.

As a member or ally of the Pagan/LGBTQ community, your end-of-life experiences is as precious, unique and complicated as your day-to-day life. In the current cultural milieu, we all exist within, members of the Pagan/LGBTQ+ community often have their own unique set of needs at the end-of life, placing them at a higher risk for discrimination and disenfranchisement.

Knowing these things and more can help ensure that your personal wishes are met. It critical to learn about care options, share your vision of a positive death and dying experience and clearly communicate your wishes, needs, and requirements before significant physical or cognitive impairment that could prevents you from making your own decisions. When it comes to death and dying, being proactive and prepared is always the best policy.

Here is a checklist to help you get started!

Start by having an honest conversation with yourself.		What are your values, beliefs, and wishes for your final days? This introspection will serve as the foundation for your plan.
Open communication		Discuss your thoughts and wishes with close family members or trusted friends. Their insights can offer a different perspective and ensure that your intentions are clear to those who matter.
Research		Familiarize yourself with the various aspects of end-of-life planning. While this document highlights some key areas and can jump start your planning process, having a broad understanding will help you make informed decisions. Make sure that you are familiar with state and local laws.
Draft a Preliminary List		Based on your reflections and research, create an initial to-do list. This list doesn't have to be exhaustive but should capture the primary areas you want to address.

Seek Professional Guidance		Consider consulting with professionals like estate planners, lawyers, or financial advisors. Their expertise can help streamline the process and ensure that all legal and financial aspects are covered.
Document Everything		Whether it's your medical wishes, how to honor your belief path or needs as a member or ally of the Pagan/LGBTQ+ community, burial or cremation preferences, asset distribution, etc. ensure that every decision is documented clearly. This clarity will be invaluable to your loved ones later on.
Review and Update		As life changes, so might your wishes. Periodically review your plan to ensure it remains aligned with your current circumstances and desires.
Share With Your Loved Ones		Once your plan is in place, share the relevant details with family members or designated representatives. This step ensures that when the time comes, they can act according to your wishes without any ambiguity.

Source: [Better Place Forests End-Of-Life Planning Checklist]

Questions to ask myself and share with my family

Preferences - What are my personal values about death and dying? How would I like to die?
Medical – Do I want to donate my organs? Do I have an advance directive or living will? What are my thoughts on life-sustaining treatment?
Funeral – What type of funeral or memorial experience do I want? Do I want to be cremated or buried? If buried, do I want to be embalmed, be interned without embalmment, have a green burial, etc. Do your research and be familiar with your options and any local or state requirements. For the Pagan/LGBTQ+ community, do my loved ones understand my path and preferences and know how to implement them?
Legal – Do I have a will and is it up-to-date? Who is your power of attorney and do they have backup?
Financial – Have your reviewed your financial affairs, created a document and shared it with a trusted individual? Where are you keeping important documents?

What important documents should I prepare and have available for my loved ones?

While this is not an exhaustive list, it's a good starting point.

Key Documents

- **Will**: Specifies how your assets will be distributed after your death.
- **Power of Attorney**: Allows someone you choose to make financial decisions on your behalf if you become incapacitated.
- **Advance Healthcare Directive** (Living Will): Outlines your wishes regarding medical treatment at the end of life.
- **Life Insurance Policies**: Provides financial support to your beneficiaries upon your death.
- **Beneficiary Designations:** Specifies who will receive benefits from specific accounts like retirement plans or life insurance.
- **Birth Certificate**: Proof of identity.
- **Marriage License**: If married, proof of marital status.
- **Property Deeds**: Documentation of ownership of real estate.
- **Bank Account Details**: Information on your bank accounts.
- **Loan Documents**: Records of any outstanding loans.
- **Vehicle Titles**: Proof of ownership of your vehicles.
- **Important Passwords**: Access details for online accounts.
- **Death Certificate**: Official document confirming your death.

Other Considerations

- **HIPAA Release**: Allows your family to access your medical records after death.
- **Letter of Intent**: A personal document detailing wishes not covered in your Will.
- **Funeral Arrangements**: Pre-planning your funeral details.
- **Social Media Accounts**: Decisions regarding your online presence after death.

Important Note: It's crucial to regularly review and update these documents as your life circumstances change.

Learning Links

Here are some learning links that can help you start your death/dying education journey

Organ Donation		**Online** - Register or change your registration on the Yes Utah website. By mail - Download an application and mail it to the Utah Donor Registry, located at 6065 S Fashion Blvd, Suite 125, Murray, Utah 84107. **At the DMV** - When you renew your driver's license at the Utah Department of Motor Vehicles, you can choose to register as an organ donor. **By calling** - You can call Intermountain Donor Services at (800) 833-6667, which is available 24 hours a day. Anyone can be a potential organ donor after death, regardless of age or medical condition. However, it's important to talk to your family about your wishes so they're aware and have a direction if it becomes a reality. If you're interested in becoming a living donor, you can fill out a questionnaire through the University of Utah Health. You can also search for transplant centers on the Organ Procurement and Transplantation Network website.
Advance Health Care Directive (Valid for UTAH ONLY)		Intermountain Healthcare (this link contains Utah Forms) University of Utah (this link contains Utah Forms) **What does an Advanced Health Care Directive Include?** **Part I**: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself. **Part II**: Allows you to record your wishes about health care in writing. **Part III**: Tells you how to revoke or change this directive. **Part IV**: Makes your directive legal. An advance directive is a legal document that includes your wishes for medical care if you are unable to communicate them. It can include: **Living will**: This document states your preferences for emergency treatment, including which treatments you want and which you want to avoid. You can also include if you want to donate your organs or tissues after you die. **Durable power of attorney for health care**: This document names a person to make health care decisions for you if you can't. This person is also known as your health care proxy, representative, surrogate, or agent. **Do not resuscitate (DNR) order**: This is another type of advance directive. Advance directives vary by state, and some states only allow certain types of advance directives. Some states have specific forms of advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST). **When preparing an advance directive, you can consider what you would want if you were in certain situations, such as**: • You have a disease that can't be cured

		• You have a disease that affects your movement or memory • You are in pain • You are in a coma
Will		**Important Note:** While you do not need an attorney to create a valid will, if you have any questions about the creation of a will, obtaining legal advice from a lawyer is always recommended. **If using a free will template online, ensure that it is for the state of Utah.** **Types of Wills in Utah:** **What to Include in a Will for the state of Utah** **Personal Representative (Executor):** Name the person who will manage your estate and carry out the terms of your will. Ensure that you have a backup Executor. **Beneficiaries**: Clearly identify the individuals or organizations who will receive your assets and specify what they will inherit. **Real and Personal Property**: List your real estate (houses, land) and personal property (vehicles, jewelry, bank accounts) and designate who will receive each item. **Guardianship for Minors**: If you have minor children, name a guardian to care for them in the event of your death. **Contingency Plans**: Specify what should happen to your assets if a named beneficiary predeceases you. **Charitable Donations**: If you wish to donate assets to charities, include details about the donation. **Funeral Arrangements**: You can include specific instructions regarding your funeral or burial arrangements if desired. **Important Considerations**: **Consult a Lawyer**: While you can create a basic will yourself, consulting with an estate planning attorney is highly recommended to ensure your will is legally sound and addresses all relevant aspects. **Regular Review**: As your life circumstances change, review and update your will periodically to reflect your current wishes. **Valid Execution**: Follow proper legal procedures for signing and witnessing your will according to Utah law.
LGBTQ+ End-of-Life Guide. This also can serve as guidance for members of the Utah Pagan community		**While a Utah-Specific end of life guide is still being created, a LGBTQ+ focused reference is from the Order of the Good Death and was created for the state of Louisiana. Make sure that you understand local and state requirements for the state of Utah.**

Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)*

Part I:	***Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.***
Part II:	***Allows you to record your wishes about health care in writing.***
Part III:	***Tells you how to revoke or change this directive.***
Part IV:	***Makes your directive legal.***

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____ Cell Phone: (_____) _____

Birth Date: _____

Part I: My Agent (*Health Care Power of Attorney)*

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 in B or C 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: (_____) _____

Part I: My Agent (*continued)*

D. Agent's Authority.

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider 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 or 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. Agent's authority when I can speak for myself.

Complete this section ONLY IF you want your Agent to have authority to access your health care records starting today. Otherwise, your Agent may only access your health records if you can't speak for yourself, as explained in Section D above.

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

Medical Records

___ YES Access all my medical records; OR

___ YES Access my medical records for the treatment dates of_____ to_____; and

___ YES Access my sensitive medical information which includes any mental health treatment, psychological testing, addiction treatment, treatment for HIV or sexually transmitted diseases.

___ YES Other (please specify) _____
_____.

Health Care Financial Records

___ YES Access all my health care financial, billing and payment records; OR

___ YES Access my healthcare financial, billing and payment records for the treatment dates of_____ to_____.

___ YES Other (please specify) _____
_____
_____.

F. Other Authority Including Limits/Expansion of Authority.

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

___ YES Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

___ YES I wish to limit or expand the powers of my health care agent as follows: _____
_____

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 alternate agent, to serve as your guardian, if a guardianship is ever necessary.

___ YES ___ NO I, being of sound mind and not acting 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.

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.

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	
_____ Initial	**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	
_____ Initial	**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.
Additional comments:	

Option 3		
_____ Initial	**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 my life.	
If you choose this option, you must also choose either (a) or (b), below		
_____ Initial	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.	
_____ Initial	(b) My health care provider should withhold or withdraw life-sustaining care if ***at least one*** of the initialed conditions is met:	
If you selected (a), above, do not choose any options under (b).		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
Additional comments:		

Option 4	
_____ Initial	I do not wish to express preferences about health care wishes in this directive.
Additional comments	

Part II: My Health Care Wishes (*continued*)

Additional instructions about your health care wishes:

_____

_____

_____

If you do not want emergency medical service 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 or Changing a Directive

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- 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; or
- Signing a new directive. (***If you sign more than one Advance Health Care Directive, the most recent one applies.)***

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 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 or 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 declarant;
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 Printed Name of Witness

_____ _____ _____ _____

Street Address City State Zip

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

_____

_____

Name: _____

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Pursuant to Utah Code Sections 75-2a-117 effective 2008 *(Conforme a la Sección 75-2a-117 del Código de Utah, vigente desde 2008)**

Part I *(Parte I)*: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself. (*Le permite designar a una persona que tome decisiones sobre su atención médica cuando usted no pueda tomar sus propias decisiones o hablar por usted mismo.)*

Part II *(Parte II)*: Allows you to record your wishes about health care in writing. (*Le permite registrar por escrito sus deseos sobre su atención médica.)*

Part III *(Parte III)*: Tells you how to revoke or change this directive. (*Le indica cómo cambiar o revocar esta directiva.)*

Part IV *(Parte IV)*: Makes your directive legal. (*Le otorga validez legal a su directiva.)*

My Personal Information
(*Datos Personales)*

Name *(Nombre)*:_____

Street Address (*Dirección)*: _____

City, State, Zip Code (*Ciudad, Estado, Código Postal)*:_____

Telephone (*Teléfono)*: (_____) _____ **Cell Phone** (*Teléfono Celular)*: (_____) _____

Birth Date (*Fecha de nacimiento)*: _____

Part I: My Agent (Health Care Power of Attorney)

Parte I: Mi Representante (Poder para Decisiones de Atención Médica)

A. No Agent *(No deseo designar un Representante):*

If you do not want to name an agent, initial the box, below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent. (*Si usted no desea designar un representante, escriba sus iniciales en el siguiente casillero, luego pase a la Parte II; no designe ningún representante en B o C. Nadie puede obligarlo a designar un representante.)*

☐ **I do not want to choose an agent.** *(No deseo designar un representante.)*

B. My Agent (*Mi Representante*):

Agent's Name (*Nombre del Representante)*:_____

Street Address (*Dirección)*: _____

City, State, Zip Code (*Ciudad, Estado, Código Postal)*: _____

Telephone (*Teléfono)*: (_____) _____ **Cell Phone** (*Teléfono Celular)*: (_____) _____

Birth Date (*Fecha de nacimiento)*: _____

C. My Alternate Agent (*Mi Representante Suplente):*

This person will serve as your agent if your agent, named above, is unable or unwilling to serve. (*Esta persona actuará como su representante en caso de que su representante ya designado, no pueda o no desee representarlo.)*

Agent's Name (*Nombre del Representante suplente)*: _____

Street Address (*Dirección)*: _____

City, State, Zip Code (*Ciudad, Estado, Código Postal)*: _____

Telephone (*Teléfono)*: (_____) _____ **Cell Phone** (*Teléfono Celular)*: (_____)_____

Birth Date (*Fecha de nacimiento)*: _____

*This document is identical to the statutory form. (*Este documento es idéntico al formulario establecido por ley.)*

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Part I: My Agent (Health Care Power of Attorney) (continued)

(*Parte I: Mi Representante (continuación)*)

D. Agent's Authority *(Facultad de mi representante):*

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: (*En caso de no poder tomar decisiones o hablar por mí mismo (es decir, luego de que mi médico o enfermera registrada de prácticas avanzadas (APRN, por sus siglas en inglés) determine que carezco de capacidad para tomar decisiones referentes a mi atención médica, conforme a la Sección 75-2a-104 de la Ley de Directiva para la Predisposición de la Atención Médica), mi representante tiene la facultad de tomar cualquier decisión sobre mi atención médica que podría haber tomado yo, tales como pero sin limitarse a):*

- **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.** *(Aceptar, rechazar o cancelar cualquier tipo de atención médica. Esto puede incluir tratamientos de soporte vital (para prolongar mi vida), la ingesta de alimentos y líquidos por intubación, uso de antibióticos, resucitación cardiopulmonar (CPR, por sus siglas en inglés), y diálisis, y atención de salud mental, como terapia convulsiva y medicamentos psicoactivos. Esta autoridad está sujeta a las limitaciones especificadas en el párrafo F de la Parte I o en la Parte II de esta directiva.)*
- **Hire and fire health care providers.** *(Contratar o despedir a proveedores de atención médica.)*
- **Ask questions and get answers from health care providers.** *(Hacer preguntas y obtener respuestas de los proveedores de atención médica.)*
- **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 or F of Part I.** (*Aceptar la admisión o transferencia a un proveedor de atención médica o una institución de atención médica, incluyendo instituciones de atención psiquiátrica, sujeto a las limitaciones establecidas en el párrafo E o F de la Parte I.)*

Get copies of my medical records. *(Obtener copias de mis registros médicos.)*

Ask for consultations or second opinions. *(Solicitar consultas o segundas opiniones.)*

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity. *(Mi representante no puede hacer que reciba atención médica contra mi voluntad, ni siquiera cuando un médico haya determinado que carezco de capacidad para tomar decisiones referentes al cuidado de mi salud.)*

E. Agent's Authority when I can speak for myself (*Poder del representante aun cuando pueda tomar decisiones por mí mismo):*

Agent's authority when I can speak for myself. Complete this section ONLY IF you want your Agent to have authority to access your health care records starting today. Otherwise, your Agent may only access your health records if you can't speak for yourself, as explained in Section D above. ***Poder del representante aun cuando pueda tomar decisiones por mí mismo.*** *Llene esta sección SOLAMENTE SI desea que su Representante posee la autoridad para acceder a su expediente médico a partir de hoy. De lo contrario, su Representante sólo podrá acceder a su expediente médico si usted no puede tomar decisiones por sí mismo, como se explica en la Sección D anterior.*

My agent has the powers below ONLY IF I initial the "yes" option that precedes the statement. I authorize my agent to: *Mi representante posee la autoridad para lo siguiente SÓLO SI elijo la opción "sí" que precede a cada declaración. Autorizo a mi representante a:*

***Medical Records** (Expediente médico)*

_____**YES** (*SÍ*) **Access all my medical records; OR** *(Acceder a la totalidad de mi expediente médico; O)*

_____**YES** (*SÍ*) **Access my medical records for the treatment dates of _____ to _____; and** *(Acceder a mi expediente médico durante las fechas de tratamiento de _____ a _____; y)*

_____**YES** (*SÍ*) **Access my sensitive medical information which includes any mental health treatment, psychological testing, addiction treatment, treatment for HIV or sexually transmitted diseases.** *(Acceder a mi información médica delicada que incluye cualquier tratamiento de salud mental, pruebas psicológicas, tratamiento de adicciones y tratamientos para el VIH o enfermedades de transmisión sexual.)* (Obtener copias de mis registros médicos en cualquier momento, aún cuando o pueda habla por mí mismo.)

_____**YES** (*SÍ*) **Other (please specify)** *(Otro (especifique))* _____

***Healthcare Financial Records** (Expediente financiero de atención médica)*

_____**YES** (*SÍ*) **Access all my healthcare financial , billing and payment records; OR** *(Acceder a la totalidad de mi expediente financiero, de facturación y de pagos de atención médica; O)*

_____**YES** (*SÍ*) **Access my healthcare financial, billing and payment records for the treatment dates of _____ to _____.** *(Acceder a mi expediente financiero, de facturación y de pagos de atención médica durante las fechas de tratamiento de _____ a _____.)*

_____**YES** (*SÍ*) **Other (please specify)** *(Otro (especifique))* _____.

Name *(Nombre):* _____

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Part I: My Agent (Health Care Power of Attorney) (continued)
(*Parte I: Mi Representante (continuación)***)**

F. Other Authority Including Limits/Expansion of Authority *(Otros tipos de autoridad, incluyendo límites o ampliaciones del poder)*

My agent has the powers and limitations below ONLY IF I initial the "yes" option that precedes the statement. I authorize my agent to: *(Mi representante posee la autoridad y las limitaciones para lo siguiente SÓLO SI elijo la opción "sí" que precede a cada declaración. Autorizo a mi representante a):*

_____**YES** (*SÍ*) Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care. *(Encargarse de mi ingreso a un centro de salud autorizado, tal como un hospital, hogar paraancianos, residencia de vivienda asistida u otro establecimiento a largo plazo sin incluir cuidados de convalecencia o de recuperación.)*

_____**YES** (*SÍ*) I wish to limit or expand the powers of my health care agent as follows: *(Deseo limitar o ampliar el poder de mi representante de atención médica de la siguiente manera)* _____

_____

G. Other Authority (*Otras facultades*):

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 alternate agent, to serve as your guardian, if a guardianship is ever necessary.

(*Aunque designar a un representante lo ayude a evitar una tutoría, la misma todavía puede ser necesaria. Marque con sus iniciales la opción "SÍ" si desea que el tribunal le asigne un representante o, en caso de que su representante no pueda o no desee representarlo, su representante suplente actúe como su tutor, si es que una tutoría es necesaria.)*

_____**YES** (*SÍ*) _____**NO** I, being of sound mind and not acting 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, become incapacitated.

(*Yo, en pleno uso de mis facultades mentales y sin actuar bajo coacción, fraude, u otro tipo de influencia indebida, por la presente designo a mi representante o, en caso de que mi representante no pueda o no desee representarme, designo a mi representante suplente, para que actúe como mi tutor en caso de que, con posterioridad a la fecha de este documento, yo quede incapacitado.)*

H. Consent to Participate in Medical Research: (*Consentimiento para participar en investigaciones médicas):*

_____**YES** (*SÍ*) _____**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.**

(*Autorizo a mi representante a aceptar mi participación en investigaciones médicas o ensayos clínicos, aún cuando no me beneficie con los resultados.)*

I. Organ Donation (*Donación de órganos):*

_____**YES** (*SÍ*) _____**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**.

(*Si no he manifestado mi voluntad de donar mis órganos de algún otro modo, mi representante puede aceptar la donación de mis órganos para transplantes.)*

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Part II: My Health Care Wishes (Living Will)

(Parte II: Mis deseos sobre mi Atención Médica (Testamento vital))

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.

(Deseo que mis proveedores de atención médica sigan las instrucciones que les dé cuando esté bajo tratamiento, aún cuando mis instrucciones contradigan éstas u otras directivas anticipadas. Mis proveedores de atención médica siempre deben brindarme asistencia médica para que pueda permanecer cómodo y funcional tanto como sea posible.)

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.

(Elija solo una de las siguientes opciones, de la Opción 1 a la Opción 4, colocando sus iniciales antes de la declaración numerada. No marque con sus iniciales más de una opción. Si no desea documentar sus deseos para el final de la vida, coloque sus iniciales en la Opción 4. Puede trazar una línea sobre las opciones que no elija.)

Option 1 *(Opción 1)*		
_____ **Initial** *(Marcar)*	**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.	(*Elijo permitir que mi representante decida. He seleccionado cuidadosamente a mi representante. He dialogado con mi representante sobre mis deseos en relación con mi atención médica. Confío en que mi representante tomará las decisiones de atención médica que yo tomaría bajo las mismas circunstancias.)*
Additional Comments (*Comentarios adicionales)*:		

Option 2 *(Opción 2)*		
_____ **Initial** *(Marcar)*	**I choose to prolong life.** Regardless of my condition or prognosis, I want my healthcare team to try to prolong my life as long as possible within the limits of generally accepted health care standards.	*(Elijo prolongar mi vida. Más allá de mi estado de salud o del pronóstico médico, deseo que mi equipo de atención médica intente prolongar mi vida tanto como sea posible dentro de los límites de las normas de atención médica generalmente aceptadas.)*
Other *(Otros)*:		

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Part II: My Health Care Wishes (Living Will) (continued)

(*Parte II: Mis deseos sobre mi Atención Médica (Testamento vital) (continuación)*)

Option 3 *(Opción 3)*

_____ **Initial** *(Marcar)*	**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 my life.	*(Elijo no recibir atención con el propósito de prolongar mi vida, incluyendo la ingesta de alimentos y líquidos por intubación, el uso de antibióticos, el suministro de CPR, o de diálisis. Deseo recibir siempre cuidados orientados al bienestar y atención médica de rutina para permanecer tan cómodo y funcional como sea posible, aún cuando ese tipo de atención prolongue mi vida.)*

If you choose this option, you must also choose either (a) or (b), below (*Si elige esta opción, también debe elegir (a) o (b), a continuación)*

_____ **Initial** *(Marcar)*	**(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.** If you selected (a), above, do not choose any options under (b).	**(a)** (*No impongo limitaciones en la capacidad de mi proveedor de atención médica o mi representante para mantener o cancelar la atención para prolongar la vida. Si seleccionó la opción (a), no elija ninguna de las opciones de (b).)*
_____ **Initial** *(Marcar)*	**(b) My health care provider should withhold or withdraw life-sustaining care if at least one of the initialed conditions is met:**	**(b)** *(Mi proveedor de atención médica debe mantener o cancelar la atención para prolongar la vida, si se cumple al menos una de las condiciones marcadas:)*

Option 3 Part (b) only *(Sólo opción 3(b))*		I have a progressive illness that will cause death *(Tengo una enfermedad progresiva que me provocará la muerte)*
You may initial more than one option *(Puede marcar más de una opción)*		I am close to death and I am unlikely to recover *(Estoy cerca de la muerte y es poco probable que me recupere)*
		I cannot communicate and it is unlikely that my condition will improve *(No puedo comunicarme y es poco probable que mi estado de salud mejore)*
		I do not recognize my friends or family and it is unlikely that my condition will improve *(No reconozco a mis familiares y amigos y es poco probable que mi estado de salud mejore)*
		I am in a persistent vegetative state *(Me encuentro en estado vegetativo persistente)*

Other *(Otros)*:

Option 4 *(Opción 4)*

_____ **Initial** *(Marcar)*	**I do not wish to express preferences about health care wishes in this directive.**	(*No deseo expresar preferencias de mis deseos referentes a mi atención médica en esta directiva.)*

Other *(Otros)*:

Additional instructions about your health care wishes:
(*Instrucciones adicionales sobre sus deseos con respecto a su atención médica):*

_____

_____

If you do not want emergency medical service 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. (*Si usted no desea que los proveedores de atención médica de emergencia le suministren CPR o algún otro método para prolongar la vida, debe pedir ayuda a un médico o un(a) APRN para completar una orden que refleje sus deseos en un formulario aprobado por el Departamento de Salud de Utah.)*

Name *(Nombre):* _____

UTAH ADVANCE HEALTH CARE DIRECTIVE

(PREDISPOSICIONES (INSTRUCCIONES) PARA LA ATENCIÓN MÉDICA EN UTAH)

Part III: Revoking or Changing a Directive (Parte III: Cambiar o Revocar una Directiva)

I may revoke or change this directive by (*Puedo cambiar o revocar esta directiva si*):

- **Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf** (*Escribo "anulado" en el formulario, quemo, rompo, o de otro modo destruyo o desfiguro este documento o pido a otra persona que lo haga en mi nombre);*
- **Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf** (*Firmo una revocación por escrito de la directiva, o pido a otra persona que firme una revocación en mi nombre*);
- **Stating that I wish to revoke 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; who will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or** (*Declaro que deseo revocar la directiva en presencia de un testigo que: tiene 18 años de edad o más; no será designado como mi representante en una directiva sustituta; no se convertirá en un sustituto por defecto si la directiva es revocada; y firma y coloca fecha a un documento escrito que confirma mi declaración; o)*
- **Signing a new directive.** (If you sign more than one Advance Health Care Directive, the most recent one applies.) (*Firmo una nueva directiva. (Si firma más de un formulario de Predisposiciones (instrucctiones) para la Atención Médica en Utah, se aplica el más reciente.))*

Part IV: Making the Document Legal (Parte IV: Otorgar Validez Legal al Documento)

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. (*Firmo esta directiva voluntariamente. Comprendo las elecciones que he hecho y declaro que soy emocional y mentalmente competente para realizar esta directiva. Mi firma en este formulario revoca cualquier formulario de testamento en vida o poder que designe a un representante de atención médica que haya completado anteriormente.)*

_____ _____

Date (*Fecha)* Signature (*Firma)*

_____

City, County, and State of Residence (*Ciudad, Condado y Estado de Residencia)*

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not (*Fui testigo de la firma de esta directiva, soy mayor de 18 años de edad y no):*

1. **Related to the declarant by blood or marriage** (*tengo un vínculo de sangre o matrimonial con el declarante)*;
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** (*tengo derecho de recibir ninguna porción del patrimonio del declarante conforme a las leyes de sucesión intestada de cualquier estado o jurisdicción o bajo cualquier testamento o codicilo del declarante)*,
3. **A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant** (*soy beneficiario de una póliza de seguro de vida, fideicomiso, plan calificado, cuenta de pago al fallecer, o transferencia o escritura por fallecimiento, que sean propiedad del declarante, o hayan sido constituidos o establecidos por, o en nombre del declarante)*;
4. **Entitled to benefit financially upon the death of the declarant** (*tengo derecho de obtener beneficios financieros por la muerte del declarante)*;
5. **Entitled to a right to, or interest in, real or personal property upon the death of the declarant** *(tengo derecho a, o interés por, bienes reales o personales por la muerte del declarante);*
6. **Directly financially responsible for the declarant's medical care** (*soy el responsable financiero directo de la atención médica del declarante)*;
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** (*soy un proveedor de atención médica que le está brindando atención al declarante o un administrador en una institución médica donde el declarante esté recibiendo atención; ni)*;
8. **The appointed agent or alternate agent.** (*soy el representante designado o el suplente.)*

_____ _____

Signature of Witness (*Firma del testigo)* **Printed Name of Witness** (*Nombre en letra de imprenta del testigo)*

_____ _____ _____ _____

Street Address (*Dirección)* **City** (*Ciudad)* **State** (*Estado)* **Zip** (*Código Postal)*

If the witness is signing to confirm a spoken directive, describe below the circumstances under which the directive was made.
(*Si el testigo firma para confirmar una directiva oral (verbal), describir a continuación las circunstancias bajo las cuales se realizó la directiva.)*

_____

_____

Utah Last Will and Testament
of

_____

Pursuant to Title 75 (Uniform Probate Code)

I, _____, resident in the City of _____, County of _____, State of Utah being of sound mind, not acting under duress or undue influence, and fully understanding the nature and extent of all my property and of this disposition thereof, do hereby make, publish, and declare this document to be my Last Will and Testament, and hereby revoke any and all other wills and codicils heretofore made by me.

I. EXPENSES & TAXES

I direct that all my debts, and expenses of my last illness, funeral, and burial, be paid as soon after my death as may be reasonably convenient, and I hereby authorize my Personal Representative, hereinafter appointed, to settle and discharge, in his or her absolute discretion, any claims made against my estate.

I further direct that my Personal Representative shall pay out of my estate any and all estate and inheritance taxes payable by reason of my death in respect of all items included in the computation of such taxes, whether passing under this Will or otherwise. Said taxes shall be paid by my Personal Representative as if such taxes were my debts without recovery of any part of such tax payments from anyone who receives any item included in such computation.

II. PERSONAL REPRESENTATIVE

I nominate and appoint _____, of _____, County of _____, State of _____ as Personal Representative of my estate and I request that (he/she) be appointed temporary Personal Representative if (he/she) applies. If my Personal Representative fails or ceases to so serve, then I nominate _____of _____, County of _____, State of _____ to serve.

III. DISPOSITION OF PROPERTY

I devise and bequeath my property, both real and personal and wherever situated, as follows:

1st Beneficiary

_____ [full name], currently of _____ [address], as my _____ [relation] whose last four (4) digits of their Social Security Number (SSN) are xxx-xx-_____ with the following property:

_____

2nd Beneficiary

_____ [full name], currently of _____ [address], as my _____ [relation] whose last four (4) digits of their Social Security Number (SSN) are xxx-xx-_____ with the following property:

_____

3rd Beneficiary

_____ [full name], currently of _____ [address], as my _____ [relation] whose last four (4) digits of their Social Security Number (SSN) are xxx-xx-_____ with the following property:

_____

If any of my beneficiaries have pre-deceased me, then any property that they would have received if they had not pre-deceased me shall be distributed in equal shares to the remaining beneficiaries.

If any of my property cannot be readily sold and distributed, then it may be donated to any charitable organization or organizations of my Personal Representative's choice. If any property cannot be readily sold or donated, my Personal Representative may, without liability, dispose of such property as my Personal Representative may deem appropriate. I authorize my Personal Representative to pay as an administration expense of my estate the expense of selling, advertising for sale, packing, shipping, insuring and delivering such property.

IV. OMISSION

Except to the extent that I have included them in this Will, I have intentionally, and not as a result of any mistake or inadvertence, omitted in this Will to provide for any family members and/or issue of mine, if any, however defined by law, presently living or hereafter born or adopted.

V. BOND

No bond shall be required of any fiduciary serving hereunder, whether or not specifically named in this Will, or if a bond is required by law, then no surety will be required on such bond.

VI. DISCRETIONARY POWERS OF PERSONAL REPRESENTATIVE

My Personal Representative, shall have and may exercise the following discretionary powers in addition to any common law or statutory powers without the necessity of court license or approval:

A. To retain for whatever period my Personal Representative deems advisable any property, including property owned by me at my death, and to invest and reinvest in any property, both real and personal, regardless of whether any particular investment would be proper for a Personal Representative and regardless of the extent of diversification of the assets held hereunder.

B. To sell and to grant options to purchase all or any part of my estate, both real and personal, at any time, at public or private sale, for consideration, whether or not the highest possible consideration, and upon terms, including credit, as my Personal Representative deems advisable, and to execute, acknowledge, and deliver deeds or other instruments in connection therewith.

C. To lease any real estate for terms and conditions as my Personal Representative deems advisable, including the granting of options to renew, options to extend the term or terms, and options to purchase.

D. To pay, compromise, settle or otherwise adjust any claims, including taxes, asserted in favor of or against me, my estate or my Personal Representative.

E. To make any separation into shares in whole or in part in kind and at values determined by my Personal Representative, with or without regard to tax basis, and to allocate different kinds and disproportionate amounts of property and undivided interests in property among the shares.

F. To make such elections under the tax laws as my Personal Representative shall deem appropriate, including elections with respect to qualified terminable interest property, exemptions and the use of deductions as income tax or estate tax deductions, and to determine whether to make any adjustments between income and principal on account of any election so made.

G. To make any elections permitted under any pension, profit sharing, employee stock ownership or other benefit plan.

H. To employ others in connection with the administration of my estate, including legal counsel, investment advisors, brokers, accountants and agents and to pay reasonable compensation in addition to my Personal Representative's compensation.

I. To vote any shares of stock or other securities in person or by proxy; to assert or waive any stockholder's rights or privilege to subscribe for or otherwise acquire additional stock; to deposit securities in any voting trust or with any committee.

J. To borrow and to pledge or mortgage any property as collateral, and to make secured or unsecured loans. My Personal Representative is specifically authorized to make loans without interest to any beneficiary hereunder. No individual or entity loaning property to my Personal Representative or trustee shall be held to see to the application of such property.

K. My Personal Representative shall also in his or her absolute discretion determine the allocation of any GST exemption available to me at my death to property passing under this Will or otherwise. The determination of my Personal Representative with respect to any elections or allocation, if made or taken in good faith, shall be binding upon all affected.

VII. CONTESTING BENEFICIARY

If any beneficiary under this Will, or any trust herein mentioned, contests or attacks this Will or any of its provisions, any share or interest in my estate given to that contesting

beneficiary under this Will is revoked and shall be disposed of in the same manner provided herein as if that contesting beneficiary had predeceased me.

VIII. GUARDIAN AD LITEM NOT REQUIRED

I direct that the representation by a guardian ad litem of the interests of persons unborn, unascertained or legally incompetent to act in proceedings for the allowance of accounts hereunder be dispensed with to the extent permitted by law.

IX. GENDER

Whenever the context permits, the term “Personal Representative” shall include “Executor” and “Administrator,” the use of a particular gender shall include any other gender, and references to the singular or the plural shall be interchangeable. All references to the Internal Revenue Code shall mean the Internal Revenue Code of 1986 or any successor Code. All references to estate taxes shall include inheritance and other death taxes.

X. ASSIGNMENT

The interest of any beneficiary in this Will, shall not be alienable, assignable, attachable, transferable nor paid by way of anticipation, nor in compliance with any order, assignment or covenant and shall not be applied to, or held liable for, any of their debts or obligations either in law or equity and shall not in any event pass to his, her, or their assignee under any instrument or under any insolvency or bankruptcy law, and shall not be subject to the interference or control of creditors, spouses or others.

XI. GOVERNING LAW

This document shall be governed by the laws in the State of Utah.

XII. BINDING ARRANGEMENT

Any decision by my Personal Representative with respect to any discretionary power hereunder shall be final and binding on all persons interested. Unless due to my Executor’s own willful default or gross negligence, no Executor shall be liable for said Executor’s acts or omissions or those of any co-Executor or prior Executor.

I, the undersigned _____, do hereby declare that I sign and execute this instrument as my last Will, that I sign it willingly in the presence of each of the undersigned witnesses, and that I execute it as my free and voluntary act for the purposes herein expressed, on this ____ day of _____, 20____.

_____ _____

Testator Signature Testator (Printed Name)

The foregoing instrument, was on this ____ day of _____, 20____, subscribed on each page and at the end thereof by _____, the

above-named Testator, and by (him/her) signed, sealed, published and declared to be (his/her) LAST WILL AND TESTAMENT, in the presence of us and each of us, who thereupon, at (his/her) request, in (his/her) presence, and in the presence of each other, have hereunto subscribed our names as attesting witnesses thereto.

_____ _____

Witness Signature Address

_____ _____

Witness Signature Address

TESTAMENTARY AFFIDAVIT

STATE OF _____

COUNTY OF _____, SS.

Before me, the undersigned authority, on this day personally appeared _____, testator, _____, witness and _____, witness, known to me to be the testator and the witnesses, respectively, whose names are signed to the attached or foregoing instrument, and, all of these persons being by me duly sworn, the testator declared to me and to the witnesses in my presence that the instrument is the testator's last will and that the testator has willingly signed or directed another to sign for him/her, and that the testator executed it as the testator's free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence of the testator, that they signed the will as witnesses and that to the best of their knowledge the testator was eighteen (18) years of age or over, of sound mind and under no constraint or undue influence.

_____ _____

Testator Signature Witness Signature

_____

Witness Signature

Subscribed and sworn to before me by the said testator and the said witnesses, this

____ day of _____, 20____.

_____

Notary Public

My Commission expires: