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HOUSE BILL NO. 2535

Offered January 13, 2025

Prefiled January 9, 2025

A BILL to amend and reenact §§ 8.01-622.1, 18.2-369, 32.1-127, as it is currently effective and as it shall become effective, 32.1-127.1:03, 32.1-138.1, 32.1-162.16, 32.1-162.18, 32.1-291.21, 32.1-309.1, 32.1-325 , 37.2-804.2, as it is currently effective and as it shall become effective, 37.2-805.1, 37.2-817.1, 37.2-837, as it is currently effective and as it shall become effective, 37.2-838, 37.2-1101, 37.2-1108, 53.1-133.04, 54.1-2807.02, 54.1-2818.1, 54.1-2818.5, 54.1-2970.1, 54.1-2987.1, 54.1-2988.1, 54.1-2993.1, 54.1-2995, 63.2-501, 63.2-1605, 64.2-2000, 64.2-2009, and 64.2-2019 of the Code of Virginia; to amend the Code of Virginia by adding in Chapter 29 of Title 54.1 an article numbered 8.1, consisting of sections numbered 54.1-2993.2 through 54.1-2993.31; and to repeal §§ 54.1-2981, 54.1-2982, 54.1-2983, 54.1-2983.2 through 54.1-2987, 54.1-2988, and 54.1-2989 through 54.1-2993 of the Code of Virginia, relating to Uniform Health Care Decisions Act.

Patron—Hope

Referred to Committee on Health and Human Services

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-622.1, 18.2-369, 32.1-127, as it is currently effective and as it shall become effective, 32.1-127.1:03, 32.1-138.1, 32.1-162.16, 32.1-162.18, 32.1-291.21, 32.1-309.1, 32.1-325, 37.2-804.2, as it is currently effective and as it shall become effective, 37.2-805.1, 37.2-817.1, 37.2-837, as it is currently effective and as it shall become effective, 37.2-838, 37.2-1101, 37.2-1108, 53.1-133.04, 54.1-2807.02, 54.1-2818.1, 54.1-2818.5, 54.1-2970.1, 54.1-2987.1, 54.1-2988.1, 54.1-2993.1, 54.1-2995, 63.2-501, 63.2-1605, 64.2-2000, 64.2-2009, and 64.2-2019 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 29 of Title 54.1 an article numbered 8.1, consisting of sections numbered 54.1-2993.2 through 54.1-2993.31 as follows:

§ 8.01-622.1. Injunction against assisted suicide; damages; professional sanctions.

A. Any person who knowingly and intentionally, with the purpose of assisting another person to commit or attempt to commit suicide, (i) provides the physical means by which another person commits or attempts to commit suicide or (ii) participates in a physical act by which another person commits or attempts to commit suicide shall be liable for damages as provided in this section and may be enjoined from such acts.

B. A cause of action for injunctive relief against any person who is reasonably expected to assist or attempt to assist a suicide may be maintained by any person who is the spouse, parent, child, sibling or guardian of, or a current or former licensed health care provider of, the person who would commit suicide; by an attorney for the Commonwealth with appropriate jurisdiction; or by the Attorney General. The injunction shall prevent the person from assisting any suicide in the Commonwealth.

C. A spouse, parent, child or sibling of a person who commits or attempts to commit suicide may recover compensatory and punitive damages in a civil action from any person who provided the physical means for the suicide or attempted suicide or who participated in a physical act by which the other person committed or attempted to commit suicide.

D. A licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority.

E. Nothing in this section shall be construed to limit or conflict with § 54.1-2971.01 or the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.). This section shall not apply to a licensed health care provider who (i) administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort and without intent to cause death, even if the medication or procedure may hasten or increase the risk of death, or (ii) withholds or withdraws ~~life-prolonging procedures as defined in~~ § ~~54.1-2982~~ *care in accordance with an advance health care directive prepared pursuant to the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)*. This section shall not apply to any person who properly administers a legally prescribed medication without intent to cause death, even if the medication may hasten or increase the risk of death.

F. For purposes of this section:

"Licensed health care provider" means a physician, surgeon, podiatrist, osteopath, osteopathic physician and surgeon, physician assistant, nurse, dentist or pharmacist licensed under the laws of this Commonwealth.

"Suicide" means the act or instance of taking one's own life voluntarily and intentionally.

§ 18.2-369. Abuse and neglect of vulnerable adults; penalties.

A. It is unlawful for any responsible person to abuse or neglect any vulnerable adult. Any responsible

person who abuses or neglects a vulnerable adult in violation of this section and the abuse or neglect does not result in serious bodily injury or disease to the vulnerable adult is guilty of a Class 1 misdemeanor. Any responsible person who is convicted of a second or subsequent offense under this subsection is guilty of a Class 6 felony.

B. Any responsible person who abuses or neglects a vulnerable adult in violation of this section and the abuse or neglect results in serious bodily injury or disease to the vulnerable adult is guilty of a Class 4 felony. Any responsible person who abuses or neglects a vulnerable adult in violation of this section and the abuse or neglect results in the death of the vulnerable adult is guilty of a Class 3 felony.

C. For purposes of this section:

"Abuse" means (i) knowing and willful conduct that causes physical injury or pain or (ii) knowing and willful use of physical restraint, including confinement, as punishment, for convenience or as a substitute for treatment, except where such conduct or physical restraint, including confinement, is a part of care or treatment and is in furtherance of the health and safety of the vulnerable adult.

"Neglect" means the knowing and willful failure by a responsible person to provide treatment, care, goods, or services which results in injury to the health or endangers the safety of a vulnerable adult.

"Responsible person" means a person who has responsibility for the care, custody, or control of a vulnerable adult by operation of law or who has assumed such responsibility voluntarily by contract or in fact.

"Serious bodily injury or disease" includes but is not limited to (i) disfigurement, (ii) a fracture, (iii) a severe burn or laceration, (iv) mutilation, (v) maiming, or (vi) life-threatening internal injuries or conditions, whether or not caused by trauma.

"Vulnerable adult" means any person 18 years of age or older who is impaired by reason of mental illness, intellectual or developmental disability, physical illness or disability, or other causes, including age, to the extent the adult lacks sufficient understanding or capacity to make, communicate, or carry out reasonable decisions concerning his well-being or has one or more limitations that substantially impair the adult's ability to independently provide for his daily needs or safeguard his person, property, or legal interests.

D. No responsible person shall be in violation of this section whose conduct was (i) in accordance with the informed consent of the vulnerable adult that was given when he was not vulnerable or a person authorized to consent on his behalf; (ii) in accordance with a declaration by the vulnerable adult under the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) that was given when he was not vulnerable or with the provisions of a valid medical power of attorney; (iii) in accordance with the wishes of the vulnerable adult that were made known when he was not vulnerable or a person authorized to consent on behalf of the vulnerable adult and in accord with the tenets and practices of a church or religious denomination; (iv) incident to necessary movement of, placement of, or protection from harm to the vulnerable adult; or (v) a bona fide, recognized, or approved practice to provide medical care.

§ 32.1-127. (Effective until July 1, 2025) Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and is primarily responsible for the emergency department shall be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a

similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of

any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ (a) *54.1-2993.13* are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ *54.1-2993.13* from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court

review, provided that the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ *54.1-2993.13*, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department, including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with § 4.1-1601;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other

opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility; and

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the

provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

§ 32.1-127. (Effective July 1, 2025) Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and is primarily responsible for the emergency department shall be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for

admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that

requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ *54.1-2993.13* (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ *54.1-2993.13* from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make ~~medical~~ *health care* decisions pursuant to § ~~54.1-2986~~ *54.1-2993.13*, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department, including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location

operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with § 4.1-1601;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat,

shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility;

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided; and

32. Shall require that every hospital where surgical procedures are performed adopt a policy requiring the use of a smoke evacuation system for all planned surgical procedures that are likely to generate surgical smoke. For the purposes of this subdivision, "smoke evacuation system" means smoke evacuation equipment and technologies designed to capture, filter, and remove surgical smoke at the site of origin and to prevent surgical smoke from making ocular contact or contact with a person's respiratory tract.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, including an audit trail of any additions, deletions, or revisions to the health record, if specifically requested, except as provided in subsections E and F and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

4. Health care entities shall, upon the request of the individual who is the subject of the health record, disclose health records to other health care entities, in any available format of the requester's choosing, as

provided in subsection E.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under ~~a power of attorney for health care or~~ an advance *health care* directive under the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" includes any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" does not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors;

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3; or

4. The release of health records to a state correctional facility pursuant to § 53.1-40.10 or a local or regional correctional facility pursuant to § 53.1-133.03.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to

discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413. Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 16.1-248.3, 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 32.1-320, 37.2-710, 37.2-839, 53.1-40.10, 53.1-133.03, 54.1-2400.6, 54.1-2400.7, 54.1-2400.9, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2967, 54.1-2968, 54.1-3408.2, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412 ;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § 19.2-169.6, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or § 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6 , or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's ~~power of attorney or to an agent or decision maker designated in an individual's~~ advance *health care* directive ~~for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of~~ *prepared pursuant to* the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or

disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the State Inspector General pursuant to Chapter 3.2 (§ 2.2-307 et seq.) of Title 2.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4, pursuant to subdivision 1;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment;

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the

individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual;

35. To a threat assessment team established by a local school board pursuant to § 22.1-79.4, by a public institution of higher education pursuant to § 23.1-805, or by a private nonprofit institution of higher education; and

36. To a regional emergency medical services council pursuant to § 32.1-116.1, for purposes limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-111.3.

Notwithstanding the provisions of subdivisions 1 through 35, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Health care records required to be disclosed pursuant to this section shall be made available electronically only to the extent and in the manner authorized by the federal Health Information Technology for Economic and Clinical Health Act (P.L. 111-5) and implementing regulations and the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and implementing regulations. Notwithstanding any other provision to the contrary, a health care entity shall not be required to provide records in an electronic format requested if (i) the electronic format is not reasonably available without additional cost to the health care entity, (ii) the records would be subject to modification in the format requested, or (iii) the health care entity determines that the integrity of the records could be compromised in the electronic format requested. Requests for copies of or electronic access to health records shall (a) be in writing, dated and signed by the requester; (b) identify the nature of the information requested; and (c) include evidence of the authority of the requester to receive such copies or access such records, and identification of the person to whom the information is to be disclosed; and (d) specify whether the requester would like the records in electronic format, if available, or in paper format. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requester as if it were an original. Within 30 days of receipt of a request for copies of or electronic access to health records, the health care entity shall do one of the following: (1) furnish such copies of or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested; (2) inform the requester if the information does not exist or cannot be found; (3) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (4) deny the request (A) under subsection F, (B) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (C) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of or electronic access to an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of or electronic access to health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical social worker, or licensed professional counselor upon whose opinion the denial is based. The designated reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician, clinical psychologist, clinical social worker, or licensed professional counselor, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical

social worker, or licensed professional counselor upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor. The health care entity shall permit copying and examination of the health record by such other physician, clinical psychologist, clinical social worker, or licensed professional counselor designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician, clinical psychologist, clinical social worker, or licensed professional counselor shall be accompanied by a statement from the custodian of the health record that the individual's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name _____

Health Care Entity's Name _____

Person, Agency, or Health Care Entity to whom disclosure is to be made

_____

Information or Health Records to be disclosed

_____

Purpose of Disclosure or at the Request of the Individual

_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) _____

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

_____

Relationship or Authority of Legal Representative

_____

Date of Signature _____

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the

party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or

administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and

adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

K. Nothing in this section shall prohibit a health care provider who prescribes or dispenses a controlled substance required to be reported to the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient's health care record to another health care provider when such disclosure is related to the care or treatment of the patient who is the subject of the record.

L. An authorization for the disclosure of health records executed pursuant to this section shall remain in effect until (i) the authorization is revoked in writing and delivered to the health care entity maintaining the record that is subject to the authorization by the person who executed the authorization, (ii) any expiration date set forth in the authorization, or (iii) the health care entity maintaining the record becomes aware of any expiration event described in the authorization, whichever occurs first. However, any revocation of an authorization for the disclosure of health records executed pursuant to this section shall not be effective to the extent that the health care entity maintaining the record has disclosed health records prior to delivery of such revocation in reliance upon the authorization or as otherwise provided pursuant to 45 C.F.R. § 164.508. A statement in an authorization for the disclosure of health records pursuant to this section that the information to be used or disclosed is "all health records" is a sufficient description for the disclosure of all health records of the person maintained by the health care provider to whom the authorization was granted. If a health care provider receives a written revocation of an authorization for the disclosure of health records in accordance with this subsection, a copy of such written revocation shall be included in the person's original health record maintained by the health care provider.

An authorization for the disclosure of health records executed pursuant to this section shall, unless otherwise expressly limited in the authorization, be deemed to include authorization for the person named in the authorization to assist the person who is the subject of the health record in accessing health care services, including scheduling appointments for the person who is the subject of the health record and attending appointments together with the person who is the subject of the health record.

§ 32.1-138.1. Implementation of transfer and discharge policies.

A. To implement and conform with the provisions of subdivision A 4 of § 32.1-138, a facility may discharge the patient, or transfer the patient, including transfer within the facility, only:

1. If appropriate to meet that patient's documented medical needs;

2. If appropriate to safeguard that patient or one or more other patients from physical or emotional injury;

3. On account of nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act and the Virginia State Plan for Medical Assistance Services; or

4. With the informed voluntary consent of the patient, or if incapable of providing consent, with the informed voluntary consent of the patient's ~~authorized decision maker~~ *agent or default surrogate* pursuant to ~~§ 54.1-2986~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* acting in the best interest of the patient, following reasonable advance written notice.

B. Except in an emergency involving the patient's health or well being, no patient shall be transferred or discharged without prior consultation with the patient, the patient's family or responsible party and the patient's attending physician. If the patient's attending physician is unavailable, the facility's medical director in conjunction with the nursing director, social worker or another health professional, shall be consulted. In the case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the facility shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge.

C. Except in an emergency involving the patient's health or well being, reasonable advance written notice shall be given in the following manner. In the case of a voluntary transfer or discharge, notice shall be reasonable under the circumstances. In the case of an involuntary transfer or discharge, reasonable advance

written notice shall be given to the patient at least five days prior to the discharge or transfer.

D. Nothing in this section or in subdivision A 4 of § 32.1-138 shall be construed to authorize or require conditions upon a transfer within a facility that are more restrictive than Titles XVIII or XIX of the United States Social Security Act or by regulations promulgated pursuant to either title.

§ 32.1-162.16. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Human research" means any systematic investigation, including research development, testing and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized knowledge. Human research shall not be deemed to include research exempt from federal research regulation pursuant to 45 C.F.R. § 46.101(b).

"Informed consent" means the knowing and voluntary agreement, without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion, of a person who is capable of exercising free power of choice. For the purposes of human research, the basic elements of information necessary to such consent shall include:

1. A reasonable and comprehensible explanation to the person of the proposed procedures or protocols to be followed, their purposes, including descriptions of any attendant discomforts, and risks and benefits reasonably to be expected;

2. A disclosure of any appropriate alternative procedures or therapies that might be advantageous for the person;

3. An instruction that the person may withdraw his consent and discontinue participation in the human research at any time without prejudice to him;

4. An explanation of any costs or compensation which may accrue to the person and, if applicable, the availability of third party reimbursement for the proposed procedures or protocols; and

5. An offer to answer and answers to any inquiries by the person concerning the procedures and protocols.

"Institution" or "agency" means any facility, program, or organization owned or operated by the Commonwealth, by any political subdivision, or by any person, firm, corporation, association, or other legal entity.

"Legally authorized representative" means, in the following specified order of priority, (i) the parent or parents having custody of a prospective subject who is a minor, (ii) the agent appointed under an advance *health care* directive, as defined in § ~~54.1-2982~~ *54.1-2993.3*, executed by the prospective subject, provided the advance *health care* directive authorizes the agent to make decisions regarding the prospective subject's participation in human research, (iii) the legal guardian of a prospective subject, (iv) the spouse of the prospective subject, except where a suit for divorce has been filed and the divorce decree is not yet final, (v) an adult child of the prospective subject, (vi) a parent of the prospective subject when the subject is an adult, (vii) an adult brother or sister of the prospective subject or (viii) any person or judicial or other body authorized by law or regulation to consent on behalf of a prospective subject to such subject's participation in the particular human research. For the purposes of this chapter, any person authorized by law or regulation to consent on behalf of a prospective subject to such subject's participation in the particular human research shall include an attorney in fact appointed under a durable power of attorney, to the extent the power grants the authority to make such a decision. The attorney in fact shall not be employed by the person, institution, or agency conducting the human research. No official or employee of the institution or agency conducting or authorizing the research shall be qualified to act as a legally authorized representative.

"Minimal risk" means that the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

"Nontherapeutic research" means human research in which there is no reasonable expectation of direct benefit to the physical or mental condition of the human subject.

§ 32.1-162.18. Informed consent.

A. In order to conduct human research in this Commonwealth, informed consent must be obtained if the person who is to be the human subject is as follows: (i) capable of making an informed decision, then it shall be subscribed to in writing by the person and witnessed; (ii) ~~incapable of making an informed~~ *lacking capacity pursuant to § 54.1-2993.5 to make a health care* decision, as defined in § ~~54.1-2982~~ *54.1-2993.3*, at the time consent is required, then it shall be subscribed to in writing by the person's legally authorized representative and witnessed; or (iii) a minor otherwise capable of rendering informed consent, then it shall be subscribed to in writing by both the minor and his legally authorized representative. The giving of consent by a legally authorized representative shall be subject to the provisions of subsection B of this section. If two or more persons who qualify as legally authorized representatives and have equal decision-making priority under this chapter inform the principal investigator or attending physician that they disagree as to participation of the prospective subject in human research, the subject shall not be enrolled in the human research that is the subject of the consent. No informed consent form shall include any language through which the person who is to be the human subject waives or appears to waive any of his legal rights, including

any release of any individual, institution, or agency or any agents thereof from liability for negligence.

Notwithstanding consent by a legally authorized representative, no person shall be forced to participate in any human research if the investigator conducting the human research knows that participation in the research is protested by the prospective subject. In the case of persons suffering from neurodegenerative diseases causing progressive deterioration of cognition for which there is no known cure, the implementation of experimental courses of therapeutic treatment, including non-pharmacological treatment, to which a legally authorized representative has given informed consent shall not constitute the use of force.

B. A legally authorized representative may not consent to nontherapeutic research unless it is determined by the human research committee that such nontherapeutic research will present no more than a minor increase over minimal risk to the human subject. A legally authorized representative may not consent to participation in human research on behalf of a prospective subject if the legally authorized representative knows, or upon reasonable inquiry ought to know, that any aspect of the human research protocol is contrary to the religious beliefs or basic values of the prospective subject, whether expressed orally or in writing. A legally authorized representative may not consent to participation in human research involving nontherapeutic sterilization, abortion, psychosurgery or admission for research purposes to a facility or hospital as defined in § 37.2-100.

C. Except as provided elsewhere in this chapter, no investigator may involve a human being as a subject in research covered by this chapter unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the legally authorized representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.

D. The human research review committee may approve a consent procedure which omits or alters some or all of the basic elements of informed consent, or waives the requirement to obtain informed consent, if the committee finds and documents that (i) the research involves no more than minimal risk to the subjects; (ii) the omission, alteration or waiver will not adversely affect the rights and welfare of the subjects; (iii) the research could not practicably be performed without the omission, alteration or waiver; and (iv) after participation, the subjects are to be provided with additional pertinent information, whenever appropriate.

E. The human research review committee may waive the requirement that the investigator obtain written informed consent for some or all subjects, if the committee finds that the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. The committee may require the investigator to provide the subjects with a written statement explaining the research. Further, each subject shall be asked whether he wants documentation linking him to the research and the subject's wishes shall govern.

§ 32.1-291.21. Effect of anatomical gift on advance health-care directive.

A. In this section:

"Advance ~~health-care~~ *health care* directive" ~~means an advance directive executed by a prospective donor~~ *has the same meaning* as provided in ~~the Health Care Decisions Act (§ 54.1-2981 et seq.)~~ *§ 54.1-2993.3*.

"Declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor.

"Health care decision" means any decision regarding the health care of the prospective donor.

B. If a prospective donor has a declaration or an advance ~~health-care~~ *health care* directive and the terms of the declaration or directive and the express or implied terms of a potential anatomical gift are in conflict with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy, the prospective donor's attending physician and the prospective donor shall confer to resolve the conflict. If the prospective donor is incapable of resolving the conflict, an agent acting under the prospective donor's declaration or directive, or, if there is no declaration or directive, or the agent is not reasonably available, another person authorized by law other than this Act, to make health care decisions on behalf of the prospective donor, shall act for the donor to resolve the conflict. The conflict shall be resolved as expeditiously as possible. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor under § 32.1-291.9. Before resolution of the conflict, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor if withholding or withdrawing the measures is not contraindicated by appropriate end-of-life care.

§ 32.1-309.1. Identification of decedent, next of kin; disposition of claimed dead body.

A. As used in this chapter, unless the context requires a different meaning:

"Disposition" means the burial, interment, entombment, cremation, or other authorized disposition of a dead body permitted by law.

"Next of kin" has the same meaning assigned to it in § 54.1-2800.

B. In the absence of a next of kin, a person designated to make arrangements for disposition of the

decedent's remains pursuant to § 54.1-2825, an agent named in an advance *health care* directive pursuant to § ~~54.1-2984~~ *54.1-2993.13*, or any guardian appointed pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 who may exercise the powers conferred in the order of appointment or by § 64.2-2019, or upon the failure or refusal of such next of kin, designated person, agent, or guardian to accept responsibility for the disposition of the decedent, then any other person 18 years of age or older who is able to provide positive identification of the deceased and is willing to pay for the costs associated with the disposition of the decedent's remains shall be authorized to make arrangements for such disposition of the decedent's remains. If a funeral service establishment or funeral service licensee makes arrangements with a person other than a next of kin, designated person, agent, or guardian in accordance with this section, then the funeral service licensee or funeral service establishment shall be immune from civil liability unless such act, decision, or omission resulted from bad faith or malicious intent.

C. Upon the death of any person, irrespective of the cause and manner of death, and irrespective of whether a medical examiner's investigation is required pursuant to § 32.1-283 or 32.1-285.1, the person or institution having initial custody of the dead body shall make good faith efforts to determine the identity of the decedent, if unknown, and to identify and notify the next of kin of the decedent regarding the decedent's death. If, upon notification of the death of the decedent, the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains is willing and able to claim the body, the body may be claimed by the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains for disposition, and the claimant shall bear the expenses of such disposition. If the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains fails or refuses to claim the body within 10 days of receiving notice of the death of the decedent, the body shall be disposed of in accordance with § 32.1-309.2.

D. If the person or institution having initial custody of the dead body is unable to determine the identity of the decedent or to identify and notify the next of kin of the decedent regarding the decedent's death, the person or institution shall contact the primary law-enforcement agency for the locality in which the person or institution is located, which shall make good faith efforts to determine the identity of the decedent and to identify and notify the next of kin of the decedent. However, in cases in which the identity of the decedent and the county or city in which the decedent resided at the time of death are known, the person or institution having initial custody of the dead body shall notify the primary law-enforcement agency for the county or city in which the decedent resided regarding the decedent's death, and the law-enforcement agency for the county or city in which the decedent resided shall make good faith efforts to identify and notify the next of kin of the decedent.

If the identity of the decedent is known to the primary law-enforcement agency or the primary law-enforcement agency is able to identify the decedent, the primary law-enforcement agency is able to identify and notify the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains, and the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains is willing and able to claim the body, the body may be claimed by the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains for disposition, and the claimant shall bear the expenses of such disposition.

If the identity of the decedent is known or the primary law-enforcement agency is able to determine the identity of the decedent but the primary law-enforcement agency is unable, despite good faith efforts, to identify and notify the decedent's next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains within 10 days of the date of contact by the person or institution having initial custody of the dead body, or the primary law-enforcement agency is able to identify and notify the decedent's next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains but the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains fails or refuses to claim the body within 10 days, the primary law-enforcement agency shall notify the person or institution having initial custody of the dead body, and the body shall be disposed of in accordance with § 32.1-309.2.

E. In cases in which a dead body is claimed by the decedent's next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains but the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains is unable to pay the reasonable costs of disposition of the body and the costs are paid by the county or city in which the decedent resided or in which the death occurred in accordance with this section, and the decedent has an estate out of which disposition expenses may be paid, in whole or in part, such assets shall be seized for such purpose.

F. No dead body that is the subject of an investigation pursuant to § 32.1-283 or autopsy pursuant to § 32.1-285 shall be transferred for purposes of disposition until such investigation or autopsy has been completed.

G. Any sheriff or primary law-enforcement officer, county, city, health care provider, funeral service establishment, funeral service licensee, or other person or institution that acts in accordance with the requirements of this chapter shall be immune from civil liability for any act, decision, or omission resulting

from acceptance and disposition of the dead body in accordance with this section, unless such act, decision, or omission resulted from bad faith or malicious intent.

H. Nothing in this section shall prevent a law-enforcement agency other than the primary law-enforcement agency from performing the duties established by this section if so requested by the primary law-enforcement agency and agreed to by the other law-enforcement agency.

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate contact information, including the best available address and telephone number, from each applicant for medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant for

medical assistance with information about advance *health care* directives pursuant to ~~Article 8~~ *the Uniform Health Care Decisions Act* (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) ~~of Chapter 29 of Title 54.1~~, including information about the purpose and benefits of advance directives and how the applicant may make an advance directive;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or advanced practice registered nurse and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary

audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant, advanced practice registered nurse, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs;

24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines;

25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3);

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No health care provider who provides health care services through telemedicine services shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

For the purposes of this subdivision, a health care provider duly licensed by the Commonwealth who provides health care services exclusively through telemedicine services shall not be required to maintain a physical presence in the Commonwealth to be considered an eligible provider for enrollment as a Medicaid provider.

For the purposes of this subdivision, a telemedicine services provider group with health care providers duly licensed by the Commonwealth shall not be required to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

For the purposes of this subdivision, "originating site" means any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom telemedicine services are provided is located;

27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the Department shall not impose any utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

28. A provision for payment of medical assistance for remote patient monitoring services provided via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex infants

and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic or acute health condition who have had two or more hospitalizations or emergency department visits related to such health condition in the previous 12 months when there is evidence that the use of remote patient monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For the purposes of this subdivision, "remote patient monitoring services" means the use of digital technologies to collect medical and other forms of health data from patients in one location and electronically transmit that information securely to health care providers in a different location for analysis, interpretation, and recommendations, and management of the patient. "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and interactive videoconferencing with or without digital image upload;

29. A provision for the payment of medical assistance for provider-to-provider consultations that is no more restrictive than, and is at least equal in amount, duration, and scope to, that available through the fee-for-service program;

30. A provision for payment of the originating site fee to emergency medical services agencies for facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As used in this subdivision, "originating site" means any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom telemedicine services are provided is located;

31. A provision for the payment of medical assistance for targeted case management services for individuals with severe traumatic brain injury;

32. A provision for payment of medical assistance for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories, as defined by the Department's durable medical equipment program policy, for patients who reside in nursing facilities. Initial purchase or replacement may be contingent upon (i) determination of medical necessity; (ii) requirements in accordance with regulations established through the Department's durable medical equipment program policy; and (iii) exclusive use by the nursing facility resident. Recipients of medical assistance shall not be required to pay any deductible, coinsurance, copayment, or patient costs related to the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories; and

33. A provision for payment of medical assistance for remote ultrasound procedures and remote fetal non-stress tests. Such provision shall utilize established CPT codes for these procedures and shall apply when the patient is in a residence or other off-site location from the patient's provider that provides the same standard of care. The provision shall provide for reimbursement only when a provider uses digital technology (i) to collect medical and other forms of health data from a patient and electronically transmit that information securely to a health care provider in a different location for interpretation and recommendation; (ii) that is compliant with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.); and (iii) that is approved by the U.S. Food and Drug Administration. For fetal non-stress tests under CPT Code 59025, the provision shall provide for reimbursement only if such test (a) is conducted with a place of service modifier for at-home monitoring and (b) uses remote monitoring solutions that are approved by the U.S. Food and Drug Administration for on-label use to monitor fetal heart rate, maternal heart rate, and uterine activity.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities With Deficiencies.

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection

A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to 42 C.F.R. Part 1002.

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of § 32.1-162.13.

For the purposes of this subsection, "provider" may refer to an individual or an entity.

E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of health care services under Medicaid and the Family Access to Medical Insurance Security Plan established under § 32.1-351.

4. Require any managed care organization with which the Department enters into an agreement for the provision of medical assistance services to include in any contract between the managed care organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the managed care organization's managed care plans. For the purposes of this subdivision:

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals.

"Pharmacy benefits manager" means a person that performs pharmacy benefits management.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to services and treatment in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

§ 37.2-804.2. (Effective until July 1, 2026) Disclosure of records.

Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently providing services to a person who is the subject of proceedings pursuant to this chapter shall, upon request, disclose to a magistrate, the court, the person's attorney, the person's guardian ad litem, the examiner identified to perform an examination pursuant to § 37.2-815, the community services board or its designee or a certified evaluator, as defined in § 37.2-809, performing any evaluation, preadmission screening, or monitoring duties pursuant to this chapter, or a law-enforcement officer any information that is necessary and appropriate for the performance of his duties pursuant to this chapter. Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently evaluating or providing services to a person who is the subject of proceedings pursuant to this chapter shall disclose information that may be necessary for the treatment of such person to any other health care provider or other provider evaluating or providing services to or monitoring the treatment of the person. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider providing services to a person who is the subject of proceedings under this chapter shall (i) inform the person that his family member or personal representative, including any agent named in an advance *health care* directive executed in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.), will be notified of information that is directly relevant to such individual's involvement with the person's health care, which may include the person's location and general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, and (ii) make a reasonable effort to so notify the person's family member or personal representative, unless the provider has actual knowledge that the family member or personal representative is currently prohibited by court order from contacting the person. No health care provider shall be required to notify a person's family member or personal

representative pursuant to this section if the health care provider has actual knowledge that such notice has been provided.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

§ 37.2-804.2. (Effective July 1, 2026) Disclosure of records.

Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently providing services to a person who is the subject of proceedings pursuant to this chapter shall, upon request, disclose to a magistrate, the court, the person's attorney, the person's guardian ad litem, the examiner identified to perform an examination pursuant to § 37.2-815, the community services board or its designee performing any evaluation, preadmission screening, or monitoring duties pursuant to this chapter, or a law-enforcement officer any information that is necessary and appropriate for the performance of his duties pursuant to this chapter. Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently evaluating or providing services to a person who is the subject of proceedings pursuant to this chapter shall disclose information that may be necessary for the treatment of such person to any other health care provider or other provider evaluating or providing services to or monitoring the treatment of the person. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider providing services to a person who is the subject of proceedings under this chapter shall (i) inform the person that his family member or personal representative, including any agent named in an advance *health care* directive executed in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.), will be notified of information that is directly relevant to such individual's involvement with the person's health care, which may include the person's location and general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, and (ii) make a reasonable effort to so notify the person's family member or personal representative, unless the provider has actual knowledge that the family member or personal representative is currently prohibited by court order from contacting the person. No health care provider shall be required to notify a person's family member or personal representative pursuant to this section if the health care provider has actual knowledge that such notice has been provided.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

§ 37.2-805.1. Admission of incapacitated persons pursuant to advance directives or by guardians.

A. An agent for a person who has been determined to be incapable of making an informed decision may consent to the person's admission to a facility for no more than 10 calendar days if (i) prior to admission, a physician on the staff of or designated by the proposed admitting facility examines the person and states, in writing, that the person (a) has a mental illness, (b) ~~is incapable of making an informed~~ *lacks the capacity, pursuant to § 54.1-2993.5, to make a health care* decision, as defined in § ~~54.1-2982~~ *54.1-2993.3*, regarding admission, and (c) is in need of treatment in a facility; (ii) the proposed admitting facility is willing to admit the person; and (iii) the person has executed an advance *health care* directive in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) authorizing his agent to consent to his admission to a facility and, if the person protests the admission, he has included in his advance directive specific authorization for his agent to make health care decisions even in the event of his protest ~~as provided in § 54.1-2986.2~~. In addition, for admission to a state facility, the person shall first be screened by the community services board that serves the city or county where the person resides or, if impractical, where the person is located.

B. A guardian who has been appointed for an incapacitated person pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 may consent to admission of that person to a facility for no more than 10 calendar days if (i) prior to admission, a physician on the staff of or designated by the proposed admitting facility examines the person and states, in writing, that the person (a) has a mental illness, (b) ~~is incapable of making an informed~~ *lacks the capacity, pursuant to § 54.1-2993.5, to make a health care* decision, as defined in § ~~54.1-2982~~ *54.1-2993.3*, regarding admission, and (c) is in need of treatment in a facility; (ii) the proposed admitting facility is willing to admit the person; and (iii) the guardianship order specifically authorizes the guardian to consent to the admission of such person to a facility, pursuant to § 64.2-2009. In addition, for admission to a state facility, the person shall first be screened by the community services board that serves the city or county where the person resides or, if impractical, where the person is located.

C. A person admitted to a facility pursuant to this section shall be discharged no later than 10 calendar

days after admission unless, within that time, the person's continued admission is authorized under other provisions of law.

§ 37.2-817.1. Monitoring and court review of mandatory outpatient treatment.

A. As used in this section, "material nonadherence" means deviation from a comprehensive mandatory outpatient treatment plan by a person who is subject to an order for mandatory outpatient treatment following a period of involuntary inpatient treatment pursuant to subsection C or D of § 37.2-817.01 or an order for mandatory outpatient treatment pursuant to subsection B of § 37.2-817.01 that it is likely to lead to the person's relapse or deterioration and for which the person cannot provide a reasonable explanation.

B. The community services board where the person resides shall monitor the person's progress and adherence to the comprehensive mandatory outpatient treatment plan prepared in accordance with § 37.2-817.01. Such monitoring shall include (i) contacting or making documented efforts to contact the person regarding the comprehensive mandatory outpatient treatment plan and any support necessary for the person to adhere to the comprehensive mandatory outpatient treatment plan, (ii) contacting the service providers to determine if the person is adhering to the comprehensive mandatory outpatient treatment plan and, in the event of material nonadherence, if the person fails or refuses to cooperate with efforts of the community services board or providers of services identified in the comprehensive mandatory outpatient treatment plan to address the factors leading to the person's material nonadherence, petitioning for a review hearing pursuant to this section. Service providers identified in the comprehensive mandatory outpatient treatment plan shall report any material nonadherence and any material changes in the person's condition to the community services board. Any finding of material nonadherence shall be based upon a totality of the circumstances.

C. The community services board responsible for monitoring the person's progress and adherence to the comprehensive mandatory outpatient treatment plan shall report monthly, in writing, to the court regarding the person's and the community services board's compliance with the provisions of the comprehensive mandatory outpatient treatment plan. If the community services board determines that the deterioration of the condition or behavior of a person who is subject to an order for mandatory outpatient treatment following a period of involuntary inpatient treatment pursuant to subsection C or D of § 37.2-817.01 or a mandatory outpatient treatment order pursuant to subsection B of § 37.2-817.01 is such that there is a substantial likelihood that, as a result of the person's mental illness, the person will, in the near future, (i) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (ii) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, it shall immediately request that the magistrate issue an emergency custody order pursuant to § 37.2-808 or a temporary detention order pursuant to § 37.2-809. Entry of an emergency custody order, temporary detention order, or involuntary inpatient treatment order shall suspend but not rescind an existing order for mandatory outpatient treatment following a period of involuntary inpatient treatment pursuant to subsection C or D of § 37.2-817.01 or a mandatory outpatient treatment order pursuant to subsection B of § 37.2-817.01.

D. The district court judge or special justice shall hold a hearing within five days after receiving the petition for review of the comprehensive mandatory outpatient treatment plan; however, if the fifth day is a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the hearing shall be held by the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The clerk shall provide notice of the hearing to the person, the community services board, all treatment providers listed in the comprehensive mandatory outpatient treatment order or discharge plan, and the original petitioner for the person's involuntary treatment. If the person is not represented by counsel, the court shall appoint an attorney to represent the person in this hearing and any subsequent hearing under this section or § 37.2-817.4, giving consideration to appointing the attorney who represented the person at the proceeding that resulted in the issuance of the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment. The same judge or special justice that presided over the hearing resulting in the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment need not preside at the nonadherence hearing or any subsequent hearings. The community services board shall offer to arrange the person's transportation to the hearing if the person is not detained and has no other source of transportation.

Any of the following may petition the court for a hearing pursuant to this subsection: (i) the person who is subject to the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment; (ii) the community services board responsible for monitoring the person's progress and adherence to the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment; (iii) a treatment provider designated in the comprehensive mandatory outpatient treatment plan; (iv) the person who originally filed the petition that resulted in the entry of the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment; (v) any health care agent designated in the advance directive of the person who is the subject of the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment; or

(vi) if the person who is the subject of the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment has been determined to ~~be incapable of making an informed~~ *lack the capacity to make a health care* decision *pursuant to § 54.1-2993.5*, the person's *agent*, guardian, or ~~other person authorized to make health care decisions for the person~~ *default surrogate* pursuant to § ~~54.1-2986~~ *54.1-2993.13*.

A petition filed pursuant to this subsection may request that the court do any of the following:

1. Enforce a mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment and require the person who is the subject of the order to adhere to the comprehensive mandatory outpatient treatment plan, in the case of material nonadherence;

2. Modify a mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment or a comprehensive mandatory outpatient treatment plan due to a change in circumstances, including changes in the condition, behavior, living arrangement, or access to services of the person who is the subject to the order; or

3. Rescind a mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment.

At any time after 30 days from entry of the mandatory outpatient treatment order pursuant to subsection B of § 37.2-817.01 or from the discharge of the person from involuntary inpatient treatment pursuant to an order under subsection C or D of § 37.2-817.01, the person may petition the court to rescind the order. The person shall not file a petition to rescind the order more than once during a 90-day period.

E. If requested in a petition filed pursuant to subsection D or on the court's own motion, the court may appoint an examiner in accordance with § 37.2-815 who shall personally examine the person on or before the date of the review, as directed by the court, and certify to the court whether or not he has probable cause to believe that the person meets the criteria for mandatory outpatient treatment as specified in subsection B, C, or D of § 37.2-817.01, as may be applicable. The examination shall include all applicable requirements of § 37.2-815. The certification of the examiner may be admitted into evidence without the appearance of the examiner at the hearing if not objected to by the person or his attorney. If the person is not incarcerated or receiving treatment in an inpatient facility, the community services board shall arrange for the person to be examined at a convenient location and time. The community services board shall offer to arrange for the person's transportation to the examination if the person has no other source of transportation and resides within the service area or an adjacent service area of the community services board. If the person refuses or fails to appear, the community services board shall notify the court, or a magistrate if the court is not available, and the court or magistrate shall issue a mandatory examination order and capias directing the primary law-enforcement agency in the jurisdiction where the person resides to transport the person to the examination. The person shall remain in custody until a temporary detention order is issued or until the person is released, but in no event shall the period exceed eight hours.

F. If the person fails to appear for the hearing, the court may, after consideration of any evidence regarding why the person failed to appear at the hearing, (i) dismiss the petition, (ii) issue an emergency custody order pursuant to § 37.2-808, or (iii) reschedule the hearing pursuant to subsection D and issue a subpoena for the person's appearance at the hearing and enter an order for mandatory examination, to be conducted prior to the hearing and in accordance with subsection E.

G. After observing the person and considering (i) the recommendations of any treating or examining physician or psychologist licensed to practice in the Commonwealth, if available, (ii) the person's adherence to the comprehensive mandatory outpatient treatment plan, (iii) any past mental health treatment of the person, (iv) any examiner's certification, (v) any health records available, (vi) any report from the community services board, and (vii) any other relevant evidence that may have been admitted at the hearing, the judge or special justice shall make one of the following dispositions:

1. In a hearing on any petition seeking enforcement of a mandatory outpatient treatment order, upon finding that continuing mandatory outpatient treatment is warranted, the court shall direct the person to fully comply with the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment and may make any modifications to such order or the comprehensive mandatory outpatient treatment plan that are acceptable to the community services board or treatment provider responsible for the person's treatment. In determining the appropriateness of the outpatient treatment specified in such order and the comprehensive mandatory outpatient treatment plan, the court may consider the person's material nonadherence to the existing mandatory treatment order.

2. In a hearing on any petition seeking modification of a mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment, upon a finding that (i) one or more modifications of the order would benefit the person and help prevent relapse or deterioration of the person's condition, (ii) the community services board and the treatment provider responsible for the person's treatment are able to provide services consistent with such modification, and (iii) the person is able to adhere to the modified comprehensive mandatory outpatient treatment plan, the court may order such modification of the mandatory outpatient treatment order or order for mandatory outpatient treatment

following a period of involuntary inpatient treatment or the comprehensive mandatory outpatient treatment plan as the court finds appropriate.

3. In a hearing on any petition filed to enforce, modify, or rescind a mandatory outpatient treatment order, upon finding that mandatory outpatient treatment is no longer appropriate, the court may rescind the order.

H. The judge or special justice may schedule periodic status hearings for the purpose of obtaining information regarding the person's progress while the mandatory outpatient treatment order or order for mandatory outpatient treatment following a period of involuntary inpatient treatment remains in effect. The clerk shall provide notice of the hearing to the person who is the subject of the order and the community services board responsible for monitoring the person's condition and adherence to the plan. The person shall have the right to be represented by counsel at the hearing, and if the person does not have counsel the court shall appoint an attorney to represent the person. However, status hearings may be held without counsel present by mutual consent of the parties. The community services board shall offer to arrange the person's transportation to the hearing if the person is not detained and has no other source of transportation. During a status hearing, the treatment plan may be amended upon mutual agreement of the parties. Contested matters shall not be decided during a status hearing, nor shall any decision regarding enforcement, rescission, or renewal of the order be entered.

§ 37.2-837. (Effective until January 1, 2025) Discharge from state hospitals or training centers, conditional release, and trial or home visits for individuals.

A. Except for an individual receiving services in a state hospital who is held upon an order of a court for a criminal proceeding, the director of a state hospital or training center may discharge, after the preparation of a discharge plan:

1. Any individual in a state hospital who, in his judgment, (a) is recovered, (b) does not have a mental illness, or (c) is impaired or not recovered but whose discharge will not be detrimental to the public welfare or injurious to the individual;

2. Any individual in a state hospital who is not a proper case for treatment within the purview of this chapter; or

3. Any individual in a training center who chooses to be discharged or, if the individual lacks the mental capacity to choose, whose legally authorized representative chooses for him to be discharged. Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no individual at a training center who is enrolled in Medicaid shall be discharged if the individual or his legally authorized representative on his behalf chooses to continue receiving services in a training center.

For all individuals discharged, the discharge plan shall be formulated in accordance with the provisions of § 37.2-505 by the community services board or behavioral health authority that serves the city or county where the individual resided prior to admission or by the board or authority that serves the city or county where the individual or his legally authorized representative on his behalf chooses to reside immediately following the discharge. The discharge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals, training centers, and community services boards or behavioral health authorities, and shall identify (i) the services, including mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will require upon discharge into the community and (ii) the public or private agencies that have agreed to provide these services. If the individual will be housed in an assisted living facility, as defined in § 63.2-100, the discharge plan shall identify the facility, document its appropriateness for housing and capacity to care for the individual, contain evidence of the facility's agreement to admit and care for the individual, and describe how the community services board or behavioral health authority will monitor the individual's care in the facility. Prior to discharging an individual pursuant to subdivision A 1 or 2 who has not executed an advance *health care* directive, the director of a state hospital or his designee shall give to the individual a written explanation of the procedures for executing an advance *health care* directive in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) and an advance *health care* directive form, which may be the form set forth in § ~~54.1-2984~~ *54.1-2993.12*.

B. The director may grant a trial or home visit to an individual receiving services in accordance with regulations adopted by the Board. The state facility granting a trial or home visit to an individual shall not be liable for his expenses during the period of that visit. Such liability shall devolve upon the relative, conservator, person to whose care the individual is entrusted while on the trial or home visit, or the appropriate local department of social services of the county or city in which the individual resided at the time of admission pursuant to regulations adopted by the State Board of Social Services.

C. Any individual who is discharged pursuant to subdivision A 2 shall, if necessary for his welfare, be received and cared for by the appropriate local department of social services. The provision of public assistance or social services to the individual shall be the responsibility of the appropriate local department of social services as determined by regulations adopted by the State Board of Social Services. Expenses incurred for the provision of public assistance to the individual who is receiving 24-hour care while in an assisted living facility licensed pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2

shall be the responsibility of the appropriate local department of social services of the county or city in which the individual resided at the time of admission.

§ 37.2-837. (Effective January 1, 2025) Discharge from state hospitals or training centers, conditional release, and trial or home visits for individuals.

A. Except for an individual receiving services in a state hospital who is held upon an order of a court for a criminal proceeding, the director of a state hospital or training center may discharge, after the preparation of a discharge plan:

1. Any individual in a state hospital who, in his judgment, (i) is recovered, (ii) does not have a mental illness, or (iii) is impaired or not recovered but whose discharge will not be detrimental to the public welfare or injurious to the individual;

2. Any individual in a state hospital who is not a proper case for treatment within the purview of this chapter; or

3. Any individual in a training center who chooses to be discharged or, if the individual lacks the mental capacity to choose, whose legally authorized representative chooses for him to be discharged. Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no individual at a training center who is enrolled in Medicaid shall be discharged if the individual or his legally authorized representative on his behalf chooses to continue receiving services in a training center.

Central State Hospital, Southern Virginia Mental Health Institute, and Southwestern Virginia Mental Health Institute shall, in consultation with the appropriate community services board or behavioral health authority, provide discharge planning for any individual to be discharged from the state hospital in 30 days or less after admission. For all individuals discharged from any other state facility in 30 days or less after admission, or from a state hospital more than 30 days after admission, or from a state training center, the discharge plan shall be formulated in accordance with the provisions of § 37.2-505 by the community services board or behavioral health authority that serves the city or county where the individual resided prior to admission or by the board or authority that serves the city or county where the individual or his legally authorized representative on his behalf chooses to reside immediately following the discharge. The discharge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals, training centers, and community services boards or behavioral health authorities and shall identify (i) the services, including mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will require upon discharge into the community, and (ii) the public or private agencies that have agreed to provide these services. If the individual will be housed in an assisted living facility, as defined in § 63.2-100, the discharge plan shall identify the facility, document its appropriateness for housing and capacity to care for the individual, contain evidence of the facility's agreement to admit and care for the individual, and describe how the community services board or behavioral health authority will monitor the individual's care in the facility. Prior to discharging an individual pursuant to subdivision A 1 or 2 who has not executed an advance *health care* directive, the director of a state hospital or his designee shall give to the individual a written explanation of the procedures for executing an advance *health care* directive in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) and an advance *health care* directive form, which may be the form set forth in § ~~54.1-2984~~ *54.1-2993.12*.

B. The director may grant a trial or home visit to an individual receiving services in accordance with regulations adopted by the Board. The state facility granting a trial or home visit to an individual shall not be liable for his expenses during the period of that visit. Such liability shall devolve upon the relative, conservator, person to whose care the individual is entrusted while on the trial or home visit, or the appropriate local department of social services of the county or city in which the individual resided at the time of admission pursuant to regulations adopted by the State Board of Social Services.

C. Any individual who is discharged pursuant to subdivision A 2 shall, if necessary for his welfare, be received and cared for by the appropriate local department of social services. The provision of public assistance or social services to the individual shall be the responsibility of the appropriate local department of social services as determined by regulations adopted by the State Board of Social Services. Expenses incurred for the provision of public assistance to the individual who is receiving 24-hour care while in an assisted living facility licensed pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2 shall be the responsibility of the appropriate local department of social services of the county or city in which the individual resided at the time of admission.

§ 37.2-838. Discharge of individuals from a licensed hospital.

The person in charge of a licensed hospital may discharge any individual involuntarily admitted who is recovered or, if not recovered, whose discharge will not be detrimental to the public welfare or injurious to the individual, or who meets other criteria as specified in § 37.2-837. Prior to discharging any individual who has not executed an advance *health care* directive, the person in charge of a licensed hospital or his designee shall give to the individual a written explanation of the procedures for executing an advance *health care* directive in accordance with the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) and an

advance *health care* directive form, which may be the form set forth in § ~~54.1-2984~~ *54.1-2993.12*. The person in charge of the licensed hospital may refuse to discharge any individual involuntarily admitted, if, in his judgment, the discharge will be detrimental to the public welfare or injurious to the individual. The person in charge of a licensed hospital may grant a trial or home visit to an individual in accordance with regulations adopted by the Board.

§ 37.2-1101. Judicial authorization of treatment.

A. An appropriate circuit court or district court judge or special justice may authorize treatment for a mental or physical disorder on behalf of an adult person, in accordance with this section, if it finds upon clear and convincing evidence that (i) the person is either incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder and (ii) the proposed treatment is in the best interest of the person.

B. Any person may request authorization of treatment for an adult person by filing a petition in the circuit court or district court or with a special justice of the county or city in which the person for whom treatment is sought resides or is located or in the county or city in which the proposed place of treatment is located. Upon filing the petition, the petitioner or the court shall deliver or send a certified copy of the petition to the person for whom treatment is sought and, if the identity and whereabouts of the person's next of kin are known, to the next of kin.

C. As soon as reasonably possible after the filing of the petition, the court shall appoint an attorney to represent the interests of the person for whom treatment is sought at the hearing. However, the appointment shall not be required in the event that the person or another interested person on behalf of the person elects to retain private counsel at his own expense to represent the interests of the person at the hearing. If the person for whom treatment is sought is indigent, his counsel shall be paid by the Commonwealth as provided in § 37.2-804 from funds appropriated to reimburse expenses incurred in the involuntary admission process. However, this provision shall not be construed to prohibit the direct payment of an attorney's fee by the person or an interested person on his behalf, which fee shall be subject to the review and approval of the court.

D. Following the appointment of an attorney pursuant to subsection C, the court shall schedule an expedited hearing of the matter. The court shall notify the person for whom treatment is sought, his next of kin, if known, the petitioner, and their respective counsel of the date and time for the hearing. In scheduling the hearing, the court shall take into account the type and severity of the alleged physical or mental disorder, as well as the need to provide the person's attorney with sufficient time to adequately prepare his client's case.

E. Notwithstanding the provisions of subsections B and D regarding delivery or service of the petition and notice of the hearing to the next of kin of any person for whom consent to treatment is sought, if the person is a patient in any hospital, including a hospital licensed by the Department of Health pursuant to § 32.1-123 or an individual receiving services in any facility operated by the Department of Behavioral Health and Developmental Services and such person has no known guardian or legally authorized representative, at the time the petition is filed, the court may dispense with the requirement of any notice to the next of kin. If treatment is necessary to prevent imminent or irreversible harm, the court in its discretion may dispense with the requirement of providing notice. This subsection shall not be construed to interfere with any decision made pursuant to the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.).

F. Prior to the hearing, the attorney shall investigate the risks and benefits of the treatment decision for which authorization is sought and of alternatives to the proposed decision. The attorney shall make a reasonable effort to inform the person of this information and to ascertain the person's religious beliefs and basic values and the views and preferences of the person's next of kin. A health care provider shall disclose or make available to the attorney, upon request, any information, records, and reports concerning the person that the attorney determines necessary to perform his duties under this section. Evidence presented at the hearing may be submitted by affidavit in the absence of objection by the person for whom treatment is sought, the petitioner, either of their respective counsel, or by any other interested party.

G. Prior to authorizing treatment pursuant to this section, the court shall find:

1. That there is no available person with legal authority under ~~Article~~ 8 ~~(§~~ 54.1-2981 ~~et seq.)~~ ~~of~~ ~~Chapter~~ 29 ~~of~~ ~~Title~~ 54.1 *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.),* under the regulations promulgated pursuant to § 37.2-400, or under other applicable law to authorize the proposed treatment. A person who would have legal authority to authorize the proposed treatment shall be deemed to be unavailable if such person (i) cannot be contacted within a reasonable period of time in light of the immediacy of the need for treatment for the person for whom treatment is sought, (ii) is incapable of making an informed decision, or (iii) is unable or unwilling to make a decision regarding authorization of the proposed treatment or to serve as the legally authorized representative of the person for whom treatment is sought;

2. That the person for whom treatment is sought is incapable of making an informed decision regarding treatment or is physically or mentally incapable of communicating such a decision;

3. That the person who is the subject of the petition is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision; and

4. That the proposed treatment is in the best interest of the person and is medically and ethically

appropriate with respect to (i) the medical diagnosis and prognosis and (ii) any other information provided by the attending physician of the person for whom treatment is sought. However, the court shall not authorize a proposed treatment that is contrary to the provisions of an advance *health care* directive executed by the person pursuant to ~~§ 54.1-2983~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* or is proven by a preponderance of the evidence to be contrary to the person's religious beliefs or basic values or to specific preferences stated by the person before becoming incapable of making an informed decision, unless the treatment is necessary to prevent death or a serious irreversible condition. The court shall take into consideration the right of the person to rely on nonmedical, remedial treatment in the practice of religion in lieu of medical treatment.

H. Any order authorizing treatment pursuant to subsection A shall describe any treatment authorized and may authorize generally such related examinations, tests, or services as the court may determine to be reasonably related to the treatment authorized. Treatment authorized by such order may include palliative care as defined in § 32.1-162.1, if appropriate. The order shall require the treating physician to review and document the appropriateness of the continued administration of antipsychotic medications not less frequently than every 30 days. The order shall require the treating physician or other service provider to report to the court and the person's attorney any change in the person's condition resulting in probable restoration or development of the person's capacity to make and to communicate an informed decision prior to completion of any authorized treatment and related services. The order may further require the treating physician or other service provider to report to the court and the person's attorney any change in circumstances regarding any authorized treatment or related services that may indicate that such authorization is no longer in the person's best interests. Upon receipt of such report or upon the petition of any interested party, the court may enter an order withdrawing or modifying its prior authorization as it deems appropriate. Any petition or order under this section may be orally presented or entered, provided a written order shall be subsequently executed.

I. Nothing in this section shall be construed to limit the authority of a treating physician or other service provider to administer treatment without judicial authorization when necessary to stabilize the condition of the person for whom treatment is sought in an emergency.

§ 37.2-1108. Effect of chapter on other laws.

A. Nothing in this chapter shall be deemed to affect the right to use and the authority conferred by any other applicable statutory or regulatory procedure relating to consent or to diminish any common law authority of a physician or other treatment provider to administer treatment to a person unable to give or to communicate informed consent to those actions, with or without the consent of the person's relative, including common law or other authority to provide treatment in an emergency situation; nor shall anything in this chapter be construed to affect the law defining the conditions under which consent shall be obtained for administering treatment or the nature of the consent required.

B. Judicial authorization for treatment pursuant to this chapter need not be obtained for a person for whom consent or authorization has been granted or issued or may be obtained in accordance with the provisions of ~~Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of Title 54.1~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* or other applicable statutes or common law of the Commonwealth.

§ 53.1-133.04. Medical and mental health treatment of prisoners incapable of giving consent.

A. The sheriff or administrator in charge of a local or regional correctional facility or his designee may petition the circuit court or any district court judge or any special justice, as defined in § 37.2-100, herein referred to as the court, of the county or city in which the prisoner is located for an order authorizing treatment of a prisoner confined in the local or regional correctional facility. Upon filing the petition, the petitioner or the court shall serve a certified copy of the petition to the person for whom treatment is sought and, if the identity and whereabouts of the person's next of kin are known, to the person's next of kin. The court shall authorize such treatment in a facility designated by the sheriff or administrator upon finding, on the basis of clear and convincing evidence, that the prisoner is incapable, either mentally or physically, of giving informed consent to such treatment; that the prisoner does not have a relevant advanced directive, guardian, or other substitute decision maker; that the proposed treatment is in the best interests of the prisoner; and that the jail has sufficient medical and nursing resources available to safely administer the treatment and respond to any adverse side effects that might arise from the treatment. The facility designated for treatment by the sheriff or administrator may be located within a local or regional correctional facility if such facility is licensed to provide the treatment authorized by the court order.

B. Prior to the court's authorization of such treatment, the court shall appoint an attorney to represent the interests of the prisoner. Evidence shall be presented concerning the prisoner's condition and proposed treatment, which evidence may, in the court's discretion and in the absence of objection by the prisoner or the prisoner's attorney, be submitted by affidavit.

C. Any order authorizing treatment pursuant to subsection A shall describe the treatment authorized and authorize generally such examinations, tests, medications, and other treatments as are in the best interests of the prisoner but may not authorize nontherapeutic sterilization, abortion, or psychosurgery. Such order shall

require the licensed physician, psychiatrist, clinical psychologist, professional counselor, or clinical social worker acting within his area of expertise who is treating the prisoner to report to the court and the prisoner's attorney any change in the prisoner's condition resulting in restoration of the prisoner's capability to consent prior to completion of the authorized treatment and related services. Upon receipt of such report, the court may enter such order withdrawing or modifying its prior authorization as it deems appropriate. Any petition or order under this section may be orally presented or entered, provided that a written order is subsequently executed.

D. Prior to authorizing treatment pursuant to this section, the court shall find that there is no available person with legal authority under the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) or under other applicable law to authorize the proposed treatment.

E. Any order of a judge under subsection A may be appealed de novo within 10 days to the circuit court for the jurisdiction where the prisoner is located, and any order of a circuit court hereunder, either originally or on appeal, may be appealed within 10 days to the Court of Appeals, which shall give such appeal priority and hear the appeal as soon as possible.

F. Whenever the director of any hospital or facility reasonably believes that treatment is necessary to protect the life, health, or safety of a prisoner, such treatment may be given during the period allowed for any appeal unless prohibited by order of a court of record wherein the appeal is pending.

G. Upon the advice of a licensed physician, psychiatrist, or clinical psychologist acting within his area of expertise who has attempted to obtain consent and upon a finding of probable cause to believe that a prisoner is incapable, due to any physical or mental condition, of giving informed consent to treatment and that the medical standard of care calls for testing, observation, or other treatment within the next 12 hours to prevent death, disability, or a serious irreversible condition, the court or, if the court is unavailable, a magistrate shall issue an order authorizing temporary admission of the prisoner to a hospital or other health care facility and authorizing such testing, observation, or other treatment. Such order shall expire after a period of 12 hours unless extended by the court as part of an order authorizing treatment under subsection A.

H. Any licensed health or mental health professional or licensed facility providing services pursuant to the court's or magistrate's authorization as provided in this section shall have no liability arising out of a claim to the extent that it is based on lack of consent to such services, except with respect to injury or death resulting from gross negligence or willful and wanton misconduct. Any such professional or facility providing services with the consent of the prisoner receiving treatment shall have no liability arising out of a claim to the extent that it is based on lack of capacity to consent, except with respect to injury or death resulting from gross negligence or willful and wanton misconduct, if a court or a magistrate has denied a petition hereunder to authorize such services and such denial was based on an affirmative finding that the prisoner was capable of making an informed decision regarding the proposed services.

I. Nothing in this section shall be deemed to limit or repeal any common law rule relating to consent for medical treatment or the right to apply or the authority conferred by any other applicable statute or regulation relating to consent.

§ 54.1-2807.02. Absence of next of kin.

In the absence of a next of kin, a person designated to make arrangements for the decedent's burial or the disposition of his remains pursuant to § 54.1-2825, an agent named in an advance *health care* directive pursuant to ~~§ 54. 1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2),* or any guardian appointed pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 who may exercise the powers conferred in the order of appointment or by § 64.2-2019, or upon the failure or refusal of such next of kin, designated person, agent, or guardian to accept responsibility for the disposition of the decedent, then any other person 18 years of age or older who is able to provide positive identification of the deceased and is willing to pay for the costs associated with the disposition of the decedent's remains shall be authorized to make arrangements for such disposition of the decedent's remains. If a funeral service establishment or funeral service licensee makes arrangements with a person other than a next of kin, designated person, agent, or guardian in accordance with this section, then the funeral service licensee or funeral service establishment shall be immune from civil liability unless such act, decision, or omission resulted from bad faith or malicious intent.

§ 54.1-2818.1. Prerequisites for cremation.

No dead human body shall be cremated without permission of the Office of the Chief Medical Examiner as required by § 32.1-309.3 and visual identification of the deceased by the next-of-kin or his representative, who may be any person designated to make arrangements for the disposition of the decedent's remains pursuant to § 54.1-2825, an agent named in an advance *health care* directive pursuant to § ~~54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2),* or any guardian appointed pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 who may exercise the powers conferred in the order of appointment or by § 64.2-2019, or, in cases in which the next of kin or his representative fails or refuses to provide visual identification of the deceased, by any other person 18 years of age or older who is able to provide positive identification of the deceased. If no such next of kin or his representative or other person 18 years of age or older is available or willing to make visual identification of the deceased, such identification shall be made by

a member of the primary law-enforcement agency of the city or county in which the person or institution having initial custody of the body is located, pursuant to court order. When visual identification is not feasible, other positive identification of the deceased may be used as a prerequisite for cremation. Unless such act, decision, or omission resulted from bad faith or malicious intent, the funeral service establishment, funeral service licensee, crematory, cemetery, primary law-enforcement officer, sheriff, county, or city shall be immune from civil liability for any act, decision, or omission resulting from cremation. Nothing in this section shall prevent a law-enforcement agency other than the primary law-enforcement agency from performing the duties established by this section if so requested by the primary law-enforcement agency and agreed to by the other law-enforcement agency.

§ 54.1-2818.5. Request for life insurance information; notification of beneficiaries.

A. In any case in which a funeral service provider licensed pursuant to this chapter believes that a decedent for whom funeral services are being provided is insured under an individual or group life insurance policy, the funeral service provider may request information regarding the deceased person's life insurance policy from the life insurer believed to have issued the policy. Such request for information shall include (i) a copy of the deceased person's death certificate filed in accordance with § 32.1-263; (ii) written authorization for the funeral service provider's submission of the request that is executed by a person designated to make arrangements for the decedent's burial or disposition of his remains pursuant to § 54.1-2825, an agent named in an advance directive pursuant to ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)*, a guardian appointed pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 who may exercise the powers conferred in the order of appointment or by § 64.2-2019, or the next of kin as defined in § 54.1-2800; and (iii) if the deceased person was covered or is believed to have been covered under a group life insurance policy, the affiliation of the deceased person entitling the deceased to coverage under the group life insurance policy.

B. Upon receipt of the information requested pursuant to subsection A, if the beneficiary of record under the life insurance contract or group life insurance policy is not the estate of the deceased person, the requesting funeral service provider shall make all reasonable efforts to contact all the beneficiaries of record within four calendar days of receiving such information and provide to the beneficiaries all information provided to the funeral service provider by the life insurer. The funeral service provider shall, prior to providing any information to the beneficiaries in accordance with this subsection, inform the beneficiaries that the beneficiary of a life insurance policy has no legal duty or obligation to pay any amounts associated with the provision of funeral services or the debts or obligations of the deceased person.

§ 54.1-2970.1. Individual lacking capacity to make health care decision; procedure for physical evidence recovery kit examination; consent by minors.

A. A licensed physician, a physician assistant, an advanced practice registered nurse, or a registered nurse may perform a physical evidence recovery kit examination for a person who is believed to be the victim of a sexual assault and who ~~is incapable of making an informed~~ *lacks the capacity to make a health care* decision regarding consent to such examination when:

1. There is a need to conduct the examination before the victim is likely to be able to make ~~an informed~~ *a health care* decision in order to preserve physical evidence of the alleged sexual assault from degradation;

2. No legally authorized representative or other person authorized to consent to medical treatment on the individual's behalf is reasonably available to provide consent within the time necessary to preserve physical evidence of the alleged sexual assault; and

3. ~~A capacity reviewer, as defined in § 54.1-2982,~~ *A person authorized to find that an individual lacks capacity pursuant to § 54.1-2993.5* provides written certification that, based upon a personal examination of the individual, the individual ~~is incapable of making an informed~~ *lacks the capacity to make a health care* decision regarding the physical evidence recovery kit examination and that, given the totality of the circumstances, the examination should be performed. The ~~capacity reviewer~~ *person* who provides such written certification shall not be otherwise currently involved in the treatment of the person assessed, unless an independent ~~capacity reviewer~~ *person authorized to find that an individual lacks capacity pursuant to § 54.1-2993.5* is not reasonably available.

A1. For purposes of this section, if a parent or guardian of a minor refuses to consent to a physical evidence recovery kit examination of the minor, the minor may consent.

B. Any physical evidence recovery kit examination performed pursuant to this section shall be performed in accordance with the requirements of §§ 19.2-11.2 and 19.2-165.1 and shall protect the alleged victim's identity.

C. A licensed physician, a physician assistant, an advanced practice registered nurse, or a registered nurse who exercises due care under the provisions of this act shall not be liable for any act or omission related to performance of an examination in accordance with this section.

§ 54.1-2987.1. Durable Do Not Resuscitate Orders.

A. As used in this section:

"Durable Do Not Resuscitate Order" means a written physician's order issued pursuant to this section to

withhold cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest. For purposes of this article, cardiopulmonary resuscitation shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, and defibrillation and related procedures. A Durable Do Not Resuscitate Order is not and shall not be construed as an advance health care directive as that term is used in the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.).

"Health care provider" includes, but is not limited to, qualified emergency medical services personnel.

"Person authorized to consent on the patient's behalf" means any person authorized by law to consent on behalf of the patient incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law.

B. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

C. A Durable Do Not Resuscitate Order or other order regarding life-prolonging procedures executed in accordance with the laws of another state in which such order was executed shall be deemed to be valid for purposes of this article and shall be given effect as provided in this article.

D. If a patient is able to, and does, express to a health care provider or practitioner the desire to be resuscitated in the event of cardiac or respiratory arrest, such expression shall revoke the provider's or practitioner's authority to follow a Durable Do Not Resuscitate Order. In no case shall any person other than the patient have authority to revoke a Durable Do Not Resuscitate Order executed upon the request of and with the consent of the patient himself.

If the patient is a minor or is otherwise incapable of making an informed decision and the Durable Do Not Resuscitate Order was issued upon the request of and with the consent of the person authorized to consent on the patient's behalf, then the expression by said authorized person to a health care provider or practitioner of the desire that the patient be resuscitated shall so revoke the provider's or practitioner's authority to follow a Durable Do Not Resuscitate Order.

When a Durable Do Not Resuscitate Order has been revoked as provided in this section, a new Order may be issued upon consent of the patient or the person authorized to consent on the patient's behalf.

E. Durable Do Not Resuscitate Orders issued in accordance with this section or deemed valid in accordance with subsection C shall remain valid and in effect until revoked as provided in subsection D or until rescinded, in accordance with accepted medical practice, by the provider who issued the Durable Do Not Resuscitate Order. In accordance with this section and regulations promulgated by the Board of Health, (i) qualified emergency medical services personnel as defined in § 32.1-111.1; (ii) licensed health care practitioners in any facility, program or organization operated or licensed by the Board of Health, the Department of Social Services, or the Department of Behavioral Health and Developmental Services or operated, licensed or owned by another state agency; and (iii) licensed health care practitioners at any continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 are authorized to follow Durable Do Not Resuscitate Orders that are available to them in a form approved by the Board of Health or deemed valid in accordance with subsection C.

F. The provisions of this section shall not authorize any qualified emergency medical services personnel or licensed health care provider or practitioner who is attending the patient at the time of cardiac or respiratory arrest to provide, continue, withhold or withdraw health care if such provider or practitioner knows that taking such action is protested by the patient incapable of making an informed decision. No person shall authorize providing, continuing, withholding or withdrawing health care pursuant to this section that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of a patient incapable of making an informed decision or the wishes of such patient fairly expressed when the patient was capable of making an informed decision. Further, this section shall not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care or to alleviate pain.

G. This section shall not prevent, prohibit or limit a physician from issuing a written order, other than a Durable Do Not Resuscitate Order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practice.

H. Valid Do Not Resuscitate Orders or Emergency Medical Services Do Not Resuscitate Orders issued before July 1, 1999, pursuant to the then-current law, shall remain valid and shall be given effect as provided in this article.

§ 54.1-2988.1. Assistance with completing and executing advance health care directives.

A. The distribution of written advance *health care* directives in a form meeting the requirements of ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* and the provision of technical advice, consultation, and assistance to persons with regard to the completion and execution of such forms by

(i) health care providers, including their authorized agents or employees, or (ii) qualified advance directive facilitators shall not constitute the unauthorized practice of law pursuant to Chapter 39 (§ 54.1-3900 et seq.).

B. The provision of ministerial assistance to a person with regard to the completion or execution of a written advance directive in a form meeting the requirements of ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* shall not constitute the unauthorized practice of law pursuant to Chapter 39 (§ 54.1-3900 et seq.). For the purpose of this subsection, "ministerial assistance" includes reading the form of an advance *health care* directive meeting the requirements of ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* to a person, discussing the person's preferences with regard to items included in the form, recording the person's answers on the form, and helping the person sign the form and obtain any other necessary signatures on the form. "Ministerial assistance" does not include the expressing of an opinion regarding the legal effects of any item contained in the form of an advance directive meeting the requirements of ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* or the offering of legal advice to a person completing or executing such form.

§ 54.1-2993.1. Qualified advance directive facilitators; requirements for training programs.

The Department of Health shall approve a program for the training of qualified advance directive facilitators that includes (i) instruction on the meaning of provisions of a form meeting the requirements of ~~§ 54.1-2984~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.),* including designating a health care agent and giving instructions relating to one or more specific types of health care, and (ii) requirements for demonstrating competence in assisting persons with completing and executing advance directives, including a written examination on information provided during the training program.

In determining whether a training program meets the criteria set forth in this section, the Department of Health may consult with the Department for Aging and Rehabilitative Services, the Department of Behavioral Health and Developmental Services, and the Virginia State Bar.

Article 8.1.

Uniform Health Care Decisions Act.

§ 54.1-2993.2. Short title.

The provisions of this article shall be known and may be cited as the Uniform Health Care Decisions Act.

§ 54.1-2993.3. Definitions.

As used in this article:

"Advance health care directive" means a power of attorney for health care, health care instruction, or both. The term includes an advance mental health care directive.

"Advance mental health care directive" means a power of attorney for health care, health care instruction, or both, created under § 54.1-2993.10.

"Agent" means an individual appointed under a power of attorney for health care to make a health care decision for the individual who made the appointment. The term includes a co-agent or alternate agent appointed under § 54.1-2993.21.

"Capacity" means having capacity pursuant to § 54.1-2993.4.

"Cohabitant" means each of two individuals who have been living together as a couple for at least one year after each became an adult or was emancipated and who are not married to each other.

"Default surrogate" means an individual authorized under § 54.1-2993.13 to make a health care decision for another individual.

"Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

"Family member" means a spouse, adult child, parent, or grandparent or an adult descendant of a spouse, child, parent, or grandparent.

"Guardian" means a person appointed under other law by a court to make decisions regarding the personal affairs of an individual, which may include health care decisions. The term does not include a guardian ad litem.

"Health care" means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual's physical or mental illness, injury, or condition. The term includes mental health care.

"Health care decision" means a decision made by an individual or the individual's surrogate regarding the individual's health care, including:

1. Selection or discharge of a health care professional or health care institution;

2. Approval or disapproval of a diagnostic test, surgical procedure, medication, therapeutic intervention, or other health care; and

3. Direction to provide, withhold, or withdraw artificial nutrition or hydration, mechanical ventilation, or other health care.

"Health care institution" means a facility or agency licensed, certified, or otherwise authorized or permitted by other law to provide health care in the Commonwealth in the ordinary course of business.

"Health care instruction" means a direction, whether or not in a record, made by an individual that

indicates the individual's goals, preferences, or wishes concerning the provision, withholding, or withdrawal of health care. "Health care instruction" includes a direction intended to be effective if a specified condition arises.

"Health care professional" means a physician or other individual licensed, certified, or otherwise authorized or permitted by other law of the Commonwealth to provide health care in the Commonwealth in the ordinary course of business or the practice of the physician's or individual's profession.

"Individual" means an adult or emancipated minor.

"Mental health care" means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual's mental illness or other psychiatric, psychological, or psychosocial condition.

"Nursing home" means a nursing facility as defined in § 1919(a)(1) of the Social Security Act, 42 U.S.C. § 1396r(a)(1), as amended, or skilled nursing facility as defined in § 1819(a)(1) of the Social Security Act, 42 U.S.C. § 1395i–3(a)(1), as amended.

"Person interested in the welfare of the individual" means:

1. The individual's surrogate;

2. A family member of the individual;

3. The cohabitant of the individual;

4. A public entity providing health care case management or protective services to the individual;

5. A person appointed under other law to make decisions for the individual under a power of attorney for finances; or

6. A person that has an ongoing personal or professional relationship with the individual, including a person that has provided educational or health care services or supported decision making to the individual.

"Physician" means an individual authorized to practice medicine pursuant to Article 3 (§ 54.1-2929 et seq.).

"Power of attorney for health care" means a record in which an individual appoints an agent to make health care decisions for the individual.

"Reasonably available" means being able to be contacted without undue effort and being willing and able to act in a timely manner considering the urgency of an individual's health care situation. When used to refer to an agent or default surrogate, the term includes being willing and able to comply with the duties under § 54.1-2993.18 in a timely manner considering the urgency of an individual's health care situation.

"Record" means information:

1. Inscribed on a tangible medium; or

2. Stored in an electronic or other medium and retrievable in perceivable form.

"Responsible health care professional" means:

1. A health care professional designated by an individual or the individual's surrogate to have primary responsibility for the individual's health care or for overseeing a course of treatment; or

2. In the absence of a designation under subdivision 1 or, if the professional designated under subdivision 1 is not reasonably available, a health care professional who has primary responsibility for overseeing the individual's health care or for overseeing a course of treatment.

"Sign" means, with present intent to authenticate or adopt a record, to:

1. Execute or adopt a tangible symbol; or

2. Attach to or logically associate with the record an electronic symbol, sound, or process.

"State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any other territory or possession subject to the jurisdiction of the United States. The term includes a federally recognized Indian tribe.

"Supported decision making" means assistance, from one or more persons of an individual's choosing, that helps the individual make or communicate a decision, including by helping the individual understand the nature and consequences of the decision.

"Surrogate" means:

1. An agent;

2. A default surrogate; or

3. A guardian authorized to make health care decisions.

§ 54.1-2993.4. Capacity.

A. An individual has capacity for the purpose of this article if the individual:

1. Is willing and able to communicate a decision independently or with appropriate services, technological assistance, supported decision making, or other reasonable accommodation; and

2. In making or revoking:

a. A health care decision, understands the nature and consequences of the decision, including the primary risks and benefits of the decision;

b. A health care instruction, understands the nature and consequences of the instruction, including the primary risks and benefits of the choices expressed in the instruction; and

c. An appointment of an agent under a health care power of attorney or identification of a default

surrogate under subdivision B 1 of § 54.1-2993.13, recognizes the identity of the individual being appointed or identified and understands the general nature of the relationship of the individual making the appointment or identification with the individual being appointed or identified.

B. The right of an individual who has capacity to make a decision about the individual's health care is not affected by whether the individual creates or revokes an advance health care directive.

§ 54.1-2993.5. Presumption of capacity; overcoming presumption.

A. An individual is presumed to have capacity to make or revoke a health care decision, health care instruction, and power of attorney for health care unless:

1. A court has found the individual lacks capacity to do so; or

2. The presumption is rebutted under subsection B.

B. Subject to §§ 54.1-2993.6 and 54.1-2993.7, a presumption under subsection A may be rebutted by a finding that the individual lacks capacity:

1. Subject to subsection C, made on the basis of a contemporaneous examination by any of the following:

a. A physician;

b. A psychologist licensed or otherwise authorized to practice in the Commonwealth; or

c. An individual with training and expertise in the finding of lack of capacity who is licensed or otherwise authorized to practice in the Commonwealth as:

(1) A physician assistant;

(2) An advanced practice registered nurse; or

(3) A licensed clinical social worker; or

d. A responsible health care professional not described in subdivision a, b, or c if:

(1) The individual about whom the finding is to be made is experiencing a health condition requiring a decision regarding health care treatment to be made promptly to avoid loss of life or serious harm to the health of the individual; and

(2) An individual listed in subdivision a, b, or c is not reasonably available;

2. Made in accordance with accepted standards of the profession and the scope of practice of the individual making the finding and to a reasonable degree of certainty; and

3. Documented in a record signed by the individual making the finding that includes an opinion of the cause, nature, extent, and probable duration of the lack of capacity.

C. The finding under subsection B may not be made by:

1. A family member of the individual presumed to have capacity;

2. The cohabitant of the individual or a descendant of the cohabitant; or

3. The individual's surrogate, a family member of the surrogate, or a descendant of the surrogate.

D. If the finding under subsection B was based on a condition the individual no longer has or a responsible health care professional subsequently has good cause to believe the individual has capacity, the individual is presumed to have capacity unless a court finds the individual lacks capacity or the presumption is rebutted under subsection B.

§ 54.1-2993.6. Notice of finding of lack of capacity; right to object.

A. As soon as reasonably feasible, an individual who makes a finding under subsection B of § 54.1-2993.5 shall inform the individual about whom the finding was made or the individual's responsible health care professional of the finding.

B. As soon as reasonably feasible, a responsible health care professional who is informed of a finding under subsection B of § 54.1-2993.5 shall inform the individual about whom the finding was made and the individual's surrogate.

C. An individual found under subsection B of § 54.1-2993.5 to lack capacity may object to the finding:

1. By orally informing a responsible health care professional;

2. By a record provided to a responsible health care professional or the health care institution in which the individual resides or is receiving care; or

3. By another act that clearly indicates the individual's objection.

D. If the individual objects under subsection C, the finding under subsection B of § 54.1-2993.5 is not sufficient to rebut a presumption of capacity in subsection A of § 54.1-2993.5 and the individual shall be treated as having capacity unless:

1. The individual withdraws the objection;

2. A court finds the individual lacks the presumed capacity;

3. The individual is experiencing a health condition requiring a decision regarding health care treatment to be made promptly to avoid imminent loss of life or serious harm to the health of the individual; or

4. Subject to subsection E, the finding is confirmed by a second finding made by an individual authorized under subdivision B 1 of § 54.1-2993.5 who:

a. Did not make the first finding;

b. Is not a family member of the individual who made the first finding; and

c. Is not the cohabitant of the individual who made the first finding or a descendant of the cohabitant.

E. A second finding that the individual lacks capacity under subdivision D 4 is not sufficient to rebut the

presumption of capacity if the individual is requesting the provision or continuation of life-sustaining treatment and the finding is being used to make a decision to withhold or withdraw the treatment.

F. As soon as reasonably feasible, a health care professional who is informed of an objection under subsection C shall:

1. Communicate the objection to a responsible health care professional; and

2. Document the objection and the date of the objection in the individual's medical record or communicate the objection and the date of the objection to an administrator with responsibility for medical records of the health care institution providing health care to the individual, who shall document the objection and the date of the objection in the individual's medical record.

§ 54.1-2993.7. Judicial review for finding of lack of capacity.

A. An individual found under subsection B of § 54.1-2993.5 to lack capacity, a responsible health care professional, the health care institution providing health care to the individual, or a person interested in the welfare of the individual may petition the circuit court in the locality in which the individual resides or is located to determine whether the individual lacks capacity.

B. The court in which a petition under subsection A is filed shall appoint a guardian ad litem. The court shall hear the petition as soon as possible, but not later than seven days after the petition is filed. As soon as possible, but not later than seven days after the hearing, the court shall determine whether the individual lacks capacity. The court may determine the individual lacks capacity only if the court finds by clear and convincing evidence that the individual lacks capacity.

§ 54.1-2993.8. Health care instruction.

A. An individual may create a health care instruction that expresses the individual's preferences for future health care, including preferences regarding:

1. Health care professionals or health care institutions;

2. How a health care decision will be made and communicated;

3. Persons that should or should not be consulted regarding a health care decision;

4. A person to serve as guardian for the individual if one is appointed; and

5. An individual to serve as a default surrogate.

B. A health care professional to whom an individual communicates or provides an instruction under subsection A shall document the instruction and the date of the instruction in the individual's medical record or communicate the instruction and date of the instruction to an administrator with responsibility for medical records of the health care institution providing health care to the individual, who shall document the instruction and the date of the instruction in the individual's medical record.

C. A health care instruction made by an individual that conflicts with an earlier health care instruction made by the individual, including an instruction documented in a medical order, revokes the earlier instruction to the extent of the conflict.

D. A health care instruction may be in the same record as a power of attorney for health care.

§ 54.1-2993.9. Power of attorney for health care.

A. An individual may create a power of attorney for health care to appoint an agent to make health care decisions for the individual.

B. An individual is disqualified from acting as agent for an individual who lacks capacity to make health care decisions if:

1. A court finds that the potential agent poses a danger to the individual's well-being, even if the court does not issue a protective order against the potential agent; or

2. The potential agent is an owner, operator, employee, or contractor of a nursing home or other residential care facility in which the individual resides or is receiving care, unless the owner, operator, employee, or contractor is a family member of the individual, the cohabitant of the individual, or a descendant of the cohabitant.

C. A health care decision made by an agent is effective without judicial approval.

D. A power of attorney for health care shall be in a record, signed by the individual creating the power, and signed by an adult witness who:

1. Reasonably believes the act of the individual to create the power of attorney is voluntary and knowing;

2. Is not:

a. The agent appointed by the individual;

b. The agent's spouse or cohabitant;

c. If the individual resides or is receiving care in a nursing home or other residential care facility, the owner, operator, employee, or contractor of the nursing home or other residential care facility; and

3. Is present when the individual signs the power of attorney or when the individual represents that the power of attorney reflects the individual's wishes.

E. A witness under subsection D is considered present if the witness and the individual are:

1. Physically present in the same location;

2. Using electronic means that allow for real-time audio and visual transmission and communication in

real time to the same extent as if the witness and the individual were physically present in the same location; or

3. Able to speak to and hear each other in real time through audio connection if:

a. The identity of the individual is personally known to the witness; or

b. The witness is able to authenticate the identity of the individual by receiving accurate answers from the individual that enable the authentication.

F. A power of attorney for health care may include a health care instruction.

§ 54.1-2993.10. Advance mental health care directive.

A. An individual may create an advance health care directive that addresses only mental health care for the individual. The directive may include a health care instruction, a power of attorney for health care, or both.

B. A health care instruction under this section may include the individual's:

1. General philosophy and objectives regarding mental health care;

2. Specific goals, preferences, and wishes regarding the provision, withholding, or withdrawal of a form of mental health care, including:

a. Preferences regarding professionals, programs, and facilities;

b. Admission to a mental-health facility, including duration of admission;

c. Preferences regarding medications;

d. Refusal to accept a specific type of mental health care, including a medication; and

e. Preferences regarding crisis intervention.

C. A power of attorney for health care under this section may appoint an agent to make decisions only for mental health care.

D. An individual may direct in an advance mental health care directive that, if the individual is experiencing a psychiatric or psychological event specified in the directive, the individual may not revoke the directive or a part of the directive.

E. If an advance mental health care directive includes a direction under subsection D, the advance mental health care directive shall be in a record that is separate from any other advance health care directive created by the individual and signed by the individual creating the advance mental health care directive and at least two adult witnesses who:

1. Attest that to the best of their knowledge the individual:

a. Understood the nature and consequences of the direction, including its risks and benefits; and

b. Made the direction voluntarily and without coercion or undue influence;

2. Are not:

a. The agent appointed by the individual;

b. The agent's spouse or cohabitant; and

c. If the individual resides in a nursing home or other residential care facility, the owner, operator, employee, or contractor of the nursing home or other residential care facility; and

3. Are physically present in the same location as the individual.

§ 54.1-2993.11. Relationship of advance mental health care directive and other advance health care directive.

A. If a direction in an advance mental health care directive of an individual conflicts with a direction in another advance health care directive of the individual, the later direction revokes the earlier direction to the extent of the conflict.

B. An appointment of an agent to make decisions only for mental health care for an individual does not revoke an earlier appointment of an agent to make other health care decisions for the individual. A later appointment revokes the authority of an agent under the earlier appointment to make decisions about mental health care unless otherwise specified in the power of attorney making the later appointment.

C. An appointment of an agent to make health care decisions for an individual other than decisions about mental health care made after appointment of an agent authorized to make only mental health care decisions does not revoke the appointment of the agent authorized to make only mental health care decisions.

§ 54.1-2993.12. Optional form.

The following form may be used to create an advance health care directive:

ADVANCE HEALTH CARE DIRECTIVE

HOW YOU CAN USE THIS FORM

You can use this form if you wish to name someone to make health care decisions for you in case you cannot make decisions for yourself. This is called giving the person a power of attorney for health care. This person is called your Agent.

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor after you die.

YOUR NAME AND DATE OF BIRTH

Name:

Date of birth:

PART A: NAMING AN AGENT

This part lets you name someone else to make health care decisions for you. You may leave any item blank.

1. NAMING AN AGENT

I want the following person to make health care decisions for me if I cannot make decisions for myself:

Name:

Optional contact information (it is helpful to include information such as address, phone, and email):

2. NAMING AN ALTERNATE AGENT

I want the following person to make health care decisions for me if I cannot and my Agent is not able or available to make them for me:

Name:

Optional contact information (it is helpful to include information such as address, phone, and email):

3. LIMITING YOUR AGENT'S AUTHORITY

I give my Agent the power to make all health care decisions for me if I cannot make those decisions for myself, except the following:

(If you do not add a limitation here, your Agent will be able make all health care decisions that an Agent is permitted to make under state law.)

PART B: HEALTH CARE INSTRUCTIONS

This part lets you state your priorities for health care and state types of health care you do and do not want.

1. INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your Agent to act while making decisions for you. You may mark or initial each choice. You also may leave any choice blank.

Treatment. Medical treatment needed to keep me alive but not needed for comfort or any other purpose should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "treatment" section.).

(____) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.

(____) Not be given to me if I am unconscious and I am not expected to be conscious again.

(____) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

Food and liquids. If I can't swallow and staying alive requires me to get food or liquids through a tube or other means for the rest of my life, then food or liquids should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "food and liquids" section).

(____) Not be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(____) Not be given to me if I am unconscious and am not expected to be conscious again.

(____) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

Pain relief. If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

(____) Never be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

(____) Be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(____) Be given to me if I am unconscious and am not expected to be conscious again.

(____) Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

2. MY PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot. It also helps others understand your preferences.

You may mark or initial each choice. You also may leave any choice blank.

Staying alive as long as possible even if I have substantial physical limitations is:
(____) Very important
(____) Somewhat important
(____) Not important
Staying alive as long as possible even if I have substantial mental limitations is:
(____) Very important
(____) Somewhat important
(____) Not important
Being free from significant pain is:
(____) Very important
(____) Somewhat important
(____) Not important
Being independent is:
(____) Very important
(____) Somewhat important
(____) Not important
Having my Agent talk with my family before making decisions about my care is:
(____) Very important
(____) Somewhat important
(____) Not important
Having my Agent talk with my friends before making decisions about my care is:
(____) Very important
(____) Somewhat important
(____) Not important
3. OTHER INSTRUCTIONS
You can write in this section more information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.
PART C: OPTIONAL SPECIAL POWERS AND GUIDANCE
This part lets you give your Agent additional powers and provide more guidance about your wishes. You may mark or initial each choice. You also may leave any choice blank.
1. OPTIONAL SPECIAL POWERS
My Agent can do the following things ONLY if I have marked or initialed them below:
(____) Admit me as a voluntary patient to a facility for mental health treatment for up to _____ days (write in the number of days you want, such as 7, 14, 30 or another number).
(If I do not mark or initial this choice, my Agent is not authorized to admit me as a voluntary patient to this type of facility.)
(____) Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill, and I object.
(If I do not mark or initial this choice, my Agent is not authorized to do this.)
2. ACCESS TO MY HEALTH INFORMATION
My Agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself. If I mark or initial below, my Agent may also obtain, examine, and share information at any time my Agent thinks it will help me.
(____) I give my Agent permission to obtain, examine, and share information about my health needs and health care whenever my Agent thinks it will help me.
3. FLEXIBILITY FOR MY AGENT
Mark or initial below if you want to give your Agent flexibility in following instructions you provide in this form. If you do not, your Agent is required to follow the instructions even if your Agent thinks something else would be better for you.
(____) I give my Agent permission to be flexible in applying these instructions if my Agent thinks it would be in my best interest based on what my Agent knows about me.
4. NOMINATION OF GUARDIAN
You can say who you would want as your guardian if you needed one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian.
If a court appoints a guardian to make personal decisions for me, I want the court to choose:
(____) My Agent named in this form. If my Agent cannot be a guardian, I want the Alternate Agent named in this form.
(____) Other (write who you would want and their contact information):
PART D: ORGAN DONATION
This part lets you donate your organs after you die. You may leave any item blank.

1. DONATION

You may mark or initial only one choice.

(____) I donate my organs, tissues, and other body parts after I die, even if it requires maintaining treatments that conflict with other instructions I have put in this form, EXCEPT for those I list below (list any body parts you do NOT want to donate):

(____) I do not want my organs, tissues, or body parts donated to anybody for any reason. (If you mark or initial this choice, you should skip the "purpose of donation" section.)

2. PURPOSE OF DONATION

You may mark or initial all that apply. (If you do not mark or initial any of the purposes below, your donation can be used for all of them.)

Organs, tissues, or body parts that I donate may be used for:

(____) Transplant

(____) Therapy

(____) Research

(____) Education

(____) All of the above

PART E: SIGNATURES

YOUR SIGNATURE

Sign your name:

Today's date:

City/Town/Village and State (optional):

SIGNATURE OF A WITNESS

You need a witness if you are using this form to name an Agent. The witness must be an adult and cannot be the person you are naming as Agent or the Agent's spouse or someone the Agent lives with as a couple. If you live or are receiving care in a nursing home, the witness cannot be an employee or contractor of the home or someone who owns or runs the home.

Name of Witness:

Signature of Witness:

(Only sign as a witness if you think the person signing above is doing it voluntarily.)

Date witness signed:

PART F: INFORMATION FOR AGENTS

1. If this form names you as an Agent, you can make decisions about health care for the person who named you when the person cannot make their own.

2. If you make a decision for the person, follow any instructions the person gave, including any in this form.

3. If you do not know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences, and goals if you know them or can learn them. Some of these preferences may be in this form. You should also consider any behavior or communication from the person that indicates what the person currently wants.

4. If this form names you as an Agent, you can also get and share the person's health information. But unless the person has said so in this form, you can get or share this information only when the person cannot make decisions about the person's health care.

§ 54.1-2993.13. Default surrogate.

A. A default surrogate may make a health care decision for an individual who lacks capacity to make health care decisions and for whom an agent, or guardian authorized to make health care decisions, has not been appointed or is not reasonably available.

B. Unless the individual has an advance health care directive that indicates otherwise, a member of the following classes, in descending order of priority, who is reasonably available and not disqualified under § 54.1-2993.15, may act as a default surrogate for the individual:

1. An adult the individual has identified, other than in a power of attorney for health care, to make a health care decision for the individual if the individual cannot make the decision;

2. The individual's spouse, unless:

a. A petition for annulment or divorce has been filed and not dismissed or withdrawn;

b. A decree of annulment or divorce has been issued; or

c. The spouse has abandoned the individual for more than one year;

3. The individual's adult child or parent;

4. The individual's cohabitant;

5. The individual's adult sibling;

6. The individual's adult grandchild or grandparent;

7. An adult not listed in subdivisions 1 through 6 who has assisted the individual with supported decision making routinely during the preceding six months;

8. The individual's adult stepchild not listed in subdivisions 1 through 7 whom the individual actively

parented during the stepchild's minor years and with whom the individual has an ongoing relationship; or

9. An adult not listed in subdivisions 1 through 8 who has exhibited special care and concern for the individual and is familiar with the individual's personal values.

C. A responsible health care professional may require an individual who assumes authority to act as a default surrogate to provide a declaration in a record under penalty of perjury stating facts and circumstances reasonably sufficient to establish the authority.

D. If a responsible health care professional reasonably determines that an individual who assumed authority to act as a default surrogate is not willing or able to comply with a duty under § 54.1-2993.18 or fails to comply with the duty in a timely manner, the professional may recognize the individual next in priority under subsection B as the default surrogate.

E. A health care decision made by a default surrogate is effective without judicial approval.

§ 54.1-2993.14. Disagreement among default surrogates.

A. A default surrogate who assumes authority under § 54.1-2993.13 shall inform a responsible health care professional if two or more members of a class under subsection B of § 54.1-2993.13 have assumed authority to act as default surrogates and the members do not agree on a health care decision.

B. A responsible health care professional shall comply with the decision of a majority of the members of the class with highest priority under subsection B of § 54.1-2993.13 who have communicated their views to the professional and the professional reasonably believes are acting consistent with their duties under § 54.1-2993.18.

C. If a responsible health care professional is informed that the members of the class who have communicated their views to the professional are evenly divided concerning the health care decision, the professional shall make a reasonable effort to solicit the views of members of the class who are reasonably available but have not yet communicated their views to the professional. The professional, after the solicitation, shall comply with the decision of a majority of the members who have communicated their views to the professional and the professional reasonably believes are acting consistent with their duties under § 54.1-2993.18.

D. If the class remains evenly divided after the effort is made under subsection C, the health care decision shall be made as provided by other law of the Commonwealth regarding the treatment of an individual who is found to lack capacity.

§ 54.1-2993.15. Disqualification to act as default surrogate.

A. An individual for whom a health care decision would be made may disqualify another individual from acting as default surrogate for the first individual. The disqualification shall be in a record signed by the first individual or communicated verbally or nonverbally to the individual being disqualified, another individual, or a responsible health care professional. Disqualification under this subsection is effective even if made by an individual who lacks capacity to make an advance directive if the individual clearly communicates a desire that the individual being disqualified not make health care decisions for the individual.

B. An individual is disqualified from acting as a default surrogate for an individual who lacks capacity to make health care decisions if:

1. A court finds that the potential default surrogate poses a danger to the individual's well-being, even if the court does not issue a protective order against the potential default surrogate;

2. The potential default surrogate is an owner, operator, employee, or contractor of a nursing home or other residential care facility in which the individual is residing or receiving care unless the owner, operator, employee, or contractor is a family member of the individual, the cohabitant of the individual, or a descendant of the cohabitant; or

3. The potential default surrogate refuses to provide a timely declaration under subsection C of § 54.1-2993.13.

§ 54.1-2993.16. Revocation.

A. An individual may revoke the appointment of an agent, the designation of a default surrogate, or a health care instruction in whole or in part, unless:

1. A court finds the individual lacks capacity to do so;

2. The individual is found under subsection B of § 54.1-2993.5 to lack capacity to do so and, if the individual objects to the finding, the finding is confirmed under subdivision D 4 of § 54.1-2993.6; or

3. The individual created an advance mental health care directive that includes the provision under subsection D of § 54.1-2993.10 and the individual is experiencing the psychiatric or psychological event specified in the directive.

B. Revocation under subsection A may be by any act of the individual that clearly indicates that the individual intends to revoke the appointment, designation, or instruction, including an oral statement to a health care professional.

C. Except as provided in § 54.1-2993.11, an advance health care directive of an individual that conflicts with another advance health care directive of the individual revokes the earlier directive to the extent of the conflict.

D. Unless otherwise provided in an individual's advance health care directive appointing an agent, the

appointment of a spouse of an individual as agent for the individual is revoked if:

1. A petition for annulment or divorce has been filed and not dismissed or withdrawn;

2. A decree of annulment or divorce has been issued; or

3. The spouse has abandoned the individual for more than one year.

§ 54.1-2993.17. Validity of advance health care directive; conflict with other law.

A. An advance health care directive created outside the Commonwealth is valid if it complies with:

1. The law of the state specified in the directive or, if a state is not specified, the state in which the individual created the directive; or

2. This article.

B. A person may assume without inquiry that an advance health care directive is genuine, valid, and still in effect and may implement and rely on it, unless the person has good cause to believe the directive is invalid or has been revoked.

C. An advance health care directive, revocation of a directive, or a signature on a directive or revocation may not be denied legal effect or enforceability solely because it is in electronic form.

D. Evidence relating to an advance health care directive, revocation of a directive, or a signature on a directive or revocation may not be excluded in a proceeding solely because the evidence is in electronic form.

E. This article does not affect the validity of an electronic record or signature that is valid under the Uniform Electronic Transactions Act (§ 59.1-479 et seq.).

F. If this article conflicts with other law of the Commonwealth relating to the creation, execution, implementation, or revocation of an advance health care directive, this article prevails.

§ 54.1-2993.18. Duties of Agent of Default Surrogate.

A. An agent or default surrogate has a fiduciary duty to the individual for whom the agent or default surrogate is acting when exercising or purporting to exercise a power under § 54.1-2993.19.

B. An agent or default surrogate shall make a health care decision in accordance with the direction of the individual in an advance health care directive and other goals, preferences, and wishes of the individual to the extent known or reasonably ascertainable by the agent or default surrogate.

C. If there is not a direction in an advance health care directive and the goals, preferences, and wishes of the individual regarding a health care decision are not known or reasonably ascertainable by the agent or default surrogate, the agent or default surrogate shall make the decision in accordance with the agent's or default surrogate's determination of the individual's best interest.

D. In determining the individual's best interest under subsection C, the agent or default surrogate shall:

1. Give primary consideration to the individual's contemporaneous communications, including verbal and nonverbal expressions;

2. Consider the individual's values to the extent known or reasonably ascertainable by the agent or default surrogate; and

3. Consider the risks and benefits of the potential health care decision.

E. As soon as reasonably feasible, an agent or default surrogate who is informed of a revocation of an advance health care directive or disqualification of the agent or default surrogate shall communicate the revocation or disqualification to a responsible health care professional.

§ 54.1-2993.19. Powers of agent and default surrogate.

A. Except as provided in subsection C, the power of an agent or default surrogate commences when the individual is found under subsection B of § 54.1-2993.5 or by a court to lack capacity to make a health care decision. The power ceases if the individual later is found to have capacity to make a health care decision, or the individual objects under subsection C of § 54.1-2993.6 to the finding of lack of capacity under subsection B of § 54.1-2993.5. The power resumes if:

1. The power ceased because the individual objected under subsection C of § 54.1-2993.6; and

2. The finding of lack of capacity is confirmed under subdivision D 4 of § 54.1-2993.6 or a court finds that the individual lacks capacity to make a health care decision.

B. An agent or default surrogate may request, receive, examine, copy, and consent to the disclosure of medical and other health care information about the individual if the individual would have the right to request, receive, examine, copy, or consent to the disclosure of the information.

C. A power of attorney for health care may provide that the power of an agent under subsection B commences on appointment.

D. If no other person is authorized to do so, an agent or default surrogate may apply for public or private health insurance and benefits on behalf of the individual. An agent or default surrogate who may apply for insurance and benefits does not, solely by reason of the power, have a duty to apply for the insurance or benefits.

E. An agent or default surrogate may not consent to voluntary admission of the individual to a facility for mental health treatment unless:

1. Voluntary admission is specifically authorized by the individual in an advance health care directive in a record; and

2. The admission is for no more than the maximum of the number of days specified in the directive or 10

days, whichever is less.

F. Except as provided in subsection G, an agent or default surrogate may not consent to placement of the individual in a nursing home if the placement is intended to be for more than 100 days if:

1. An alternative living arrangement is reasonably feasible;

2. The individual objects to the placement; or

3. The individual is not terminally ill.

G If specifically authorized by the individual in an advance health care directive in a record, an agent or default surrogate may consent to placement of the individual in a nursing home for more than 100 days even if:

1. An alternative living arrangement is reasonably feasible;

2. The individual objects to the placement; and

3. The individual is not terminally ill.

§ 54.1-2993.20. Limitation on powers.

A. If an individual has a long-term disability requiring routine treatment by artificial nutrition, hydration, or mechanical ventilation and a history of using the treatment without objection, an agent or default surrogate may not consent to withhold or withdraw the treatment unless:

1. The treatment is not necessary to sustain the individual's life or maintain the individual's well-being;

2. The individual has expressly authorized the withholding or withdrawal in a health care instruction that has not been revoked; or

3. The individual has experienced a major reduction in health or functional ability from which the individual is not expected to recover, even with other appropriate treatment, and the individual has not:

a. Given a direction inconsistent with withholding or withdrawal; or

b. Communicated by verbal or nonverbal expression a desire for artificial nutrition, hydration, or mechanical ventilation.

B. A default surrogate may not make a health care decision if, by other law of the Commonwealth, the decision:

1. May not be made by a guardian; or

2. May be made by a guardian only if the court appointing the guardian specifically authorizes the guardian to make the decision.

§ 54.1-2993.21. Co-agents; alternate agent.

A. An individual in a power of attorney for health care may appoint multiple individuals as co-agents. Unless the power of attorney provides otherwise, each co-agent may exercise independent authority.

B. An individual in a power of attorney for health care may appoint one or more individuals to act as alternate agents if a predecessor agent resigns, dies, becomes disqualified, is not reasonably available, or otherwise is unwilling or unable to act as agent.

C. Unless the power of attorney provides otherwise, an alternate agent has the same authority as the original agent:

1. At any time the original agent is not reasonably available or is otherwise unwilling or unable to act, for the duration of the unavailability, unwillingness, or inability to act; or

2. If the original agent and all other predecessor agents have resigned or died or are disqualified from acting as agent.

§ 54.1-2993.22. Duties of health care professional; responsible health care professional; health care institution.

A. A responsible health care professional who is aware that an individual has been found to lack capacity to make a decision shall make a reasonable effort to determine if the individual has a surrogate.

B. If possible before implementing a health care decision made by a surrogate, a responsible health care professional as soon as reasonably feasible shall communicate to the individual the decision made and the identity of the surrogate.

C. A responsible health care professional who makes or is informed of a finding that an individual lacks capacity to make a health care decision or no longer lacks capacity, or that other circumstances exist that affect a health care instruction or the authority of a surrogate, as soon as reasonably feasible, shall:

1. Document the finding or circumstance in the individual's medical record; and

2. If possible, communicate to the individual and the individual's surrogate the finding or circumstance and that the individual may object under subsection C of § 54.1-2993.6 to the finding under subsection B of § 54.1-2993.5.

D. A responsible health care professional who is informed that an individual has created or revoked an advance health care directive, or that a surrogate for an individual has been appointed, designated, or disqualified, shall:

1. Document the information as soon as reasonably feasible in the individual's medical record; and

2. If evidence of the directive, revocation, appointment, designation, or disqualification is in a record, request a copy and, on receipt, cause the copy to be included in the individual's medical record.

E. Except as provided in subsections F and G, a health care professional or health care institution

providing health care to an individual shall comply with:

1. A health care instruction given by the individual regarding the individual's health care;

2. A Durable Do Not Resuscitate Order issued pursuant to § 54.1-2987.1;

3. A reasonable interpretation by the individual's surrogate of an instruction given by the individual; and

4. A health care decision for the individual made by the individual's surrogate in accordance with §§ 54.1-2993.18 and 54.1-2993.19 to the same extent as if the decision had been made by the individual at a time when the individual had capacity.

F. A health care professional or a health care institution may refuse to provide health care consistent with a health care instruction, health care decision, or Durable Do Not Resuscitate Order issued pursuant to § 54.1-2987.1 if:

1. The instruction, decision, or Durable Do Not Resuscitate Order is contrary to a policy of the health care institution providing care to the individual that is based expressly on reasons of conscience and the policy was timely communicated to the individual or to the individual's surrogate;

2. The care would require health care that is not available to the professional or institution; or

3. Compliance with the instruction, decision, or Durable Do Not Resuscitate Order would:

a. Require the professional to provide care that is contrary to the professional's religious belief or moral conviction if other law permits the professional to refuse to provide care for that reason;

b. Require the professional or institution to provide care that is contrary to generally accepted health care standards applicable to the professional or institution; or

c. Violate a court order or other law.

G. A health care professional or health care institution that refuses to provide care under subsection F shall:

1. As soon as reasonably feasible, inform the individual, if possible, and the individual's surrogate of the refusal;

2. Immediately make a reasonable effort to transfer the individual to another health care professional or health care institution that is willing to comply with the instruction, decision, or Durable Do Not Resuscitate Order; and

3. Either:

a. If care is refused under subdivision F 1 or 2, provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible, until a transfer is made; or

b. If care is refused under subdivision F 3, provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards, until a transfer is made or, if the professional or institution reasonably believes that a transfer cannot be made, for at least 10 days after the refusal.

§ 54.1-2993.23. Decision by guardian.

A. A guardian may refuse to comply with or revoke the individual's advance health care directive only if the court appointing the guardian expressly orders the noncompliance or revocation.

B. Unless a court orders otherwise, a health care decision made by an agent appointed by an individual subject to guardianship prevails over a decision of the guardian appointed for the individual.

§ 54.1-2993.24. Immunity.

A. A health care professional or health care institution acting in good faith is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

1. Complying with a health care decision made for an individual by another person if compliance is based on a reasonable belief that the person has authority to make the decision, including a decision to withhold or withdraw health care;

2. Refusing to comply with a health care decision made for an individual by another person if the refusal is based on a reasonable belief that the person lacked authority or capacity to make the decision;

3. Complying with an advance health care directive based on a reasonable belief that the directive is valid;

4. Refusing to comply with an advance health care directive based on a reasonable belief that the directive is not valid, including a reasonable belief that the directive was not made by the individual or, after its creation, was substantively altered by a person other than the individual who created it;

5. Determining that an individual who otherwise might be authorized to act as an agent or default surrogate is not reasonably available;

6. Complying with an individual's direction under subsection D of § 54.1-2993.10; or

7. Issuing, consenting to, making, or following a Durable Do Not Resuscitate Order pursuant to § 54.1-2987.1.

B. An agent, default surrogate, or individual with a reasonable belief that the individual is an agent or a default surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for a health care decision made in a good faith effort to comply with § 54.1-2993.18.

§ 54.1-2993.25. Prohibited conduct; civil penalty.

A. A person may not:

1. Intentionally falsify, in whole or in part, an advance health care directive;

2. For the purpose of frustrating the intent of the individual who created an advance health care directive or with knowledge that doing so is likely to frustrate the intent:

a. Intentionally conceal, deface, obliterate, or delete the directive or a revocation of the directive without consent of the individual who created or revoked the directive; or

b. Intentionally withhold knowledge of the existence or revocation of the directive from a responsible health care professional or health care institution providing health care to the individual who created or revoked the directive;

3. Coerce or fraudulently induce an individual to create, revoke, or refrain from creating or revoking an advance health care directive or a part of a directive; or

4. Require or prohibit the creation or revocation of an advance health care directive as a condition for providing health care.

B. An individual who is the subject of conduct prohibited under subsection A, or the individual's estate, has a cause of action against a person that violates subsection A for statutory damages of $25,000 or actual damages resulting from the violation, whichever is greater.

C. Subject to subsection D, an individual who makes a health care instruction, or the individual's estate, has a cause of action against a health care professional or health care institution that intentionally violates § 54.1-2993.22 for statutory damages of $50,000 or actual damages resulting from the violation, whichever is greater.

D. A health care professional who is an emergency medical services provider is not liable under subsection C for a violation of subsection E of § 54.1-2993.22 if:

1. The violation occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care was appropriate to avoid imminent loss of life or serious harm to the individual;

2. The failure to comply is consistent with accepted standards of the profession of the professional; and

3. The provision of care does not begin in a health care institution in which the individual resides or was receiving care.

E. In an action under this section, a prevailing plaintiff may recover reasonable attorney fees, court costs, and other reasonable litigation expenses.

F. A cause of action or remedy under this section is in addition to any cause of action or remedy under other law.

§ 54.1-2993.26. Effect of copy; certified physical copy.

A. A physical or electronic copy of an advance health care directive, revocation of an advance health care directive, or appointment, designation, or disqualification of a surrogate has the same effect as the original.

B. An individual may create a certified physical copy of an advance health care directive or revocation of an advance health care directive that is in electronic form by affirming under penalty of perjury that the physical copy is a complete and accurate copy of the directive or revocation.

§ 54.1-2993.27. Judicial relief.

A. On petition of an individual, the individual's surrogate, a health care professional or health care institution providing health care to the individual, or a person interested in the welfare of the individual, the court may:

1. Enjoin implementation of a health care decision made by an agent or default surrogate on behalf of the individual, on a finding that the decision is inconsistent with § 54.1-2993.18 or 54.1-2993.19;

2. Enjoin an agent from making a health care decision for the individual, on a finding that the individual's appointment of the agent has been revoked or the agent:

a. Is disqualified under subsection B of § 54.1-2993.9;

b. Is unwilling or unable to comply with § 54.1-2993.18; or

c. Poses a danger to the individual's well-being;

3. Enjoin another individual from acting as a default surrogate, on a finding that the other individual acting as a default surrogate did not comply with § 54.1-2993.13 or the other individual:

a. Is disqualified under § 54.1-2993.15;

b. Is unwilling or unable to comply with § 54.1-2993.18; or

c. Poses a danger to the first individual's well-being; or

4. Order implementation of a health care decision made:

a. By and for the individual; or

b. By an agent or default surrogate who is acting in compliance with the powers and duties of the agent or default surrogate.

B. In this article, advocacy for the withholding or withdrawal of health care or mental health care from an individual is not itself evidence that an agent or default surrogate, or a potential agent or default surrogate, poses a danger to the individual's well-being.

§ 54.1-2993.28. Construction.

A. This article does not authorize mercy killing, assisted suicide, or euthanasia.

B. This article does not affect other law of the Commonwealth governing treatment for mental illness of an individual involuntarily committed to a facility, as defined in § 37.2-100, pursuant to Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2.

C. Death of an individual caused by withholding or withdrawing health care in accordance with this article does not constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity.

D. This article does not create a presumption concerning the intention of an individual who has not created an advance health care directive.

E. An advance health care directive created before, on, or after July 1, 2025, shall be interpreted in accordance with other law of this Commonwealth, excluding the Commonwealth's choice-of-law rules, at the time the directive is implemented.

§ 54.1-2993.29. Uniformity of application and construction.

In applying and construing this uniform act, a court shall consider the promotion of uniformity of the law among jurisdictions that enact it.

§ 54.1-2993.30. Saving provisions.

A. An advance health care directive created before July 1, 2025, is valid if it complies with this article or complied at the time of creation with the law of the state in which it was created.

B. This article does not affect the validity or effect of an act done before July 1, 2025.

C. An individual who assumed authority to act as default surrogate before July 1, 2025, may continue to act as default surrogate until the individual for whom the default surrogate is acting has capacity or the default surrogate is disqualified, whichever occurs first.

§ 54.1-2993.31. Transitional provision.

This article applies to an advance health care directive created before, on, or after July 1, 2025.

§ 54.1-2995. Filing of documents with the registry; regulations; fees.

A. A person may submit any of the following documents and the revocations of these documents to the Department of Health for filing in the Advance Health Care Planning Registry established pursuant to this article:

1. A ~~health care~~ power of attorney *for health care*.

2. An advance *health care* directive created pursuant to ~~Article 8 (§ 54.1-2981 et seq.)~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.)* or a subsequent act of the General Assembly.

3. A declaration of an anatomical gift made pursuant to the Revised Uniform Anatomical Gift Act (§ 32.1-291.1 et seq.).

4. Any other document that supports advance health care planning, including ~~Durable Do Not Resuscitate Order or~~ portable medical order forms.

B. The document may be submitted for filing only by the person who executed the document or his legal representative or designee and shall be accompanied by any fee required by the Department of Health.

C. All data and information contained in the registry shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

D. The Board of Health shall promulgate regulations to carry out the provisions of this article, which shall include, but not be limited to (i) a determination of who may access the registry, including physicians, other licensed health care providers, the declarant, and his legal representative or designee; (ii) a means of annually reminding registry users of which documents they have registered; and (iii) fees for filing a document with the registry. Such fees shall not exceed the direct costs associated with development and maintenance of the registry and with the education of the public about the availability of the registry, and shall be exempt from statewide indirect costs charged and collected by the Department of Accounts. No fee shall be charged for the filing of a document revoking any document previously filed with the registry.

§ 63.2-501. Application for assistance.

A. Except as provided for in the state plan for medical assistance services pursuant to § 32.1-325, application for public assistance shall be made to the local department and filed with the local director of the county or city in which the applicant resides; however, when necessary to overcome backlogs in the application and renewal process, the Commissioner may temporarily utilize other entities to receive and process applications, conduct periodic eligibility renewals, and perform other tasks associated with eligibility determinations. Such entities shall be subject to the confidentiality requirements set forth in § 63.2-501.1. Applications and renewals processed by other entities pursuant to this subsection shall be subject to appeals pursuant to § 63.2-517. Such application may be made either electronically or in writing on forms prescribed by the Commissioner and shall be signed by the applicant or otherwise attested to in a manner prescribed by the Commissioner under penalty of perjury in accordance with § 63.2-502.

If the condition of the applicant for public assistance precludes his signing or otherwise attesting to the accuracy of information contained in an application for public assistance, the application may be made on his behalf by his guardian or conservator. If no guardian or conservator has been appointed for the applicant, the

application may be made by any competent adult person having sufficient knowledge of the applicant's circumstances to provide the necessary information, until such time as a guardian or conservator is appointed by a court.

B. Local departments or the Commissioner shall provide each applicant for public assistance with information regarding his rights and responsibilities related to eligibility for and continued receipt of public assistance. Such information shall be provided in an electronic or written format approved by the Board that is easily understandable and shall also be provided orally to the applicant by an employee of the local department, except in the case of energy assistance. The local department shall require each applicant to acknowledge, in a format approved by the Board, that the information required by this subsection has been provided and shall maintain such acknowledgment together with information regarding the application for public assistance.

C. Local departments or the Commissioner shall provide each applicant for Medicaid with information regarding advance *health care* directives pursuant to ~~Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of Title 54.1~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.),* including information about the purpose and benefits of advance *health care* directives and how the applicant may make an advance directive.

D. The Commissioner and local departments shall administer the Child Care Subsidy Program as provided for in the State Child Care Plan prepared by the Department of Education.

§ 63.2-1605. Protective services for adults by local departments.

A. Each local board, to the extent that federal or state matching funds are made available to each locality, shall provide, pursuant to regulations and subject to supervision of the Commissioner for Aging and Rehabilitative Services, adult protective services for adults who are found to be abused, neglected, or exploited and who meet one of the following criteria: (i) the adult is 60 years of age or older or (ii) the adult is 18 years of age or older and is incapacitated. The requirement to provide such services shall not limit the right of any individual to refuse to accept any of the services so offered, except as provided in § 63.2-1608.

B. Upon receipt of the report pursuant to § 63.2-1606, the local department shall determine the validity of such report and shall initiate an investigation within 24 hours of the time the report is received in the local department. Local departments shall consider valid any report meeting all of the following criteria: (i) the subject of the report is an adult as defined in this article, (ii) the report concerns a specific adult and there is enough information to locate the adult, and (iii) the report describes the circumstances of the alleged abuse, neglect, or exploitation.

C. The local department shall immediately refer the matter and all relevant documentation to the local law-enforcement agency where the adult resides or where the alleged abuse, neglect, or exploitation took place or, if these places are unknown, where the alleged abuse, neglect, or exploitation was discovered for investigation, upon receipt of an initial report pursuant to § 63.2-1606 involving any of the following or upon determining, during the course of an investigation pursuant to this article, the occurrence of any of the following:

1. Sexual abuse as defined in § 18.2-67.10;

2. Death that is believed to be the result of abuse or neglect;

3. Serious bodily injury or disease as defined in § 18.2-369 that is believed to be the result of abuse or neglect;

4. Suspected financial exploitation of an adult; or

5. Any other criminal activity involving abuse or neglect that places the adult in imminent danger of death or serious bodily harm.

Local law-enforcement agencies shall provide local departments with a preferred point of contact for referrals.

D. The local department shall refer any appropriate matter and all relevant documentation, to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation.

E. If a local department is denied access to an adult for whom there is reason to suspect the need for adult protective services, then the local department may petition the circuit court for an order allowing access or entry or both. Upon a showing of good cause supported by an affidavit or testimony in person, the court may enter an order permitting such access or entry.

F. In any case of suspected adult abuse, neglect, or exploitation, local departments, with the informed consent of the adult or his legal representative, shall take or cause to be taken photographs, video recordings, or appropriate medical imaging of the adult and his environment as long as such measures are relevant to the investigation and do not conflict with § 18.2-386.1. However, if the adult is determined to be incapable of making an informed decision and of giving informed consent and either has no legal representative or the legal representative is the suspected perpetrator of the adult abuse, neglect, or exploitation, consent may be given by an agent appointed under an advance ~~medical~~ *health care* directive ~~or medical power of attorney,~~ or by a ~~person authorized,~~ *default surrogate* pursuant to § ~~54.1-2986~~ *54.1-2993.13*. In the event no agent or ~~authorized representative~~ *default surrogate* is immediately available, then consent shall be deemed to be given.

G. Local departments shall foster the development, implementation, and coordination of adult protective

services to prevent adult abuse, neglect, and exploitation.

H. Local departments shall not investigate allegations of abuse, neglect, or exploitation of adults incarcerated in state correctional facilities.

I. The report and evidence received by the local department and any written findings, evaluations, records, and recommended actions shall be confidential and shall be exempt from disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), except that such information may be disclosed to persons having a legitimate interest in the matter in accordance with §§ 63.2-102 and 63.2-104 and pursuant to official interagency agreements or memoranda of understanding between state agencies.

J. All written findings and actions of the local department or its director regarding adult protective services investigations are final and shall not be (i) appealable to the Commissioner for Aging and Rehabilitative Services or (ii) considered a final agency action for purposes of judicial review pursuant to the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

K. Each local department may foster, when practicable, the creation, maintenance, and coordination of community-based multidisciplinary teams that shall include, where possible, members of the medical, mental health, social work, nursing, education, legal, and law-enforcement professions. Such teams shall:

1. Assist the local department in identifying abused, neglected, and exploited adults as defined in § 63.2-1603.

2. Coordinate medical, social, and legal services for abused, neglected, and exploited adults and their families.

3. Develop innovative programs for detection and prevention of the abuse, neglect, and exploitation of adults.

4. Promote community awareness and action to address the abuse, neglect, and exploitation of adults.

5. Disseminate information to the general public regarding the problem of abuse, neglect, and exploitation of adults, strategies and methods for preventing such abuse, neglect, and exploitation, and treatment options for abused, neglected, and exploited adults.

Such multidisciplinary teams may share information among the parties in the performance of their duties but shall be bound by confidentiality and shall execute a sworn statement to honor the confidentiality of the information they share. A violation of this subsection is punishable as a Class 3 misdemeanor. All such information and records shall be used by the team only in the exercise of its proper function and shall not be disclosed. No person who participated in the team and no member of the team shall be required to make any statement as to what transpired during a meeting or what information was collected during the meeting. Upon the conclusion of a meeting, all information and records concerning the adult shall be returned to the originating agency or destroyed. Any information exchanged in accordance with the multidisciplinary review team shall not be considered to be a violation of any of the provisions of § 63.2-102, 63.2-104, or 63.2-105.

§ 64.2-2000. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Advance *health care* directive" shall have the same meaning as provided in § ~~54.1-2982~~ *54.1-2993.3*.

"Annual report" means the report required to be filed by a guardian pursuant to § 64.2-2020.

"Conservator" means a person appointed by the court who is responsible for managing the estate and financial affairs of an incapacitated person and, where the context plainly indicates, includes a "limited conservator" or a "temporary conservator." "Conservator" includes (i) a local or regional program designated by the Department for Aging and Rehabilitative Services as a public conservator pursuant to Article 6 (§ 51.5-149 et seq.) of Chapter 14 of Title 51.5 or (ii) any local or regional tax-exempt charitable organization established pursuant to § 501(c)(3) of the Internal Revenue Code to provide conservatorial services to incapacitated persons. Such tax-exempt charitable organization shall not be a provider of direct services to the incapacitated person. If a tax-exempt charitable organization has been designated by the Department for Aging and Rehabilitative Services as a public conservator, it may also serve as a conservator for other individuals.

"Estate" includes both real and personal property.

"Facility" means a state or licensed hospital, training center, psychiatric hospital, or other type of residential or outpatient mental health or mental retardation facility. When modified by the word "state," "facility" means a state hospital or training center operated by the Department of Behavioral Health and Developmental Services, including the buildings and land associated with it.

"Guardian" means a person appointed by the court who has the powers and duties set out in § 64.2-2019, or § 63.2-1609 if applicable, and who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of involuntary admission, residence. Where the context plainly indicates, the term includes a "limited guardian" or a "temporary guardian." The term includes (i) a local or regional program designated by the Department for Aging and Rehabilitative Services as a public guardian pursuant to Article 6 (§ 51.5-149 et seq.) of Chapter 14 of Title 51.5 or (ii) any local or regional tax-exempt charitable organization established pursuant to § 501(c)(3) of the Internal

Revenue Code to provide guardian services to incapacitated persons. Such tax-exempt charitable organization shall not be a provider of direct services to the incapacitated person. If a tax-exempt charitable organization has been designated by the Department for Aging and Rehabilitative Services as a public guardian, it may also serve as a guardian for other individuals.

"Guardian ad litem" means an attorney appointed by the court to represent the interests of the respondent and whose duties include evaluation of the petition for guardianship or conservatorship and filing a report with the court pursuant to § 64.2-2003.

"Incapacitated person" means an adult who has been found by a court to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator. A finding that the individual displays poor judgment alone shall not be considered sufficient evidence that the individual is an incapacitated person within the meaning of this definition. A finding that a person is incapacitated shall be construed as a finding that the person is "mentally incompetent" as that term is used in Article II, Section 1 of the Constitution of Virginia and Title 24.2 unless the court order entered pursuant to this chapter specifically provides otherwise.

"Individualized education plan" or "IEP" means a plan or program developed annually to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives specialized instruction and related services as provided by 20 U.S.C. § 1414.

"Individual receiving services" or "individual" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client."

"Limited conservator" means a person appointed by the court who has only those responsibilities for managing the estate and financial affairs of an incapacitated person as specified in the order of appointment.

"Limited guardian" means a person appointed by the court who has only those responsibilities for the personal affairs of an incapacitated person as specified in the order of appointment.

"Mental illness" means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Petition" means the document filed with a circuit court to initiate a proceeding to appoint a guardian or conservator.

"Power of attorney" has the same meaning ascribed to it in § 64.2-1600.

"Property" includes both real and personal property.

"Respondent" means an allegedly incapacitated person for whom a petition for guardianship or conservatorship has been filed.

"Supported decision-making agreement" has the same meaning ascribed to it in § 37.2-314.3.

"Temporary conservator" means a person appointed by a court for a limited duration of time as specified in the order of appointment.

"Temporary guardian" means a person appointed by a court for a limited duration of time as specified in the order of appointment.

"Transition plan" means the plan that is required as part of the IEP used to help students and families prepare for the future after the student reaches the age of majority.

§ 64.2-2009. Court order of appointment; limited guardianships and conservatorships.

A. The court's order appointing a guardian or conservator shall (i) state the nature and extent of the person's incapacity; (ii) define the powers and duties of the guardian or conservator so as to permit the incapacitated person to care for himself and manage property to the extent he is capable; (iii) specify whether the appointment of a guardian or conservator is limited to a specified length of time, as the court in its discretion may determine; (iv) specify the legal disabilities, if any, of the person in connection with the finding of incapacity, including but not limited to mental competency for purposes of Article II, § 1 of the Constitution of Virginia or Title 24.2; (v) include any limitations deemed appropriate following consideration of the factors specified in § 64.2-2007; (vi) set the bond of the guardian and the bond and surety, if any, of the conservator; and (vii) where a petition is brought prior to the incapacitated person's eighteenth birthday, pursuant to subsection C of § 64.2-2001, whether the order shall take effect immediately upon entry or on the incapacitated person's eighteenth birthday.

A1. Beginning July 1, 2023, the court shall set a schedule in the order of appointment for periodic review hearings, to be held no later than one year after the initial appointment and no later than every three years thereafter, unless the court orders that such hearings are to be waived because they are unnecessary or impracticable or that such hearings shall be held on such other schedule as the court shall determine. Any such determination to waive the hearing or use a schedule differing from that prescribed in this subsection shall be supported in the order and address the reason for such determination, including (i) the likelihood that

the respondent's condition will improve or the respondent will regain capacity, (ii) whether concerns or questions were raised about the suitability of the person appointed as a guardian or conservator at the time of the initial appointment, and (iii) whether the appointment of a guardian or conservator or the appointment of the specifically appointed guardian or conservator was contested by the respondent or another party.

The court shall not waive the initial periodic review hearing scheduled pursuant to this subsection where the petitioner for guardianship or conservatorship is a hospital, convalescent home, or certified nursing facility licensed by the Department of Health pursuant to § 32.1-123; an assisted living facility, as defined in § 63.2-100, or any other similar institution; or a health care provider other than a family member. If the petitioner is a hospital, convalescent home, or certified nursing facility licensed by the Department of Health pursuant to § 32.1-123 or an assisted living facility as defined in § 63.2-100, nothing in this chapter shall require such petitioner to attend any periodic review hearing.

Any person may file a petition, which may be on a form developed by the Office of the Executive Secretary of the Supreme Court of Virginia, to hold a periodic review hearing prior to the scheduled date set forth in the order of appointment. The court shall hold an earlier hearing upon good cause shown. At such a hearing, the court shall review the schedule set forth in the order of appointment and determine whether future periodic review hearings are necessary or may be waived.

A2. If the court has ordered a hearing pursuant to subsection A1, the court shall appoint a guardian ad litem, who shall conduct an investigation in accordance with the stated purpose of the hearing and file a report. The incapacitated person has a right to be represented by counsel, and the provisions of § 64.2-2006 shall apply, mutatis mutandis. The guardian ad litem shall provide notice of the hearing to the incapacitated person and to all individuals entitled to notice as identified in the court order of appointment. Fees and costs shall be paid in accordance with the provisions of §§ 64.2-2003 and 64.2-2008. The court shall enter an order reflecting any findings made during the review hearing and any modification to the guardianship or conservatorship.

B. The court may appoint a limited guardian for an incapacitated person who is capable of addressing some of the essential requirements for his care for the limited purpose of medical decision making, decisions about place of residency, or other specific decisions regarding his personal affairs. The court may appoint a limited conservator for an incapacitated person who is capable of managing some of his property and financial affairs for limited purposes that are specified in the order.

C. Unless the guardian has a professional relationship with the incapacitated person or is employed by or affiliated with a facility where the person resides, the court's order may authorize the guardian to consent to the admission of the person to a facility pursuant to § 37.2-805.1, upon finding by clear and convincing evidence that (i) the person has severe and persistent mental illness that significantly impairs the person's capacity to exercise judgment or self-control, as confirmed by the evaluation of a licensed psychiatrist; (ii) such condition is unlikely to improve in the foreseeable future; and (iii) the guardian has formulated a plan for providing ongoing treatment of the person's illness in the least restrictive setting suitable for the person's condition.

D. A guardian need not be appointed for a person who has appointed an agent under an advance *health care* directive executed in accordance with the provisions of ~~Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of Title 54.1~~ *the Uniform Health Care Decisions Act (§ 54.1-2993.2 et seq.),* unless the court determines that the agent is not acting in accordance with the wishes of the principal or there is a need for decision making outside the purview of the advance *health care* directive. A guardian need not be appointed for a person where a health care decision is made pursuant to, and within the scope of, the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.).

A conservator need not be appointed for a person (i) who has appointed an agent under a durable power of attorney, unless the court determines pursuant to the Uniform Power of Attorney Act (§ 64.2-1600 et seq.) that the agent is not acting in the best interests of the principal or there is a need for decision making outside the purview of the durable power of attorney or (ii) whose only or major source of income is from the Social Security Administration or other government program and who has a representative payee.

E. All orders appointing a guardian shall include the following statements in conspicuous bold print in at least 14-point type:

1. Pursuant to § 64.2-2009 of the Code of Virginia, (name of guardian), is hereby appointed as guardian of (name of respondent) with all duties and powers granted to a guardian pursuant to § 64.2-2019 of the Code of Virginia, including but not limited to: (enter a statement of the rights removed and retained, if any, at the time of appointment; whether the appointment of a guardian is a full guardianship, public guardianship pursuant to § 64.2-2010 of the Code of Virginia, limited guardianship pursuant to § 64.2-2009 of the Code of Virginia, or temporary guardianship; and the duration of the appointment).

2. Pursuant to the provisions of subsection E of § 64.2-2019 of the Code of Virginia, a guardian, to the extent possible, shall encourage the incapacitated person to participate in decisions, shall consider the expressed desires and personal values of the incapacitated person to the extent known, and shall not restrict an incapacitated person's ability to communicate with, visit, or interact with other persons with whom the

incapacitated person has an established relationship, unless such restriction is reasonable to prevent physical, mental, or emotional harm to or financial exploitation of such incapacitated person and after consideration of the expressed wishes of the incapacitated person. Such restrictions shall only be imposed pursuant to § 64.2-2019.1.

3. Pursuant to § 64.2-2020 of the Code of Virginia, an annual report shall be filed by the guardian with the local department of social services for the jurisdiction where the incapacitated person resides.

4. Pursuant to § 64.2-2012 of the Code of Virginia, all guardianship orders are subject to petition for restoration of the incapacitated person to capacity; modification of the type of appointment or areas of protection, management, or assistance granted; or termination of the guardianship. In lieu of such a petition, if the person subject to the guardianship is not represented by counsel, such person may initiate the process by sending informal written communications to the court. All orders appointing a guardian, conservator, or both shall include the current mailing address, email address, and physical address of the court issuing the order and to which such informal written communication shall be directed.

§ 64.2-2019. Duties and powers of guardian.

A. A guardian stands in a fiduciary relationship to the incapacitated person for whom he was appointed guardian and may be held personally liable for a breach of any fiduciary duty to the incapacitated person. A guardian shall not be liable for the acts of the incapacitated person unless the guardian is personally negligent. A guardian shall not be required to expend personal funds on behalf of the incapacitated person.

B. A guardian's duties and authority shall not extend to decisions addressed in a valid advance directive or durable power of attorney previously executed by the incapacitated person. A guardian may seek court authorization to revoke, suspend, or otherwise modify a durable power of attorney, as provided by the Uniform Power of Attorney Act (§ 64.2-1600 et seq.). Notwithstanding the provisions of the *Uniform* Health Care Decisions Act (§ ~~54.1-2981~~ *54.1-2993.2* et seq.) and in accordance with the procedures of § 64.2-2012, a guardian may seek court authorization to modify the designation of an agent under an advance directive, but the modification shall not in any way affect the incapacitated person's directives concerning the provision or refusal of specific medical treatments or procedures.

C. A guardian shall maintain sufficient contact with the incapacitated person to know of his capabilities, limitations, needs, and opportunities and as needed to comply with the duties imposed upon him pursuant to the order of appointment and this section and any other provision of law. The guardian shall visit the incapacitated person as often as necessary and at least three times per year, with at least one visit occurring every 120 days. Except as otherwise provided in subsection C1, of the three required visits, at least two visits shall be conducted by the guardian. The guardian shall conduct at least one of such visits in person; the second such visit may be conducted by the guardian via virtual conference or video call between the guardian and incapacitated person, provided that the technological means by which such conference or call can take place are readily available.

The remaining visit may be conducted (i) by the guardian; (ii) by a person other than the guardian, including (a) a family member or friend monitored by the guardian or (b) a skilled professional retained by the guardian to perform guardianship duties on behalf of the guardian and who is experienced in the care of individuals, including older adults or adults with disabilities; or (iii) via virtual conference or video call between either the guardian or such family member or friend monitored by the guardian or skilled professional and the incapacitated person, provided that the technological means by which such conference or call can take place are readily available. If a person other than the guardian conducts any such visit, he shall provide a written report to the guardian regarding any visit conducted by such person.

A telephone call shall meet the requirements of this subsection only if such technological means are not readily available.

C1. If for reasons outside the guardian's control the guardian cannot make an in-person visit to an incapacitated person, then such visit may be conducted in person by an individual designated by the guardian pursuant to subsection C. If either the guardian or such individual designated by the guardian is unable to conduct an in-person visit, then such visit may be conducted virtually through electronic means such as a virtual conference or video call, or, if such technological means are not readily available, by telephone.

C2. In the event of a state of emergency or public health crisis in which a facility in which the incapacitated person resides is not allowing in-person visitation, visitation requirements required pursuant to subsection C may be met via a virtual conference or video call between the guardian and incapacitated person, to the extent feasible for the facility to provide the technological means by which such conference or call can take place. A telephone call shall meet the requirements of this subsection only if such technological means are not readily available.

D. A guardian shall be required to seek prior court authorization to change the incapacitated person's residence to another state, to terminate or consent to a termination of the person's parental rights, or to initiate a change in the person's marital status.

E. A guardian shall, to the extent feasible, encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage personal affairs. A guardian, in

making decisions, shall consider the expressed desires and personal values of the incapacitated person to the extent known and shall otherwise act in the incapacitated person's best interest and exercise reasonable care, diligence, and prudence. A guardian shall not restrict an incapacitated person's ability to communicate with, visit, or interact with other persons with whom the incapacitated person has an established relationship, unless such restriction is reasonable to prevent physical, mental, or emotional harm to or financial exploitation of such incapacitated person and after consideration of the expressed wishes of the incapacitated person. Such restrictions shall only be imposed pursuant to § 64.2-2019.1.

E1. A guardian and any skilled professional retained by such guardian to perform guardianship duties on behalf of the guardian pursuant to clause (ii) (b) of subsection C shall complete the training developed by the Department for Aging and Rehabilitative Services pursuant to § 51.5-150.1 within 120 days after the date of the qualification of such guardian, unless such training was completed within the past 36 months in conjunction with another guardianship appointment made pursuant to § 64.2-2009. No guardian or skilled professional retained by such guardian shall be required to complete such training more frequently than once every 36 months.

F. A guardian shall have authority to make arrangements for the funeral and disposition of remains, including cremation, interment, entombment, memorialization, inurnment, or scattering of the cremains, or some combination thereof, if the guardian is not aware of any person that has been otherwise designated to make such arrangements as set forth in § 54.1-2825. A guardian shall have authority to make arrangements for the funeral and disposition of remains after the death of an incapacitated person if, after the guardian has made a good faith effort to locate the next of kin of the incapacitated person to determine if the next of kin wishes to make such arrangements, the next of kin does not wish to make the arrangements or the next of kin cannot be located. Good faith effort shall include contacting the next of kin identified in the petition for appointment of a guardian. The funeral service licensee, funeral service establishment, registered crematory, cemetery, cemetery operator, or guardian shall be immune from civil liability for any act, decision, or omission resulting from acceptance of any dead body for burial, cremation, or other disposition when the provisions of this section are met, unless such acts, decisions, or omissions resulted from bad faith or malicious intent.

2. That §§ 54.1-2981, 54.1-2982, 54.1-2983, 54.1-2983.2 through 54.1-2987, 54.1-2988, and 54.1-2989 through 54.1-2993 of the Code of Virginia are repealed.

3. That the provisions of this act may result in a net increase in periods of imprisonment or commitment. Pursuant to § 30-19.1:4 of the Code of Virginia, the estimated amount of the necessary appropriation cannot be determined for periods of imprisonment in state adult correctional facilities; therefore, Chapter 2 of the Acts of Assembly of 2024, Special Session I, requires the Virginia Criminal Sentencing Commission to assign a minimum fiscal impact of $50,000. Pursuant to § 30-19.1:4 of the Code of Virginia, the estimated amount of the necessary appropriation is $0 for periods of commitment to the custody of the Department of Juvenile Justice.