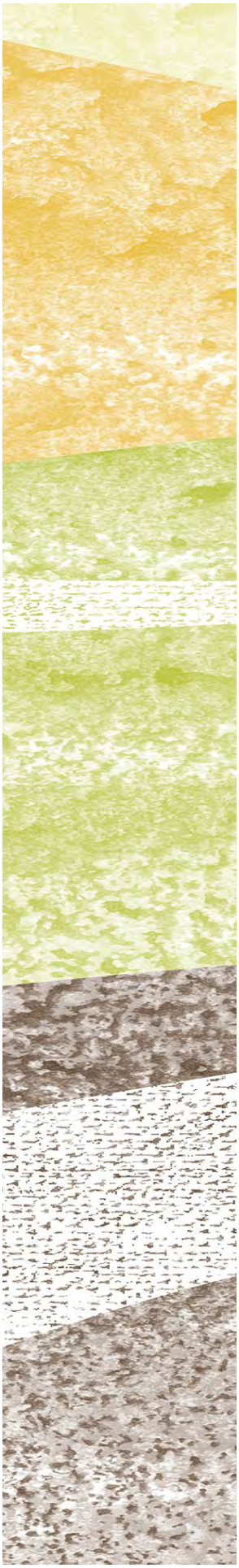

the power of attorney for health care

Advance Directive document, includes living will, information, and instructions

WAHA End of Life Choices
Whatcom Alliance for Health Advancement
WAHA 360.788.6594 | TTY 1.800.833.6388
waha.acp@hinet.org
www.whatcomalliance.org

overview

You have the right to make decisions about your health care. No health care may be given to you over your objections, and necessary health care may not be stopped or withheld if you object. In some cases, however, because of a serious accident or illness, you may be unable to speak for yourself or make your wishes known.

This Power of Attorney for Health Care meets Washington State's legal requirements for you to appoint another person to make your health care decisions if you become unable to make these decisions for yourself. This person is your health care agent. In this document you may write out any types of health care that you do or do not want, and you may limit the authority of your health care agent.

This Power of Attorney for Health Care is an important legal document that gives your health care agent broad powers to make health care decisions for you, but only when your doctors have determined you are incapable to make your own health care decisions. It does not give your health care agent any authority to make your financial or business decisions or certain decisions about mental health treatment. When you sign this document, it revokes any prior Power of Attorney for Health Care that you may have made.

If you wish to change your Power of Attorney for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked. If you revoke it, you should notify your health care agent, your health care providers, and any other person to whom you have given a copy.

If you complete a new document, the one with the most recent date is the legal one.

If your Agent is your spouse and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as health care agent will no longer be valid.

If you have any questions, contact WAHA. All services are free and confidential.

360.788.6594 | TTY 1.800.833.6388
waha.acp@hinet.org
whatcomalliance.org/end-of-life-care

how to complete this document

This Power of Attorney for Health Care form is divided into five parts.

PART I appointing a health care agent

PART II granting authority to the health care agent

PART III stating desires, special provisions, or limitations

PART IV making the document legal

PART V distributing your power or attorney for health care document

Each of these parts has instructions. Please read and follow the instructions carefully.

PART I

appointing a health care agent

instructions

Understand the situation clearly. If you are no longer able to make your own health care decisions because you have been determined to be incapable under state law, the person you name to be your health care agent will make your health care decisions for you.

When selecting someone to be your health care agent, pick someone who

- knows you well
- you trust
- is willing to respect your views and values
- is able to make difficult decisions in stressful circumstances

Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you.

Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent and alternate agents.

Your health care agent

- must be at least 18 years or older and
- cannot be one of your health care providers or an employee of your health care provider unless they are your spouse, state registered domestic partner, or adult child or brother or sister.

Space has been provided for you to identify an alternate health care agent who will speak for you if your first choice is unavailable.

If you wish to name additional alternate agents, you may need to attach another sheet of paper.

IMPORTANT!

Complete this section on **every** page in this document.

Jane Smith — name (print)

3/22/1972 — birthdate

PART I

Power of Attorney for Health Care Document for

your name _____ birthdate _____

day phone _____ cell phone _____

address _____

city _____ state _____ zip code _____

The person I want for my health care agent is

name _____

day phone _____ cell phone _____

address _____

city _____ state _____ zip code _____

This person will make my health care decisions when I am determined to be incapable to make health care decisions as provided under state law.

If this Health Care Agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced or legally separated, then my next choice for a Health Care Agent is:

name _____

day phone _____ cell phone _____

address _____

city _____ state _____ zip code _____

name (print) _____ birthdate _____

PART II

granting authority to the health care agent

instructions

If you agree with the statement, put your initials next to it (for example: DS To make choices for me...)

If you do NOT agree or if the statement does not apply to you, cross out the entire statement (for example: ~~To make choices for me...~~).

I want my health care agent to be able to do the following:

_____ Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my health care agent can keep it going or have it stopped depending upon my stated instructions or my best interests.

_____ Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.

_____ Review and release my medical records and personal files as needed for my medical care.

_____ Arrange for my medical care and treatment in Washington or another state, as my health care agent thinks appropriate.

_____ Determine which health professionals and organizations provide my medical treatment.

_____ Make decisions about organ/tissue or body donation decisions (anatomical gifts) after my death according to my known wishes or values.

_____ Admit me to a nursing home or community-based residential facility for a long-term stay, subject to any limits I have set forth in this document.

_____ Have a feeding tube or IV hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

name (print) birthdate

PART III

stating desires, special provisions, or limitations

instructions

In this section, you have the option of providing specific instructions for your health care agent and/or the physicians giving you medical care. By completing this form you indicate that you want the information you provide to be followed based on your common law and constitutional right to direct your own health care.

You are not required to provide any written instructions or make any selections in Part III.

If you choose not to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest.

Where indicated below

- If you agree with the statement, put your initials next to it (e.g. DS).
- If you do NOT agree or if the statement does not apply to you, cross out the entire statement (e.g. ~~cross out the entire statement~~).
- If you choose not to provide any instructions at all, it is recommended that you draw a line and write "no instructions" across the entire page.

You may add additional sheets of paper and/or re-write in your own words.

1. life-prolonging treatments

_____ If I reach a point where my doctors feel it is reasonably certain that I will not recover my ability to interact meaningfully* with myself, my family, friends, and environment, I want to continue ONLY the following treatments which might be used to prolong my life. (Please put your initials besides the treatments you DO WANT and put a line through those that you DO NOT WANT.)

_____ CPR (Chest compressions)

_____ Breathing machines (intubation)

_____ Tube feedings

_____ IV hydration

_____ Antibiotic treatment

_____ I do not want to receive any treatments that may help prolong my life

**This is what "to interact meaningfully" means to me:*

_____

_____

_____

name (print) birthdate

PART III

2. pain and symptom control

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable.

The following are important to me for comfort (for example, enough pain medicine to relieve pain even if it makes me drowsy, spiritual/religious support, referral to Hospice). If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.

3. other requests for care

_____ I would like my health care agent and others to see that my preferences on the following topics are honored as much as possible (having visitors / having privacy; tending to my personal care; music I might want to listen to / silence; a light room / a dark room, etc.)

_____ When I am nearing my death, I would like my health care agent and others to help make my death more meaningful by doing the following (ceremonies, faith practices, hold my hand, play music / be silent, etc.)

4. People to include in the process

_____ In addition to your health care agent/s, who else would you like to have kept informed about your medical situation, if anyone?

5. religious beliefs

I am of the _____ faith, and am a member of the _____ _____ (specific faith community you attend).
Phone number (if known): _____.
Please attempt to notify them.

name (print) birthdate

PART III

6. requests for services after death

After I die, I would like my agent / family / others to try to do the following (services, memorials, ceremonies, burial, or cremation):

_____

_____

7. autopsy requests

An autopsy is a medical examination to learn the cause of death

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me.

8. organs or tissue donations

(Examples of organs that you could donate include kidney, liver, heart, lung; examples of tissues that you could donate include eye, skin, bone, or heart valve.)

_____ I consent to donate any organs or tissue if I am a candidate.

_____ for transplant only

_____ for transplant or research

_____ I consent to donate only the following organs or parts if possible (name the specific organs or tissue):

_____

_____

_____ I do not want to donate any organ or tissue.

If you wish to donate your whole body after death to medical science, you must make arrangements in advance. Here are some places to contact:

- University of Washington Willed Body Program
  wbp.biostr.washington.edu/Overview/overview.html
- Washington State University Willed Body Program
  https://medicine.wsu.edu/willed-body-program/

name (print) birthdate

PART IV

making the document legal

instructions

Washington State residents must sign and date this document in the presence of two witnesses.

It is recommended (though not required) that you sign and have it witnessed in front of a Notary Public.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My signature Date

Notary Public

STATE OF WASHINGTON (COUNTY OF_____)

I certify that I know or have satisfactory evidence that the GRANTOR,

_____

signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this____day of_____(month),_____(year).

_____

NOTARY PUBLIC in and for the State of Washington,

residing at _____

My commission expires _____

Your name (print) _____

name (print) birthdate

PART IV

Statement of Witnesses

I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage, or adoption.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for that person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

Witness Number 1 Signature Date

Print name

Address

Witness number 2:

Witness Number 2 Signature Date

Print name

Address

name (print) birthdate

PART V

distributing your Power of Attorney for Health Care Document

After you complete and notarize the document, make copies of the numbered pages to be given out as follows:

- One copy for yourself.
- One copy for your health care agent and the alternates you appoint in this document.
- One copy to share and discuss with your family doctor.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney), listed here:

_____

_____

_____

_____

Mail or deliver one copy to:

Health Information Management/Medical Records
PeaceHealth St. Joseph Medical Center
2901 Squalicum Parkway Bellingham, WA 98225-1898

A photo or fax copy is as legally valid as an original.

Keep the original document at home in an accessible but safe place.

The Whatcom Alliance can also assist with

- advance care planning conversations
- document completion
- notary service (an appointment is required, please call first)
- copying
- sharing these documents with your physicians and the hospital

If you have any questions, contact WAHA. All services are free and confidential.

360.788.6594 | TTY 1.800.833.6388
waha.acp@hinet.org
whatcomalliance.org/end-of-life-care/