AN OVERVIEW

Honoring Choices®
PACIFIC NORTHWEST
AN INITIATIVE OF
Washington State Hospital Association | WSMA Foundation for Health Care Improvement

This form meets the requirements of Washington state law.

What is advance care planning?

Advance care planning is thinking about what health care you might want in the future. This type of planning includes talking about, writing down, and sharing what is important to you. This helps others make health care decisions for you if you cannot make your own decisions. In this situation, a person close to you would need to make decisions for you. This person is called a health care agent, also known as an attorney-in-fact, surrogate, or legal medical decision maker.

It is important that you prepare your health care agent by sharing how you would want them to make health care decisions for you.

What is an advance directive?

An advance directive is a voluntary, legal way to write down your advance care planning decisions. You should share your advance directive with people who matter to you—like your health care agent and loved ones—and your health care providers, clinic, and hospital. An advance directive should be updated regularly. All adults 18 and older can complete an advance directive.

There are two types of advance directives in Washington state:

1) a durable power of attorney for health care and

2) a health care directive

The advance directive in this booklet is a durable power of attorney for health care (DPOA-HC). The DPOA-HC is based on Washington state law (chapter 11.125 RCW). This legal form allows you to name your health care agent to make health care decisions for you if you cannot make your own decisions. This form also helps you prepare your health care agent by sharing your goals, values, and preferences. Research shows that the best way to ensure your wishes are followed is to name and prepare a health care agent.

The advance directive in this booklet is not a health care directive (chapter 70.122 RCW). Health care directives are also known as living wills. You may consider also completing a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under

Washington state law. For more information on a health care directive, visit:

www.HonoringChoicesPNW.org or talk with your health care provider.

What is a health care agent?

A health care agent is the person you choose to make health care decisions for you if you cannot make them for yourself. You should tell your health care agent what is important to you, like your personal values and goals for treatment. This information can guide your health care agent and health care providers to make the best possible decisions on your behalf if you cannot make your own decisions. By completing this advance directive (a durable power of attorney for health care) you allow this person to make decisions with your health care providers about your care. Your health care agent will not be personally financially responsible for care they select for you as your health care agent.

What makes a good health care agent?

Your health care agent SHOULD:

- ✓ Understand what a health care agent does and be willing to fill this role.
- ✓ Share your goals, values, and preferences with your health care providers, and describe what "living well" or a "good day" means to you.
- ✓ Carry out your decisions, even if they do not agree with your decisions. Be able to make decisions in difficult or stressful times.

Your health care agent CANNOT be:

- Under 18 years old.
- Your physician or your physician's employee (unless they are your spouse, state registered domestic partner, parent, adult child, or adult sibling).
- An owner, administrator, or employee of a health care facility or long-term care facility where you receive care or live (unless they are your spouse, state registered domestic partner, parent, adult child, or adult sibling).

What can a health care agent do?

If you cannot make your own health care decisions, your health care agent will be asked to make health care decisions for you.

Your health care agent can use the information you share in this advance directive and in conversations to guide your care.

Consistent with state law and using their understanding of your goals, values, and preferences, your health care agent can:

- Decide on treatments and surgeries, including whether to use cardiopulmonary resuscitation (CPR), a breathing machine, a feeding tube, and other treatments.
- Decide whether to end life-support treatment and focus on comfort care.

- Review and release medical records for your care and/or apply for health care insurance benefits on your behalf.
- Choose the health care providers and organizations to provide your health care.

What is CPR?

Cardiopulmonary resuscitation or CPR is a procedure used when your heart and breathing stop. CPR works best if your body is healthy and CPR is started right away after your heart stops. CPR is less likely to be successful if you are weak, elderly, or have a serious illness.

If you survive, you might need a ventilator (breathing machine) because of weakened lungs. It is important to talk to your health care providers about whether CPR would meet your goals.

Standard care in Washington state is to provide CPR to people if their heart and breathing stop. Sharing your CPR wishes on this DPOA-HC form can guide

your “code status” if you are hospitalized. Code status means the type of emergent treatment a person would or would not receive in the hospital if their heart or breathing stop.

Some people who choose not to receive CPR in a hospital also do not want CPR in other settings. In this situation you should ask your health care provider about completing a Portable Orders for Life-Sustaining Treatment (POLST). POLST is a medical order that communicates health care decisions to emergency responders and other medical professionals.

What is life support?

Life-support (also known as life-sustaining) treatments are medical treatments that keep you alive by supporting or replacing important body functions. These treatments do not cure medical conditions. They keep you alive until you either get better or you are taken off life support and are

allowed to die naturally. Some examples of life-support treatments are CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. It is important to know that easing pain and providing comfort are part of routine care and not considered life-support treatments.

What happens if I do not name a health care agent?

If you cannot make your own health care decisions and a health care agent is not named, your health care providers will follow Washington state law to determine who can act as your medical decision maker. This means they will ask family members or friends to make health care decisions for you. If family or friends cannot be identified from the list below, health care providers may ask a court to appoint a guardian to make health care decisions on your behalf.

Health care providers will contact people in the following order until they can identify a medical decision maker for you (chapter 7.70.065 RCW).

1. A guardian appointed by a court (if applicable)
2. Named health care agent(s)*
3. Spouse or registered domestic partner
4. Adult children*
5. Parents*
6. Adult siblings*
7. Adult grandchildren who are familiar with the patient*
8. Adult nieces and nephews who are familiar with the patient*
9. Adult aunts and uncles who are familiar with the patient*
10. A close adult friend who meets certain criteria

* *For any group that has more than one person, everyone in the group must agree to the care.*

What are some situations that may apply?

Naming your spouse as your health care agent

If you choose your spouse or registered domestic partner as your health care agent in this form, they will stop being your named health care agent if either of you file for dissolution, annulment, or legal separation (chapter 11.125.100 RCW). However, this form allows you to choose to have them continue as your health care agent, even after divorce.

If this situation applies to you, initial next to this statement on Page 1 of this form: “If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.”

Not naming a health care agent in this form

Although a primary goal of this form is to name a health care agent, you have the option not to name one. If a health care agent is not named, health care providers will follow Washington state law to determine who can act as your medical decision maker (chapter 7.70.065 RCW).

If you complete the other sections of this form, it will be considered a personal values statement and not

an advance directive. A personal values statement is a summary of your goals, values, and preferences. This information can guide your medical decision maker on how to make decisions on your behalf.

If this situation applies to you, initial next to this statement on Page 1 of this form: "I am not naming a health care agent. By sharing my goals and values in this form, it will be considered a personal values statement and not an advance directive."

In this situation, you may also consider completing a health care directive, also known as a living will, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information, visit **www.HonoringChoicesPNW.org** or talk with your health care provider.

What should I do with this advance directive?

Once you complete this advance directive, you should talk about your wishes and give copies to the people who matter to you—like your health care agent and loved ones —and your health care providers, clinic, and hospital. If it applies, consider sharing copies with your nursing home or assisted living facility too. It is important that everyone has a copy.

What if I change my mind?

If you change your mind about the decisions in your advance directive, tell everyone who has a copy, including your health care agent, loved ones, health care providers, clinic, and hospital. You can revoke or void your advance directive at any time. You will need to tell your health care provider that you want to revoke it either by writing them a letter (make sure to sign and date it) or by verbally telling them. It is important to complete a new advance directive. Be sure to give copies of the new advance directive to the people who matter to you—like your health care agent and loved ones—and your health care providers, clinic, and hospital.

What about organ and tissue donation?

If you want to be a donor, please tell your health care agent, family, and health care providers. You can also record your organ and tissue donation wishes at **www.registerme.org**.

Who decides how to handle my body after I die?

This form does not direct the disposal of your remains. Consider completing a form that specifically provides instructions on how to handle your body after you die consistent with state law (chapter 68.50.160 RCW).

Who can I contact if I need help with advance care planning?

Honoring Choices PNW is here to help you. Visit **www.honoringchoicespnw.org/locations** or contact us at **info@honoringchoicespnw.org** for help.

ATTENTION HEALTH CARE PROVIDERS	**PLEASE HONOR** MY WISHES
MY NAME: _____ MY DATE OF BIRTH: / / **MY HEALTH CARE PROVIDER:** _____ PROVIDER OFFICE PHONE: ( ) _____	**MY HEALTH CARE AGENT** (named on DPOA-HC): _____ BEST PHONE: ( ) _____ MY ☐ ADVANCE DIRECTIVE ☐ POLST CAN BE FOUND AT: _____

Clip and carry this wallet card with you to let others know you have a health care agent.

ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My Information:

FULL NAME:_____

PRONOUNS (optional):_____

(i.e., he/she/they)

DATE OF BIRTH:_____

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME:_____

PRONOUNS (optional):_____

(i.e., he/she/they)

DATE OF BIRTH:_____

RELATIONSHIP:_____

BEST PHONE:_( )_____

ALTERNATE PHONE:_( )_____

ADDRESS, CITY, STATE, ZIP:

_____

The people I designate as my alternate agents are:

First Alternate:

FULL NAME:_____

PRONOUNS (optional):_____

(i.e., he/she/they)

DATE OF BIRTH:_____

RELATIONSHIP:_____

BEST PHONE:_( )_____

ALTERNATE PHONE:_( )_____

ADDRESS, CITY, STATE, ZIP:

_____

Second Alternate:

FULL NAME:_____

PRONOUNS (optional):_____

(i.e., he/she/they)

DATE OF BIRTH:_____

RELATIONSHIP:_____

BEST PHONE:_( )_____

ALTERNATE PHONE:_( )_____

ADDRESS, CITY, STATE, ZIP:

_____

Situations that may apply:

Initial next to the statements below that apply to you. You may draw a line through statements that do not apply to you. For more information: see the ACP Overview, visit www.HonoringChoicesPNW.org, or talk with your health care provider.

_____ If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.

_____ I am not naming a health care agent. By sharing my goals and values in this form, it will be considered a personal values statement and not an advance directive.

PREPARING A HEALTH CARE AGENT

What matters most to me?

This section helps you think about what matters most to you. This information can guide the people who matter to you — like your health care agent and loved ones — to make health care decisions for you if you cannot make them yourself. Consider sharing:

- What do you love to do, mentally and physically?
- How important is it for you to know who you are and who you are with?
- How important is communicating with family and friends to you?
- What does "living well" or "a good day" look like to you?
- What do you value most in your life?

The following is what matters most to me: *(Be specific. Add pages if needed.)*

_____

_____

_____

_____

_____

_____

PREPARING A HEALTH CARE AGENT

What are my beliefs, preferences, and practices?

It is important for the people who matter to you—like your health care agent and loved ones—and your health care team to know about your beliefs, preferences, and practices. Consider sharing:

- What provides you support, comfort, and strength during difficult times?
- What medical treatments would you want or not want (e.g., blood transfusion, pain management, artificial feeding)?
- How are health care decisions made in your community, culture, or family?

The following beliefs, preferences, and practices are important to me: *(Be specific. Add pages if needed.)*

_____

_____

_____

_____

_____

_____

PREPARING A HEALTH CARE AGENT

I would want the following person(s) contacted to support my beliefs, preferences, and practices: (They will not have power to make health care decisions.)

NAME:_____ ROLE:_____

PHONE:_( )_____ ORGANIZATION:_____

In answering the following questions, I am sharing my health care preferences. If I cannot make health care decisions for myself, I want my health care agent to use this information to guide their decisions. I understand that this information can guide my care, but it might not be possible to follow my wishes exactly in every situation.

CPR: What are my wishes?

Standard care in Washington state is to provide cardio-pulmonary resuscitation (CPR) to people if their heart and breathing stop. This section can guide your health care agent and health care providers on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as "code status").

If I am hospitalized and my heart and breathing stop:

☐ I want CPR attempted.

☐ I want CPR attempted, unless there has been a change in my health, and I have:

- Little chance of living a life that aligns with the goals and values I have stated in this form and/or discussed with my health care agent; or
- A disease or injury that cannot be cured, and I am likely to die soon; or
- Little chance of survival even if my heart is started again.

☐ I do not want CPR attempted. I want to be allowed to die naturally. *(Talk to your health care provider about a POLST form.)*

Life Support: What are my wishes?

Your response below is intended to guide your health care agent. Answering this question does not make this form a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information, visit www.HonoringChoicesPNW.org or talk with your health care provider.

If I am so sick or injured that I am likely to die soon or am in a coma and unlikely to recover, I want my health care agent to:

☐ Use all life-support treatments to keep me alive even if there is little chance of recovery. I want to stay on life support.

☐ Try all life-support treatments that my health care providers think might help me recover. If the treatments do not work and there is little chance of living a life that aligns with my goals and values, I do not want to stay on life support. At that point, allow me to die naturally.

☐ Allow me to die naturally. I do not want to be on life support. If life-support treatments have been started, I want them to be stopped.

☐ I want my health care agent to decide for me.

Additional Directions

If I am dying and my medical care, support system, and resources allow, my preference would be to die:

☐ At my home or the home of a loved one (with hospice if desired).

☐ In a medical facility.

☐ I do not have a preference.

☐ Other (please describe**):**

_____

_____

If I am pregnant and cannot make health care decisions for myself, I would like my health care agent and health care providers to take the following into consideration as they make health care decisions on my behalf:

_____

_____

Additional Directions

Write any additional information you want your health care agent, health care providers, or others to know about your health care wishes. Please note that your wishes for organ donation and plans for your remains should be documented separately.

_____

_____

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: I authorize my health care agent to give consent for medical treatments when I cannot make my own decisions. I authorize my health care agent to carry out my wishes regarding life-support treatments such as a CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

AUTHORIZING A HEALTH CARE AGENT

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE:_____DATE:_____

ADDRESS, CITY, STATE, ZIP:

_____

Witnesses or Notary Requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

Rules for Witnesses:

- Must be at least 18 years of age and competent
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live

OPTION 1 – TWO WITNESSES

Witness Attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE:_____

DATE:_____

NAME PRINTED:_____

WITNESS #2 SIGNATURE: _____

DATE: _____

NAME PRINTED: _____

OPTION 2 – NOTARY

STATE OF WASHINGTON)

COUNTY OF _____)

This record was acknowledged before me on this_____day of _____,_____ by (name of individual):_____

Signature:_____

Title:_____

Exp:_____