ENHANCED LIVING WILL
AND
DURABLE POWER OF ATTORNEY
FOR
HEALTH CARE

Provided by

Susan M. Graham, J.D., M.B.A.

Certified Elder Law Attorney

SENIOR EDGE LEGAL

1009 W. Fort Street, Boise, Idaho 83702
Phone 208-344-0375 · Fax 208-344-1510 . Text 208-608-3490
info@senioredgelegal.com · www.SeniorEdgeLegal.com

INSTRUCTIONS

LIVING WILL

1) Fill in the date, your name. date of birth, address, and email address on page 1.

2) Indicate which one of the three end-of-life decisions you want on page 3. Put a "check" or "X" in the box you elect and follow it with your initials. Be sure to check and initial one of the choices marked A, B, or C on page 3.

3) If you want "assisted suicide" referred to on page 4, put a "check" or "X" in the box you elect and follow it with your initials.

4) Check one box to indicate if you have or have not completed a Physician Orders for Scope of Treatment (paragraph 5, page 4). Put a "check" or "X" in the box you elect and follow it with your initials.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1) Put your name on page 5.

2) Put the name, relation to you, address, email address, and telephone number of your first health care agent on page 5.

3) Put the names, relations to you, addresses, email addresses, and phone numbers of your alternate agents in the spaces provided on page 6.

4) Indicate if you want to donate your organs on page 7. Put a "check" or "X" in the box you elect and follow it with your initials.

5) If you want "assisted suicide" referred to on page 8, put a "check" or "X" in the box you elect and follow it with your initials.

6) Sign this document before a Notary Public. Enter the date you sign the document and sign your name, then print your name and address on page 9.

7). Have the Notary Public complete page 10.

7) If you want to expand on your health care instructions, including but not limited to what you are allergic to (examples: Poison Ivy, Tylenol, Sulfa drugs), print your name on the line at top of Exhibit "A" on the last page. Enter the date and sign the document.

SUMMARY

Complete the form. SIGN THE FORM BEFORE A NOTARY PUBLIC. Keep the original.
Give a copy to each of your named health agents.
Give a copy to your physician.

Enhanced Living Will and
Durable Power of Attorney for Health Care
Idaho Code § 39-4510

Date of Directive: _____ day of _____ 20____

Name of Person executing Directive: _____

Date of birth of Person executing Directive: _____

Address of Person executing Directive: _____

_____

Email address of Person executing Directive: _____

A LIVING WILL

A Directive to Withhold or to Provide Treatment

I willfully and voluntarily make the following instructions regarding the withholding or withdrawal of artificial life-sustaining treatment in the event that:

a. According to the reasonable medical judgment of a licensed physician, who has examined me, my death is imminent within hours or a few days regardless of whether treatment is provided;

OR

b. I am in a persistent vegetative state in which I am in a state of partial arousal rather than true awareness, am completely unresponsive to psychological or physical stimuli; and display no sign of higher brain function.

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This directive shall be effective only if I am unable to communicate my instructions and:

a. I have an incurable injury, disease, illness or condition and one (1) medical doctor who has examined me has certified:

1) That such injury, disease, illness or condition is terminal; and

2) That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and

3) That my death is imminent, whether or not artificial life-sustaining procedures are utilized;

OR

b. I have been diagnosed as being in a persistent vegetative state; then:

c. I direct that the following marked expression of my intent be followed, and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

For this election to be effective, a box must be "checked" and initial the line after such box.

☐ _____ I direct that all medical treatment, care and procedures necessary to restore my health, sustain my life, and to abolish or alleviate pain or distress be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

☐ _____ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows: (If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)

A. ☐ _____ Only hydration of any nature, whether artificial or non-artificial, shall be administered.

B. ☐ _____ Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

C. ☐ _____ Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

☐ _____ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration. I specifically direct that I do not receive food by gastric or nasogastric tube or in any way other than by mouth, and that I do not receive fluids in any way other than by mouth. If because of disability, stroke, accident, or other cause, I should become incompetent and unable to make decisions concerning my medical care, I direct my family and physicians not to use artificial means, including tube and intravenous feeding, to prolong my life unless, based on the then current medical knowledge, there is a medically reasonable expectation of a substantial recovery of my mental and physical functions. I specifically request that under such

circumstances, I not be resuscitated and that I not receive any cardiopulmonary resuscitation, electric shock treatments or blood transfusions.

I specifically authorize my Representative to refuse to allow implantation or installation of a pacemaker or the replacement of a pacemaker battery, and to direct health care staff to turn off or de-activate a pacemaker if one has already been implanted in me.

For the following item #2 to be effective, check the box and initial the line after the box if you want "assisted suicide".

2. Humane administration of life-terminating drugs or mechanisms:

☐ _____ I request my health care agent assist me in ending my life by legal means or authorize the humane administration of life-terminating drugs or mechanisms, if applicable law permits euthanasia or physician-assisted suicide, and if I am suffering from a terminal condition or an irreversible injury, disease or illness. My agent shall have the legal authority to move me to jurisdictions that allow assisted suicide, or generally that allow euthanasia or assisted suicide.

3. This Directive shall be the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal or acceptance.

4. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

For this election to be effective, a box must be "checked" and initial the line after such box.

5. Physician Orders for Scope of Treatment (POST)

☐ _____ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

OR

☐ _____ I have NOT completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician and me or my agent, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

6. If my health care provider refuses to honor my agent's decisions, my agent is empowered to direct the health care provider responsible for my care to transfer my care to another health care provider who will comply; if this authority is thwarted, undermined, or not honored to its fullest extent, I further instruct and empower my agent to initiate action for battery against such providers.

7 It is my desire that this document, duly executed in Idaho, shall be presumed to comply with the provisions of any similar Act in any other State, and may, in good faith, be relied upon by a health care provider or health care facility in Idaho as well as any other state.

A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT. None of the following may be designated as your agent: (1) your treating health care provider; (2) a non-relative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a non-relative employee of an operator of a community care facility. If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereon revoked.

I, _____, do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive:

Name of Health Care Agent: _____

Relation to Person _____

Address of Health Care Agent: _____

_____

Email Address of Health Care Agent: _____

Telephone Number of Health Care Agent: _____

Designation of Successor Agent:

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____

Relation to Person: _____

Address of Successor Agent: _____

_____

Email Address of Successor Agent: _____

Telephone Number of Successor Agent: _____

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

Name of Second Successor Agent: _____

Relation to Person: _____

Address of Second Successor Agent: _____

_____

Email Address of Second Successor Agent: _____

Telephone Number of Second Successor Agent: _____

For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this Directive, including as set forth in paragraph 2 immediately above, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise

made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in a Physician Orders for Scope of Treatment (POST) form, living will or similar document executed by me, if any. Additional statements of desires, special provisions, and limitations are attached as Exhibit "A," each page of which is dated and signed by me and incorporated by reference herein as fully set forth.

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
- Execute on my behalf any releases or other documents that may be required in order to obtain this information;
- Consent to the disclosure of this information; and

Check a box and initial the line after such box:

Concerning my organ donation:

☐ _____ I consent to the donation of any of my organs for medical purposes.

OR

☐ _____ I do NOT consent to the donation of any of my organs for medical purposes.

Desire to Reside at Home: If my home has not been sold, I would like to live my last days at home, if doing so does not jeopardize the chance of my recovery to a meaningful life and if it does not impose an undue burden on my family. I would prefer to receive hospice care, rather than care in a hospital, during the last days of my life, if this is feasible. I ask that all medical providers engage in palliative care for my benefit during the last days of my life.

For the following item to be effective, check the box and initial the line after the box if you want "assisted suicide".

Humane administration of life-terminating drugs or mechanisms:

☐ _____ I request my health care agent assist me in ending my life by legal means or authorize the humane administration of life-terminating drugs or mechanisms, if applicable law permits euthanasia or physician-assisted suicide, and if I am suffering from a terminal condition or an irreversible injury, disease or illness. My agent shall have the legal authority to move me to jurisdictions that allows assisted suicide, or generally that allow euthanasia or assisted suicide.

This Directive shall be the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal or acceptance.

I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160 through 164. I authorize:

- any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction:

- all my individually identifiable health information and medical records regarding any past, present or future medical and mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my

individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

6. SIGNING DOCUMENTS, WAIVERS AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following: (a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or "Leaving Hospital Against Medical Advice"; and (b) Any necessary waiver or release from liability required by a hospital or physician.

7. DRIVING INSTRUCTIONS. My agent is authorized to tell my doctor that in my agent's opinion, I am a danger to others when I drive. I realize that this might result in the loss of my driving license and driving privileges. I also realize that I may not agree with my agent when my agent comes to this conclusion. However, I do not want to endanger myself and I do not want to endanger others. Therefore, I put this decision in my agent's hands, as I have the utmost trust and confidence in my agent.

8. AUTHORITY TO MAKE FUNERAL ARRANGEMENTS. If I fail to pre-arrange my funeral, I designate my agents named in this Durable Power of Attorney for Health Care to make those arrangements as provided in Idaho Code Section 54-1142, as amended.

10. PRIOR DESIGNATIONS REVOKED. I revoke any prior living will and durable power of attorney for health care.

11. DATE AND SIGNATURE OF PRINCIPAL. I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on _____, 20___.

_____

Signature

Printed Name: _____

Street Address: _____

City, State, Zip: _____

STATE OF IDAHO)
: ss.
County of Ada)

On _____, 20___, before me personally appeared _____, known to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year in this certificate above written.

_____
Notary Public in and for Idaho
Residing at Boise, Idaho.
My commission expires_____.

EXHIBIT "A"
STATEMENT OF
SPECIAL PROVISIONS AND LIMITATIONS FOR

_____

[Print your name on the above line]

My Living Will and Durable Power of Attorney for Health Care, executed _____, 20_____, Paragraph 4 of the Durable Power of Attorney for Health Care, refers to the use of an Exhibit "A" for additional statements of desires, special provisions and limitations. I hereby make this statement for that purpose.

_____

_____

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_____

_____

Date: _____ Signature: _____