

ENHANCED LIVING WILL
AND
DURABLE POWER OF ATTORNEY FOR
HEALTH CARE

Provided by

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This form is provided as a public service and is not intended as legal advice concerning your particular needs and circumstances. If you have questions regarding the operation and legal effect of this document, we recommend that you contact legal counsel of your choice.

INSTRUCTIONS LIVING WILL

- 1) Fill in the date, your name, date of birth, address, and phone number on **page 1**.
- 2) Indicate which one of the three **end of life decisions** you want on **page 2**. Put an "X" in the box you elect and follow it with your initials. Be sure to check and initial one of the choices marked 1, 2 or 3 on page 2.
- 3) If you want the option of "**Medical Assistance in Dying**" referred to on **page 3**, put an "X" in the box you elect and follow it with your initials.
- 4) If you want the option of "**Voluntary Stopping of Eating and Drinking**" [VSED] referred to on **page 3**, put an "X" in the box you elect and follow it with your initials.
- 5) If you have or have not completed a "**Physician Orders for Scope of Treatment**" [PSOT] form, on **page 4** put an "X" in the box that applied to you and follow it with your initials.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

- 1) Fill in your name, as the Principal on **page 5**.
- 2) For each **agent you want to make medical decisions** for you when you are able to communicate, fill in the name, relation to you, address, and telephone number in their order of priority on **pages 5 and 6**.
- 3) Indicate if you want to **donate your organs** on **page 7** put an "X" in the box that applied to you and follow it with your initials.
- 4) If you want the option of "**Medical Assistance in Dying**" referred to on **page 7**, put an "X" in the box you elect and follow it with your initials.
- 5) If you want to **give your health agents the right to make decisions about your mental health** care, when you are not able, then on **page 9**, put an "X" in the box that applies to you and follow it with your initials.
 - If you make this election, then you **must have two witnesses** see you sign on page 10, and a **Notary Public must notarize** the two witnesses and you signing the document. If this applies, complete **page 11**.
 - If you make this election, **when your agent takes over to make mental health decisions** they must sign the form on **page 12** and have their signature notarized.
- 6) **Enter the date you sign the document and sign your name, then print your name and address on 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"**, list the items, fill in the date in two places and sign the document

SUMMARY

You 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: _____.

Name of Person executing Directive: _____.

Date of Birth of Person executing Directive: _____.

Address of Person executing Directive: _____.

Phone Number of Person executing Directive: _____.

A LIVING WILL
A Directive to Withhold or to Provide Treatment

This portion of my Advance Directive creates my Living Will which allows me to make choices about any life-sustaining medical treatment I want or do not want. This Advance 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 a medical doctor who has examined me has certified:

- i. That such injury, disease, illness, or condition is terminal; and
- ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
- iii. 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.

If I am in one of the above situations, my choices are as follows:

[Choose Box 1, 2 or 3 below, Put an "X" the box and initial the line after the box for this to be effective]

Regardless of the box chosen, pain and symptom management (comfort care) will be provided.

1. _____ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started, and if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) 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.

OR

2. _____ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and hydration as follows:

Check one box and initial the line after the box you checked for this to be effective:

A. _____ Only artificial hydration

B. _____ Only artificial nutrition

C. _____ Both artificial hydration and nutrition

OR

3. _____ If my death is imminent, I want all medical treatment, care and procedures necessary to sustain my life, including artificial nutrition and hydration.

C. Medical Assistance in Dying.

[Put an "X" the box and initial the line after the box for this to be effective]

_____ 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.

D. Voluntary Stopping of Eating and Drinking (VSED).

[Choose Box 1, 2 or 3 below. Put an "X" the box and initial the line after the box for this to be effective].

The quality of my life is more important to me than extending my life as long as possible. In the event I exhibit symptoms such as extreme loss of independence, loss of dignity, loss of appetite or significant weight loss, the complete inability to care for my personal needs or immobility, or similar symptoms, the following reflects my current preferences for VSED.

1. _____ I do NOT consent to VSED and my agent may take reasonable efforts to offer or persuade me to eat or drink.
2. _____ I do not currently have a preference regarding VSED and request that my agent discuss this issue with me in the event that I experience the above described symptoms.
3. _____ I CONSENT to VSED and if this should occur, my agent may take reasonable efforts to prevent caregivers or others from offering or persuading me to eat or drink.

The above reflects my wishes at the time of this document's execution. If, at a future time, I am unable to explicitly express my wishes regarding oral nutrition and hydration, I want my Agent and care providers to consider the following when trying to determine my wishes and whether to provide oral nutrition and hydration:

- I no longer appear to desire to eat or drink.
- I appear to be indifferent to being fed.
- I do not willingly open my mouth.
- I turn my head away or try to avoid being fed or given fluids in any other way.
- I spit out food or fluids.
- I begin a pattern of coughing, gagging, or choking on or aspirating food or fluids.
- The negative medical consequences or symptoms of continued feeding and drinking, as determined by a qualified medical provider, outweigh the benefits.

E. Physician Orders for Scope of Treatment (POST)

[Put an "X" the box and initial the line after the box for this to be effective]

_____ I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Advanced Directive. I hereby approve of those orders and make them a part of this Advanced Directive.

OR

_____ I have NOT completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

F. Final Decision.

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.

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.

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

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective only when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

I. 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, _____, the Principal, 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 the Principal: _____

Address of Health Care Agent: _____

Telephone Number of Health Care Agent: _____

DESIGNATION OF SUCCESSOR AGENT(S):

Name of Successor Health Care Agent: _____

Relation to the Principal: _____

Address of Successor Health Care Agent: _____

Telephone Number of Successor Health Care Agent: _____

Name of 2nd Successor Health Care Agent: _____

Relation to the Principal: _____

Address of 2nd Successor Health Care Agent: _____

Telephone Number of 2nd Successor Health Care 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 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 to obtain this information;
- Consent to the disclosure of this information; and

Concerning my organ donation:

[Put an "X" the box and initial the line after the box for this to be effective]

_____ 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.

Medical Assistance in Dying

[Put an "X" the box and initial the line after the box for this to be effective]

_____ 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.

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.

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.

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 if 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 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. 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.

9. **MENTAL HEALTH CARE POWERS.**

[Put an "X" in the box and initial the line after the box for this to be effective]

_____ My agent is authorized to make decisions for all matters relating to my mental health care including, without limitation, full power to give or refuse consent to all medical care related to my mental health condition. My agent is authorized to admit me to a secure health care facility, hospital, skilled nursing facility, assisted living facility, inpatient or outpatient behavioral or psychiatric health treatment facility, licensed in this or in another state. Such authority applies if I am unable to make health care decisions for myself. Thereafter, my agent's authority applies no matter whether I agree with my agent's decision to admit me to such a secure health care facility or not.

My agent is specifically authorized to provide the facility permission for me to remain in such a secure facility for treatment, even if I do not recognize the benefits of the services I am receiving in that health care environment and wish to leave the facility. I specifically do not want my family or other interested persons to have to go to court to obtain a guardianship to assume the authority set forth in this Mental Health Care Powers section. The authority granted to my agent in this section is specifically provided to avoid the necessity of going to court to have a guardian appointed to make health care decisions for me.

I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

If my wishes regarding mental health care are unknown to my agent, I want my agent to make decisions regarding my mental health care that are consistent with what my agent in good faith believes to be in my best interests. My agent is also authorized

to receive information regarding proposed mental health treatment and to receive, review, and consent to disclosure of any medical records relating to that treatment.

My agent's power to make mental health decisions for me is irrevocable if I am unable to give informed consent.

10. INPUT FROM RELATIVES AND OTHERS. I specifically instruct my agent to make decisions based on my agent's expertise and knowledge of my desires and not on guidance or instruction from 1) anyone claiming to be my relative or 2) others.

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

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

[your signature]

Printed Name: _____

Street Address _____

City, State, Zip Code. _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE and MENTAL HEALTH
WITNESS DECLARATION

[Idaho Code Section 66-604]

We, _____ and _____, the witnesses, sign our names to this instrument, and, being first duly sworn, do hereby declare that _____, the Principal is personally known to us. We further attest that the Principal signed and executed this instrument knowingly and willingly, that the Principal signed this instrument in our presence and hearing, and that the Principal appeared to be of a sound mind, and not under any duress, fraud, or undue influence.

Witness Signature _____
Print Name of Witness _____

Witness Signature _____
Print Name of Witness _____

STATE OF IDAHO)
 : ss.
County of _____)

On _____, 20____, before me personally appeared _____, as Principal and _____, as a Witness and _____, as a Witness, known to me to be the persons whose names are subscribed to the within instrument, and acknowledged to me that they 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 _____, Idaho.
My commission expires: _____.

ACCEPTANCE OF APPOINTMENT BY AGENT

[Optional Idaho Code Section 66-603]

STATE OF IDAHO)
: ss.
County of Ada)

I, _____, having reviewed this document and being informed of the rights and duties contained here, hereby accept the appointment as agent and healthcare power of attorney, including the right to make decisions about mental health treatment on behalf of _____ only when he/she is incapable and consistent with his/her desires.

If I was named as a successor agent, that the prior agent is no longer able or willing to serve; and (Insert other relevant statements):

Date _____

Agent's Signature _____

Agent's Name Printed: _____

Agent's Address: _____

Agent's Phone Number: _____

STATE OF IDAHO)
: ss.
County of Ada)

On _____, 20____, before me, a Notary Public for the State of Idaho, personally appeared _____, known or identified 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 _____
My commission expires: _____

