Planning Ahead

How to Make Future Healthcare Decisions NOW

Your Questions Answered About Iowa Living Wills and Powers of Attorney for Health Care
Making Future Healthcare Decisions NOW
Table of Contents

P 1  What You Need to Know About Advance Directives
     • Power of Attorney for Health Care Questions
     • Living Will Questions
     • Questions About Power of Attorney for Health Care and Living Wills

P 5  Instructions for Completing the Living Will and Power of Attorney for Health Care Form
     • Living Will and Power of Attorney for Health Care Form
Power of Attorney for Health Care Questions

What is a power of attorney for health care?
A power of attorney for health care is a document you sign that names another person, called your “agent,” to make healthcare decisions for you if you are unable to do so.

Who can create a power of attorney for health care?
Any competent person who is at least 18 years old may create and sign a power of attorney for health care. Please consult a lawyer if you want legal advice.

Who can act as an agent (known legally as the “attorney-in-fact”)?
Any person 18 years or older who can understand and decide about healthcare matters can be an agent. However, no physician, nurse or other healthcare provider who is giving you treatment may act as your agent. Most people choose a trusted relative or friend.

What happens if I name my spouse as an agent and we are later divorced?
You should destroy all copies of the power of attorney and create new documents to replace the ones that your doctor(s) and/or hospital(s) have on file.

Will my agent be held liable for my healthcare costs?
No, your agent will not be held personally responsible for the cost of healthcare services and treatment that he or she arranges.
How do I create a power of attorney for health care?
The surest way is to complete and sign the Durable Power of Attorney for Health Care Decisions form that is provided in this booklet.

What powers do I give to my agent by completing the form?
After the power of attorney for health care goes into effect, your agent may make any healthcare decision that you could make if you were able to do so. However, you can limit your agent’s powers or give your agent special instructions by clearly stating them in your power of attorney.

Living Will Questions

What is a living will?
A living will (also called a “declaration”) is a document you sign that states you do not want your physician to use death-delaying procedures if you develop a terminal condition.

Who may create a living will?
Any competent person at least 18 years old.

How do I create a living will?
The surest way is to fill out and sign the Declaration Relating to Life-Sustaining Procedures (living will) and Durable Power of Attorney for Health Care Decisions (Medical Power of Attorney) form included in this booklet. It must be signed by you, or another person at your direction, in the presence of two witnesses.

What happens if I have a living will and a terminal illness and I am pregnant?
A living will does not take effect so long as the attending physician believes the fetus could develop to the point of live birth if death-delaying procedures are used for the mother.

Who can witness the signing of my living will?
Anyone at least 18 years old who is not entitled to inherit from your estate or financially responsible for your medical care.

When does a living will take effect?
When a physician certifies you have a terminal condition.

What is a death-delaying procedure?
Death-delaying procedures serve only to postpone the moment of death. They may include assisted ventilation, artificial kidney treatments, medication, blood transfusions and tube feeding.

If I have a living will, can I still receive pain medication?
Yes, your physician can provide you with pain medication or other care to make you comfortable.
Questions About Power of Attorney for Health Care and Living Wills

How is a power of attorney for health care different from a living will?
A living will takes effect only if you have a terminal illness and cannot speak for yourself. Also, it addresses only decisions concerning life-sustaining treatment. A health care power of attorney is broader and more flexible and, in that way, is preferable to a living will. Under a power of attorney for health care, your agent can make healthcare decisions for you in any situation when you are unable to do so.

Should I have both a power of attorney for health care and a living will?
Your living will does not take effect so long as your agent under a power of attorney for health care is available and willing to make life-sustaining treatment decisions. If you do not wish to be kept alive by life-sustaining treatment, you should consider signing both documents because:

- The living will reinforces the intent of the power of attorney for health care.
- Your agent under the power of attorney for health care may die or be unable or unwilling to act when it comes time to make healthcare decisions.

Will hospitals and physicians honor my living will and power of attorney for health care?
Providers must comply with healthcare decisions of an agent or the directions stated in a living will unless they are morally opposed to them. If the provider is unwilling to comply, the provider must inform your agent, who is then responsible for arranging your transfer to another provider.

For how long are my living will and power of attorney for health care effective?
They remain valid until you revoke them.

What should I do with my signed power of attorney for health care and living will?
Copies should be given to the people you have named as the agent and successor agents under the power of attorney for health care. Give copies “to your physician, family and friends, and discuss your wishes with them all as well. Let your agent know where the original documents are kept.”
In case of an emergency, how will a hospital know that I have a living will or who my agent is?
A hospital can locate your agent or living will if you complete the health care agent/living will wallet identification card included and carry it with you in your wallet or purse. This cannot guarantee that your wishes will be carried out, but it will go far in letting others know of them.

Can I revoke or change my power of attorney for health care or my living will?
They can be revoked at any time, regardless of your physical or mental condition, by doing one of the following:

- Tear up or otherwise destroy the document; OR
- Revoke the document in writing, sign and date it, or direct someone else to do it for you; OR
- Express (orally or otherwise) in the presence of a witness at least 18 years old, your intent to revoke the document. Have the witness sign and date a statement confirming that such an expression of intent was made.

To change your power of attorney for health care, write in the changes and sign and date the document. To change your living will, revoke the current form and sign a new one. Also, a court may revoke or change your documents if it believes clarification is needed or your agent is not acting in your best interests.

Should I have my living will and power of attorney for health care notarized?
It is recommended that you have your documents notarized because some other states require notarization.
Instructions for Completing the Living Will and Power of Attorney for Health Care Form

Any adult 18 or older of sound mind may execute a living will declaration.

Health care employees involved in your care may not witness the above-named documents. We also encourage you to discuss your plans with a friend or family member, your physician and your attorney.

Complete the paragraphs as follows:

Section 1. Read over the declaration relating to life-sustaining procedures and make sure it reflects your wishes. This statement can be revised by writing your wishes in the Additional Provisions section on the bottom half of the page.

Section 2. Insert your name and birthdate and the name of your agent with his/her address. You may list a secondary agent in case your first choice is unable to serve. You may insert specific instructions in this section and agree to life-sustaining procedures to complete an organ donation.

Please sign the final part of this section before a notary or two witnesses.

The third page of the form authorizes the release of health information to your agent. You can limit what type of health information your agent has access to. Please sign and date the form at the bottom and also in the box located in the middle of the form. The form for witnesses or a notary to sign is on the second page of the form.

If you have both a living will declaration and a power of attorney for health care, the living will declaration will not be used as long as there is an agent available to act under the power of attorney for health care. If no agent is available to act, the living will declaration will be used if you have a terminal condition.

If you have any questions about these documents and what they mean, you should consult your attorney.
DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES
(Living Will)
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, __________________________________________, born __________________________, designate __________________________________________________________

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision. OPTINAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

________________________________________
(Type or Print) Name of Alternate, Street Address, City, State, Zip Code and Phone Number

OPTIONAL: ADDITIONAL PROVISIONS - Insert specific instructions or statement of desires (if any):

YES ☐ NO ☐ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this ____day of __________________, _____.

_____________________________________
Your Signature (Declarant/Principal)

Address, Street, City, State and Zip

Type or Print Your Name

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.
NOTARY PUBLIC FORM

STATE OF ____________________, COUNTY OF ______________________ ss:
This record was acknowledged before me this ______ day of ________________, _______, by
_______________________________________________________________________________.

_________________________
Signature of Notary Public

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the
Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another
person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is
appointed as attorney in fact by this document; that neither of us are health care providers who are presently
treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at
least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or
adoption.

____________________________________  ______________________________________
Signature of First Witness  Signature of Second Witness

Type or Print Name of Witness  Type or Print Name of Witness

Street Address, City, State and Zip Code  Street Address, City, State and Zip Code

GENERAL INFORMATION REGARDING THIS DOCUMENT
1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's
   physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or
   intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital
   function, and when applied to a person in a terminal condition, would serve only to prolong the dying process.
   "Life sustaining procedure" does not include administration of medication or performance of any medical
   procedure deemed necessary to provide comfort care or to alleviate pain.
2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only
   when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document
   authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what
   you want, you should set forth your specific instructions in the space provided on page 1.
3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a
   durable power of attorney for health care:
   a. A health care provider attending the principal on the date of execution.
   b. An employee of such a health care provider unless the individual to be designated is related to the principal
      by blood, marriage, or adoption within the third degree of consanguinity.
4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures
   may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent
to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health
care provider upon its communication to the provider by the principal/declarant or by another to whom the
principal/declarant has communicated the revocation.
5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this
   document.
6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's
   condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the
   declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED
1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated ______________________________, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

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 the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my “HIPAA personal representative”) is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this _____ day of ____________________, ________.

___________________________________________
Grantor
Making Future Healthcare Decisions NOW
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  - Qualified interpreters
  - Information written in other languages

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ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-851-3379 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫 1-800-851-3379（TTY: 711）。


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Δήλωση: τοις ισχορός το ιφάντωμα, υπηρεσίες της υποστήριξης γλώσσας είναι διαθέσιμοι, με έμπριμη χρήση, για όσους τις αναγνωρίζει. Καλείτε 1-800-851-3379 (TTY: 711).

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ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-851-3379 (TTY: 711).