Planning Ahead
How to Make Future Healthcare Decisions NOW
Your Questions Answered About Washington Living Wills and Powers of Attorney for Health Care
Making Future Healthcare Decisions NOW
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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?
Any person who is at least 18 years old and is able to 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?
Your ex-spouse will no longer have authority to act under the power of attorney for health care. Even so, you should attempt to destroy all copies of the power of attorney, because doctors or hospitals may rely on it if they don’t know about the divorce.

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 Washington’s Durable Power of Attorney for Health Care form.
As of January 1, 2017, Washington requires a power of attorney for health care to be witnessed by two people or notarized. However, a power of attorney for health care created before 2017 will remain valid.

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 “health care directive”) 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?
Fill out and sign the health care directive; there is one included in this booklet. It must be signed by you or another person at your direction in the presence of two witnesses.

Who can witness the signing of my living will?
Anyone at least 18 years old who is not:
- Entitled to inherit from your estate
- Financially responsible for your medical care
- The attending physician
- An employee of the attending physician or healthcare facility in which you are a patient

When does a living will take effect?
In Washington, the directive is used only if you have a terminal condition where life-sustaining treatment would only artificially prolong the process of dying; or if you are in an irreversible coma and there is no reasonable hope of recovery.

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 Durable Power of Attorney for Health Care and Living Wills

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.

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 only addresses decisions concerning life-sustaining treatment. A power of attorney for health care
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 health care 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 and carry it with you in your wallet or purse.

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 an adult* witness, 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.

As of January 1, 2017, Washington requires a power of attorney for health care to be witnessed by two people or notarized. However, a power of attorney for health care created before 2017 will remain valid.

*In Washington, an adult is defined as someone 18 years or older, or someone under 18 who is or has been married.
Mental Health Advance Directive

What is a mental health advance directive?
It is a written document that describes what you want to happen if you become so incapacitated by mental illness that your judgment is impaired and/or you are unable to communicate effectively. It can inform others about what treatment you want or don’t want, and it can identify a person to whom you have given the authority to make decisions on your behalf. To learn more, call 360-725-3709 or go to dshs.wa.gov and search for “mental health advance directive form” to download a copy.

How does a mental health advance directive differ from other advance directives?
If you have a mental health advance directive and you need mental health treatment, you may not revoke the advance directive unless you specifically state in the advance directive that you want it to be revocable when you are incapacitated. The durable power of attorney for health care and health care directive (living will) may be revoked at any time regardless of your mental condition.

How do I create a mental health advance directive?
Complete and sign the form, which you can download at dshs.wa.gov by searching for “mental health advance directive form.” Your mental health provider may also have copies of the form.

Healthcare Surrogates

What is a healthcare surrogate?
A surrogate is someone who, in the absence of an advance directive, can make medical decisions for you if you are unable to do so.

What decisions can a surrogate make?
In Washington, surrogates are authorized to make medical decisions on your behalf if you are unable to do so. A surrogate may not make decisions concerning electroconvulsive therapy, psychotropic drugs or admission to a mental health facility.

Who may act as a surrogate?
In Washington, the people authorized to make medical decisions on behalf of an incompetent individual are as follows, in order of priority:

1. The appointed guardian of the patient, if any.
2. The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make healthcare decisions.
3. The patient’s spouse or state–registered domestic partner.
4. Children of the patient who are at least 18 years of age.
5. Parents of the patient.
6. Adult brothers and/or sisters of the patient.

With a healthcare surrogate, why should I create a power of attorney for health care?
A power of attorney for health care allows you to name your agent and give him or her instructions now, while you are still able to communicate.
1. An individual of sound mind and having reached the age of majority (18 in Washington) may execute a living will declaration.

2. The declaration must be signed by the individual, or by another person at the direction of the individual, and witnessed by two adults* who are not entitled to any portion of the estate of the individual if the individual dies without a will; who are not, to the best of the witness’s knowledge, a beneficiary under the individual’s will and who are not financially responsible for the individual’s medical care.

3. If the individual is an emancipated minor or if the living will is to be signed by another person at the direction of the individual, you should consider consulting your attorney. In addition, if you have any questions about the living will declaration or what it means, you should consult your attorney.

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

Directions for Completing a Durable Power of Attorney for Health Care

1. Read through the bullet points carefully and the statement under “Creation of Durable Power of Attorney for Health Care.” Make sure you understand and agree with the statements.

2. Fill out the “Designation of Health Care Agent and Alternate Agents” section with the name and information of the people you want to name as your healthcare agent and successor agent(s).

3. Read through “General Statement of Authority Granted.” Make sure you understand and agree with the statements.

4. Write in any provisions (limitations), or leave it blank if you have none.

5. Have two witnesses sign or have the document notarized. Some states require notorization, so you may want to do so in case you travel out of state.

Be sure to also read and sign the Information Release in this booklet.

*In Washington, an adult is defined as someone 18 years or older, or someone under 18 who is or has been married.
HEALTH CARE DIRECTIVE

Directive made this _______________________________ day of _________ , ______________ .

I,_____________________________________________ being of sound mind, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(A) If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand “terminal condition” means an incurable and irreversible condition caused by injury, disease or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [Choose one]

I want _________ do not want _________

artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(E) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

________________________________________________________________
________________________________________________________________
________________________________________________________________

Signed: ____________________________________________

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not the attending physician, an employee of the attending physician or health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer’s decease at the time of the execution of the directive.

Witness: ______________________________

Witness: ______________________________
What to do with these forms
Copies of the Health Care directive (Living Will) and the Durable Power of Attorney for Health Care should be given to your physician to be included in your medical record, to any person to whom you give your durable power of attorney, including any successor agents you may have named, and to your personal attorney. The originals should be kept by a designated person or in a designated place where they can be obtained in any emergency situation.

For further information
These forms have been provided to you as a public service by the Washington State Medical Association. Any legal questions you may have about the execution or operation of a Durable Power of Attorney for Health Care should be directed to a lawyer.
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document
This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.

- Your Health Care Agent should be someone you trust to make health care decisions on your behalf. Your Health Care Agent may be any adult, including relatives such as your spouse, state registered domestic partner, father, mother, adult child, or adult brother or sister. Unless they are one of the relatives listed above, your Health Care Agent may not be any of your physicians or your physicians’ employees, or the owners, administrators or employees of a health care facility or long-term facility (as defined by RCW 43.190.020) where you reside or receive care.

- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.

- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical condition. You can limit that right in this document.

- When exercising authority to make health care decisions for you on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or in another manner.

- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care
I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by Washington law. This power of attorney shall become effective when I become disabled and I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent’s power shall cease if and when I regain my capacity to make health care decisions.

2. Designation of Health Care Agent and Alternate Agents
If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I ____________________________, designate and appoint:

Name ____________________________________________ Address ____________________________________________

City________________________ State________ Zip________ Phone________
as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in Washington law and authorize him or her to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that ____________________________ is unable or unwilling to serve, I grant these powers to

Name ____________________________________________ Address ____________________________________________

City________________________ State________ Zip________ Phone________

In the event that both ____________________________ and ____________________________ are unable or unwilling to serve, I grant these powers to

Name ____________________________________________ Address ____________________________________________

City________________________ State________ Zip________ Phone________
My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of “living will” I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:
   (1) Therapy or other procedure given for the purpose of inducing convulsion;
   (2) Surgery solely for the purpose of psychosurgery;
   (3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to Chapter 71.05 RCW;
   (4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.


Dated this __________________day of __________________, __________-

(Year)

GRANTOR: ___________________ GRANTOR’S SIGNATURE ______________________

NOTE: Washington state requires this directive to be notarized or witnessed by two different witnesses.

WITNESS ___________________ WITNESS ___________________

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:
• Home care providers for the individual completing this document;
• Care providers at an adult family home or long-term care facility if you live there; or
• Related to you or the designated Health Care Agent by blood, marriage, or state registered domestic partnership.

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 __________________, __________-

(Year)

____________________________________

NOTARY PUBLIC in and for the State of Washington,
residing at _____________________________

Printed name __________________________________

My commission expires ____________________________
This form authorizes healthcare facilities to share your medical information with your
health agent.

This declaration is made this _______________ day of ________________________, ___________.
I, _________________________________________________________________________________,
being of sound mind, willfully and voluntarily make known my desires that my moment of death should
not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease or illness judged to be a
terminal condition by my attending physician who has personally examined me and has determined
that my death is imminent except for death-delaying procedures, I direct that such procedures
which would only prolong the dying process be withheld or withdrawn, and that I be permitted to
die naturally with only the administration of medication, sustenance or the performance of any medical
procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death-delaying procedures,
it is my intention that this declaration shall be honored by my family and physician as the final
expression of my legal right to refuse medical or surgical treatment and accept the consequences
from such refusal.

Signed __________________________________________________________________________
City, County and State of Residence

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the
declarant sign the declaration in my presence (or the declarant acknowledged in my presence that
he or she had signed the declaration) and I signed the declaration as a witness in the presence of the
declarant. I did not sign the declarant’s signature above for or at the direction of the declarant. At the
date of this instrument, I am not entitled to any portion of the estate of the declarant according to the
laws of interstate succession or, to the best of my knowledge and belief, under any will or declarant
or other instrument taking effect at the declarant’s death, or directly financially responsible for the
declarant’s medical care.

Witness __________________________________________________________________________
Witness __________________________________________________________________________
Making Future Healthcare Decisions
DISCRIMINATION IS AGAINST THE LAW

Health Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medical Plans, Customer Service, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.


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）。

注意: あなたは、日本語、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-851-3379コール（TTY: 711）。


Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. Anruf 1-800-851-3379 (TTY: 711).

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