



Triage Cancer Estate Planning Toolkit: Idaho

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Idaho probate courts accept written and holographic wills. To make a valid written will in Idaho:

1. You need to be in the right state of mind to create a will. This means you need to be:
 - At least 18 years old
 - Of “sound mind” (meaning you know what you’re doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are at least 18 years old.
3. Your will does not need to be notarized to be legal in Idaho. But you can make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Due to the COVID-19 pandemic, Idaho now allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state’s laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Idaho:

1. You need to be in the right state of mind to create a will. This means you need to be:
 - At least 18 years old
 - Of “sound mind” (meaning you know what you’re doing)
2. Your will must be written and signed in your handwriting.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove their validity in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Idaho’s statutory form for power of attorney allows you to appoint someone to manage your finances for you, including your property, taxes, and government benefits. You can also appoint a successor agent or co-agent in the “special instructions” section. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a conservator in advance, in

case a court decides one is necessary. Your agent is entitled to reasonable compensation for their help if you do not specify otherwise in the “special instructions” section. Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it and will remain in effect until you die, unless you revoke your power of attorney.

Part III includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Idaho, this document includes three parts:

1. **Living Will:** You can use a living will to express your wishes for your medical care in the event you become seriously ill or unconscious. You can also provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include. If you are pregnant or may become pregnant, this document will not be honored.
2. **Durable Power of Attorney for Health Care:** This document lets you appoint a proxy to make all health care decisions for you, until you say otherwise. You can also appoint an alternate person to make these decisions if the first person you chose isn’t available. If there are directions you want your proxy to follow, you can share those in the “other directions” section.
3. **Organ Donation:** This section lets you indicate if you would like to make an organ or tissue donation at the time of your death

To make your AHCD valid, all you have to do is sign it. But, it is recommended that you sign your living will in front of at least one person who knows you and believes you to be of sound mind. Your witnesses should not be:

- The person you chose to make health care decisions for you
- Your doctor or an employee of your health care provider
- An operator of a community care facility
- An employee of an operator of a community care facility, unless this person is related to you

If you change your mind about the instructions in your AHCD, you can revoke your AHCD at any by destroying the document, signing a written revocation, or orally expressing that you would like to revoke the document.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

Idaho allows you to completed an AHCD online on their Idaho Healthcare Directive Registry at <https://idaho-acp.vyncahealth.com/patientportal/user/login>. Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician orders for scope of treatment (POST) is a medical order completed by a seriously ill person and signed by a physician. The POST does not replace an advance health care directive. You can complete a POST form with your doctor. In Idaho, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a “Do not resuscitate,” or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

In Idaho, a health care provider can access the form. The Idaho Secretary of State's Office suggests that you see your doctor to review and complete an Idaho POST.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Idaho does not have a funeral designation form. You can indicate your wishes in a living will and appoint an individual to carry them out in the durable power of attorney for healthcare.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Idaho does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information:

www.cdc.gov/phlp/publications/topic/hipaa.html.



Triage Cancer Estate Planning Toolkit: Idaho

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Scope of Treatment (POST)
- HIPAA Authorization Form



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

IDAHO STATUTORY FORM POWER OF ATTORNEY

OF

JANE SMITH

Important Information

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent can make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the uniform power of attorney act, chapter 12, title 15, Idaho Code.

This power of attorney does not authorize the agent to make health care decisions for you.

You should select someone you trust to serve as your agent. The agent's authority will continue until your death unless you revoke the power of attorney or the agent resigns.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

The form provides for designation of one (1) agent. If you wish to name more than one (1) agent, you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

1. Designation of Agent. I, Jane Smith, name the following person as my agent:

Name:	<u>Spouse</u>
Address:	<u>123 Main</u>
Telephone Number:	<u>456-7890</u>

2. Designation of Successor Agent(s) (Optional). If my agent is unable or unwilling to act for me, I name as my successor agent:

Name: Sister Smith
Address: 456 Broadway
Telephone Number: 123-4567

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

Name: Brother Smith
Address: 789 Center
Telephone Number: 987-6543

3. Grant of General Authority. I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the uniform power of attorney act, chapter 12, title 15, Idaho Code:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

- Real Property
- Tangible Personal Property
- Stocks and Bonds
- Commodities and Options
- Banks and Other Financial Institutions
- Operation of an Entity or Business
- Insurance and Annuities
- Estates, Trusts, and Other Beneficial Interests
- Claims and Litigation
- Personal and Family Maintenance
- Benefits from Governmental Programs or Civil or Military Service
- Retirement Plans
- Taxes
- All Preceding Subjects

4. Grant of Specific Authority (Optional). My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

- _____ Create, amend, revoke, or terminate an inter vivos trust
- _____ Make a gift, subject to the limitations of the uniform power of attorney act, chapter 12, title 15, Idaho Code, and any special instructions in this power of attorney
- _____ Make a gift without limitations except any special instructions in this power of attorney
- _____ Create or change rights of survivorship
- _____ Create or change a beneficiary designation
- _____ Authorize another person to exercise the authority granted under this power of attorney
- _____ Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
- _____ Exercise fiduciary powers that the principal has authority to delegate

5. Limitation on Agent's Authority. An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

6. Special Instructions (Optional). On the following lines you may give special instructions: _____

7. Effective Date. This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

8. Nomination of Conservator (Optional). If it becomes necessary for a court to appoint a conservator of my estate, I nominate the following person(s) for appointment:

Name: _____ Spouse
Address: _____ 123 Main
Telephone Number: _____ 456-7890

9. Reliance on This Power of Attorney. Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it is terminated or invalid.

10. Signature and Acknowledgement.

Signature: _____
Date: _____
Name Printed: Jane Smith
Address: 123 Main
Phone Number: 456-7890

STATE OF IDAHO)
) ss.
County of Ada)

On this 2nd day of August, 2012, before me, a Notary Public in and for said state, personally appeared Jane Smith, known or identified to me to be the person whose name is subscribed to the foregoing Power of Attorney, and acknowledged to me that she executed the same.

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

Notary Public for Idaho
Residing at _____
My commission expires _____

IMPORTANT INFORMATION FOR AGENT

1. Agent's Duties. When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. The relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

- a. Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
- b. Act in good faith;
- c. Do nothing beyond the authority granted in this power of attorney; and
- d. Disclose your identity as an agent whenever you act for the principal by signing the name of the principal and signing your own name as "agent" in the following manner:

_____ (Principal's Name) by _____ (Your Signature) _____ as agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

- a. Act loyally for the principal's benefit;
- b. Avoid conflicts that would impair your ability to act in the principal's best interest;
- c. Act with care, competence and diligence;
- d. Keep a record of all receipts, disbursements, and transactions conducted for the principal;
- e. Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and
- f. Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

2. Termination of Agent's Authority. You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

- a. Death of the principal;
- b. The principal's revocation of the power of attorney or your authority;
- c. The occurrence of a termination event stated in the power of attorney;
- d. The purpose of the power of attorney is fully accomplished; or
- e. A legal action is filed with a court to end your marriage to the principal, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

3. Liability of Agent. The meaning of the authority granted to you is defined in the act. If you violate the act or act outside the authority granted, you may be liable for any damages caused by your violation.

IF THERE IS ANYTHING ABOUT THIS DOCUMENT OR YOUR DUTIES THAT YOU DO NOT UNDERSTAND, YOU SHOULD SEEK LEGAL ADVICE.



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Advance Health Care Directive

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL OF

_____ (name of person)

I.
DESIGNATION OF HEALTH CARE AGENT

I, _____, of _____ (address), do hereby designate and appoint _____, _____ (name, address, and phone number), as my attorney-in-fact (agent) to make health care decisions for me as authorized in this Directive. 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.

II.
CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this Directive I intend to create a Durable Power of Attorney for Health Care. This Power of Attorney shall not be affected by my subsequent incapacity. This Power of Attorney shall be effective only when I am unable to communicate rationally.

III.
GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this Directive, I hereby grant to _____ 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, _____ shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to _____, including but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging

care, treatment, services, and procedures, including such desires set forth in my Living Will, Physician's Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

IV.
STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

In exercising the authority under this Durable Power of Attorney for Health Care, _____, shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Living Will, Physician's Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

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

A. A General Grant of Power and Authority.

Subject to any limitations in this Directive, _____ has the power and authority to do all of the following:

- (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
- (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- (c) Consent to the disclosure of this information.
- (d) Consent to the donation of any of my organs for medical purposes.

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 and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, and 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 that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or 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.

VI.
SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that _____
is authorized by this Directive to make, _____ 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 "Leaving Hospital Against Medical Advice".
- (b) Any necessary waiver or release from liability required by a hospital or physician.

VII.
DESIGNATION OF ALTERNATE AGENTS

If _____ is not available or becomes ineligible to act as my
agent to make a health care decision for me or loses the mental capacity to make health care decisions for
me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions
for me, then I designate and appoint the following persons to serve as my agent to make health care
decisions for me as authorized in this Directive, such persons to serve in the order listed below:

- (a) First Alternate Agent (name, address, and phone number):

- (b) Second Alternate Agent (name, address, and phone number):

VIII.
PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney or Living Will for Health Care.

IX.
REVOCATION

This Durable Power of Attorney for Health Care may be revoked at any time by me, without regard to my mental state or competence, by any of the following methods:

- (a) By being canceled, defaced, obliterated or burned, torn or otherwise destroyed by me or by some person in my presence and by my direction.
- (b) By a written, signed revocation by me expressing my intent to revoke.
- (c) By a verbal expression by me of my intent to revoke.

LIVING WILL

A Directive to Withhold or Provide Treatment

To my family, my relatives, my friends, my physicians, my employers, and all others whom it may concern:

I, _____, the declarant, being of sound mind, willfully and voluntarily make known my desire as to how I wish to be cared for under the circumstances set forth below, and do hereby declare and direct as follows. This Living will revokes any prior living wills executed by me.

1. If at any time

- a) I should have an incurable or irreversible injury, disease, illness, or condition, and a medical doctor who has examined me has certified:
 - 1) That such injury, disease, illness or condition is terminal; and
 - 2) That the application of life-sustaining procedures of any kind would serve only to artificially prolong my life; and
 - 3) That my death is imminent, whether or not life-sustaining procedures are utilized; or
- b) I have been diagnosed as being in a persistent vegetative state;

then, 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.**

I have checked and placed my initials next to only one of the following three boxes:

- If at any time I should become unable to communicate my instructions, I direct that all medical treatment, care and procedures (including artificial life-sustaining procedures) and nutrition and hydration necessary to restore my health, sustain my life, and to abolish or alleviate pain or distress be provided to me. Nutrition and hydration shall not be withheld from me if I would likely die from malnutrition or dehydration rather than from injury, disease, illness or condition. **"Artificial life-sustaining procedure" means any medical procedure or intervention that utilizes mechanical means to sustain or supplant a vital function which, when applied to a qualified patient, would serve only to artificially prolong life. Artificial life-sustaining procedure does not include the administration of pain management medication or the performance of any medical procedure deemed necessary to provide comfort care to alleviate pain.**

-OR-

- If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to artificially prolong my life, I direct that all such medical treatment, care and procedures be withheld or withdrawn, except that the administration of nutrition and hydration 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 or disease, illness or condition, as follows: (if none of the following boxes are checked and initialed, then both nutrition and hydration shall be administered):

- only hydration, of any nature, whether artificial or nonartificial, shall be administered; **OR**
- only nutrition, of any nature, whether artificial or nonartificial, shall be administered; **OR**
- both nutrition and hydration, of any nature, whether artificial or nonartificial, shall be administered.

"Artificial nutrition and hydration" means supplying food and water through a conduit, such as a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily, but does not include assisted feeding, such as spoon or bottle feeding.

-OR-

- If at any time I should become unable to communicate my instructions and the application of artificial life-sustaining procedures shall serve only to artificially prolong my life, I direct that all medical treatment, care and procedures be withheld or withdrawn including withdrawal of the administration of nutrition and hydration.

2. In the absence of my ability to give further directions regarding my treatment, including the use of artificial, life-sustaining procedures, it is my intention that this Directive shall be honored by my family and physicians as the final expression of my legal right to refuse or accept medical and surgical treatment; and I accept the consequences of such refusal. This Directive shall only be effective if I am unable to communicate my instructions.

3. I understand the full importance of this Directive and am emotionally and mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect, whether it be a medical doctor, my spouse, a relative, friend, or any other person, shall be held responsible in any way, legally, professionally, or socially, for complying with my directions.

4. I have discussed these decisions with my physician, advanced practice professional nurse, or physician assistant, 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, advanced practice professional nurse, or physician assistant, then this living will shall be deemed modified to be compatible with the terms of the POST form.

5. This Directive shall be in effect from the date of execution unless otherwise revoked. This Directive may be revoked at any time by me, without regard to my mental state or competence, by any of the following methods:

- (a) By being canceled, defaced, obliterated or burned, torn or otherwise destroyed by me or by some person in my presence and by my direction.
- (b) By a written, signed revocation by me expressing my intent to revoke.
- (c) By a verbal expression by me of my intent to revoke.

DATE AND SIGNATURE OF PRINCIPAL

I sign my name to this Durable Power of Attorney for Health Care and Living Will on
this ____ day of _____ 20_____.

(Signature)

STATE OF IDAHO)
)ss
County of _____)

On this ____ day of _____ 2021, before me,
_____, a Notary Public in and 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 executed the same.

NOTARY PUBLIC FOR IDAHO

Residing at: _____

Commission expires: _____

(SEAL)



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

Idaho Physician Orders for Scope of Treatment (POST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- This form must be signed by an authorized practitioner in **Section E** to be valid
- **If any section is NOT COMPLETE provide the most comprehensive treatment in that section**
- **EMS:** If questions arise contact on-line **Medical Control**

Last name _____

First name _____

Date of birth ____/____/____

Last four digits of SS # _____

Male Female

Section A
Select 1 OR 2

Cardiopulmonary Resuscitation: Patient is not breathing and/or does not have a pulse

1. Do Not Resuscitate: Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions

2. Resuscitate (Full Code): Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

Additional resuscitation instructions: _____

Section B
Select only ONE box

Medical interventions: Patient has a pulse and is breathing

Comfort measures only: Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**

Limited additional interventions: In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.

Aggressive interventions: In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

Section C

Artificial Fluids and Nutrition:

Yes No Feeding tube
 Yes No IV fluids

Other instructions: _____

Antibiotics and blood products:

Yes No Antibiotics
 Yes No Blood products

Other instructions: _____

Section D

Advance Directives: The following documents also exist:

Living Will DPAHC Other _____

Section E

I request that this document be submitted to the Idaho Health Care Directive Registry

Patient/Surrogate Signature: **X**

Print Patient/Surrogate name Relationship (Self, Spouse, etc.) / / Date

Physician/APRN/PA Signature: **X**

Print Physician/APRN/PA name ID license number Phone # ____ - ____ - ____ / / Date

Discussed with: Patient Spouse DPAHC Other _____

The basis for these orders is: Patient's request Patient's known preference

*****ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED*****

*****PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED*****

*****COPY OF ORIGINAL LEGALLY VALID*****

Directions for Healthcare professionals

Completing the POST

- Use of the form is designed for persons with advanced chronic, progressive and/or end-stage illness
- For information on how to complete the POST online go to this site <http://www.sos.idaho.gov/>, click on the “Health Care Directive Registry” link, then click on “POST Login” link, then click on the “Instructions” link
- The POST form is also available for on-line completion on the Idaho Secretary of State Health Care Registry Website: <http://www.sos.idaho.gov/general/hcdr.htm>
- In order to be valid, the POST form must be completed by a physician (physician assistant when delegated) or Advanced Practice Registered Nurse (APRN) using patient preferences and medical indications
 - If the goal is to support quality of life using only comfort measures in the last phases of life, then select number 1 in section A
 - If the goal is to support both function and quality of life then any selection in section A may be appropriate
 - If the goal is for aggressive treatment and to live as long as possible then select number 2 in section A
- The patient/surrogate should be instructed to initial the first box in Section E if they would like to request their POST be submitted to the Idaho Healthcare Directive registry
- If applicable, provide the patient with information on how to obtain a DNR POST necklace or bracelet. To do so, go to the following web address to download the order form: www.idahoendoflife.org

Using the POST

- If any section is NOT COMPLETE provide the most comprehensive treatment in that section
- An automatic external defibrillator (AED) should not be used if the patient has selected “Do not resuscitate” or “No” to “defibrillation” in section A
- Oral fluids and nutrition must always be offered if medically feasible
- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort Measures Only” should be transferred to a setting conducive to achieving comfort
- Artificially administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.
- A patient with capacity or the surrogate (if patient lacks capacity) can temporarily suspend or revoke the POST at any time and request alternative treatment

Reviewing the POST

- The POST shall be reviewed:
 1. Each time the physician, PA or APRN examines the patient, or at least every seven days, for patients who are hospitalized,
OR
 2. Each time the patient is transferred from one care setting or level of care to another,
OR
 3. Each time there is substantial change in the patient health status,
OR
 4. Each time the patient’s treatment preferences change

Failure to meet these review requirements does not affect the POST form’s validity or enforceability. As conditions warrant, the physician or nurse practitioner may issue a superseding POST form in consultation with the patient or the patient’s agent.

Information for Patients

1. Anytime you access healthcare please make your healthcare provider aware that you have a POST
2. If you have a necklace, bracelet or a Health Care Directive card, please show them your Healthcare Directive ID number. Otherwise, you may want to carry a copy of your POST with you.
3. Please inform family members and/or friends if you wish them to be aware that you have a POST
4. Your POST is honored in any healthcare setting in the State of Idaho and in some other states (check with State laws)
5. You have the right at any time to revoke or initiate a new POST to reflect your current wishes
6. Display your POST form in a prominent location in your home. On the refrigerator is most recommended.



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship:

Contact information: _____

Health Information to be disclosed upon the request of the person named above --
(Check either A or B):

- A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify):

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524