Triage Cancer Estate Planning Toolkit: Washington

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.

Washington probate courts accept written wills, and oral wills in certain circumstances. To make a valid written will in Washington:

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, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. Your will does not need to be notarized to be legal in Washington. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Due to the COVID-19 pandemic, Washington now allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). 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.

Oral wills are only valid for people in "last sickness" (terminal illness) distributing "personal property," or personal belongings like clothing or photographs, unless you are a soldier in actual military service or mariner at sea. In that case, you can distribute wages and personal property. You must declare your oral will in front of two witnesses, one of whom should write down and submit your will to probate court within six months of your death. Under these circumstances, you can only dispose of $1,000 or less of personal property.

While having an oral will is better than having no will at all, most estate planning experts do not recommend relying on them, because it is more difficult to prove that they are valid 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.

Washington's general power of attorney allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose an alternate agent, who will take charge separately if the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. This document will take effect immediately after you sign it, but

will not remain in effect if you become incapacitated, unless you complete a durable power of attorney. You can revoke your power of attorney at any time.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

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. The **Washington Advance Directive** includes four parts. You can complete Part I, Part II, Part III, but you must sign Part IV to make the document valid.

1. **Part I - Washington Durable Power of Attorney:** This document lets you chose someone (your "attorney-in-fact") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can also choose an alternate person to make these decisions if the first person you chose isn't available. If there are directions you want your agent to honor, you can share those in the "other directions" section.

- **Part II - Washington Declaration:** You can use this document to express your preferences for life-sustaining care in case you become seriously ill or permanently unconscious. This includes specific situations, including administering or withholding life-prolonging procedures, artificially administered nutrition (food offered through surgically-placed tubes), and any other instructions you would like to include.

- **Part III - Organ Donation:** This section allows you to record your preferences for organ and/or tissue donation.

- **Part IV - Execution:** You must sign your advance directive in front of a notary public, or two adult witnesses. Your witnesses cannot be:
    - Related to you or entitled to anything in your will
    - Have a claim against any portion of your estate
    - Financially responsible for your health care, or
    - Your health care provider or an employee of your provider

You can revoke all or part of your advance health care directive at any time by:

- Signing a written revocation
- Making an oral revocation
- Destroying the document

If you are or become pregnant, your Advance Health Care Directive will not be followed.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance directive. You can complete a POLST form with your doctor. This form lets you indicate your preferences for:

- Existing medical conditions and individual goals of care
- 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
- Additional orders

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.

Part III of this toolkit includes a sample form.

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.

Washington does not have a dedicated funeral designation form, but you can use your advance health care directive to designate someone to oversee the disposal of your remains.

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.

The Washington Death with Dignity Act was passed on November 4, 2008, and went into effect on March 5, 2009. This act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. Qualified patients must:

- Be 18 years or older
- Be mentally competent, or able to make health care decision for yourself
- Be a Washington resident
- Be diagnosed with an incurable terminal illness with a prognosis of six months or less to live
- For details, please see https://doh.wa.gov/you-and-your-family/illness-and-disease-z/death-dignity-act.

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 15 days apart.
- After your request, your doctor will refer you to another doctor to verify your diagnosis and prognosis.
- Submit a written request for the medication using the required form. This request should come after you have met with both your attending physician and a consulting physician.
- At least 48 hours after your written request for medication, you may receive the prescribed medications from a pharmacy.

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place. If your doctor refuses to administer an aid-in-dying medication, you can look for another doctor to see if they are willing to assist.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one.

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 a 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: Washington

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

WASHINGTON
GENERAL POWER OF ATTORNEY FORM

I. NOTICE - This legal document grants you (Hereinafter referred to as the "Principal") the right to transfer unlimited financial powers to someone else (Hereinafter referred to as the "Attorney-in-Fact"), unlimited financial powers are described as: **all financial decision making power legal under law**. The Principal's transfer of financial powers to the Attorney-in-Fact are granted upon authorization of this agreement, and DO NOT stay in effect in the event of incapacitation by the Principal (incapacitation is described in Paragraph II). This agreement does not authorize the Attorney-in-Fact to make medical decisions for the Principal. The Principal continues to retain every right to all their financial decision making power and may revoke this General Power of Attorney Form at anytime. The Principal may include restrictions or requests pertaining to the financial decision making power of the Attorney-in-Fact. It is the intent of the Attorney-in-Fact to act in the Principal's wishes put forth, or, to make financial decisions that fit the Principal's best interest. All parties authorizing this agreement must be at least 18 years of age and acting under no false pressures or outside influences. Upon authorization of this General Power of Attorney Form, it will revoke any previously valid General Power of Attorney Form.

II. INCAPACITATION – The powers granted to the Attorney-in-Fact by the Principal in this General Power of Attorney Form DO NOT stay in effect upon incapacitation by the Principal, incapacitation is describes as: **A medical physician stating verbally or in writing that the Principal can no longer make decisions for them self.**

III. REVOCATION - The Principal has the right to revoke this General Power of Attorney Form at anytime. Any revocation will be effective if the Principal either:

A. Authorizes a new General Power of Attorney Form.
B. Authorizes a Power of Attorney Revocation Form.

IV. WITNESS & NOTARY - This document is not valid as a General Power of Attorney unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when the Principal signs or acknowledges the Principal's signature**. It is recommended to have this General Power of Attorney Form notarized.**

V. PRINCIPAL - I, _____, residing at
Name of Principal

_____
Street Address of Principal

City of _____, State of _____, appoint
City of Principal *State of Principal*
the following as my Attorney-in-Fact, whom I trust with any and all my financial decision making power immediately upon the authorization of this form:

VI. ATTORNEY-IN-FACT - _____, residing at
Name of Attorney-in-Fact

_____
Street Address of Attorney-in-Fact

City of _____, State of _____ grant
City of Attorney-in-Fact *State of Attorney-in-Fact*
the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VII. SUCCESSOR ATTORNEY-IN-FACT (*Optional*) - If the Attorney-in-Fact named above cannot or is unwilling to serve, then I appoint _____,
Name of Successor Attorney-in-Fact
residing at

_____
Street Address of Successor Attorney-in-Fact

City of _____, State of _____ grant
City of Successor Attorney-in-Fact *State of Successor Attorney-in-Fact*

the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VIII. TERMS & CONDITIONS – Upon authorization by all parties, the Attorney-in-Fact accepts their designation to act in the Principal's best interests for all financial decisions legal under law.

IX. THIRD PARTIES – I, the Principal, agree that any third party receiving a copy via: physical copy, email, or fax that I, the Principal, will indemnify and hold harmless any and all claims that may be put forth in reference to this Durable Power of Attorney Form.

X. COMPENSATION – The Attorney-in-Fact agrees not to be compensated for acting in the presence of the Principal. The Attorney-in-Fact may be, but not entitled to, reimbursement for all: food, travel, and lodging expenses for acting in the presence of the Principal.

XI. DISCLOSURE - I intend for my attorney-in-fact under this Power of Attorney to 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 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164

XII. PRINCIPAL'S SIGNATURE - I, _____, the Principal,
Printed Name of Principal

sign my name to this power of attorney this _____ day of
Day
_____ and, being first duly sworn, do declare to the
Month
undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____
Signature of Principal

XIII. ATTORNEY-IN-FACT'S SIGNATURE - I, _____
Name of Attorney-in-Fact
have read the attached power of attorney and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge and accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

SUCCESSOR ATTORNEY-IN-FACT'S SIGNATURE (*Optional)* -

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Notary Acknowledgement (*Must be completed by Notary*)

State of _____ County of _____ Subscribed, Sworn and acknowledged before me by _____, the Principal, and subscribed and sworn to before me by _____, witness, this _____ day of _____.

_____
Notary Signature

Notary Public
In and for the County of _____
State of _____
My commission expires: _____ Seal

Acknowledgement and Acceptance of Appointment as Attorney-in-Fact

I, _____ have read the attached power of attorney
Name of Attorney-in-Fact
and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge that accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

Acceptance of Appointment as successor Attorney-in-Fact

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Witness Attestation

I, _____, the first witness, and I _____
Printed Name of First Witness *Printed Name of Second Witness*
the second witness, sign my name to the foregoing power of attorney being first duly sworn and do not declare to the undersigned authority that the principal signs and executed this instrument as him or her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____ _____
Signature of First Witness *Signature of Second Witness*

WASHINGTON
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Info, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Washington Advance Directive

This packet contains a **Washington Advance Directive**, which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. You may complete Part I, Part II, Part III, or any or all parts, depending on your advance-planning needs. You must complete Part IV.

Part I, **Washington Durable Power of Attorney for Health Care**, lets you name someone, called an "attorney-in-fact," to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. This is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part I goes into effect when your doctor and one other doctor determine that you are no longer capable of making or communicating your health care decisions.

Part II, **Washington Declaration**, lets you state your wishes about health care in the event you cannot speak for yourself and you develop a terminal condition or you are permanently unconscious.

Part II goes into effect when your doctor and one other doctor determine that you are no longer capable of making or communicating your health care decisions and diagnose you in writing with a terminal condition or as permanently unconscious.

Part III allows you to record your organ and tissue donation wishes.

Part IV contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old).

INSTRUCTIONS FOR COMPLETING YOUR WASHINGTON ADVANCE DIRECTIVE

How do I make my Washington Advance Directive legal?

If you complete Part II and/or Part III, you must either:

Alternative 1: Sign your document in the presence of two adult witnesses. Your witnesses **cannot** be:

- related to you,
- entitled to any portion of your estate,
- a person who has a claim against your estate, or
- your attending physician, an employee of your attending physician, or an employee of a health facility in which you are a patient.

In addition, if you have completed Part III, one of your witnesses must also be disinterested with regard to any anatomical gift you make (i.e., they are not interested in receiving your organs).

Alternative 2: Sign and acknowledge your document before a notary public or other individual authorized by law to take acknowledgements.

There are no specific witnessing requirements if you complete ONLY Part I. However, you should consider having your signature witnessed in the same manner in order to avoid any problems in the event your advance directive is challenged.

Whom should I appoint as my attorney-in-fact?

Your attorney-in-fact is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your attorney-in-fact may be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate attorney-in-fact. The alternate will step in if the first person you name as an attorney-in-fact is unable, unwilling, or unavailable to act for you.

The person you appoint as your attorney-in-fact **cannot** be:

- your doctor,
- an employee of your doctor, or
- an administrator, owner, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

However, you may appoint any of the individuals listed above if he or she is also your spouse, state registered domestic partner, adult child, brother or sister.

Should I add personal instructions to my Washington Advance Directive?

One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your attorney-in-fact carry out your wishes, but be careful that you do not unintentionally restrict your attorney-in-fact's power to act in your best interest. In any event, be sure to talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Health Care Directive at any time by:

- Canceling, defacing, obliterating, burning, tearing, or otherwise physically destroying your Directive or having another destroy it for you at your direction and in your presence,
- Executing a written and dated revocation, or
- Orally expressing your intent to revoke your Directive.

Your revocation becomes effective on communication to your attending physician and your attorney-in-fact, if you have appointed one.

Note: If you registered an advance directive with the Washington State Living Will Registry prior to July 1, 2011, you should notify the registry if you make changes to or revoke that advance directive. The Washington State Living Will Registry discontinued on July 1, 2011, but you can still access your advance directive if filed prior to that date. To do so visit: http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/CenterforHealthStatistics/LivingWillRegistry.aspx.

Is there anything else I should know?

If you are pregnant and your doctor is aware of your pregnancy, your advance directive will have no force or effect during the course of your pregnancy.

PART I. Durable Power of Attorney for Health Care

I understand that my wishes as expressed in my advance directive may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.

PRINT YOUR NAME

Therefore, I, _____, as principal, designate and appoint the person(s) listed below as my attorney-in-fact for health care decisions.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR FIRST CHOICE TO ACT AS YOUR ATTORNEY-IN-FACT

First Choice: Name: _____

Address: _____

City/State/Zip Code: _____

_____

Telephone Number: _____

If the above person is unable, unavailable, or unwilling to serve, I designate:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SECOND CHOICE TO ACT AS YOUR ATTORNEY-IN-FACT

Second Choice: Name: _____

Address: _____

City/State/Zip Code: _____

_____

Telephone Number: _____

1. This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

2. My attorney-in-fact shall have all the powers necessary to make decisions about my health care on my behalf. These powers shall include, but not be limited to, the power to obtain medical records in order to make a fully-informed decision, the power to have me admitted to a health care facility, and the power order the withholding or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. My attorney-in-fact's powers shall survive my death to the extent that my attorney-in-fact shall have all the powers necessary to direct the donation of my organs and the final disposition of my remains.

4. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my first choice (on page 1) to serve as my guardian. My second choice (on page 1) will serve as my guardian if the first person is unable or unwilling.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES OR ORGAN DONATION

5. When making health care decisions for me, my attorney-in-fact should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other clear expression of my desires, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my attorney-in-fact should make decisions for me that my attorney-in-fact believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

6. I give the following additional instructions as guidance for my attorney-in-fact:

_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

ATTACH ADDITIONAL PAGES IF NEEDED

PRINT THE DATE

PRINT YOUR NAME

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

INITIAL YOUR WISHES ABOUT ARTIFICIAL NUTRITION AND HYDRATION

PART II. Declaration

Directive made this _____ day of _____, _____.
(date) *(month)* *(year)*

I, _____,
(name)

having the capacity to make health care decisions, 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 be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, 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 by using this form that a 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, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (initial one):

_____ I DO want to have artificially provided nutrition and hydration.

_____ I DO NOT want to have artificially provided nutrition and hydration.

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(d) 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.

(e) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(f) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

(g) I make the following additional instructions regarding my care:

(attach additional pages if needed)

PART III. Organ Donation

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney-in-fact, other agent, or your family, may have the authority to make a gift of all or part of your body.

INITIAL ONLY ONE

_____ I do not want to make an organ or tissue donation and I do not want my attorney-in-fact, other agent, or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Washington State law, I hereby give, effective on my death (initial one):

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____

_____

INITIAL WHICH PURPOSE(S) MATCH YOUR WISHES.

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

SIGN, DATE AND PRINT YOUR NAME AND YOUR CITY, COUNTY, AND STATE OF RESIDENCE

IF YOU COMPLETED PARTS II AND/OR III YOU MUST HAVE TWO WITNESSES SIGN, DATE, AND PRINT THEIR NAMES HERE

IF YOU COMPLETED PART III, ONE WITNESS MUST ALSO SIGN HERE

PART IV. Execution
Alternative No. 1: Sign before 2 witnesses

I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive. I also understand that I can change or revoke all or part of this directive at any time.

Signed: _____Date_____

Printed Name: _____

City, County, and State of Residence:
_____

The declarer, who signed the above Directive, is personally known to me or has provided proof of identity and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive. In addition, I am not the attending physician, an employee of the attending physician or a 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 above Directive.

Witness 1:
_____Date:_____

Printed Name:
_____

Witness 2:
_____Date:_____

Printed Name:
_____

I further attest that I am disinterested with regard to any anatomical gift made by declarer.
Disinterested

Witness:_____

SIGN, DATE AND PRINT YOUR NAME AND YOUR CITY, COUNTY, AND STATE OF RESIDENCE

NOTARY PUBLIC MUST COMPLETE THIS SECTION ONLY IF YOU DID NOT HAVE THE DOCUMENT SIGNED BY 2 WITNESSES

Alternative No. 2: Sign before a notary public

I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive. I also understand that I can change or revoke all or part of this directive at any time.

Signed:
_____Date_____

Printed Name:
_____

City, County, and State of Residence:
_____

The declarer, who signed the above Directive, is personally known to me or has provided proof of identity and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive. In addition, I am not the attending physician, an employee of the attending physician or a 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 above Directive.

NOTARY SEAL:_____

Date:_____

Printed Name:_____

Courtesy of Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A

CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): **When the individual has NO pulse and is not breathing.**

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*

☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B

CHECK ONE

Level of Medical Interventions: **When the individual has a pulse and/or is breathing.**

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**		DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**		PHONE
X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**			PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: <u>Use this section to update and confirm order and preferences.</u>

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

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