8-17-17

Family Health Center
your medical home

FAQ's

Because of advanced age, illness or an accident, it is possible that you may become temporarily or even permanently unable to direct finances or to make decisions about our health care. If you act in advance, there is a way to make sure your wishes are carried out even upon incapacitation. There are multiple documents that allow for you to chart the course of your future health care decisions.

**What is a POST Form?**
A POST Form is a simple and easy way to make your end of life desires know.
POST is appropriate for anyone that:
- Has an incurable or irreversible injury
- Has a chronic, progressive, or end-stage disease, illness or condition
- Is in a terminal state
- Wishes to define their preferences for medical care

**What is a Living Will?**
The living will is your statement of medical procedures you assign without the use of an agent.

**What is a Medical Power of Attorney?**
This document serves to appoint an individual to make the multitude of day-to-day decisions taking into account your written requests. Under State law, the only adult(s) specifically ***excluded*** from being an Agent is your physician and anyone one else who is involved commercially in providing your health care, unless that person is a blood relative. It is important to choose someone who will be available locally to deal in person with your health care providers. The Agent you choose should be patient, persistent, willing to travel, and able to uphold your values and your desires even when confronted by strong willed people who may hold differing beliefs.

**What is a Durable Power of Attorney form used for?**
This document allows you to name any adult to be your decision maker, and that person is designated as your Agent. He or she should share your views on business and money matters, and it is obvious that you should be confident of this individual's honesty and integrity. It's a wise idea to name an alternate agent, in case your first choice isn't available if and when the time comes. Because many people choose their spouse, it is important to note that the agreement doesn't cease automatically if you divorce.

Your Durable Power of Attorney for Health Care cannot override your POST form unless they can provide evidence that your last known expressed wishes are different from those indicated on the POST.

**Can I revoke a Living Will, Durable Power of Attorney for Health Care or POST once I sign it?**
A POST form or any other directives may be revoked at any time by any of the following methods:
- By being intentionally cancelled, defaced, obliterated or burned, torn otherwise destroyed by you, or by some person in your presence and by your direction;
- By your written, signed revocation expressing your intent to revoke,
- Or by your oral expression of your intent to revoke.
- Your POST may also be suspended by your written, signed or oral expression expressing your intent to suspend your POST.

Note that you are responsible for notifying your physician if you revoke or suspend your living will or durable power of attorney for health care.

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

**1.** DESIGNATION OF HEALTH CARE AGENT

None of the following may be designated as your agent:
(a) your treating health care provider;
(b) a non-relative employee of your treating health care provider;
(c) an operator of a community care facility; or
(d) a non-relative employee of an operator of a community care facility.

If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

**I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.**

**Name of Health Care Agent:** _____

**Address of Health Care Agent:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Telephone Number of Health Care Agent:** (_____) _____ - _____

For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical condition.

**2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

**3. GENERAL STATEMENT OF AUTHORITY GRANTED**

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4. *"Statement of Desires, Special Provisions, and Limitations"*, below. You can indicate your desires by including a statement of your desires in the same paragraph.)

**4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS**

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations: (You may attach additional pages or documents if you need more space to complete your statement.)

_____

_____

_____

_____

_____

_____

_____

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

A. General Grant of Power and Authority Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

(1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;

(2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;

(3) Consent to the disclosure of this information; and

(4) Consent to the donation of any of my organs for medical purposes. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)

B. HIPAA Release Authority

My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all 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.

**6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES**

Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice"; and

(b) Any necessary waiver or release from liability required by a hospital or physician.

**7. DESIGNATION OF ALTERNATE AGENTS**

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1 above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is thereafter dissolved.)

If the person designated as my agent in paragraph 1 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:

Name of First Alternate: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____ - _____

Name of Second Alternate: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____ - _____

Name of Third Alternate: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____ - _____

8. **PRIOR DESIGNATIONS REVOKED**

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

SIGNATURE OF PRINCIPAL: _____ DATE: _____

***I sign my name to this Statutory Form Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at:***

Signature: _____ City: _____ State: _____

***(You must date and sign this Durable Power of Attorney for Health Care.)***

# LIVING WILL FOR HEALTH CARE

Date of Directive: _____

Name of person executing Directive: _____

Address of person executing Directive: _____ City: _____ St: _____ Zip: _____

## A Living Will
## A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life ***shall not*** be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:

a. I 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 artificial life-sustaining procedures would serve only to prolong artificially my life; and
3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

b. I have been diagnosed as being in a persistent vegetative state.

In such event, 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.

**Check one box and initial the line after such box:**

☐ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

☐ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial 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, disease, illness or condition, as follows: (If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.) Check one box and initial the line after such box:

☐ A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

☐ B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

☐ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

☐ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check one box and initial the line after such box:

☐ I have discussed these decisions with my physician 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, then this living will shall be deemed modified to be compatible with the terms of the POST form.

***I sign my name to this Statutory Form Living Will on the date set forth at the beginning of this Form at:***

Signature: _____ City: _____ State: _____

***(You must date and sign this Living Will for Health Care)***

# POWER OF ATTORNEY - IDAHO

## 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.

This form provides for designation of one (1) agent. If you wish to name more than one (1) agent, you may name a co-agent in the Special Instructions. Co-agents 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.

## DESIGNATION OF AGENT

I,_____, name the following person as my agent:

- Name of Agent _____.
- Agent's Address: _____City:_____ State: _____ Zip: _____.
- Agent's Phone Number: (_____) _____-_____.

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

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

- Name of Successor Agent: _____.
- Successor Agent's Address: _____City:_____ State: _____ Zip: _____.

  Successor Agent's Phone Number: (_____) _____-_____.

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

- Name of Second Successor Agent: _____.
- Second Successor Agent's Address: _____City:_____ State: _____ Zip: _____.
- Second Successor Agent's Phone Number: (_____) _____-_____.

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

## 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

## 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.

SPECIAL INSTRUCTIONS (OPTIONAL)

On the following lines you may give special instructions:

_____

_____

_____

_____

***EFFECTIVE DATE:*** _____

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

## 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 of Nominee for conservator or my estate: _____.
- Nominee's Address: _____ City: _____ State: _____ Zip: _____.
- Nominee's Phone Number: (_____) _____-_____.

## 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.

Date: _____

Principal's Name Printed: _____

Principal's Address: _____ City: _____ State: _____ Zip: _____. Principal's Phone Number: (_____) _____-_____.

## (OPTION ONE - IF YOU ARE ABLE TO SIGN ON YOUR OWN)

**SIGNATURE AND ACKNOWLEDGMENT**

Principal's Signature: _____ Date: _____

Principal's Name Printed: _____

Principal's Address: _____ City: _____ State: _____ Zip: _____. Principal's Phone Number: (_____) _____-_____.

## NOTARY - REQUIRED FOR RECORDING AND FOR REAL PROPERTY

STATE OF _____ Idaho )
SS.
COUNTY OF _____ )

On this _____ day of _____, 20_____, before me, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that he/she/they 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 of: _____
Residing at: _____
My Commission Expires: _____

**(OPTION TWO - IF YOU ARE UNABLE TO SIGN ON YOUR OWN AND DIRECT THE NOTARY TO)**

Signature of person by notary: _____

Witness Signature: _____

Signature affixed by notary in the presence of (Name of person and witness) _____.

STATE OF _____ Idaho )
SS.
COUNTY OF _____ )

On this _____ day of _____, 20_____, before me, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that he/she/they 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 of: _____
Residing at: _____
My Commission Expires: _____