DURABLE POWER OF ATTORNEY FOR HEALTH CARE and HEALTH CARE DIRECTIVE of:

____
{Your name here.}

This document states my choices about the use of life-sustaining medical treatment and comfort care. It is meant to inform and guide whoever will make health care decisions for me, if I become unable to make my own health care decisions. I understand that such inability may only be temporary. When I can make my own health care decisions I want to do so. Even when I cannot make my own health care decisions, I want my physician and my health care decision maker(s) to talk to me honestly about my condition and treatment. I want this directive to remain in effect after my death for autopsy, organ donation, use of my body for medical research, and for my agent to arrange for the disposition of my remains, if I authorize that in section 9.

1. MY HEALTH CARE AGENT

I appoint as my primary agent, below:

Name ______________________________

Address ______________________________

Phone ______________________________
(mobile) (alternate)

I appoint as my alternate agent, below: If my primary agent is unable or unwilling to serve, or is unavailable when decisions need to be made for me, then I name this alternate agent:

Name ______________________________

Address_ ________________ ______________

Phone ______________________________
(mobile) (alternate)

(No signature from individuals needed legally)

2. THE AUTHORITY I GIVE MY AGENT

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (Mark all authorities granted)

- _____ consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments;
- _____ requesting particular medical treatments;
- _____ employing and dismissing health care providers;
- _____ changing my health care insurers;
- _____ signing a Physician Orders for Life-Sustaining Treatment (POLST) form;
- _____ transferring me to another facility, private home, or other place; and
- _____ accessing my medical records and information. This authority applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 and any further changes to HIPAA.

3. WHY I AM MAKING THIS DOCUMENT/ HOW TO MAKE HEALTHCARE DECISIONS FOR ME

I want whoever makes health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. I do not want others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interest. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind. If what I would want is not known, then I want decisions to be made in my best interest, based on (a) my values, (b) the contents of this document, and (c) medical information provided by my health care providers.
I have added below or attached an additional statement of my values.

3. Continued {Optional}

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. If I initial an item in this section it means that if such an initialed life-threatening event should occur, I would **not want** to receive life-sustaining treatment. I want my care-givers to focus on comfort care and pain management. I should be allowed to die as peacefully as possible in the case of : **{initial all that apply}**

____ Unconsciousness or coma that probably will prevent me from communicating, permanently.
____ Experiencing irreversible dementia such as Alzheimer's Disease.
____ Total dependence on others for my care because of physical deterioration, which is probably permanent.
____ In pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.
____ Below are other circumstances in which I would not want life-sustaining treatment:

5. WHEN I MAY WANT TEMPORARY USE OF LIFE-SUSTAINING TREATMENT

I understand that I could become unconscious or unable to communicate, temporarily. If I were to become unconscious or unable to communicate temporarily, then **(initial only ONE line):**

____ I would want to receive life-sustaining treatment, for up to ___ weeks (please specify)
____ I would want to receive life-sustaining treatment for a period of time determined by my health care agent, based on the judgement of my doctor(s).
____ I still would want no life-sustaining treatment.

6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT - Detailed

If I experience a condition in which I would not want life-sustaining treatment or if I experience a quality of life my agent believes I would consider unacceptable,

I do not want the following life-sustaining treatments started. If already started, I want them stopped.
{Initial all that you do not want.}

____ I do not want all cardiopulmonary resuscitation (CPR) measures to try to restart my heart and breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart regulating drugs, ICDs or any other treatment for heart failure.
____ I do not want artificial ventilation when I can no longer breathe on my own.
____ I do not want heart-regulating drugs, if my heartbeat becomes irregular.
____ I do not want nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.
____ I do not want surgeries for the purpose of prolonging my life rather than for providing comfort.
____ I do not want dialysis if my kidneys do not work normally.
____ I do not want medications, treatments or procedures, when their primary purpose is to prolong life rather than control pain.
____ I do want my implantable cardioverter-defibrillator (ICD) to be turned off.
____ I do not want anything else intended to prolong my life.

7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

Yes ____ No ____

8. IF A HEALTH CARE PROVIDER REFUSES TO HONOR MY DECISIONS OR DECISIONS OF MY HEALTH CARE AGENT

(Cross out this section, if you do not agree.)

If I am ever in a healthcare facility that refuses to honor my decisions expressed in this document or decisions made for me by my health care agent, I want my agent to take whatever actions he or she decides are appropriate to secure those decisions, including but not limited to changing my physician(s) or moving me out of the facility.

9. MY WISHES CONCERNING OTHER MATTERS

	Yes	No
a. I consent to medical treatments that are experimental.	___	___
b. I want to donate organs/tissues.	___	___
c. I consent to an autopsy.	___	___
d. I consent to the use of all or part of my body for medical education or research.	___	___

I have named the following individual(s) as my agent(s) for funeral arrangements:
My agent for funeral arrangements:

I appoint as my primary funeral arrangements agent, below:
I appoint as my alternate agent for funeral arrangements below: If my primary agent is unable or unwilling to serve, or is unavailable when decisions need to be made for me, then I name this alternate agent:

Name ______________________________	Name ______________________________
Address ______________________________	Address_ ______________ ___________
Phone ______________________________	Phone ______________________________
(mobile) (alternate)	(mobile) (alternate)

10. IF A COURT APPOINTS A GUARDIAN FOR ME

If I have named a health care agent, I want my agent to be my guardian. If they cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

11. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document. Note: The signed and witnessed Advance Directive with the latest date will take precedence over older Advance Directives. I reiterate that this directive does NOT end in death.

12. If I am alone and dying, please call South Side No One Dies Alone 360-504-8272 Yes ____ No ____

13. If i have been diagnosed aas pregnant and that diagnosis is known to my physicicia, this directive shall have no force or effect during the course of my pregnancy. RCW 70.122.030

13. SUMMARY AND SIGNATURE

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective, even if I become incompetent or otherwise disabled.

____

Signature   Date

{Sign only in the presence of two witnesses or a notary, if notarizing.}

13. STATEMENT OF WITNESSES

____

{Print the legal name of the person making this document on this line.}

I believe this person to be of sound mind and to have completed this document voluntarily.
I affirm I am at

- least 18 years old,
- not related to the signer of this document by blood, marriage, or adoption,
- and am not their health care agent named in this document.
- not a beneficiary of the signer's will or any codicil, and I have no claim against their estate, as far as I know
- I am not directly involved in their health care
- I am not an employee of their physician or a healthcare facility where the person making this document may reside.
- I am not a home care provider for this person, nor am I a care provider at facility in which this person resides.

Witness 1
:
Name ______________________________
Address ______________________________
Phone ______________________________
(mobile) (alternate)

Witness 2
Name ______________________________
Address ______________________________
Phone ______________________________
(mobile) (alternate)

NOTARIZATION {optional} STATE OF WASHINGTON County of ______________________

I certify that I know or have satisfactory evidence that ____________________________ signed this document

and acknowledged it to be their free and voluntary act for the uses and purposes mentioned in this document.

Dated this _______ day of ________, 20 _____

____

NOTARY PUBLIC in and for the State of Washington

Residing at ________________________ County ______________ My commission expires ___________

(Seal or stamp)

Durable Power of Attorney for Finances
Durable Power of Attorney for Finances for

____
[My Name]

1. Agent. I choose ________________________as my Agent with full authority to manage my finances.

2. Alternate. If ________________________is unable or unwilling to act, I choose ______________________ as my Agent with full authority to manage my finances.

3. My Rights.
I keep the right to make financial decisions for myself as long as I am capable.
4. Durable POA.
My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.
5. Start Date.
This power of attorney document is effective: (check one) Immediately. Only if my medical provider signs a letter saying I cannot make decisions for myself.
6. End Date.
This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.
7. Revocation.
I revoke any power of attorney for finances documents I have signed in the past. I understand that I may revoke this power of attorney document at any time by giving written notice of revocation to my Agent.
8. Powers.
My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to make deposits to, and payments from, any account in my name in any financial institution, to open and remove items from any safe deposit box in my name, to sell, exchange or transfer title to stocks, bonds or other securities, and to sell, convey or encumber any real or personal property. My agent shall also have the following special powers: (check all that apply) create, amend, revoke, or terminate a living trust make gifts of my money or property create or change my rights of survivorship create or change my beneficiary designation(s) delegate some authority granted in this document to someone else waive my right to be the beneficiary of an annuity or retirement plan create, amend, revoke, or terminate my community property agreement tell a trustee to make distributions from a trust just as I could
9. No Power to Agree to Binding Pre-Dispute Arbitration.
I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue

the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

10. Accounting.

My Agent shall keep accurate records of my finances and show these records to me at my request.

11. Nomination of Guardian.

I nominate my Agent as the guardian of my estate for consideration by the court if guardianship proceedings become necessary.

12. HIPAA Release.

I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

___________________________________ __________________

My Signature Date Notarization (optional, but recommended)

State of Washington County of ____________________ I certify that I know or have satisfactory evidence that____________________________, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument. SUBSCRIBED and SWORN to before me on __________________. _____

____

SIGNATURE OF NOTARY

____

PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires

____

___________________________________ _____________________________________

Witness 1 Signature Witness 2 Signature

___________________________________ _____________________________________

Witness Printed Name Witness Printed Name

Disposition Authorization Washington State

I, ______________________________ hereby declare that it is my desire, based upon the authority of the **Revised Code of Washington 68.50.160,** to direct and authorize that upon my death my remains be: (initial either cremated or buried or aqumated)

___ Cremated   ___ Buried   __ Aquamation

<u>If my desire is to be Cremated or Aquamated,</u> I may further direct that the Funeral Home or Crematory release my remains in the following manner: (initial and complete only ONE of the following four choices)

1) ___ Release my cremated remains to the following person or persons:
Name: ______________________ Relationship: __________________
Address: ____
or
Name: ______________________ Relationship: __________________
Address:____

2) ___ **Deliver** for Inurnment: In a ___**Niche** or ___**In the Ground** (initial choice)
To Place of Inurnment:
____
City/County & State:

3) ___ Ship to:
Name: ______________________ Relationship: __________________
Address: ____

4) ___ Scatter where? ____
If my desire is to be Buried, I may further direct that my body be Buried at the following:
(initial choice) ___Cemetery or ___ Mausoleum

Name of Place of Interment:
____

City/County & State:
____

Special Instructions to my survivors regarding disposition of my remains:

____
____
____
____
____
____
____
____
____
____

I direct that all of my family and survivors shall honor this authorization. I direct that no funeral home, cemetery, cremation authority, or memorial society shall be liable for arranging or for undertaking the disposition of my remains, if done in reliance on this authorization.

Declarant's Signature: ____________________________Date: _____________
Printed Name of Declarant: _________________________________
Date of Birth: _________

UNDER WASHINGTON LAW, TO BE VALID, THIS FORM MUST BE SIGNED IN THE PRESENCE OF A WITNESS:
Witness Signature: ______________________________ Date: _____________

Printed Name of Witness: ____
Address of Witness:____