worry-free wednesdays

This packet was created with one heartfelt purpose: to create a legacy of love for those who may care for you when you are ill or dying.

In times of uncertainty and grief, no one wants to feel doubt about how to carry out your wishes. By completing these documents, you can offer the clarity and guidance they'll need—so they can act with confidence, not guesswork, and remember your intentions with peace rather than regret.

Inside, you'll find some of the essential tools to help communicate your preferences in advance of a healthcare emergency or your passing. These documents are not just authorized forms – they are acts of love, designed to protect your quality of life and ease the burden on those who matter most.

For additional resources tailored to your unique healthcare or lifestyle needs, please visit worryfreewednesdays.com

We are also available to help guide you through the planning process via in-person, phone, Zoom. Simply reach out at info@worryfreewednesdays.com

Warmest regards,

The Worry-Free Wednesdays Team

WorryFreeWednesdays.com

Below is a list of actions you can take to have your wishes known by all who care for you and those that are left behind. For questions about which are essential or to be considered, contact us at info@worryfreewednesdays.com.

END-OF-LIFE ACTIONS	ESSENTIAL	TO CONSIDER
1. Complete an End-of-Life Values Worksheet		
Help clarify your perspective and beliefs about living and dying		
Use as a guide for conversations with those who support you to explain your choices		
2. Complete Advance Directives		
Select, complete and sign a Durable Power of Attorney for Healthcare		
Select, complete and sign a Healthcare Directive/Living Will		
Evaluate need for POLST and Dementia/Mental Health Directives		
Add addendum in writing or video as I see fit to share additional end-of-life wishes or reinforce choices		
3. Identify Supportive Primary Care Physician and Care Providers		
Talk to you physician and care providers about options you would want to consider regarding a Natural Death, Medical Aid in Dying, Voluntarily Stopping Eating and Drinking and Stopping Treatment		
Make sure they can and will support these choices		
4. Provide Copies of Advance Directives and Display POLST		
Share end-of-life documents with loved ones, healthcare agent, other support team members, and ask all medical providers to add a copy to electronic files		
Display copy of POLST prominently if you have one		
Consider medical alert jewelry or emergency contact cards and apps to ensure your wishes can be known		
5. Last Will & Testament, Financial Records, Digital Accounts, Insurance		
Create Will or Trust, Name Executor or Trustee, Fill our a Durable Power of Attorney for Finance		
Update insurance as needed as health status changes (medical updates can change coverage)		
Ensure updated financial and legal documents, and all digital account usernames and passwords, are accessible by the named individuals		
Designate beneficiaries of assets and sentimental items		
6. Final Disposition Arrangement and Designated Agent		
Decide how you want your body cared for after you die and who will be responsible. Complete After-Death Disposition Forms		
7. Shape Your Legacy		
Document and share anything you do or do not want for a remembrance, gathering, eulogy, obituary and after you die		
Consider letters, gifts, sentiments or designation of items to individuals and groups you choose		

WORRY-FREE WEDNESDAYS

VALUES WORKSHEET of _____

(Name)

Consider how important these values are to me.	**1 (Low – High) 5**				
Staying true to my values and traditions. (For example: decisions made about my healthcare are consistent with the way I've lived my life prior to becoming ill, even if it means I could lose quality of life, die sooner or not be in the best care.)	**1**	**2**	**3**	**4**	**5**
Following my spiritual and religious beliefs. (For example: I want my healthcare to be consistent with my spiritual and religious beliefs and the religious doctrine/teachings I follow.)	**1**	**2**	**3**	**4**	**5**
Letting nature take its course. (For example: I would or would not want life extending treatment or curative treatment to interfere with the natural dying process.)	**1**	**2**	**3**	**4**	**5**
Living as long as possible, regardless of quality of life. (For example: Provide me with all curative treatment to sustain my life, even if it impacts my health.)	**1**	**2**	**3**	**4**	**5**
Shortening the dying process rather than prolonging life if terminally ill or suffering. (For example: I would consider Medical Aid in Dying or Voluntarily Stopping Eating and Drinking.)	**1**	**2**	**3**	**4**	**5**
Having autonomy and making choices about my care. (For example: I want to remain in control of all healthcare decisions as long as I am capable. I do not have someone I trust to make decisions for me.)	**1**	**2**	**3**	**4**	**5**
Being independent. (For example: how important it is to me to care for myself vs allowing others to care for me if I were to lose cognitive or physical independence, and to what degree.	**1**	**2**	**3**	**4**	**5**

Being conscious, even if uncomfortable and experiencing pain. (For example: I want my pain medications balanced to allow for some cognitive capacity to make my own healthcare decisions or decisions with my Healthcare Proxy.)	**1**	**2**	**3**	**4**	**5**
Being slightly sedated, to avoid pain. (For example: I trust those I've named or healthcare professionals to make decisions for me so I can remain comfortable when/if experiencing pain.)	**1**	**2**	**3**	**4**	**5**
Being free of physical limitations or disabilities. (For example: how important is my physical ability and what limitations or disabilities would or would not be acceptable in relation to my quality of life.)	**1**	**2**	**3**	**4**	**5**
Being free of cognitive limitations and disabilities. (For example: how important is my mental capacity and ability to make my own decisions and live independently vs letting others make decisions for me.)	**1**	**2**	**3**	**4**	**5**
Remaining in my place of residence vs. moving for better care, safety, or cost.	**1**	**2**	**3**	**4**	**5**
Leaving good memories for my family and friends, saying goodbye. (For example: consider whether I would want loved ones to see me suffering or in a compromised state if I was ill and or in the dying process. Importance of letters, gestures, gifts you want to leave.)	**1**	**2**	**3**	**4**	**5**
Contributing to life-extension for others or medical research/teaching through organ and/or full body donation. (For example: how important it is to offer my full body, tissue or organs to provide sustained life for others or to medical research or teaching.)	**1**	**2**	**3**	**4**	**5**
Avoiding expensive care that doesn't extend quality of life. (For example: how important it is to avoid expensive extreme measures that would not extend quality of life vs doing everything possible regardless of the outcome.)	**1**	**2**	**3**	**4**	**5**
Leaving money and valuables to family, friends, and/or charity. (For example: how important it is to me to leave and designate valuable items or money to friends, family, loved ones or charity.)	**1**	**2**	**3**	**4**	**5**

IDAHO HEALTHCARE DIRECTIVE REGISTRY
Your voice. Your choice.

Account Registration Form

Please complete this form to register for an account with the Idaho Healthcare Directive Registry. Include a copy of your Advance Directive (Living Will, Durable Power of Attorney for Healthcare) or signed POST Form (Physician Orders for Scope of Treatment), to be added to your account.

Completed forms may be mailed to **450 W. State St., 4th Floor. Boise, ID 83702** or emailed to IHDR@dhw.idaho.gov. For questions about this form or related documents, please call (208) 334-5501 to speak with a registry representative.

PAPER DOCUMENTS WILL NOT BE RETURNED

First Name, Middle Name, Last Name **required*		Date of Birth **required*
Address **required*		Gender **required*
City, State, Zip Code **required*	Phone **required*	Last Four SSN *(optional)*
Email Address *(can only be used on one account for one person. If no email, enter "none")*		

To help us improve our education and outreach, please share how you heard about the Idaho Healthcare Directive Registry:

- ☐ Healthcare Provider
- ☐ Family Member/Friend(s)
- ☐ Community Event
- ☐ Newspaper Ad
- ☐ Social Media
- ☐ Other: _____

_____
Signature of Registrant

_____
Date

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: _____ **Phone Number:** _____

Address: _____ **Birth Date:** _____

An Advance Directive is a general term used to describe this document. There are two parts: 1) the Durable Power of Attorney for Healthcare and 2) the Living Will. The purpose of this form is to help you plan ahead so your loved ones and healthcare team know what care you want if you experience a medical crisis and cannot speak for yourself.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT.** I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Advance Directive:

Name of Healthcare Agent: _____

Relationship: _____ Phone Number of Healthcare Agent: _____

Address: _____

2. **DESIGNATION OF ALTERNATE AGENTS.** If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Advance Directive (*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 healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

A. Name of First Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

B. Name of Second Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

If any of the agents designated above is my spouse, and our marriage is dissolved (divorce or annulment) after creation of this Advance Directive, appointment of that agent is automatically revoked as of the date of the dissolution.

None of the following may be designated as your agent or alternate agent:

- *Your treating healthcare provider.*
- *A non-relative employee of your treating healthcare provider.*
- *An operator of a community care facility; or*
- *A non-relative employee of an operator of a community care facility.*

3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** I hereby grant to my agent full authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. My agent shall make healthcare decisions that are consistent with my desires as stated in this Advance Directive or otherwise made known to my agent verbally or in writing. This includes, but is not limited to, my desires concerning obtaining, refusing, or withdrawing life-sustaining care, treatment, procedures. This authority includes following my desires as stated in a living will or similar document executed by me.

4. **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 Advance Directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records.
- Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- Consent to the disclosure of this information; and
- 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 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

through 164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical Information Bureau, Inc. or other healthcare 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 healthcare providers to restrict access to or disclosure of my individually identifiable health information.

5. **SIGNING DOCUMENTS, WAIVERS AND RELEASES.** When necessary to implement the healthcare decisions that this Advance Directive authorizes my agent to make, my agent has the 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.

6. **PRIOR DESIGNATIONS REVOKED**. I revoke any prior durable power of attorney for healthcare.

Continue to Living Will on next page.

LIVING WILL
Directive to Withhold or to Provide Treatment

This portion of my Advance Directive creates my Living Will which allows me to make choices about any life-sustaining medical treatment I want or do not want. This Advance Directive shall be effective only if I am unable to communicate my instructions and:

A. I have an incurable injury, disease, illness or condition AND a medical doctor who has examined me has certified:

i. That such injury, disease, illness, or condition is terminal; and
ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
iii. 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.

IF I AM IN ONE OF THE ABOVE SITUATIONS, my choices are as follows: *(Choose Box 1, 2, or 3 below, check the box, and initial the line after the box you checked).*

Regardless of the box chosen, pain and symptom management (comfort care) will be provided.

1. ☐ _____ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started and, if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and hydration.

OR

2. ☐ _____ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and hydration as follows:

*Check **one** box* and initial the line after the box you checked:

A. ☐ _____ Only artificial hydration
B. ☐ _____ Only artificial nutrition
C. ☐ _____ Both artificial hydration and nutrition

OR

3. ☐ _____ If my death is imminent, I want all medical treatment, care, and procedures necessary to sustain my life, including artificial nutrition and hydration.

SPECIAL PROVISIONS (OPTIONAL)

The following are additional statements of my wishes. *Check all boxes that apply and initial on the line after the boxes you checked:*

IF I AM DIAGNOSED AS PREGNANT:

☐ _____ This Advance Directive shall be honored in its entirety during the course of my pregnancy.

OR

☐ _____ I direct the following treatment ☐ shall ☐ shall not be withheld or withdrawn:

_____

_____

_____

OR

☐ _____ My instructions regarding medical care shall have no force during my pregnancy except that my Healthcare Agent is authorized to make such decisions for me.

☐ _____ If I have a medical condition from which I am not imminently dying, and from which I will not likely recover, am unable to think or communicate, and am dependent on others for my care, I do not want life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration. In such condition, I want care to be focused on my comfort.

☐ _____ Other situations as described in the box below *(If needed, attach, and sign additional pages.):*

This section is not required but can be used to describe any additional desires or wishes. For example: no admission to the intensive care unit, time limits to treatment options, and funeral/burial wishes, etc.

IDAHO POST FORM VERIFICATION. *Check one box and initial the line after the box you checked:*

☐ _____ I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Advance Directive. I hereby approve of those orders and make them a part of this Advance Directive.

OR

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

SIGNATURE OF PRINCIPAL. *You must sign this Durable Power of Attorney for Healthcare and Living Will for it to be valid.*

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

The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing.

I sign my name below to this Idaho Durable Power of Attorney for Healthcare and Living Will, effective on the date below.

_____ _____

Signature Effective Date

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 _____ Phone #____-____-_____

Print Physician/APRN/PA name | ID license number | 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*****

Orig 7/2007; Rev 7/2012

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 (phyisican 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.

IDAHO HEALTHCARE DIRECTIVE REGISTRY
Your voice. Your choice.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Advance Directive Registration Form

This form is **required** to add a hard copy Advance Directive or POST to the registry. Email the form and Advance Directive documents to IHDR@dhw.Idaho.gov or mail to the address below (***email preferred***). Please call 208-334-5501 for questions.

I want to:

☐ Store a copy of my healthcare Advance Directive and/or POST in the Registry.

☐ Replace my Advance Directive currently in the Registry, number _____, with the one included.

☐ Revoke my healthcare Advance Directive from the Registry.

The personal information below is provided with this request to store my Advance Directive the Idaho Healthcare Directive Registry. I certify the Advance Directive, Durable Power of Attorney for Healthcare, and/or POST that accompanies this agreement is my effective healthcare directive executed in accordance with State of Idaho laws.

I understand registry use is entirely voluntary and not required. Registration only makes these documents more accessible to healthcare providers, healthcare organizations, and individuals that I choose.

*REGISTRATION CONFIRMATION WILL BE SENT TO THE REQUESTOR VIA **EMAIL ONLY**. ADVANCE DIRECTIVE DOCUMENTS WILL **NOT BE RETURNED**.*

Fill in this registration form and email/enclose it with a COPY of your healthcare Advance Directive and/or POST.

First Name, Middle Name, Last Name *required		Date of Birth *required
Address *required		Gender(M/F/other)*required
City, State, Zip Code *required	Phone *required	Last Four SSN *(optional)*
Email Address *required and cannot not be used by another registrant		

ADDRESS TO SEND ADVANCE DIRECTIVE REGISTRATION CONFIRMATION VIA EMAIL, IF DIFFERENT FROM ABOVE.

First Name, Last Name	
Address	City, State, Zip Code
Phone	Email Address

_____
Signature of Registrant

_____
Date

Sign, date, and send to:
Email (preferred): IHDR@dhw.Idaho.gov
OR
Idaho Healthcare Directive Registry
450 W State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83702-0036

DURABLE POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

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:_____, Address: _____ and phone number: _____. In the event _____is not able or willing to serve as my agent, I name as my successor agent: _____, address: _____ and 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
____ 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

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
____ Create, amend, revoke, or terminate a "Miller Trust" for Medicaid long-term care eligibility purposes
____ 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

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.

This power of attorney will remain in effect despite any future incapacity or disability of the principal.

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.

PRIOR DESIGNATIONS REVOKED

I hereby revoke any prior power of attorney for financial affairs.

SIGNATURE AND ACKNOWLEDGMENT

Your Signature: _____

Date: _____

Your Name Printed: _____

Your Address: _____

Your Phone Number: _____

NOTARY - REQUIRED FOR RECORDING AND FOR REAL PROPERTY

STATE OF IDAHO)
: ss.
County of ADA)

On the _____ day of _____ before me, the undersigned Notary Public, personally appeared_____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that she executed the same.

IN WITNESS WHEREOF, I have set my hand and seal the day and year as above written.

Notary Public for Idaho
Residing at _____
Commission Expires: _____

IMPORTANT INFORMATION FOR AGENT

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. This relationship imposes legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) 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;

(2) Act in good faith;

(3) Do nothing beyond the authority granted in this power of attorney; and,

(4) 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:

(1) Act loyally for the principal's benefit;

(2) Avoid conflicts that would impair your ability to act in the principal's best interest;

(3) Act with care, competence and diligence;

(4) Keep a record of all receipts, disbursements, and transactions conducted for the principal;

(5) 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

(6) 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.

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:

(1) Death of the principal;

(2) The principal's revocation of the power of attorney or your authority;

(3) The occurrence of a termination event stated in the power of attorney;

(4) The purpose of the power of attorney is fully accomplished; or

(5) 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.

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.

TO BE PRESENTED TO FUNERAL HOME/REDUCTION FACILITY AT TIME OF DEATH

Designated Agent for Disposition

I, _____designate the following agent(s) to act on my behalf for the sole purpose of directing my disposition arrangements.

Primary Agent's Full Name: _____

Primary Agent's Address: _____

Primary Agent's Phone(s): _____ Relationship: _____

If.my.Primary.Agent.is.for.any.reason.unable.or.unwilling.to.serve.in.this.capacity.or.does.not.make.contact.with.the disposition.entity.I've.named.within.❶business.days.of.my.death?I.then.name.the.following.person¡

Alternate Agent's Full Name: _____

Alternate Agent's Address: _____

Alternate Agent's Phone(s): _____ Relationship: _____

I direct that all of my family and survivors shall honor this authorization. I direct that any funeral home, cemetery, cremation authority, memorial society or designated agent shall be held harmless for arranging or handling the disposition of my remains, if done in reliance upon this authorization. If I have not executed a written disposition request or authorization, nor filed or prepaid my arrangements with a licensed funeral establishment or cemetery authority, then I authorize the designated agent(s) listed here to select appropriate disposition arrangements for me including the type, place and method. Neither my designated agent(s) nor my surviving relatives can alter any prearrangements I have made. If I have not provided sufficient funds to cover my prearrangements, I direct my designated agent(s) to pay the remainder of the cost and my estate to promptly reimburse my designated agent(s) for any personal funds advanced to pay for my disposition arrangements. My designated agent(s) have complete authority to act on my behalf and direct any and all details related to my disposition arrangements that I have not already prearranged or authorized, including but not limited to obituary, funeral or memorial service, cemetery, monument, memorialization, reception or other related matters.

Declarant's Signature: _____ Date: _____
(Only.the.Declarant.may.sign?not.the.POA.or.Spouse)

Printed Name of Declarant: _____Date of Birth: _____

TO.BE.VALID?THIS.FORM.MUST.BE.SIGNED.IN.THE.PRESENCE.OF.A.WITNESS¿

Witness Signature: _____Date: _____

Printed Name of Witness: _____ Phone:_____

Address of Witness: _____

KEEP WITH IMPORTANT END-OF-LIFE PLANNING DOCUMENTS

Directions for the Disposition of my Body

I, _____ hereby declare that it is my desire upon my death for my remains to be handled in the following manner: (Initial.your.choice.below)

_____ BURIAL	_____ ALKALINE HYDROLYSIS (Aquamation)	_____ CREMATION
_____ GREEN BURIAL	_____ NATURAL ORGANIC REDUCTION	_____ FULL BODY DONATION

I may further direct the following funeral home, reduction facility or organization to manage my disposition.

_____ _____

(Name of funeral home, reduction facility or organization) (Phone number)

_____

(Address)

☐ I HAVE filled out the necessary disposition authorization forms and they are on file with the named entity above.
☐ I HAVE filled out the necessary organ donation or full body donation forms.
☐ I HAVE prearrangements where I have purchased a final expense whole life insurance policy with the named entity above.
☐ I HAVE prearrangements where I have placed funds into a master trust managed by the named entity above.
☐ I HAVE purchased (check all those purchased) ____cemetery property____headstone____opening/closing fee _____burial vault/liner with _____.
☐ I HAVE NOT purchased any of the above and need my designated disposition agent to do that on my behalf and be reimbursed from my estate where possible.

I may further direct that the funeral home or reduction facility release my remains in the following manner:

☐ Release my remains to the following person(s):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City/State/Zip:_____ City/State/Zip:_____

Phone: _____ Phone: _____

☐ Deliver or ship my remains to:

Name: _____ Relationship: _____

Address: _____

City/State/Zip:_____ Phone: _____

I may further direct that my remains be buried at the following:

☐ Cemetery/ Established Family Burial Ground

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

☐ Mausoleum

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

I may further direct that my remains be scattered/spread in the following location:

Name/Address of Location: _____

Name/Address of Location: _____

Name/Address of Location: _____

Other: _____

Declarant's Signature: _____ Date: _____

Printed Name of Declarant: _____ Date of Birth: _____

Organ, Tissue and Full Body Donation

I, _____ hereby declare that it is my desire upon my death for the following organ, tissue or full body donations to be made if determined to be eligible at time of death. If not eligible, please refer to disposition directions.

Eye/Cornia Donation

I ☐ do ☐ do not wish to donate my eyes at the time of my death to the eye bank.

☐ I have chosen an organization to work with on my donation like Sightlife, Eye Bank Association of America, etc.

_____

(Name of Organization) (City) (State) (Zip)

Organ/Bone/Tissue Donation

I ☐ do ☐ do not wish to donate such other organs, bone or tissue, at the time of death as may be considered medically useful. This also authorizes donation of pacemaker, if applicable.

☐ I have chosen an organization:

_____

(Name of Organization) (City) (State) (Zip)

Full Body Donation

I ☐do ☐do not wish to donate my body to a university willed body program such as the one at Idaho State University for teaching or research purposes.

I have registered with the following program:

_____

(Name of Organization) (City) (State) (Zip)

Declarant's Signature: _____ Date: _____

Printed Name of Declarant: _____Date of Birth: _____

Vital Statistics Form
Information.Required.for.Death.Certificate

Personal Information:

Full Legal Name: _____
(First) (Middle) (Last)

Other Names/(AKAs): _____
(First) (Middle) (Last)

Date of Birth: _____
(Month) (Date) (Year)

Birthplace: _____
(City) (County) (State or Country)

Marital Status: ☐ Single ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Registered Domestic Partner

Name of spouse or domestic partner: _____
(First) (Middle) (Last – *must use maiden name*)

Father's Name: _____
(First) (Middle) (Last)

Mother's Maiden Name: _____
(Before first marriage) (First) (Middle) (Last)

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary **Served in the US Armed Forces?** ☐ Yes ☐ No

Social Security Number _____-_____-_____ **Race(s) List all that apply:** _____

Hispanic Ethnicity: ☐ No ☐ Yes ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Residence:

_____
(Street Address, Apt. #) (City) (State) (Zip)

Resided at this address since: _____ **Residence Inside City Limits?** ☐Yes ☐ No ☐ Unknown
(Year)

Tribal Reservation Name:_____
(Name of Reservation)

Education/Occupation:

Education completed (highest degree earned): ☐ 8th Grade or Less ☐ 9 th-12th grade: no diploma ☐ High School Graduate or GED completed ☐ Some college credit, no degree ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate ☐ Unknown

Occupation (Kind of Work Done. Do not use "retired", give former occupation(s): _____
Industry (Do not use company name(s), i.e. "Education"): _____

My Wishes to Honor My Life
Instructions.to.Surviving.Relatives.and.Designated.Agents

I, _____ declare my wishes to have my life honored in the following manner after I die. I will look to my surviving relatives and/or designated agents to follow these directions where possible and only to make changes if and when my wishes can not be honored.

Declarant's Signature: _____ Date: _____

Type of gathering (Funeral, Memorial, Graveside Service, Celebration of Life, Wake, etc. Be as specific as possible):

_____

_____.

Location of gathering (Place of Worship, Home, Specific Location in Community, etc. Be as specific as possible):

_____

_____.

People I would like to speak/communicate at my gathering:

_____.

Gifts, gestures, mementos I would like given away to those who attend:

_____

_____.

Specific food, flowers, music, photos, or other items/wishes I would like represented:

_____

_____.

Notices: I ☐ do ☐ do not want notices of my death published.

Memorial Gifts: I ☐ do ☐ do not prefer memorial gifts or donations in lieu of flowers. If memorials requested, I ask that donations be sent to the following organization(s):

_____.

☐ A gathering to honor my life and all other decisions are up to surviving relatives and loved ones to decide.

Thoughts for My Obituary/Eulogy
Instructions of What to Include/What I Want Written About Me

The name in which I'd like to be referred to _____

Date and place of birth_____.

Parents names _____ _____
(Mother, Maiden Name) (Father)

Locations where I grew up and lived and when _____

_____

_____.

Education/military history (schools I went to and when I attended, graduated, degrees)_____

_____

_____.

Personal life highlights/mentions_____

_____

_____

_____.

Hobbies, interests, groups highlights/mentions _____

_____

_____

_____

_____.

Profession and career highlights/mentions_____

_____

_____

_____

_____.

Survivors I would like mentioned and relationship to me:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Predeceased by:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Other thoughts/mentions I would like included in my obituary and/or eulogy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you would like to write your own obituary or eulogy, simply staple or attach a document to this form.

WORRY-FREE WEDNESDAYS

AFTER-DEATH CHECKLIST FOR: _____

(NAME)

NAME OF PERSON TO COORDINATE AND/OR MANAGE

First Steps Immediately After a Death

_____ ☐ Determine if any after-death instructions/wishes were documented by deceased to guide decision about management of the body (look for disposition instruction forms)

_____ ☐ Contact funeral home, reduction facility or organization to manage body after death

_____ ☐ Identify who needs to be notified right away – family, friends, employer, caretakers/hospice/health care providers, power of attorney, executor of estate

_____ ☐ Arrange care for minors, dependents, surviving spouse or partner who may need assistance, pets

_____ ☐ Check that property and personal items are properly secured and protected - home, car, business, valuables in a home, etc. (Especially before obituary or death announcement is made public)

Day or Two After

_____ ☐ Make appointment with funeral home or reduction facility (they will notify social security and order death certificates needed for finances, insurance, Veteran's Admin, etc.)

- Copies of death certificate can often be used for official records if a certified original copy is shown in-person to verify its authenticity

Within a Week

_____ ☐ Determine if there are recurring home delivery items that need to be canceled to avoid waste or theft

_____ ☐ Contact attorney, accountant, executor or estate to discover/review what Will/Trusts/End-of-Life plans are in place

_____ ☐ **Locate important financial and legal documents** →

_____ ☐ Begin work on obituary/death announcement and plans for funeral/remembrance/gathering

Within Two Weeks

_____ ☐ Forward mail to responsible party or to be held at post-office (as needed)

_____ ☐ Identify financial matters that need immediate attention – review debts, pay bills, begin to close accounts or cancel payments

_____ ☐ Contact insurance companies and file claim with life insurance company

_____ ☐ Make appointment with social security office to switch benefits to qualified relations (payments stop when death is reported by funeral home)

Within a Month

_____ ☐ Finish gathering and organizing personal and financial documents

_____ ☐ Collect asset and liability information if not in a Last Will & Testament

_____ ☐ If deceased did not have a Will or Trust, and meets a financial threshold, probate may be required for distribution of assets and management of debt

_____ ☐ Change titles on assets - car, home, stocks, other property (as needed)

_____ ☐ Decide how to manage social media accounts if no instructions were given (different platforms have different options for archive/cancel)

_____ ☐ Notify any union or fraternal organizations where there may be benefits

Within Two Months

_____ ☐ Begin to inventory and distribute personal belongings (as appropriate)

After Several Months

_____ ☐ Begin process for filing federal and state income taxes

_____ ☐ Follow up with settlement of assets and financial matters (as needed)

Important Documents (Examples)

- ✓ Wills/Trust Agreements
- ✓ Mortgage documents/Promissory Notes
- ✓ Deeds/Titles
- ✓ Vehicle titles and registrations
- ✓ Insurance Policies (funeral, life, heath, accident, long-term care, dental, property, vehicle)
- ✓ Financial Accounts (acct#, username and passwords for: bank, brokerage, stocks, bonds, annuities, credit and debit card, safety deposit box documents and keys)
- ✓ Other financial records (retirement, annuity, pension records, tax returns, financial statements, contracts, etc)
- ✓ Legal Papers (Power of Attorney, adoption and divorce papers, prenuptial/postnuptial agreements, military service papers, social security records, citizenship records, passports, proof of intent to donate organs, etc)
- ✓ Usernames, acct#s and passwords for devices, online apps and subscriptions
- ✓ List of bills, amount and due dates