Honoring Choices® IDAHO

Idaho Advance Directive for Health Care
INFORMATIONAL GUIDE

What is an Advance Directive for Health Care?

An Advance Directive for Health Care, or Advance Directive, allows you to write down your goals, values and preferences for future health care decisions and who you want to communicate your health care decisions if you are unable to communicate for yourself. For adults 18 and older, completing an Advance Directive is important if you had a life threatening event, like an accident or serious illness, and cannot make your own decisions.

Idaho's legal requirements for an Advance Directive for Health Care includes two (2) separate documents:

(1) Durable Power of Attorney for Health Care (Health Care Agent) (located on pages 1-2 of this packet)
Allows you to name one or more persons to communicate health care decisions on your behalf if you cannot communicate for yourself. This person(s) is called your Health Care Agent.

(2) Living Will for Health Care (located on pages 3-6 of this packet)
Allows you to provide written instructions for health care treatments based upon your values and what is important to you. These written instructions are important if you had a life threatening event, like an accident or serious illness, and cannot communicate for yourself.

It is recommended that you complete both documents.

Please contact your health care provider for more information about:

- Advance Directives
- Choosing a Health Care Agent
- Cardiopulmonary Resuscitation (CPR) and other life-prolonging treatments

Online Information Guides from Honoring Choices® Idaho can also be found at:
www.honoringchoicesidaho.org/guides
info@honoringchoicesidaho.org
(208) 947-4285

FREQUENTLY ASKED QUESTIONS

You can decide what happens with your health care. If you become unable to communicate your health care decisions, your health care provider may not always know your values, preferences, or other important details affecting your decisions. This document allows you to choose a person(s), called a Health Care Agent, to be your voice and communicate health care decisions you would make for yourself.

What is a Health Care Agent?

This is the person(s) you choose and authorize to consult with your health care team about your health care decisions if you are unable to communicate for yourself. This document does not authorize your Health Care Agent to make financial or business decisions for you. It does not give your Health Care Agent authority to make decisions about your mental health treatment.

Who should I choose as my Health Care Agent?

Your Health Care Agent must meet all of the following criteria:

- Be at least 18 years old.
- **Not** be your health care provider or an employee at your hospital, clinic, or other place where you receive care (unless he/she is a close relative).
- Carry out your instructions on this document and follow the health care choices you make on the document *Living Will for Health Care* (even if he or she does not agree with them).
- Carry out any other health care instructions you have discussed with him/her.

What does a Health Care Agent do?

- Understand the role of a Health Care Agent.
- Accept this role.
- Talk with you about your goals, values and preferences.
- Follow your decisions, even if he/she does not agree.
- Make decisions in difficult or stressful moments according to your instructions.
- Make decisions in your best interest that reflect your goals, values and preferences.

Can I change my mind later about my decisions in this document?

Yes, you may change your mind and make changes to this document at any time. If you make changes, please give copies of your revised document to your new and previous Health Care Agent(s), your health care providers, and any others who may have an outdated copy.

If you name your spouse as your Health Care Agent (or Alternate) and your marriage is later annulled or you are divorced, the designation of your spouse as Health Care Agent or Alternate is no longer valid. You may name your ex-spouse as your Health Care Agent (or Alternate) only if you complete the Durable Power of Attorney for Health Care document again after your annulment or divorce.

What do I do when my documents are complete?

- Talk to your Health Care Agent(s) to make sure they understand and are willing to perform this important role for you.

- Give a copy of these documents to the following people:
  - Your Health Care Agent(s)
  - Your health care provider(s).

- Talk to those you love and trust to make sure they know your wishes and who your Health Care Agent(s) is.

- Keep a signed and dated copy of these documents in a well-known place.

- If you go to a clinic, hospital or other medical setting, take a copy of these documents and ask that they be placed in your medical record.

- Schedule to review and update these documents every year and when any of the "Six D's" occur:

***D**ecade:*	when you begin a new decade in your life
***D**eath:*	you experience the death of someone you love
***D**ivorce:*	your Health Care Agent is your spouse or partner and your relationship ends. A new Health Care agent should be identified.
***D**iagnosis:*	you are diagnosed with a serious illness
***D**ischarge:*	you are discharged from a hospital stay
***D**ecline:*	your illness gets worse

- If your goals or wishes change, tell your Health Care Agent(s), your family, your health care provider, and everyone with copies of your Durable Power of Attorney for Health Care and Living Will. You should complete new documents that reflect your current wishes.

- Make sure you take a copy with you when you are travelling. Most states will accept a properly executed document from another state.

- Fill out an Honoring Choices® Idaho wallet card and keep an updated card in your wallet.

- Register your documents online with the Idaho Health Care Directive Registry at https://sos.idaho.gov/health-care-directive-registry-index/. A registration form is required and is available on the Registry website. You may also submit documents by mail, via fax (208) 334-2282 or email to: hcdr@sos.idaho.gov. For more details, call (208) 334-2300.

I HAVE AN ADVANCE DIRECTIVE	**Card holder information**
Name _____	Address_____
Date _____	City/State/ZIP _____
Honoring Choices® IDAHO	Phone _____ Date of birth_____
	My Health Care Agent is_____
	Address_____
	City/State/ZIP _____
	Phone _____

Name (First, Middle Initial, Last)**:**_____

Date of Birth: _____

Address: _____

Telephone: (Primary) _____ (Secondary) _____

Copies of these documents are being or have been given to following organizations and people (e.g. Health Care Agent(s), health care providers, hospitals, family, friends and faith community leaders):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

IDAHO ADVANCE DIRECTIVE FOR HEALTH CARE

Durable Power of Attorney for Health Care/Health Care Agent (Pages 1 to 2)

My First Name, Middle Initial, Last Name:_____

My birthdate: (MM/DD/YYYY) _____

My address: _____

_____

My telephone number(s): (Primary) _____ (Secondary) _____

Last 4 digits of my Social Security Number: xxx-xx- ___ ___ ___ ___

If I am ill or injured and unable to communicate my health care decisions, or if my health care provider determines I cannot make my own health care decisions, then I choose the person(s) listed below to communicate my health care decisions on my behalf.

My choice for Health Care Agent is:

Name _____ Relationship to me_____

Telephone (Primary) _____ (Secondary) _____

Address (if known) _____

City_____ State_____ ZIP _____

If my first choice for Health Care Agent is unable, unavailable, or unwilling to communicate these choices for me, then **my alternate Health Care Agent** is:

Name _____ Relationship to me_____

Telephone (Primary) _____ (Secondary) _____

Address (if known) _____

City_____ State_____ ZIP _____

If this alternate Health Care Agent is unable, unavailable, or unwilling to communicate these choices for me, then **my 2nd alternate Health Care Agent** is:

Name _____ Relationship to me_____

Telephone (Primary) _____ (Secondary) _____

Address (if known) _____

City_____ State_____ ZIP _____

_____ Initial here if you **do not wish to name a Health Care Agent** and direct your health care providers to use the instructions and decisions written in the document *Living Will for Health Care* to guide medical decisions.

Durable Power of Attorney for Health Care/Health Care Agent (Pages 1 to 2)

Decisions my Health Care Agent(s) may communicate and direct on my behalf:

If I am unable to communicate my health care decisions, my Health Care Agent(s) above have the following authority and responsibilities:

- Follow the instructions on this directive that are based on my wishes, values and beliefs.
- Consent for treatment(s) such as tests, medications, surgery, or other treatments.
- Refuse or stop treatment(s) such as tests, medications, surgery, or other treatments.
- Release my medical records as needed, as stated by law (HIPAA and the Idaho Health Records Act).
- Determine which health care provider(s) and organization(s) will best meet my health care needs.
- Arrange for the care of my body after death if my wishes are not already known.

Limits or comments on the authority and responsibility of my Health Care Agent:

_____

_____

_____

_____

_____

I understand that any Durable Power of Attorney/Health Care Agent document created before today is no longer valid.

_____

Signature **Date**

END OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

IDAHO ADVANCE DIRECTIVE FOR HEALTH CARE

Living Will for Health Care (Pages 3 to 6)

Below are my values, preferences, and goals for health care should a time come when I cannot communicate for myself. I want these instructions to be followed.

My First Name, Middle Initial, Last Name: _____

My birthdate: (MM/DD/YYYY) _____

My address: _____

_____

My telephone number(s): (Primary) _____ (Secondary) _____

Last 4 digits of my Social Security Number: xxx-xx- ___ ___ ___ ___

Part A. My Values and Preferences

Often people use past experiences in their life to make important decisions about the future. How have these experiences influenced how you feel about future health care? What abilities are so important to you that you cannot imagine life without them? _____

_____

_____

_____

_____

Imagine the following situation:

A life threatening event has left you unable to communicate with those around you or to participate in your daily care, treatment planning, or decision making. Even though all care and available treatments are being provided, your doctors have determined your illness or injury cannot be cured and death is likely, or your brain function will not return.

In the situation described above, here is what you need to know about me as a person to provide the best care possible: _____

_____

_____

_____

Religious and spiritual support may also provide comfort. Here is what is important to me:

_____

_____

_____

☐ Please contact my faith community: _____ in (city) _____.
The telephone number: (_____) _____.

Living Will for Health Care (Pages 3 to 6)
Part B. My Goals of Care

If your health care provider determines your illness or injury cannot be cured and death is likely, or your brain function will not return, the treatments below can keep you alive. These treatments may or may not provide benefit and can cause suffering. To respect your wishes and maintain comfort and dignity, treatments can be started or stopped as guided by your goals, values and preferences.

Examples of life prolonging treatments may include:

- **Tube feeding**: a tube placed in your nose or stomach to provide liquid nutrition when you cannot eat by mouth.
- **Ventilator**: a breathing machine attached to a tube that is placed into your windpipe when you cannot breathe on your own.
- **IV fluids:** a tube placed in your vein to supply water when you are unable to drink.
- **Dialysis**: a machine that removes excess fluid and waste products from your blood when your kidneys no longer work.
- **Blood Products**: donated blood from a blood bank that is provided through a tube placed in your vein and is used to replace blood or blood parts you have lost.

Again, imagine the following situation:

A life threatening event has left you unable to communicate with those around you or to participate in your daily care, treatment planning, or decision making. Even though all care and available treatments are being provided, your doctors have determined your illness or injury cannot be cured and death is likely, or your brain function will not return.

Would you want to continue medical treatment? Or would you want to stop medical treatment? In all situations, you will be kept comfortable.

Select the box beside the statement that fits your goals for the above situation. ***Select ONLY one.***

☐ **I want all treatments** to keep me alive. These may include but are not limited to: tube feedings, ventilator (breathing machine), IV fluids, dialysis, and blood products. I want treatments to continue until my health care provider and Health Care Agent agree they are no longer helpful or are harmful.

OR

☐ **I want *only* the following treatments:**

- ○ Only IV fluids.
- ○ Only tube feeding.
- ○ Both IV fluids and tube feeding.

OR

☐ **I do not want treatments** that keep me alive. I want to be allowed a natural death.

Living Will for Health Care (Pages 3 to 6)

Here are other instructions regarding my care:

_____

_____

_____

_____

_____

Part C. Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary Resuscitation (CPR) is a treatment that attempts to restore my heart beat and/or breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to circulate blood), medications, electrical shock(s), insertion of a breathing tube, and hospitalization. Although CPR may restore my heart beat and breathing, it does not always work, and may cause painful bruising, broken ribs, and a difficult recovery. CPR does not work as well for people who are weak, frail, or have chronic disease.

Again, imagine this situation:

> *A life threatening event has left you unable to communicate with those around you or to participate in your daily care, treatment planning, or decision making. Even though all care and available treatments are being provided, your doctors determine your illness or injury cannot be cured and death is likely, or your brain function will not return.*

In this situation would you want CPR attempted if your heart stops or you stop breathing?

Select the box next to the statement that fits your goals for the above situation. ***Select ONLY one.***

☐ I **want** CPR.

OR

☐ I do **not want** CPR✧.

✧For people living with progressive, chronic illness it is recommended you discuss your preferences with your health care provider.

Part D. Signature and Date

Please read and sign below:

I understand this document replaces any Living Will for Health Care completed before today's date. I understand this document cannot be honored if I am pregnant. I understand the importance of this document and confirm that it reflects my values, preferences, and goals for future health care decisions. This document is validated by my signature and date below.

_____

Signature **Date**

END OF LIVING WILL FOR HEALTH CARE DOCUMENT