

IDAHO Advance Directive Planning for Important Healthcare Decisions

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

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

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

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Idaho Advance Directive

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Idaho Living Will** lets you state your wishes about medical care in the event that you are terminally ill or in a persistent vegetative state and can no longer make your own medical decisions. Your Living Will becomes effective when two doctors certify either (a) that you are terminally ill that the application of artificial life-sustaining procedures would only serve to prolong artificially your life, and that your death will occur with or without the use of life-sustaining procedures, or (b) that you are in a persistent vegetative state. Idaho law also provides for the preparation of a Physician Orders for Scope of Treatment (POST) form, which is appropriate in cases where a patient has an incurable or irreversible injury, disease, illness or condition, or is in a persistent vegetative state. It is similar to a Do Not Resuscitate (DNR) order, but broader. It must be obtained from, and signed by, your physician. If there is a conflict between the instructions included in an individual's POST and their Living Will, the orders of the POST will be followed.

2. The **Idaho Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

The Living Will and Durable Power of Attorney for Health Care may be set forth in one document or in separate documents.

Your Idaho Living Will, Durable Power of Attorney and POST forms also may be registered with the Idaho Health Care Directive Registry through the Secretary of State's Office. Registering these forms is not required to make them legal or binding, but may make them more easily accessible to health care providers.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old) or an emancipated minor.

INSTRUCTIONS COMPLETING YOUR IDAHO LIVING WILL

How do I make my Idaho Living Will legal?

State law requires that you sign your Living Will. Although state law does not require you to sign your Living Will in the presence of a witness, it is a good idea to have your Living Will witnessed by at least one person who also signs the document to show that he/she personally knows you and believes you to be of sound mind. Your witnesses **should not** be

- a healthcare provider,
- an employee of a healthcare provider,
- the operator of a community care facility,
- or an employee of an operator of a community care facility.

Note: You do not need to notarize your Idaho Declaration.

Should I add personal instructions to my Idaho Living Will?

No. If you want to record your wishes about specific treatments or conditions, you should use your Idaho Durable Power of Attorney for Health Care.

What if I change my mind?

You may revoke your Living Will at any time, regardless of your mental condition, by:

- canceling, defacing, obliterating, burning, tearing, or otherwise destroying the document, or directing another to do so in your presence,
- signing a written revocation, or
- orally expressing your intent to revoke your document.

What other important facts should I know?

- A pregnant patient's Idaho Living Will will not be honored due to restrictions in the state law.

INSTRUCTIONS COMPLETING YOUR IDAHO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An agent may also be called an "attorney-in-fact" or "proxy.")

The person you appoint as your agent **cannot** be:

- your doctor or other treating healthcare provider,
- an employee of your treating healthcare provider, unless he or she is related to you,
- an operator of a community care facility, or
- an employee of an operator of a community care facility, unless he or she is related to you

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling, or unavailable or ineligible to act for you.

How do I make my Idaho Durable Power of Attorney for Health Care legal?

The law requires that you sign your Durable Power of Attorney for Health Care. Although state law does not require you to have the document witnessed, it is a good idea to have your Durable Power of Attorney for Health Care witnessed by at least one person who also signs the document to show that he/she personally knows you and believes you to be of sound mind. Your witnesses should not be

- a healthcare provider,
- an employee of a healthcare provider,
- the operator of a community care facility,
- or an employee of an operator of a community care facility.

Note: You do not need to notarize your Idaho durable Power of Attorney for Health Care

Can I add personal instructions to my Durable Power of Attorney for Health Care?

Yes. You can add personal instructions in the part of the document called "Statement of Desires, Special Provisions, and Limitations."

INSTRUCTIONS COMPLETING YOUR IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE (Continued)

If you have appointed an agent and you want to add personal instructions to your Durable Power of Attorney for Health Care, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my Durable Power of Attorney for Health Care are to be decided by my agent."

What if I change my mind?

You may revoke your Durable Power of Attorney for Health Care at any time, regardless of your mental condition, by:

- canceling, defacing, obliterating, burning, tearing, or otherwise destroying the document, or directing another to do so in your presence,
- signing a written revocation, or
- orally expressing your intent to revoke your document.

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME
AND ADDRESS

**IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 1 OF 9**

This document uses the text provided by chapter 45, title 39, Idaho Code, as amended and in effect on July 1, 2007.

Date of Directive: _____

Your name: _____

Address: _____

A LIVING WILL

A DIRECTIVE TO WITHHOLD OR TO PROVIDE TREATMENT

1. Being of sound mind, 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 only be effective 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 artificially prolong my life; and
 - 3. That my death is imminent, whether or not artificial life-sustaining procedures are employed; 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.

**IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 2 OF 9**

CHECK THE
STATEMENT THAT
REFLECTS YOUR
WISHES, THEN
INITIAL THE LINE

Check one box and initial the line after such box:

_____ I direct that all medical treatment, care and procedures necessary to restore my health, sustain my life, and to abolish or alleviate pain or distress be provided to me. Nutrition and hydration, whether artificial or nonartificial, 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 nonartificial 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 nonartificial, shall be administered.)

Check one box and initial the line after such box:

_____ Only hydration of any nature, whether artificial or nonartificial, shall be administered;

_____ Only nutrition, of any nature, whether artificial or nonartificial, shall be administered;

_____ Both nutrition and hydration, of any nature, whether artificial or nonartificial 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.

**IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 3 OF 9**

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.

NOTE: POST forms must be obtained from the individual's physician.

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

POST FORMS MUST
BE OBTAINED FROM
YOUR PHYSICIAN

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FOR HEALTH CARE — PAGE 4 OF 9**

ORGAN DONATION
(OPTIONAL)

5. ORGAN DONATION or Anatomical Gift (OPTIONAL)

(Under Idaho law, you may make a gift of all or part of your body to a hospital, accredited medical school, dental school, college, or university; organ procurement organization; or other appropriate person, for research or education. You may also authorize your agent to do so, or if you do not have a designated agent a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift.)

If any of the statements below reflects your desire, initial on the line next to that statement. If you do not initial any of the statements, your agent, or if you do not have an agent or your agent is not authorized to make a gift, your family will have the authority to make a gift of all or part of your body under Idaho law.

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

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

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

_____ Pursuant to Idaho law, I hereby give, effective on my death:

_____ Any needed organ/tissue or parts.

_____ The following parts or organs listed below:

I give these organs or parts for (initial one or more):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes.

_____ Research or educational purposes

**IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 5 OF 9**

1. Designation of Health Care Agent.

None of the following may be designated as your agent: (1) your treating health care provider; (2) a nonrelative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a nonrelative 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 and Phone Numbers of Health Care Agent:

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.

Subject to any limitations in this Directive, including as set forth in paragraph 2 immediately above, 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 life-prolonging 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.

PRINT THE NAME,
ADDRESS AND
HOME AND WORK
TELEPHONE
NUMBER OF YOUR
AGENT

POST FORMS MUST
BE OBTAINED FROM
YOUR PHYSICIAN

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(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 life-prolonging 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:

Additional statement of desires, special provisions, and limitation:

(Attach additional pages or documents if you need more space to
complete your statement.)

POST FORMS MUST
BE OBTAINED FROM
YOUR PHYSICIAN

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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**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 through 164. 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:

ALTERNATE
AGENTS

PRINT THE NAMES,
ADDRESSES AND
TELEPHONE
NUMBERS OF YOUR
ALTERNATE
AGENTS

A. 1st Alternate Agent _____

Address _____

Telephone number _____

B. 2nd Alternate Agent _____

Address _____

Telephone number _____

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PRINT THE NAMES,
ADDRESSES AND
TELEPHONE
NUMBERS OF YOUR
ALTERNATE
AGENTS

C. 3rd Alternate Agent _____

Address _____

Telephone number _____

8. Prior Designations Revoked.

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

Date and Signature of Principal.

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

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

_____, _____.
(city) (state)

(signature)

SIGN AND DATE
YOUR DOCUMENT

WITNESSING
PROCEDURE

Statement of Witnesses

I declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this Living Will and Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: _____

Print name: _____

Residence address: _____

Date: _____

Signature: _____

Print name: _____

Residence address: _____

Date: _____

TWO WITNESSES
MUST SIGN AND
DATE YOUR
DOCUMENT AND
PRINT THEIR
NAMES AND
ADDRESSES

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You Have Filled Out Your Advance Directive, Now What?

1. Your Idaho Living Will and Idaho Durable Power of Attorney for Healthcare are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternate, doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Idaho documents.
6. Be aware that your Idaho documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**