WASHINGTON
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. 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.

4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR WASHINGTON ADVANCE HEALTH CARE DIRECTIVE

This packet contains a **Washington Advance Directive**, which protects 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.

Part I, **Washington Durable Power of Attorney for Health Care**, lets you name someone, called an "attorney-in-fact," to make decisions about your health care— including decisions about life-sustaining treatments—if you can no longer speak for yourself. This is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part II, **Washington Declaration**, lets you state your wishes about health care in the event you cannot speak for yourself and you develop a terminal condition or you are permanently unconscious.

Part III allows you to record your organ and tissue donation wishes.

Part IV contains the signature and witnessing provisions so that your document will be effective.

You may complete Part I, Part II, Part III, or any or all parts, depending on your advance-planning needs. **You must complete Part IV**.

How do I make my Washington Advance Health Care Directive legal?

If you complete Part II and/or Part III, you must either:

Option 1: Sign your document in the presence of two adult witnesses. Your witnesses **cannot** be:

- related to you,
- entitled to any portion of your estate,
- a person who has a claim against your estate, or
- your attending physician, an employee of your attending physician, or an employee of a health facility in which you are a patient.

In addition, if you have completed Part III, one of your witnesses must also be disinterested with regard to any anatomical gift you make (i.e., they are not interested in receiving your organs).

Option 2**:** Sign and acknowledge your document before a notary public or other individual authorized by law to take acknowledgements.

There are no specific witnessing requirements if you complete ONLY Part I. However, you should consider having your signature witnessed in the same manner in order to avoid any problems in the event your advance directive is challenged.

Whom should I appoint as my attorney-in-fact?

Your attorney-in-fact is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your attorney-in-fact may be a family member or a close friend whom you trust to make serious decisions. The person you name should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as your alternate attorney-in-fact. The alternate will step in if the first person you name as an attorney-in-fact is unable, unwilling, or unavailable to act for you.

The person you appoint as your attorney-in-fact **cannot** be:

- your doctor,
- an employee of your doctor, or
- an administrator, owner, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

However, you may appoint any of the individuals listed above if he or she is also your spouse, state registered domestic partner, adult child, brother, or sister.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part I, **Washington Durable Power of Attorney for Health Care**, goes into effect when your doctor and one other doctor determine that you are no longer capable of making or communicating your healthcare decisions.

Part II, **Washington Declaration**, goes into effect when your doctor and one other doctor determine that you are no longer capable of making or communicating your healthcare decisions and diagnose you in writing with a terminal condition or as permanently unconscious.

You retain the primary authority for your healthcare decisions as long as you are able to make

your wishes known.

Agent Limitations

If you are pregnant and your doctor is aware of your pregnancy, your advance directive will have no force or effect during the course of your pregnancy, and your agent will be bound by the current laws of Washington as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Health Care Directive at any time by:

- Canceling, defacing, obliterating, burning, tearing, or otherwise physically destroying your Directive or having another destroy it for you at your direction and in your presence,
- Executing a written and dated revocation, or
- Orally expressing your intent to revoke your Directive.

Your revocation becomes effective on communication to your attending physician and your attorney-in-fact, if you have appointed one.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

Note: If you registered an advance directive with the Washington State Living Will Registry prior to July 1, 2011, you should notify the registry if you make changes to or revoke that advance directive. The Washington State Living Will Registry discontinued on July 1, 2011, but you can still access your advance directive if filed prior to that date at http:www.uslivingwillregistry.com.

PART I. Durable Power of Attorney for Health Care

I understand that my wishes as expressed in my advance directive may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.

PRINT YOUR NAME

Therefore, I, _____, as principal, designate and appoint the person(s) listed below as my attorney-in-fact for health care decisions.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR FIRST CHOICE TO ACT AS YOUR ATTORNEY-IN-FACT

First Choice: Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____

If the above person is unable, unavailable, or unwilling to serve, I designate:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SECOND CHOICE TO ACT AS YOUR ATTORNEY-IN-FACT

Second Choice: Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____

1. This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

2. My attorney-in-fact shall have all the powers necessary to make decisions about my health care on my behalf. These powers shall include, but not be limited to, the power to obtain medical records in order to make a fully-informed decision, the power to have me admitted to a health care facility, and the power order the withholding or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. My attorney-in-fact's powers shall survive my death to the extent that my attorney-in-fact shall have all the powers necessary to direct the donation of my organs and the final disposition of my remains.

4. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my first choice (on page 1) to serve as my guardian. My second choice (on page 1) will serve as my guardian if the first person is unable or unwilling.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES OR ORGAN DONATION

5. When making health care decisions for me, my attorney-in-fact should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other clear expression of my desires, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my attorney-in-fact should make decisions for me that my attorney-in-fact believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

6. I give the following additional instructions as guidance for my attorney-in-fact:

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

(attach additional pages if needed)

PRINT THE DATE

PRINT YOUR NAME

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

INITIAL YOUR WISHES ABOUT ARTIFICIAL NUTRITION AND HYDRATION

PART II. Declaration

Directive made this _____day of _____, _____.
(date) *(month)* *(year)*

I, _____,
(name)

having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (initial one):

_____ I DO want to have artificially provided nutrition and hydration.

_____ I DO NOT want to have artificially provided nutrition and hydration.

STRIKE THROUGH AND INITIAL ANY LANGUAGE WITH WHICH YOU DO NOT AGREE

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(e) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(f) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

(g) I make the following additional instructions regarding my care:

(attach additional pages if needed)

PART III. Organ Donation

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney-in-fact, other agent, or your family, may have the authority to make a gift of all or part of your body.

INITIAL ONLY ONE

_____I do not want to make an organ or tissue donation and I do not want my attorney-in-fact, other 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:

Name of individual/institution:_____

_____Pursuant to Washington State law, I hereby give, effective on my death (initial one):

INITIAL WHICH PURPOSE(S) MATCH YOUR WISHES.

_____Any needed organ or parts.

_____The following part or organs listed below:

_____

_____

For (initial one):

_____Any legally authorized purpose.

_____Transplant or therapeutic purposes only.

SIGN, DATE AND PRINT YOUR NAME AND YOUR CITY, COUNTY, AND STATE OF RESIDENCE

IF YOU COMPLETED PARTS II AND/OR III YOU MUST HAVE TWO WITNESSES SIGN, DATE, AND PRINT THEIR NAMES HERE

IF YOU COMPLETED PART III, ONE WITNESS MUST ALSO SIGN HERE

PART IV. Execution
Alternative No. 1: Sign before 2 witnesses

I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive. I also understand that I can change or revoke all or part of this directive at any time.

Signed: _____Date_____

Printed Name: _____

City, County, and State of Residence:

_____

The declarer, who signed the above Directive, is personally known to me or has provided proof of identity and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive. In addition, I am not the attending physician, an employee of the attending physician or a health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the above Directive.

Witness 1:

_____Date:_____

Printed Name:

_____

Witness 2:

_____Date:_____

Printed Name:

_____

I further attest that I am disinterested with regard to any anatomical gift made by declarer.
Disinterested

Witness:_____

SIGN, DATE AND PRINT YOUR NAME AND YOUR CITY, COUNTY, AND STATE OF RESIDENCE

NOTARY PUBLIC MUST COMPLETE THIS SECTION ONLY IF YOU DID NOT HAVE THE DOCUMENT SIGNED BY 2 WITNESSES

Alternative No. 2: Sign before a notary public

I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive. I also understand that I can change or revoke all or part of this directive at any time.

Signed: _____ Date _____

Printed Name: _____

City, County, and State of Residence: _____

The declarer, who signed the above Directive, is personally known to me or has provided proof of identity and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive. In addition, I am not the attending physician, an employee of the attending physician or a health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the above Directive.

NOTARY SEAL: _____

Date: _____

Printed Name: _____