ENHANCED LIVING WILL
AND
DURABLE POWER OF ATTORNEY
FOR
HEALTH CARE

Provided
by
Susan M. Graham, Certified Elder Law Attorney
of
The Graham Law Office, P.A.,
1009 W. Fort Street, Boise, Idaho 83702,
(208) 344-0375
www.graham-lawoffice.com

This form is provided as a public service and is not intended as legal advice concerning your particular needs and circumstances. If you have questions regarding the operation and legal effect of this document, we recommend that you contact legal counsel of your choice.

INSTRUCTIONS

LIVING WILL

1) Fill in the date, your name and address number on page 1.

2) Indicate which one of the three end of life decisions you want on page 2. Put a "check" or "X" in the box you elect and follow it with your initials. Be sure to check and initial one of the choices marked A, B, or C on page 2 if you choose the second option.

3) Check one box to indicate if you have or have not completed a Physician Orders for Scope of Treatment (paragraph 4, page 3). Put a "check" or "X" in the box you elect and follow it with your initials.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1) Put your name on page 5.

2) Put the name, address and phone number of your first health care agent on page 5.

3) Indicate if you want to donate your organs on page 6. Put a "check" or "X" in the box you elect and follow it with your initials.

4) Put the names, addresses and phone numbers of your alternate agents in the spaces provided on page 8.

5) Enter the date you sign the document and sign your name, then print your name and address on page 8.

6) If you want to expand on your health care instructions, print your name on the line at top of Exhibit "A" on page 9 and put the date you signed the Living Will and Durable Power of Attorney for Health Care in the space provided in Exhibit "A" on page 9. Date and sign this Exhibit A.

Provided by Susan M. Graham, Certified Elder Law Attorney
[Certified by the National Elder Law Foundation, the only Elder Law Certification Program approved and accredited by the American Bar Association and the Idaho State Bar]
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ENHANCED LIVING WILL AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
Idaho Code § 39-4510

Date of Directive: _____ day of ______________________ 20____

Name of Person executing Directive: ________________________________

Address of Person executing Directive: ______________________________

____

A LIVING WILL
A Directive to Withhold or to Provide Treatment

1. 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 be effective only if I am unable to communicate my instructions and:

a. I have an incurable injury, disease, illness or condition and one (1) 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 prolong artificially my life; and
> 3) 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. 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.

For this election to be effective, a box must be "checked" 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 non-artificial, 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 non-artificial 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 non-artificial, shall be administered.)

A. ☐ _____ Only hydration of any nature, whether artificial or non-artificial, shall be administered.

B. ☐ _____ Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

C. ☐ _____ Both nutrition and hydration, of any nature, whether artificial or non-artificial 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. I specifically direct that I not receive food by gastric or nasogastric tube or in any way other than by mouth, and that I not receive fluids in any way other than by mouth. If because of disability, stroke, accident, or other cause, I should become incompetent and unable to make decisions concerning my medical care, I direct my family and physicians not to use artificial means,

including tube and intravenous feeding, to prolong my life unless, based on the then current medical knowledge, there is a medically reasonable expectation of a substantial recovery of my mental and physical functions. I specifically request that under such circumstances, I not be resuscitated and that I not receive any cardiopulmonary resuscitation, electric shock treatments or blood transfusions.

2. This Directive shall be the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal or acceptance.

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 and me or my agent, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

5. If my health care provider refuses to honor my Agent's decisions, my Agent is empowered to direct the health care provider responsible for my care to transfer my care to another health care provider who will comply; if this authority is thwarted, undermined, or not honored to its fullest extent, I further instruct and empower my Agent to initiate action for battery against such providers.

6. It is my desire that this document, duly executed in Idaho, shall be presumed to comply with the provisions of any similar Act in any other State, and may, in good faith, be relied upon by a health care provider or health care facility in Idaho as well as any other state.

7. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT. None of the following may be designated as your agent: (1) your treating health care provider; (2) a non-relative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a non-relative 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 thereon 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 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-sustaining 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.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. 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 a Physician Orders for Scope of Treatment (POST) form, living will or similar document executed by me, if any. Additional statements of desires, special provisions, and limitations are attached as Exhibit "A," each page of which is dated and signed by me and incorporated by reference herein as fully set forth.

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:

- 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

Check one box and initial the line after such box:

☐ _____I consent to the donation of any of my organs for medical purposes.

OR

☐ _____I do NOT 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, 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 and 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 “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. 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:

A. First Alternate Agent: ______________________________, of ______________________________, phone number________________

B. Second Alternate Agent: ______________________________, of ______________________________, phone number________________

C. Third Alternate Agent: ______________________________, of ______________________________, phone number________________

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior living will and durable power of attorney for health care.

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at Boise, Idaho.

Dated: ____________________________

____
Signature

Printed Name: ________________________________
Street Address: ________________________________
City, State, Zip: ________________________________

EXHIBIT "A"
STATEMENT OF
SPECIAL PROVISIONS AND LIMITATIONS FOR

____

My Living Will and Durable Power of Attorney for Health Care, executed ____________________, 20___, Paragraph 4 of the Durable Power of Attorney for Health Care, refers to the use of an Exhibit "A" for additional statements of desires, special provisions and limitations. I hereby make this statement for that purpose.

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Date:________________ Signature:_______________________________