ADVANCE CARE PLANNING DOCUMENT (ACPD)

Pursuant to Idaho Code § 39-4510

Date of ACPD: _____

Name of Person Executing ACPD: _____

Telephone Number: _____

Date of Birth: _____

Mailing Address: _____

_____

PART I. LIVING WILL

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. Part I of this ACPD shall be effective only 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 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.

Check **one** box and initial the line after such box on the following page:

☐ _____ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life 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 Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.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direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows: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.)

Check one box and initial the line after such box:

☐ _____ 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.

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

3. I understand the full importance of this ACPD and am mentally competent to make this ACPD. No participant in the making of this ACPD 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 ACPD. 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.

PART II. 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 ACPD *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 ACPD.

(Insert name, address and telephone number of one individual only as your agent to make health care decisions for you.)

Name of Health Care Agent: _____

Address of Health Care Agent: _____

Telephone Number of Health Care Agent: _____

For the purposes of this ACPD, "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 ACPD, 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

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 ACPD or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial 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.

(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 artificial life-sustaining 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 ACPD, 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:

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

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 ACPD, 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 through164. 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 ACPD 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 ACPD, such persons to serve in the order listed below:

A. First Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

B. Second Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

C. Third Alternate Agent

Name: _____

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 Advance Care Planning Document.)

I sign my name to this Advance Care Planning Document on the date set forth at the beginning of this ACPD:

_____

(Signature) (City, State)