Advance Directive WASHINGTON




LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Contents

This booklet will tell you how to plan for health care decisions in case you become seriously ill and are unable to speak for yourself.

Advance directives for health care

A serious illness or accident can happen to anyone, at any age. Advance care planning can help you document decisions about your health care in case you become ill or injured and cannot speak for yourself.

Preparing advance directives for health care is one of the best ways to make sure your family, friends, and health care providers know about your health care choices. Advance directives for health care include the following forms:

- Durable Power of Attorney for Health Care
- Health Care Directive (Living Will)
- Organ Donor Card

The information and forms in this booklet can help you think about the choices you have and prepare your advance directives. You can fill out all of the forms or only the parts you want. If you have any questions, talk with your health care provider, social workers, family, or friends.

The following information is included in this booklet:

Part 1: Making your own health care choices

Start planning by learning about health care decisions you might face and by knowing your own thoughts and feelings. Making plans ahead of time can help your health care provider, family, or others understand the treatment you would want or the treatment that would be in your best interest if you become unable to speak for yourself.

Part 2: Choosing a health care agent

When you choose a health care agent, you are giving someone else durable power of attorney for health care. This means the person you have as your health care agent is authorized to make medical decisions for you if you are unable to make them yourself. Signing a health care power of attorney does not remove your ability to make your own decisions unless you are unable to speak for yourself.

Part 3: Creating a health care directive (living will)

When you create a health care directive, also called a living will, you are choosing the treatment you would want if you become terminally ill or permanently unconscious. Your living will lets others know that you wish to die naturally and not receive treatment that will artificially prolong the process of dying. This form also lets others know whether you want artificial nutrition and hydration.

Part 4: Sharing your advance directive forms

Once you've filled out the forms you want, share the information with your health care provider, family, and friends. Give a copy to your health care provider and to the people who need to know this information if anything happens to you. Keep the original form(s) with you and send copies to Kaiser Permanente.

Part 5: Resources

You'll find additional resources that can help you prepare advance directive forms.

PART 1: Making your own health care choices

The following checklist can help you think about the treatment you want in the event of a serious illness or accident. After you've gone through the checklist, fill out and sign the 2 forms in this booklet: Durable Power of Attorney for Health Care and Health Care Directive (Living Will).

Think about what makes your life worth living. Put an "X" next to the statements you most agree with:

My life is only worth living if I can:

☐ Talk to family or friends

☐ Wake up from a coma

☐ Feed, bathe, and take care of myself

☐ Live without pain

☐ Live without being hooked up to machines

My life is always worth living no matter how sick I am.

☐ Yes

☐ No

If I am dying, it is important for me to be:

☐ At home

☐ In the hospital

Religion or spirituality is important to me.

☐ Yes

☐ No

I want my health care provider to know the following information about my religious or spiritual beliefs:

Life support treatment is medical care that may help you live longer. It can include surgery, medicine, or any of the following:

- Blood transfusions
  - A blood transfusion is used to replace blood that might be lost from surgery, injury, or disease.
- Breathing machine or ventilator
  - This machine pumps air into your lungs and breathes for you when you aren't able to breathe on your own.
- CPR (cardiopulmonary resuscitation)
  CPR may involve:
  - Pressing hard on your chest to keep your blood pumping.
  - Electric shocks to restart your heart.
  - Putting medicine in your veins.
- Dialysis
  - Dialysis uses a machine to clean your blood if your kidneys stop working.
- Feeding tube
  - A feeding tube is placed down your throat and into your stomach to feed you if you cannot swallow.

Put an "X" next to the statements you most agree with:

If I am so sick that I may die soon:

☐ Try all life support treatments my health care provider thinks might help. If the treatments don't work and there is little hope of getting better, I do want to stay on life support machines.

☐ Try all life support treatments my health care provider thinks might help. If the treatments don't work and there is little hope of getting better, I don't want to stay on life support machines.

☐ Try any or all of the following life support treatments my health care providers think might help:

- ☐ CPR
- ☐ Breathing machine or ventilator
- ☐ Dialysis
- ☐ Feeding tube
- ☐ Blood transfusions
- ☐ Medicine
- ☐ Other treatments: _____

☐ I don't want any life support treatments

☐ I want my health care agent to decide for me

Deciding about organ donation

Donating your organs can help save lives. Organs and tissues – including eyes, kidneys, heart, heart valves, liver, bones, lungs, and skin – can be used by other people who may need these things to stay alive. Organs and tissues can also be used for research purposes.

Put an "X" next to the statements you most agree with:

☐ I want to donate my organs.

Which organs do you want to donate?

☐ Any organs

☐ Only these organs:

_____

☐ I do not want to donate my organs

☐ I want my health care agent to decide

Is there anything else that you want your health care provider, family, or others to know about the health care that you wish to receive if you become sick or injured and can't speak for yourself?

_____

_____

If you want to donate your organs, you should sign an organ donor card.

There are two ways to do this:

- Call LifeCenter Northwest toll-free 1-877-275-5269 and ask for an organ donor card.
- Let the Department of Licensing (DOL) know that you want to be an organ donor when you apply for a driver's license, instruction permit, or state identification card.

PART 2: Choosing your health care agent (durable power of attorney for health care)

Your health care agent is a person you choose to make medical decisions for you if you cannot make them yourself. You authorize this person to make decisions with your health care providers about your care.

Who can I choose to be my health care agent?

You can choose any family member or friend who:

- Is at least 18 years old
- Can be available when you need him or her
- Is someone you trust to do what is best for you
- Can let your doctors know about the decisions you made about your health care

You **can't** choose your health care provider or anyone who works at your hospital, nursing home, assisted living facility, or clinic to be your health care agent, unless that person is a family member.

What will happen if I don't choose a health care agent?

If you cannot make medical decisions yourself and have not chosen a health care agent, Washington state law says that your doctors must get consent from people in the following categories, in the order listed below:

- Court-appointed legal guardian, if you have one
- The individual named on the Durable Power of Attorney for Health Care form, if you have one
- Spouse or Washington state–registered domestic partner
- Adult children of patient (all must be in agreement)
- Parents of patient (all must be in agreement)
- Adult siblings of patient (all must be in agreement)
- Adult grandchildren of patient (all must be in agreement)
- Adult nieces and nephews of patient (all must be in agreement)
- Adult aunts and uncles of patient (all must be in agreement)
- Any adult who meets the criteria as outlined in RCW 7.70.065

What kind of decisions can my health care agent make?

Your health care agent can make decisions about:

- Medicines or tests you might receive
- What happens to your organs after you die
- Following advice from your health care providers and social workers
- The hospitals or clinics you will stay in
- Life support treatments you may or may not receive, including:
  - CPR
  - Breathing machine or ventilator
  - Dialysis
  - Feeding tube
  - Blood transfusions
  - Medicine
  - Other treatments

How do I make my decision official?

After you've chosen your health care agent, fill out and sign the Durable Power of Attorney for Health Care form found in **Appendix 1** of this booklet. Instructions for filing the completed form are included in **PART 4: Sharing your advance directive forms**.

Do I need to get the form notarized?

Washington residents must have their signature on the Durable Power of Attorney (DPOA) for Health Care form either witnessed by 2 people OR acknowledged by a notary public.

Please see witnessing requirements included on the DPOA form in **Appendix 1**.

PART 3: Creating a health care directive (living will)

In addition to talking to your health care providers, family, and friends, you should put your wishes in writing. One of the documents you can use is the living will, also known as a health care directive or directive to physicians.

The living will is a directive to doctors and families stating a person's decision to refuse life-sustaining medical treatment if the person has a terminal illness or illness/injury that leaves him or her permanently unconscious. The directive lets your doctor withhold or stop life-sustaining treatment. You will still get comfort care.

The right to create a living will is established in Washington state's Natural Death Act.

To complete a health care directive (living will), fill out the form in **Appendix 2** of this booklet. Instructions for filing the completed form are included in **PART 4: Sharing your advance directive forms**.

Do I need to get the form notarized?

Washington residents must have their signature on the Health Care Directive (Living Will) form either witnessed by 2 people OR acknowledged by a notary public.

Please see witnessing requirements included on the Health Care Directive (Living Will) form in **Appendix 2**.

PART 4: Sharing your advance directive forms

The Health Care Directive (Living Will) and Durable Power of Attorney for Health Care forms are all legal documents once they are completely filled out and either signed with the appropriate signatures or notarized.

Keep the original files for your records. Make copies for family members or others who may be called upon to make decisions on your behalf, including your health care agent and your personal attorney.

In addition, you need to make sure the forms are put in your Kaiser Permanente medical record. To do this, you can:

☐ Mail (1) copy of each form to:

Kaiser Permanente Medical Records – Advance Directive
500 NE Multnomah St.
Floor 11
Portland, OR 97232

OR

☐ Email to: **nw-med-rec@kp.org**, fax to: **1-866-248-9695**, or submit through **kp.org** – go to medical records section and select the life care planning tile.

OR

☐ Give copies to your health care team.

Once the forms are in your medical record, Kaiser Permanente physicians have 24-hour access to them.

Making choices not included on the forms

If you want to make choices about your health care that are not included on the forms:

- Write your choices on a piece of paper
- Keep those papers with your other advance directive forms
- Share your choices with people who care for you

Editing or updating your forms

If you want to make changes to your advance directives, tell the people who care for you first. Then, once you've made the changes to the forms, distribute copies of them to your health care agent, family members and loved ones, and Kaiser Permanente, just like you did the first time. Ask that the previous versions be destroyed.

PART 5: Resources that may be helpful when you are preparing your advance directive forms

Kaiser Permanente Northwest "Life Care Planning" class

1-866-301-3866 (toll free)

Provides free, 2-hour workshops about advance directives.

Washington State Medical Association

206-441-9762 (Seattle area)

1-800-552-0612

Offers Durable Power of Attorney for Health Care and Health Care Directive (Living Will) forms.

LifeCenter Northwest

1-877-275-5269

lcnw.org

Provides information about donating organs and tissues.

Washington State Bar Association Lawyer Referral

1-800-945-9722

Can provide the number of the nearest lawyer referral service in your area.

Washington State Department of Social and Health Services

dshs.wa.gov/altsa/home-and-community-services/legal-planning

Provides information and resources about advance directives.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, the Durable Power of Attorney for Health Care, allows you to name the person who makes health care decisions for you when you are unable to make them for yourself. This person is the Health Care Agent. This form meets the requirements of Washington state law.

My information:

Full Name: Medical Record Number:

Date of Birth: / /
(mm/dd/yyyy)

MY HEALTH CARE AGENTS

The person I designate as my Health Care Agent is:

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

In the event that the person listed above is unable or unwilling to serve, or is unable to be contacted with reasonable effort, then I grant these powers to the next qualifying Health Care Agent listed below:

First Alternate

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

Second Alternate

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: My Health Care Agent is specifically authorized to give consent for health care treatment when I cannot make my own decisions. My Health Care Agent is authorized to carry out my wishes regarding life-sustaining treatments such as feeding tube, CPR, breathing machine, and kidney dialysis. This includes consent to start, continue, or stop medical treatment. This document gives the person you designate as your Health Care Agent the power to make health care decisions for you and is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions. Your wishes for medical treatment can be attached to this form. You may include specific limitations in this document on the Health Care Agent's authority to make health care decisions if you choose.

I attest to the following: I understand the importance and meaning of this Durable Power of Attorney for Health Care (DPOA-HC). This form reflects my choices for Health Care Agent. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can replace this form at any time which will then revoke any prior DPOA-HC. I want this DPOA-HC to become

Full Name: Medical Record Number:

Date of Birth: / /

effective if a physician or designee of my choosing determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

Two witnesses OR a notary must watch me sign this form for it to be legally valid.

My Signature: **Date:**

WITNESSES OR NOTARY REQUIREMENT

Without witness signatures or notarization, this form is not legally valid.

Option 1: Two Witnesses

Witness Requirements:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.

Witness Attestation: I declare I meet the rules for being a witness.

Witness #1 Signature: Date:

Name Printed:

Witness #2 Signature: Date:

Name Printed:

Option 2: Notary

State of Washington)
)
County of _____)

This record was acknowledged before me on this day of

by (name of individual):

Signature: Title: Exp:

HEALTH CARE DIRECTIVE (LIVING WILL)

Full Name: Medical Record Number:

Date of Birth: / /

Directive made this _____ day of _____, _____.
(Year)

I, _____ being of sound mind, 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 have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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 "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.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [choose one]

_____ I DO want artificially administered nutrition and hydration.

_____ I DO NOT want artificially administered nutrition and hydration.

I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians, and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(E) 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.

(F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

_____

_____

_____

My Signature *and* ***Notary*** *or* ***Two Witness Signatures*** *required on next page*

Full Name: Medical Record Number:

Date of Birth: / /

Two witnesses OR a notary must watch me sign this form for it to be legally valid.

My Signature: **Date:**

WITNESSES OR NOTARY REQUIREMENT

Without witness signatures or notarization, this form is not legally valid.

Option 1: Two Witnesses

Witness Requirements:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be 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 directive.

Witness Attestation: I declare I meet the rules for being a witness.

Witness #1 Signature: Date:

Name Printed:

Witness #2 Signature: Date:

Name Printed:

Option 2: Notary

State of Washington)

)

County of _____)

This record was acknowledged before me on this day of

by (name of individual):

Signature: Title: Exp:

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

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Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية (Arabic): إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية والمساعدات والخدمات المتوفرة لك مجانًا. اتصل بالرقم **1-800-813-2000** (رقم هاتف الصم والبكم: **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi): اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی و تسهیلات رایگان در دسترس شما است. با **1-800-813-2000** تماس بگیرید (TTY: **711**).

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY: **711**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັ້ງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

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