IDAHO
Advance Directive
Planning for Important Healthcare Decisions

Caring Info
1731 King St., Suite 100 Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Info, 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.

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. Idaho maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.idaho.gov/hcdr/index.html**.**

6. You may also want to save a copy of your form in 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 Idaho Advance Directive

This packet contains an **Idaho Living Will and Durable Power of Attorney for Health Care**. This is a legal document that 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:

The first part of your document is a **Living Will**. This section 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 your doctor determines that 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.

The second part of your document is a **Durable Power of Attorney for Health Care**. This section lets you name someone to make decisions about your medical care — including decisions about life sustaining treatment — if you can no longer speak for yourself.

Your Durable Power of Attorney goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions. 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.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Following your Living Will and Durable Power of Attorney for Health Care is an **Organ Donation Form**.

Idaho law 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 order, but broader. It must be obtained from, and signed by, your health care provider. If there is a conflict between the instructions included in an individual's POST and their Living Will and Durable Power of Attorney for Health Care, the orders of the POST will be followed. We suggest you speak to your health care provider if you are interested in obtaining this form. **Caring Info does not distribute these forms.**

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 for Completing your Idaho Living Will and Durable Power of Attorney for Health Care

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

Idaho law requires that you sign your Living Will and Durable Power of Attorney for Health Care. Although state law does not require you to sign your Directive for Health Care 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

- your agent,
- 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

Note: You do not need to notarize your Idaho Living Will and 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 may 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.

You can appoint several alternate agents. The alternates will step in if the first person you name as an appointed person is unable, unwilling, or unavailable to act for you.

The person you appoint as your agent or alternate 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

Instructions for Completing your Idaho Living Will and Durable Power of Attorney for Health Care (Continued)

Should I add personal instructions to my Idaho Living Will and Durable Power of Attorney for Health Care?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Living Will and Durable Power of Attorney for Health Care at any time 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?

If you are pregnant, the terms of your Living Will will not be honored during the course of your pregnancy. Your agent will still be able to make decisions for you, if you cannot make your own decisions.

In 2010, the Idaho Legislature passed the *Freedom of Conscience for Health Care Professionals Act*, which gives a physician the right to abstain from providing any health care service—including end-of-life treatment and care—that violates his or her conscience. Under the new law, "conscience" means the religious, moral, or ethical principles sincerely held by any person. Because this new law may have consequences regarding your advance-care planning, it is important that you talk to your health care provider about your advance-care wishes.

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME AND ADDRESS

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.

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

CHECK ONLY ONE

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 ONLY ONE

IF YOU CHECKED THE SECOND BOX, ABOVE, AND IF NONE OF THE FOLLOWING BOXES ARE CHECKED AND INITIALED, THEN BOTH NUTRITION AND HYDRATION WILL BE GIVEN TO YOU

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.

2. If I have been diagnosed as pregnant, the above provisions of 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:

INITIAL THE CORRECT LINE, DEPENDING ON WHETHER YOU HAVE COMPLETED A POST FORM

_____ I have discussed these decisions with my physician, advanced practice professional, nurse, or physician assistant, 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

POST FORMS MUST BE OBTAINED FROM YOUR PHYSICAN, ADVANCED PRACTICE PROFESSIONAL, NURSE, OR PHYSICIAN ASSISTANT

_____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, advanced practice professional, nurse, or physician assistant 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.

DURABLE POWER OF ATTORNEY

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.

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

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. (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.)

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

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 MIB Group, Inc. (formerly 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 _____

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.

SIGN AND DATE YOUR DOCUMENT

Date and Signature of Principal.
(You must date and sign this Living Will and Durable Power of Attorney for Health Care.)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care _____ at
(date)

_____, _____.
(city) (state)

_____
(signature)

WITNESSING PROCEDURE

IDAHO LAW DOES NOT REQUIRE THAT YOU HAVE YOUR SIGNATURE WITNESSED, BUT IT IS RECOMMENDED TO ENSURE THAT YOUR WISHES ARE HONORED

Witnesses (Optional)

Witness 1
Signature: _____

Print name: _____

Residence address: _____

_____

Date: _____

Witness 2
Signature: _____

Print name: _____

Residence address: _____

_____

Date: _____

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

IDAHO ORGAN DONATION FORM — Page 1 OF 1

ORGAN DONATION (OPTIONAL)

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 agent or your family may 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:

Name of individual/institution:_____

ADD NAME OR INSTITUTION (IF ANY)

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

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

Witness _____Date_____

Address _____

_____

Courtesy of Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Idaho Living Will and Durable Power of Attorney for Health Care is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, health care provider(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 document placed in your medical records.

3. Be sure to talk to your agent(s), health care provider(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. Idaho maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at https://sos.idaho.gov/hcdr/index.html

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

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Idaho document.

8. Be aware that your Idaho document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   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 order, but broader. It must be obtained from, and signed by, your health care provider. If there is a conflict between the instructions included in an individual’s POST and their Living Will and Durable Power of Attorney for Health Care, the orders of the POST will be followed.

   We suggest you speak to your health care provider if you are interested in obtaining these forms. **Caring Info does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and Caring Info allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free HelpLine
$64	helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate