



Protecting your preferences regarding health care

A guide to advance directives for Kaiser Permanente members living in Washington state

- Values Worksheet
- Durable Power of Attorney for Health Care form
- Health Care Directive (Living Will) form

(Revised as of July 28, 2019)

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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.

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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)
- Physician Orders for Life-Sustaining Treatment (POLST)
- 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: Completing a Physician Orders for Life-Sustaining Treatment (POLST) form

If you have a serious terminal illness, a qualified health care provider can fill out a form called Physician Orders for Life-Sustaining Treatment (POLST). This form represents your wishes as clear and specific medical orders for people treating you.

Part 5: 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 the Advance Directives Registry at Kaiser Permanente.

Part 6: 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. There is also a Values Worksheet on page 9 to help you clarify your values, beliefs, and goals. After you've gone through the checklist and Values Worksheet, 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 the life support treatments my health care providers think might help, but not the following treatments:

Mark everything you want:

- 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

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.

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?

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 to 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 do not choose 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 on pages 11-12 of this booklet.* Instructions for filing the completed form are included in Part 5.

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. All DPOA forms dated prior to January 1, 2017, remain legally valid without notarization or witness signatures. There is no need to resubmit your form for this purpose.

Please see witnessing requirements included on the DPOA form on pages 11-12.

* The Durable Power of Attorney for Health Care form in this booklet form is not a substitute for the advice of an attorney. Any legal question you may have about a Durable Power of Attorney for Health Care should be directed to an attorney.

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* on pages 13 and 14 of this booklet. Instructions for filing the completed form are included in Part 5.

Do I need to get the form notarized?

Effective July 28, 2019, 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. All Health Care Directive (Living Will) forms dated prior to July 28, 2019, will remain legally valid with just the witness signatures. There is no need to resubmit your form for this purpose.

Please see witnessing requirements included on the Health Care Directive (Living Will) form on page 14.

PART 4: Completing a Physician Orders for Life-Sustaining Treatment (POLST) form

Physician Orders for Life-Sustaining Treatment (POLST) is a form you fill out with a qualified health care provider that tells certain people (such as doctors in the hospital and paramedics in an ambulance) about what kind of medical care you want if you have a serious illness or injury.

The POLST is a set of medical orders authorized by a qualified health care provider that lists the types of life-sustaining treatment you want or do not want at the end of your life.

The POLST form documents:

- Your medical conditions
- Your preferences for:
 - Receiving CPR if your heart is not beating and you are not breathing
 - The use of antibiotics
 - The use of artificially provided fluids and nutrition

The POLST form is voluntary and is intended to:

- Help you and a qualified health care provider talk about and develop plans that support your wishes
- Assist doctors, nurses, health care facilities, and emergency workers in honoring your wishes for life-sustaining treatment
- Direct appropriate treatment by emergency medical services personnel

Frequently asked questions about the POLST form:**

- **Does the POLST form need to be signed?**
Yes. A doctor, nurse practitioner, or certified physician assistant (PA-C) must sign the bright green form in order for it to be a physician order that is understood and followed by other health care professionals.

*The Health Care Directive (Living Will) form in this booklet has been reprinted with permission from the Washington State Medical Association.

**This section used with permission by the Washington State Medical Association.

- **If I have a signed POLST form, do I need an advance directive too?** Yes, we recommend that you also have an advance directive, although it is not required. Talk with your health care provider if you'd like more information about advance directives.
- **What if my loved one can no longer communicate his or her wishes for care?** If you are the designated health care representative for your loved one, you can speak on behalf of this person. A qualified health care provider can complete the POLST form based on your understanding of your loved one's wishes.
- **In what setting is the POLST form used?** The completed POLST form is a physician order form that will stay with you if you are transported between care settings, whether you are at home, in the hospital, or in a long-term care facility.
- **Where is the POLST form kept?** If you live at home, you should keep the original bright green POLST form in a location where it can be easily seen by people coming into your home (for example, on the front of the refrigerator, on the back of the bedroom door, on a bedside table, or in your medicine cabinet). If you live in a long-term care facility, your POLST form can be kept in your medical chart along with other medical orders.
- **How do I get a copy of the POLST form?** Ask your doctor or other health care provider for a POLST form.

PART 5: 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:

- Give copies of the forms to your doctor or nurse.

OR

- Give copies to the Business Office at any Kaiser Permanente medical facility.

OR

- Mail (1) copy of each form to:

Kaiser Permanente Advance Directives Registry
Mailstop ACN-AC3
P.O. Box 204
Spokane, WA 99210-0204

Once the forms are in your medical record, Kaiser Permanente physicians have 24-hour access to them. If you want to make sure your forms are in your medical record, you can call Kaiser Permanente's Advance Directives Registry at 1-877-850-9445.

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. Note: Any changes to POLST must have a qualified health care provider's signature.

PART 6: Resources that may be helpful when you are preparing your advance directive forms

Kaiser Permanente Washington “Your Life, Your Choices” Program

1-866-458-5276

Email: kpwa.yourlifeyourchoices@kp.org

Provides free, two-hour workshops about advance directives at various Kaiser Permanente facilities.

Kaiser Permanente Washington Resource Line

1-800-992-2279

Email: KPWA.resource-L@kp.org

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

KING COUNTY ONLY: Provides contact information for Senior Rights Assistance volunteers who can talk with you about filling out advance directive forms.

Kaiser Permanente Washington Advance Directives Registry

1-877-850-9445

Can help get your advance directives scanned and filed into your medical record.

Kaiser Permanente Washington Home Health Services, Palliative Care, and Hospice Services

1-800-332-5735

Provides care at home when you need rehabilitation care or comfort care services for advanced illnesses.

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

www.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

www.adsa.dshs.wa.gov/pubinfo/legal

Provides information and resources about advance directives.

VALUES WORKSHEET

The following are questions to think about as you make decisions and prepare documents for your health care wishes. You may want to write down your answers and give copies to your family and health care providers, or just use the questions for thought and discussion.

How important to you are the following items?

	VERY IMPORTANT			→	NOT IMPORTANT	
Letting nature take its course	4	3	2	1	0	
Preserving my quality of life	4	3	2	1	0	
Staying true to my spiritual beliefs and traditions	4	3	2	1	0	
Living as long as possible, regardless of quality of life	4	3	2	1	0	
Being independent	4	3	2	1	0	
Being comfortable and as pain-free as possible	4	3	2	1	0	
Leaving good memories for family and friends	4	3	2	1	0	
Making a contribution to medical research or teaching	4	3	2	1	0	
Being able to relate to family and friends	4	3	2	1	0	
Being free of physical limitations	4	3	2	1	0	
Being mentally alert and competent	4	3	2	1	0	
Being able to leave money to family, friends, charity	4	3	2	1	0	
Dying in a short time rather than lingering	4	3	2	1	0	
Avoiding expensive care	4	3	2	1	0	

What will be important to you when you are dying (for example, physical comfort, no pain, family members present, etc.)?

How do you feel about using life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness or disability (for example, Alzheimer’s disease)?

Do you always want to know the facts about your condition, even if the facts may make you uncomfortable?

Do you have strong feelings about certain medical treatments? Some treatments you might want to decide about include: mechanical breathing (respirator), CPR (cardiopulmonary resuscitation), artificial nutrition and hydration (nutrition and fluid given through a tube in the veins, nose, or stomach), antibiotics, kidney dialysis, hospital intensive care, pain-relief drugs, chemo or radiation therapy, and surgery.

Would your feelings about these treatments change depending on your health condition and prognosis? Would you want to avoid certain treatments only when death was certain, or also when you would probably be left incapacitated? Would you want to avoid certain treatments if they were used only to prolong the dying process, but accept them if they would alleviate pain?

What limitations to your physical and mental health would affect the health care decisions you would make?

Do you want to have finances taken into account when treatment decisions are made?

Do you want to be placed in a nursing home?

Do you want hospice care, with the goal of keeping you comfortable in your home during the end of life, instead of hospitalization?

Do you want to take part in making decisions about your health care and treatment?

Do you want to be an organ donor at the time of your death?

My Name _____

My Date of Birth _____

My Medical Record # _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST 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.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you if you choose.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by attaching them to this document or by making them known in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions. Please see Chapter 11.125 RCW for more information.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I designate and appoint:

Health Care Agent Name _____ Phone _____

Address _____ City, State, ZIP _____

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

Alternate agents

In the event that the person listed above is unable or unwilling to serve, or is unavailable to be contacted with reasonable effort, then I grant these powers to the people listed below as my first and second alternate choices.

1st alternate name _____ Phone _____

Address _____ City, State, ZIP _____

2nd alternate name _____ Phone _____

Address _____ City, State, ZIP _____

My Name _____

My Date of Birth _____

My Medical Record # _____

3. General Statement of Authority Granted

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 includes actions such as organ donation and care and disposal of the body after I die, unless otherwise legally specified.

The above authorization to make health care decisions does not include the following absent a court order:

- (1) Therapy or other procedure given for the purpose of inducing convulsion;
- (2) Surgery solely for the purpose of psychosurgery;
- (3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;
- (4) Sterilization.

I hereby revoke any prior grants of Durable Power of Attorney for Health Care.

4. Your wishes for medical treatment may be attached to this form should you choose to include them.

5. Signatures

MY SIGNATURE (Principal) _____

I understand that **two witnesses** OR **a notary** must watch me sign this form for it to be legally valid.

• Option 1—Two witness signatures

By my signature below as witness, I attest that: (a) I am not related to the Principal by blood, marriage, or state registered domestic partnership; (b) I am not the Principal’s health care provider, an employee of the provider, or an employee of an adult family home or long-term care facility where Principal resides; and (c) I am in the presence of the Principal and am acting at the Principal’s direction or request.

DATED this _____ day of _____, _____ .
(Year)

Witness signature: _____

Witness signature: _____

• Option 2—Notary

STATE OF WASHINGTON) _____)ss.

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the PRINCIPAL, _____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this _____ day of _____, _____ .
(Year)

NOTARY PUBLIC in and for the State of Washington,
residing at _____
My commission expires _____

My Name _____

My Date of Birth _____

My Medical Record # _____

HEALTH CARE DIRECTIVE (LIVING WILL)

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.

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

My Name _____

My Date of Birth _____

My Medical Record # _____

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

Signed:* _____

*I understand that **two witnesses** OR a **notary** must watch me sign this form for it to be legally valid.

• **Option 1—Two witness signatures**

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not related by blood or marriage, nor the attending physician, an employee of the attending physician or 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 directive.

DATED this _____ day of _____, _____.
(Year)

Witness signature: _____

Witness signature: _____

• **Option 2—Notary**

STATE OF WASHINGTON) _____)ss.

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the GRANTOR, _____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this _____ day of _____, _____.
(Year)

NOTARY PUBLIC in and for the State of Washington,
residing at _____
My commission expires _____

Notes
