# ~ Idaho ~

# Durable Power of Attorney for Health Care Christian Version

## NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior durable power of attorney for health care that you may have made. If you wish to change your durable power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift that you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

# STATE OF IDAHO
# DURABLE POWER OF ATTORNEY
# FOR HEALTH CARE

Written in accordance with Idaho § 39-4510, § 39-4514

Document made this _____ day of _____, _____.
Month Year

## CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney for health care. This durable power of attorney shall not be affected by my subsequent incapacity.

## DESIGNATION OF HEALTH CARE AGENT

I, _____, _____,
Insert your full name Address

do hereby designate and appoint _____, _____
Health care agent Address

_____, ( ____ ) _____, as my health care agent to make
Phone
health care decisions for me as authorized in this document. For the purposes of this document, "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.

**None of the following may be designated as your agent:** (1) your doctor or other treating health care provider, (2) a non-relative employee of a hospital, your doctor, or other treating health care provider, (3) an operator of a nursing home, assisted living facility, or a community care facility, or (4) a non-relative employee of an operator of a nursing home, assisted living facility, or a community care facility.

## GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this document, 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 document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in "STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS" below. You may indicate your desires in the same section.)

## STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR 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 in this section. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You may include a statement of your desires concerning other matters relating to your health care. 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 provided in this section. If you want to limit in any other way the authority given your agent by this document, 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 authority under this document, my agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 6-11) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my health care agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

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

## HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

## INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including 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.

4. Consent to the donation of any of my organs for medical purposes. (If you want to limit the authority "STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS" above.)

## SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

2. Any necessary waiver or release from liability required by a hospital or physician.

## DESIGNATION OF ALTERNATE AGENTS
### *Optional*

**NOTE:** You are not required to designate any alternate agents, but we recommend that you do. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated on page 2, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.

If the person designated as my agent on page 2 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 for me as authorized in this document, such persons to serve in the order listed below:

**First Alternate Agent**

Name: _____ Phone: (_____) _____

Address: _____

**Second Alternate Agent**

Name: _____ Phone: (_____) _____

Address: _____

## PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

**YOU MUST DATE AND SIGN THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE.**

## DATE AND SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on ____/_____/_____,
Date

at _____, _____.
City State

**Signature:** _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

## STATEMENT OF WITNESS(ES)

***Optional***

*Idaho law does not require your signature to be witnessed on your durable power of attorney for health care document. We recommend the signatures of two qualified witnesses to ensure your document is fully compliant with the requirements of all states.*

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this durable power of attorney for health care is voluntary.

### Witness #1

Print name: _____ Date: _____

Address: _____

**Signature:** _____

### Witness #2

Print name: _____ Date: _____

Address: _____

**Signature:** _____

# ADDENDUM TO THE STATE OF IDAHO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

## HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

## EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

## LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

## ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may only admit me for short–term stays for recuperative care or respite care.

## PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

## NUTRITION AND HYDRATION

***Food & fluids***

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Durable Power of Attorney for Health Care Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

## HEALTH CARE DECISIONS FOR PREGNANT WOMEN

**NOTE:** Idaho statutes require that life-sustaining measures continue regardless of any directive to the contrary until the pregnancy is complete.

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

## PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

## ANATOMICAL GIFTS

***Optional***

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire or refusal to make an anatomical gift.

**Signature:** _____ Date: _____

**YOU MUST DATE AND SIGN THIS ADDENDUM TO THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE.**

## DATE AND SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I have read this Addendum to the Idaho Durable Power of Attorney for Health Care – Christian Version. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this Durable Power of Attorney and Addendum at any time by notifying my agent, my physician, or the facility in which I am a patient or resident.

I sign my name to this Addendum to the Idaho Durable Power of Attorney for Health Care – Christian Version

on ____/_____/_____, at _____, _____.
Date City State

**Signature:**_____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

## STATEMENT OF WITNESS(ES)

***Optional***

*Idaho law does not require your signature to be witnessed on your durable power of attorney for health care document. We recommend the signatures of two qualified witnesses to ensure your document is fully compliant with the requirements of all states.*

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this durable power of attorney for health care is voluntary.

### Witness #1

Print name: _____ Date: _____

Address: _____

**Signature:** _____

### Witness #2

Print name: _____ Date: _____

Address: _____

**Signature:** _____

## STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care
Name of principal
agent if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

**Agent's signature:** _____

Address: _____

## STATEMENT OF ALTERNATE HEALTH CARE AGENTS

I understand that _____ has designated me to be his or her alternate
Name of principal
health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

**First alternate agent's signature:** _____

Address: _____

**Second alternate agent's signature:** _____

Address: _____

## CLERGY
***Optional***

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

**Clergy's signature:** _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____ _____

_____ _____

_____ _____