

Advance Care Planning

Do It for Those You Love

What is a Durable Power of Attorney for Health Care Decisions? (DPOAHC)

- It is a document that allows you to name a person to make health care decisions for you if you ever become unable to speak for yourself.
 - You give the agent the right to make decisions on your behalf.
 - You may give specific directions or general guidelines.
 - You may clarify specific care that you *do* or *do not* want to receive.
 - The goal is to ensure that your wishes will be known and will be honored.
- Remember...
- The agent you name will make health care decisions for you *when and only when* you cannot communicate for yourself.
 - You may change your instructions or agent at any time.

Will I need an attorney's help? Do I need witnesses?

- Although you may desire to consult an attorney, you certainly may complete a DPOAHC on your own.
- You are required to have two witnesses OR to have the DPOAHC notarized. In some states, the document *must* be notarized, so you may choose to have yours notarized.
- The witnesses must be at least 18 years old, unrelated to you, not beneficiaries of your estate, and not financially responsible for your health care.
- Be sure to date and initial changes on all copies of the document.

How does the DPOAHC differ from a Power or Durable Power of Attorney?

- Neither a Power of Attorney nor a Durable

Power of Attorney empower anyone to make health care decisions for you. They normally address financial and/or business matters.

What about the Living Will?

- A DPOAHC expresses your wishes for health care in the event you should ever be unable to speak for yourself under any circumstances. A Living Will expresses your wishes for health care in the event that you are unable to speak for yourself and two physicians agree that you are terminally ill.
- A Living Will may be useful, but it does not replace the need for Kansans to complete a DPOAHC.
- Too often, a family is already in crisis at the time a Living Will is completed. The Living Will is best completed before one becomes gravely ill.
- Visit our website for more information. See www.LIFEProject.org/_cr_ad.htm.

Will my wishes be honored?

- The law requires that health care providers honor your wishes, but we do have work to do in this area. Sometimes wishes have not been honored, and sometimes the documents have created conflict when persons have not talked with family members.

The LIFE Project is working to ensure that your wishes will be honored. You can help by naming an agent and sharing your wishes.

Will my DPOAHC be honored if I am outside the state?

- There are efforts to make these documents more portable, but you could, at present, encounter problems.
- It helps if you have the DPOAHC notarized, because some states require this.

Helping all Kansans live with dignity, comfort and peace at the end of life

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

It is important to choose someone to make health care decisions for you when you cannot. Talk with the person (agent) you choose about what you would want. You may write any specific instructions for what you DO or DO NOT want. The person you choose has the same right as you do to make decisions and to make sure your wishes are honored. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, (print your name) _____, appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done. This is a Durable Power of Attorney for Health Care Decisions, and the power of my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for Health Care Decisions. My agent may not appoint anyone else to make decisions for me. I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following this Durable Power of Attorney for Health Care Decisions or my written directive. Any costs should be paid from my own resources. I grant to my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my wishes. My agent is authorized to:

- Consent, refuse or withdraw consent to any care, treatment, service or procedure (including artificially supplied nutrition and/or hydration / tube feeding) used to maintain, diagnose or treat a physical or mental condition;
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other health care organization; employ or discharge health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall deem necessary for my physical, mental, or emotional well being.
- Request, receive, and review any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; execute any releases of other documents that may be required to obtain such information;
- Move me into or out of any State or institution for the purpose of complying with my written directive or the decisions of my agent;
- Take legal action, if needed, to do what I have directed;
- Make decisions about autopsy and organ donation, and the disposition of my body; and
- Become my guardian if one is needed.

If you DO NOT want the person (agent) you name to be able to do any of the above things, draw a line through it, and put your initials at the end of the line. You may choose to add additional instructions for what you DO or DO NOT want from your agent.

Agent's Name _____ Phone # _____
Address _____

If the above-named agent is unable or unwilling to make health care decisions for me, I designate the following person(s), in the order listed, to be my agent for health care decisions. If you do NOT want to name an alternate, write "none."

First Alternate Agent	Second Alternate Agent
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

SIGN HERE for the *Durable Power of Attorney for Health Care Decisions*. Many states require notarization. Please ask at least two (2) persons at least 18 years of age to witness your signature who are not related to you nor financially connected to you or your estate.

Signature _____ Date _____

Witness _____ Date _____ Witness _____ Date _____

NOTARIZATION:

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his / her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seat in the County of _____, State of _____, on the date above written.

_____ My commission expires: _____