Seattle Cancer Care Alliance

Fred Hutch · Seattle Children's · UW Medicine

Durable Power of Attorney for Health Care (DPOAHC) Questions and Answers

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

The DPOAHC lets you name a health care agent, to make decisions about your medical care. These include decisions about life support if you can no longer speak for yourself.

How should I choose a health care agent?

Be sure the person you appoint as your health care agent understands your wishes, agrees to honor them, and will take responsibility for making medical decisions for you even if others challenge your wishes.

The person you name to be your health care agent:

- Must be at least 18 years old and mentally competent.
- May be a family member or close friend you trust to make serious decisions.
- Does not have to be your spouse, partner, or a member of your biological family.
- Need not live in Washington but would need to be readily available in a medical emergency.

The person you appoint as your health care agent cannot be:

- Your physician or an employee of your physician.
- An owner, operator, administrator, or employee of a health care facility in which you are a patient at the time you sign your DPOAHC.

What happens if I do not choose a health care agent?

If you do not designate a health care agent, Washington law will assign one for you. An agent will be chosen from the list below in the following order:

- A guardian with health decision-making authority, if one has been appointed by a court.
- Your spouse or registered domestic partner (even if you are separated but not legally divorced).
- Your adult children.
- Your parents.
- Your adult siblings.

<u>When there is more than one person given authority, such as your children, parents, or siblings, all must agree</u>.

What if I have a same-sex spouse or registered domestic partner?

Your domestic partner or spouse may not have the right to make your health care decisions or even have access to you in an emergency medical situation outside of Washington. List your domestic partner or spouse as your health care agent on your DPOAHC form if you travel outside of Washington and want him/her to make health care decisions for you.

What if the court appoints a guardian for me?
Washington law does not direct that a health care agent should be the court's first choice for guardian. It makes sense to request that one of your health care agents serve as your guardian, because that is the person you trust. A judge is not required to appoint the person you request, but the court would probably give your wishes serious consideration.

How can I revoke or cancel my DPOAHC?
You may revoke your DPOAHC at any time by doing any one of the following:

- Canceling, defacing, obliterating, burning, tearing, or otherwise physically destroying it or having another person destroy it for you in your presence. All copies should be destroyed.
- Executing a written and dated revocation.
- Orally expressing your intent to revoke it.

Where should I keep my DPOAHC?
Keep the original signed documents in a secure but accessible place that your agent knows about. Copies of your DPOAHC are just as valid as the original. Give photocopies of the signed original to your health care agent(s), physician(s) lawyer, family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records. To ensure your DPOAHC is accessible, you may want to keep copies in your wallet/purse, car or in a suitcase.

What if I want to make changes?
If you want to make changes to your documents after they have been signed, you should complete a new document. However, updating addresses or phone numbers is permissible. Updates should be initialed and dated.

What if I travel to other states?
If you travel, you may want to take copies of your DPOAHC with you, as other states may honor it. Although they may have specific requirements about notarization or witnessing, most states do not require a specific form or format.

Do I need to have my DPOAHC witnessed or notarized?
Beginning January 1, 2017, the DPOAHC must be either witnessed by 2 witnesses or notarized in order to be legally binding.

The witnesses must be:

- At least 18 years old,
- Not related to you by blood, marriage, or adoption,
- Not your health care agent named in this document,
- As far as they know, not beneficiaries of your will, and no claim against your estate,
- Not directly involved in your health care,
- Not an employee of your physician or a health care facility where you may reside.

DPOAHC completed prior to January 1, 2017, will remain legally valid as long as its version complied with the Washington State law at the time of its completion. In addition, some states do require DPOAHC to be notarized. SCCA provides complimentary notarization of advance care planning documents in our Patient and Family Resource Center located on the 3rd floor of the clinic.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE of: ______________________________

{print your name here}

This document is meant to inform and guide my health care agent, if I become unable to speak for myself. I understand that before I sign this directive, I can add to, delete from, or otherwise change the wording of this directive. I may add to or delete from this directive at any time, and any changes shall be consistent with Washington State law or federal constitutional law to be legally valid. I hereby cancel all healthcare powers of attorney previously signed by me.

1. When I Want This Document To Apply

I want this document to apply if I become unable to make my own health care decision(s) due to disability or incapacity. I understand that such inability may be temporary. I also understand that if I become unable to make certain decisions, I may still be able to make others. When I can make my own health care decisions, I want to do so.

2. My Health Care Agent

I appoint as my agent:		My alternate agent (optional):	
Name	______________________	Name	______________________
Address	______________________	Address	______________________
Telephone	______________________	Telephone	______________________

I have previously completed *{initial all that apply}*:

Health Care Directive (i.e. living will, advance directive)	________ Yes	________ No
Physician Order for Life-Sustaining Treatment (POLST)	________ Yes	________ No

3. The Authority I Give My Agent

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to:

- Consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physician, including life-sustaining treatments;
- Asking for particular medical treatments;
- Accessing my medical records and information;
- Employing and dismissing health care providers;
- Changing my health care insurers;
- Making a Physician Order for Life-Sustaining Treatment (POLST) form for me;
- Removing me from any health care facility to another facility, a private home, or other place.

This release authority additionally applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 as hereafter amended.

4. If A Court Appoints A Guardian For Me

If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

5. How This Directive Can Be Revoked Or Canceled

This directive can be revoked by a written statement to that effect, or by any other expression of intent to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document.

Photocopies and faxes of this signed document are legal and valid

TEAM

NAME [M]

PLACE EPIC LABEL HERE

PT NO [F]

DOB

HIM023 (10/16)

6. Summary And Signature

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing my agent to make health care decisions for me. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective even if I become incompetent.

____ __________________

Signature *{sign only in the presence of two witnesses, if witnessing* OR *notary, if notarizing}* Date

Note: You must complete either section 7 (Statement of Witnesses) or section 8 (Notarization) in order for this document to be legally binding.

7. Statement Of Witnesses *{print your name - not the names of your witnesses – on the line below}*

______________________________________ is personally known to me, and I believe him/her to be capable of making health care decisions. I affirm I am at least 18 years old, not related to him/her by blood, marriage, or adoption, and not his/her health care agent named in this document. As far as I know I am not a beneficiary of his/her will or any addition to his/her will, and I have no claim against his/her estate. I am not directly involved in his/her health care, and I am not an employee of his/her physician or a health care facility where the person making this document may reside.

WITNESS 1

Signature ____________________ Date __________

Printed Name ____________________ Phone __________

Address ______________________________

WITNESS 2

Signature ____________________ Date __________

Printed Name ____________________ Phone __________

Address ______________________________

8. Notarization

State of Washington, County of ____

I certify that I know or have satisfactory evidence that ______________________________ signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this document.

Dated this __________ day of __________________, 20 _______

____

NOTARY PUBLIC in and for the State of Washington

Residing at ______________________________

My commission expires ________________________

Note: SCCA provides complimentary notarization for your DPOAHC in the Patient and Family Resource Center located on the 3rd floor of the clinic.

Photocopies and faxes of this signed document are legal and valid

TEAM

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