Honoring™ Your Wishes
A COMMUNITY-WIDE ADVANCE CARE PLANNING INITIATIVE

UnityPoint Health

Health Care Directive

Overview

Adults with decision-making capacity have the right to make choices about their health care. No treatments may be given to someone who does not want them.

The attached Durable Power of Attorney for Health Care form is a legal health care directive document, developed to meet the requirements of Iowa Code Chapter 144B. It allows you to appoint another person and alternate persons to make your health care decisions if you become unable. The person you ask to make health care choices for you is your **health care agent.**

This document gives your agent the authority to make health care decisions for you only if:

- **you are unable to communicate your wishes and health care decisions due to illness or injury, and**
- **health care providers have determined that you are not able to make your own health care decisions**

This document does not give your agent permission to make your financial or other business decisions. As stated by Iowa law, "health care" means any care, treatment, service, or procedures to maintain, diagnose, or treat your physical or mental condition.

Take the time to read this document carefully before you complete it. You can list in this document the types of health care you do and do not want. You can limit the types of choices your health care agent can make. It is very important that you discuss your views, values, and this document with your health care agent. If you do not closely involve your agent, your views and values may not be fully respected because they may not be understood.

What if I decide not to complete a Durable Power of Attorney for Health Care document?

You do not have to sign a Durable Power of Attorney for Health Care document. Doctors, insurance providers, or hospitals cannot force you to have this type of document to receive their services. Under Iowa Code Chapter 144B, your life insurance cannot be canceled if your health care is being withdrawn or withheld according to your wishes in this document.

Initials _____
Date _____

Notary Public

State of _____) County of _____)

This form was acknowledged before me on _____ (date)

by _____
Name of Person

_____
Signature of Notary Public

Seal/Stamp

OR

Statement of Witnesses

By signing, I affirm that _____
Name of Person

and the other witness listed, signed this form while I watched. I also affirm that:

- I know them or they could prove who they are
- I am 18 years or older
- I am not their Health Care Agent
- I am not their health care provider
- I do not work for their health care provider

One witness must also affirm that:

- I am not related to them by blood, marriage, or adoption

Witness #1 (Sign your name at the X and write the date below):

X _____ _____/_____/_____
Sign your name Date

_____
Print your name

_____
Address City State Zip Code

Witness #2 (Sign your name at the X and write the date below):

X _____ _____/_____/_____
Sign your name Date

_____
Print your name

_____
Address City State Zip Code

Initials _____
Date _____

What do I do with the form after I fill it out?

When you have completed your health care directive, you should:

- Tell the person you named as your health care agent if you haven't already done so. Make sure that the person feels able to perform this important job for you in the future.
- Make copies:
  - ✓ one copy for yourself
  - ✓ one copy for your health care agent and any alternates
  - ✓ one copy to share and discuss with your doctor or other health care providers
  - ✓ one copy for the hospital where you have been treated or would go in an emergency
  - ✓ extra copies to share with others (friends, family, clergy, attorney)

A copy of this document is as legally valid as the original.

Copies of this document will be given or have been given to:

1. _____

2. _____

3. _____

4. _____

5. _____

While you have a choice not to complete this document, you should know that others may have to make health care decisions for you at some point in the future. Without telling someone your wishes, it may be hard for them to decide what you would want. Completing this document can help you talk to your circle of support about what is important to you and can help them make decisions that match your goals and values.

What if I decide to cancel my Durable Power of Attorney for Health Care document?

You have the right to cancel your Durable Power of Attorney Health Care document at any time. You can do this by telling your health care agent or anyone else at any time and in any way. It is recommended that you inform your health care provider. Also, let anyone else know who may have received a copy. Your current and valid document will cancel out any older versions. If your spouse is your health care agent, and you get divorced, the power granted to your spouse by this document is revoked. If you would remarry your spouse, this power is reinstated unless you cancel it.

Who should I choose to be my Health Care Agent?

A family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- Is willing to learn about your goals and values for health care decisions
- You trust will do what is best for you, and will follow your wishes
- Can make decisions under sometimes stressful situations

What kind of choices can my Health Care Agent make?

They can decide:

- Which doctors, nurses, or social workers may provide care to you
- Which hospitals or clinics will treat your conditions
- The types of medicines, immunizations/vaccinations, tests, or treatments you could get

Initials _____
Date _____

Honoring Your Wishes
A COMMUNITY-WIDE ADVANCE CARE PLANNING INITIATIVE

UnityPoint Health

Durable Power of Attorney for Health Care Decisions

I, _____, (date of birth) _____,

select as my **Health Care Agent**:

Name: _____

Home:_____ Cell: _____ Work:_____

Address:_____

and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending doctor, to make my own health care decisions. My Health Care Agent must act consistently with my desires as stated in this document or otherwise made known.

If the first person cannot be my Health Care Agent, I then select the following person to be my **alternate Health Care Agent:**

Name: _____

Home:_____ Cell: _____ Work :_____

Address: _____

I understand that my Health Care Agent:

- will make choices for me **only** after I cannot make them myself in the judgment of my doctor.
- can tell my doctor to stop giving me health care, even if it is needed to keep me alive.
- can make decisions regarding all aspects of my care including but not limited to immunizations and vaccinations.
- can choose my health care providers, including hospitals, doctors, and end-of-life care.
- can look at my medical records and share my health care information as permitted (see page 2).
- can sign releases or other forms about my medical treatment.
- can decide if I should join a research study.

I now cancel all prior Durable Powers Of Attorney for Health Care Decisions.

Initials _____
Date _____

Consent for My Health Care Agent to Act as My Personal Representative and Consent for Release of Protected Health Information

I authorize my Health Care Agent to act as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This includes amendments to HIPAA during any time that my Health Care Agent is acting on my behalf.

I give my Health Care Agent permission to ask for, receive, or look at any information about my physical or mental health. I approve that any health care provider, health plan, hospital, clinic, laboratory, pharmacy, insurance company, or other health care related business can share my personal health information and medical records with my Health Care Agent. This includes any past, present or future medical or mental illness regarding my ability to make health care choices. This permission includes information protected by HIPAA.

I understand my Health Care Agent can sign authorizations, releases, or other records that may be needed to get this information. My Health Care Agent can also consent for the release of my information to others. I understand that my Health Care Agent may share this information with others. This means that my information is no longer protected by HIPAA.

I also have the right to look at any information shared with my Health Care Agent.

I will mark with my initials the information that my Health Care Agent **cannot** have access to:

_____ Alcohol, drug, and other substance abuse

_____ Behavioral and mental health

_____ Sexually transmitted diseases, AIDS, and HIV-related information

_____ Genetic tests

I understand my Health Care Agent's access to my personal health information by this document terminates when I die. I can cancel this permission and consent at any time by telling my health care provider.

X_____ _____/_____/_____

Sign your name Date

_____

Print your name

Initials _____

Date _____

People Who My Health Care Agent Should Include in Decision-Making Steps

I ask that my health care agent make an effort to include these persons in my health care decisions:

_____

_____

Religion / Faith:

I am of the _____ faith, and am a part of the _____ community.

Contact person and phone number of faith community: _____.

I ask that my health care agent call my faith-based group.

List of Desires, Special Provisions, or Limits

The following are specific instructions for my health care agent and/or doctor providing my health care. If I need treatment in a state that does not accept this Durable Power of Attorney for Health Care, or my health care agent cannot be contacted, I want the instructions below to be followed based on common law and my legal right to direct my health care.

Instructions for Filling in This Part

You do not have to give any written instructions or make any selections in this section. If you choose not to give any instructions, your health care agent will make choices based on:

- Your verbal instructions
- What is felt to be in your best interest

If you choose not to give any instructions, draw a line and write "no instructions" across the page. Place your initials before each statement that you want your health care agent, your doctor, and other health care providers to follow.

Initials _____
Date _____

My Wishes

I understand that I will receive care to keep me as comfortable as possible. I will be offered pain medicine. I will be offered food and fluids by mouth if I am able to swallow. I have the following additional requests:

If possible, I would like the following for comfort and support (rituals, music, visitors, etc.):

The things that make life most worth living to me are:

My beliefs about when life would no longer be worth living:

My thoughts and feelings about where I would like to die:

A message to my family and friends:

Initials _____
Date _____

Stopping Treatments to Prolong My Life

Life-support treatments are used to try and keep you alive.

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am (write initials on line if you agree):

____ I want to **stop or withhold all treatments that are prolonging my life.** This includes but is not limited to tube feedings, IV (intravenous) fluids and medications, respirator/ventilator (breathing machine), dialysis, blood products and antibiotics.

Cardiopulmonary Resuscitation (CPR)

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions, medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) health problems and/or an illness that can no longer be treated.

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information. My health care agent may act on my behalf if I cannot make my own choices.

If I do not want CPR tried, my doctor should be told about my choice. If I show below that I do not want CPR, I understand this choice alone will not stop emergency workers from attempting CPR in an emergency. Other papers may be needed to control the actions of emergency workers.

Select ONE option. Mark with your initials.

____ **I want CPR** attempted if my heart stops or if I stop breathing.

OR

____ **I want CPR** attempted if my heart stops or if I stop breathing unless my doctor decides any one of the following:

- I have an untreatable illness or injury and am dying; OR
- I have little chance of surviving if my heart or breathing stops; OR
- I have little chance of living much longer and the process of CPR would cause me significant suffering.

OR

____ **I do not want CPR** attempted if my heart stops or if I stop breathing. Rather, I want to allow a natural death.

Initials _____
Date _____

After I Die

Organ donation (Mark with your initials):

____ **I want** to donate my organs, tissues, and eyes if able. My specific wishes (if any) are:

____ I am registered with the Iowa Donor Network.

____ My driver's license is marked "Y" for "yes".

____ **I do not want** to donate my organs, tissues or eyes.

Body Donation:

A different option is to donate your body. These arrangements must be made **before** your death. If you wish to donate your body after death to medical science, please call a school listed below.

- University of Iowa Carver College Of Medicine
  Department of Anatomy and Cell Biology (319) 335-7762

- Palmer College of Chiropractic in Davenport
  Department of Life Sciences (563) 884-5785

- Des Moines University Body Donor Program
  Department of Anatomy (515) 271-1481

____ I have registered my body to be donated to _____

Initials _____
Date _____

How to Make This a Legal Document

In order for this document to be valid, it must be acknowledged or witnessed in one of the following ways:

- It must be signed by you in the presence of a notary public in Iowa.

OR

- It must be signed by two witnesses. You and your two witnesses must all be present when the document is signed.

If you are physically unable to sign this document, you can ask another person to sign it for you in your presence and in the presence of your witnesses OR in the presence of a notary.

If you choose to use witnesses, they must:

- Be at least 18 years old
- Watch you sign this form
- Watch the other witness sign this form

Your witnesses cannot:

- Be your health care agent or alternate health care agent
- Be your health care provider attending to you on the date that this form is signed
- Work for your health care provider

Also, one witness cannot:

- Be related to you by blood, marriage, or adoption

Sign your name at the X and write the date below:

X _____ _____/_____/_____

Sign your name Date

_____

Print your name

_____

Address City State Zip Code

OR

I cannot sign my name because:

_____

If I cannot sign my name, I ask the following person to sign for me (print name):

_____

Signature (of person asked to sign):

_____

Initials _____

Date _____