IDAHO ADVANCE CARE PLANNING DOCUMENT
ALSO KNOWN AS A HEALTH CARE DIRECTIVE
IDAHO CODE §39-4510

"Advance Care Planning Document", also called a "Health Care Directive", is a general term used to describe this document. The purpose of this document is to help me plan ahead so my loved ones and healthcare team know what care I want if I experience a medical crisis and cannot speak for myself.

1. MANDATORY PROVISIONS:

Name of person executing Directive:
Date of Directive:
Address of person executing Directive:
My Telephone Number(s):
Birth Date

2. OPTIONAL PROVISIONS:

a. Email Address: My email address is:

b. Nomination of Persons to Act as a Health Care Agent:

This portion of my Health Care Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective only when I am unable to communicate or make my own healthcare decisions.

None of the following may be designated as your agent or alternate agent:

- *Your treating healthcare provider;*
- *A non-relative employee of your treating healthcare provider;*
- *An operator of a community care facility; or,*
- *A non-relative employee of an operator of a community care facility.*

I designate and appoint the following individual as my health care agent to make health care decisions for me as authorized in this Health Care Directive:

Name of Health Care Agent:
Relationship to me:
Agent's Telephone numbers:
Address:
Email Address:

If the person designated as my healthcare agent is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or, loses the mental capacity to make healthcare decisions for me; or, if I revoke that person's designation or authority to act as my agent to make healthcare decisions for me; then I designate and appoint the following person(s), in the order of priority shown below, to serve as my agent to make healthcare decisions for me as authorized in this Health Care Directive.

First Alternate Agent:

Relationship to me:
Telephone:
Address:
Email address:

Second Alternate Agent:

Relationship to me:
Telephone:
Address
Email address:

Third Alternate Agent:

Relationship to me:
Telephone:
Address
Email address:

c. HIPAA Release Authority.

My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical information Bureau, Inc. or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information.

d. Prior Designations Revoked. I revoke any prior advance care planning document or medical directive, however denominated.

e. Resuscitation Instructions:

If I have a medical condition:

1. from which I am not imminently dying; and,
2. from which I will not likely recover; and,
3. I am unable to make or communicate my medical decisions; and,
4. I am dependent on others for my care.

Then in that event I do not want artificial life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as a feeding tube) and artificial hydration.

In such condition, I want care to be focused on my comfort.

I have instructions related to my resuscitation in the attached documents, including the Information for Health Care Agent document.

I understand that the provisions of Idaho Code §39-4514(5), presumed consent to resuscitation, apply, subject to the provisions of parts (a) through (e) of Idaho Code §39-4514(5), which can remove that presumption.

f. Pregnancy Instructions:

If I Am Diagnosed as Pregnant:

This Advance Directive shall be honored in its entirety during the course of my pregnancy.

OR

I direct the following treatment ☐ shall ☐ shall not be withheld or withdrawn:

OR

My instructions regarding medical care shall have no force during my pregnancy except that my Healthcare Agent is authorized to make such decisions for me.

g. POST/POLST FORM - Idaho Code §39-4512A

I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Advance Directive. I hereby approve of those orders and make them a part of this Advance Directive.

OR

I have not completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this advance care planning document shall be deemed modified to be compatible with the terms of the POST form.

h. Instructions for end-of-life care

I have instructions related to my end-of-life care in the attached documents, including the Information for Health Care Agent document.

i. Treatment Objectives

I have instructions related to my treatment objectives in the attached documents, including the Information for Health Care Agent document.

j. Attached Incorporated Documents

I have attached one or more documents to this Directive which are hereby incorporated as if set forth in full in this Directive. Documents attached:

1. Information for Health Care Agent;
2.

k. Health Care Directive Registry Idaho Code §39-4515

I request that this Directive be registered in the Department of Health and Welfare Health Care Directive Registry. I authorize any appropriate person, including my attorney, to make such registration.

REQUIRED:

SIGNATURE OF PRINCIPAL: I understand the full importance of this Advance Care Planning Document. I am mentally competent to make this document. No participant in the making of this document or in its being carried into effect shall be held responsible in any way for complying with my directions. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing.

I sign my name below to this Idaho Advance Care Planning Document on the date at the beginning of this document.

_____

OPTIONAL NOTARY AND WITNESSES

STATE OF IDAHO)
) ss.
COUNTY OF)

On (Date), before me personally appeared (Client), to me known (or proved to me on basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that said person executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public for Idaho
Residing at
My commission expires on

STATEMENT OF WITNESSES

Each of the undersigned declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility. further declare under penalty of perjury under the laws of Idaho that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

First Witness	Second Witness
Residence address:	Residence address:
Date:	Date: