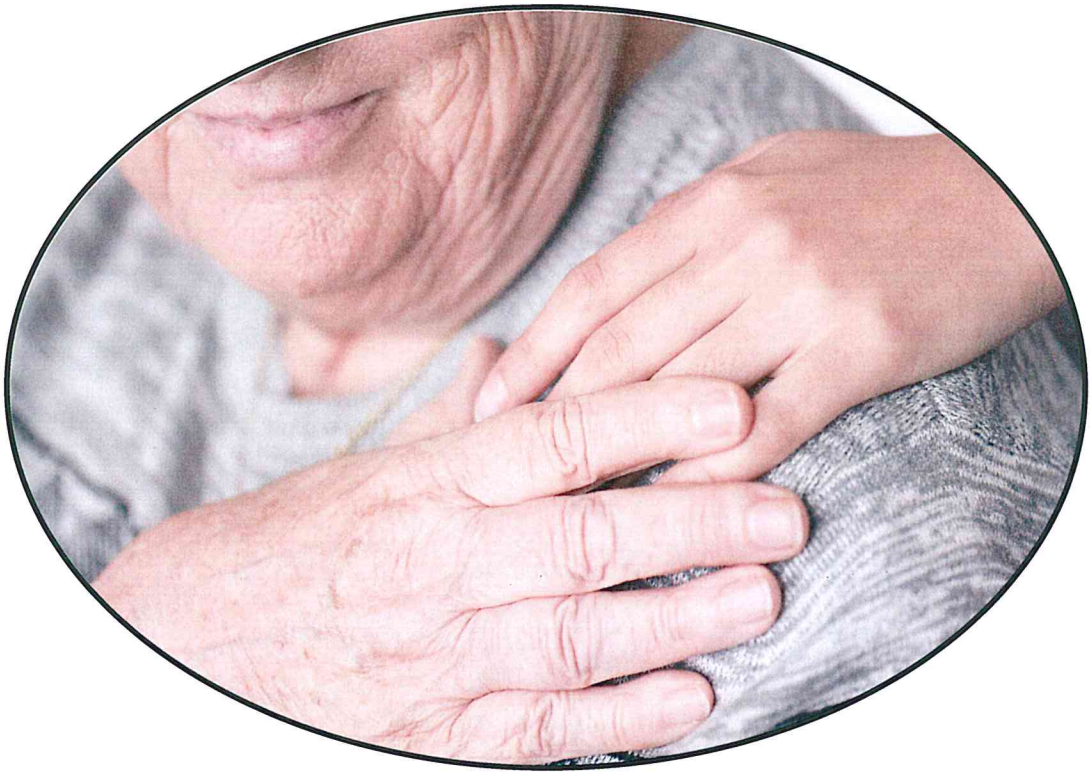
Caring for an Aging Spouse or Parent?



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Caring for an Aging Spouse or Parent

Caring for an aging spouse or parent is something that many, if not most, of us will face at some time in our lives. This can appear to be a daunting task but can be made much easier with some prior planning. This checklist, while not exhaustive, can help families navigate these difficult times by developing a plan that can be put together one piece at a time.

It is highly recommended that health care, legal, and financial planning professionals be consulted during the preparation and implementation of the items found in this document.

Section I Resources to Investigate before You Need Them

ATTORNEY	Legally protect yourself and your loved one.
REAL ESTATE AGENT	Will a home have to be sold to pay for assisted living?
FINANCIAL PLANNER	Make sure the proceeds of that home sale will outlive the parent and their spouse.
INSURANCE AGENT	Find one that can keep up with the changes in Medicare/ Medicaid and how that may impact your private medical Insurance. Is burial insurance needed?
TRANSPORTATION PROVIDERS	What happens when they can't – or shouldn't – drive anymore?
ASSISTED LIVING/MEMORY CARE FACILITY	This is an incredibly expensive proposition. Research what is out there before you have to make an immediate decision.
HOSPICE CARE	For easing those final days.
FUNERAL HOME/MORTICIAN	Making decisions regarding coffins, services and burial plots can be made in advance and eliminate any added expenses due to being emotional and overwhelmed at the time of a loved one's death. The People's Memorial Association (peoplesmemorial.org) is a nonprofit that can provide pricing comparisons for reference. Who should be the designated agent for funeral arrangements?
IDENTIFICATION	♦ Parent's legal name ♦ Address ♦ Phone/mobile number(s) ♦ Birth date

- Social security number, Veteran's DD214 card
- Medicare, Medicaid and Insurance cards, PINs, Passwords (cell phone, computer, airlines, utility companies, credit cards, Apple ID)
- Legal state of residence (if more than one home)
- Grandmother's maiden name, mother's maiden name: necessary for many companies in order legitimize communication with you (e.g., for shutting off services, paying bills, Medicare)

LOCATIONS: knowing where to find things

- Names, phone/mobile/fax numbers/email addresses of significant professionals: attorney, physician(s), financial advisor, emergency contact(s), parent's close friends–as well as people who help in a variety of ways (cleaning person, companion, veterinarian (should pet need care or boarding) and neighbors
- Bank account(s)
- Bills and checkbook
- Birth and marriage certificates, divorce decree(s), if applicable. You will need marriage certificate for proof of marriage if receiving any of spouse's pension
- Citizenship and military papers
- Deeds, ownership records, car titles
- Hiding place of valuables
- Insurance policies
- Keys (identifying what they open)
- Letters of instruction to be read after death
- Safety deposit box(es) and keys
- 3 previous years' income tax records
- PINS and passwords, including cell phones
- Spouses death certificate or certificate of trust if applicable
- VA DD214 card

HEALTH

- If caregiving at home, keep calendar of doctor's appointments in a prominent place.
- Keep a booklet to record observations, vital signs, food, and water intake–anything else a doctor wants–on a daily basis
- Maintain up-to-date list of medications and their dosage
- Maintain allergy list if applicable
- Up-to-date emergency contact list (2 names minimum) for supervisor or employer if parents work (paid or volunteer)
- Have ambulance service phone # handy. Know when it's necessary to have ambulance transport to hospital as opposed to your driving (e.g., if a person falls, it's almost always preferable NOT to move him or her
- Know which siblings, friends or neighbors you can call in emergencies; have their contact numbers handy. Stressful situations can cause us to forget

numbers, especially as *we* age
- Maintain up to date immunization/booster records

HOUSING

- Is parent's current home satisfactory? Do they need accommodations, grab bars, emergency alert buttons, etc.?
- Have you discussed this, as well as a "PLAN B" if a change is necessary?
- Are you familiar with housing options: remaining home with care; moving in with a family member; assisted living, continuing care retirement communities, senior apartments, nursing home?

RESPITE (to give you time for yourself)

- Adult day care options for elders. Some hospitals and some senior living communities offer respite as a temporary "break" for caregivers. (If your dad is like mine, you need to know I've never seen such adamant refusal as the weekend respite suggestion…I think he thought he might be stuck there.)
- Family member or loyal friend who can help you out when needed. (Few of us have ESP; you must initiate –there will no doubt be a time when you're "in need.")
- Family member or loyal friend for pick up at airport, should you be away when an emergency strikes
- Do they have insurance to cover respite care?

MONEY MATTERS

- Is your parent a veteran, entitled to benefits? Does parent have insurance? Health, long-term care, life, auto, homeowner's, liability, other?
- Is there enough money from savings, dividends, interest to maintain lifestyle?
- Is there a mortgage on home?
- Are there credit card or other debts?
- Should adult child's name be added to accounts? (Dad took me to the bank and brokerage firm to meet the "guys" and add my name to his accounts several years before he died. I learned a great deal and ultimately helped writing checks–didn't want to do this electronically as he still needed to–and could–be in charge. Result: I didn't feel as overwhelmed by money matters when he died)
- If money could be or is in short supply, a family meeting way ahead of time can give an idea as to how members can–or can't–help

Section III Important Documents

LEGAL

DURABLE POWER OF ATTORNEY— MEDICAL ***(Appendix B)***

Also called a Health Care Proxy, Healthcare Power of Attorney, or Living Will, a Durable Medical Power of Attorney is a type of advance directive that designates a person to make healthcare decisions for you if you are not able to do so.

BIRTH CERTIFICATE & MARRIAGE LICENSE ***(Appendix F)***

Seniors should keep their birth certificates and marriage license accessible to their adult children or other loved ones.

DIVORCE DECREE(S)

If the senior has been divorced, having the divorce the decree available will spell out any conditions that adult children should be aware of.

DEATH CERTIFICATE OF SPOUSE (if applicable)

A death certificate may be necessary to sell the house, a car, or to transfer assets.

VETERAN'S DISCHARGE PAPERS

When vets are discharged, they receive discharge papers that are needed for such things as VA benefits, reduced mortgage rates, VA pensions, etc.

CITIZENSHIP PAPERS

Adult children or the relatives who are caring for an elderly loved one should be able to locate citizenship papers if the senior has become a citizen.

SOCIAL SECURITY NUMBER

It's not a bad idea to have at least a copy of the social security card on file just in case it's needed for any reason. Although, that information would most likely already be recorded with some of the other documents listed above.

MEDICAL

HEALTH CARE DIRECTIVE ***(Appendix C)***

A difficult topic but a necessary one. This includes decisions to be made about end of life wishes, hospice, organ donations and funeral wishes.

HIPPA DISCLOSURE FORM FOR ALL PHYSICIANS ***(Appendix E)***

Most clinics, hospitals, and dental or healthcare providers have their own HIPAA release forms for patients, which authorizes the disclosure of all, or a part of the principal's health details.

Section III Legal Documents
continued

PROPERTY

DEEDS TO THE HOME

Knowing where the deed to the senior's house is can make the process of selling or changing home ownership much easier.

VEHICLE TITLES

If your senior parent can no longer drive or becomes incapacitated, someone will need to sell their vehicle, so the title should be kept in an easily accessible place.

FINANCIAL

DURABLE POWER OF ATTORNEY—FINANCIAL DECISIONS *(Appendix D)*

A Durable Power of Attorney is a document that gives one individual the legal right to appoint another person to act on their behalf in financial affairs.

BANK ACCOUNT INFORMATION

Adult children should at least know at which financial institutions their senior parents do their banking.

FINANCIAL ACCOUNT(S) INFORMATION

Just like bank account information, stocks, bonds, brokerage accounts, pensions, 401K accounts and social security contact information should be recorded somewhere.

RETIREMENT ACCOUNT(S)

Knowing this information ensures that the individual and their heirs receive the benefits they deserve.

DEBT DOCUMENTATION

This includes information for credit cards, loans, purchase contracts, rental agreements, etc. These accounts will need to be paid.

MEDICAL & LIFE INSURANCE POLICIES

Should the senior need medical attention, do you know who their insurance carrier is, aside from Medicare? Is there a life insurance policy and what is the purpose of that policy?

WILL, ESTATE PLAN or TRUST *(Appendix H)*

A will is a binding legal document that comes into effect after the death of the individual writing the will (known as a testator).

END OF LIFE

DESIGNATED AGENT FOR FUNERAL ARRANGEMENTS *(Appendix G)*

Ensures that the funeral arrangement wishes of the deceased are honored. Will also eliminate family arguments should disagreements arise.

Notes

Section IV APPENDIX

It is highly recommended that health care, legal, and financial planning professionals be consulted during the preparation and implementation of the items found in this document.

A.	Personal Information
B.	Durable Power of Attorney for Health Care
C.	Health Care Directive
D.	Durable Power of Attorney for Financial Decisions
E.	HIPPA Release for all Physicians
F.	Certificates, Licenses & Decrees
G.	Designated Agent for Funeral Arrangements
H.	Estate Planning
I.	Assisted Living: What to Ask
J.	Senior Resources

Appendix A: Personal Information

Parent/Spouse Name: _____
Date of Birth: _____ Place of Birth: _____
Their Street Address: _____
City: _____ State: _____ ZIP: _____
Home Phone (_____) _____ Cell Phone (_____) _____
E-mail #1: _____ E-mail #2: _____

Physician #1: _____
Specialty: _____
Phone: (_____) _____

Physician #2: _____
Specialty: _____
Phone: (_____) _____

Physician #3: _____
Specialty: _____
Phone: (_____) _____

Dentist: _____
Phone: (_____) _____

Optomitrist: _____
Phone: (_____) _____

Preferred Hospital: _____
Phone: (_____) _____

Bank #1: _____
Banker: _____ Phone: (_____) _____

Bank #2: _____
Banker: _____ Phone: (_____) _____

Financial Planner _____
Contact: _____ Phone: (_____) _____

Insurance Company (home):_____
Policy #:_____
Agent:_____ Phone: (_____)_____

Insurance Company (vehicle):_____
Policy #:_____
Agent:_____ Phone: (_____)_____

Insurance Company (life):_____
Policy #:_____
Agent:_____ Phone: (_____)_____

Insurance Company (medical):_____
Policy #:_____
Agent:_____ Phone: (_____)_____

Attorney:_____
Phone: (_____)_____

Pharmacy:_____
Phone: (_____)_____
Medication 1:_____ Medication 5:_____
Medication 2:_____ Medication 6:_____
Medication 3:_____ Medication 7:_____
Medication 4:_____ Medication 8:_____

Veterinarian:_____
Phone: (_____)_____

Veterans Status:_____DD214_____
Branch of Service:_____
Date Entered Service:_____Date Left Service:_____

Hospice Program:_____
Contact:_____Phone: (_____)_____

Funeral Home/Mortician:_____
Contact:_____Phone: (_____)_____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- Your Health Care Agent should be someone you trust to make health care decisions on your behalf. Your Health Care Agent may be any adult, including relatives such as your spouse, state registered domestic partner, father, mother, adult child, or adult brother or sister. Unless they are one of the relatives listed above, your Health Care Agent may not be any of your physicians or your physicians' employees, or the owners, administrators or employees of a health care facility or long-term facility (as defined by RCW 43.190.020) where you reside or receive care.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical condition. You can limit that right in this document.
- When exercising authority to make health care decisions for you on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by Washington law. This power of attorney shall become effective when I become disabled and I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I _____, designate and appoint:

Name _____ Address _____

City _____ State _____ ZIP _____ Phone _____

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in Washington law and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that _____ is unable or unwilling to serve, I grant these powers to

Name _____ Address _____

City _____ State _____ ZIP _____ Phone _____

In the event that both _____ and _____

are unable or unwilling to serve, I grant these powers to

Name _____ Address _____

City _____ State _____ ZIP _____ Phone _____

3. General Statement of Authority Granted.

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:

(1) Therapy or other procedure given for the purpose of inducing convulsion;
(2) Surgery solely for the purpose of psychosurgery;
(3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to Chapter 71.05 RCW;
(4) Sterilization.

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

4. Special Provisions

_____

_____

_____

DATED this _____ day of _____, _____.
(Year)

GRANTOR: _____ GRANTOR'S SIGNATURE _____

NOTE: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Your designated health care agent(s).

WITNESS _____ WITNESS _____

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____ day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

(Stamp)

_____
(Title of office)

My commission expires: _____

Appendix C: Health Care Directive

HEALTH CARE DIRECTIVE

Directive made this _____ day of _____, _____.
(Year)

I, _____ being of sound mind, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(A) If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand "terminal condition" means an incurable and irreversible condition caused by injury, disease or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [*Choose one*]

I want _____ do not want _____

artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(E) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

_____

_____

_____

_____

SIGNED: _____

Note: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate upon your death.
- Your attending physician or an employee of your attending physician or health care facility where you are a patient.
- Any person who has claim against any portion of your estate at the time of signature of this document.

The declarer has been personally known to me or has provided proof of identity. I believe him or her to be capable of making health care decisions.

WITNESS:_____ WITNESS: _____

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

(Stamp)

_____
(Title of office)

My commission expires: _____

Appendix D: Durable Power of Attorney—Financial Decisions

.Durable Power of Attorney for Finances for

_____

[My Name]

Agent. I choose _____as my Agent with full authority to manage my finances.

Alternate. If _____is unable or unwilling to act, I choose _____ as my Agent with full authority to manage my finances.

My Rights. I keep the right to make financial decisions for myself as long as I am capable.

Durable. My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.

Start Date. This power of attorney document is effective: (check one)

Immediately.

Only if my medical provider signs a letter saying I cannot make decisions for myself.

End Date. This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.

Revocation. I revoke any power of attorney for finances documents I have signed in the past. I understand that I may revoke this power of attorney document at any time by giving written notice of revocation to my Agent.

Powers. My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to make deposits to, and payments from, any account in my name in any financial institution, to open and remove items from any safe deposit box in my name, to sell, exchange or transfer title to stocks, bonds or other securities, and to sell, convey or encumber any real or personal property. My agent shall also have the following **special powers**: (check all that apply)

create, amend, revoke, or terminate a living trust

make gifts of my money or property

create or change my rights of survivorship
create or change my beneficiary designation(s)
delegate some authority granted in this document to someone else
waive my right to be the beneficiary of an annuity or retirement plan
create, amend, revoke, or terminate my community property agreement
tell a trustee to make distributions from a trust just as I could

No Power to Agree to Pre-Dispute Binding Arbitration. My Agent does not have the power to agree to pre-dispute binding arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

Accounting. My Agent shall keep accurate records of my finances and show these records to me at my request.

Nomination of Guardian. I nominate my Agent as the guardian of my estate for consideration by the court if guardianship proceedings become necessary.

HIPAA Release. I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

_____ _____

My Signature Date

Notarization

State of Washington
County of _____

I certify that I know or have satisfactory evidence that_____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

_____ _____

Date Signature of Notary
NOTARY PUBLIC for the State of Washington.
My commission expires _____.

Appendix E: HIPPA Disclosure

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): **When the individual has NO pulse and is not breathing.**

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B CHECK ONE

Level of Medical Interventions: **When the individual has a pulse and/or is breathing.**
Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST.**

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.

Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.

☐ Preference is to discuss medically assisted nutrition options, as indicated.*

Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: Use this section to update and confirm order and preferences.

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME ☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

Appendix F: Certificates, Licenses, Decrees

It is highly recommended to have originals or copies available. This page is for quick reference purposes on-

BIRTH CERTIFICATE

Date of Birth:_____ Hospital:_____

City:_____ County:_____ State:_____

Mother's Maiden Name:_____ Father's Name:_____

Certificate #:_____

WEDDING LICENSE

Date of Marriage:_____ Spouse's Name:_____

Location:_____ City:_____County_____ State:_____

Officiant:_____

License #:_____

DIVORCE DECREE

Date of Marriage:_____ Date of Divorce:_____

Former Spouse's Name:_____

Location:_____ City:_____County_____ State:_____

Document #:_____

DESIGNATED AGENT FOR FUNERAL ARRANGEMENTS

WASHINGTON STATE

I, _____ designate the following agent(s) to act on my behalf for the sole purpose of directing my funeral and cemetery arrangements.

I ☐ have ☐ have not *(initial one)* **executed a written Disposition Authorization.**

I ☐ have ☐ have not *(initial one)* **Filed or Prepaid my final arrangements with a funeral home.**

If I have not executed a written disposition authorization, nor filed or prepaid my arrangements with a licensed funeral establishment or cemetery authority, then I authorize my designated agent to select appropriate funeral arrangements for me including the type, place and method of the final disposition. Neither my designated agent nor my survivors may substantially alter any prearrangements I have made. If I have not provided sufficient funds to cover my prearrangements, the designated agent is responsible for the balance of my funeral and cemetery costs. I direct that my estate promptly reimburse my designated agent for any personal funds advanced to pay for my funeral arrangements. My designated agent has complete authority to act on my behalf and direct any and all details related to my funeral arrangements that I have not already prearranged or authorized, including but not limited to obituary, funeral or memorial service, cemetery, monument, memorialization, reception or other related matters.

I name the following person to be my designated agent for funeral arrangements:

Primary Agent's Full Name: _____ Relationship: _____

Primary Agent's Address: _____

Primary Agent's Phone(s): _____

If my Primary Agent is for any reason unable or unwilling to serve in this capacity or does not make contact with the funeral home within 5 business days of my death, I then name the following person to be my designated agent for funeral arrangements:

Alternate Agent's Full Name: _____ Relationship: _____

Alternate Agent's Address: _____

Alternate Agent's Phone(s): _____

I direct that all of my family and survivors shall honor this authorization. I direct that any funeral home, cemetery, cremation authority, memorial society or designated agent shall be held harmless for arranging or handling the disposition of my remains, if done in reliance upon this authorization.

Declarant's Signature: _____ **Date:** _____

Full Legal Name of Declarant: _____ Date of Birth: _____

UNDER WASHINGTON LAW, TO BE VALID, THIS FORM MUST BE SIGNED IN THE PRESENCE OF A WITNESS AND DATED

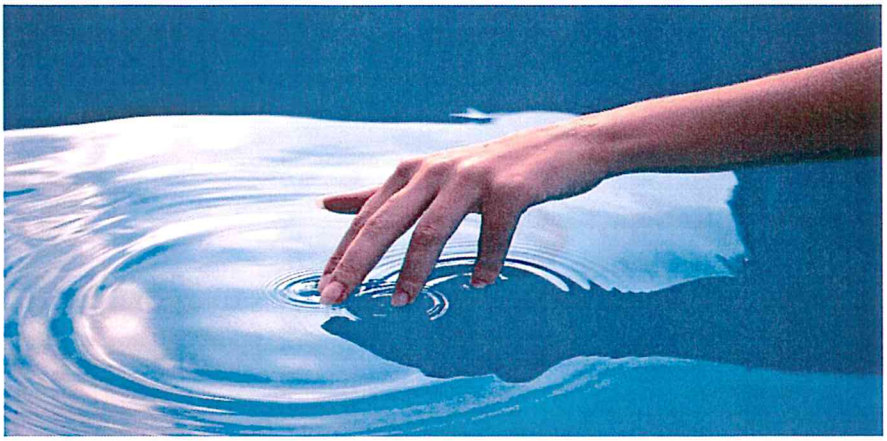
Witness Signature: _____ **Date:** _____

Full Legal Name of Witness: _____ Date of Birth: _____

KEEP WITH YOUR IMPORTANT PAPERS DISCUSS WITH YOUR DESIGNATED AGENT & NEXT OF KIN
HAVE THEM PRESENT THIS FORM TO FUNERAL HOME AT TIME OF DEATH

Discover How Everyone Benefits From Planned Gifts.

How and why to plan a gift



Your Goal	Your Gift	Your Method	Your Benefit
Make a gift while leaving more of your estate to your heirs	**Gifts of Retirement Assets (e.g., 401-K, IRA)**	Name us as the beneficiary of your retirement plan, and pass less-taxed assets to your heirs	Avoid up to 60% income tax on your retirement's assets; pass more of your estate to your heirs
Make a gift that costs you nothing during your lifetime	**Gifts Through your Will or Trust ("Bequest")**	Include a gift of cash, property, or a share of your estate through your will or trust	A gift that does not affect your cash flow, and you can adjust your gift as circumstances change
Make a gift while avoiding capital gains liability	**Gift of Appreciated Securities**	Give us appreciated stocks, bonds, or mutual funds to sell and use the proceeds	Make a significant gift; receive an immediate income tax deduction; pay no capital gains tax
Make a gift and receive a guaranteed "paycheck" for life	**Charitable Gift Annuity**	Donate cash or securities in a plan where the remainder comes to us after your passing	Receive higher rate of return tax-advantaged payments for life, charitable tax deduction, and avoid capital gains tax
Make a gift and receive a steady income for life	**Charitable Remainder Unitrust, Charitable Remainder Annuity Trust**	Share your assets with us in a plan that gives you an income for life and passes us the remainder	Diversity assets, avoid or defer capital gains tax, receive charitable tax deduction, secure often greater income, and possible inflation protection
Make a large gift at little cost	**Gift of Life Insurance**	Donate a life insurance policy you no longer need or name us as a beneficiary in an existing one	Take a tax-deduction now; take possible future deductions through gifts to pay policy premiums
Plan a future gift in the simplest way possible	**Gift the balance your account (POD or TOD)**	Designate the balance of your bank or brokerage account, retirement plan, annuity, or life insurance policy to us	Make an extraordinary contribution that costs you nothing now and is as simple as signing your name
Make a gift that preserves your assets for your heirs	**Charitable Lead Trust**	Use appreciating assets to create a trust that will pay us income for a period of years and then pass the assets back to you or your heirs	Shelter your growing assets and benefit us right away; reduce or eliminate gift and estate tax

Appendix I: Assisted Living: What to Ask

Choosing an assisted living facility for a loved one can be a daunting process. While each individual's situation will dictate an appropriate living environment, the following questions can help to compare and contrast different facilities.

Your Initial Phone Call:

- ⇒ Where is the residence located? Is it within close visiting distance?
- ⇒ How many living units are in the residence?
- ⇒ Are different size of units available?
- ⇒ Do any units have kitchens or kitchenettes?
- ⇒ Are the rooms private? Are the bathrooms private?
- ⇒ What are the entrance fee(s)?
- ⇒ What is the monthly rent?
- ⇒ What is the security deposit?
- ⇒ Are deposits refundable?
- ⇒ Are utilities included? Which ones?
- ⇒ Is telephone included? Long distance? How are rate increases or late payments handled?

During Your Initial Visit:

- ⇒ Is the residence clean?
- ⇒ Do you feel good about it?
- ⇒ Are stairs and hallways well lit?
- ⇒ Are exits well marked?
- ⇒ Do rooms and bathrooms have handrails and call buttons?
- ⇒ Are there safety locks on the doors and windows?
- ⇒ Are there security and fire safety systems?
- ⇒ Is there an emergency generator or alternate power source?
- ⇒ Is the floor plan logical and easy to follow?
- ⇒ Is the residence cheerful?
- ⇒ Are rooms large enough for a resident's need
- ⇒ Are there enough common areas, such as dens and living rooms?

Care Provided:

- ⇒ Does the residence offer special care units such as those serving people with Alzheimer's disease?
- ⇒ What role does the resident have in developing their care plan?
- ⇒ Does the residence offer special care units such as those serving people with Alzheimer's disease?
- ⇒ Is there a written care plan for each resident?
- ⇒ Are additional services available on the same campus if a resident's needs change?
- ⇒ Can residents choose their own doctors, therapists, or pharmacies?
- ⇒ Can residents come and go at will?
- ⇒ Can personal visitors come and go at will?

Financials/Contract

- ⇒ Is a contract available that details fees, services, and admission and discharge policies?
- ⇒ Is the contract easy to read?
- ⇒ Does the contract address levels of care? How many levels? Who determines level of care?
- ⇒ What do additional services cost?
- ⇒ Does the contract include all of the services you are looking for?
- ⇒ How frequently are services provided?
- ⇒ How does the residence bill for services?
- ⇒ What if a resident runs out of money?
- ⇒ Under what conditions would a resident have to leave the residence?
- ⇒ Do you understand everything in it?
- ⇒ Are specific services provided by the residence?
- ⇒ Are health care services included? Which ones?
- ⇒ When and where are meals served? Are all meals served 7 days a week?
- ⇒ Are linens/laundry provided?
- ⇒ Are transportation services provided?
- ⇒ Is there a parking fee for residents? For visitors
- ⇒ Does the residence offer worship services?
- ⇒ Is transportation to worship services provided?
- ⇒ Does the contract cover transfer and discharge policies? Who makes a transfer or discharge decision?
- ⇒ How much notice is given to residents who have to leave?
- ⇒ Is the living area held if the resident is in the hospital? For what cost?
- ⇒ Can residents have a pet?
- ⇒ Can residents have personal furniture?
- ⇒ Does the contract deny your right to bring legal action against the residence for injury, negligence, or other cause?

NOTES:

Appendix J: Senior Resources

The organizations listed below are suggestions for potential support for seniors and caregivers. It is the responsibility of the user to verify current available services.

AARP
ww.aarp.org

Adult Protective Services—Washington
https://www.dshs.wa.gov/altsa/adult-protective-services-aps

Aging and Elder Care
https://access.wa.gov/topics/publichealth/agingeldercare.html

Alzheimers Association
https://www.alz.org/alzwa

Eldercare Directory
Essential resources for senior citizens and their caregivers
https://www.eldercaredirectory.org/

Greater Maple Valley Community Center
www.maplevalleycc.org

King County Bar Association—Pro Bono services
https://www.kcba.org/For-the-Public

King County Veterans Program
www.kingcounty.gov/veterans

Meals on Wheels in King County
www.mealsonwheels@soundgenerations.org

METRO Access
https://kingcounty.gov/depts/transportation/metro/travel-options/accessible/programs/access-transportation.aspx

People's Memorial Association
(provides price comparisons for funeral homes)
www.peoplesmemorial.org/

Social Security Administration
https://www.ssa.gov/

U.S. Department of Housing & Urban Development
Housing Resources
https://www.hud.gov/states/washington/homeownership/seniors

U.S. Department of Veterans Affairs
www.va.gov

Volunteer Services
Volunteers assist older adults and those with disabilities with household chores
www.ccsww.org\vcs

Washington State Department of Social and Health Services
Aging and long term support
https://www.dshs.wa.gov/altsa/home-and-community-services/agencies-help

Washington State Hospice & Palliative Care
https://wshpco.org/

Widowed Information & Consultation Services
Support group for widows and widowers
www.kcwics.org