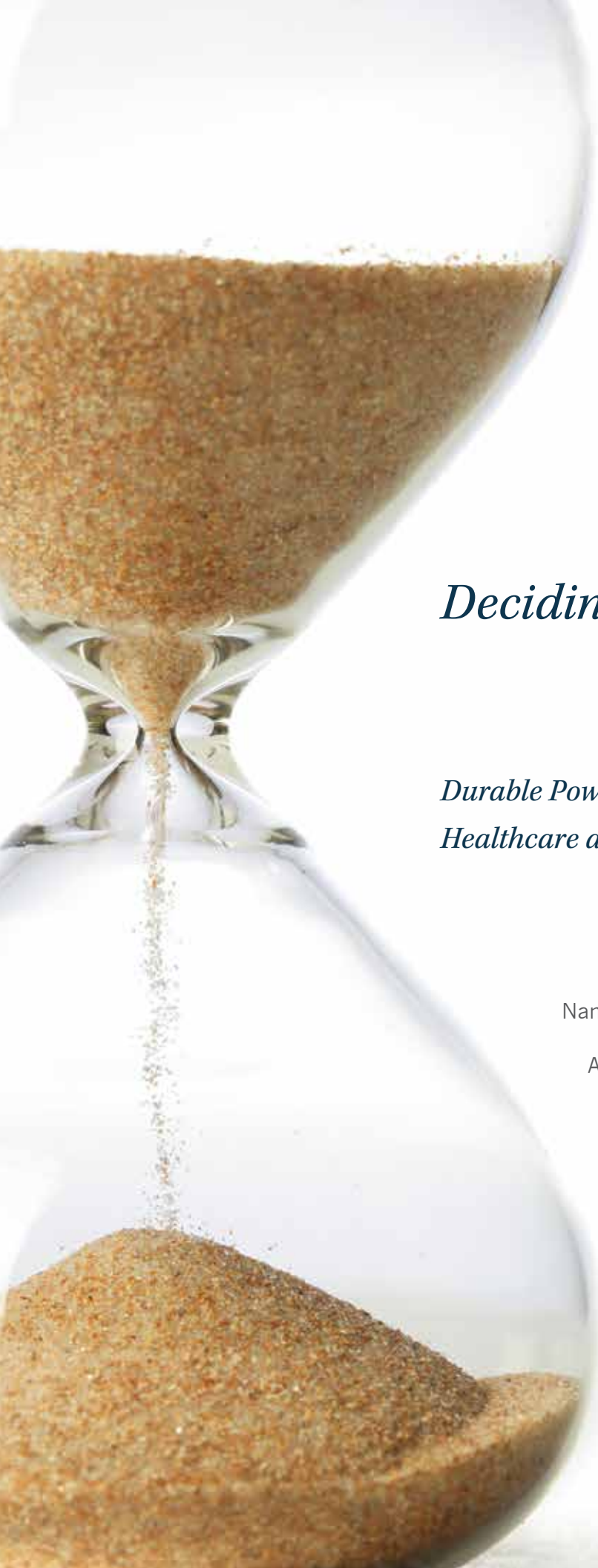

Deciding Tomorrow. . .

today.

Durable Power of Attorney (DPOA) for Healthcare and Living Will for Nevada

Name: _____

Address: _____

Date of Birth: _____

Date: _____

Deciding Tomorrow... today

How do I choose a healthcare agent, the person who will make healthcare decisions on my behalf, if I cannot do it myself? It's a good idea to consider choosing a person you trust to make these decisions and who can effectively communicate your wishes regarding treatment goals, procedures, and all healthcare related matters in the event that you are unable to make these decisions yourself. Deciding Tomorrow... Today is a program and toolkit to help facilitate those important conversations about end of life values, choice and priorities between individuals, family members, friends, faith leaders and healthcare providers both now and in the future. The sooner you talk about your wishes the sooner you and your loved ones will feel comfortable and prepared. This toolkit is designed to help make those important considerations as simple and easy as possible.

The toolkit, found at www.decidingtomorrowtoday.org, includes the following information:

1. Selecting a healthcare agent with Durable Power of Attorney (DPOA) for healthcare care (DPOA) (also called healthcare proxy or attorney-in-fact).
2. Worksheet on identifying personal priorities and values important to your medical decisions.
3. Definitions of "life-sustaining" interventions.
4. Proxy quiz for family and physicians.
5. Tips for sharing your decisions and values with your physician, family and other important people.
6. The *Nevada Living Will Lockbox*.
7. Leaving a legacy.
8. Obtaining a trained facilitator to provide training or technical assistance on completing the DPOA.
9. A list of additional resources.

This document should be used with the resources listed above. It includes the designation of a healthcare agent with Durable Power of Attorney (DPOA) for healthcare and a Living Will with a statement of desires.

Before choosing a healthcare agent it's good to know some important facts:

1. The person you choose as your agent in this document will have the power to make healthcare decisions for you. This power is subject to the desires that you outline in this document. The decisions your agent may be making can include consent, refusal of consent or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. Of course, you may also indicate any type of healthcare that you do not want.

2. The person you choose as your agent has a duty to honor your desires, or make known if your desires are unknown, and act in your best interest.

3. Unless you otherwise specify, your agent will have the power to make healthcare decisions that may include the power to consent to your doctor to not give treatment or stop treatment.

4. Unless you specify a shorter period of time, this power will exist indefinitely from the date you sign this document. If you are unable to make healthcare decisions for yourself, this ability to make decisions on your behalf will continue until the time you are able to make healthcare decisions for yourself.

5. You have the right to make healthcare decisions for yourself so long as you can give informed consent, meaning communicate clearly. In addition, no treatment may be given to you over your objection.

6. You always have the option to revoke the person you choose as your agent by notifying that individual of the revocation orally or in writing.

7. In addition, you may revoke the authority granted to your agent simply by notifying the treating physician, hospital, or other provider of healthcare orally or in writing.

8. Your agent will have the have access to your medical records and agree to their disclosure unless you indicate you limit this right.

9. This document revokes any prior durable power of attorney for healthcare.

11. If you reside in a hospital, residential facility for groups, facility for skilled nursing or home for individual residential care, at the time you execute this document, it is not effective unless it has a certification of competency from a physician, psychologist or psychiatrist attached. A certificate of competency is located at www.decidingtomorrowtoday.org.

12. Unless this person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your healthcare agent:

(1) Your treating provider of healthcare;

(2) An employee of your treating provider of healthcare;

(3) An operator of a healthcare facility; or

(4) An employee of a healthcare facility.

13. Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for, or other restrictions you wish to place on your agent's authority, you should list them in the space below. If you do not write any limitations, your agent will have the broad powers to make healthcare decisions on your behalf, which are set forth in paragraph 3, except to the extent that there are limits provided by law.

14. You don't have to choose an alternative healthcare agent. Any alternative agent you choose will be able to make the same healthcare decisions as the agent you chose. If the healthcare agent you choose is your spouse, his or her designation is automatically revoked by law if your marriage is dissolved.

15. With respect to decisions to withhold or withdraw life-sustaining or resuscitating treatment, your healthcare agent must make healthcare decisions that are consistent with your known desires. If your desires are unknown, your healthcare agent has the duty to act in your best interests

16. If you have questions after reviewing this document it's always a good idea to consult a lawyer before signing it.

Durable Power of Attorney for Healthcare

1. Durable Power of Attorney (DPOA) for Healthcare.

By this document, I intend to create a Durable Power of Attorney (DPOA) for healthcare by appointing the person designated below to make healthcare decisions for me in the event that I am unable to speak for myself with respect to healthcare decisions. This power of attorney shall not be affected by my subsequent incapacity.

2. Designation of Durable Power of Attorney (DPOA) for healthcare.

I, _____ (insert your name) do hereby designate and appoint: Name: _____

Address: _____

Telephone Number: _____ as my healthcare agent to make healthcare decisions for me as authorized in this document.

3. Designation of Alternative Healthcare Agent.

If the agent above is unable to make healthcare decisions for me, I designate the following persons in the order listed to serve as my healthcare agent to make healthcare decisions for me if I am unable to:

a. First Alternative healthcare agent

Name: _____

Address: _____

Telephone Number: _____

b. Second Alternative healthcare agent

Name: _____

Address: _____

Telephone Number: _____

4. Authority Granted.

In the event that I am incapable of giving informed consent with respect to healthcare decisions, I hereby grant to the healthcare agent named above full power and authority to;

(a) To make health care decisions for me before or after my death, including consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;

(b) Request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; and

(c) Execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any healthcare facility including any skilled nursing facility.

This authority is subject only to the limitations and special provisions, if any, set forth below in Special Provisions and Limitations.

5. Special Provisions and Limitations.

The authority of my healthcare agent is subject to the following special provisions and limitations:

Leave blank if you do not wish to include any special limits.

6. Duration.

I understand that this DPOA will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make healthcare decisions for myself when this power of attorney expires, the authority I have granted to my healthcare agent will continue to exist until the time when I become able to make healthcare decisions for myself.

I wish to have this DPOA end on the following date: _____

Write N/A or cross through the blank if you wish the DPOA to last indefinitely.

7. Desires.

Initial the answer(s) that reflect your desires and/or write your desires in the spaces below.

(a) I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

I agree: _____ I disagree: _____

(b) If I am in a coma, which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used.

I agree: _____ I disagree: _____

(c) If I have an incurable or terminal condition and not expected to recover, or I am in a coma which my doctors have reasonably concluded is irreversible, I desire that artificial nutrition and hydration be withheld. If it has been started, I would desire it to be stopped. I understand that withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration.

I agree: _____ I disagree: _____

(d) I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My DPOA is to consider the relief of suffering, the preservation or restoration of functioning, the quality of life, and amount of any possible extension of my life.

I agree: _____ I disagree: _____

(e) If I have an incurable or terminal condition and not expected to recover, or I am in a coma which my doctors have reasonably concluded is irreversible, I desire to have only comfort measures administered and nothing that sustains or prolongs my life.

I agree: _____ I disagree: _____

(f) I desire my attending physician to administer medication that will alleviate any suffering I might be experiencing.

I agree: _____ I disagree: _____

(g) If possible, I desire to die at home with appropriate medical, nursing, social and emotional support and necessary medical equipment needed to keep me comfortable. Alternatively, my DPOA may choose hospice care or care in a facility that he or she deems appropriate.

I agree: _____ I disagree: _____

(h) I desire that my DPOA discuss the specifics of any proposed decision regarding my medical care and treatment with me if I am able to communicate in any manner, even blinking my eyes.

I agree: _____ I disagree: _____

(i) If the person or persons I have appointed are not reasonably available or are unwilling to serve, I direct my attending physician, pursuant to this section, to fulfill the directives contained herein.

I agree: _____ I disagree: _____

Additional statements of desires:

8. Prior Designations Revoked..

I revoke any prior durable power of attorney for healthcare.

9. Waiver of Conflict of Interest.

If my designated agent is my spouse or is one of my children, I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney (DPOA) for healthcare that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

10. Challenges.

If my physician, agent or any other person challenges the validity of this document, my agent is authorized to have the court determine the validity and meaning of this document. The cost of any such action is to be paid from my estate. This document must be construed and interpreted in accordance with the laws of the State of Nevada.

11. Nomination of Guardian.

If, after execution of this Durable Power of Attorney (DPOA) for healthcare, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court:

_____ My healthcare agent herein named, in the order named; or.

_____ The following person:

Name: _____

Address: _____

Telephone Number: _____

12. Release of Information.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my healthcare to my healthcare agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended and applicable regulations. I further intend for my healthcare agent, named above, to 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 POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC

I sign my name to this Durable Power of Attorney (DPOA) for healthcare on _____ (date) at _____ (city) _____ (state).

Signature: _____

OPTION 1

Certificate of Acknowledgment of Notary Public

State of Nevada

County of: _____

On this _____ day of _____, in the year _____, before me _____ (here insert name of notary public) personally appeared _____ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledge that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL:

_____

(Signature of Notary Public)

OPTION 2

Sign your document in the presence of two witnesses who meet the eligibility criteria described below.

I sign my name to this Durable Power of Attorney (DPOA) for healthcare on

_____ (date) at _____ (city), _____ (state).

Signature: _____ Print Name: _____

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, and 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 agent by this document, that I am 18 years of age or older and that I am not a provider of healthcare, an employee of a provider of healthcare, the operator of a community care facility or an employee of an operator of a healthcare facility.

Witness 1: (you are agreeing to statement above)

Signature: _____ Print Name: _____

Residence Address: _____ Date: _____

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney (DPOA) for healthcare in my presence, and 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 agent by this document, that I am 18 years of age or older, and that I am not a provider of healthcare, an employee of a provider of healthcare, the operator of a community care facility or an employee of an operator of a healthcare facility.

Further, I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that 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.

Witness 2: (you are agreeing to statement above)

Signature: _____ Print Name: _____

Residence Address: _____ Date: _____

*If you reside in a hospital, residential facility for groups, facility for skilled nursing or home for individual residential care, Nevada requires that you include a certification of competency from a physician, psychologist or psychiatrist along with your power of attorney.

You may obtain a form at www.decidingtomorrowtoday.org.

Other desires I want my healthcare agent and loved ones to know

I ask that those involved in my medical care conduct themselves so as to maintain my dignity, regardless of my condition.

My desires for funeral arrangements are:

My desire for my body or remains to be placed in the following location:

My desires for how I want to be remembered:

My desire for inclusion in my memorial service (songs, music, poems, readings, etc.):

My desire for organ donation:

My desire for charity to receive memorial contributions:

Message to my loved ones:

Notes

Nathan Adelson
HOSPICE

When it's time for a trusted partner

www.decidingtomorrowtoday.org
702.938.3964