end of life WASHINGTON
Your life. Your death. Your choice.

ALZHEIMER'S DISEASE/DEMENTIA MENTAL HEALTH ADVANCE DIRECTIVE OF:

_____

(Print your name here.)

As a person with capacity, I willfully and voluntarily execute this mental health advance directive, so that my choices regarding my mental health care and Alzheimer's/dementia care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my future care. If I live in a state that has not adopted laws that provide me with the legal right to make this advance directive, then I want this document to be used as a guide for those who make decisions on my behalf when I am no longer capable of making them for myself.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed.

I understand that nothing in this directive, including any refusal of treatment that I consent to, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I intend this Alzheimer's Disease/Dementia Mental Health Directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this Alzheimer's Disease/Dementia Mental Health Advance Directive.

I understand that there are some circumstances where my provider may not have to follow my directive, specifically if compliance would be in violation of the law or accepted standards of care.

1. WHEN AND HOW LONG I WANT THIS DOCUMENT TO APPLY

(*Initial only one – a., b., or c. – and draw a line through the others*)

a. _____ I intend that this directive become effective **immediately** upon signing and that it remains valid and in effect until revoked according to the terms specified in section 16 or until my death.

b. _____ I intend that this directive become effective if I become incapacitated to the extent that I am unable to make informed consent decisions or provide informed consent for my care, as determined by my treating medical provider, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death.

c. _____ I intend that this directive become effective when any of the following circumstances, symptoms, or behaviors occur, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death: *(Initial all that apply, and draw a line through the rest.)*

(1) _____ I am no longer able to communicate verbally.

(2) _____ I can no longer feed myself.

(3) _____ I can no longer recognize my partner/spouse.

(4) _____ I put myself or my family or others in danger because of my actions or behaviors.

(5) _____ Other *(describe)*:_____

2. WHEN I MAY REVOKE THIS DIRECTIVE

I intend that I be able to revoke this directive: *(Initial one, and draw a line through the other.)*

_____ Only when I have capacity: I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I mayreceive treatment that I specify in this directive, even if I object at the time.

_____ Even if I am incapacitated: I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

3. MY MENTAL HEALTH CARE AGENT

I appoint the following person as my primary mental health care agent to make mental health care treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective: *(Optional, but highly recommended.)*

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

If the person named above is my partner or spouse at the time I make this document: {Initial one and put a line through the other. If your primary mental health care agent is not your spouse or partner, cross this section out.}

_____ His or her authority to act is hereby revoked if I am separated or divorced from her or him.

_____ His or her authority to act shall be unaffected if I am separated or divorced from her or him.

In the event that my primary mental health care agent is unable, unavailable, or unwilling to serve, or I revoke his or her authority to serve, then I name this alternate mental health care agent and request that this person be notified immediately when this directive becomes effective or when the primary mental health care agent is no longer my agent: *(Optional, but highly recommended.)*

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

If my alternate mental health care agent acts for me because my first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

4. THE AUTHORITY I GIVE MY MENTAL HEALTH CARE AGENT

I grant my mental health care agent complete authority to make all decisions about mental health care on my behalf. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for mental health treatment recommended by my physicians and other medical providers; (b) requesting particular mental health treatments consistent with any instructions and/or limitations I have set forth in this directive; (c) accessing my medical records and information pertaining to my mental health care; (d) employing and dismissing mental health care providers; and (e) removing me from any mental health care facility to another facility, a private home, or other place. I authorize and request that all “covered entities” under the Health Insurance Portability and Accounting Act of 1996, as hereafter amended, release and disclose full and complete protected medical information to my health care agent named herein. Such information should include, but not be limited to, medical records, office notes, laboratory results, radiology and other visualization records, prescription records,

medical opinions, and all other materials that might assist in medical decision-making or a determination of my capacity. I understand that this information may include information about sexually transmitted diseases, AIDS, HIV, and the use/abuse of alcohol and drugs. This consent is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon my death.

The authority conferred herein shall be exercisable notwithstanding my disability or incapacity.

5. HOW TO MAKE MENTAL HEALTH CARE DECISIONS AND IMPLEMENT THIS DIRECTIVE

I want whoever makes mental health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on my values, the contents of this document, and information provided by my health care providers.

I do not want my mental health care agent or others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interests. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind.

6. PERSONAL HISTORY AND CARE VALUES STATEMENT

(Optional. If you attach a statement, initial this. If not, draw a line through it.)

_____ I have completed and attached an additional statement describing why I am making this metal health advance directive and/or to provide information about the important people in my life, some personal history, general values around care, or anything else that is not addressed by this document.

7. PREFERENCES AND INSTRUCTIONS ABOUT MY CARE AND TREATMENT

a. Preferences regarding care in my home.

(1) **I prefer that my personal care and assistance be provided by:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ Family members who would do so voluntarily.

_____ Individuals who are not family members who would do so voluntarily.

_____ Family members who are hired to provide my care.

_____ Individuals who are not family members who are hired to provide my care.

_____ Other *(describe)*:

(2) **I have the following cultural, religious, and/or gender preferences about my care and assistance:**
(Optional. If you do not have any preferences, draw a line through this space.)

b. Preferences and instructions involving out-of-home placements.

I recognize that I may need to receive care outside of my home – even in my least desirable setting (a nursing home or other placement) – when my care at home becomes too burdensome or difficult to manage. This may be necessary if I become combative, aggressive, incontinent, resistant to care, or too difficult to transfer. If my mental health care agent decides that I need to live in a setting outside of my home, then the following are my preferred locations and settings, in order of preference:

(1) **The location where I would prefer to live:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ With/near the following family member or other loved one near my current home:
_____

_____ With/near the following family member or other loved one far away from my current home:
_____

_____ Near my current home.

_____ Other *(describe)*:

(2) **The setting where I would prefer to live:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ Adult family home. Name: *(optional)*_____

_____ Assisted living facility. Name: *(optional)* _____

_____ Nursing home. Name: *(optional)*_____

_____ Specialized memory care unit. Name: *(optional)* _____

_____ Moving in with family. Name: *(optional)* _____

_____ Other *(describe)*:

(3) **If an assessment and/or recommendations about my ability to remain in my home become necessary, the following person/people or agency/agencies is preferred:** *(Optional. If you do not have a preference, draw a line through this space.)*

c. Preferences and instructions about dealing with combative, assaultive, or aggressive behaviors, with authority to consent to inpatient treatment. *(Initial all that apply, and draw a line through those that do not.)*

(1) I recognize that sometimes people with Alzheimer's/dementia become aggressive, assaultive, or combative, despite good care. If this happens, and emergency or other treatment is necessary: *(Initial one or the other directly below; i.e., give your consent or do not consent. If neither is initialed, or you do not consent to voluntary admission to inpatient treatment, commitment could still occur without consideration of the provisions in the "I consent…" statement.)*

_____ I consent and authorize my mental health care agent to consent to voluntary admission to inpatient treatment for up to 14 days, if deemed appropriate by my agent and treating physician. I prefer to receive treatment in a facility specializing in Alzheimer's/dementia care to work on the reduction of my behavioral symptoms and stabilization of my condition.

_____ I do not consent to voluntary admission to inpatient treatment.

(2) _____ I want treatment from trained caregivers who know me and my history, and who know how to handle the situation.

(3) _____ My preference is to be admitted to the specialized geriatric or dementia care unit at

_____
or a similar facility, if available.

(4) ____ My preference is **not** to be admitted to the following facility or facilities:
(Optional. If you do not have a preference, draw a line through this space.)

d. Preferences regarding the financing of my care.

I know that the cost of my care could become high over the course of my illness. I have the following preferences regarding the financing of my care: *(Initial all that apply. Draw a line through those that do not.)*

_____ My hope is that my care costs will not consume the lifetime of savings I have reserved for retirement and for my children or other heirs at my death.

_____ I want my partner/spouse to maintain the standard of living we now have as much as possible.

_____ I want to preserve as much as possible of my income, assets, and savings for my partner/spouse, children, and heirs. Please use all available planning options to meet this goal, including, but not limited to: *(Cross out any that you do not agree with or that are not applicable.)*

(1) Medicaid planning.
(2) Gifting.
(3) Divorce or legal separation.
(4) Changing estate planning documents.
(5) Tax planning.

_____ Please use my income, assets, and savings to buy the highest quality private care for me.

_____ If my savings run out, I want my home to be sold to finance any further care I need.

_____ I prefer public assistance only if no other option exists for paying for my care.

e. Preferences regarding future intimate relationships.

(1) **Continuation of my intimate relationships with my partner/spouse:** *(Initial all that apply. Draw a line through those that do not. Cross out this entire section if it is not applicable.)*

_____ My intimate relationship with my partner/spouse,

*(name here)*_____, is important to both of us.

_____ I consent to maintaining our sexual relationship even in the event that we dissolve our partnership or legal domestic partnership or divorce.

_____ We want to maintain our sexual relationship for as long as possible.

_____ I know that I may forget my partner/spouse as my Alzheimer's/dementia progresses. Even if this happens, I want to continue to be intimate for as long as my partner/spouse wants to and feels comfortable doing so.

_____ If I need nursing home care, I request the privacy needed for us to continue our relationship, as required by law.

_____ I completely trust my partner/spouse to make any judgments about the continuation of our intimate relationship, including when to stop if s/he is no longer comfortable.

_____ Other preference(s):

(2) **Preferences regarding my partner/spouse having relationships outside the bounds of our partnership/marriage or other commitment, legally recognized or otherwise:** *(Initial all that apply. Draw a line through those that do not. Cross out this entire section if it is not applicable.)*

_____ I understand that my illness may last a long time, and that I likely will no longer recognize or be able to function emotionally or sexually for my partner/spouse. I also care deeply that my partner/spouse not continue to be a victim of this disease and that s/he live her/his life to the fullest. This could include becoming involved in other relationships. I would not consider this a violation of our vows to each other. Rather, I hope that s/he does seek out companionship and intimacy when I can no longer provide that in the relationship.

_____ Our moral, religious, and/or ethical values dictate that we remain faithful to one another through sickness and in health. We have both discussed this, and believe that a relationship outside our partnership/marriage or other committed relationship is not permissible and should not be pursued.

_____ I completely trust my partner/spouse to make any judgments about having relationships outside the bounds of our partnership/marriage, or other committed relationship.

_____ Other preference(s):

(3) **Preference regarding future intimate relationships for myself:** *(Initial all that apply. Draw a line through those that do not.)*

_____ I know that residents at long-term care facilities sometimes develop relationships with each other that can result in a less depressing and/or happier time for both. I am not completely opposed to my having such a relationship if, in my mental health care agent's judgment, I seem happier and am not coerced in any way.

_____ My moral, religious, and/or ethical beliefs preclude my engagement in any other relationship besides my partnership/marriage, or other committed relationship, whether legal or otherwise. I do not consent to any other intimate relationships, even if I appear to be happier at the time.

_____ Other preference(s):

f. **Preferences regarding my pet(s).** *(If you have a pet or pets, write your preferences here. If not, draw a line through this space.)*

8. CONSENT TO PARTICIPATION IN EXPERIMENTAL ALZHEIMER'S/DEMENTIA DRUG TRIALS

(If you initial a, b, or c, or any combination of a, b, or c, you must draw a line through d. If you initial d, you must draw a line through a, b, and c. Draw a line through any that you do not initial.)

a. _____ I consent to participation in any clinical drug trials for drugs that have the potential to ameliorate the symptoms of Alzheimer's/dementia or prevent the full onset of the disease. I not only hope to improve my own health, but also to contribute to research to find a cure for the disease. I give my mental health care agent full power to consent on my behalf to my participation in any such study, considering my preferences regarding side effects.

b. _____ I do not want to take medications that have the following side effects or have the following treatments: {optional}

c. _____ If my memory loss can be slowed down by the experimental drug(s), I am willing to participate in the trial even if it could lead to my earlier death. I would rather die sooner but with my memory more intact.

d. _____ I do not consent to participation in any drug trials.

9. CONSENT REGARDING SUSPENSION OF MY DRIVING PRIVILEGES

(Initial only one, and draw a line through the other.)

_____ My ability to drive is a very important part of my maintenance of independence. I enjoy driving and want to continue to do so as long as I am safe. On the other hand, I know that the time will come when I no longer have the ability to drive safely. I trust my physician(s) or other skilled health care professional(s) who are providing my treatment. *(Name of health care professional(s) here; optional. If you do not want to name someone, put lines through these spaces.)*

_____

_____

_____.

If s/he is not available, I want any other skilled health care professional to test my visual and mental acuity to determine if I am no longer safe to drive.

_____ I trust my mental health care agent's judgment on this issue. If my mental health care agent determines that I am unfit to drive, I consent to my driving privileges being suspended. If I continue to drive or attempt to drive after this, I agree to my keys being hidden or taken away from me and/or access to my car being eliminated.

10. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

(Initial all that reflect your views. Draw a line through any that do not.)

_____ I understand that circumstances beyond my control may cause me to be admitted to a health care or long-term care facility whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs or organizational policies. If I am a patient in such a health care institution or long-term care facility when this Alzheimer's/Dementia Mental Health Advance Directive takes effect, I direct that my consent to admission shall not constitute implied consent to procedures, policies, or courses of treatment mandated by religious or other policies of the institution or facility, if those procedures, policies, or courses of treatment conflict with this mental health advance directive.

_____ If the health care or long-term care facility in which I am a patient declines to follow my wishes as set out in this mental health advance directive, I direct that I be transferred, if possible, in a timely manner to another institution or facility which will agree to honor the instructions set forth in this mental health advance directive.

11. IF A COURT APPOINTS A GUARDIAN FOR ME

If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent and preferences. The appointment of a guardian of my estate or my person or any other decision-maker shall not give that guardian or decision-maker the power to revoke, suspend, or terminate this Directive or the powers of my mental health care agent, except as authorized by law.

In the event the court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

12. OTHER DOCUMENTS

In planning for my health care, estate, and potential incapacity, I have executed the following documents: *(Initial and provide information for all that apply. Draw a line through those that do not.)*

_____ **General Power of Attorney:** *(Name and contact info of primary agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Durable Power of Attorney for Finances:** *(Name and contact info of primary agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Durable Power of Attorney for Health Care:** *(Name and contact info of primary health care agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Living Will/Health Care Directive/Directive to Physicians:** *(Name and contact info of person who has a copy.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Portable Orders for Life-Sustaining Treatment (POLST):**
(Optional; name and contact information of person who has access to your POLST.)

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Other Document:** *(Optional; name here: _____.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

13. SUMMARY AND SIGNATURE

I understand what this document means. I make this document of my free will, and I believe I have the mental and emotional capacity to do so.

By signing here, I indicate that I understand the purpose and effect of this document, and that I am giving my informed consent to the treatments and/or admission that I have consented to, or that I have authorized my agent to consent to, in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under RCW chapter 7.70 in the State of Washington or applicable law in other states.

_____ _____

Signature of person making this document. Date

(Sign only in the presence of two witnesses.)

14. STATEMENT OF WITNESSES

This directive was signed and declared by

(Print your name – not the names of your witnesses – on the following line.)

_____ to be her/his directive. It was signed in our presence at her/his request. We declare that at the time of the creation of this directive

(Print your name – not the names of your witnesses – on the following line.)

_____ is personally known to us and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

a. A person designated to make medical decisions on the principal's behalf.
b. A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed.
c. An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident.
d. A person who is related by blood, marriage, legal domestic partnership, or adoption to the person, or with whom the person making this document has a dating relationship as defined in RCW 26.50.010 in the State of Washington or applicable law in other states.
e. An incapacitated person.
f. A person who would benefit financially if the principal undergoes mental health treatment.
g. A minor.

WITNESS 1

_____ _____

Signature Date

_____ _____

Printed Name Phone

_____

Address

WITNESS 2

_____ _____

Signature Date

_____ _____

Printed Name Phone

_____

Address

15. RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT: DO NOT FILL OUT THIS PAGE UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE.

16. REVOCATION OF MY ALZHEIMER'S DISEASE/DEMENTIA MENTAL HEALTH ADVANCE DIRECTIVE

(Initial either 1 or 2, and draw a line through the one you did not initial. If you initial 1, then list the sections that you are revoking by number. For example: "Sections 2, 6, and 7.")

_____ 1. I am revoking the following part(s) of this directive (specify):

_____

_____

_____

_____

_____ 2. I am revoking this entire directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

_____ _____

Signature of person who made this document Date