DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

MAR 28 2008

Robin Arnold-Williams, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

Dear Ms. Arnold-Williams:

The Department of Social and Health Services submitted Washington Title XIX State Plan Transmittal 08-003 to the Centers for Medicare & Medicaid Services (CMS) for review and approval. This amendment updates the mental health advanced directive in attachment 4.34, pages 1 through 20.

We have completed our review of the transmittal along with the additional information submitted on March 5, 2008. The amendment is approved effective January 1, 2008, as requested.

If you have additional questions or require further assistance, please contact Lydia Skeen at (206) 615-2339 or Lydia.Skeen@cms.hhs.gov.

Sincerely,

Arthur W. Pagan
BLR

Arthur W. Pagan
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Doug Porter, Assistant Secretary, Health and Recovery Services Adminisntration
Richard Kellogg, Director, Mental Health Division, Department of Social and Health Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-003**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
Jan. 1, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 $ 0
b. FFY 2009 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.34-A, page 2, 1, 5, 6 (P+I)
Supplement A to Attachment 4.34-A, pages 1-20 (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.34-A, page 2, 1, 5, 6 (P+I)

10. SUBJECT OF AMENDMENT:
Advance Directives – Mental Health

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robin Arnold Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
Jan. 7, 2008

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 01-08-08

18. DATE APPROVED: MAR 28 2008

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
Arthur W. Pagan - BLR

21. TYPED NAME:
Arthur W. Pagan

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
Pen + Ink changes authorized by the state on 3/5/08.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

1. Introduction

a. The Patient Self-Determination Act, as part of OBRA 1990, requires that each state develop a written description of the law of the state concerning advance directives. The following is a summary of Washington law.

b. Applicable law in this area is primarily statutory. Washington recognizes three types of advance directives:
(1) A Directive to Physicians (or "Living Will");
(2) A Durable Power of Attorney for Health Care; and
(3) A Mental Health Advance Directive.

The related subjects of informed consent and anatomical gifts will also be summarized.

2. Health Care Directives

a. Washington Natural Death Act ("Act") provides for the use of health care directives. The pertinent parts are codified at RCW 70.122.010 - 100. Under the Act, a patient may direct that his/her life not be artificially prolonged if he/she is suffering from an incurable injury, disease or illness that has been certified to be terminal, when such measures would only prolong the moment of death.

b. Two physicians must diagnose and certify in writing that the patient is afflicted with a terminal condition. One of the two physicians must be the attending physician and both must personally examine the patient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE (cont.)

c. The client has a right to create an Advance Directive for psychiatric care which complies with RCW 71.32 and the requirements of 42 CFR §422.128, Subpart I of part 489 and 42 CFR §438.6 as they pertain to psychiatric care. The Advance Directive must be a written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both.

d. Before a directive is effectuated, the written certification of the diagnosis shall be attached to the directive and made a permanent part of the patient's medical records. The directives must be in writing, and signed and witnessed by two persons who are not related to the signer by blood or marriage, and who, at the time of signing are not entitled to any portion of the signer's estate by will, codicil or operation of law, or have a claim against the estate. The witness may also not be treating physicians, the physicians' employees, or employees of the health care facility where the signer is a patient.

e. A directive may be revoked by destroying it with the intent of revoking it. A revocation is effective without regard to competency. A living will may also be revoked verbally or in writing, but the cancellation does not take effect until it is made known to the attending physician. If the person is comatose or is incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until the patient is able to communicate with the attending physician.

f. There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation, unless that person has actual or constructive notice of the revocation.

g. No physician, health facility, or licensed health personnel (acting under the direction of a physician), acting in good faith and within the requirements of the Act shall be held civilly, criminally or professionally liable for withholding or withdrawing life-sustaining procedures.

h. No physician and no licensed health personnel acting in good faith under the direction of a physician may be held civilly or criminally liable for failing to effectuate a directive. However, if the physician refuses to effectuate the directive, the physician must make a good faith effort to transfer the patient to a physician who will effectuate the directive.

i. The Act does not authorize mercy killings or other affirmative acts or omissions to end life, other than to permit the natural process of dying. The Act also provides criminal penalties for violation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE (cont.)

5. Anatomical Gifts (cont.)

c. An anatomical gift may be made by will or separate document. The document may or may not be delivered to the donee, without affecting the gift's validity. The document must be signed and witnessed by two persons. The document may be amended or revoked orally or in writing, or if made by will, in the same manner as an amendment or revocation of a will under Washington law.

6. Mental Health Advance Directive

a. The client has the right to create a Mental Health Advance Directive which complies with chapter 71.32 RCW as it exists on January 1, 2008, and the requirements of 42 CFR 422.128, subpart I of part 489, and 42 CFR 438.6 as they pertain to psychiatric care. The Advance Directive must be a written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both.

7. Forms

A. RCW 70.122.030 provides in part: ...The directive may be in the following form, but in addition may include other specific directions.

HEALTH CARE DIRECTIVE

Directive made this _____ day of _____ (month, year).

I, _____having the capacity to make health care decisions, willfully, and voluntarily make known 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 be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, 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 by using this form that a 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, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE (cont.)

7. Forms (cont.)

b. 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 and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

c. If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.

I DO NOT want to have artificially provided nutrition and hydration.

d. 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.

e. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

f. I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

g. It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed _____

City, County, and State of Residence

The declarer has been personally known to me and I believe him/her to be of sound mind.

Witness _____

Witness _____

B. To comply with chapter 71.32 RCW, the Mental Health Advance Directive must be in essentially the form described in Supplement A to Attachment 3.34-A; any other form must meet the requirements in chapter 71.32 RCW.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Example of Mental Health Advance Directive Form

NOTICE TO PERSONS CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

(1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.
IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.

If you choose to complete and sign this document, you may still decide to leave some items blank.

(2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

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YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.

(5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

(6) You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

(7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) You may ask the court to rule on the validity of your directive.

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PART I.

STATEMENT OF INTENT TO CREATE A MENTAL HEALTH ADVANCE DIRECTIVE

I, _____being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. 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.

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. If I have not expressed a choice, my agent should make the decision that he or she determines is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, 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 understand that there are some circumstances where my provider may not have to follow my directive.

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PART II.

WHEN THIS DIRECTIVE IS EFFECTIVE

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I intend that this directive become effective *(YOU MUST CHOOSE ONLY ONE)*:

_____Immediately upon my signing of this directive.

_____If I become incapacitated.

_____When the following circumstances, symptoms, or behaviors occur:

_____

_____

_____

_____

_____

PART III.

DURATION OF THIS DIRECTIVE

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I want this directive to *(YOU MUST CHOOSE ONLY ONE)*:

_____Remain valid and in effect for an indefinite period of time.

_____Automatically expire _____ years from the date it was created.

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PART IV.

WHEN I MAY REVOKE THIS DIRECTIVE

YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.

I intend that I be able to revoke this directive *(YOU MUST CHOOSE ONLY ONE):*

_____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 may receive 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.

PART V.

PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS

A. Preferences and Instructions About Physician(s) to be Involved in My Treatment

I would like the physician(s) named below to be involved in my treatment

decisions:

Dr. _____

Contact information:_____

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Dr. _____

Contact information:_____

I do not wish to be treated by

Dr._____

B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____

Profession _____

Contact information _____

Name _____

Profession _____

Contact information _____

C. Preferences and Instructions About Medications for Psychiatric Treatment *(initial and complete all that apply)*

_____I consent, and authorize my agent (if appointed) to consent, to the following medications:

_____

_____

_____

_____

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_____I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

_____

_____

_____I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include

_____

_____

and these side effects can be eliminated by dosage adjustment or other means.

_____I am willing to try any other medication the hospital doctor recommends.

_____I am willing to try any other medications my outpatient doctor recommends.

_____I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

_____

_____

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Other Medication Preferences or Instructions

I have the following other preferences or instructions about medications

Preferences and Instructions About Hospitalization and Alternatives

(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

_____In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

_____I would also like the interventions below to be tried before hospitalization is considered:

_____Calling someone or having someone call me when needed.

Name:_____

Telephone:_____

_____Staying overnight with someone.

Name:_____

Telephone:_____

_____Having a mental health service provider come to see me.

_____Going to a crisis triage center or emergency room.

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_____Staying overnight at a crisis respite (temporary) bed.

_____Seeing a service provider for help with psychiatric medications

_____Other, specify:_____

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Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days *(not to exceed 14 days)*
(Sign one):

_____If deemed appropriate by my agent (if appointed) and treating physician.

_____
(Signature)

or

_____Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

_____

_____

_____
(Signature)

or

_____I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

_____
(Signature)

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Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

_____

_____

I do not consent to be admitted to the following hospitals:

_____

_____

E. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered *(initial all that apply)*:

_____ "Talk me down" one-on-one
_____ More medication
_____ Time out/privacy
_____ Show of authority/force
_____ Shift my attention to something else
_____ Set firm limits on my behavior
_____ Help me to discuss/vent feelings
_____ Decrease stimulation
_____ Offer to have neutral person settle dispute
_____ Other, specify _____

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F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen *(choose "1" for first choice, "2" for second choice, and so on)*:

_____Seclusion

_____Seclusion and physical restraint (combined)

_____Medication by injection

_____Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are *(sign one)*:

_____I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

_____

(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

_____

(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions: _____

_____

_____

(Signature

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____

Name: _____

Name: _____

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

_____

In case of emergency, please contact:

Name:_____Address:_____

Work telephone:_____ Home telephone:_____

Physician: _____ Address:_____

Telephone: _____

The following may help me to avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of the hospital or crisis unit can help me by doing the following:

_____

J. Refusal of Treatment

I do not consent to any mental health treatment.

_____

(Signature)

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PART VI.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(Fill out this part only if you wish to appoint an agent or nominate a guardian.)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name:_____ Address:_____

Work telephone:_____ Home telephone:_____

Relationship: _____

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name:_____ Address:_____

Work telephone:_____ Home telephone: _____

Relationship: _____

C. When My Spouse is My Agent ***(initial if desired)*****:**

_____If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

_____

_____

E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

_____

_____

F. Preference as to Court-Appointed Guardian

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

Name:_____Address:_____

Work telephone:_____ Home telephone: _____

Relationship: _____

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

_____

(Signature required if nomination is made)

PART VII.

OTHER DOCUMENTS

(Initial all that apply)
I have executed the following documents that include the power to make decisions regarding health care services for myself:

_____ Health care power of attorney (chapter 11.94 RCW)

_____ "Living will" (Health care directive; chapter 70.122 RCW)

_____ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

PART VIII.

NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(Fill out this part only if you wish to provide nontreatment instructions.)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name:_____ Address:_____

Day telephone:_____ Evening telephone: _____

Name:_____Address:_____

Day telephone:_____ Evening telephone: _____

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

C. Additional Preferences and Instructions:

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PART IX.

SIGNATURE

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 to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature: _____ Date: _____

Printed Name: _____

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal 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, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
(E) An incapacitated person;
(F) A person who would benefit financially if the principal undergoes mental health treatment; or
(G) A minor.

Witness 1: Signature: _____ Date: _____

Printed Name: _____

Telephone _____

Address _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Witness 2: Signature: _____ Date: _____

Printed Name: _____

Telephone _____

Address _____

PART X.

RECORD OF DIRECTIVE

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

_____

_____

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

PART XI.

REVOCATION OF THIS DIRECTIVE

(Initial any that apply):

_____I am revoking the following part(s) of this directive (specify):

_____

_____

_____

_____

_____I am revoking all of this 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: _____Date: _____

Printed Name:_____

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE