DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Iowa Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Iowa Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Iowa Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Iowa state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:
LIVING WILL DECLARATION
and Personal Instructions

(*IC Title IV: Subtitle 2: Ch.144A: §144A.1 to §144A.12*)

1. INTRODUCTION: *Iowa statutes provide for an adult, having capacity to leave individual health care instructions in a living will. The following pages constitute such instructions. You should complete this section with directions that are as clear as possible, to better guide others in the event you are unable to make or communicate your own health care wishes at any time in the future.*

DECLARATION

2. Be it known that I _____, herein declare that, if I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that:

(*initial only one*)

A) _____ My life should *not* be prolonged by the administration of life-sustaining procedures. Therefore, if I am unable to otherwise participate in my health care decisions, I direct my attending physician to *withhold or withdraw* life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

B) _____ I am *unsure* of my desires about the use of life-sustaining procedures in a terminal or permanently unconscious condition.

C) _____ I direct that life-sustaining procedures should be *given* to me, even if I am in a terminal or permanently unconscious condition.

3. Other Additional Directions (if any): _____

_____

_____

_____

_____

By signing below, I indicate that I am fully aware of the contents of this document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Do not sign until in the presence of <u>two</u> qualified, adult witnesses; see below – unless signed before a notary public. Both are recommended.*)

4. Signed: _____

Date: _____

Address: _____

Statement of Witnesses

5. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has affixed (or caused to be affixed) his/her signature or mark in our mutual presence. It appears that this document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption (to the third degree of consanguinity), nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician or another health care provider, nor an employee of the physician or other health care provider or of any current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the individual, and to the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will or codicil now existing, nor by any other operation of law.

6. Witness: _____
Printed Name: _____
Address: _____

7. Witness: _____
Printed Name: _____
Address: _____

SECTION II:
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

(*IC Title IV. Sub.2: Ch.144B §144B.1 to §144B.12*)

8. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel*.

9. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

10. Do I hereby designate:

Name of Agent: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). This power exists only when I am unable, in the judgment of my attending physician, to make health care decisions. The attorney-in-fact (my agent") must act consistently with my desires as stated in this document or otherwise made known.

11. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

12. Name of Alternate #1:_____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

13. Name of Alternate #2: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

14. Specific Agent Powers and Authorities:

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the law of this state, to:

A. Consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

B. Make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to the provision of any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

C. Examine my medical records and to consent to disclosure of such records.

D. To act in every other way in making decisions regarding my health care and treatment as I could myself when possessed of full capacity.

15. Additional Agent Powers and Authorities: My agent is further empowered and directed as follow, below:

_____
_____
_____
_____

16. Agent Authority Limitations: This power is subject to any statement of my desires and any limitations included, below in this document:

_____
_____
_____
_____

17. Agent(s) Statement and Acknowledgment of Appointment:

I herein acknowledge my appointment as health care agent in behalf of the Principal, by whom this document has been created. I recognize that I must act consistently with the Principal's desires as stated in this document, to me directly, or as otherwise made known.

18. _____ _____
Agent's Signature Date

19. _____ _____
Alternate #1 Signature Date

20. _____ _____
Alternate #2 Signature Date

21. By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Do not sign until in the presence of two qualified, adult witnesses; see below – unless signing before a notary public.*)

22. Signed:_____ Date: _____

At: (City) _____ (State) _____

QUALIFIED WITNESSES

23. This Power of Attorney for Health Care may not be upheld unless it is signed by two adult witnesses. Notarization is not required, but is also recommend as witnesses may become unavailable in the future. Your witnesses must qualify to sign the following statement:

Statement of Witnesses

24. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has affixed (or caused to be affixed) his/her signature or mark in our mutual presence. It appears that this document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood (within the third degree of consanguinity), marriage, or adoption, nor am I directly responsible for his or her medical care or costs. I am not the agent or an alternate or successor named in this document. Further, I am not the attending physician, nor an employee of the physician or other health care provider, nor of a current care facility, nor am I a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the principal, and to the best of my knowledge I am not entitled to any part of the principal's estate upon his or her death under a will now existing nor by any other operation of law.

25. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

26. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

27. ***State of Iowa***,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

28. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my agent and alternate agents, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My agent(s) and my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

29. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ________________________________
Address ________________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ________________________________

Name: ________________________________
Address: ___________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ____________________________

Name: ________________________________
Address ________________________________
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E-mail: ________________________________

Name: ________________________________
Address: ___________________________
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Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ____________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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