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#ProBonoWeek #LALawLibrary

ELDER CARE: PLANNING FOR THE FUTURE

CASBO Session RET21

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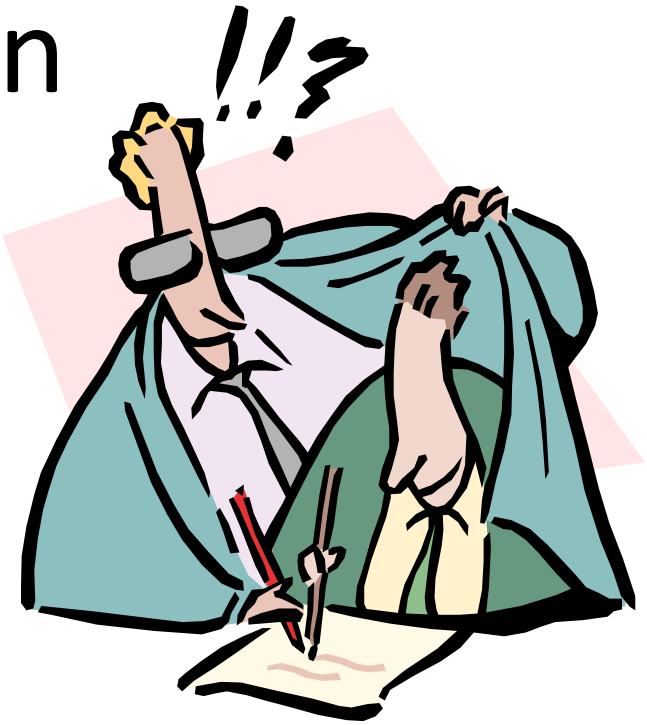
Capacity to Make Decisions

- Legal and financial decisions
- Health decisions
- Due Process in Competency Determinations Act

Surrogate Decision making



Surrogate Decision Making

- Durable Power of Attorney for Finance

POWER OF ATTORNEY FOR FINANCES

I,_____ appoint_____, as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

INITIAL

____	**(A)**	**Real property transactions.**
____	**(B)**	**Tangible personal property transactions.**
____	**(C)**	**Stock and bond transactions.**
____	**(D)**	**Commodity and option transactions.**
____	**(E)**	**Banking and other financial institution transactions.**
____	**(F)**	**Business operating transactions.**
____	**(G)**	**Insurance and annuity transactions.**
____	**(H)**	**Estate, trust and other beneficiary transactions.**
____	**(I)**	**Claims and litigation.**
____	**(J)**	**Personal and family maintenance.**
____	**(K)**	**Benefits from social security, medicare, medicaid, or other governmental programs, or civil or military service.**
____	**(L)**	**Retirement plan transactions.**
____	**(M)**	**Tax matters.**
____	**(N)**	**ALL OF THE POWERS LISTED ABOVE.**

YOU DO NOT NEED TO INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

This power of attorney shall take effect upon my incapacity. My incapacity shall be determined by my primary care physician in writing.

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

This power of attorney will continue to be effective even though I become incapacitated.

Signed this _____ day of _____, 2004

_____(your signature)

_____(your social security number)

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

Surrogate Decision Making

- Joint Accounts
- Representative Payee

TRUSTS

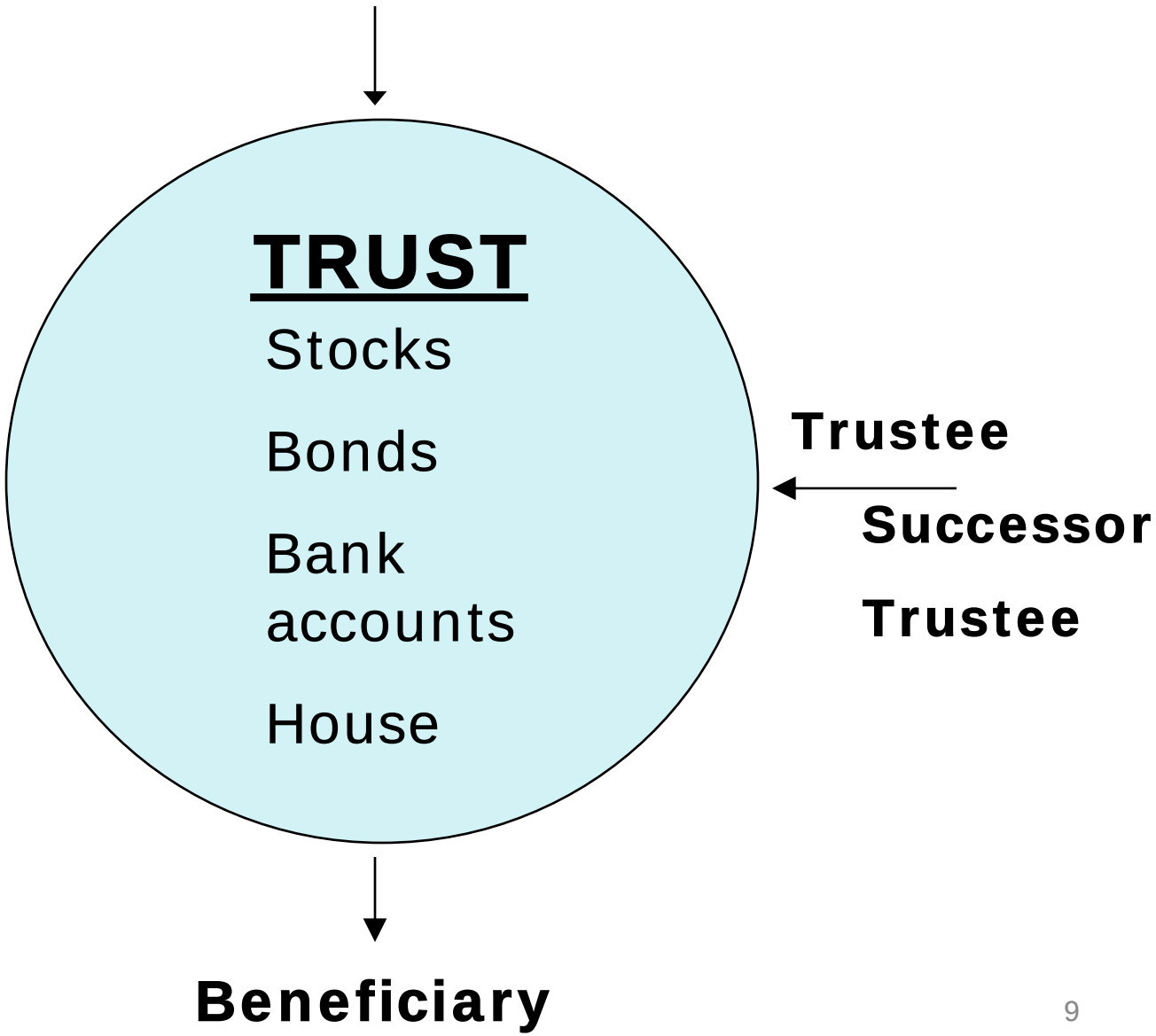
ASSETS:

Stocks

Bonds

Bank accounts

House



Wills

- Prepared Will/Statutory Will
- Holographic Will
- Intestate- no will

Health Decisions

- Advance Directives
- LACMA/LACBA Guidelines
- Emergency DNR Form
- POLST

California Power of Attorney for Health Care

My name is: _____.

Part 1 - NAMING YOUR AGENT *The following persons **cannot** be selected as your agent:*

Your primary physician.

An employee of the health care institution or residential care facility where you receive care (unless you are related to that person).

AGENT

Name: _____

Address: _____

Work Phone: (_____)_____ Home Phone: (_____)_____

My agent will have authority to make health care decisions for me to the extent that I now have authority to make my own health care decisions. This authority includes the authority to:

1) to accept or refuse treatment, nutrition and hydration,

2) to choose a particular physician or health care facility

3) to receive, or consent to the release of, medical information and records.

Also, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains. The agent's actions must be consistent with my will or trust, and with any funeral arrangements or other arrangements which I have made. (Cross this out if you do not wish your agent to have this authority.)

I make the following instructions to my agent:

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued:

(1) if I am in an irreversible coma or persistent vegetative state; or

(2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or

(3) under any other circumstances where the burdens of treatment outweigh the expected benefits. In making decisions about life sustaining treatment, I want my agent to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

If this statement reflects your desires, initial here: _____

Part 2 - HEALTH CARE INSTRUCTIONS (For individuals without an agent or for when no agent is available.)

If I am in an irreversible coma or persistent vegetative state; or if I am terminally ill and the provision of life sustaining procedures would serve to artificially delay the moment of my death; then, I make the following instruction, by placing my signature in front of my request:

_____ I authorize all treatments to prolong my life for as long as possible.

_____ I authorize the treatment needed to provide me with food, water, and pain control, and to keep me comfortable, but otherwise do not authorize active treatment for my medical conditions.

_____ I authorize the treatment needed to provide me with pain control and to keep me comfortable, but do not authorize the provision of food or water through a tube or an intravenous line, and do not authorize active treatment for my medical conditions.

SIGNATURE OF PRINCIPAL (Sign and date form here in front of witnesses or a notary.)

Date: _____ Signature: _____

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

POLST

Physician's Order for Life Sustaining Treatment

1. CPR
2. Intubation and Mechanical Respiration
3. Artificial Nutrition and Hydration

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — Cardiopulmonary Resuscitation (CPR): *Person has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — Medical Interventions: *Person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — Signatures and Summary of Medical Condition:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Conservatorships

- Probate
- Alzheimer’s
- LPS

Caregiver Resources

- Alzheimer's Greater Los Angeles www.alzgla.org 844-435-7529
- Bet Tzedek Legal Services

  www.bettzedek.org 323-939-0506
- Los Angeles Caregiver Support Center www.fcsgero.com
- LA City Department of Aging www.aging.lacity.org
- Family Caregiver Alliance www.caregiver.org
- Geriatric Case Managers