IOWA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR IOWA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part One. The **Iowa Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care — including decisions about life- sustaining procedures — if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. The person you choose is called your "agent." You may also hear the term "attorney-in-fact."

You may also appoint a designee to make choices regarding the final disposition of your remains.

Part Two. The **Iowa Declaration** is your state's living will. It lets you state your wish to have life-sustaining procedures withheld or withdrawn in the event that you develop a terminal condition and can no longer make your own medical decisions. If this is not your wish, you should not fill out part two.

Part Three contains the signature and witness provisions so that your document will be effective.

Following the advance directive form is an **Iowa Organ Donation Form**

You may complete Part One, Part Two, or both, depending on your advance planning needs. **You must complete Part Three**.

How do I make my Iowa Advance Health Care Directive legal?

The law requires that you sign and date your advance directive. You must also have it witnessed in one of two ways:

Option 1: Have your signature witnessed by a notary public,

OR

Option 2: Sign your document, or direct another to sign it, in the presence of two witnesses. These witnesses **cannot** be:

- your doctor or other treating health-care provider,
- an employee of your treating health-care provider,
- the person you appointed as your agent, or
- an individual who is less than 18 years of age.

At least one of your witnesses must be a person who is not related to you by blood, marriage, or adoption within the third degree of consanguinity. This means that your witness must be more distantly related to you by blood or adoption than your uncles, aunts, nephews, nieces, great-grandparents, and great-grandchildren or by marriage than your step uncles, step aunts, step nephews, step nieces, step great grandparents, and step great-grandchildren.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

The person you appoint as your agent cannot be:

- your doctor or other treating health-care provider, or
- an employee of your treating health-care provider, unless he or she is related to you by blood, marriage, or adoption within the third degree of consanguinity.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your **Iowa Durable Power of Attorney** goes into effect when your doctor determines that you are no longer able to make or communicate your health-care decisions.

Your **Iowa Declaration** goes into effect when your doctor determines that you have a terminal condition and can no longer make your own health-care decisions or that you are permanently unconscious.

You retain the primary authority for your healthcare decisions as long as you are able to make

your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Iowa as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Durable Power of Attorney for Health Care or Declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective when you, or someone else, communicate this revocation to your attending physician.

If you appoint your spouse as your agent and your marriage ends, your agent's power is automatically revoked.

If you decide to declare a designee to make choices regarding the final disposition of your remains, you may only revoke that power in a signed writing.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

Part One: Durable Power of Attorney for Health Care

I hereby designate _____, of
(name of attorney-in-fact)

_____
(address)

_____
(city) (state) (zip code)

_____
(home telephone number) (work telephone number)

as my attorney-in-fact (my "agent") and give to my agent the power to make health-care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health-care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

In the event the person I designate above is unable, unwilling or unavailable to act as my agent, I hereby designate

_____, of
(name of alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home telephone number) (work telephone number)

as my agent.

INSTRUCTIONS

POWERS OF YOUR AGENT

OPTIONAL

PRINT THE NAME OF THE PERSON YOU WOULD LIKE TO DESIGNATE TO MAKE DECISIONS REGARDING THE FINAL DISPOSITION OF YOUR REMAINS

Part One: Durable Power of Attorney for Health Care (continued)

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the law of this state, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to 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. This power is subject to any statement of my desires and any limitations included in this document.

My agent has the right to examine my medical records and to consent to disclosure of such records.

Final Disposition Declaration (optional)

I hereby designate _____ as my designee under the Iowa Final Disposition Act. My designee shall have the sole responsibility for making decisions concerning the final disposition of my remains and the ceremonies to be performed after my death. This final disposition declaration hereby revokes all prior final disposition declarations. This designation becomes effective upon my death.

My designee shall act in a manner that is reasonable under the circumstances.

I may revoke or amend this final disposition declaration at any time. I agree that a third party (such as a funeral or cremation establishment, funeral director, or cemetery) who receives a copy of this final disposition declaration may act in reliance on it. Revocation of this final disposition declaration is not effective as to a third party until the third party receives notice of the revocation. My estate shall indemnify my designee and any third party for costs incurred by them or claims arising against them as a result of their good faith reliance on this declaration.

Part One: Durable Power of Attorney for Health Care (continued)

Optional instructions:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Part Two: Declaration

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 my life not be prolonged by the administration of life-sustaining procedures. If I am unable to 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.

Additional, specific directions (if any):

_____

_____

_____

_____

Limitations or special wishes, if any, list below:

_____

_____

_____

_____

_____

_____

_____

_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

SIGN AND DATE YOUR FORM

YOUR SIGNATURE MUST BE EITHER WITNESSED OR NOTARIZED

WITNESS # 1

WITNESS # 2

ONE WITNESS MUST ALSO AGREE WITH THIS STATEMENT AND SIGN HERE

OR

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

Part Three: Execution

Signed this _____ day of _____, _____.
(day) (month) (year)

Signature _____

Alternative No. 1, Witnesses:
The declarant is known to me and voluntarily signed this document in my presence.

Witness _____

Address _____

_____

Witness _____

Address _____

_____

I further declare that I am not a relative of the declarant by blood, marriage, or adoption within the third degree of consanguinity.

_____
(signature of first or second witness)

- OR -

Alternative No. 2, Acknowledgment by Notary Public:

On _____, before me came _____,
(Date) (name of declarant)

whom I know to be such person, and the declarant did then there execute this declaration.

Sworn to before me this _____ day of _____, 20_____.

_____
(notary public)

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

IOWA ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney-in-fact, guardian, or other agent, or your family may have the authority to make a gift of all or part of your body under Iowa law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney-in-fact, guardian, other agent, or family to do so.
___ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____Pursuant to Iowa law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

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