HAYSMED

Durable Power of Attorney for Healthcare Decisions

■ ***Take a copy of this with you whenever you go to the hospital or on a trip*** ■

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. The person you choose will be your Agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the Agent's name.

I,_____, DOB:_____, SS# _____ (optional), appoint the person named in this document to be my Agent to make my healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My Agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My Agent may not appoint anyone else to make decisions for me. My Agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My Agent shall not be responsible for any costs associated with my care. I give my Agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life−prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My Agent is authorized to:

- Consent, refuse consent, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well−being;
- Request, receive, and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.
- Execute any appropriate authorizations for the use or disclosure of my protected health information.

In exercising this power, I expect my Agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my Healthcare Treatment Directive (*see reverse side*).

If you DO NOT want the person (Agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.

Agent's name_____ Home Phone_____ Cell Phone_____

Address _____ Relationship to you _____

Alternate Agent

If the person designated above is unavailable or ceases to act as my Agent due to death, resignation, removal, disability or incapacity, I appoint the following person to so serve, in the order listed below, as my Alternate Agent, with all the same powers granted to the originally−appointed Agent:

First Alternative Agent's Name _____
Address_____
Relationship to you _____ Home Phone _____ Cell Phone_____

Second Alternative Agent's Name _____
Address_____
Relationship to you _____ Home Phone _____ Cell Phone_____

Effective Date of Appointment :
This Durable Power of Attorney for Healthcare Decisions shall become effective immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity.

SIGN HERE :
Please ask two persons to witness your signature who are at least 18 years old and are not related to you by blood or marriage, entitled to any portion of your estate according to the laws of intestate succession or under any will or codicil hereto, or directly financially responsible for your medical care.

Signature _____ Date _____/_____/_____

Witness_____ Date_____/_____/_____ Witness_____ Date_____/_____/_____

Printed Name of Witness _____ Printed Name of Witness_____

NOTARIZATION:

On this _____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public Signature _____

Commission Expires _____/_____/_____

Notary Seal:

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Healthcare Treatment Directive

■ ***If you only want to name a Durable Power of Attorney for Healthcare Decisions, draw a large X through this page.***■

I,_____ (Declarant), DOB:_____, SS# _____ (optional) want everyone who cares for me to know what healthcare I want.

I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

I want my doctor to try treatments/interventions on a time−limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments/interventions withdrawn when they cannot achieve this goal or become too burdensome to me.

I want my dying to be as natural as possible. Therefore, I direct that no treatment including: surgery, dialysis, heart−lung resuscitation "CPR", antibiotics, mechanical ventilator (respirator), or tube feeding (food and water delivered through a tube in the veins, nose, or stomach) be given just to keep my body functioning when I have

- a condition that will cause me to die soon, or
- a condition so bad (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me.

If you do not agree with one or other of the above statements, draw a line through the statement and put your initials at the end of the line.

An acceptable quality of life to me is one that includes the following capacities and values. (Describe here the things that are most important to you when you are making decisions to choose or refuse life−sustaining treatments.)

_____

_____

Examples: ❖ recognize family or friends ❖ make decisions ❖ communicate
❖ feed myself ❖ take care of myself ❖ be responsive to my environment

I also want: _____

_____

Examples: ❖ to donate my organs ❖ Hospice care ❖ to die at home (if possible)

In facing the end of my life, I expect my Agent (if I have one) and my caregivers to honor my wishes, values, and directives.

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you, your doctors, family, friends, and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date below.
Initials_____ Date _____/_____/_____ Initials_____ Date _____/_____/_____ Initials_____ Date _____/_____/_____

SIGN HERE :
I understand the full impact of this declaration and I am emotionally and mentally competent to make this declaration. This declaration shall be clear and convincing evidence of my intentions.

Signature _____ Date _____/_____/_____

The Declarant has been personally known to me and I believe the Declarant to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant. I am not related to the Declarant by blood or marriage, entitled to any portion of the estate of the Declarant according to the laws of intestate succession or under any will of Declarant or codicil thereto, or directly financially responsible for Declarant's medical care.

Witness Signature_____ Date_____/_____/_____ Printed Name of Witness _____

Witness Signature_____ Date_____/_____/_____ Printed Name of Witness _____

NOTARIZATION:
On this _____ day of _____, in the year of _____, personally appeared before me the person signing, known to me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public Signature _____

Commission Expires _____/_____/_____

Notary Seal:

Discrimination is Against the Law

Hays Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Hays Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hays Medical Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Hays Medical Center provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Director of Clinical Care Coordination at 785.623.5297, or the Operator at 785.623.5000.

If you believe that Hays Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Chief Legal Officer
Hays Medical Center
2220 Canterbury Drive
Hays, Kansas 67601
Telephone Number: 785.650.2759
TTY/TDD or State Relay Number: 800.766.3777 (V/T); or Dial 711
Fax: 785.623.5524
Email: joannah.applequist@haysmed.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joannah Applequist, Chief Legal Officer, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1−800−368−1019, 800−537−7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services are available to you free of charge. Call 1–855-429-7633 (TTY: 1–800-766-3777).

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1–855-429-7633 (TTY: 1–800-766-3777).

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1–855-429-7633 (TTY: 1–800-766-3777).

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1–855-429-7633 (TTY: 1–800-766-3777)。

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1–855-429-7633 (TTY: 1–800-766-3777).

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1–855-429-7633 (TTY: 1–800-766-3777) 번으로 전화해 주십시오.

LAOTIAN
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1–855-429-7633 (TTY: 1–800-766-3777).

ARABIC
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-429-7633 (TTY: 1-800-766-3777).

TAGALOG
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1–855-429-7633 (TTY: 1–800-766-3777)

BURMESE
သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဉ်ဆောင်ရွက်ပေးပါမည်။
ဖုန်းနံပါတ် 1–855-429-7633 (TTY: 1–800-766-3777) သို့ ခေါ်ဆိုပါ။

FRENCH
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1–855-429-7633 (TTY: 1–800-766-3777).

JAPANESE
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1–855-429-7633 (TTY: 1–800-766-3777)まで、お電話にてご連絡ください。

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855-429-7633 (телетайп: 1–800-766-3777).

HMONG
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1–855-429-7633 (TTY: 1–800-766-3777).

PERSIAN (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY: 1–800-766-3777) 1–855-429-7633 تماس بگیرید.

SWAHILI
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1–855-429-7633 (TTY: 1–800-766-3777).

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