Poder Notarial Duradero

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Un formulario de poder notarial permite que usted seleccione a un amigo o pariente de confianza para que le ayude con sus decisiones sobre sus finanzas y/o atención de la salud. (Formularios e Instrucciones)

Form attached:
Poder Notarial Duradero para la Salud (NJP Planning 501 ES)

Form attached:
Poder Notarial Duradero para Finanzas (NJP Planning 500 ES)

¿Qué es un poder notarial?

Un formulario de poder notarial permite que usted seleccione a un amigo o pariente de confianza para que le ayude con sus decisiones sobre sus finanzas y/o atención de la salud. Después de que usted lo firme, la persona que usted seleccione llevará el poder notarial a sus proveedores médicos, banco, escuela y otros lugares para tomar decisiones y firmar contratos tal como si fuera usted.

El amigo o pariente de confianza que usted seleccione para ayudarle con sus decisiones sobre finanzas y/o atención de la salud se llama su “representante”.

Un poder notarial es “duradero” si dice que su representante puede usarlo incluso si usted se enferma o se lesiona y no puede tomar decisiones por sí mismo(a).

¿Necesito firmar mi poder notarial delante de un notario?

Debería firmar sus formularios de Poder Notarial Duradero ante notario. Si no puede encontrar un notario, puede firmarlo ante dos testigos "desinteresados". Sin embargo, se prefiere la notarización, especialmente para un Poder Notarial Duradero para Finanzas.

¿Qué debo hacer después de firmarlo?

Después de firmar sus formularios, haga 2 copias. Dele el formulario original a su representante, dele una copia a su representante suplente y conserve la segunda copia para usted.

¿Puedo cambiar mi poder notarial y elegir un nuevo representante?

Sí. Usted puede cancelar (puede revocar) su poder notarial en cualquier momento mediante aviso por escrito a su representante.

Después de revocar su poder notarial antiguo, puede firmar un formulario de poder notarial nuevo para seleccionar a un representante diferente. En su nuevo poder, asegúrese de decir que todos los poderes notariales anteriores quedan revocados.

¿Y si el banco no quiere aceptar mi formulario de poder notarial?

A veces, un banco u otro negocio le dirá a su representante que no aceptará su formulario de poder. Hay 2 motivos comunes por los que esto puede ocurrir:

1. **Formulario no notarizado.** La ley de Washington dice que su formulario de poder notarial es válido cuando lo firme ante notario **o** ante dos testigos desinteresados. Pero algunos bancos u otros negocios insisten en que **tiene** que estar notarizado. Usted puede firmar un nuevo formulario ante notario. Pero su representante también puede pedir hablar con el departamento legal de la institución y referirles al Código Revisado de Washington (RCW) 11.125.050 (https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.050). Si su formulario fue debidamente atestiguado por dos testigos desinteresados en lugar de ser notarizado, el formulario sigue siendo válido según la ley de Washington. Su banco **debería** aceptarlo.
2. **No es el formulario "correcto".** Los formularios de poder notarial en esta página son válidos conforme a la ley de Washington, pero algunos bancos y otros negocios quieren que use el formulario de *ellos*. Si un banco u otro negocio no acepta el formulario de poder notarial suyo, su representante puede pedir ponerse en contacto con el departamento legal de la institución y referirles a las leyes RCW 11.125.050 (https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.050) y RCW 11.125.200(3)(a) (https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.200).

A los representantes se les puede pedir una certificación. El banco puede decir que solo aceptará el poder notarial si el representante firma una declaración de "certificación" que confirme que el poder notarial es válido.

Esto es legal. Sin embargo, si el banco quiere una declaración de certificación, tiene que pedirla dentro del plazo de 7 días del día en que usted les entregue el poder notarial. Solo el representante tiene que firmar la declaración de certificación.

Trate de obtener ayuda legal si un banco o institución está negándose a aceptar el formulario de poder suyo o está exigiendo que use el de ellos.

Durable Power of Attorney for Health Care

My name is _____. My date of birth is _____.

1. **Agent.** I choose (*name*): _____ as my Agent with full authority to manage my health care.

   ☐ **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

   ☐ **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

2. **My Rights.** I keep the right to make health care decisions for myself if I am capable.

3. **Durable.** My Agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

4. **Start Date.** This power of attorney is effective on the day I sign it.

5. **End Date.** This power of attorney will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney will end if either of us files for divorce in court.

6. **Revocation.** I revoke any other power of attorney for health care documents I have signed in the past. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my Agent.

7. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to:

   ✓ Make health care decisions and give informed consent to my health care

   ✓ Refuse and withdraw consent to my health care

   ✓ Employ and discharge my health care providers

   ✓ Apply for and consent to my admission to a medical, nursing, residential, or other similar facility that is **not** a mental health treatment facility

   ✓ Serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended

   ✓ Visit me at any hospital or other medical facility where I reside or receive treatment

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8. **Government Benefits.** My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

9. **Mental Health Treatment.** Unless I give my Agent power of attorney for mental health care **and** I have a Mental Health Advance Directive that specifically consents to these things:

   - ✓ My Agent is **not** authorized to arrange for my commitment to or placement in a mental health treatment facility.
   - ✓ My Agent is **not** authorized to consent to electroconvulsive therapy, psychosurgery, or other psychiatric or mental health procedures that restrict physical freedom of movement.

10. **Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.

11. **Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.

12. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (*date*) _____
by (*name*) _____.

▶ _____

Signature of Notary
Notary Public for the State of Washington.
My commission expires _____.

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Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Durable Power of Attorney in my presence. I agreed to witness their signature at their request.

- I am not related to this person by blood, marriage, or state registered domestic partnership.
- I do not provide care for this person at home or in a long-term care facility.

Witness 1

_____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Witness 2

_____
Signature

Print name: _____

Address: _____

_____

Phone: _____

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Durable Power of Attorney for Health Care
Attachment: Contact Info

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

✓ I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

My health care agent

Agent's name _____

Agent's relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Agent's phone number _____

Agent's email address _____

My alternate health care agent (if any)

Alternate's agent's name _____

Alternate agent's relationship to me (friend, partner, spouse, sister, etc.)

_____

Alternate agent's phone number _____

Alternate agent's email address _____

My 2nd alternate health care agent (if any)

2nd alternate's name _____

2nd alternate's relationship to me (friend, partner, spouse, sister, etc.)

_____

2nd alternate's phone number _____

2nd alternate's email address _____

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Durable Power of Attorney for Finances

My name is _____. My date of birth is _____.

1. **Agent.** I choose (*name*): _____ as my Agent with full authority to manage my finances.

   ☐ **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my finances.

   ☐ **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my finances.

2. **My Rights.** I keep the right to make financial decisions for myself if I am capable.

3. **Durable.** My Agent can use this power of attorney to manage my finances even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

4. **Start Date.** This power of attorney is effective (*check one*):

   ☐ Immediately.

   ☐ only if my medical provider signs a letter saying I cannot make decisions for myself.

5. **End Date.** This power of attorney will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney will end if either of us files for divorce in court.

6. **Revocation.** I revoke any power of attorney for finances documents I have signed in the past. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my Agent.

7. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to:

   ✓ Make deposits to, and payments from, any account in my name in any financial institution

   ✓ Open and remove items from any safe deposit box in my name

   ✓ Sell, exchange, or transfer title to stocks, bonds, or other securities

   ✓ Sell, convey, or encumber any real or personal property

   ✓ Apply for and manage governmental benefits, including Medicaid

8. **Special Powers.** My agent shall also have the following powers:

   ☐ Yes ☐ No – Give gifts of my money or property

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☐ Yes ☐ No – Create, change, or cancel my rights of survivorship

☐ Yes ☐ No – Create, change, or cancel beneficiary designations

☐ Yes ☐ No – Give up my right to be the beneficiary of an annuity or retirement plan

☐ Yes ☐ No – Create, change, or cancel a trust

☐ Yes ☐ No – Tell a trustee to make distributions from a trust just as I could

☐ Yes ☐ No – Create, change, or cancel a community property agreement

☐ Yes ☐ No – Give authority granted in this document to someone else

9. **Accounting.** My Agent shall keep accurate records of my finances and show these records to me at my request.
10. **Nomination of Conservator.** I nominate my Agent as the conservator for consideration by the court if conservatorship proceedings become necessary.
11. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (*date*) _____
by (*name*) _____.

▶ _____

Signature of Notary
Notary Public for the State of Washington.
My commission expires _____.

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